Medway NHS
NHS Foundation Trust

PUBLIC MEETING OF THE TRUST BOARD
THURSDAY 30 JUNE 2016, 13.30 – 16.00
TRAFALGAR CONFERENCE SUITE, LEVEL 3 GREEN ZONE, MEDWAY MARITIME HOSPITAL

Time	Item	Subject	Presenter	Format	Action
1.30		Quality Insight – Management of Frailty in the Hospital	Ian Sturgess	Presentation	To note
OPENING OF THE MEETING					
2.00	1.	Chair's welcome and apologies for absence	Chairman	Verbal	To note
	2.	Quorum	Chairman	Verbal	To note
	3.	Register of Interests	Chairman	Paper	To note
MEETING ADMINISTRATION					
	4.	Minutes of the previous meeting held on 26 May 2016	Chairman	Paper	To approve
	5.	Matters Arising Action Log	Chairman	Paper	To note
MAIN BUSINESS					
2.10	6.	Chair's Report	Chairman	Verbal	To note
2.15	7.	Chief Executive's Report	Chief Executive	Paper	To note
2.25	8.	Strategy	Director of Strategy & Partnerships	Paper	To note
2.35	9.	Trust Recovery Plan	Executives	Paper	To note
2.45	10	Quality and Performance Reports a) Chief Quality Officer b) Clinical Operations Report c) Medical Director d) Director of Nursing e) Director of Workforce f) Corporate Governance Report g) IQPR Report	 Chief Quality Officer James Lowell Medical Director Director of Nursing Acting Director of Workforce Director of Corporate Governance, Risk, Compliance & Legal	Paper	To discuss
3.10	11	Finance Report	Finance Director	Paper	To note
3.30	12	Appraisal and Revalidation of Medical Staff Annual Board Report	Medical Director (Kirti Mukherjee)	Paper	To approve
3.35	13	Director of Medical Education's Annual Report	Medical Director (Jeanette Cansick)	Paper	To note
3.40	14	Communications Report	Communications Director	Paper	To note
FURTHER INFORMATION ITEMS					
	15	Single Quality Oversight Committee	Chief Executive	Verbal	To note
	16	Performance Committee Report	Chairman	Verbal	To note
	17	Audit Committee Report	Audit Chairman	Verbal	To note
	18	Investment & Contracts Committee	ICC Chair	Verbal	To note
	19	Quality Assurance Committee Report	QAC Chair	Verbal	To note
AOB					
4.00	20	AOB	Chairman	Verbal	To note
	21	Questions from members of the public relating to the Agenda	Chairman		
CLOSE OF MEETING					

		Date of next meeting: Thursday 28 July 2016, Trafalgar Conference Suite, Level 3 Green Zone, Medway Maritime Hospital

Medway NHS
NHS Foundation Trust

MEDWAY NHS FOUNDATION TRUST

REGISTER OF INTERESTS FOR BOARD MEMBERS

1.	Patricia Bain Director of Health Informatics	• Director of Qualitas Independent Consultancy Ltd • Specialist Advisor CQC • Associate Consultant Capsticks Legal • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
2.	Rebecca Bradd Director of Workforce	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
3.	Ewan Carmichael Non-Executive Director	• Timepathfinders Ltd • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
4.	Darren Cattell Interim Director of Finance	• Director and shareholder of Mill Street Consultancy Limited • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
5.	Stephen Clark Non-Executive Director	• 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
6.	Lesley Dwyer Chief Executive	• Member of the Corporate Trustees of Medway NHS Foundation Trust Charitable Funds
7.	Diana Hamilton-Fairley Medical Director	• 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
8.	Martin Jamieson Non-Executive Director	• Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Director, Lightpoint Medical Ltd • Senior Adviser, ArchiMed Private Equity • Non-Executive Director – C-Major Ltd • Strategic Planning Consultant, Rocket Medical Pl • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
9.	Anthony Moore Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
10.	Joanne Palmer Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
11.	Karen Rule Chief Nurse Designate	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
12.	Jan Stephens	• Trustee of Medway Youth Trust

	Non Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
13.	Shena Winning Chair	• Director, BBK Enterprises Limited • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
14.	David Rice Company Secretary	• Director and shareholder of Shooters Hill Management Co Limited

PUBLIC MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON THURSDAY, 26 MAY 2016 AT 1.30PM IN TRAFALGAR CONFERENCE SUITE, LEVEL 3, GREEN ZONE, MEDWAY MARITIME HOSPITAL

Present: Mrs. S Winning, Chairman
Mrs. L Dwyer, Chief Executive
Dr P Bain, Chief Quality Officer
Ms. B Bradd, Director of Workforce
Dr. D Hamilton-Fairley, Medical Director
Mr. M Jamieson, Non-Executive Director
Mr. T Moore, Non-Executive Director
Mrs. K Rule, Director of Nursing
Ms. J Stephens, Non-Executive Director

In attendance: Ms. P Bagnall, Director of Strategy & Partnerships
Dr. A Choudhury, Consultant in Emergency Medicine
Dr. A Da'Costa, Consultant in Emergency Medicine
Mrs. D King, Governor Representative
Mr. P Lehmann, Director of Communications
Ms. E McCallum, R&D Manager
Mr. D Rice, Trust Secretary
Dr M Shah, Consultant in Anaesthetics
Mr. B Stevens, Director of Clinical Operations, Co-ordinated Surgical Directorate
Mrs. L Stuart, Director of Corporate Governance, Risk, Compliance & Legal

Observers: Members of the public/staff/Governors (6)

QUALITY INSIGHT – INTERNATIONAL FORUM

Dr Choudhury gave a presentation on the International Forum. He explained that a team of directors and clinicians had attended the Forum to learn about initiatives and innovations to improve quality.

There followed a discussion about how the Trust had found it difficult to successfully introduce change. It was agreed that there were a number of factors which influenced this including:

- A lack of analysis of the bigger picture
- Staff failing to own specific projects leading to a failure for new ideas to become business as usual;
- Theoretical training but no clear practical application; and
- New practices focusing on a particular area or individual but not being disseminated across the Trust.

Following a video presentation, there was a further discussion about how change could be implemented differently in future and this could involve the following:

- Fewer projects would be selected;
- Projects would be have joined-up ownership; and
- A greater focus on longer term goals and ensuring resilience rather than fire-fighting.

There was a round the table discussion of the areas of the Trust which concerned the members of the Board, the executive team and the attendees at the meeting.

The Chairman thanked Dr. Choudhury for his presentation and looked forward to a new approach for instigating change focused on quality improvement and sustainability at the Trust.

16/05-01 WELCOME AND APOLOGIES FOR ABSENCE

The Chairman welcomed everyone to the meeting and in particular, Ben Stevens, a Director of Clinical Operations from the Co-Ordinated Surgical Directorate. Apologies had been received from the non-executive directors Ewan Carmichael, Stephen Clark and Jo Palmer.

16/05-02 QUORUM

The Chairman confirmed that a quorum was present.

16/05-03 REGISTER OF INTERESTS

3.1 The Chairman noted that the register of interests had been included in the board pack and if there were any changes required to be made they should be passed to the Trust Secretary.

16/06-04 MINUTES OF THE PREVIOUS MEETING

4.1 The minutes of the meeting held on 28 April 2016 were APPROVED for signature as a true and accurate account of the meeting

16/04-05 MATTERS ARISING – ACTION LOG OUTSTANDING FOR UPDATING

5.1 The Board of Directors RECEIVED the Action Log and the following updates were noted:

Action number PUB 0306 – To present a retention strategy to be finalised after the Workforce plan is finalised at the June 2016 Board meeting.

Action number PUB 0316 – To present the plans for implementing electronic patient records to the August Board meeting.

Action number PUB 0346 – The Digital Road Map to be brought to the August Board meeting.

16/06-06 CHAIR'S REPORT

6.1 The Chair highlighted that since the last meeting the Trust had been involved in the following areas:

- developing the Kent & Medway Sustainability & Transformation Plan (STP);
- a Single Quality Oversight Committee had been established and the Trust and regulators were meeting once a month to provide a collaborative approach between the Trust and regulators to support the next phase of the recovery plan. The group is chaired by Anne Eden, the Regional Director of NHS Improvement;
- there had been a positive Board to Board meeting with the Medway CCG on 19 May;
- an Improving Working Lives Awards ceremony was held at the Priestfield Stadium on 20 May which had been well attended;

- nominations have been received for the Governor Elections and there were 7 for Medway, 1 for Swale, 2 for the Rest of England and 1 staff governor.

At the private meeting of the Board held earlier in the day, the following had been agreed:

- a proposal for a 2016 clinical excellence awards scheme had been reviewed and approved up to a capped limit of £100k;
- a business case for the Bed Management and E-track and Trigger had been discussed and approved;
- a further version of the ED plan had been discussed with a full business case to follow at the board meeting to be held in June;
- The Trust's Annual Report and Accounts, following a recommendation from the Integrated Audit Committee had been approved; and
- a further version of the Operating Plan had been reviewed and a final version of the plan would need to be approved by the Board and submitted to NHSI by 10 June 2016.

The Board was reminded that these items were taken in private session because of their commercial sensitivity.

16/05-07 CHIEF EXECUTIVE'S REPORT

7.1 The Chief Executive presented her report and it was noted that:

- The report contained a section on Corporate Governance which will become a separate standing item for future reports;

- The Department of Health had agreed to pause the introduction of the new junior doctors contract to allow for an eight day negotiating period with the BMA and on 18 May 2016 it was announced that agreement had been reached by the British Medical Association Junior Doctors Committee, NHS Employers and the Secretary of State of terms which, subject to a referendum of BMA members, will form the basis of a new contract in 2016;

- The Trust continued to make plans towards making the site smoke-free with effect from October to coincide with the national stop smoking "Stoptober" campaign.

16/05-08 TRUST RECOVERY PLAN

8.1 The Board noted the Recovery Plan Status Update and associated papers. In summary the current programme status was as follows: -

- The Medical Model had now been in place for 9 weeks and was reducing patients length of time in ED;
- The Emergency Pathway Programme was now fully mobilised and the bed modelling project was reviewing capacity and demand across all directorates;
- The Deteriorating Patient Programme was making steady progress; and
- The Trust's trajectory for RTT was improving with the mobile MRI scanner helping to clear the backlog.

8.2 On the Trust's CQC action plan, the Trust had been working through the 73 actions of which 5 remained on a red status and related to staff numbers (2 actions), medicines management, patient transport service and complaints. There were also additional

actions for End of Life Care and Safeguarding. The red areas were now in the early stages of having actions applied to resolve them.

16/05-09 STRATEGY UPDATE

9.1 In discussion it was recognised that there were some 18-20 weeks before a further CQC inspection and there would be a Board workshop on 30 June to review the recovery plan in detail with particular emphasis on the plan to take the Trust out of Special Measures. The Board noted the presentation from the Director of Strategy & Partnerships which set out the process for developing a strategy for 2016-2020. The matter had been discussed in detail at the Performance Committee and the Board meeting held in private. A high level Strategic Intent to provide an integrated system of quality care for the local population had been shared with the management and clinical staff. The next stage would involve a process of stakeholder engagement with all key partners both internally and externally. It was expected that the strategy development work would be completed by the end of July or early August.

9.2 At the Medway Strategy Formulation Workshop held in November 2015 a strategic intent had been formulated and this was to cover four main areas:

- Focus on the health of the population;
- Develop an integrated system of healthcare through partnerships;
- Achieve clinical excellence; and
- Ensure sustainability and value for money.

9.3 The Steering Group covering Kent and Medway needed to prepare a Sustainability and Transformation Plan (STP) to be submitted to NHS England by the end of June 2016. The priority was for the partners across Kent to prioritise the health needs of the population rather than the healthcare entities. In financial terms Kent, as a health system, faced a deficit of £120m and there was an expectation that this would be eliminated by 2020.

9.4 Following a question with regard to public and patient engagement it was noted that there were mature models from Manchester and the West Midlands which could be used as examples of where there had been good community engagement for review and consideration. The Chief Quality Officer reported that there was a clinical aspect to the project and this would be presented to the Executive Committee. It is planned that the STP would be considered by the Board before the final version would be submitted to NHS England by 30 June 2016.

16/05-10 QUALITY & PERFORMANCE REPORTS

10.1 The executive directors presented their reports which were included in the Board pack. The Performance Review Scorecard highlighted the results of the key performance areas which were a summary of the full Integrated Quality & Performance Report.

10.2 The Chief Quality Officer reported that there were 34 Serious Incidents (SI's) currently open as at 11 May 2016. A trajectory had been set to reduce number of SI reports breaching and breach time.

10.3 With regard to Health Informatics, the Trust continued to work with the CCG on the system wide development of the digital road map. KPMG had provided a "positive assurance" in their draft report on the quality account indicators (62 day cancer waiting times, urgent referrals, screening and VTE risk assessment compliance). NHSE, the CCG and NHSI would be assessing the Trust's systems relating to 18 week reporting and management and, following this review, the commissioners and stakeholders will agree or not with the Trust's request to return to reporting in the next few months.

10.4 The Director of Clinical Operations reported that the Trust was not currently reporting externally for RTT and return to reporting was planned for June. The total incomplete waiting list size had reduced by approximately 1000 patients for April and this had been due to effective validation and a focus on delivering additional capacity. Incomplete performance for April stood at 69%, however, this was likely to increase to 72% for May due to increased activity. Cardiology performance remained a risk due to the lack of available capacity and limited outsource options. The backlog of patients waiting over 18 weeks was falling and the trends was below the trajectory. This had ensured positive feedback on the Trust at a recent meeting with NHSI.

10.5 The Trust had achieved a performance of 88.85% for diagnostic tests completed within 6 weeks compared to the national target of 99%. The three poorest performing areas were flexi sigmoidoscopy, gastroscopy and colonoscopy which was due to the shortfall in endoscopy capacity at Medway which was to be addressed with a review of the endoscopy function to ensure that it could cope with increasing demand. MRI was one of the biggest risk areas for imaging diagnostics, however, a mobile MRI scanner was now on site to help clear the backlog.

10.6 In ED there had been a 12% reduction in attendees from the previous month although the reduction in the number of ambulance attendances had reduced by only 7.5%. The ED 4 hour performance target had improved each month since February this year and stood at 77.81% for April. During April 1,062 patients had their care managed in the corridor for all or part of their stay which was a reduction of 24% from March and the second lowest figure this year. Regarding ambulance performance, the Trust had seen 3,115 ambulance arrivals in April with 54.5% of patients being handed over within 15 minutes which showed Medway as third best in the sector.

10.7 The Board noted the Cancer update and at a meeting held between the Trust, Maidstone and Tunbridge Wells assurance had been provided that the Trust was providing a safe service. The Trust had failed to achieve the GP referral standard but performance had improved on the previous two months. There was a discussion around the setting of trajectories for Cancer, ED, RTT and Diagnostics and how these would need the approval of NHS England. It was clarified that these trajectories were not specific to Medway and it was agreed that these should be presented to the next Board meeting for consideration.

ACTION: **The Board to consider the trajectories which had been discussed with NHS England.**

10.8 The construction of new road layout had placed more pressure on ED, however, it had been possible to maintain the same rate of elective surgery.

10.9 The Medical Director reported that the Medical Model was now in its 10th week and was becoming business as usual. The nursing staff were in agreement not to use the second escalation ward.

10.10 Following Dr Hussein's appointment to a new position, the role of Director of Medical Education has been revised to enable two Deputy Medical Directors to be appointed to support Dr Janette Cansick, the Director of Medical Education. The two appointees were Dr Virginia Bowbrick and Dr Rajesh Hembrom who brought with them a broad range of expertise.

10.11 The Director of Nursing gave her report noting the nursing revalidation process had started on 1st April 2016 and there was continued interest in the workshops and to date over 130 members of staff had attended.

10.12 There had been 73 inpatient falls in April which represented a decrease on the previous month and the lowest number since 2014. In April there were eight pressure ulcers graded 2 but none were graded 3 or 4. During Q4 2015/16 there had been a 28% reduction in the total number of pressure ulcer incidents in the Trust and a 44% reduction in grade 2 pressure ulcer incidents compared to the same quarter last year. A further analysis was being carried out as 37% of pressure ulcers related to end of life patients.

10.13 The Trust had not met the target for MRSA screening as it had 94% compliance and a Regulation 28 of the Coroners (Investigations) Regulations 2013 Report, to prevent future deaths was received following the death of an MRSA case and this had led to a list of actions for the Trust to take forward. There were no major issues with diarrhoea and vomiting due to the Norovirus this year and the wards and infection control team were commended for managing the situation.

10.14 It was reported that there had been a quarterly census of the number of adult in-patients with dementia, suspected dementia and delirium (without dementia) which impacted on the appropriate staffing required and therefore affecting the nursing strategy.

10.15 Work was continuing on the delivery of the End of Life Care Improvement plan and a review of the EOLC incidents was being carried out by the End of Life Steering Group and would involve learning from incidents and complaints received by the ward. Staff and relatives who had raised concerns would be contacted by an End of Life Care CNS. The National End of Life Care Audit was noted and they demonstrated that Medway was performing well compared to the national benchmark; areas like hydration and assisted feeding which needed attention were part of an overall improvement plan monitored by the Quality Assurance Committee.

10.16 On assurance, April had seen 21 Perfect Ward inspections across 21 different areas with an average score of 83% and most wards had completed a web based Super-7 audit in April. There was a zero score for where staff could describe a change in practice or learning from a complaint or incident and this was being addressed through nursing quality forums to ensure the cascading down of information from the level of ward sister.

10.17 The Director of Workforce reported that a number of actions were being undertaken to address the staffing gap which included a focus on recruitment to business critical posts, accelerating the recruitment process and developing a recruitment and retention plan. Following the review of the workforce budgets for 2016/17 the vacancy rates had changed and stood at 25% for nurses and midwives, 17% for consultants and 15% for healthcare assistants. In terms of retention April was the third month in a row when there had been more starters than leavers.

10.18 The Trust's recruitment process took on average eleven weeks compared an average of ten for benchmarked trusts.

10.19 Following the implementation of the staff bank there had been a marked improvement in the rate of filling the posts of Clinical Support Workers.

10.20 The retention of nurses at the Trust remained at a similar level since the previous month (9.66% compared to 9.67%) but had improved over the last six months. Turnover for staff under one year's service remained high at 17%, however there was also a downward trajectory with 79.78 whole time equivalents within the last six months compared to 243.72 overall in the last year.

10.21 There would be a First and Lasting Impressions event on 27th May and a further one in July which was an event for new starters within the first three months (and after one

year). This was a new initiative to provide HR with an insight into their experiences and what is needed by them to support them at the Trust. The feedback is used in conjunction with feedback from leavers in addressing any issues.

10.22 The Staff Friends and Family test for Quarter 4 had been undertaken in March 2016. All staff had been encouraged to complete the survey. The response rate was 19% of all staff, a fall from 23.1% for Quarter 2 in 2015. Since the last survey the percentage likely to recommend the Trust to friends and family for care had fallen from 68% to 66% but there was an increase from 49% to 52% from those recommending the Trust as a place to work.

10.23 Workforce was a critical enabler for the delivery of the Trust's recovery objectives. The priority workforce programmes for the next six months have been agreed as part of the Recovery Plan by the Executive and would form part of the workforce strategy to be presented to the Board and included the following areas:

- Workforce modelling
- Staffing recruitment and retention plan
- Temporary staffing plan
- Staff engagement and culture change
- Workforce informatics

ACTION: Presentation of a Workforce and Organisational development Strategy to be presented at the Board meeting in June.

10.24 Leadership was key to staff engagement and culture and it had been recognised that there was a developmental need in this area due to the new multidisciplinary leadership teams and developing leaders. A multi-disciplinary leadership forum was held on 10 May 2016 which had focused on Respecting Others.

10.25 The Every Person Counts (Respecting others) anti-bullying campaign continued and awareness training had started that month and materials distributed to managers following the launch of the new behaviours as part of the Trust's new Vision and Values.

10.26 Following the executives reports a number of areas were queried as follows:

(a) There was a discussion about improving the level of infection rates and it was noted that the focus had been on protecting the beds in the orthapaedic department. It was queried whether best practice included a specific target and Mr Stevens agreed to confirm the target outside of the meeting. It was noted that bed numbers would be reduced with the closure of the second escalation ward.

(b) On End of Life Improvement Programme had been reviewed by the Trust's End of Life Steering Group who had confirmed that it met the national guidelines and some progress had been made to date in delivering some of the actions. In addition there was a transforming nursing care programme, which had not been formally launched and there would be sub-groups led by named matrons, focusing on the areas of nutrition, hydration and personal hygiene.

(c) For palliative care the Trust offered a seven day service between 9am and 5pm. It was explained that specialist palliative care was a service commissioned from the Medway Community Healthcare and was available on site Monday to Friday between 9am and 5pm and out of these hours there was a telephone helpline in operation.

(d) There was a discussion about the return to reporting and it was confirmed that NHSI had visited the Trust that day and that reporting would be in June in relation to the May data.

(e) In response to a question about the nurse bank it was noted that the use of the Trust's own nursing bank had enabled the improvement to the 1 to 8 nursing staff to patient ratio.

(f) In response to an enquiry in respect of clinical coding development it was noted that there had been continuing improvement in clinical coding and that coding had increased from 2 to 4 (by comparison GSTT would be at a level of 12). The improvement in this area was having a positive impact on the Trust's Hospital Standardised Mortality Ratio (HMSR) which continued to show a downward trend and currently stood at 102.76. Clinical coding was an area which formed part of a larger project to raise the level of the Trust's generated income.

16/05-11 FINANCE REPORT

11.1 The Director of Finance reported on the Trust's financial performance for month 1 of the year 2016-17. It was confirmed that last year's run rate would be used for the first three months of the current financial year. The month 1 performance was in-line with the financial situation at the end of the previous financial year with cash flow relatively strong.

11.2 The Board noted the status of the loan conditions clause 8.2 being the most pressing as this required that agency nurses were employed within the maximum agency cap. There was increasing compliance with price caps and this was now on an improving trajectory.

11.3 The Director of Finance reported that the directorates each had their own list of specific actions which would involve the phasing in of cost improvements by the end of the financial year.

11.4 The Finance Director referred the Board to the Balance Sheet and in particular the section on debtors noting that the trade receivables debt outstanding to the Trust had continued its downward trend and was £2.7m lower than in March 2016. The NHS debtors had fallen by £2.07m month on month. This represented a significant step in the first milestone which was to review and update all areas of control and process that impact on financial delivery.

11.5 There was a discussion regarding the metrics contained in the Carter Report and it was confirmed that the template dashboard contained in the report would be used by the executive team.

11.6 Ms Stephens noted that in previous reports there had been a schedule comparing staff numbers to value and but this appeared to be missing from this month's report. It was agreed that this should be reinstated.

ACTION: **To reinstate the staff data schedule comparing staff numbers to value.**

11.7 Ms Stephens noted that the Carter Review suggested significant cost improvements would be expected by the end of the financial year and queried if the process had started for them to be identified. The Finance Director explained that this would involve an in-depth consultation with the directorates and Mr Stevens explained that there were some 340 CIP ideas under consideration 160 of which had yet to be quantified and that there would also be benefits from wider efficiencies across the Trust.

11.8 Mr Moore referred to the run-rate analysis and suggested that it would be helpful if this covered a 15 month rather than a 12 month period and this approach was agreed.

ACTION: **For the Finance Report to include a run-rate analysis for a 15 month rather than a 12 month period.**

11.9 Mr Moore noted on the Clinical Activity table that total actual PBR activity for the year to date stood at 51,799 while the prior year in month was 44,427, however, the income did not appear to have altered significantly. The Finance Director noted that this was due to an increase in short stay patients which had kept the income level constant.

ACTION: **The Finance Director agreed to investigate the disclosure of PBR data.**

11.10 There was a discussion around the budget and the fact that the income from the CCG had yet to be settled and some CQUINs had not been agreed. The Director of Nursing noted that the review of CQUINs was being carried out by a multi-disciplinary team. The Chief Quality Officer explained that CQUINs were presented at the monthly meetings of the Quality Assurance Committee.

16/05-12 EMERGENCY PREPAREDNESS, RESILIENCE & RESPONSE GROUP ANNUAL REPORT (EPRR Report)

LS joined the meeting.

12.1 LS joined the meeting and explained that the EPRR report provided assurance to the Board that the Trust was prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response. An EPRR Work Plan for 2016/17 had been attached for information.

12.2 The report provided evidence that the Trust will comply with the core standards, however, more focus was required for continuing support and that this was being addressed with assistance from the Executive Lead for EPRR for 2016/17.

12.3 There was a discussion regarding the staff training required for a major incident. It was noted that whilst training was available it was not always taken up by staff and that this was being actively followed to ensure that all relevant staff had received the training.

12.4 The Chair thanked Mrs Stuart for reaffirming the Board's understanding of the matter, noting that this was being taken forward by the Executive and that the workplan for 2016/17 was acceptable.

LS left the meeting.

16/05-13 RESEARCH & DEVELOPMENT ANNUAL BOARD REPORTS

Ms Edyta McCallum joined the meeting.

13.1 The Board noted the Research & Development Annual Report for the period to 1st April 2015. The Medical Director explained that the report demonstrated the Trust's commitment to research and development and how it earned the Trust over a £1million per annum.

13.2 The Trust was actively involved in research supported by the National Institute for Health Research. For the period 1 April 2015 to 31 March 2016, there were a total of 147 research studies across 21 specialties conducted at the Trust.

13.3 The active research programme played a key part in the Trust's commitment to improving patient outcomes. Between 1 April 2015 and 31 March 2016 the

Investigators at the Trust published fifteen articles. The continued growth in research activity indicated the Trust's commitment to work in successful partnership and to provide flexible, first class health care to local people and to improve patient outcomes across the NHS.

13.4 The Chairman noted the successful presentation by Dr Kanagaonkar to the Governors earlier in May when he explained some of the projects he had been involved with at the Trust.

13.5 There was a general discussion about the importance of ensuring effective communication about research and development.

Ms McCallum left the meeting.

16/05-14 COMMUNICATIONS REPORT

14.1 The Board took the Communications Report as read. The Director of Communications reported that the last few weeks had been successful in terms of improving the Trust's external profile and there was continued building of staff engagement.

14.2 A considerable effort had been made to ensure that both staff and stakeholders knew about the letter from Sir Mike Richards to Jeremy Hunt which had noted that the latest CQC inspection in March had demonstrated the considerable improvements made at the Trust.

14.3 There had been an item on the BBC regarding the Home First project and this included a positive patient interview.

14.4 The site was expected to be Smoke-Free by October this year and there would be a members event in July to explain the steps to make this happen and local residents would be invited to attend.

16/05-15 PERFORMANCE COMMITTEE REPORT

15.1 The Chair reported that at the Performance Committee meeting held earlier that day there had been a further discussion about the STP and a first draft of the Recovery Plan.

16/05-16 AUDIT COMMITTEE REPORT

16.1 The Chairman of the Audit Committee noted that at an extraordinary meeting of the Committee the Annual Report and Accounts had been reviewed and questions asked of both the external and internal auditors, KPMG and Deloitte respectively.

16.2 Mr Jamieson congratulated the Finance department for their assistance in ensuring that the Annual Report and Accounts were completed within the deadline.

16.3 Mr Jamieson had recommended that the Financial Accounts be approved following the audit by external auditors Deloitte. This had been addressed at the private meeting of the Board held that day prior to the Board meeting.

16.4 The project to analyse the productivity of the Trauma and Orthopaedic department was continuing with a review to follow by the Chief Executive and the Chief Medical Officer.

16.5 On Counter Fraud there would be a Fraud Awareness Week in June and this would serve to alert staff to being vigilant in spotting cases within the Trust.

16.7 KPMG, as internal auditors, had carried out a review of the Trust's activity and income and concluded that the interface between the operational systems and the financial system was robust.

16/05-17 CHARITABLE FUNDS COMMITTEE

17.1 Mr Moore reported that the Committee had met on 5 May 2016 and had determined that list of actions which included consolidating the 180 funds to around 20. It was the intention to encourage the investment of the funds balance. A further meeting was scheduled for later in the summer with some recommendation for the Board members, as trustees of the Fund, to consider.

16/05-18 QUALITY ASSURANCE COMMITTEE REPORT

18.1 Ms Stephens reported on behalf of the Committee Chairman, Mr Carmichael. The May meeting of QAC was cancelled because of the Trust's first year anniversary to the "sign up for safety" programme and both non-executives directors had attended the all-day event.

18.2. The Safety Day had been successful and the directorates were encouraged to send more attendees where possible.

18.3 A couple of key points arising from the Safety Day were that there is not consistent compliance with the sepsis bundle and the recording of fundamental information such as fluid balance with acute kidney injury still requires improvement. There was a recognition that all healthcare professionals in the hospital must understand the role they need to play in the prevention of pressure ulcers so that when patients are discharged their skin is in the best condition possible.

16/05-19 ANY OTHER BUSINESS

19.1 Mrs King noted that the Governors would like to have an update from the Charitable Funds Committee at the next meeting of the Council of Governors meeting in July.

19.2 The Board noted the improved format of the board papers and it was appreciated that they had been circulated a week ahead of the meeting to allow time to be reviewed prior to the meeting.

19.3 The Chair thanked the Company Secretary and Sharon Tree for their hard work in achieving this.

16/05-20 QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

20.1 There was a question regarding whether there was a project for the Trust to have a consistent corporate image with regard to décor, notices and communications in general. It was noted that this was a matter currently under review by the Director of Nursing and the Director of Communications.

ACTION: **A review of the Trust's corporate image to be carried out by the Director of Nursing and the Director of Communications.**

20.2 The topic of bullying was raised and whether there was adequate support for staff where they were bullied by their managers. BB noted that staff could talk in confidence to independent counsellors.

20.2 There was discussion about outpatients and patient correspondence and how it was an area which needed to be improved. The Chair noted that this was included within the Trust Recovery plan.

16/05-21 DATE OF NEXT MEETING

The next meeting of the Trust Board will be held on Thursday 30 June 2016 in the Trafalgar Conference Suite, Level 3 Green Zone, Medway Maritime Hospital.

The meeting closed at 4:00pm

Shena Winning: Date:
Chair

PUBLIC BOARD ACTION LOG
ITEM 05
Bd/16/06-05

Medway NHS
NHS Foundation Trust

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB-0306	24/9/15	9.7	To present a retention strategy to a future Trust Board meeting	Director of Workforce	To be added to the January Board agenda. 22/1/16 – Strategy to go to the Clinical Executive Group prior to Board. Proposal to be made after Workforce plan finalised at the **July 2016** Board meeting.	Open (red)
PUB-0316	26/10/15	14.5	To present the plans for implementing electronic patient records to a future Trust Board meeting.	Chief Quality Officer/ Director of Health Informatics	21/04/16 Aiming to present to the **August Board meeting**	Open (red)
PUB-0338	26/11/15	8.5.9	To provide an update at the December Board meeting of the internal audit reviews of the Trust's financial controls and financial planning.	Director of Finance	24/06/16 – Awaiting report from Audit Committee	Open (red)
PUB-0346	25/02/16	11.2	The Digital Road Map would be brought to the August Board Meeting	Company Secretary	22/04/16 - To be presented at the **August Trust Board meeting**	Open (red)
PUB-0349	31/03/16	9.10	Update explaining the significance of research and development income to the Trust	Medical Director	22/04/16 – See item 13 on May agenda	Closed (green)
PUB-0355	28/04/16	9.5	Diana Hamilton-Fairley to prepare a report explaining the significance of research and development to the Trust for the May meeting	Medical Director	20/05/16 See Item 13 on May Board agenda	Closed (green)
PUB-0356	28/04/16	10.5	To check the increase in non-elective patient compared to last year	Finance Director	20/05/16 Finance Director to provide verbal update at May meeting	Closed (green)
PUB-0357	26/05/16	10.6	The Board to consider the trajectories which had been discussed with NHS England	Clinical Ops	24/06/16 to prove an update at June meeting	Open (red)
PUB-0358	26/05/16	10.22	Presentation of a Workforce and Organisational development strategy to be presented at the Board meeting in June	Director of Workforce	24/06/16 to be presented at the July meeting	Open (red)
PUB-0359	26/05/16	11.6	To reinstate the staff date schedule comparing staff numbers to value	Director of Finance	24/06/16 Finance Director to address	Open (red)
PUB-0360	26/05/16	11.8	For the Finance Report to include a run-rate analysis for a 15 month rather than a 12 month period	Finance Director	24/06/16 Finance Director to address	Open (red)
PUB - 0361	26/05/16	11.9	The Finance Director agreed to investigate the disclosure of PBR data	Finance Director	24/06/16 Finance Director to provide an update	Open (red)
PUB-0362	26/05/16					

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date: 30 June 2016

Title of Report	Chief Executive's Report
Reporting Officer	Lesley Dwyer
Lead Director	Lesley Dwyer
Responsible Sub-Committee	
Executive Summary	The Chief Executive's report provides the Board with an update on key issues since the last meeting of the Board that are not covered elsewhere on the agenda.
Risk and Assurance	Detailed within the report.
Legal Implications/Regulatory Requirements	
Recovery Plan Implication	The content of this report supports the recovery plan.
Quality Impact Assessment	Not Required.
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	The Board are asked to note the information within the portfolio reports and direct any questions to the responsible executive to provide views on their assurance in relation to the information and responses given.
Recommendation	The Board are asked to note the information contained within the Chief Executive's report

Chief Executive's Report: June 2016

Background

The Chief Executive's report provides the Board with an update on key issues since the last meeting of the Board that are not covered elsewhere on the agenda.

1. PERFORMANCE

(a) The Monthly Operations Report, item 10b, on the Public Trust Board agenda, provides the Board with an update on the following areas:

Referral to Treatment (RTT)
Diagnostics
Emergency Department Performance
Cancer Performance
Site/Flow Update

(b) Following on from last month's Chief Executive's report, the Monthly Operations Report also includes an update on the Remedial Action Plans RTT trajectories.

2. CARE QUALITY COMMISSION (CQC)

On 3 June 2016, the Care Quality Commission (CQC) attended our Swale special needs nursery, situated within the Orchards Multi Agency Specialist Hub (MASHs) centre for disabled children and their families. The visit was prompted by the Trust identifying a need to register the nursery with the CQC. The visit resulted with CQC agreeing that the unit was fit for registration and that a full inspection would follow in due course. A formal report has not yet been received by the organisation however the centre is now permitted to continue to provide normal services.

3. CORPORATE GOVERNANCE

This month, the Corporate Governance report is an item on the Public Trust Board agenda, item 10f, and will be presented by Lynne Stuart, Director of Corporate Governance, Risk, Compliance & Legal.

4. JUNIOR DOCTORS' INDUSTRIAL ACTION

ACAS confirms the agreement between the BMA, NHS Employers and the Secretary of State for Health of negotiated terms which, subject to a referendum of relevant BMA members, form the basis of a new contract in 2016. The referendum is scheduled to take place from 17 June - 1 July 2016 and results will be known by 6 July 2016.

5. HORIZON SCANNING

There have been a number of stories in the media recently around the health service both locally and nationally

- The problems encountered by SECAMB continue to mount. The departure of the chief executive, Paul Sutton, was announced at the end of May. Earlier this month, leaked initial findings from a CQC investigation reported a culture of bullying and harassment. The CQC's full report is awaited.
- The High Court ruled against Kent Community Health's bid to overturn the award of community care services to Virgin Care in Sittingbourne and Sheppey as well as Dartford and Gravesend.
- North Middlesex hospital in Edmonton, North London, has been seeking help from other Trusts to deal with the shortage of A&E consultants and avoid the need for its A&E to close. The CQC issued a warning notice to the Trust, ordering a significant improvement in the treatment of patients in A&E.
- Simon Stevens, chief executive of NHS England, made a speech to NHS leaders at which he noted that the NHS might need near the top end of the £8m-£21m extra funding over the next five years, forecast in the 2014 NHS Forward View document.

6. SMOKING

We are making good progress with our drive to go smoke-free. Hopefully Board members will have seen the banners and posters publicising this around the hospital. Since the last Board meeting, we have announced to staff that the date of go-live will be 17 October, and communicated this to the media, our local ward councillors and MPs.

Various initiatives are planned to support the move to going smoke-free: these include, ensuring that nicotine replacement therapy is stocked on wards around the hospital, designing training for ward-based staff and others, scoping what enhanced security is needed, and designing highly visible no-smoking signs for the public

The Trust continues to work very closely with the stop smoking team at Medway Council, whose support has been invaluable.

We are holding a meeting on 13 July for Foundation Trust members and residents around the hospital, to discuss and gain input into our plans.

7. ATTENDANCE AT CONFERENCES

Earlier in the month, James Lowell, Director of Clinical Operations – Women & Children's Directorate, and Rebecca Bradd, Acting Director of Workforce, attended the NHS Confederation Annual Conference & Exhibition in Manchester. This year the conference, in addition to building on the momentum for change, focused on the huge effort underway in the NHS, and wider health and care system, to transform

care for patients. Having attended many informative seminars, workshops and discussions, James and Rebecca will share their findings with the executive team and wider hospital teams.

8. ORGANISATIONAL STRUCTURE

The interviews for the Director of Communications and Directors of Nursing positions have now been arranged and will take place during the last week of June and mid-July.

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date: June 30th 2016

Title of Report	Progress Report on the Kent and Medway Sustainability and Transformation Plan
Reporting Officer	Pippa Bagnall Director of Strategy and Partnerships
Lead Director	Lesley Dwyer Chief Executive
Responsible Sub-Committee	There is a Kent and Medway Steering Group which has overall responsibility for the development of the STP and accountability to NHS England and NHS Improvement. Glenn Douglas, CE of MTW is the SRO.
Executive Summary	NHS England published The Five Year Forward View on October 2014. This set of the direction for achieving the triple aim of reducing the inequalities gap, the quality gap and the financial gap. The Sustainability and Transformational Plan (STP) is expected to set out the 3-5 main priorities for system redesign and transformation. The Kent and Medway STP is one of 44 across the country. A checkpoint version of the STP will be submitted to NHS England and NHS Improvement on June 30th. Feedback is expected in early July and this will shape the further development of the STP. The STP is supported by a Financial Plan.
Risk and Assurance	Nil at present
Legal Implications/Regulatory Requirements	Nil at present
Recovery Plan Implication	The STP is complimentary to the recovery plan and sets out a longer term plan to 2020/21 for system wide health and social care service improvement and financial sustainability.
Quality Impact Assessment	N/A
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	This paper is for information
Recommendation	The Board is asked to note the paper

Medway NHS
NHS Foundation Trust

MFT Board Paper June 30th 2016

Kent and Medway Sustainability and Transformation Plan

Context

The Five Year Forward View (published in October 2014) set out the reasons why the NHS must change and encouraged new ways of designing and delivering high quality and safe health and social care within a financially sustainable system.

The triple aim is to:

- Reduce the inequalities gap
- Reduce the quality gap
- Reduce the financial gap

Some of the transformation can be brought about by the NHS itself. Other actions require new partnerships with local communities, local authorities and employers. Some critical decisions – for example on investment, on various public health measures, and on local service changes will need collaboration and joint decision making across Kent and Medway.

The "Delivering the Forward View: NHS Planning Guidance 2016/17-2020/21" was published in December 2015, quickly followed by the Technical Guidance for NHS Planning in 2016/17 in January 2016. This guidance led the way to the development of Sustainability and Transformation Plans (STP). There are 44 across the country.

An initiation document was prepared for Kent and Medway which set out the governance structure and process for development of the STP. Glenn Douglas was appointed as the Chairman/SRO of the STP steering group by Simon Stevens, Chief Executive of NHS England.

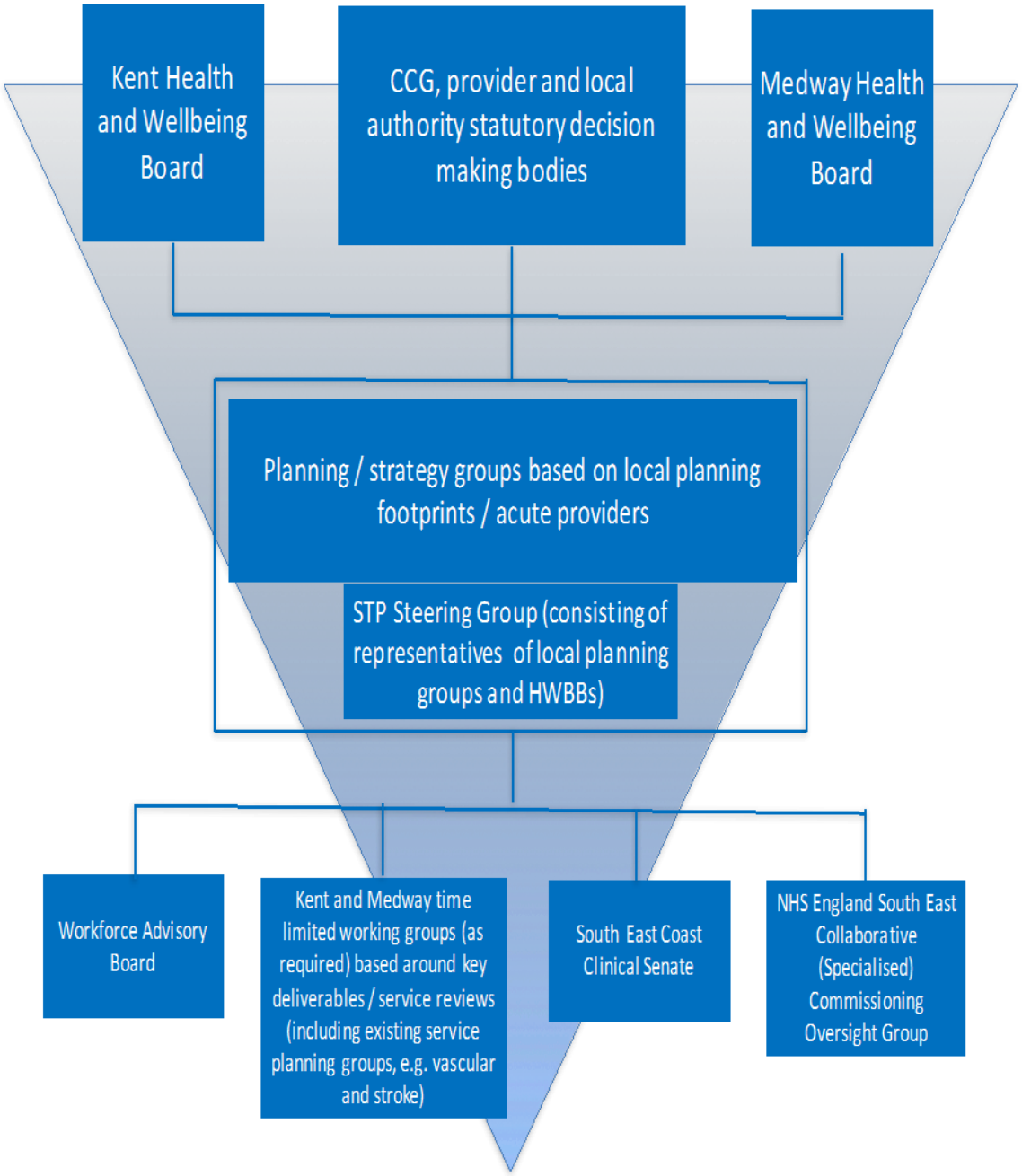
The role of the Kent and Medway STP Steering Group is to:

- establish a senior leadership team from across health and social care to support strategic planning, including enabling the development of a shared vision and objectives
- agree those projects and initiatives / strategies that need to be progressed at a Kent and Medway level
- establish a planning arrangement to ensure the successful delivery of the Kent and Medway initiatives / strategies
- identify collective strategic priorities and hold each other to account for their delivery

- ensure links and consistency with STP and Better Care Fund plans
- shared problem solving to ensure the effective delivery of shared objectives.

Diagram 1 sets out the original structure for the development of the STP. As the process has evolved it has become apparent that the requirements for system leadership and governance require further development. Meetings are taking place with NHS England and senior leaders across Kent and Medway to determine the longer term resource and leadership arrangements.

Diagram 1 STP Governance and Engagement Structure



First submission

The first version of the STP was submitted using an NHS England prescribed template of 10 slides on April 15th 2016. Feedback from NHS England and NHS Improvement soon afterwards indicated that the Kent and Medway STP must be a single footprint rather than four separate chapters and we should be bold and set out our 3-5 top priorities. It was acknowledged that every footprint is at different starting points in terms of their current position and their proposals for the future.

June 30th Submission Checkpoint

The Steering Group has continued to meet regularly to shape and prepare the next version of the STP for submission due on June 30th.

The STP has five broad themes which include:

- The development of out-of-hospital care through the integration of primary, community and social care.
- Designing the future of in-hospital acute care
- Developing mental health services to deliver parity of esteem
- Promotion of health and prevention of ill-health
- Achieving a financially sustainable system.

The submission will form the basis for face to face personal conversations with the national leadership in the NHS during July. Following this there will be further development of the STP including consultation and engagement with a wide group of stakeholders.

Next stage of development

Once feedback has been received the Steering Group will reconvene to agree the next steps. It will be necessary to identify adequate resources to support the delivery of the STP objectives.

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

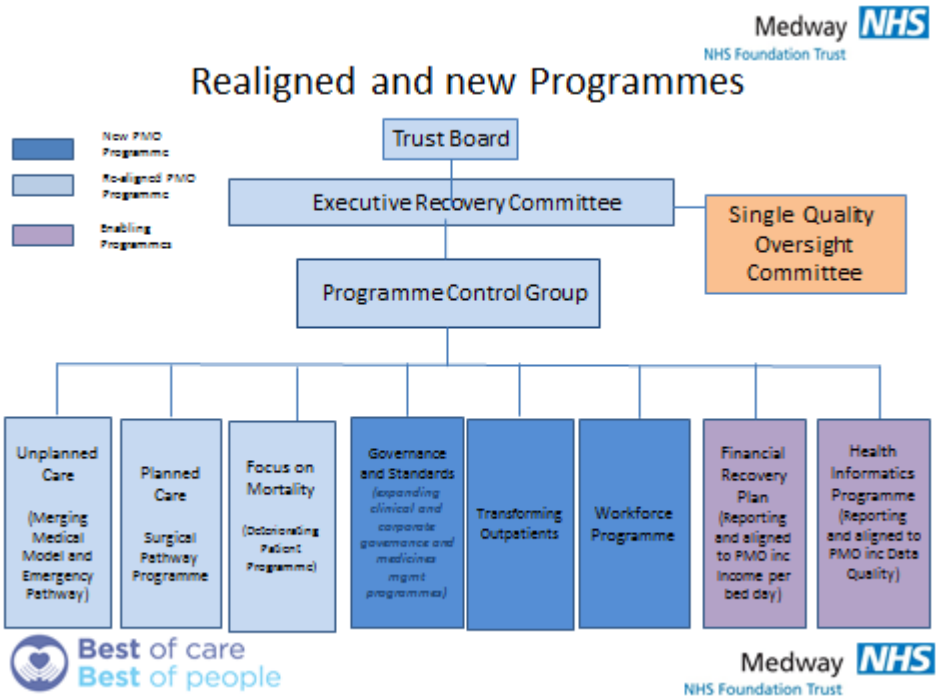
Board Date : 30 June 2016

Title of Report	Recovery Programme Status Update
Reporting Officer	Jane Rooney, Programme Director
Lead Director	Jane Rooney
Responsible Sub-Committee	
Executive Summary	Summary of the Recovery Programme progress includes: • An update on the progress of the Unplanned Care Programme and the progress made to date. An update on the improvements recognised through the Medical Model as it entered its 14th week • An update on the Focus on Mortality Programme progess, recent milestones achieved and plans to progress • An update on Workforce providing an overview of the work that is now being supported through a programme within the PMO • An update on Communications explains the commencement of the communications strategy for Recovery Phase 2 • An update on the Governance and Standards Programme detailing progress made to date on planning for the next CQC visit and reporting going forward
Risk and Assurance	Key risks to delivery of The Recovery Programme are detailed in Recovery Board Status Update Paper and were agreed as part of the CQC Quality Improvement Plan. Management actions are also detailed in this paper.
Legal Implications/Regulatory Requirements	Progress and achievement of the Recovery Plan will enable the Trust to exit Special Measures and provide a substantial financial platform.
Recovery Plan Implication	
Quality Impact Assessment	N/A

Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Assurance
Recommendation	No decisions are required – for information only

Update for Recovery Plan: Summary

Three weeks ago, the Trust Recovery Plan phase 2 commenced with six key programmes and two enabling programmes



No programme from phase one has been lost but several have developed into more mature, expanded programmes to be taken forward.

The Programme Management Office (PMO) continues to move at pace, progressing these programmes of work which are all supported by workstream leads from within the organisation thus ensuring full integration across The Trust.

Reporting structures for all programmes have now been agreed providing high level milestones against which progress can be monitored. In addition, a suite of reports is being produced at monthly, fortnightly and weekly intervals to monitor progress at various levels of granularity. Currently all programmes are on track with the exception of Planned Care which has a revised date for production of the planning documentation. The CQC programme is currently 2 weeks ahead of schedule.

This month, the key focus has been on planning and preparation for the '20 week plan' relating to CQC and the next visit in November. Forming part of the Governance and Standards programme, we now have a clear view of the plans for identification of risk, monitoring, action planning, escalation, inspection and reporting.

Good progress has also been made on the Workforce programme as workshops on each workstream have identified the key priorities for action in the coming weeks.

Supported by Guys and St Thomas', we have also made good progress on the scoping and planning related to Planned Care. This significant programme will drive efficiency into the surgical pathway allowing our already safe service to operate more effectively

Medway NHS
NHS Foundation Trust

Trust Recovery Plan
Status Update to Board

June 2016

Medway NHS
NHS Foundation Trust

Contents

1. Highlights

Phase two of the Recovery Plan continues to make progress at pace and in line with timelines agreed by the Executive Team. Milestones achieved during June include:

- The Unplanned Care pathway has shown a 30% reduction in overall waiting times in ED for 95% of patients between April and the end of May. The Medical Model has now entered its 14th week and continues to drive service improvements
- The Focus on Mortality Programme continues to make progress and has reached the set milestones this month
- Governance and Standards Programme is moving at pace with agreement reached on reporting processes
- The Planned Care Programme team is being established and initial scoping work is taking place
- Communications has initiated the first phase of the communications strategy for The Recovery Plan phase 2

2. Priority Programme Status

2.1 Governance and Standards Programme (Previously CQC)

The Governance and Standards programme is now moving forward at pace. The programme manager has now commenced and the planned phase for the programme is complete. The programme has been renamed 'Governance & Standards' to reflect the need of the organisation to deliver a sustainable process that integrates with normal everyday working. Reporting structures have been agreed with NHSI and will be shared at The Oversight Committee in early July.

A baselining exercise is being undertaken and will be finalised by early July. This will highlight known risks and plans to address them. Mock inspection planning is also now finalised for the 20 week period to the inspection.

Governance processes are in place to integrate the overall recovery plan with this programme to ensure Trust wide synergies are maximised, risks are flagged and there is no disconnect between the actions needed for a successful inspection and the work being undertaken

2.2 Planned Care

Scoping work is being undertaken between the Surgical Directorate and the PMO to clearly identify the work streams required

A workshop is planned for July to confirm work stream leads, governance structure and programme launch arrangements. It will also encompass a diagnostic of the day surgery and pre-assessment areas.

GSTT is supporting on the programme and expect to have a full scope agreed by mid-August. Following this, action plans will be developed with phase 1 plans being implemented by September 2016.

2.3 Focus on Mortality

The Deteriorating Programme continues to make progress in key areas. Handover processes and additional key training will commence imminently.

Software to support the identification and escalation of deteriorating patients will be in place by January 2017. Additional specialist staff recruitment is underway and the Avoidable Harm Project has commenced.
The Green Book developed by Junior Doctors as part of this programme has won the Quality Improvement & Clinical Audit Awards 2016.

2.4 Unplanned Care Programme

The second phase of the Trust Recovery Plan sees the alignment of the Medical Model with the broader Emergency Pathway Programme to form the Unplanned Care Programme.

There have been a number of demonstrable improvements across aligned programme in the last month including

- 30% overall reduction in waiting times in ED
- Reduction in overall length of stay from 6.5 to 5.5 days
- Better use of the acute admission wards to avoid co-horting of patients
- Review of the Frailty and emergency surgical pathways by ECIP
- Almost 150 patients being seen as part of the Home First initiative

2.5 Workforce

Recruitment and retention remain a trust priority and this continues to receive significant focus.
Workforce has been drawn into the PMO and as such is now being managed through a programme approach with clear milestones and actions being monitored and reported to the Trust executive.
Additional support from GSTT to support this is being discussed with GSTT on 27th June.

Underpinned by on-going strategy work, work streams within this programme will be:

- Recruitment and retention
- Workforce modelling
- Temporary staffing
- Staff engagement

Workforce Task and Finish groups including clinical staff, operations, HR and finance teams have been organised for business critical staff groups to support local plans and provide corporate support and consistency in oversight

2.6 Transforming Outpatients

Reporting on this programme will commence from July 2016

3. Communications

Communications narratives for the 8 new programmes have been agreed (17 June) and will form the basis of all communications in support of phase 2 between now and November.

Communications supporting phase 2 began in earnest with the Senior Managers Meeting and global email on 21st June and will be followed by the introduction of a concertina business card and new look fortnightly newsletter in July.

Continued support between now and November will be provided through the newsletter, intranet Trust recovery plan section, CEO weekly email, global emails, staff meetings and drop-in events. Further support will come from the news@medway newspaper and local media coverage.

4. Risks to delivery

As previously reported in the CQC Quality Improvement Plan, some key risks to the successful delivery of the recovery programme include:

Risk	**Mitigant**
Change is not sustained beyond the high visibility recovery period	Care is being taken to ensure ownership of change sits with the operational level of the Trust. The PMO provide support but does not lead clinicians, senior nurses and managers in planning, delivering and implementing change
Resource constraints negatively impact pace and/or quality of change.	Following the CQC inspection, the Trust is now entering Phase 2 of its Recovery Plan with the proposed programmes for recovery being presented to the May Trust Board. The Trust will then ensure the programmes are adequately resourced
Reporting and monitoring divert focus from the process of improvement and change.	The Trust is pleased to have had the support of CQC and Monitor (amongst others) in planning the next stage of its recovery. Indications are that both CQC and Monitor appreciate the need for a core focus on delivery activities in the coming weeks. Appropriate, measured review and oversight arrangements have been put in place which, with support of the PMO, will minimise disruption to the core recovery activities
Lack of staff buy-in to recovery	The Trust has recognised the need for strategic, targeted communications campaign to support the next stage of its recovery programme. The Trust's communications team have mobilised

	accordingly and a communications strategy is now being implemented to compliment the recovery activities

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date : June 2016

Title of Report	Quality and Health Informatics Update
Reporting Officer	Chief Quality Officer
Lead Director	Directors Health Informatics, Quality , Safety and Effectiveness Leads
Responsible Sub-Committee	Quality Improvement Group/Corporate Informatics Group
Executive Summary	The report outlines the current position against Serious incidents, including themes and trends within IQPR. Activities relating to clinical systems development, data quality and business intelligence are also outlined within the report.
Risk and Assurance	Current key risks relate to capacity and capability in relation to conducting serious incident investigations. Assurance processes in relation to serious incidents are becoming embedded with evidence of learning and improved quality of reports as recognised by the CCG.
Legal Implications/Regulatory Requirements	Regulation 28 reports – reported in May have been responded to via the legal team.
Recovery Plan Implication	Aligned to HI recovery plan and clinical governance/CQC recovery plans.
Quality Impact Assessment	n/a
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Information
Recommendation	Review information and raise any additional questions in relation to assurance.

Medway NHS
NHS Foundation Trust

Quality and Health Informatics Update: May 2016

Background

The report highlights progress made within the Health Informatics remit over the last month in relation to:

- IQPR – KPI status
- Clinical Systems development :
- Data Quality Programme
- Business Intelligence and Performance Framework
- Supporting Infrastructure
- Quality systems and processes

QUALITY AND HEALTH INFORMATICS: CURRENT STATUS

1. IQPR – KPI UPDATE

The following KPIs show changing status this month, areas of concern/progress are highlighted:

Serious Incidents: Position as of 15th June 2016

There were no Never Events reported for May 2016.

STEIS Number	Description	Immediate Actions
2016 12401	Delay in Treatment of grade 4 pressure ulcer. Unexpected death	Tissue viability team is delivering training to all the ward staff on Pressure ulcer prevention, Pressure ulcer grading, Wound assessment
2016 14431	52 week breach cardiology	Review of Cardiology position relating to excessive waits for first outpatients appointments All patients that have breached 52 weeks have been reviewed by clinical staff detailed action plan is in place
2016 13099	MRSA Bacteraemia	Detailed action plan is in place which includes robust training, all lessons from previous SI's are included this is closely monitored.

The trend to date for 2016/**17 is favourable compared to last year's figure** with a reduction in the number of serious incidents reported for the same period.

- 3 incidents were reported on STEIS in May, 2 occurred in May and 1 in March 2016. Two of the SI's **were clinical and one was non clinical.**
- **9 reports were closed in May.**
- **2 reports were downgraded in May.**
- **There were a total of 25 serious incidents open in May of which 14 were breaching and 11 were in date.**
- **14 Breach position in detail:**
- **8 reports have been submitted to the CCG for June closure.**
- 1 report has been declined by the CCG further work to be completed for readmission by 10th June 2016.
- **5 reports** are still under investigation all within Acute and Continuing Care, support is being providing to ensure these are completed

Issues and risks leading to breached serious incident reports

The main issues which continue to cause the risks are:

- Limited number of investigators
- Investigators handing the SI's back due to work commitments across the Trust
- The standard and quality of the investigation reports
- Directorate and governance sign off processes
- Action planning - not SMART

Actions to mitigate the breach rates:
1 Trajectory has been set target to reduce breaches to 10 by June 2016 and for the Trust to be in a position of zero breaches by August 2016. Currently the Trust is on trajectory if the reports submitted for the June closure panel are closed.

2. Directorates are allocating and identifying their own investigators and will be responsible for ensuring compliance with the timeframes set out by the patient safety team.

3. SI Tracker is in place and is shared weekly with the Directorates

4. Patient Safety Team is supporting the Directorates to ensure SI breaching reports are being completed.

5. Training needs analysis has been undertaken and further RCA training has been scheduled for quarter 3 and 4.

A training matrix is being developed to include additional training for a cohort of 30 highly competent investigators -skills in cognitive interviewing, statement taking and report writing. The gold standard investigators will support, mentor and guide investigators with less experience to ensure consistency and high quality

investigations are undertaken.Business case has been prepared and financial commitment is required

6. An escalation framework is in place to identify any potential risks - monitored at the SI monitoring group.

Reporting requirements:
To ensure compliance with national and contractual requirements potential serious incidents are being reported onto to STEIS within the 48hr timeframe, a formal request to the CCG for downgrade and removal is submitted if evidence suggests criteria is not met.

SI Monitoring Group
A report on outstanding actions will be produced monthly and a Tracker system has been developed to monitor compliance. Trends and themes from Serious Incidents will be discussed and items for the SI Newsletter will be agreed at this group. Trust has been issued with two Regulation 28's / Prevention of Future Deaths following inquests from the Coroner and these actions will be monitored at the group.

Learning from Serious Incidents

Trends and Themes
The Trust has seen an increase in the number of serious incidents relating to **attributable pressure ulcers.** Action weekly meeting with safeguarding, tissue viablity, patient safety and directorate representation has commenced to review all the grade 3, 4 multiple 2's and unstageable pressure ulcers to ensure actions and trends are acted upon immediately.

Learning Events
Learning events continue to be delivered across the Trust, Nursing and Quality forum , FY1 and 2 training programme and presentations on SI learning at the Sign up to Safefy Event.The patient safety team and investigator will facilitate feedback directly to the Team, Ward involved in the incident. The third newsletter is to be published and articles on serious incidents, patient safety and learning have been published.

Serious Incident Thematic Action Plan
The Trust has been requested to present the progress on the SI action plan to the CCG on June 16th. Ongoing actions from the overarching SI action plan have been realigned into the Trust recovery plan.

Harm Free Meeting
The harm free meeting continues to be effective with incidents, complaints, inquests and safeguarding. These are being discussed and impact and risk accessed.

Risks
Trends are being identfied and actions are being taken, handover of care has been identified as a theme and this has resulted in new process being developed across the Trust. Pressure ulcers and heel damage has lead to a rapid review of slide sheet use and has been escalated to the Moving and Handling Advisor to audit.

1b. Clinical Effectiveness/QI Update

- On Friday 20th May, Medway NHS Foundation Trust held its National Sign up to Safety 'One Year On' event; a day of sharing and reflecting on patient safety and celebrating the achievements so far. The event was well attended with several external speakers including the Regional Medical Director of NHS England and Director of the Kent Surrey and Sussex Patient Safety Collaborative.
- The Quality Improvement Team is currently cleansing the Trust's incident reporting system Datix, which will enable it to be used to its full potential. The cleansed system will be more efficient with the aim of making reporting simpler, include improved categorisation of incidents and provide directorate level dashboards to support the identification of trends and themes. As part of this work the Senior Patient Safety Incident Manager is working with Directorates to close all historic incidents and improve the review process moving forward.
- The mortality review process is now firmly in place, with all relevant specialties completing review forms and holding specialty mortality meetings. Divisional mortality reports are now being produced on a monthly basis for 'Acute and Emergency Medicine' and 'Co-ordinated Surgical Care'. These include details regarding trust-level mortality data, reviews and meetings completed at specialty level, and themes identified. These reports are also discussed at the Trust Mortality and Morbidity Meeting. A working group has been established to look at the current death process and ensure it is as efficient as possible; also ensuring a policy is put in place to cover all aspects.
- The Trust's position within the published mortality indicators, the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) continues to improve. The current HSMR position (March 2015 – February 2016) is 102.92 and within benchmarked limits, the current SHMI position (January 2015 – December 2015) is 1.13 which while higher than expected is the lowest Trust position since 2013.
- 2016/17 National Sepsis CQUIN is proving challenging. We are currently undertaking Quarter 1 of the CQUIN and setting a baseline for the rest of the year which will be approved after consultation with the CCG on 15th July 2016. A business plan has been written with the aim of securing the additional resources required and new resources are being developed in line with new NICE guidelines for sepsis due to be published at the end of July.
- To assist with our monitoring work, the department has launched two new databases, one for NICE compliance and one for registered clinical effectiveness projects. We are now able to monitor compliance with NICE and progress of audit projects more efficiently. The systems also provide a robust method for recording evidence of actions and compliance. Reporting functionality is currently in development, and we hope to have this completed by the end of June.

- The annual Clinical Audit and Quality Improvement Awards took place on coming up on 09 June; and The Green Book won the overall competition – newsletter provides updates.

- Newsletters continue to be produced for patient safety, mortality and now for clinical effectiveness.

2. HEALTH INFORMATICS:

2A CLINICAL SYSTEMS DEVELOPMENT

Electronic Order Comms Programme

- Pre-qualification Questionnaire (PQQ) phase of procurement closed 2nd May 2016, with 5 suppliers responding to the published requirements.
- One of the responders did not meet the minimum requirements, 3 suppliers have therefore moved into the Invitation to Tender Phase (ITT) with the Trust. This Phase is scheduled to close 16th June. Supplier Demonstrations have been planned for Thursday 23rd June, with the formal tender review period set for the 2 weeks commencing Monday 20th June.
- The Trust should then be in a position to make a formal contract award by early July 2016.

Bed Management and Electronic Observations

- The revised business case to cover the extended scope, incorporating Electronic Observations (which did not form part of the initial Bed Management Business Case) is being submitted to the trust Executive Committee on 11th May, and then presented to the Board in May.
- A full tender process has already been undertaken and a preferred supplier determined. Subject to Executive and Board approval of the revised scope and business case, a contract award will then be made during the first week of June.
- Subject to the contractual cooling off period, pre-configuration planning and work streams will commence towards the end of June 2016.
- An additional site visit has been undertaken to give assurance to the Board that a solution supplier, that had not responded to the formal tender, did not represent a better product set for the Trust than the current preferred supplier.

E-Referral

- Following the successful go live of 2 Cancer services on E-Referral in Mid-April, the HI PMO Team have requested approval from the mid-May Cancer Board to progress investigative and business change work with the next preferred service area. This was agreed as Colorectal.

Mobile Interoperability Gateway (MIG)

- The Trust are working closely with Medway CCG to enable Clinicians within the Emergency Department to have access to a basic set of personal

information from the GP records, to aid clinical decisions at the point of care. It is anticipated that early phases of this (a secure web portal) will be made available in summer 2016, with integration with the ED System (Symphony) in the autumn.

NHS Mail 2

- Plans are currently underway to migrate all current NHS Mail users to the new NHS Mail 2 Service during late spring / early summer 2016. NHS Mail have appointed Accenture to support the national project and the HI PMO are working in conjunction with Accenture to scope the requirements.
- There is an additional organisational requirement to cease the use of medway.nhs.uk email addresses and servers and move all users across to nhs.net email accounts. Migration plans are currently being drafted in order to safely and securely complete these migrations in with a minimum of disruption to Trust staff. The intention is to migrate all users over a 10-14 week period commencing late summer 2016.

Other Programmes

- Electronic Document Management (EDM) – HI PMO are preparing a Digital Strategy Document to inform the Trust's direction of travel towards an Electronic Patient Record (EPR) and prepare a Technical Specification to support the EDM solution.
- E-Prescribing – Discussions are currently underway for early pre-planning of the scale and potential outcomes and timelines for a comprehensive e-prescribing programme, to meet the compliance deadline requirement of 2017/ 2018.
- Maternity System – The Trust's current Euroking contract is due to expire in summer 2016 and cannot be further extended beyond summer 2017. Plans are being created to look at the scale and scope of a complete replacement of the Euroking solution and a move towards a potential paperless system.
- The HI Team are also involved in supporting a number of other departmental programmes, such as the roll out of Hybrid Mail by the Procurement Team, a new Learning Management System with the HR department and Mobile technology for the Estates Team.

2B DATA QUALITY AND SUPPORTING STRATEGIES

- NHSE, CCG and are assessing our systems and processes relating to 18 week reporting and management, following an initial and positive review by NHSI on May 26th. Following this assessment our commissioners and stakeholders will agree or not with the Trusts request to return to reporting in the next few months. Currently we anticipate returning to reporting in August with 3 months of data from May, June, July- this will provide assurance of a stable position.
- We are reviewing and strengthening our Data Quality Strategy – available for July Board, the Digital Strategy will be presented to August Board.
- As part of the data quality strategy we are re-configuring roles to enable the trust to have a Data Quality team to drive forward the work programme

- The Data Warehouse business case has now been finalized and will be presented to the executive on 6th July. This will enable many current systems to be automated and configured to provide real-time standardized data sets and reports. The case has been developed to allow positive outcomes in the next few months within a 6 month programme and will support the development of further data systems i.e. PLICs financial reporting tool, by the end of the year.

2C BUSINESS INTELLIGENCE ; PERFORMANCE MANAGEMENT & ACCOUNTABILITY FRAMEWORK

- A workshop was held this month to review all KPIs, reports currently being produced by the BI team and the PMO. The aim to reduce duplication of effort , rationalise reporting and focus on automating key KPIs.
- The current data assurance document which documents all KPIs from source to reporting is also being refreshed to allow more accurate quantification of data quality via kite marking.
- A new interim Head of BI has been recruited whose expertise is in data quality frameworks he will work with the current team on the strategy and also in ensuring we have robust assurance and validation processes across the function

2D SUPPORTING INFRASTRUCTURE

- **The Digital Road Map was presented to the Clinical Council on June 8th.** The presentation was received very positively and we are now working with the Medical Directors Office to **develop the Clinical HI Advisory Group to drive forward and direct the strategy. We anticipate we will also recruit HI leads in each specialism to support the work programmes**.

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date: June 2016

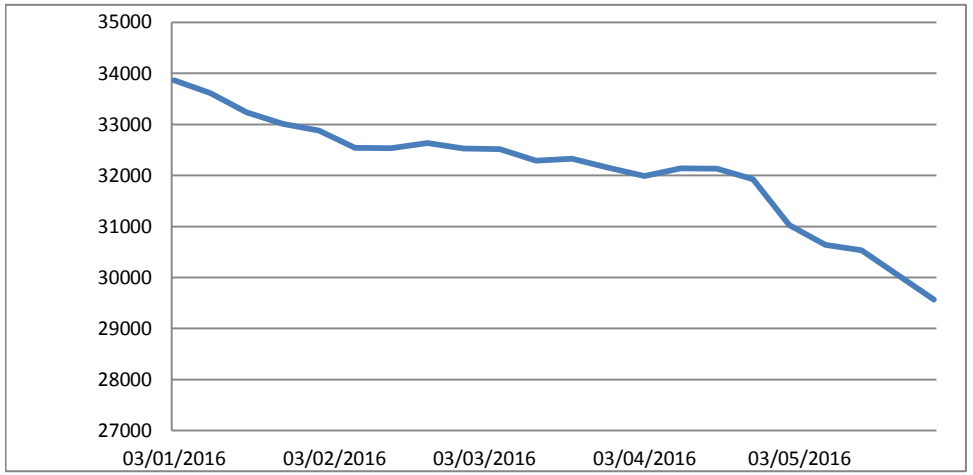
Title of Report	Monthly Operations Report
Reporting Officer	James Lowell, Director of Clinical Operations
Lead Director	Ben Stevens, Margaret Dalziel, James Lowell
Responsible Sub-Committee	Access Board Emergency Pathway Board
Executive Summary	To provide the Board with an update on performance in the following areas: • RTT: 4% improvement to 72% (Incomplete) • Diagnostics: 4% improvement to 93.39% • ED performance: 3.9% improvement to 81.71% • Cancer performance: • Site/Flow update
Risk and Assurance	Performance against the access standards and emergency pathway standard does not meet the national targets. Improvements continue to be made and action plans remain in place to support the maintenance of the improvement trajectory.
Legal Implications/Regulatory Requirements	The updates are provided in the context of national requirements for access and emergency pathway standards and against requirements from CQC inspections and improvement expectations.
Recovery Plan Implication	The subject matter of the report supports the recovery plan in the following areas: • Continuing to modernise our Emergency Department and pathway, reducing the time it takes for patients to be seen and assessed. • Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.
Quality Impact Assessment	QIA not required.
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	The board are asked to note the contents of the report for information.
Recommendation	The report is provided for information only.

RTT Update – May Position

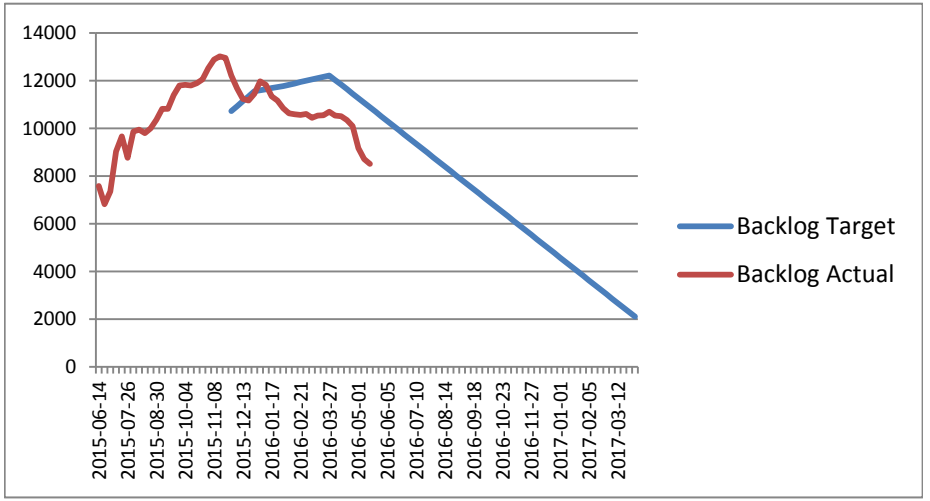
Summary of May position

- The Trust is not currently reporting externally for RTT.
- The total incomplete waiting list size reduced by approximately 1500 patients across the month of May. The reduction has been achieved through the effective validation and a focus on delivering additional capacity.
- Incomplete performance for May is 72% an improvement of 4% from April
- The current backlog size is below trajectory. Ongoing validation continues to support the backlog reduction.
- Cardiology performance remains a risk due to the lack of available capacity and limited outsource options. The Trust is working closely with the CCG to develop a plan for Cardiology.
- A revised PTL meeting has been implemented with good representation from all specialities in attendance.
- Due to the ongoing validation the proposed return to reporting date is now July reporting June's data.
- A meeting was held with NHSi to review current processes with feedback received. A more detailed deep dive meeting to include the CCG and NHSE will be held in July to ensure that support is received for the return top reporting in July.
- Following detailed discussions the Trust is continuing to work towards delivery of the 92% incomplete RTT standard by the end of March 2017. It is acknowledged by all parties that this is particularly challenging and delivery is reliant on additional supporting actions from the CCG.

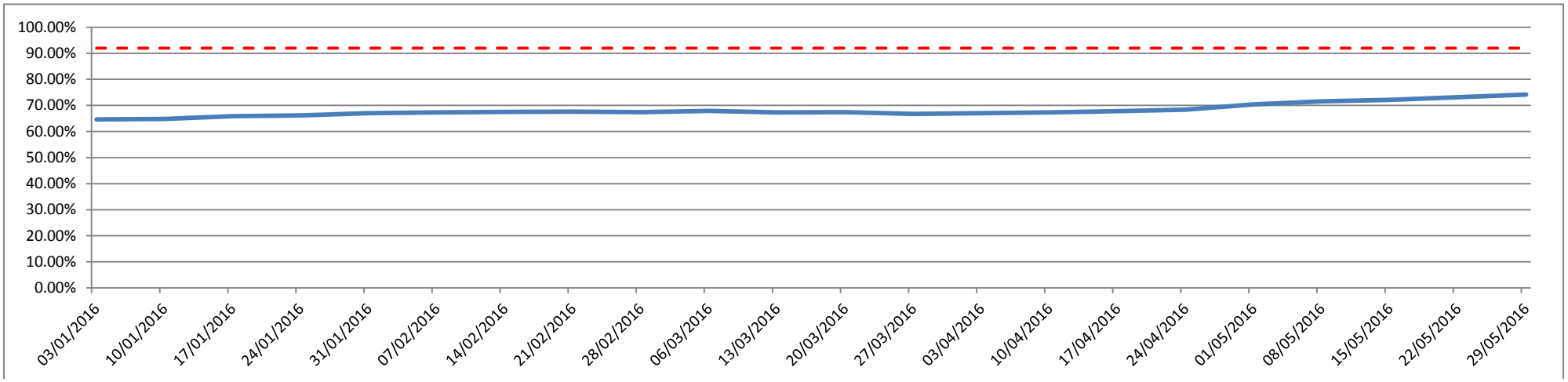
Total Waiting List Size



Backlog Trajectory



Incomplete Performance



18 week RTT Sustainability Plan

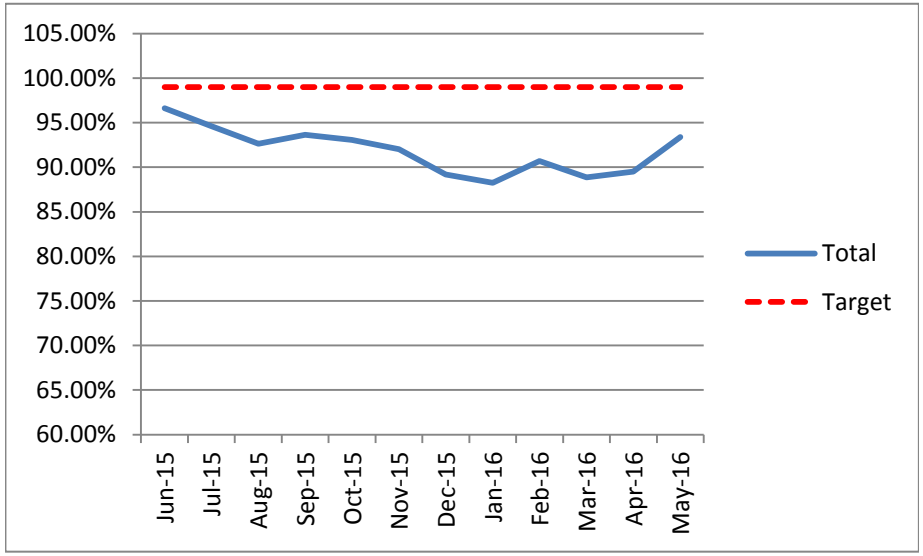
- Demand & Capacity modelling has been completed across all specialities.
- Work will be undertaken in the speciality teams to identify additional internal capacity opportunities.
- Additional outsource capacity is being progressed with contracts with Ashford one due for sign off on board approval of the business case.
- The CCG are working to identify additional outpatient capacity in the independent sector to support achievement of the incomplete standard.
- The PID is in development for the surgical pathway programme which will have a focus on improving efficiency and productivity through theatres.
- The access board has had its inaugural meeting and will now continue to meet monthly.

Diagnostic Update – May Position

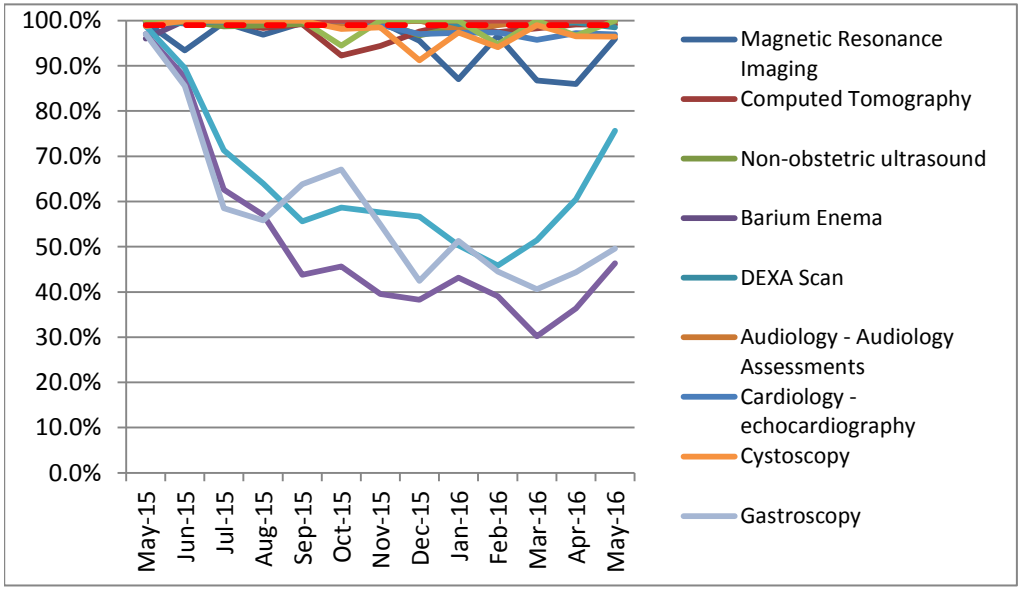
Summary of May position

- The Trust improved performance to 93.39% for diagnostic tests completed within 6 weeks in May
- The national target for diagnostics is 99% of diagnostic tests to be completed within 6 weeks.
- The three poorest performing areas are flexi sigmoidoscopy, gastroscopy and colonoscopy due to the shortfall in endoscopy capacity at Medway however improvements in all three areas can be seen.
- MRI is the biggest risk for imaging diagnostics however following the use of the mobile scanner performance has improved by 10% to 96%.

Trust Performance – Diagnostic 6 Week Target



Modality Performance



Diagnostic Sustainability Plan

- Work is on-going to define the endoscopy estate required to deliver both JAG accreditation and the increasing demand.
- An in-source contract has been agreed and work commenced for endoscopy.
- A business case for the second CT scanner is in progress and would support delivery of the 6 week diagnostic target.
- A strategic review of all areas within imaging is planned for completion by the end of 2016.

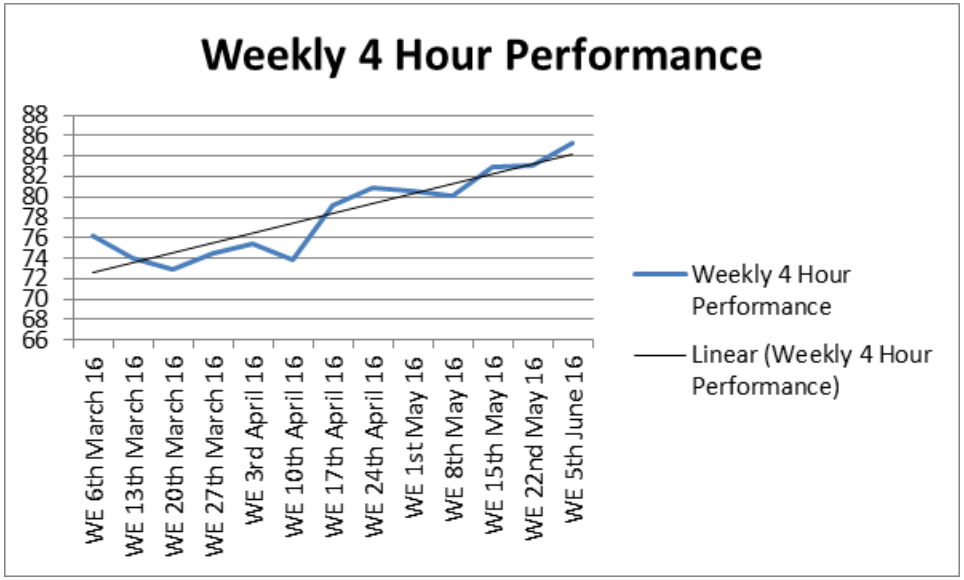
ED Update – MAY 2016 Position

Summary of May 2016 position

May saw a 12% increase in total attenders on April and a 1.3% increase on March. There was a 6% increase in ambulance attenders – there were some data omissions on Qlikview so data source taken from SECAmb. Emergency Admissions were 7% more than the previous month. As a result of some of the activity markers reducing, 4 Hour performance has improved month on month from March and sits at 81.71% for May, an almost 3% improvement on April. 1062 patients saw their care managed in the corridor for all or part of their stay in May; this was the same as April and 24% less than March, second lowest number this year. Consistently just over 23 % of ED presentations were streamed to MEDDOC month on month over the last 4.

Access target Performance (95%)

Remained below the trajectory set as part of the 12 week programme and significantly below 95% however upwards trend clearly evident



Quality indicators

- Clinical markers performing well with 95% - 100% NEWS compliance and 100% of patients in the corridor are meeting the acceptable clinical criteria. This is recorded through snapshot audits covering all times of day and night.
- Ambulance Performance – Medway saw 3302 conveyances in May, still the second highest in the sector and over 14% above the next highest. 57.1% of patients were handed over within 15 minutes, with several weeks above the trajectory. 30 minute performance was 7.5%, in the top 5 out of 18 in the region. 60 minutes was only 1%, down from last month, In the top 7in the region
- Measurement of the LOS in ED still shows an improving trend at the 80th and 95th percentile
- DTA process is monitored throughout the day and night to ensure this decision happens as early as possible.
- Daily breach validation looks at all key points in the patient's journey to determine primary and secondary causations to clearly defined measurements of time to all measurable points such as 1st assessment, DTA, referral, interventions and LOS in the department
- ED Nursing vacancy now sits at 28.5% (60% in November 2015)

ED Improvement Plan

Ambulance Performance: Despite being 2nd highest out of 18 Trusts in the Region in terms of total attenders, Medway was 2nd inj total performance of all handovers with 57.1% within 15 minutes. This has been achieved along with a process that provides a meaningful clinical assessment to take place and a NEWS based plan of care to be put in place. This is commendable and has put MFT in a position of being hailed as a 'shining light' (SECAMB).

Recruitment: Nursing staff is now less than 26% vacancy opposed to 60% in November. The plan is 10% by October 2016. This has been achieved through bespoke and targeted focus by the ED Leadership team.

Site/Flow Update – May 2016 Position

Summary of May position

- Trust Escalation was predominately Amber with some Red. Most days saw multiple DTA's in the ED awaiting placement. Lister Assessment Centre saw an average of 35-40 patients a day. Since opening there has been a 50% conversion to admissions across all areas of the Lister Assessment Centre (GPAU/Hot clinics/FED/Ambulatory)
- The site continues to experience delays in progressing patients through the department once speciality referral takes place and a Decision to admit is in place. In response, a DTA SOP was put in place allowing a much earlier decision to admit when it was clear admission was necessary. This has been successful in managing patients through the emergency pathway much quicker than would previously been expected. We measure this at the 80th and 95th percentiles. The 80th percentile is a good measure of the non-admitted pathway. This has improved from 4 hours 32 for April to 3 hours 50 for May, the first month this year below 4 hours at this point. At the 95th percentile, a measure of the admitted pathway, it has improved from 11 hours 27 in March to 9 hours 33 in April and 9 hours 16 in May. Long delays are evident for some particular pathways such as patients under the care of IDT and mental health presentations, particularly admissions.
- A stronger focus has been placed on the site team in terms of prediction and understanding the site as well as leadership and their role and function within this. Further site team away days are planned to consolidate this and expand on their role within the admitting pathways, medical model, site flow meetings and out of hours.

Quality indicators

MSA - There were no mixed sex breaches recorded outside of excluded areas for April 2016. All site flow meetings are recorded in a template that allows audit of flow, surges, response, actions and the ability to develop learning and improvement. 5 key questions were circulated to support the CSP's SMOC and Site flow meetings:

- What is the situation report matched against predicted Demand?
- Is the Trust in a negative or positive Bed position?
- What Escalation is required to return to a situation in which the Site is proactively rather than reactively managed?
- What is the escalation status and is the Trust in an escalation of Red or Black that requires immediate executive action?
- Will we get through the Night if the current situation continues? If not what are the contingencies?

Medical Model & Emergency Pathway Programme update:

This month, the Programmes have merged and become the Unplanned Care Programme as part of the Trust Recovery Plan – Phase 2.
Key Highlights for the past month include:

- The updated Trust Daily Concept of Operations has been circulated to all group members with a view to delivering a new model of Site Operations by September 2016
- The Trust-wide Internal Professional Standards have been drafted are now in circulation with Clinical and Operational colleagues. These are due to be presented to Clinical Council in July 2016
- Agreement has been given by the Programme Board to expand the scope of the Discharge Workstream to include a targeted piece of work regarding Frailty Inpatients in advance of the winter period. This workstream is also progressing activity related to improving weekend discharges and supporting safe, effective supported early discharge pathways

Cancer Update – May 2016 Position

There is a general improvement in cancer waiting times although we are not yet compliant against a number of standards, most notably the 62 day GP referral. Detailed breach reports and route cause analysis is being undertaken to reduce avoidable breaches and improve pathways.

2WW – Trust maintained compliance with the 2 week wait standard but failed symptomatic breast. Breast breaches were predominantly due to patient choice.

- The Trust has introduced a script beginning of June for the 2 week wait booking team and an audit to understand whether the GPs are discussing the reason for the referrals and sharing the distributed Macmillan 2 week wait referral leaflet with patients
- Commissioners have shared Macmillan 2 week wait referral patient leaflet with GPs and communicated the need to discuss importance of attending within 2 weeks

31D - The Trust narrowly failed to achieve the first definitive treatment standard but was compliant with both subsequent treatment standards.

- Breast have issues with service capacity and cover of consultant leave but the team are planning to meet to resolve
- Urology breaches are as a result of MTW surgeon availability and this is being discussed with the MTW service team with an aim to address

62D – The Trust failed to achieve the GP referral and screening standards for various reasons due to delays in diagnostic tests, endoscopy capacity, patient choice, complex pathways and late referrals from other Trusts.

- Delays in diagnostic pathways are being discussed with Imaging and the endoscopy capacity issues for cancer patients are now resolved
- Delays in pathways due to patient choice are being reviewed to ensure all appropriate adjustments are being recorded
- Late referrals from other Trusts are being discussed in the regional cancer meetings alongside the implementation of the Kent & Medway Inter-Hospital Transfer Policy and National guidance on shared breach allocation

Cancer Waiting Time Summary Performance

	Target	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
2WW cancer	93%	82.14%	85.23%	87.43%	95.77%	96.42%	94.06%	93.40%
2WW symptomatic breast	93%	77.59%	83.70%	90.40%	88.24%	92.31%	81.42%	89.81%
31D first treatment	96%	92.91%	92.20%	94.12%	90.84%	93.38%	89.31%	95.61%
31D sub treatment surgery	94%	88.00%	94.44%	87.50%	85.00%	83.33%	82.86%	94.29%
31D sub treatment drug	98%	100.00%	100.00%	88.24%	92.00%	100.00%	100.00%	100.00%
62D GP referral	85%	77.56%	87.73%	83.33%	65.41%	75.40%	83.02%	73.77%
62D screening	90%	93.55%	87.50%	90.63%	92.86%	96.15%	72.73%	84.85%
62D consultant upgrade	n/a	50.00%	100.00%	64.29%	71.43%	78.95%	71.43%	100.00%

Cancer Remedial Action Plan

- The outstanding Cancer Remedial Action Plan actions are being progressed and a meeting is arranged for later this month with commissioners to agree updates to the RAP and evidence of action completion.
- The Trust is developing an ongoing Cancer Improvement Plan which will incorporate recommendations or best practice from reports, audits, National guidance and other providers to continually improve and develop cancer service provision and performance.

Cardiology Remedial Action Plan

- Cardiology services remain under great pressure with demand far outstripping capacity - Patients are currently being offered their first OPA at 35 weeks for routine, 8 weeks for urgent appointments.
- Outsourcing and demand management is actively being pursued and in discussion with private providers and the CCG to take this forward. The use of KIMS for cardio-respiratory tests is being investigated as the department has seen a significant increase in request for echocardiograms with an estimated 244 appointments un-dated.
- Number of clinics has reduced as one agency locum has ended their contract; we are currently out for a replacement.
- Clinical review of 90 referrals was undertaken on the 15th June in order to gain an understanding of the conditions and types of referrals received for Consultant clinics. Data now needs be analysed. A Clinical Council in conjunction with the CCG is being set up in order to validate the backlog and ensure clinical safety is being maintained.

Dermatology Remedial Action Plan

Considerable work has been undertaken to manage the long waits in Dermatology and the number of patients over 40 weeks has reduced from 437 in December to a current position of 42. There remains a risk to 52 week breach position but with a low incidence due to both patient cancellations and rebooking as well as some clinical investigations that are unable to be completed in time due to the point that the initial appointment was scheduled. The focus on the long waiters has resulted in the current position with only 5 patients over 46 weeks compared to 47 patients in December. The service continues to be supported by outsourcing to Concordia and the current wait for a new appointment has reduced to 11 weeks.

Staffing remains a risk as recruitment to Consultant workforce is both a local and national problem which we are working to develop a strategy to address.

Endoscopy Remedial Action Plan

Endoscopy capacity remains extremely challenged due to demand outstripping available resources. Using mixture of outsourcing, additional sessions and insourcing to manage the demand and reduce the backlog. The current week day Capacity is 174 units per week: average Demand is 207 units per week leaving a shortfall of 33 units per week.

Finding sufficient providers is challenging (national issue) but currently we have an insource solution that will provide 52 additional units per week, and the outsourcing available to us is to be extended to provide an additional 48 units per week plus some ad hoc as space is available. A refreshed trajectory dated shows backlog compliance by early August 2016 if we maintain the levels of out and in sourcing.

The next JAG visit is proposed for 5/10/16 and the action plan continues to be implemented successfully.

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date : June 2016

Title of Report	Medical Directorate Update
Reporting Officer	Dr Diana Hamilton-Fairley
Lead Director	Dr Diana Hamilton-Fairley
Responsible Sub-Committee	Not applicable
Executive Summary	• Update on progress May - June 2016
Risk and Assurance	None
Legal Implications/Regulatory Requirements	None
Recovery Plan Implication	Medical Model key component of reducing admissions and improving flow
Quality Impact Assessment	Not applicable
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	**Information**
Recommendation	

Medway NHS
NHS Foundation Trust

Medical Director Update: June 2016

Background

The report highlights progress made within the Medical Director remit over the last month in relation to:

1. NEW MEDICAL MODEL

The Medical Model is now in its 15th week.

Significant improvements have been made in the Trusts performance (please see PMO reports for detail), however particular points to note are:

- Escalation beds in the Acute and Continuing Care Directorate care remain closed as a result of improved flow and reduced Length of Stay from 6.5 days to 5.5 days.
- Further reductions in patients staying in hospital longer than seven days
- Wakeley and Gundulph are functioning Acute Admissions Wards with 60% of patients admitted through the 'Take' going to these wards, a significant improvement on the 25% in March this year. The benefits for patients are it speeds up diagnosis and treatment and provides for an increase in senior clinical oversight.
- The Acute Admissions wards have made significant reductions in the length of stay. In March the length of stay was between 10 and 11 days, however this has now reduced to 2.5 days in May.
- The clinical teams are currently reviewing and refining the medical model. The next six weeks will see changes in the consultant rota and alterations to junior doctor allocation. Both these changes are aimed at improving continuity of care and increasing efficiency

2. JUNIOR DOCTORS CONTRACT

Recruitment to the role of Guardian of Safe Working hours is underway with interviews planned on 30 June 2016.

3. MEDICAL EDUCATION

The Annual Report forms part of the main agenda.

4. RESEARCH & DEVEOPMENT

Medway NHS Foundation Trust held its annual Clinical Research Day on Monday, 6 June, which was open to patients and members of the public in Kent and Medway.

The Clinical Research Day is part of the wider National Institute for Health Research (NIHR) 'Ok to Ask' campaign, which calls on patients, families and carers to ask their nurse or doctor about taking part in health research.

There were presentations from pioneering research clinicians about the key work they are undertaking to improve patient care and quality of life including the steps being taken to treat children who are diagnosed with Attention Deficit Hyperactivity Disorder (ADHD), improvements in catheter removal and how iPhone technology can be used for patients at home to detect chronic hearing problems, reducing unnecessary hospital visits and increasing independence.

Both local MP's were present at the event.

5 MEDICAL REVALIDATION

The Annual Report forms part of the main agenda.

6 CLINICAL EXCELLENCE AWARDS LAUNCHED

The 2015 – 2016 Clinical Excellence Awards have been launched with a closing date of August 24 2016 for submission.

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date: 30 June 2016

Title of Report	Director of Nursing Update
Reporting Officer	Karen Rule, Director of Nursing
Lead Director	Karen Rule, Director of Nursing
Responsible Sub-Committee	N/A
Executive Summary	Safe staffing – the Trust continues with a high level of activity and acuity demands, requiring high levels of nursing hours to support the delivery safe effective patient care. The first submission of Care Hours Per Patient Day ("CHPPD") data for May 2016 was completed successfully. Infection Prevention & Control – the Trust reported two acquired bacteraemias. Both cases have been submitted for arbitration.
Risk and Assurance	Staffing levels remains a Trust quality risk. Actions to mitigate the risk of current staffing levels are in place and embedded. Stabilising and retaining the nursing and midwifery workforce in clinical areas is a priority as we move through 2016.
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	Nil to note
Quality Impact Assessment	N/A
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	The purpose of this report is to provide the Board with • An overview of nurse, midwifery staffing levels in inpatient areas as outlined in the Nurse Staff Guide 'How to ensure the right people, with the right skills are in the right place at the right time!' • An overview of key work and achievements relating to the portfolio held by the Director of Nursing
Recommendation	The Board of Directors is asked to note the information contained in this report and the actions that are in place.

Medway NHS
NHS Foundation Trust

Director of Nursing Update: June 2016

Safe Staffing

- This safe staffing report provides the Board with an overview of nurse, midwifery staffing levels in inpatient areas as outlined in the Nurse Staff Guide 'How to ensure the right people, with the right skills are in the right place at the right time!' Published by the National Quality Board and the NHS Commissioning Board.
- It highlights any workforce issues identified across the inpatient ward areas during the month of May 2016.
- The monthly UNIFY submission regarding fill rates for ward areas is attached at Appendix 1. The submission is supported by a number of quality metrics with an accompanying narrative.

Key Points:

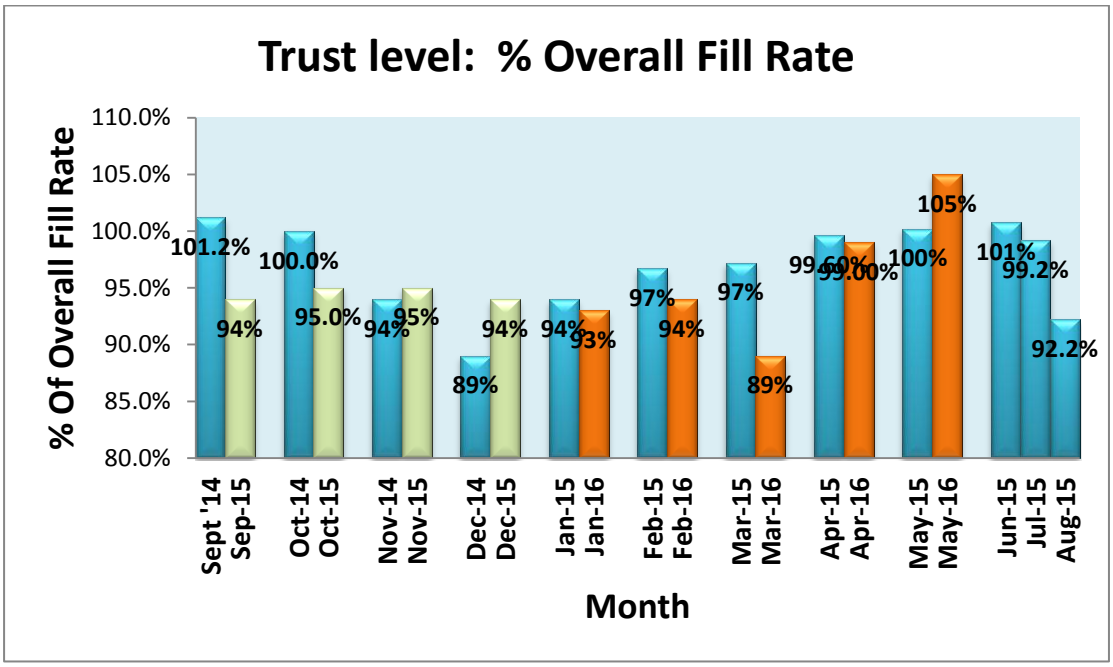
- The information in the appendices relates to May 2016 fill rates, as per inpatient ward, for both registered and unregistered staff, broken down by day and night.
- In line with National Recommendations from the Carter review the Trust is now required to report Care hours per patient per day (CHPPD). This will be the principle measure of nursing and healthcare support workers deployment on inpatient wards. This will enable the Trust to ensure that the right staff skill mix is in the right place at the right time. CHPPD information is contained in the reports attached in appendix 1
- In May there has been one period of red escalation due to high levels of activity. Response to this was in line with agreed escalation procedures.
- Meetings to discuss site safety, staffing and capacity are held three times each day to identify and escalate capacity and staffing challenges across the organisation. The expectation is that senior staff in attendance gain early visibility of organisational challenges and are able to put in place corrective action to ensure safe standards of care and to mitigate risk.
- Since February 2016 a system has been in place to improve the reporting of staffing levels that fall below 1:8 nurse: patient ratio. Escalation of poor staffing levels has a defined approach and reporting mechanism through to the Director of Nursing. The data continues to be collected and reported on a weekly basis. The total number of breaches

across inpatient wards during May was 129. This continues on a downward trend and is a 41% decrease on the breaches reported in April 2016

Summary Points of Appendix One: Planned Vs Actual Nursing Hours

- The Trust Summary of Planned Vs Actual hours for May 2016 was 5.3% above planned - the actual number of nursing hours worked was higher than the nursing hours planned on the nursing roster system. This is a 4.7% increase on the previous month. This change reflects the increase in the fill rate of temporary staff, as well as additional beds that were opened due to escalation and the requirement for extra staff for 1:1 specialling.
- Figure 1 shows overall fill rate. This fill rate is the highest since the reporting started and is reflective of the need for an extra staff to maintain patient safety with 1.1 specialing and additional beds which were opened in line with escalation.
- The IT system used by the temporary staffing service is now able to fully capture all the booked shifts. Although a manual calculation was done in two ward areas where the staffing templates have not been adjusted, to ensure that the figures accurately reflect the actual staffing position against planned.

Figure One: Trust level: % Overall fill rate of nurse, midwifery and care staff - September 2014 – May 2016



- There were twelve wards which recorded a deficit of actual nursing hours against planned nursing hours. In May no wards saw a deficit of more than 10 %
- When staffing levels are lower than planned the staffing escalation procedure is followed and actions taken to mitigate risk. Actions will include a review of acuity and dependency of our patients using the accredited Safer Nursing Care Tool (SNCT), review by a Matron of staffing alongside patient acuity, movement of staff across the Trust to cover vulnerable wards or departments and by Ward Sisters, Matrons and specialist nurses working clinically to deliver patient care.
- In May 2016 twelve wards recorded higher actual nursing hours than planned. Seven wards recorded more than 10% over the extra hours. The wards included:
  - Byron (care of the elderly ward)
  - Gundulph (short stay admission medical ward)
  - Keats (Acute medical ward)
  - McCulloch (Acute surgical ward)
  - Milton (care of the elderly ward)
  - Victory (mixed medical and surgical ward)
  - Wakeley (short stay admission medical ward)
- During May there were 33 formal escalations due to staffing issues. This is a decrease of 33% from April data. Teams have been encouraged to document escalation concerns to ensure this information is captured.
- In May 19.3% of all requested shifts remained unfilled. This is a decrease of 3.9% on April figures. The use of agency continues to be higher, with 51.9% of shifts filled by agency against 28.8% filled by bank staff. This remains consistent with previous months. The top reason for booking temporary staff remains to cover vacancy (63%), which is a 10% decrease on the previous month. The was followed by specialling (15%) escalation (11%) and sickness (8%) These figures remain in line with previous months.

Other workforce indicators

- 19.0 WTE Registered Nurses and 6.0 WTE Midwives commenced employment in the Trust in May 2016 against 10.0 WTE Registered Nurses who left. Additionally another 6.0 WTE nurses commenced employment whilst waiting for professional registration to be attained. This is the fourth consecutive month where there have been more registered nurses and Midwives starting than leaving.
- There were 9.00 WTE clinical support workers who commenced employment against 10.0 WTE who left the organisation in May 2016.

Key other workforce developments

- **Care hours per patient per day (CHPPD) Data -** The first submission of CHPPD data for May 2016 was completed successfully. Going forward the bed occupancy numbers at midnight will be taken from safe care data, which each ward needs to ensure this is completed accurately.
- **EU Nurses** - There are now 18 nurses and 3 midwives from the EU working across the Trust. To date 8 of the nurses and all the midwives have attained registration with the NMC. Eleven of the Nurses attended a study day recently to support them to improve their English and understanding of medical terminology.
- **Recruitment –** This continues to be a high priority for the Trust. Attendance at Trust recruitment assessment days remains stable and numbers are increasing slowly. There is ongoing work to ensure a seamless and quick process to decrease the time it takes to start work following interview.
- **Post Registration CPD funding -** The money allocated from HEKSS for Training Plans for the year 2016/17 is approximately 1/3 less than previous years. There are some challenging decisions to be made around what is funded. The priorities will be clinical courses that meet the needs of both the staff and the service and mentorship, followed by BSc and MSc pathways. It is unlikely that any conferences will be funded from the central fund. The reduction in support for study may have a detrimental impact on staff retention and the opportunity to promote academic study as a recruitment incentive is likely to be limited.

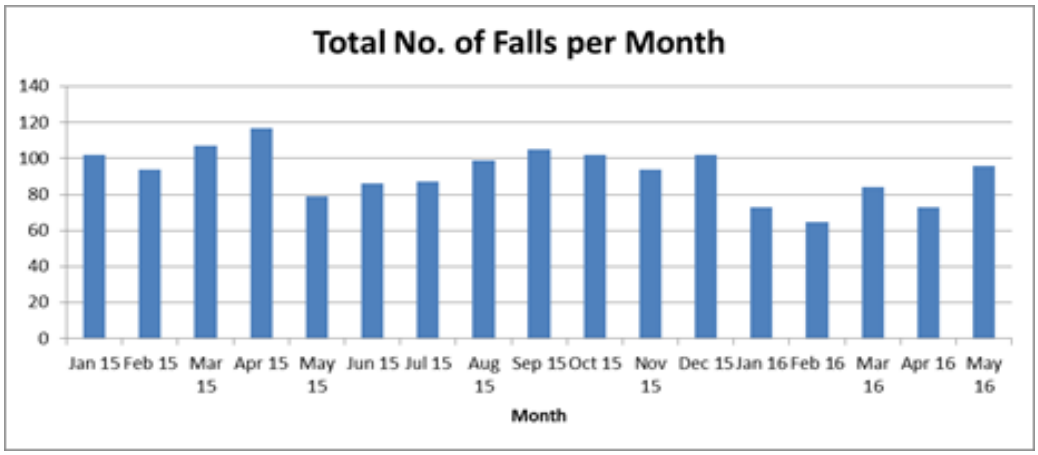
Implications:

- The Trust continues with a high level of activity and acuity demands, requiring high levels of nursing hours to deliver safe effective patient care. Stabilising and retaining the nursing and midwifery workforce in clinical areas is a priority as we move through 2016.

Nursing & Midwifery Care Indicators

Falls

- During May there were 96 inpatient falls, this was an increase on 23 on the previous month's total.



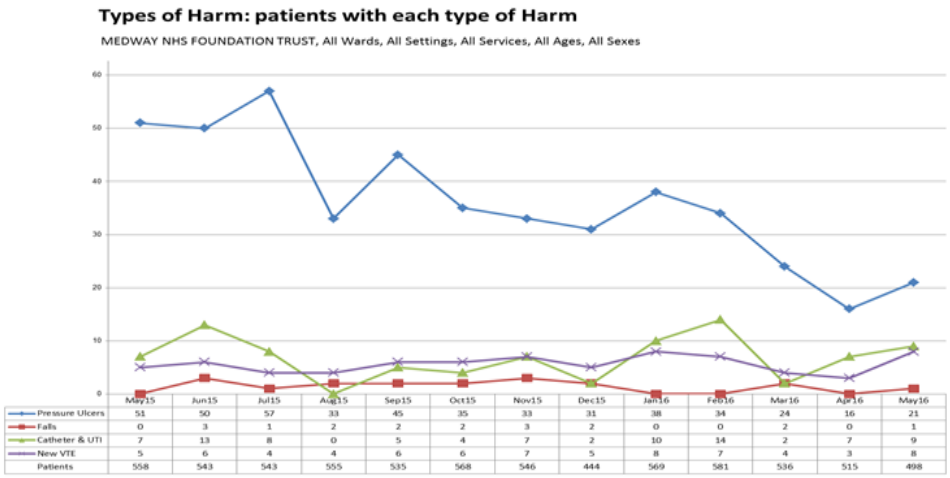
- One fall resulted in a clavicle fracture caused by a postural drop in blood pressure. Lessons learned from this incident are being shared with staff.
- Most of the falls occurred between the hours of 5pm and 6pm (8%). This is a busy time on the ward with meals being served and medications being administered.
- The slips, trips and falls policy has been updated and approved.

Pressure Ulcers

- In May there were eight grade 3 pressure ulcers acquired in our wards.
- One grade 3 pressure ulcer was reported in May 2016. This has been reported as a SI and is subject to an RCA.
- Key highlights and learnings from the quarter 1 Pressure Ulcer report will be included in next month's board update.

Safety Thermometer

- The NHS Safety Thermometer provides a quick and simple method for surveying patient harms and analysing results to measure and monitor local improvement and harm free care over time. However it must be remembered that the data collection is at one point in time (the first Wednesday of each month).
- 459 (92%) of the 498 patients surveyed in the May 2016 Safety Thermometer experienced harm-free care. This is a 3% reduction from the previous month but follows 2 months of improvement. No immediate new actions are required.



	May15	Jun15	Jul15	Aug15	Sep15	Oct15	Nov15	Dec15	Jan16	Feb16	Mar16	Apr16	May16
Pressure Ulcers	51	50	57	33	45	35	33	31	38	34	24	16	21
Falls	0	3	1	2	2	2	3	2	0	0	2	0	1
Catheter & UTI	7	13	8	0	5	4	7	2	10	14	2	7	9
New VTE	5	6	4	4	6	6	7	5	8	7	4	3	8
Patients	558	543	543	555	535	568	546	444	569	581	536	515	498

- For the second time in 2016 there were no falls with harm.
- 2 new catheters and UTI's were recorded, a decrease from Q4 last year. The Safety Thermometer audit tool is now completed electronically by frontline staff. The connectivity and compatibility issues have been resolved. Staff are reporting the data entry is less time-consuming and find the tool user-friendly. The quality of data entry has improved making validation of the data much easier.

Infection Prevention & Control

- The Trust reported two MRSA bacteraemia cases – Victory ward and Milton ward. Both cases were considered to be unavoidable at post infection review and have been referred to arbitration for third party assignment. Outcome is awaited.

Safeguarding

- The Head of Safeguarding has implemented a new process for reporting of patients requiring DOLS applications.
- The Trust now has a WRAP (Workshop to Raise Awareness of Prevent) trainer and PREVENT training is being delivered.
- Progress against the safeguarding improvement plan will be reported at the July board meeting with the 2015/2016 annual report.

End of Life Care

- A task and finish group of key stakeholders has been established to develop the End of Life Care Standards for Medway NHS Foundation Trust. The first meeting is scheduled for 14 June, 2016.
- A revised End of Life Care Policy was approved by the End of Life Care Steering Group subject to one amendment.
- The Hospital Palliative Care Team and End of Life Nurse Specialist are working together to deliver education on the Tissue Viability Study Days, Essential Skills and Student Surgeries sessions. The EoLC CNS will provide ward based teaching fundamental skills to care for the dying patient, e.g. mouth care/repositioning/hydration and nutrition/personal hygiene.
- The EoLC CNS conducted an audit of 50 'Comfort Plan for the Dying Patient' held in the Patient Affairs office. The audit identified poor documentation in many sections of the plan. The comfort plan does not need redesign; the EoLC CNS will re-embed into practice through training and ward support.
- The Trust participated in the Medway and Swale EOLC workshop on 5 May 2016. A Medway & Swale End of Life Care Programme Board has been established. The first meeting is scheduled for 17 June 2016. The Director or Nursing is a member of the board.

Dementia and Delirium

- The DaD Team are now attending the 8.00am Medical Take board round on Wakeley Ward to detect at the earliest opportunity any newly admitted patients who may need DaD Team intervention. Anecdotally, this is proving to be beneficial. An audit will be undertaken to gain more data on this intervention and its outcomes.
- The DaD Team are making plans for Dementia Awareness week in June 2016.

Patient Experience

- The Friends & Family Test (FFT) response targets have been reviewed and amended in line with national performance.

- For the third consecutive month more of our admitted patients would recommend us. ED sustained the improved performance reported last month.
- A proposal for a revised complaints management process has been provisionally agreed with the Directors of Clinical Operations and trajectories are being agreed to clear the backlog of complaints.

Recommendations

The Board of Directors is asked to note the information contained in this report and the actions that are in place.

Appendices

Appendix One – UNIFY data –May 2016

Appendix Two – Nursing, Midwifery and Care Staff Return – May 2016

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RPA Medway NHS Foundation Trust

Period: May_2016-17

Please provide the URL to the page on your trust website where your staffing information is available

(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

Comments

Validation alerts (see control panel)	Only complete sites your organisation is accountable for	Hospital Site Details		Ward name	Main 2 Specialties on each ward		Day				Night				Day		Night		Care Hours Per Patient Day (CHPPD)			
							Registered midwives/nurses		Care Staff		Registered midwives/nurses		Care Staff		Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Average fill rate - registered nurses/midwives (%)	Average fill rate - care staff (%)	Cumulative count over the month of patients at 23:59 each day	Registered midwives/ nurses	Care Staff	Overall
		Site code *The Site code is automatically populated when a Site name is selected	Hospital Site name		Specialty 1	Specialty 2	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								
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Arethusa	110 - TRAUMA & ORTHOPAEDICS		1885	1901	1139.9	1418	1364	1331	1012	1057	100.8%	124.4%	97.6%	104.4%	816	4.0	3.0	7.0
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Bronte WARD	340 - RESPIRATORY MEDICINE		1495.5	1,362	1124.5	1,070	1069.25	1,152	728.5	729	91.0%	95.2%	107.7%	100.0%	554	4.5	3.2	7.8
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Byron	430 - GERIATRIC MEDICINE		1463.333333	1,593	1108.233333	1,271	1046.25	1,193	1035	1,576	108.9%	114.7%	114.0%	152.3%	806	3.5	3.5	7.0
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	CCU	320 - CARDIOLOGY		709.5	714	0	-	713	727	0	-	100.6%	-	101.9%	-	124	11.6	0.0	11.6
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Delivery	501 - OBSTETRICS		2623.216667	2,700	600	586	2628	2,607	516	480	102.9%	97.6%	99.2%	93.0%	211	25.2	5.0	30.2
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Dolphin (Paeds)	420 - PAEDIATRICS		2966.25	3,344	733.5	693	2449.5	2,426	345	403	112.7%	94.4%	99.0%	116.7%	616	9.4	1.8	11.1
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Gundulph	300 - GENERAL MEDICINE		1401	1,715	1177	1,291	1092.75	1,495	1092.75	1,245	122.4%	109.6%	136.8%	113.9%	757	4.2	3.3	7.6
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Harvey	328-STROKE MEDICINE		1263.25	1,249	1255.483333	1,445	1384.75	1,241	1035	990	98.8%	115.1%	89.6%	95.7%	732	3.4	3.3	6.7
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3533.25	3,338	0	-	3138.75	3,081	0	-	94.5%	-	98.2%	-	225	28.5	0.0	28.5
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Keats	301 - GASTROENTEROLOGY	307-DIABETIC MEDICINE	1734.25	2,037	1232.5	1,325	1023	1,630	1023	1,089	117.4%	107.5%	159.3%	106.5%	804	4.6	3.0	7.6
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Kent	501 - OBSTETRICS		1121	1,121	419.5	390	744	746	744	720	100.0%	93.0%	100.2%	96.8%	590	3.2	1.9	5.0
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Kingfisher SAU	100 - GENERAL SURGERY		1854.266667	1,612	1506.55	1,527	1363	1,377	682	693	87.0%	101.4%	101.0%	101.6%	424	7.1	5.2	12.3
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Lawrence	823 - HAEMATOLOGY		1104.5	920	756.5	845	697.5	811	697.5	833	83.3%	111.7%	116.2%	119.4%	589	2.9	2.8	5.8
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	McCulloch	100 - GENERAL SURGERY		1458.5	1,585	1105.5	1,592	1023	1,617	1022	1,056	108.6%	144.0%	158.1%	103.3%	700	4.6	3.8	8.4
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Medical HDU	192 - CRITICAL CARE MEDICINE		1411.5	1,434	357	357	1069.5	1,079	356.5	355	101.6%	100.0%	100.8%	99.5%	164	15.3	4.3	19.7
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Milton	430 - GERIATRIC MEDICINE		1589.166667	1,876	1166.75	1,508	1023.75	1,502	1046.25	1,279	118.0%	129.2%	146.7%	122.2%	866	3.9	3.2	7.1
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Nelson	320 - CARDIOLOGY		1349	1,190	1203	1,189	1001	979	682	671	88.2%	98.8%	97.8%	98.4%	742	2.9	2.5	5.4
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	NICU	422- NEONATOLOGY		3719.25	3,463	420	138	3552.75	3,565	0	-	93.1%	32.9%	100.4%	-	729	9.6	0.2	9.8
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Ocelot	502 - GYNAECOLOGY		909	938	414	615	744	744	372	372	103.1%	148.6%	100.0%	99.9%	343	4.9	2.9	7.8
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Pearl	501 - OBSTETRICS		1172.75	1,174	667.25	433	1116	1,152	372	371	100.1%	64.8%	103.2%	99.6%	355	6.6	2.3	8.8
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Pembroke	110 - TRAUMA & ORTHOPAEDICS		1474	1,437	1217	1,089	1023	1,045	1012	1,023	97.5%	89.5%	102.2%	101.1%	784	3.2	2.7	5.9
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Phoenix	100 - GENERAL SURGERY		1855.5	1,609	1573.916667	1,313	1364	1,437	1364	1,308	86.7%	83.4%	105.4%	95.9%	903	3.4	2.9	6.3
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Sapphire Ward	300 - GENERAL MEDICINE		1482.75	1,181	2373.5	2,088	1023	1,221	1364	1,342	79.6%	88.0%	119.4%	98.4%	865	2.8	4.0	6.7
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	SDCC	100 - GENERAL SURGERY		1635.25	1,680	1522.5	964	660	916	691.25	658	102.7%	63.3%	138.8%	95.2%	517	5.0	3.1	8.2
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Surgical HDU	192 - CRITICAL CARE MEDICINE		2051	2,020	373.5	333	1694	1,705	0	-	98.5%	89.1%	100.6%	-	306	12.2	1.1	13.3
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Tennyson	430 - GERIATRIC MEDICINE		1559.25	1,413	1208.483333	1,118	1023.75	1,249	1046.25	1,046	90.6%	92.5%	122.0%	100.0%	836	3.2	2.6	5.8
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	The Birth Place	501 - OBSTETRICS		1118.75	1,115	372	372	1116	1,118	372	360	99.7%	100.0%	100.2%	96.8%	91	24.5	8.0	32.6
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Victory	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1165.483333	1,876	755.5166667	1,336	1012	1,177	682	1,672	161.0%	176.8%	116.3%	245.2%	536	5.7	5.6	11.3
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Wakeley	300 - GENERAL MEDICINE		1880.516667	2,024	1247.5	1,276	1046.25	1,541	1046.25	1,136	107.6%	102.3%	147.3%	108.6%	769	4.6	3.1	7.8
		RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Will Adams	301 - GASTROENTEROLOGY	307-DIABETIC MEDICINE	1486.5	1,436	1160.75	1,167	1023	1,354	1023	1,100	96.6%	100.6%	132.4%	107.5%	804	3.5	2.8	6.3

Fill rate indicator return

Staffing: nursing, midwfery and care staff

May-16

		Day				Night				Day		Night		Quality Metrics / Actual Incidents					Associate Chief Nurse (Divisonal) review			Internal KPIs					Care Hours Per Patient Day (CHPPD)			
		Registered Staff		Care Staff		Registered Staff		Care Staff																						
WARD	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	*Average fill rate - registered staff (%)*	*Average fill rate - care staff (%)*	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Number of escalations of nurse staffing	Number of hospital acquired Pressure Ulcers grade 2 and above	Number of Falls withmoderate to severe harm	Number of patient related medication errors - moderate to severe harm	Number of complaints relating to nursing care	ACND rag rating	Assurance statement	ACND signoff	Total Planned Hours (registered & care)	Total Actual Hours (registered & care)	Overall fill rate	Difference total Actual vs Planned hs	Difference total Actual vs Planned %	Cumulative count over the month of patients at 23:59 each day	Registered midwives / Nurses	Care Staff	Overall
Arethusa	27	1885	1,901	1139.9	1,418	1364	1,331	1012	1,057	*101%*	*124%*	*98%*	*104%*	1	1	0	0	0		Arethusa and Pembroke wards work as one specialist orthopaedic unit and staff move across the two wards to ensure safe staffing levels. Additionally the ward sister and Matron work clinically when required to ensure staffing is levels remain safe.	SH	*5,401*	*5,707*	*106%*	*306*	*6%*	816	4.0	3.0	7.0
Bronte WARD	18	1495.5	1,362	1124.5	1,070	1069.25	1,152	728.5	729	*91%*	*95%*	*108%*	*100%*	1	1	0	0	0				*4,418*	*4,312*	*98%*	*- 106*	*-2%*	554	4.5	3.2	7.8
Byron	26	1463.333	1,593	1108.23333	1,271	1046.25	1,193	1035	1,576	*109%*	*115%*	*114%*	*152%*	0	0	0	0	0				*4,653*	*5,633*	*121%*	*980*	*21%*	806	3.5	3.5	7.0
CCU	4	709.5	714	0	-	713	727	0	-	*101%*	*#DIV/0!*	*102%*	*#DIV/0!*	0	0	0	0	0				*1,423*	*1,441*	*101%*	*18*	*1%*	124	11.6	0.0	11.6
Delivery	15	2623.217	2,700	600	586	2628	2,607	516	480	*103%*	*98%*	*99%*	*93%*	0	0	0	0	0		Staff moved from other clinical areas in response to chaning acuity	DS	*6,367*	*6,372*	*100%*	*5*	*0%*	211	25.2	5.0	30.2
Dolphin (Paeds)	34	2966.25	3,344	733.5	693	2449.5	2,426	345	403	*113%*	*94%*	*99%*	*117%*	0	0	0	0	0				*6,494*	*6,865*	*106%*	*371*	*6%*	616	9.4	1.8	11.1
Gundulph	25	1401	1,715	1177	1,291	1092.75	1,495	1092.75	1,245	*122%*	*110%*	*137%*	*114%*	0	1	1	0	1				*4,764*	*5,746*	*121%*	*982*	*21%*	757	4.2	3.3	7.6
Harvey	24	1263.25	1,249	1255.48333	1,445	1384.75	1,241	1035	990	*99%*	*115%*	*90%*	*96%*	0	0	0	0	1				*4,938*	*4,924*	*100%*	*- 14*	*0%*	732	3.4	3.3	6.7
Intensive Care Unit	9	3533.25	3,338	0	-	3138.75	3,081	0	-	*94%*	*#DIV/0!*	*98%*	*#DIV/0!*	0	1	0	0	0		Safely staffed - no concerns. Staff work flexibly across all critical care areas. Delayed discharge led to patients being appropriate for ward based care remaining on the unit, therefore staffing levels are able to be adjusted without impacting on patient safety.	SH	*6,672*	*6,419*	*96%*	*- 253*	*-4%*	225	28.5	0.0	28.5
Keats	27	1734.25	2,037	1232.5	1,325	1023	1,630	1023	1,089	*117%*	*108%*	*159%*	*106%*	1	0	0	0	2				*5,013*	*6,080*	*121%*	*1,068*	*21%*	804	4.6	3.0	7.6
Kent	24	1121	1,121	419.5	390	744	746	744	720	*100%*	*93%*	*100%*	*97%*	0	0	0	0	0		unit safely staffed	DS	*3,029*	*2,976*	*98%*	*- 52*	*-2%*	590	3.2	1.9	5.0
Kingfisher SAU	14	1854.267	1,612	1506.55	1,527	1363	1,377	682	693	*87%*	*101%*	*101%*	*102%*	1	0	0	0	1		When staffing levels fell below the recommended level the nurse in charge worked clinically in the numbers to provide patient care. We have a Matron of the day who oversees the directorate and coordinates staffing across all areas moving staff where required	SH	*5,406*	*5,210*	*96%*	*- 196*	*-4%*	424	7.1	5.2	12.3
Lawrence	19	1104.5	920	756.5	845	697.5	811	697.5	833	*83%*	*112%*	*116%*	*119%*	0	0	0	0	0				*3,256*	*3,408*	*105%*	*152*	*5%*	589	2.9	2.8	5.8
McCulloch	24	1458.5	1,585	1105.5	1,592	1023	1,617	1022	1,056	*109%*	*144%*	*158%*	*103%*	1	1	0	0	2		When staffing levels fell below the recommended level the nurse in charge worked clinically in the numbers to provide patient care. We have a Matron of the day who oversees the directorate and coordinates staffing across all areas moving staff where required. To manage increased activity 6 additional flex beds were opened for much of the month, requiring additional nurses and there were a number of medical patients in surgical beds.	SH	*4,609*	*5,850*	*127%*	*1,241*	*27%*	700	4.6	3.8	8.4
Medical HDU	6	1411.5	1,434	357	357	1069.5	1,079	356.5	355	*102%*	*100%*	*101%*	*100%*	3	0	0	0	0		Safely staffed - no concerns. Staff work flexibly across all critical care areas. Delayed discharge led to patients being appropriate for ward based care remaining on the unit, therefore staffing levels are able to be adjusted without impacting on patient safety.	SH	*3,194*	*3,224*	*101%*	*30*	*1%*	164	15.3	4.3	19.7
Milton	27	1589.167	1,876	1166.75	1,508	1023.75	1,502	1046.25	1,279	*118%*	*129%*	*147%*	*122%*	0	1	0	0	1				*4,826*	*6,164*	*128%*	*1,338*	*28%*	866	3.9	3.2	7.1
Nelson	24	1349	1,190	1203	1,189	1001	979	682	671	*88%*	*99%*	*98%*	*98%*	0	0	0	0	0				*4,235*	*4,028*	*95%*	*- 207*	*-5%*	742	2.9	2.5	5.4
NICU	25	3719.25	3,463	420	138	3552.75	3,565	0	-	*93%*	*33%*	*100%*	*#DIV/0!*	0	0	0	0	0				*7,692*	*7,167*	*93%*	*- 526*	*-7%*	729	9.6	0.2	9.8
Ocelot	12	909	938	414	615	744	744	372	372	*103%*	*149%*	*100%*	*100%*	0	0	0	0	0		unit safely staffed	DS	*2,439*	*2,668*	*109%*	*229*	*9%*	343	4.9	2.9	7.8
Pearl	23	1172.75	1,174	667.25	433	1116	1,152	372	371	*100%*	*65%*	*103%*	*100%*	6	0	0	0	0		unit safely staffed	DS	*3,328*	*3,129*	*94%*	*- 199*	*-6%*	355	6.6	2.3	8.8
Pembroke	27	1474	1,437	1217	1,089	1023	1,045	1012	1,023	*97%*	*89%*	*102%*	*101%*	0	0	0	0	0		Arethusa and Pembroke wards work as one specialist orthopaedic unit and staff move across the two wards to ensure safe staffing levels. Additionally the ward sister and Matron work clinically when required to ensure staffing is levels remain safe.	SH	*4,726*	*4,594*	*97%*	*- 132*	*-3%*	784	3.2	2.7	5.9
Phoenix	30	1855.5	1,609	1573.91667	1,313	1364	1,437	1364	1,308	*87%*	*83%*	*105%*	*96%*	1	0	0	0	0		When staffing levels fell below the recommended level the nurse in charge worked clinically in the numbers to provide patient care. We have a Matron of the day who oversees the directorate and coordinates staffing across all areas moving	SH	*6,157*	*5,667*	*92%*	*- 490*	*-8%*	903	3.4	2.9	6.3
Sapphire Ward	28	1482.75	1,181	2373.5	2,088	1023	1,221	1364	1,342	*80%*	*88%*	*119%*	*98%*	0	0	0	0	0				*6,243*	*5,832*	*93%*	*- 411*	*-7%*	865	2.8	4.0	6.7
SDCC	14	1635.25	1,680	1522.5	964	660	916	691.25	658	*103%*	*63%*	*139%*	*95%*	0	0	0	0	0		When staffing levels fell below the recommended level the nurse in charge worked clinically in the numbers to provide patient care. We have a Matron of the day who oversees the directorate and coordinates staffing across all areas moving staff where required. To manage increased activity additional flex beds were opened for much of the month, requiring additional nurses and there were a number of	SH	*4,509*	*4,217*	*94%*	*- 292*	*-6%*	517	5.0	3.1	8.2
Surgical HDU	10	2051	2,020	373.5	333	1694	1,705	0	-	*98%*	*89%*	*101%*	*#DIV/0!*	1	0	0	0	0		Safely staffed - no concerns. Staff work flexibly across all critical care areas. Delayed discharge led to patients being appropriate for ward based care remaining on the unit, therefore staffing levels are able to be adjusted without impacting on patient safety.	SH	*4,119*	*4,057*	*99%*	*- 61*	*-1%*	306	12.2	1.1	13.3
Tennyson	27	1559.25	1,413	1208.48333	1,118	1023.75	1,249	1046.25	1,046	*91%*	*93%*	*122%*	*100%*	0	3	0	0	1				*4,838*	*4,826*	*100%*	*- 11*	*0%*	836	3.2	2.6	5.8
The Birth Place	9	1118.75	1,115	372	372	1116	1,118	372	360	*100%*	*100%*	*100%*	*97%*	0	0	0	0	0		Staff moved from other clinical areas in response to chaning acuity		*2,979*	*2,965*	*100%*	*- 14*	*0%*	91	24.5	8.0	32.6
Victory	18	1165.483	1,876	755.516667	1,336	1012	1,177	682	1,672	*161%*	*177%*	*116%*	*245%*	1	2	0	0	1		When staffing levels fell below the recommended level the nurse in charge worked clinically in the numbers to provide patient care. We have a Matron of the day who oversees the directorate and coordinates staffing across all areas moving staff where required. To manage increased activity additional flex beds were opened for much of the month, requiring additional nurses and there were a number of medical patients in surgical beds. A number of our	SH	*3,615*	*6,061*	*168%*	*2,446*	*68%*	536	5.7	5.6	11.3
Wakeley	25	1880.517	2,024	1247.5	1,276	1046.25	1,541	1046.25	1,136	*108%*	*102%*	*147%*	*109%*	1	0	0	1	0				*5,221*	*5,977*	*114%*	*757*	*14%*	769	4.6	3.1	7.8
Will Adams	26	1486.5	1,436	1160.75	1,167	1023	1,354	1023	1,100	*97%*	*101%*	*132%*	*108%*	0	0	0	0	3				*4,693*	*5,057*	*108%*	*364*	*8%*	804	3.5	2.8	6.3
Trust total	**621**	**50,472**	**51,054**	**28,191**	**28,747**	**39,229**	**43,213**	**21,362**	**23,562**	***101.2%***	***102.0%***	***110.2%***	***110.3%***	**18**	**11**	**1**	**1**	**13**				**139,255**	**146,576**	**105%**	**7321**	**5.3%**				

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date: June 2016

Title of Report	Workforce Update
Reporting Officer	Rebecca Bradd
Lead Director	Rebecca Bradd, Acting Director of Workforce
Responsible Sub-Committee	Executive
Executive Summary	The report provides an update regarding the Workforce Priority programmes and strategy development.
Risk and Assurance	Safe staffing levels is a significant risk and workforce planning and recruitment is being undertaken to minimise this risk. The Trust recognises that previous recruitment and retention strategies have not adequately addressed the urgent need for improvement in staffing levels and the team have been looking at other NHS and best practice organisations that have been successful in recruitment and retention to ensure that all appropriate activity is being undertaken. Changes have already been identified to ensure that the activity is being supported by a streamlined recruitment, on boarding and developmental process. Improvements in leadership capability and staff engagement should improve retention and organisational performance.
Legal Implications/Regulatory Requirements	Staffing levels, staff engagement, leadership and culture have been identified as areas of urgent 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 of the Recovery plan.
Quality Impact Assessment	n/a
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Information
Recommendation	n/a

Medway NHS
NHS Foundation Trust

Workforce Update: June 2016

Summary

In this month's update progress is provided in relation to the following areas:

- Update regarding Workforce priority programmes:
  - Staffing recruitment and retention plan
  - Temporary staffing plan
  - Staff engagement and culture change
  - Workforce modelling
  - Workforce informatics
- People strategy development

WORKFORCE: CURRENT STATUS

WORKFORCE PRIORITY PROGRAMMES

Workforce is a critical enabler for the delivery of the Trust's strategic objectives, its recovery and an improvement in organisational performance. Priority workforce programmes for the next six months have been agreed as part of the Recovery Plan by the Executive including:

- Staffing recruitment and retention plan
- Temporary staffing plan
- Staff engagement and culture change
- Workforce modelling
- Workforce informatics

The detailed work stream plans and key deliverables are being presented at the Executive on 29th June.

STAFFING RECRUITMENT AND RETENTION PLAN

The Staffing Recruitment and Retention work stream is focusing on high impact recruitment and retention initiatives including recruitment branding, targeted recruitment campaigns for business critical posts and retention initiatives. This work stream is supported by focussed clinical, operational, HR and corporate task and finish groups for the nursing and medical staff groups. The nursing task and finish group is already in place and meeting regularly. The medical task and finish group commences on 7th July.

The work stream will be supported by improvements being made to the Resourcing materials, quality and speed of recruitment and improved communication with candidates further to selection and through on boarding.

TEMPORARY STAFFING

The Temporary Staffing service has been in place since the end of March 2016. The Temporary Staffing work stream will move from a focus of implementation of the bank to focus on three particular areas; improvement of the fill rate of the temporary staffing requirement, the recruitment to bank positions (movement away from agency) and a reduction in overall agency expenditure and any strategies/ initiatives will closely align to the Recruitment and Retention work stream.

STAFF ENGAGEMENT AND CULTURE CHANGE

There has been a number of activities including implementation of the Vision and Values, improved communication with staff, leadership development, anti-bullying campaign and Staff Survey plans that has taken place and/or are underway. This work stream going forward will focus on high impact activities to improve our staff engagement and expedite culture change within the organisation.

WORKFORCE MODELLING

This work stream will focus on the shape and size of the current organisation; aligning current activity and demand with the right number of staff with the right skills to ensure that we maximise the efficiency of our current staff. This work stream will also look to the skills required for the future and work with our partners to develop a sustainable workforce plan for Medway.

WORKFORCE INFORMATICS

This work stream will focus on the improvement of vacancy visibility and control through the Electronic Staff Record, will develop a rollout plan for rostering across the organisation and develop the plan to move to real time workforce information.

WORKFORCE ACTIVITY

Key deliverables this month include:

- Net improvement of nursing starters and leavers in May (9 wte)
- 5 consultants recruited in month in May
- Improvement in planned vs actual nursing hours due to improved temporary fill rate in May (see nursing report)
- Engagement with recruitment branding agency- output of early July
- Recruitment and retention task and finish groups arranged
- Management development programme commenced in June
- Workforce programme plans developed (to be presented to Executive 29th June)

STRATEGY DEVELOPMENT

The Priority programmes form the foundations of the People and Organisational Development Strategy which is being presented at Executive on 29th June. This will be socialised with the wider Board members and be presented to Board in July for approval.

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date: 30 June 2016

Title of Report	Corporate Governance Report
Reporting Officer	Lynne Stuart
Lead Director	Lynne Stuart
Responsible Sub-Committee	
Executive Summary	The report outlines current activity and issues in corporate governance.
Risk and Assurance	Outlined in report.
Legal Implications/Regulatory Requirements	Outlined in report. Trust is in breach of NHS Improvement Licence condition CoS3 – Standards of corporate governance and financial management
Recovery Plan Implication	• Continuing the work to improve our corporate and clinical governance, which will support both safe and high quality patient care and a productive working culture for staff.
Quality Impact Assessment	Not Required.
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Information
Recommendation	Not applicable.

Corporate Governance Report: June 2016

1. Executive Summary

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

2. Care Quality Commission - Notifications

There have been three separate incidents within the CT department that occurred during the period 20 - 27 May 2016 but which were only reported internally on 1 June. All three patients underwent CT of the wrong area and therefore were exposed to a greater level of radiation than that intended. All three incidents were reported to the CQC under IR(ME)R regulations. A level 1 Serious Incident investigation is underway. A fourth incident occurred mid-June and this cluster of incidents is being amalgamated into a single SI investigation.

On 16 May the Assistant Coroner issued a Regulation 28 Report to Prevent Future Deaths following the inquest into the death of Jonathan Lewis Fry. The Report was copied by the Assistant Coroner to the CQC who requested a copy of the Trust response to the Coroner. The matters of concern raised by the Coroner were:

- There was no senior review by a consultant from admission to time of death and no locum cover
- There was no daily review of test results and no consideration given to instances where tests had not been performed or consideration given to the reasons why
- Medical records were inconsistent and/or incomplete leading to a lack of clarity as to reviews and care plan

The response to the Report was issued to the Coroner and CQC on 10 June. The matter is subject to review and scrutiny via the Trust's clinical governance framework.

The Trust has also received a request from the CQC to submit a copy of the Trust response to the Coroner on a previously issued Regulation 28 Report, following the inquest into the death of Alwyn Head, which was reported to the Board in April 2016.

The CQC has confirmed in writing that it has now registered the Orchards Centre Special Needs Nursery to provide the Regulated Activity: Treatment of Disease, disorder or injury as a separate Location; this means that the Trust now has three Locations registered.

3. Legal

Legal services are developing a programme of bite-sized seminars with Brachers solicitors targeted at clinicians and staff. Subjects to be scheduled over the next quarter include:

- Confidentiality, Consent and Capacity
- Witness skills
- Legal implications of record keeping

An inquest support pack is also being prepared together with templates for statements to help improve the information supplied to the Coroner and to better prepare staff who are required to attend.

4. Documentation management

New document templates are now available on the intranet and can be accessed using the search facility on Q-Pulse. One system is now being used to manage Trust documents.

A suite of standardised templates is being created for all formal trust groups/ committees, this will include Terms of Reference, agendas, minutes and matters arising logs and will be available in early July.

Whilst some streamlining of policies has been undertaken, there is considerably more work to be undertaken. Currently 18 Corporate Policies require review and 337 local documents will have reached their review date. The rolling programme is now being sent out monthly to the sponsoring Directors and documentation leads have been established across the Trust. Policy training sessions will shortly be available to authors and document owners through the new 'bite size' learning and development forums. All out of date documents will be in date by the end of September provided that reviewers undertake the work assigned. There are three documents still required for the NHS Contract which the sponsoring directors are aware of must be approved by end of June.

5. Information Governance

Beverley Adams-Reynolds, the new Information Governance Manager commenced on 1 June.

A level 2 Serious Incident was notified to the Information Commissioner's Office via the IG Toolkit submission on 6 June 2016 relating to USB drives held in lost property, one of which had a significant amount of patient identifiable data relating to 1500 patient discharge summaries over the course of April to August 2010. The documents contained

full name, hospital number, NHS number, address, telephone number, allergies, MRSA status, admission and discharge date, gender, diagnosis, details of care, medication prescribed and doctor details. This incident has been investigated by the Director of Governance, Risk, Compliance and Legal and the Head of Integrated Governance. An incident of this grade results in automatic referral to the ICO, which has been completed. The secure destruction of the USB drives is being carried out.

The incident also highlights a lack of management of lost property as the USB drives had been held for a number of years. The Director of Estates and Facilities is addressing lost property management issues.

A further incident has arisen which will be reportable at Serious Incident level 2. Occupational Therapists manage their workflow and referrals manually in A4 books. A book, shared between wards has gone missing. The incident has been investigated by the Head of Integrated Governance and the Information Governance Manager. Two differing systems of data capture in the books exist: one capturing patient names, NHS numbers, a brief description of treatment, Ward and bed number – a full book has the potential to hold hundreds of patient data. The second style captures this information but also patient home addresses and contact details. It is the former style of patient book that has gone missing with estimated patient details of between 50 – 100 patients. The referral to the ICO will happen on 20 June now that the investigation has concluded.

The incident has highlighted the OT teams' reliance on paper-based systems. Short term recommendations from the investigation included reducing the volume of data being carried around by moving to carrying only the last two weeks information, and storing older records (which are not in constant use) in a file based system. The longer term solution is for the teams to use iPads and a web based application to access information. The first two iPads are scheduled to arrive week commencing 20 June which will be trialled within a team, before more are ordered and a broader roll-out is taken forward.

The Information Governance Group met on 7 June. The Group have requested assurance on the information security systems that are in place to prevent or deter downloading data onto USB drives.

<u>Health Records management</u>

It is clear that current records management practices are not currently fulfilling all the requirements of the Data Protection Act. Deficiencies include:

- No active records management to ensure that records are not held longer than necessary and are destroyed at the required time; this breaches Principle 5 of the DPA: Personal data processed for any purpose or purposes shall not be kept for longer than is necessary for that purpose or those purposes

- Records being held in areas where the data may be corrupted by water ingress; the Deceased Records Library is in a building that is prone to flooding and has been known to be a flood risk for a number of years; this breaches Principle 7: Appropriate technical and organisational measures shall be taken against unauthorised or unlawful processing of personal data and against accidental loss or destruction of, or damage to, personal data.
- Records being kept in multiple locations and incomplete records being maintained. It has been identified that breast care notes have been maintained separately from other patient notes and have not been integrated into patient records. This practice has been in place in excess of 10 years. As well as breaching Trust policies which require patients' notes to be complete, it breaches Principle 3 of the DPA: Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed.

The Information Governance Manager and the Director of Corporate Governance, Risk, Compliance and Legal are coordinating responses across the Trust to address these issues.

6. Health and Safety

On 23 May the Trust received a letter from the Health and Safety Executive (HSE) regarding a notification about magnetic locks not working on a set of doors in A&E. Upon investigation all magnetic locks in A&E appeared to be in working order. Subsequently a response was sent to the HSE on 25 May, which the HSE found satisfactory and stated that no further action was necessary. It appears that this notification came from a member of staff that has not utilised the Estates hotline or Datix by following the Trust reporting system. The staff member remains anonymous which is standard practice with the HSE. Staff have been reminded of the correct protocols for raising health and safety issues in a global email sent on 31 May.

7. Emergency Preparedness, Resilience and Response

The heatwave plan for England has been released by NHS England and the campaign launch for the hospital has commenced.

NHS England has published details of the assurance process for 2016/17. The core standards for EPRR remain unchanged from 2015. A comprehensive paper on the assurance process will be presented at the board meeting in September.

8. Risk Management

Relevant staff were trained on the HealthAssure RiskAssure system on 20 June. They have been tasked with inputting their refreshed and reworked risk registers onto the

system so that the board can anticipate reviewing the first resulting Trust wide risk register at the July board meeting. A report containing all risks will be presented to the board as a considerable period of time has lapsed since the board had oversight of all organisational risks.

9. CQCAssure implementation

The implementation of the CQCAssure is now underway. Train the trainer sessions took place on 8 June and a subsequent roll out of training is now underway. The first cohort of staff being trained are the Matrons and Senior Sisters, who along with the Clinical Directors have the responsibility of completing a CQC self-assessment of their areas against the Key Lines of Enquiry for each of the five domains. The level of compliance, or otherwise, will be approved by the Deputy Directors of Nursing and Directors of Clinical Operations and remedial action plans developed and implemented. Similarly the Executive Directors will be shown how to self-assess the organisation against the Fundamental standards. This will allow cross sectional oversight of the Trusts level of compliance. It is expected that CQC self-assessments of all areas will be complete by 29 July 2016.

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date: June 2016

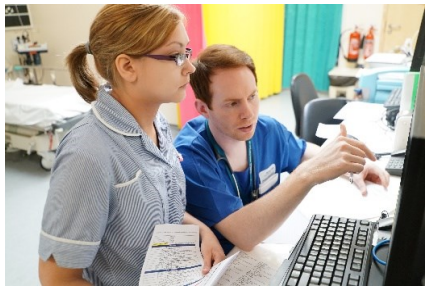
Title of Report	Integrated Quality and Performance Report
Reporting Officer	Emma Birdsey, Senior Business Intelligence Analyst
Lead Director	Dr Trisha Bain CQO
Responsible Sub-Committee	N/A
Executive Summary	SIs - There has been a decrease in the number of breaching SIs due to an intensive review of the outstanding incidents in the system. There has also been a decrease in SIs reported on STEIs in May. Cancer - The Trust maintained compliance with the 2 week wait standard across most tumour sites. The Trust failed to achieve the 31 day first definitive standard. The Cancer 31 day subsequent treatment surgical and 31 day anti-cancer drug treatment were compliant. The 62 day urgent GP referrals remain below target. A&E –ED 4 hour performance continues to see improvement as we have seen a 3.38% increase on last month's performance, which is the second increase in two months. Performance for May is 83%
Risk and Assurance	N/A
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	N/A
Purpose & Actions required by the Board : • **Assistance** • **Approval**	To inform/advise the Board of current performance across all functions and key performance indicators

• **Decision** • **Information**	
Recommendation	N/A

Medway NHS
NHS Foundation Trust

Integrated Quality and Performance Report

June 2016



Integrated Quality and Performance Report

June 2016

Contents and Key

Medway NHS Foundation Trust

Section	Content
Overview	Trust overview
Domain scorecards	1. Safe
	2. Effective
	3. Caring
	4. Responsive
	5. Well-led
	7. Enablers

Key to scorecard coding

Trust overview

Status	
Outlook	
Update	Expected to improve over next reporting period
Stable	Not expected to change over next reporting period
Escalate	Expected to deteriorate over next reporting period

Status	
Priority this/last month	
Yes	Larger/significant new risks to be/being managed in month
No	Smaller/maintainance risks to be/being managed in month

Scorecards

RAG	
Status	
G	Achieving target with good margin in month
A	Achieving target with small margin in month
R	Not achieving target in month

Executive Summary

Safe

Legend: Compliant with target; Breaching target

- **Serious Incidents 1.1.1** – There were no never event reports and 3 serious incidents reported on STEIS in May.
  - One due to infection control – MRSA: Action plan is in place.
  - One due to a Grade 4 pressure ulcer: Tissue viability staff is delivering training to all ward staff.
  - One due to 52 week waiter – delay in treatment actions: Review of Cardiology position relating to excessive waits has been under taken, and all patients that have breached 52 weeks have been reviewed by clinical staff, with a detailed action plan in place.

- **Proportion of harm free care 1.2.1** – The trust was below target at 92%.

- **MRSA Bacteraemia 1.3.2** – Two MRSA bacteraemia cases on Victory and Milton wards. Both cases considered to be unavoidable at post infection review, and have been referred to arbitration for third party assignment. Outcome is awaited.

- **HSMR & SHMI 1.4.1 & 1.4.2** – The Trust's position for the HSMR & SHMI continues to improve. The current HSMR position (Mar15 – Feb16) is 102.92, and within benchmarked limits. The SHMI position (Jan15 – Dec15) is 1.13, which while higher than expected is the lowest trust position since 2013.
  Acute Kidney Injury is a diagnosis group of concern at present, as the SMR for patients in this group has increased month on month, currently standing at 132.29. The AKI action group will be undertaking a 'deep dive' in to this, and are producing a report to be presented at the next Quality Assurance Committee, and subsequently the Trust Board.

Effective

CQUIN - CQUIN schemes for 16/17 are being discussed internally and externally with an agreement to be reached by 30th June 2016. Any milestones for Q1 have been moved to Q2 which has been mutually agreed by all parties.

NICE compliance 2.4.1 & 2.4.4 – Since April 2016 there have been 28 Nice guidelines and quality standards published. Responses have been received for 10 (35.7%), 4 of which were assessed as not applicable. 18 remain under review, with the 90 day response deadline for these being the 31st July 2016.

Caring

- **Mixed Sex Accommodation Breaches 3.1.3** – Good performance continues as a result of not opening Lister Ward overnight, and greater vigilance within Site Management and within wards of mixed sex principles.

- **Friends and Family % Recommended 3.1.2** – May recommended % is at 85.6%, which continues to be above the monthly target of 83%. However, response rates are just below target at 24.4%

Responsive

- **RTT 4.1.1, 4.1.2, 4.1.3 & 4.1.4 –** The overall backlog (72.27% under 6 weeks in May, improved from 67.94% in April) continues to reduce due to validation and clock stops through clinical activity with continued improvement, especially in Dermatology.
  Admitted backlog remains a key area of challenge. Plans are in development to increase capacity internally, and through the independent sector. A challenging trajectory has been set to deliver compliance with the incomplete RTT standard by 31st March 2017. The risk around delivery of this is high, and actions are being taken in conjunction with the CCG to mitigate.
  - Progress against backlog target remains ahead of plan, due to intensive validation that has taken place.

- **Overall Time in A&E 4.2.2** - The introduction of a 'Decision to Admit' policy has reduced the unnecessary length of stay patients had previously been experiencing within the ED. We have seen a reduction each month, and are currently sitting at a 95th percentile in A&E of 09:16:00 hrs.

- **A&E 4 hour breaches 4.2.3 –** Performance has improved (from 74.71% in March to 81.70% in May) due to the improved ability to see patients as a result of the increased flow and increase of staffing. ED will shortly be undertaking in-depth analysis of breaches as part of a performance review to focus on improving 4 hour times.

- **Ambulance handover times 4.2.7** - The recent introduction of the new strategy, increased staffing levels and the education of staff has had a profound effect on the EDs ability to promptly assess and treat patients arriving by ambulance, seen by the fact that in March 39% of ambulance patients were handed over in 15 minutes, increasing to 57.1% in May.

Cancer:

- **4.3.1** Trust maintained compliance with 2WW standard across most tumour sites (93.40% overall).
- **4.3.2** Trust failed to achieve symptomatic breast standard (89.81%) due to patient choice, and 1 interpreting service being unavailable.
- **4.3.3** Trust marginally failed to achieve the 31 day first definitive standard (95.61%).
- **4.3.7** Trust failed to meet the 62 day GP referral standard across a number of tumour sites at 73.77% overall for May. Pathway breaches were varied, and due to delay in diagnostic tests, endoscopy capacity, patient choice, complex pathways and late referrals from other Trusts.
- **4.3.9** Trust failed to meet the 62 day screening standard at 84.85% for May. The single Gynaecology referral was due to a delay in clinic appointment to discuss treatment, and 2 lower GI breaches were due to multiple diagnostic tests and lack of theatre availability.

- **Diagnostic waits - under 6 weeks 4.4.1** - We are reporting 454 (down from 707 in April) breaches. The majority of breaches have been caused by capacity issues. Imaging is at 94 breaches (down from 287), and Endoscopy is at 341 breaches (down from 287).

Well-Led

- **Recruitment & Retention 5.3.7** – This remains a trust priority. The new Head of HR Operations has been working with the new permanent Head of Resourcing to improve the quality of recruitment documentation and embed our values, whilst streamlining the process with a new quality assurance process put in place. Currently turnover rate has remained stable at 9.7% (target of 8%).
  Directorates are validating their recruitment vacancies and plans to address these and Workforce Task and Finish groups including clinical staff, operations, HR and finance teams have been organised for business critical staff groups (nursing having already met) to support local plans and provide corporate support and consistency in oversight. A First and Lasting Impressions event was undertaken in May with new starters.

- **Mandatory training rates 5.3.6** - We have seen an improvement in this figure from April to May, and are currently sitting at 85.5% compliance. The policy has been refreshed and includes an escalation and consequence process which is being communicated to managers and staff.

- **Appraisals completed (% all staff) 5.3.4** - Appraisal rates are shown as deteriorating, currently at 69.1%. However, there are a further 190 completed (around 5%) which are awaiting confirmation of mandatory training booking or completion which are not currently showing as completed. The appraisal and performance process is being refreshed and launched in July and the team will be working with the operations team in how this will be embedded.

- **Local Induction % Compliance 5.3.13** - The local induction process is being refreshed taking into account feedback from staff from the First and Lasting impressions event and this will be relaunched in July.

Enablers

Data quality – The main area of work is around daily DQ reports that go out to operational teams. Each issue is being looked at and given a priority for fixing, the priority is based on patient safety, financial impact and how many records it affects. In the future there will be a process put in place which will identify users which create DQ errors, these users will be given extra training on a 1:1 basis.
There is also work currently underway to build on the data quality assurance framework in the BI strategy and create a standalone DQ strategy which will give a whole trust framework for data quality improvement. This will be in a final draft form by the end of July.

Estates - key issues relating to Estates services are being maintained to the correct statutory and mandatory levels and where they are not being achieved an action plan is in place to achieve the necessary level.
The primary elements requiring action have been highlighted, which are; Water Safety, Fire Safety and Electricity at work;
- In relation to Water Safety there has been a marked improvement in compliance that the Authorised Engineer's audit from 68% to 81%. In relation to Fire Safety an action plan with approved funding by the Trust is in place and the work is being carried out.
-In relation to Electricity at Work an Authorised Engineers report was recently carried out and an action plan is being developed.

			RAG			Trend							Alignment			
Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	*Monthly target*	Mar-16	Apr-16	May-16	12m Trend	YTD avg	Data Quality	18m plan	Carter	Monitor	Quality Account
1.1 Patient safety - incident reporting	1.1.1	Total patient safety incidents (attributable, 1 month in arrears)				*N/A*	216	165			165					
	1.1.3	Total serious incidents	G	0		*5*	5	3	3		3.0					
	1.1.21	Number of SI's breaching	R	0		*0*	20	21	14		17.5					
	1.1.4	Never events	G	0		*0*	0	0	0		0.0					✓
	1.1.5	Incidents resulting in unexpected death (1 month in arrears)				*< 7*	4	6			6.0					✓
	1.1.6	Incidents resulting in severe harm (per 1000 bed days) (1 month in arrears)				*0.113*	0.06	0.06			0.06					✓
	1.1.7	Incidents resulting in moderate harm (per 1000 bed days) (1 month in arrears)				*1.871*	1.0	0.9			0.9					✓
	1.1.8	Incidents resulting in low harm (per 1000 bed days) (1 month in arrears)				*7.769*	11.2	18.6			18.6					✓
	1.1.9	Incidents resulting in no harm (per 1000 bed days) (1 month in arrears)				*18.2*	20.8	29.3			29.3					✓
	1.1.10	Incidents with moderate or severe harm with duty of candour response (1 month in arrears)				*100%*	28%	33%			0.3					✓
	1.1.11	Safeguarding alerts reported (Children and Midwifery)	R			*0*	26	21	11		16.0					
	1.1.12	Safeguarding alerts reported (Adults)	R			*0*		5	6		5.5					
	1.1.13	Deprivation of Liberty - Applications Made and Accepted				*N/A*			4		4.0					
	1.1.14	Pressure ulcers (grade 2) attributable to trust	G	0	Jun-15	*10*	6	8	9		8.5					✓
	1.1.15	Pressure ulcers (grade 3&4)	R	1		*0*	0	0	1		0.5					✓
	1.1.16a	Administration or supply of a medicine from a clinical area				*tbc*	0.4									✓
	1.1.16b	Medication error during the prescription process				*tbc*	0.0									
	1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	G			*0.2*	0.2	0.0	0.1		0.0					
	1.1.18	Falls per 1000 bed days	G	1		*6.63*	4.86	4.12	6.22		5.2					
	1.1.19	Number of falls to fracture (per 1000 bed days)	G	1		*0.2*	0.2	0.0	0.1		0.0					
	1.1.20	Transfer of Care Concerns (TOCC) relating to pressure ulcers (reported 1 month in arrears)		2		*3*	3	0			0.0					
1.2 NHS Patient safety - safety thermometer	1.2.1	Proportion of Harm Free Care - point prevalence in month	R	0		*95%*	94%	95%	92%		94%			✓		
	1.2.2	New VTEs - point prevalence in month	R	2		*0.4%*	0.8%	0.6%	1.6%		1.1%					
	1.2.3	CAUTIs - point prevalence in month	R	2	Jun-15	*0.3%*	0.4%	1.4%	1.8%		1.6%					
	1.2.4	New harms - point prevalence in month	R	1	Jun-15	*2.2%*	1.9%	1.9%	3.0%		2.5%					
	1.2.5	New Pressure ulcers - point prevalence in month	G	0	Jun-15	*0.9%*	0.6%	0.2%	0.8%		0.5%					

Theme	Ref	Indicator	RAG			Trend							Alignment			
			Status	Number of m YTD at red	Escalation month	*Monthly target*	Mar-16	Apr-16	May-16	12m Trend	YTD avg	Data Quality	18m plan	Carter	Monitor	Quality Account
1.3 Infection control and cleanliness	1.3.1	MRSA screening of admissions	G	1	Jun-15	*95%*	98%	94%	98%		96%					✓
	1.3.2	MRSA bacteraemia (trust – attributable)	R	1	Jun-15	*0*	0	0	2		1					
	1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	G	0	Jun-15	*2*	0	0	0		0					✓
	1.3.4	Hand Hygiene compliance	G	0		*95%*	99%	95%	95%		95%					
	1.3.5	Number of MSSA cases post 48 hours	G	0	Jul-15	*10*	2	0	1		1					
	1.3.6	Number of E-coli cases post 48 hours			Jun-15	*N/A*	3	2	6		4					
	1.3.7	Surgical Site Infection - Hip Replacement (reported 1 quarter in arrears)	G	0		*1.1%*		0.0%								
	1.3.8	Surgical Site Infection - Knee Replacement (reported 1 quarter in arrears)	R	0		*1.6%*		2.9%								
	1.3.9	Surgical Site Infection - Repair of neck of femur (reported 1 quarter in arrears)	G	0		*1.5%*		0.0%								
1.4 Mortality	1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	R	1		*100*		102.92			102.9					✓
	1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	R	1		*100*		115			115			✓		✓
	1.4.3	Number of Deaths in low risk diagnosis groups **(Quarter 4 15/16)**	R	2	Jun-15	*0.65*	2	2	1		1.5					
	1.4.4	Crude Mortality **(Quarter 4 15/16)**			Jul-15	N/A	141	131	123		127					
1.4 Mortality	1.4.13	Septicaemia SMR (Rolling 12 Month)	R			*100*		101.30								
	1.4.15	Pneumonia SMR (Rolling 12 Month)	G			*100*		99.74								
	1.4.18	Congestive Cardiac Failure SMR (Rolling 12 Month)	G			*100*		89.18								
1.5 Safe Staffing	1.5.1	Safe Staffing – ratio of actual to planned nursing hours				*TBC*	89%	99%	105%		102%					

1.1 Safe - Incidents

Although 3 incidents were reported on STEIS in May, 2 of these 3 occurred in May while the other one occurred in March 2016.

9 reports were closed in May.
2 reports were downgraded in May.

There were a total of 25 serious incidents open in May of which 14 were breaching and 11 were in date.

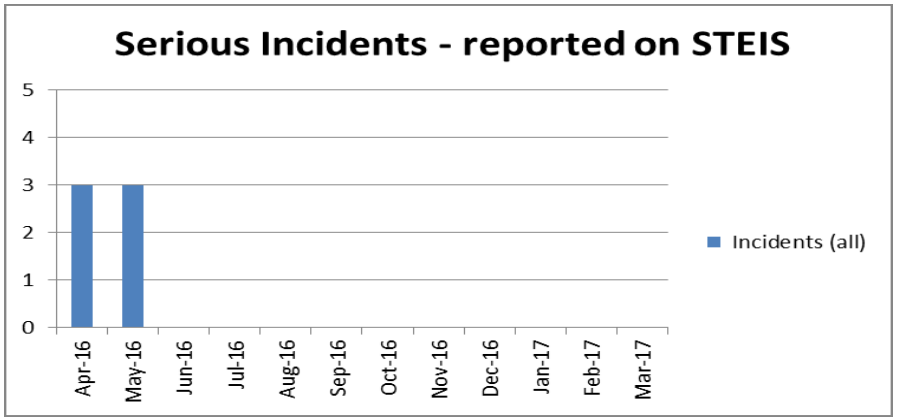
Breach breakdown:

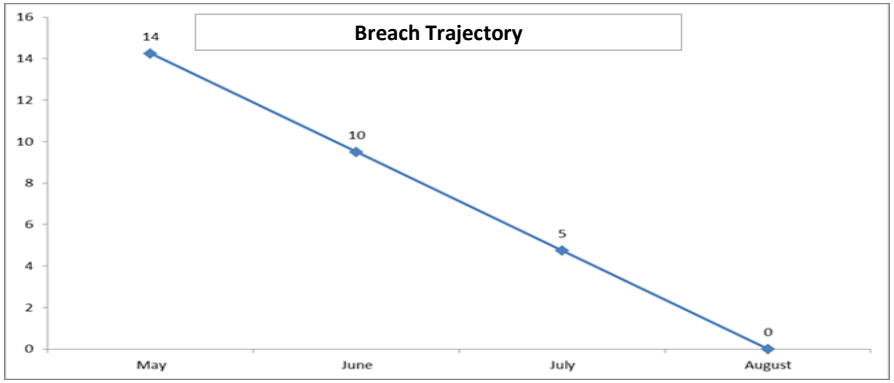
8 reports have been submitted to the CCG for June closure.
1 report has been declined by the CCG further work to be completed for readmission by 10th June 2016

5 reports are still under investigation all within Acute and Continuing Care

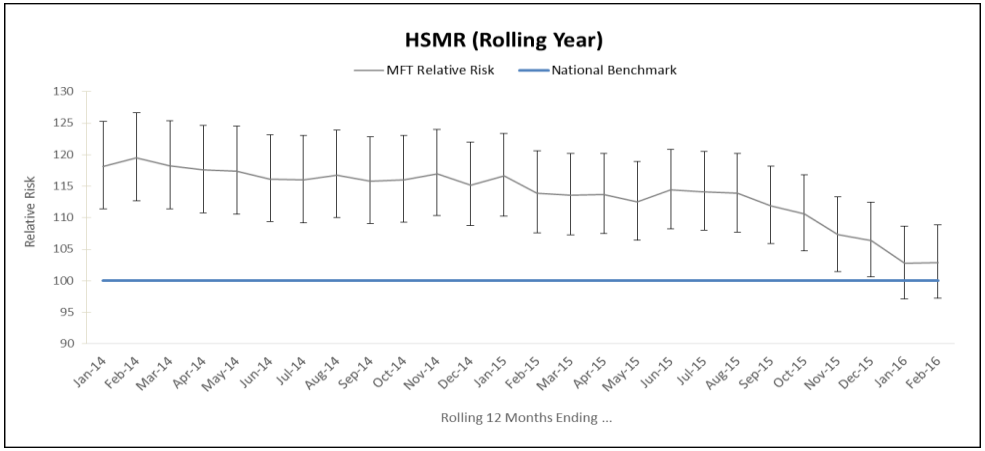
Actions to mitigate the breach rates:
Trajectory has been set target to reduce breached to 10 by June 2016
Directorates are allocating investigators
SI Tracker is in place and an escalation framework
Patient Safety Team is supporting the Directorates to ensure SI breaching reports are being completed.

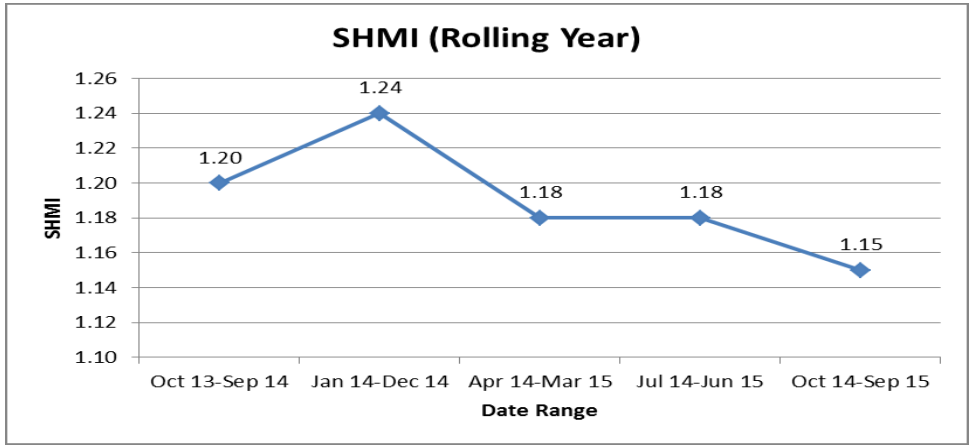
Trends





1.4 Safe - Mortality





Theme	Ref	Indicator	Status			Trend						Alignment		
			Status	Number of m YTD at red	Escalation month	*Monthly target*	Mar-16	Apr-16	May-16	12m Trend	Data Quality	18m plan	Carter	Monitor
2.1. CQUINs – national	2.1.1	NHS Staff and Wellbeing - Staff Survey				*TBC*	*CQUIN Schemes currently awaiting sign off*							
	2.1.2	NHS Staff and Wellbeing - Healthy Food				*TBC*								
	2.1.3	NHS Staff and Wellbeing - Flu Vaccinations				*TBC*								
	2.1.4	Identification and Early Treatment of Sepsis - Treatment in ED				*TBC*								
	2.1.5	Identification and Early Treatment of Sepsis - Treatment in acute inpatient settings				*TBC*								
	2.1.6	Antimicrobial Resistance - Reduction in Antibiotic Consumption				*TBC*								
	2.1.7	Antimicrobial Resistance - Empiric Review of Antibiotic Consumption				*TBC*								
2.2. CQUINs – local	2.2.1	Reduction in Community Acquired Pressure Ulcers				*TBC*	*CQUIN Schemes currently awaiting sign off*							
	2.2.2	Formulary adherence – Percentage reduction in the number of hospital FP10 prescriptions issued by the Trust.				*TBC*								
	2.2.3	Discharges before midday				*TBC*								
	2.2.4	Medication Safety Thermometer				*TBC*								
	2.2.5	Effective review of patients on Oral Nutritional Supplements (ONS) in the hospital prior to discharge.				*TBC*								
	2.2.6	Paediatric outpatient referral management system				*TBC*								
	2.2.7	Development of electronic clinical communications to GPs, including a standard template for the Electronic Discharge Note				*TBC*								
	2.2.8	Paediatric asthma and wheeze pathway				*TBC*								
2.3. CQUINs – NHS England	2.3.1	Optimal Device - (ICD's)				*TBC*	*CQUIN Schemes currently awaiting sign off*							
	2.3.2	Adult Critical Care Timely Discharge				*TBC*								

Theme	Ref	Indicator	Status			Trend						Alignment		
			Status	Number of m YTD at red	Escalation month	*Monthly target*	Mar-16	Apr-16	May-16	12m Trend	Data Quality	18m plan	Carter	Monitor
2.4. CQUINs – NHS England (Public Health)	2.4.0	Increase Take Up of School Immunisations					*CQUIN Schemes currently awaiting sign off*							
2.5. Nice Compliance	2.4.1	NICE Technology Appraisals implemented					5	4	0					
	2.4.4	NICE Quality Standards escalated					10	18	#N/A					
2.6. Clinical best practice	2.5.3	Emergency readmissions within 7 days	R	1		*4.6%*	6.1%	4.5%	5.2%					
	2.5.4	Emergency readmissions within 28 days	R	2		*4.9%*	11.6%	11.4%	11.2%					
	2.5.5	Elective surgical readmissions within 28 days	R	2		0%	3.3%	4.2%	3.1%					
	2.6.9	VTE screening (Quarter Behind)	G			*95%*	97.0%							
2.7. Best practice tarriff	2.6.0	FNOF: Time to surgery within 36 hours from arrival (1 month in arrears)					74.8%	82.0%						

2. Effective - Final MFT CQUIN Schedule 15/16

Final MFT CQUIN Schedule 15/16					**£177,988,830**					
	Ref.	**Ref.**	**Responsible Officer**	**MFT value**	**(£)Value**	**Forecast as at M12**	**Forecast Amount**	**Comments**	**Achievement**	
National	AKI	S1	Sarah Leng	0.25%	£444,972	50%	£222,486	Q4 unmet	Partial	
National	Sepsis (a)	S2a	Sarah Leng	0.13%	£222,486	90%	£200,237	Q4 Partially met	Partial	
National	Sepsis (b)	S2b	Sarah Leng	0.13%	£222,486	70%	£155,740	Q4 Partially met	Partial	
National	Dementia - FAIR	S3a	Ursula Clarke	0.15%	£266,983	100%	£266,983	Met in Full	Achieved	
National	Dementia - leadership/training	S3b	Ursula Clarke	0.03%	£44,497	100%	£44,497	Met in Full	Achieved	
National	Dementia - carers	S3c	Ursula Clarke	0.08%	£133,492	100%	£133,492	Met in Full	Achieved	
National	Imp diagnosis MH	S8	Margaret Dalziel	0.50%	£889,944	25%	£222,486	Q1-Q3 unmet	Partial	TBC
Local	non elective LOS	L1	Margaret Dalziel	0.18%	£320,380	85%	£272,579	Partially met on some Specialties	Partial	TBC
Local	braden/must including PU reduction	L2	Ursula Clarke	0.18%	£320,380	100%	£320,380	Met in Full	Achieved	
Local	PU Collab	L3	Ursula Clarke	0.18%	£320,380	100%	£320,380	Met in Full	Achieved	
Local	Complaints	L4	Karen Rule	0.18%	£320,380	35%	£112,133	Only partially met as per CCG	Partial	
Local	VTE Collab	L5	Ursula Clarke	0.18%	£320,380	100%	£320,380	Met in Full	Achieved	
Local	Local FFT (ED positive/negative score improvement)	L6	Karen Rule	0.18%	£320,380	0%	£0	Met in Full	Not Achieved	
Local	smoking at time of delivery	L7	Stephanie Parrick	0.17%	£302,581	100%	£302,581	Met in Full	Achieved	
	TOTAL			**2.50%**	**£4,449,721**	**65.05%**	**£2,894,355**			
Specialised	Hepatitis C Network	S1	Margaret Dalziel	35.00%	£136,645	80%	£109,316	Evidence supplied to NHS England	Partial	TBC
Specialised	Neo-Natal Term Admissions	S2	Jill Lane	25.00%	£97,604	100%	£97,604	Met in Full	Achieved	
Specialised	Pharmacy - SACT	S3	Busola Ade-Ojo	25.00%	£97,604	100%	£97,604	Met in Full	Achieved	
Specialised	Pharmacy - Oncotype DX	S4	Alistair Lindsey	15.00%	£58,562	15%	£8,784	Activity Based - Slow Take up.	Partial	TBC
	TOTAL				**£390,415**	**80.25%**	**£313,308**			
	Grand Total				**£4,840,136**	**66.27%**	**£3,207,663**			

2. Effective - NICE Guidelines

Since April 2016 there have been 28 NICE guidelines and Quality Standards published. Of these responses have been received for 10 (35.7%), 4 of which were assessed as not applicable. 18 (64.3%) remain under review, and the 90 day response deadline for these is no earlier than 31st July 2016

May 2016, the NICE Co-ordinator met with the Regional Implementation Consultant for NICE to discuss current processes and systems. The meeting was overwhelmingly positive, with the recently implemented review process and new monitoring spreadsheet commended.

Domain 3: Caring

Medway NHS Foundation Trust

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Mar-16	Apr-16	May-16	12m Trend	YTD avg	Data Quality	18m plan	Carter	Monitor	Quality Account
3.1 Admitted	3.1.1	Friends and Family Test response rate	R	2	May-15	*25%*	25.5%	24.5%	24.4%		24%					
	3.1.2	Friends and Family Test % extremely likely/likely to recommend	G	0		*83%*	80.4%	83.9%	85.6%		85%			✓		
	3.1.3	Mixed Sex Accommodation breaches	G	0	Jun-15	*0*	13	0	0		0.0					
	3.1.6	Dementia screening (% of patients over 75) (Reported 1 month in arrears)	G	0		*90%*	94.9%	96.2%			96%					
3.2 A&E	3.2.1	Friends and Family Test response rate	R	2	May-15	*18%*	16.2%	15.6%	15.4%		16%					
	3.2.2	Friends and Family Test % extremely likely/likely to recommend	G	0	May-15	*65%*	69.0%	75.3%	76.5%		76%					
3.3 Maternity	3.3.1	Friends and family test response rate	G	0		*40%*	37.1%	54.2%	60.5%		57%					
	3.3.2	Friends and family test % extremely likely/likely to recommend	G	0		*79%*	98.6%	99.0%	99.8%		99%					
3.4 General Patients and Carers	3.4.1	Number of Complaints	G	1	Jul-15	*45*	50	50	44		47			✓		
	3.4.3	Number of complaint returners	R	2		↓	7.0	7.0	8.0		7.5					

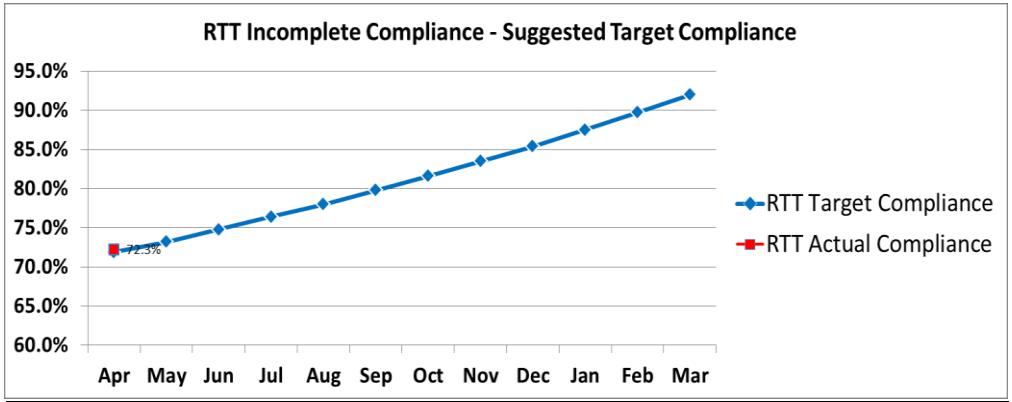
FFT A&E and maternity response rate targets are taken from the overall England Average score for 2014/15

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	*Monthly target*	Mar-16	Apr-16	May-16	12m Trend	YTD avg	Data Quality	18m plan	Carter	Monitor	Quality Account
4.1 Elective Treatment (reported 1 month in arrears)	4.1.1	RTT – Incomplete pathways (overall)	R	1	Jul-15	*92%*	67.94%	72.27%			72.27%					
	4.1.2	RTT – Treatments over 52 weeks	R	1	Jul-15	*0*	19	18			18					
	4.1.3	RTT – Total complete pathways (non admitted)	R	1	Jul-15	*95%*	71.14%	71.40%			71.40%			✓		
	4.1.4	RTT –Total complete pathways (admitted)	R	1	Jul-15	*90%*	56.30%	49.07%			49.07%			✓		
4.2 A&E	4.2.1	Trolley wait >12 hours	G	1		*0*	0	2	0		1					
	4.2.2	Overall Time in A&E (95th percentile overall time in A&E Dept)	R	2	Jun-15	*04:00*	11:27:00	09:33:09	09:16:00		09:24:34					
	4.2.3	A&E stays less than 4 hours	R	2		*95%*	74.71%	77.81%	81.70%		79.76%			✓		
	4.2.7	Ambulance handover time - within 15 minutes	R	1	0	*70%*	39.0%	54.5%	57.1%		55.8%					
	4.2.6	Patients left without being seen	G	2		*5%*	4.27%	3.62%	3.47%		3.55%					
4.3 Cancer ***(reported 1 month in arrears)***	4.3.1	Cancer – 2 week wait	G	0	Jun-15	*93%*	94.06%	93.40%			93%			✓		
	4.3.2	Cancer – symptomatic breast	R	1	Jun-15	*93%*	81.42%	89.81%			90%					
	4.3.3	Cancer – 31 day first treatments	R	1	Jun-15	*96%*	89.31%	95.61%			96%					
	4.3.4	Cancer – 31 day subsequent treatments – surgical	G	0	Jun-15	*94%*	82.86%	94.29%			94%					
	4.3.5	Cancer – anti cancer drug treatment <31 days	G	0	Jun-15	*97%*	100.00%	100.00%			100%					
	4.3.7	Cancer – 62 day urgent GP referrals	R	1	Jun-15	*85%*	83.02%	73.77%			74%					
	4.3.8	Cancer – internal 62 day referrals	G	0	Jun-15	*85%*	71.43%	100.00%			100%					
	4.3.9	Cancer – 62 day screening	R	1	Jun-15	*90%*	72.73%	84.85%			85%					
4.4 Diagnostics (reported 1 month in arrears)	4.4.1	Diagnostic waits - under 6 weeks	R	1	Jun-15	*100%*	88.85%	89.50%			90%					
	4.4.2	Diagnostic referral levels			Jun-15	*N/A*	7399	6736			6736					

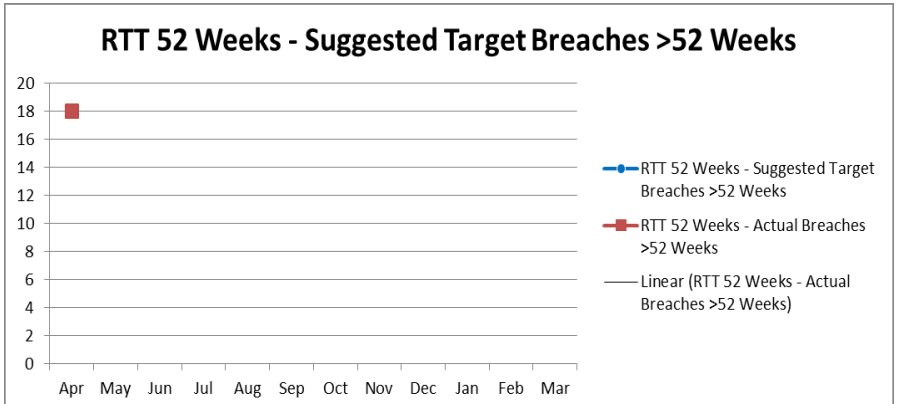
Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Mar-16	Apr-16	May-16	12m Trend	YTD avg	Data Quality	18m plan	Carter	Monitor	Quality Account
							Jan-16	**Feb-16**	**Mar-16**	For Stroke Only						
4.5 Stroke services ***(one quarter in arrears)***	4.5.1	Stroke patients scanned within one hour of arrival	G	0	Jul-15	*50%*	49%	56%	61%		52%					
	4.5.2	Stroke patients scanned within twelve hours of arrival	G	0	Jul-15	*95%*	95%	100%	96%		97%					
	4.5.3	Patients admitted to a stroke unit within 4 hours of adm	R	0	Jul-15	*90%*	53%	42%	46%		42%					
	4.5.4	Patients with at least 90% of their stay on a stroke unit	G	0	Jul-15	*90%*	81%	77%	94%		79%					
	4.5.5	Patients receiving thrombolysis (RCP criteria)	R	0	Jul-15	*90%*	100%	100%	83%		91%					
	4.5.6	Patients that receive thrombolysis within one hour	R	0	Jul-15	*55%*	20%	25%	40%		13%					
	4.5.7	Patients seen by a stroke nurse within 24 hours	R	0	Jul-15	*95%*	87%	84%	93%		88%					
	4.5.8	Patients seen by a stroke consultant within 24 hours	R	0	Jul-15	*95%*	54%	60%	50%		55%					
4.6 Bed capacity and management	4.6.1	Average elective Length of Stay (Age 0 - 65)	G	0		*<5*	1.9	1.86	2.94		2.3					
	4.6.2	Average elective Length of Stay (Age > 65)	R	2		*<5*	4.4	6.25	5.24		3.7					
	4.6.3	Average non-elective Length of Stay (Age 0 - 65)	G	0		*<5*	2.1	3.42	3.25		1.3					
	4.6.4	Average non-elective Length of Stay (Age > 65)	R	2		*<5*	9.4	10.79	8.39		3.1					
	4.6.5	Discharges before noon	R	2	Aug-15	*25%*	15%	14%	15%		14%					
4.7 Outpatient Management	4.7.1	Did Not Attend rate	G	0	0	*10%*	8.8%	8.7%	8.8%		9%					

4.1 Responsive - RTT

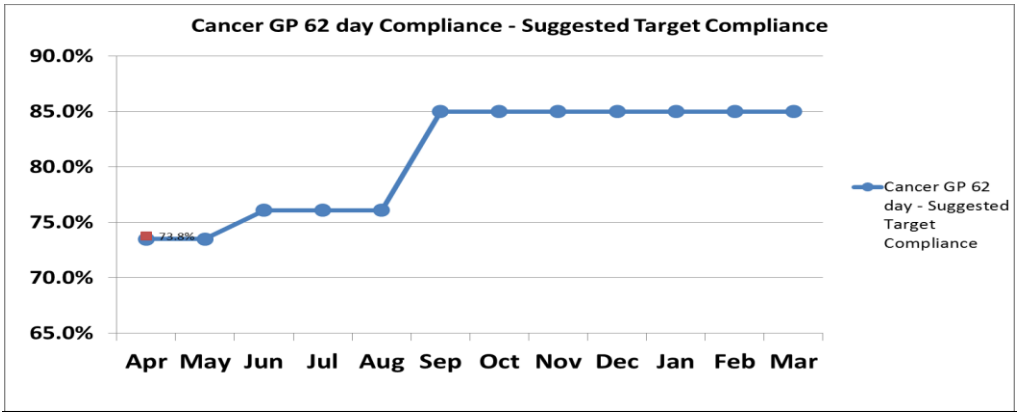
Please see below the Tripartite trajectories for RTT, 52 waiters, Diagnostics and Cancer, with our current performance highlighted.



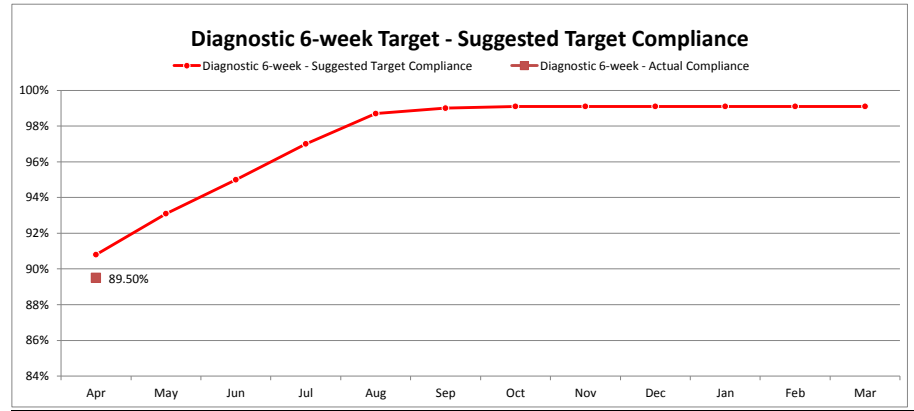
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
RTT Target Total PTL	28,653	25,753	22,852	22,377	21,902	21,427	20,953	20,478	20,003	19,528	19,053	18,578
RTT Target Backlog PTL	8,040	6,900	5,760	5,285	4,810	4,335	3,861	3,386	2,911	2,436	1,961	1,486
RTT Target Compliance	71.9%	73.2%	74.8%	76.4%	78.0%	79.8%	81.6%	83.5%	85.4%	87.5%	89.7%	92.0%
RTT Actual Compliance	72.3%											



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
RTT 52 Weeks - Suggested Target Breaches >52 Weeks												
RTT 52 Weeks - Actual Breaches >52 Weeks	18											



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cancer GP 62 day - Suggested Target Activity	70	70	70	70	70	70	70	70	70	70	70	70
Cancer GP 62 day - Suggested Target Breaches	18	18	17	17	17	10	10	10	10	10	10	10
Cancer GP 62 day - Suggested Target Compliance	73.5%	73.5%	76.1%	76.1%	76.1%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Cancer GP 62 day - Actual Compliance	73.8%											



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Diagnostic 6-week - Suggested Target Activity	8100	7905	7751	7602	7484	7467	7447	7447	7447	7447	7447	7447
Diagnostic 6-week - Suggested Target Activity >6 weeks	747	546	385	227	101	74	67	67	67	67	67	67
Diagnostic 6-week - Suggested Target Compliance	90.8%	93.1%	95.0%	97.0%	98.7%	99.0%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%
Diagnostic 6-week - Actual Compliance	89.5%											

4.3 Responsive - Cancer Waits

The Trust maintained compliance with the 2 week wait standard across most tumour sites. Lower GI breaches were due to a clinic cancellation with the remainder as a result of patient choice. Breaches within Skin were predominantly as a result of patient choice.

The Trust has marginally failed to achieve the 31 day first definitive standard. This was as a result of Consultant leave impacting a single breast referral and theatre capacity for one Lower GI referral. The 2 urology referrals were unable to have treatment scheduled within target dates due to MTW consultant availability. The single skin breach was as a result of patient choice.

The Trust maintained compliance with 31 day subsequent surgery treatment standard. Two Urology referrals were unable to have treatment scheduled within the target date due to MTW consultant availability.

Table

2 week wait standard - 93%

Tumour Site	Patients seen	Seen within 2 weeks	Breaches	Performance
Leukaemia	1	1	0	100.00%
Brain	9	9	0	100.00%
Breast	134	127	7	94.78%
Children	8	8	0	100.00%
Gynaecology	84	82	2	97.62%
Haematology	2	2	0	100.00%
Head & Neck	143	134	9	93.71%
Lower GI	177	160	17	90.40%
Lung	18	18	0	100.00%
Other	1	1	0	100.00%
Skin	453	412	41	90.95%
Testicular	11	11	0	100.00%
Thyroid	11	11	0	100.00%
Upper GI	102	98	4	96.08%
Urology	104	101	3	97.12%
TOTAL	**1258**	**1175**	**83**	**93.40%**

2-WEEK WAIT (SYMPTOMATIC BREAST) - Target: 93%

Breast Symptom	108	97	11	89.81%

31-DAY FIRST DEFINITIVE TREATMENT - Target: 96%

Tumour Site	Patients treated	Treated within 31 days	Breaches	Performance
Breast	21	20	1	95.24%
Gynaecology	6	6	0	100%
Haematology	13	13	0	100.00%
Head & Neck	0	0	0	No patients
Lower GI	10	9	1	90.00%
Lung	10	10	0	100.00%
Other	1	1	0	100.00%
Skin	18	17	1	94.44%
Testicular	0	0	0	No patients
Thyroid	0	0	0	No patients
Upper GI	6	6	0	100.00%
Urology	29	27	2	93.10%
TOTAL	**114**	**109**	**5**	**95.61%**

31-DAY SUBSEQUENT TREATMENT - SURGERY - Target: 94%

Tumour Site	Patients treated	Treated within 31 days	Breaches	Performance
Breast	12	12	0	100.00%
Gynaecology	0	0	0	No patients
Head & Neck	0	0	0	No patients
Lower GI	0	0	0	No patients
Skin	12	12	0	100.00%
Thyroid	0	0	0	No patients
Upper GI	1	1	0	100.00%
Urology	10	8	2	80.00%
TOTAL	**35**	**33**	**2**	**94.29%**

4.3 Responsive - Cancer Waits

The Trust was compliant with the 31 day subsequent drug treatment standard.

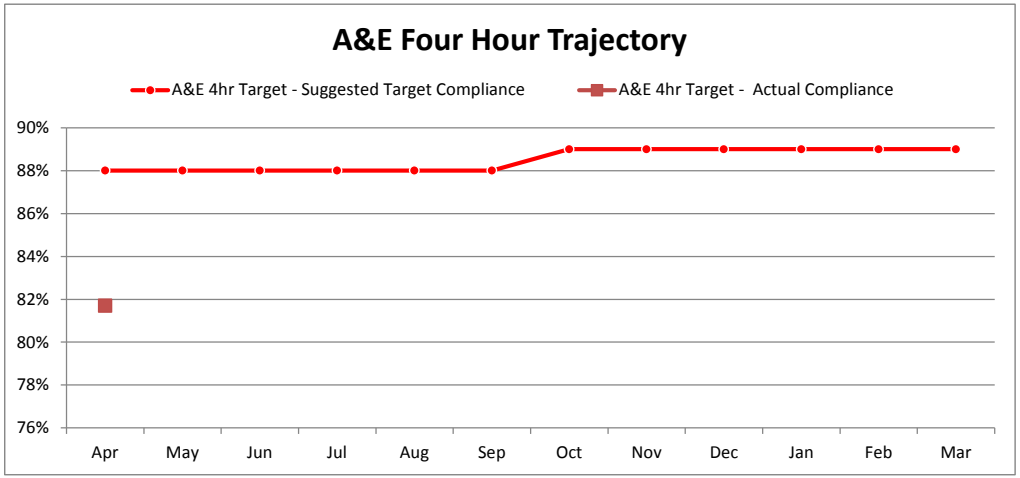
There is no performance standard for 62 day consultant upgrades.

Table

31-DAY SUBSEQUENT TREATMENT - DRUG TREATMENT - Target: 98%				
Tumour Site	**Patients treated**	**Treated within 31 days**	**Breaches**	**Performance**
Breast	3	3	0	100%
Haematology	10	10	0	100%
Lower GI	0	0	0	No patients
Lung	3	3	0	100%
Urology	12	12	0	100%
TOTAL	**28**	**28**	**0**	**100.00%**
62-DAY STANDARD FROM GP REFERRAL - Target: 85%				
Tumour Site	**Patients treated**	**Treated within 62 days**	**Breaches**	**Performance**
Breast	10	9	1	90.0%
Gynaecology	4	3	1	75.0%
Haematology	5	4	1	80.0%
Head & Neck	1	0.5	0.5	50.0%
Lower GI	5.5	1	4.5	18.2%
Lung	2	0	2	0.0%
Other	1.5	1.5	0	100.0%
Skin	14	14	0	100.0%
Thyroid	0	0	0	No patients
Upper GI	5	4	1	80.0%
Urology	12.5	8	4.5	64.0%
TOTAL	**61**	**45.0**	**16.0**	**73.77%**
62-DAY SCREENING SERVICES - Target: 90%				
Tumour Site	**Patients treated**	**Treated within 62 days**	**Breaches**	**Performance**
Breast	11	11	0	100.0%
Gynaecology	2.5	2	0.5	80.0%
Lower GI	3	1	2	33.3%
TOTAL	**17**	**14**	**3**	**84.85%**
Tumour Site	**Patients treated**	**Treated within 62 days**	**Breaches**	**Performance**
Gynaecology	0	0	0	No patients
Haematology	2	2	0	100.0%
Head & Neck	0	0	0	No patients
Lower GI	0	0	0	No patients
Lung	2.5	2.5	0	100.0%
Skin	0	0	0	No patients
Thyroid	0	0	0	No patients
Upper GI	0	0	0	No patients
TOTAL	**4.5**	**4.5**	**0**	**100.00%**

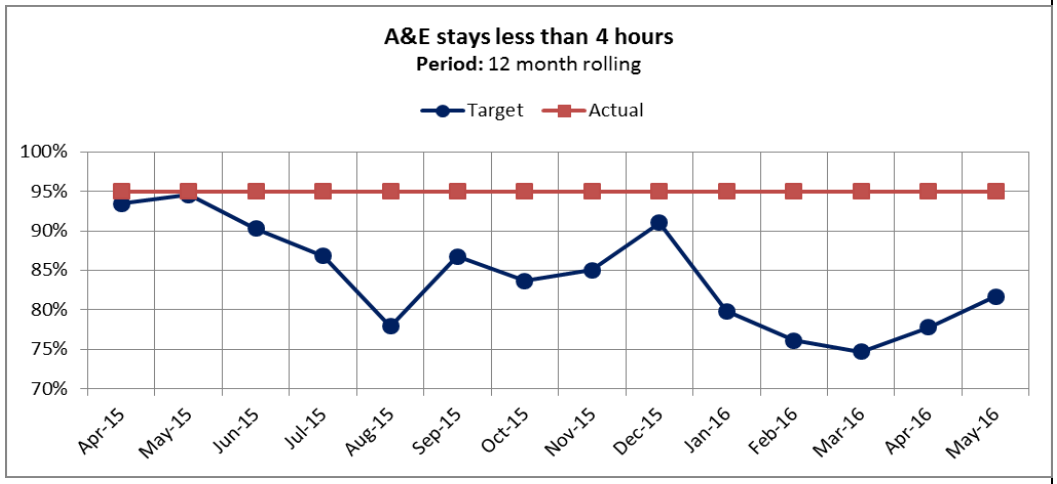
4.2 Responsive - A&E

Please see below the Tripartite trajectory for A&E, with our current performance shown.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E 4hr Target - Suggested Target Attendances	9170	9237	9304	9371	9438	9505	9572	9639	9706	9706	9706	9907
A&E 4hr Target - Suggested Target Attendances >4 hrs	1100	1108	1116	1125	1133	1141	1053	1060	1068	1068	1068	1090
A&E 4hr Target - Suggested Target Compliance	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%
A&E 4hr Target - Actual Compliance	81.7%											

Trends



Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	*Monthly target*	Mar-16	Apr-16	May-16	12m Trend	YTD avg	Data Quality	18m plan	Carter	Monitor	Quality Account
5.1 External assessments	5.1.1	Monitor governance rating	R	2	Jul-15	*3*	1	1	1		1					
	5.1.2	CQC rating	R	0	Jul-15	Good	Inadequate									
5.2 Staff experience (Figures for Q2)	5.2.1	Staff Friends and Family – Recommend as place to work	R			*62%*	48.8%									
	5.2.2	Staff Friends and Family – Recommend for care or treatment	R			*79%*	67.5%									
5.3 Workforce indicators	5.3.1	Vacancy rate - Medical (unfilled % of budgeted WTE)	R	0		*8%*	#N/A									
	5.3.2	Vacancy rate - Nursing (unfilled % of budgeted WTE)	R	0		*8%*	#N/A									
	5.3.3	Vacancy rate - Others (unfilled % of budgeted WTE)	R	0		*8%*	#N/A									
	5.3.4	Appraisals completed (% all staff)	R	2	Jun-15	*95%*	75.1%	72.5%	69.1%		71%					
	5.3.5	% of medical staff completing revalidation who were due to be re-validated within the month	G	0		*100%*	100%	100%	100%	To be validated						
	5.3.6	Mandatory training compliance	G	0	Jun-15	*80%*	84.6%	84.3%	85.5%		85%					
	5.3.7	Rolling annual turnover rate	R	2	Jun-15	*8%*	9.7%	9.7%	9.7%		10%					
	5.3.8	Overall Sickness rate	R	2		*3.0%*	3.9%	3.9%	3.9%		3.9%			✓		
	5.3.9	Sickness rate – Short term	R	2		*2.0%*	2.6%	2.6%	2.6%		2.6%					
	5.3.10	Sickness rate – Long term	R	2		*1.0%*	1.3%	1.3%	1.3%		1.3%					
	5.3.11	Temporary staff % of pay bill	R	0		*15%*	#N/A									
	5.3.12	Employee relations cases (excluding sickness)			Aug-15	*N/A*	61	61	59		60					
	5.3.13	Local Induction % Compliance	R	2		*80%*	50.72%	49.66%	47.49%		48.58%					
	5.3.14	Starters				*N/A*	72	69	79		74					
	5.3.15	Leavers				*N/A*	51	45	37.0		41					

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	*Monthly target*	Mar-16	Apr-16	May-16	12m Trend	**YTD avg**	Data Quality	18m plan	Carter	Monitor	Quality Account
7.2 Clinical coding, information and IT* (1 month in arrears)	7.2.1	APC – NHS number completeness (1 month in arrears)	R	1		*99%*	98.8%	98.8%			98.8%				✓	✓
	7.2.2	APC – Primary diagnosis (1 month in arrears)	G	0		*96%*	99.8%	99.8%			99.8%				✓	✓
	7.2.3	APC – HRG4 (1 month in arrears)	G	0		*96%*	99.8%	99.8%			99.8%				✓	✓
	7.2.4	OP – NHS number completeness (1 month in arrears)	G	0		*99%*	99.5%	99.5%			99.5%				✓	✓
	7.2.5	OP – Primary procedure (1 month in arrears)	G	0		*99%*	100.0%	100.0%			100.0%				✓	✓
	7.2.6	OP – HRG 4 (1 month in arrears)	G	0		*98%*	100.0%	100.0%			100.0%				✓	✓
	7.2.7	A&E – NHS number completeness (1 month in arrears)	R	1	Jul-15	*95%*	93.6%	94.1%			94.1%				✓	✓
	7.2.8	A&E – Attendance disposal (1 month in arrears)	R	1	Jul-15	*99%*	96.5%	96.4%			96.4%				✓	✓
	7.2.9	A&E – HRG4 (1 month in arrears)	G	0		*97%*	100.0%	100.0%			100.0%				✓	✓
7.3 Data quality improvement	7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	R	1		*0*	482	43			43.0		✓		✓	✓
	7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	R	1		*0*	2.0%	0.1%			0.1%		✓		✓	✓
	7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	R	1		*0*	737	694			495.0		✓		✓	✓
	7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	R	1		*0*	2.30%	2.10%			1.7%		✓		✓	✓
	7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	R	1		*0*	1051	640			640.0		✓		✓	✓
	7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	R	1		*0*	1	2			2.0		✓		✓	✓
	7.3.12a	A&E No. missing left department times	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.12b	A&E % missing left department times	G	0		*0*	0%	0%	0%		0.0%		✓		✓	✓
	7.3.13a	A&E No. missing breach reason on breached attendances	R	2		*0*	553	488	496		492.0		✓		✓	✓
	7.3.13b	A&E % missing breach reason on breached attendances	R	2		*0*	78.4%	74.9%	73.0%		73.9%		✓		✓	✓
	7.3.16	Cancer 2ww missing NHS number	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.17	Cancer 2ww invalid NHS Number	R	2		*0*	7	1	8		4.5		✓		✓	✓
	7.3.18	Cancer 2ww missing referral received date	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.19	Cancer 2ww missing urgent referral type	R	1		*0*	0	1	0		0.5		✓		✓	✓
	7.3.20	Cancer 2ww missing org code first seen	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.21	Cancer 2ww missing breach reason	R	2		*0*	28	6	24		15.0		✓		✓	✓
	7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex	R	2		*0*	2.97%	0.59%	0.53%		4%		✓		✓	✓
	7.3.23	Cancer 31 day missing NHS number	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.24	Cancer 31 day invalid NHS number	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.25	Cancer 31 day missing primary diagnosis	R	2		*0*	10	7	16		11.5		✓		✓	✓

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	*Monthly target*	Mar-16	Apr-16	May-16	12m Trend	**YTD avg**	Data Quality	18m plan	Carter	Monitor	Quality Account
	7.3.26	Cancer 31 day missing tumour laterality	R	2		*0*	9	7	16		11.5		✓		✓	✓
	7.3.27	Cancer 31 day missing decision to treat date	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.28	Cancer 31 day missing org code for treatment	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.29	Cancer 31 day missing breach reason	R	2		*0*	7	6	1		3.5		✓		✓	✓
	7.3.30	Cancer 62 day missing NHS number	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.31	Cancer 62 day invalid NHS number	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.32	Cancer 62 day missing primary diagnosis	R	2		*0*	6	4	11		7.5		✓		✓	✓
	7.3.33	Cancer 62 day missing tumour laterality	R	2		*0*	4	4	11		7.5		✓		✓	✓
	7.3.34	Cancer 62 day missing decision to treat date	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.35	Cancer 62 day missing org code for treatment	G	0		*0*	0	0	0		0.0		✓		✓	✓
	7.3.36	Cancer 62 day missing breach reason	R	2		*0*	4	7	3		5.0		✓		✓	✓
	7.3.37	Cancer 62 day missing consultant upgrade	R	2		*0*	57	44	29		36.5		✓		✓	✓

Enablers

Data Quality

Each issue is being assigned to a department within the Trust: operational service teams, system team, a DQ team or BI team.

Once these issues have been prioritised and assigned, each one that is for the operational service teams will have a keystroke level guide drawn up to let the users know how to fix the issue in the system. An overall guide will also be drawn up to let the users know the timescale for each fix to be in place. A dashboard will be built which will monitor the issues and show improvement/decline in the number of issues.

Themes will be picked up from the issues and the general user training and refresher training will be amended to take these themes into account.

Estates

Need to improved Planned preventative maintenance items noted within the Water Risk Assessment 2013 as outstanding.
Need for decant ward to enable completion of the Electricity at work items which are outstanding.

Recruitment of staff to necessary levels and complete necessary PPM as indicated on Water Safety Plan.
Deliver Fire Safety action plan
Continue campaign for decant ward to enable Electricity at Works items to be completed (this needs to continue until bed pressures reach an appropriate level).

Zero harm in relation to Water Safety, Fire Safety and Electricity at work.

May-16

Performance Review Scorecard - Executive Directorate Summary

Ref	Indicator	Units	Target	R/G	All areas	Acute & Continuing Care			Co-ordinated Surgical			Womens and Children		
					Trust	Current Reporting Period	Previous Reporting Period	Trend	Current Reporting Period	Previous Reporting Period	Trend	Current Reporting Period	Previous Reporting Period	Trend
Safe														
1.1.3	Total Serious Incidents	Number	5		3	1	2		2	0		0	1	
1.1.4	Never Events	Number	0		0	0	0		0	0		0	0	
1.2.1	Proportion of harm free care - Point prevelance in month	Monthly %	95%		92.17%	90.88%	95.01%		92.81%	93.90%		100.00%	100.00%	
1.2.3	Pressure ulcers (grade 3&4)	Number	0		1	0	0		1	0		0	0	
1.2.5	Patient falls with moderate or severe harm	Cases	0		1	1	0		0	0		0	0	
1.3.1	MSRA screening of admissions	Monthly %	95%		98%	96%	97%		100.00%	93.57%		93.75%	90.00%	
1.3.3	C-Diff acquisitions (Trust-attributable)	Number	0		0	0	0		0	0		0	0	
1.4.1	Hospital Standardised Mortality Ratio (HSMR) - Weekend **	Number	100		105.1	103.11	101.87		113.75	109.17		145.47	215.13	
1.4.4	Deaths in Hospital	Number	N/A		112	99	93		13	23		0	0	
1.5.1	Safe staffing – ratio of actual to planned nursing hours	Ratio	0		0		1.02			0.97			0.98	
Effective														
2.2.1	Non elective Length of Stay	Cum ALOS	N/A		3.55	4.75	5.97		4.08	5.06		1.53	1.31	
2.2.4	Complaints	Number	N/A		44	29	28		12	11		3	4	
2.5.2	Number of day cases (Quality Account)	Number	N/A		1636	667	790		831	843		138	117	
2.5.3	Emergency readmissions within 7 days	Monthly %	N/A		5.19%	5.48%	5.39%		3.98%	3.27%		6.14%	4.75%	
2.5.4	Emergency readmissions within 28 days	Monthly %	10%		11.22%	14.73%	12.10%		7.01%	7.31%		11.57%	10.67%	
Caring														
3.1.3	Mixed sex accommodation breaches	Cases	0		0	0	0		0	0		0	0	
3.1.4	No. Patients cancelled on day of Surgery	Number			36	9	4		23	18		4	2	
3.1.5	Patients cancelled and not admitted within 28 days	Number	0		0	0	0		0	0		0	0	
3.1.6	Friends and Family Test response rate (Admitted)	Monthly %	25%		20%	23.90%	22.70%		26.90%	28.20%		23.90%	22.50%	
3.1.7	Friends and Family Test % recommend (Admitted)	Monthly %	83%		83%	81.50%	78.40%		79.40%	84.70%		85.90%	89.20%	

Please note There is a specialiy called "other" in the RTT data - this is included in trust totals but excluded by directorate - it is currently in

Responsive														
4.1.1	RTT – Incomplete pathways (overall)	Monthly %	92%		72.27%	67.04%	63.65%		70.42%	65.83%		95.70%	91.40%	
4.1.2	RTT – Treatments over 52 weeks	Number	0		18	11	7		1	3		0	0	
4.1.3	RTT – Total complete pathways (non admitted)	Monthly %	95%		71.40%	59.90%	57.38%		69.53%	72.12%		94.70%	94.80%	
4.1.4	RTT –Total complete pathways (admitted)	Monthly %	90%		49.30%	53.80%	56.67%		38.90%	43.40%		83.40%	89.00%	
4.3.1	Cancer – 2 week wait (1 month in arrears)	Monthly %	93%		93.40%	92.32%	94.66%		93.79%	92.93%		97.83%	96.77%	
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	Monthly %	94%		94.29%	100.00%	69.23%		90.91%	90.91%		No pts	No pts	
4.3.5	Cancer – secondary chemotherapy <31 days (1 month in arrears)	Monthly %	98%		100.00%	100.00%	100.00%		100.00%	100.00%		No pts	No pts	
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	Monthly %	85%		73.77%	83.93%	85.71%		63.79%	80.00%		75.00%	85.71%	
4.3.9	Cancer – 62 day screening (1 month in arrears)	Monthly %	98%		84.85%	No pts	No pts		85.71%	72.73%		80.00%	No pts	
4.6.1	Average elective length of stay	Cum ALOS	<5		2.94	1.22	0.63		2.39	1.51		1.94	1.2	
4.6.3	Discharges before noon	Monthly %	25%		14.84%	15.94%	13.88%		12.71%	14.57%		18.03%	20.88%	
4.7.2	Follow-up to new ratio	Ratio			2.02	2.66	2.9		1.87	1.91		1.31	1.33	
4.7.3	Did not attend rate	Monthly %	10%		8.70%	7.41%	8.00%		9.39%	9.10%		9.89%	9.20%	
Well-Led														
5.3.4	Appraisals completed (% all staff)	Monthly %	95%		69%	66.54%	70.57%		64.69%	67.78%		59.78%	63.70%	
5.3.6	Mandatory training compliance	Monthly %	85%		85%	81.63%	79.91%		87.08%	86.71%		88.98%	87.42%	
5.3.7	Rolling annual turnover rate	Monthly %	8%		10%	12.93%	12.59%		12.01%	10.87%		6.16%	7.10%	
5.3.8	Overall Sickness rate	Monthly %	3%			3.70%	3.73%		4.12%	4.04%		3.41%	3.38%	
5.3.10	Temporary staff % of pay bill	Monthly %	15%										4.62%	
Enablers														
6.2.2	CIP variance to plan	Monthly %	95%											
6.4.1	NHS number completeness (Inpatients and Outpatients) *****	Monthly %	TBC		0.00%		98.85%			98.85%			98.85%	
6.4.2	Primary Diagnosis (Inpatients) *****	Monthly %	TBC		0.00%		99.84%			99.84%			99.84%	
6.4.5	Primary Procedure (Inpatients and Outpatients) ***Under Review***		TBC											
560	Elective activity vs profiled plan - cumulative variance	Cum var %	0%											
606T	New patients seen vs plan (all categories, in arrears)	Mthly var	0											
Income	Income against plan - var ytd (in arrears)	Cum £k	£0											
102	Overall budgetary variance	Mthly % var	£0											
Pay	Pay expenditure in month (neg=bad)	Mthly % var	0%											
Non-pay	Non-pay expenditure in month (neg=bad)	Mthly % var	0%											

Under Review with Finance to agree Financial KPIs

WOMEN'S & CHILDREN'S DIRECTORATE

Medway NHS
NHS Foundation Trust

Type	Section	Metric Name	Measure	Goal	Red Flag	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	YTD		
Organisation	Closing unit		No. of occasions	nil	>1	0	0	0	0	0	2	0	0	4	3	1	0	0	10		Total
		Unit Not accepting Admissions	No. Of Women affected			0	0	0	0	0	0	0	0	0	5	4	0	0	9		Total
Activity	Women Delivered	Benchmarked to 5100 (425)	Women delivered	400	<400 >460	402	431	425	379	463	436	432	414	431	385	416	411	423	5025		Total
	Spontaneous Vaginal Deliveries	Maintain spontaneous Vaginal Delivery rate as per criteria	No. of women	>70%	<60%	63%	62%	61%	63%	62%	60%	64%	61%	61%	62%	63%	67%	64%	62%		average
	Instrumental Vaginal Delivery	Ventouse & Forceps	Instrumental Vaginal delivery rate	10-15%	<5%/or >20%	9%	10%	10%	11%	11%	12%	8%	8%	8%	7%	8%	7%	7%	9%		average
		Failed Instrumental Vaginal Delivery	Failed Instrumental vaginal delivery rate	<1%	>3%	<1%	<1%	<1%	<1%	<1%	<1%	1%	<1%	1%	2%	<1%	1%	<1%	1%		average
	Induction	Induction of labour	Induction rate	<20%	>25%	29%	26%	27%	30%	27%	32%	27%	26%	30%	28%	28%	30%	30%	28%		average
	C- Section	Total rate (planned & unscheduled)	C/S rate overall	<23%	>25%	27%	28%	29%	26%	25%	28%	27%	30%	30%	29%	27%	25%	26%	28%		average
		Elective caesarean section	Elective	<10%	>11%	13%	9%	13%	9%	10%	11%	11%	11%	10%	11%	10%	9%	12%	11%		average
		Emergency caesarean section	Emergency	<13%	>14%	14%	19%	16%	17%	15%	17%	16%	19%	20%	18%	17%	16%	15%	17%		average
	VBAC	Successful VBAC (opting women)	VBAC rate	>75%	<50%	64%	67%	73%	71%	77%	100%	64%	40%	95%	59%	57%	83%	65%	71%		average
Clinical Indicators	Neonatal morbidity	Number of cases of meconium aspiration	No. of babies	0	1 or more	0	3	1	3	0	2	2	1	1	1	0	2	3	16		Total
		Intrapartum stillbirths	No. of babies	0	1 or more	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Total
		Term neonatal deaths < 7 days	No. of babies	0	1 or more	0	0	0	0	0	0	0	0	0	0	0	0	0	0		Total
		Number of cases of hypoxic encephalopathy (Grades 2&3)	No. of babies	0	1 or more	0	1	1	1	1	0	3	0	0	0	0	0	0	7		Total
	Risk Management	Number of SIs	Incidence	0	1 or more	1	1	0	1	0	0	0	0	0	3	2	0	0	8		Total
		Number of Complaints	Received	0	1 or more	0	7	1	1	3	5	6	2	3	1	2	2	2	33		Total
		Number of Datix	Reported	>70	<70	119	134	122	120	97	115	97	95	128	117	112	123	127	1379		Total
		Massive PPH >2000mls	No. of women	<10/MONTH	>15/MONTH	3	3	4	5	2	4	3	4	1	5	6	3	3	43		Total
		3rd/4th degree tear	No. of women	<6/MONTH	>10/MONTH	10	12	6	5	10	8	5	3	5	6	5	2	13	77		Total
		3rd/4th as % of vaginal deliveries	% of women			3%	4%	1.44%	1.60%	2.64%	2.32%	1.60%	0.89%	1.55%	2.00%	1.00%	0.57%	3.70%	2.00%		average
	BBAs	No. of BBAs	No. of women			0	3	0	1	4	2	2	2	3	2	2	5	4	26		Total
	Neonatal unit closures	No. of closures	No. of occasions	Nil	1 or more	1	1	1	1	1	0	0	1	3	3	1	1	1	14		Total

Dashboard adapted from RCOG.
Data obtained from Euroking and Datix
Percentages rounded up/down so may not equal 100%

Notes:

LSCS-weekly meeting reviewing all EMCS from previous week examining care and decision making.
To review regional Dashboard to compare report content
New Induction of Labour (IOL) Pathway commences 4th May 2016
NICU reviewing 2015/16 Term admission report due May 2016

Medway NHS
NHS Foundation Trust

Monthly Performance Review Scorecard - Trust

Month - May 2016

		Current Month Score	Previous Month Score	Target	NHS Good Practice
Caring	% Positive Response FFT	83.86%	80%	83%	85%
	Written Complaints Rate (/1000 bed days)			2	2
Effective	Average Length of Stay (Hours)	127.24	140	100	60
	Delayed Transfers of Care	86	96	70	40
	Medically fit to Discharge (/1000 Bed Days)			25	0
	Summary Hospital-level Mortality Indicator (SHMI)	115	118	103	105
	Theatre Utilisation	73.52%	74.27%	85%	85%
Responsive	Cancelled Operations			6%	5%
	Emergency Department - Seen Within 4 Hours	77.81%	75%	95%	95%
	RTT - Admitted *	49.30%	54%	95%	90%
	RTT - Cancer (2 Week Wait Performance) *	94.06%	96.42%	93%	96%
	RTT - Non-Admitted *	71.40%	71.30%	95%	95%
Safe	% Harm Free Care	92.17%	94.95%	95%	95%
	Medical Outliers			50	0
	Medical Outliers as a proportion of the Surgical Bed Base			25%	0
	Serious Events Index			100	100

MOST IMPROVED	MOST DETERIORATED	ACTIONS

People Management & Culture: Well-Led	Current Month Score	Previous Month Score	Target	NHS Good Practice
Doctors Hours per Patient Day			8	9
Care Hours per Patient Day			9	9
Absence Rate	3%	3%	7%	4%
Engagement Index			91%	85%
Leadership Index			91%	85%
Dignity Index			90%	85%
Patient Centred Index			90%	85%

Our Money	Current Month Score	Previous Month Score	Target	NHS Good Practice
Income vs Plan			£0.00M	
Expenditure vs Plan			£0.00M	
Liquidity (Days)			-12	
YTD Forecast Deficit in £			£35.00M	
Performance against the Purchasing Price Index			1	1
£'s spent with NHS SC / £s spent on comparable goods.			95%	85%
Temporary staffing as a % of Trust Pay bill			5%	5%

Medway NHS
NHS Foundation Trust

Monthly Performance Review Scorecard - Trust

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Safe	% Harm Free Care	92.17%	94.95%	95%	95%
	Medical Outliers			50	0
	Medical Outliers as a proportion of the Surgical Bed Base			25%	0
	Serious Events Index			100	100

MOST IMPROVED

MOST DETERIORATED

ACTIONS

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Leadership Index			91%	85%
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Liquidity (Days)			-12	
YTD Forecast Deficit in £			£35.00M	
Performance against the Purchasing Price Index			1	1
£'s spent with NHS SC / £s spent on comparable goods.			95%	85%
Temporary staffing as a % of Trust Pay bill			5%	5%

* RTT Figures reported 1 month in arrears.

	Indicator
Caring	% Positive Response FFT
	Written Complaints Rate (/1000 bed days)
Effective	Average Length of Stay (Hours)
	Delayed Transfers of Care
	Medically fit to Discharge (/1000 Bed Days)
	Summary Hospital-level Mortality Indicator (SHMI)
	Theatre Utilisation
Responsive	Cancelled Operations
	Emergency Department - Seen Within 4 Hours
	RTT - Admitted
	RTT - Cancer (2 Week Wait Performance)
	RTT - Non-Admitted
Safe	% Harm Free Care
	Medical Outliers
	Medical Outliers as a proportion of the Surgical Bed Base
	Serious Events Index
People Management & Culture: Well-Led	Doctors Hours per Patient Day
	Care Hours per Patient Day
	Absence Rate
	Engagement Index
	Leadership Index
	Dignity Index
	Patient Centred Index
Our Money	Income vs Plan
	Expenditure vs Plan
	Liquidity (Days)
	YTD Forecast Deficit in £
	Performance against the Purchasing Price Index
	£'s spent with NHS SC / £s spent on comparable goods.
	Temporary staffing as a % of Trust Pay bill

Definition	Data Source	Notes
Percentage of those surveyed who would recommend the trust to others	FFT Report	
Number of written complaints received per 1000 bed days	Lyndsay Barrow or Nicky Rumbold. Also refer to the bed occupancy report	The number of complaints will be confirmed to us. We will need to divide by the number of bed days and multiply by 1000
Average Length of Stay for the trust in hours, excluding daycases	Admissions and Discharges query.sql	
Number of instances where care transfer has been delayed for a patient medically fit for discharge	Tarina Phillips or Amanda Gibson	
Number of patients medically fit to discharge per 1000 bed days	Tarina Phillips or Amanda Gibson. Also refer to the bed occupancy report	
The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there	Dr Foster	
Percentage of actual time spent in theatre (from Induced to time out) compared to planned time	Theatre Qlikview App	
Percentage of operations cancelled by the trust (potentially reportable cancellations)	Samantha Chapman	
Percentage of patients in ED seen, treated or discharged within 4 hours of arrival	AE Qlikview app	
The percentage of admitted patients seen within 18 weeks of referral	Monthly RTT	
The percentage of cancer patients seen within 2 weeks of referral	Cancer 2WW	
The percentage of non-admitted patients seen within 18 weeks of referral	Monthly RTT	
Percentage of patients that have not been harmed in the trusts care - Harms fall into 4 categories: Pressure Ulcers Falls UTIs in patients with a catheter VTEs	Safety Thermometer	
Percentage of clinical staff absent during the month	Dan Knox	

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date : 30th June 2016

Title of Report	Financial Plan and Month 2 Finance Report
Reporting Officer	Steve Smith, Financial Controller, Yasmin Ahmed, Deputy Director of Finance
Lead Director	Darren Cattell, Director of Finance
Responsible Sub-Committee	Executive Committee
Executive Summary	This paper provides the Board with an update on two issues 1. A high summary of the overall Trust and Directorate financial plan for the year ended 2016-17. 2. A M2 finance report of Trust financial performance against the plan The narrative of the Operating Plan has previously been circulated and agreed by the Board. This is available for wider distribution should it be required. The Board is reminded there have been a number of sessions where we have debated the financial plan within the overall Operating Plan and last week the Board signed this off. We have been informed that the final submission date for this plan to NHSI is the 29th June. Given the timing of the public Trust Board it is therefore not possible to provide an advanced copy of this plan however a simplified summary is presented to the Board at the meeting. In addition to the 2016/17 Operating Plan a longer term Financial Recovery Plan is being prepared to take the Trust from the current deficit position to financial sustainability, this will include the impact of the STP over the longer term. The first stage of this is to establish financial control throughout the whole Trust. This financial recovery plan will include (amongst other things) the expected operational efficiency improvements of c£40m from Carter. The Board is asked to note that the framework for this plan will be presented to the July public Board and the final version of the plan will be presented to the August public Board for approval. The financial plan has been developed over recent months and is based on the following premise and assumptions; • The gross projected deficit is £56.9m,after adjusting for fines and STF funding receipt this deficit is £43.8m this compares to the £52.5m deficit in 2015-16 • This deficit has been based on the exit run rate from 2015-16. The end of year deficit for 2015-16 has been audited and given a true and fair opinion by Deloitte, external auditors, as part of our annual accounts audit • The opening financial position into 2016-17 has also

	been validated by EY as part of the baseline review • Directorate budgets have been set on the basis of run rate with an in year, phased reduction of this run rate for CIP delivery. • CIPs are set at a minimum of £12.6m which is 4.1% and are allocated and will be presented at Directorate level • The Trust is holding a set of earmarked reserves for specific in year cost increases, these are either nationally mandated or have been proposed by the Directorates and will only be accessed through the agreed business case process under the scheme of delegation for approval. This expenditure will be presented as part of the monthly finance reports when approved. Each case is expected to be at worst cost neutral but each will be considered on merit against Trust risks. Escalated approval will need to be sought depending on materiality. • The Trust has also planned for the costs of change on a non-recurrent basis • At the time of publishing the Directorates have proposed a wte increase of 2.8% over the whole year should all posts be approved. This is not where we expect to end up as far greater clarity on CIP actions is expected including the removal of wte posts where appropriate after a QIA process. This presents an as yet unquantified opportunity however is in reality only ever likely to close the unidentified CIP planning gap. • The proposed 2016-17 Capital programme is a total of £28.2m including over £11m on the ED programme. In summary this is a pragmatic financial plan and recognises the absolute requirement that the Trust must finally exit special measures by the turn of the calendar year. The Trust recognises and welcomes the support of the DH within the STF and loan funding. Overall improvements in the financial position are expected to be limited in year however planning will be strong and any quick wins not fully reflected in the plan (early adoption of Carter efficiencies) will be pursued with vigour whilst a risk based approach to quality of services will be taken. In terms of M2 financial performance, the Board is asked to note the following; **Activity and Income Summary** Activity and income is above plan in the Acute and Continuing Care Directorate for non elective inpatients and outpatients. T&O elective and non elective activity is below plan, income is also below plan in the Co-ordinated Surgical Directorate. The Co-ordinated Surgical Care Directorate has been requested to review this and report to the Performance Review Meeting

	(PRM). Overall clinical income is adverse to plan YTD by £0.27m. High cost drugs income is largely on plan YTD. **Workforce Summary** Workforce wte are significantly below plan (the plan has been rebased on run rate including vacancies) due to vacancies across clinical areas. The use of temporary staff continues however not all shifts are covered, from a safety perspective, number of breaches on the 1:8 ratio continues to reduce. Expenditure Summary Pay : Pay is £0.60m favourable to plan in month due to the continued (uncovered) vacancies in Directorates. Run rate remains broadly static. Non-Pay Clinical supplies in month and YTD is adverse to plan mainly due to external outsourcing to improve RTT performance. A budget transfer is pending approval which will reduce this overspend and will match planned income levels. Drugs expenditure is slightly adverse to plan mainly due to high costs drugs and increased activity. **Run Rate Analysis** Pay : The pay run rate is similar to the position reported at month 1 (£16.8m), however agency spend has increased compared to month 1 due to updated agency usage information being received relating to month 1 for the Acute and Continuing Care Directorate. Non-pay : Overall non pay run rate is similar to the position reported at month 1 of £8.8m. Clinical supplies and drugs expenditure have increased due to increased activity. A reduction in other non pay is reported mainly due to a technical adjustment on the clinical income provision to clinical income and the reclassification of fuel to stock in the Facilities and Estates Directorate, when this is taken into account of the non pay run rate is actually £9.2m
Risk and Assurance	This is a month 2 financial performance report. The financial plan and base budgets have been based on V2 Operating plan as at the 31st May 2016, the Board is asked to note that the budgets will be updated for V3 Operating Plan from M3 or 30th June 2016. Residual risks include CIP planning and delivery and CCG contracts not yet agreed.
Legal Implications/Regulatory Requirements	Terms of Licence, legal undertakings and breach of Licence
Recovery Plan Implication	Completely integrated under Financial Recovery Plan and financial performance
Quality Impact	Will be built in to any financial change expectations eg CIPs

Assessment	
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	To note
Recommendation	The Board is reminded that the V3 operating plan has already been signed off, this is outlined in this report. The Board is asked to this financial performance update when compared to V2 Operating plan due to timing. The Board is asked to note the further action required from Directorates to recover any areas of unexpected negative financial performance.

Finance Report

Month 2

2016/17

Best of care
Best of people

Medway NHS
NHS Foundation Trust

Finance Report for May 2016

1. Executive Summary

1a. Executive Summary (May 2016)

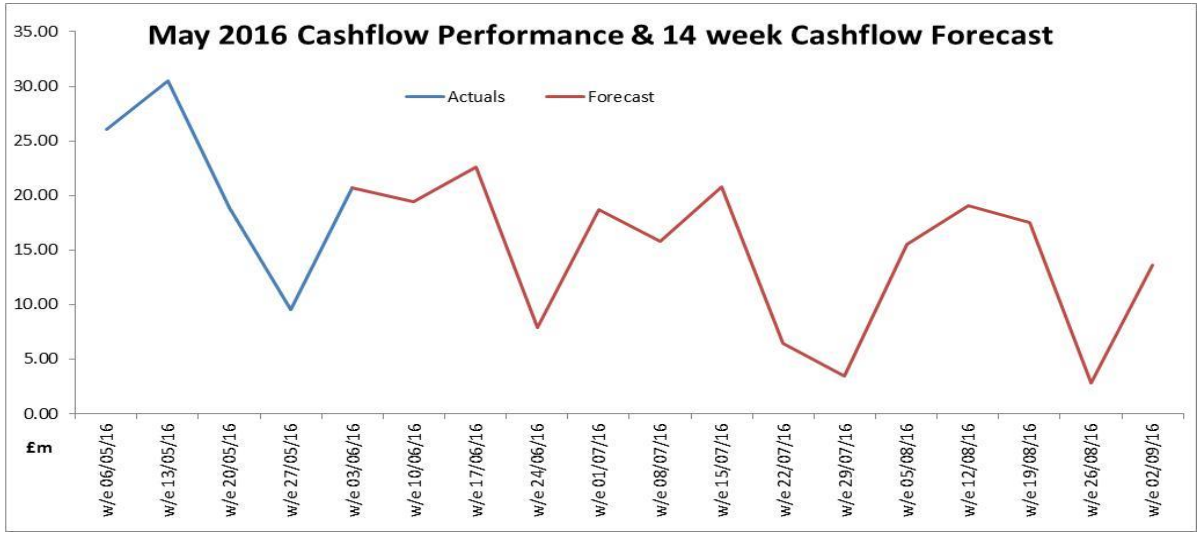
Key Messages	Report Reference
Activity and Income Summary	Page 11/12
Activity and income is above plan in the Acute and Continuing Care Directorate for non elective inpatients and outpatients. T&O elective and non elective activity is below plan, income is also below plan in the Co-ordinated Surgical Directorate. The Co-ordinated Surgical Care Directorate has been requested to review this and report to the Performance Review Meeting (PRM). Overall clinical income is adverse to plan YTD by £0.27m. High cost drugs income is largely on plan YTD.	
Workforce Summary	Page 13/14
Workforce wte are significantly below plan (the plan has been rebased on run rate including vacancies) due to vacancies across clinical areas. The use of temporary staff continues however not all shifts are covered, from a safety perspective, number of breaches on the 1:8 ratio continues to reduce.	
Expenditure Summary	Page 9
Pay:	
Pay is £0.60m favourable to plan in month due to the continued (uncovered) vacancies in Directorates. Run rate remains broadly static.	
Non Pay:	
Clinical supplies in month and YTD is adverse to plan mainly due to external outsourcing to improve RTT performance. A budget transfer is pending approval which will reduce this overspend and will match planned income levels.	
Drugs expenditure is slightly adverse to plan mainly due to high costs drugs and increased activity.	
Run Rate Analysis	Page 10
Pay:	
The pay run rate is similar to the position reported at month 1 (£16.8m), however agency spend has increased compared to month 1 due to updated agency usage information being received relating to month 1 for the Acute and Continuing Care Directorate.	
Non Pay:	
Overall non pay run rate is similar to the position reported at month 1 of £8.8m. Clinical supplies and drugs expenditure have increased due to increased activity. A reduction in other non pay is reported mainly due to a technical adjustment on the clinical income provision to clinical income and the reclassification of fuel to stock in the Facilities and Estates Directorate, when this is taken into account of the non pay run rate is actually £9.2m.	

2. Liquidity

2a. Cash Flow

14 Week Forecast

	Actual				Forecast													
£m	w/e 06/05/16	w/e 13/05/16	w/e 20/05/16	w/e 27/05/16	w/e 03/06/16	w/e 10/06/16	w/e 17/06/16	w/e 24/06/16	w/e 01/07/16	w/e 08/07/16	w/e 15/07/16	w/e 22/07/16	w/e 29/07/16	w/e 05/08/16	w/e 12/08/16	w/e 19/08/16	w/e 26/08/16	w/e 02/09/16
BANK BALANCE BFWD	**13.65**	**26.05**	**30.46**	**18.91**	**9.51**	**20.71**	**19.43**	**22.58**	**7.87**	**18.70**	**15.77**	**20.82**	**6.42**	**3.48**	**15.51**	**19.06**	**17.56**	**2.83**
Receipts																		
NHS Contract Income	14.73	3.32	0.10	0.03	13.91	0.00	0.00	0.32	13.28	0.00	3.56	0.00	0.00	13.28	0.00	3.56	0.26	13.33
Other	0.16	1.23	0.39	0.42	0.49	1.49	4.27	0.26	0.80	0.25	0.30	0.25	0.80	1.97	0.36	0.25	0.30	0.65
Total receipts	**14.89**	**4.55**	**0.48**	**0.46**	**14.39**	**1.49**	**4.27**	**0.58**	**14.08**	**0.25**	**3.86**	**0.25**	**0.80**	**15.24**	**0.36**	**3.81**	**0.56**	**13.98**
Payments																		
Pay Expenditure (excl. Agency)	0.00	0.00	(5.85)	(7.75)	(0.10)	0.00	(2.16)	(11.35)	(0.05)	0.00	(2.16)	(11.35)	(0.10)	0.00	0.00	(2.16)	(11.35)	(0.05)
Non Pay Expenditure	(2.29)	(0.13)	(6.10)	(2.09)	(3.09)	(2.77)	(2.89)	(3.40)	(2.82)	(2.82)	(2.82)	(2.82)	(2.82)	(2.82)	(2.93)	(2.82)	(3.57)	(2.82)
Capital Expenditure	(0.21)	0.00	(0.01)	0.00	(0.01)	(0.01)	(0.31)	(0.53)	(0.38)	(0.35)	(0.43)	(0.48)	(0.82)	(0.39)	(0.36)	(0.33)	(0.36)	(0.33)
Total payments	**(2.50)**	**(0.13)**	**(11.96)**	**(9.85)**	**(3.20)**	**(2.78)**	**(5.36)**	**(15.29)**	**(3.25)**	**(3.17)**	**(5.41)**	**(14.65)**	**(3.74)**	**(3.21)**	**(3.29)**	**(5.31)**	**(15.29)**	**(3.20)**
Net Receipts/ (Payments)	**12.39**	**4.41**	**(11.47)**	**(9.39)**	**11.19**	**(1.28)**	**(1.10)**	**(14.71)**	**10.83**	**(2.92)**	**(1.55)**	**(14.40)**	**(2.94)**	**12.03**	**(2.93)**	**(1.50)**	**(14.73)**	**10.78**
Funding Flows																		
FTFF/DOH	0.00	0.00	0.00	0.00	0.00	0.00	4.25	0.00	0.00	0.00	6.60	0.00	0.00	0.00	6.48	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	(0.08)	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
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
Total Funding Flows	**0.00**	**0.00**	**(0.08)**	**0.00**	**0.00**	**0.00**	**4.25**	**0.00**	**0.00**	**0.00**	**6.60**	**0.00**	**0.00**	**0.00**	**6.48**	**0.00**	**0.00**	**0.00**
BANK BALANCE CFWD	**26.05**	**30.46**	**18.91**	**9.51**	**20.71**	**19.43**	**22.58**	**7.87**	**18.70**	**15.77**	**20.82**	**6.42**	**3.48**	**15.51**	**19.06**	**17.56**	**2.83**	**13.61**



Commentary

This graph shows the Actual cash profile for the Trust for May 2016; it also illustrates the forecasted profile up to the 2nd September 2016.

The Trust commenced May with £13.65m and ended the month with £9.22m. This balance complies with the liquidity tramline required by DoH (£1.4m).

The Trust does not currently have a Revenue Loan facility in place for 2016/17; nor did the Trust require to make use of the Working Capital Facility (WCF) during the month.

Capex spend remains sluggish, however this spend is expected to pick up with the commencement of the redevelopment of the Ambulance Parking / Drop Off area as part of the wider Emergency Department Project.

The forecast assumes that the Trust will require funding from the WCF in June.

2b. Loan agreement - status of compliance with additional terms

The full year revenue support loan agreement with the Department of Health requires the Trust to comply with a number of additional terms. These have been agreed by the Board and are summarised here, along with the current status of each and required timeframes for compliance.

Loan Agreement Clause	Description	Implementation Timeframe	Progress	Compliance with Loan Status	Risk to Organisation	Comments
8 – 1	Notification to Monitor / DH if anticipating to miss reforecast and require additional cash support	Immediately if anticipating missing reforecast and not less than 2 months prior to requiring the cash support	Trust is reporting a V3 plan by 29 June in line with new control totals. NHSi/DH are aware of revenue and capital funding required in 16/17			Trust is reporting operating deficit within V3 of the plan
8 – 2	Agency nursing procured through approved frameworks and within maximum cap	Immediately	All agencies routinely used are compliant with frameworks. Following introduction of 1st April price cap compliance is stable but plans are being developed to put on a downward, improving trajectory.			The 1st April price cap has resulted in an increase in the trajectory which needs to be managed
8 – 3	Consultancy spend in excess of £50K pre-approved by Monitor	Immediately	Working through all business cases with Monitor team.			No new contracts introduced without pre-approval.
8 – 4	Implementation of controls over VSMs and off-payroll workers	Immediately	In progress			Market Forces and compliance through Remuneration Committee
8 – 5	Review / benchmarking of Estates and Facilities costs	31st May 2016	Behind schedule.			New Interim Director of Facilities & Estates recently appointed and timing to be confirmed of benchmarking exercise
8 – 6	Produce an Estates strategy	Summer 2106	In progress			Estates strategy needs to be developed in conjunction with overall Trust strategy.
8 – 7	Use P21+ Procurement framework for publicly funded capital work	Immediately	Major capital works are being undertaken for the ED project. Specific dispensation was sought from Monitor for these works to be tendered outside of the P21+ contract.			ED redevelopment of Majors using P21+
8 – 8	Commission an assessment from SBS of benefit in outsourcing Finance, Accounting and Payroll services	9th May 2016	Payroll is being provided by SBS since February 2016. Outsourcing of other Finance and Accounting services to be further reviewed.			In relation to transactional services, SBS have been provided with Trust data; they have reviewed and we have worked with them to ensure they understand our submission. Final confirmation to be given on their notes by us and then they will submit their proposal
8 – 9	Assess benefit of outsourcing staff bank provider	9th May 2016	Completed - benefit is in moving in-house with a go-live date of 26th March 2016.			
8 – 10	Review savings opportunities in increased usage of NHS Supply Chain and provide copies of medical capital asset register and procurement plans	9th May 2016	Savings opportunities from using NHS Supply Chain are regularly reviewed by Procurement. Medical capital asset register is available.			
8 – 11	Test savings opportunities in use of CCS framework	9th May 2016	CCS framework used			
8 – 12	Become a member of the EEA portal and report relevant activity	Not specified	Member since 2010, activity is reported.			
8 – 13	Provide access to relevant authorised individuals to allow monitoring of progress on above conditions	Immediately	Ongoing			

3. Financial Performance

3a. Consolidated Income & Expenditure

Consolidated I&E (May 2016)

	Current Month			Year to Date			V3 Annual	V3 Updated Annual
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Plan*	*Plan*
	£m	£m	£m	£m	£m	£m	£m	£m
Revenue								
Clinical income	17.61	17.87	-0.26	35.23	35.50	-0.27	217.65	230.71
High Cost Drugs	1.62	2.01	-0.38	3.42	3.33	0.10	21.45	21.45
Other Operating Income	2.12	2.00	0.13	4.06	3.97	0.09	24.30	24.30
Total Revenue	**21.36**	**21.87**	**-0.51**	**42.71**	**42.80**	**-0.08**	**263.40**	**276.46**
Expenditure								
Substantive	-13.28	-15.08	1.80	-26.62	-30.10	3.48	-181.91	-181.91
Bank	-0.54	-0.26	-0.28	-1.13	-0.52	-0.61	-3.10	-3.10
Locum	-0.24	-0.25	0.01	-0.49	-0.50	0.01	-2.99	-2.99
Agency	-2.76	-1.83	-0.93	-5.39	-3.67	-1.72	-21.02	-21.02
Total Pay	**-16.82**	**-17.42**	**0.60**	**-33.62**	**-34.78**	**1.16**	**-209.02**	**-209.02**
Clinical supplies	-3.41	-3.17	-0.23	-6.60	-5.83	-0.76	-31.19	-31.19
Drugs	-2.85	-3.03	0.17	-5.55	-5.42	-0.13	-30.56	-30.56
Consultancy	-0.10	-0.08	-0.02	-0.13	-0.16	0.02	-1.43	-1.43
Other non pay	-2.41	-2.61	0.21	-5.34	-5.35	0.01	-35.07	-35.07
Total Non Pay	**-8.77**	**-8.89**	**0.12**	**-17.62**	**-16.76**	**-0.86**	**-98.26**	**-98.26**
Total Expenditure	**-25.59**	**-26.31**	**0.73**	**-51.24**	**-51.54**	**0.30**	**-307.28**	**-307.28**
EBITDA	**-4.23**	**-4.44**	**0.21**	**-8.53**	**-8.74**	**0.21**	**-43.88**	**-30.82**
	-20%	*-20%*		*-20%*	*-20%*		*-17%*	*-11%*
Post EBITDA								
Depreciation	-0.79	-0.83	0.04	-1.59	-1.59	0.00	-9.69	-9.69
Interest	-0.13	-0.10	-0.03	-0.24	-0.26	0.02	-2.02	-2.02
Dividend	-0.11	-0.11	0.00	-0.22	-0.22	0.00	-1.31	-1.31
	-1.03	**-1.03**	**0.01**	**-2.06**	**-2.08**	**0.02**	**-13.02**	**-13.02**
Net (Deficit) / Surplus	**-5.25**	**-5.47**	**0.22**	**-10.58**	**-10.82**	**0.23**	**-56.90**	**-43.84**

Commentary

Net (Surplus) / Deficit and Plan Figure

The Trust reported a £5.25m deficit in month 2, favourably to plan by £0.22m. As at month 2 the Trust's planned deficit for the year is £56.9m (as outlined in V3 of the Operating Plan presented to the Board in June). Work continues on V3 to incorporate STF funding (£8.4m) and the removal of contract penalties (£4.7m) due to be submitted to NHSi on the 29th June 2016. The revised planned deficit to be reported from month 3 onwards is £43.8m. This is in line with the NHSi control total.

Clinical Income

Clinical income is adverse to plan YTD by £0.27m mainly due to elective and non elective T&O activity below plan. The Co-ordinated Surgical Care Directorate has been requested to review this and report to the Performance Review Meeting (PRM). High cost drugs income is largely on plan. Activity and income is above plan in the Acute and Continuing Care Directorate for non elective inpatients and outpatients. Contract negotiations are yet to be finalised with CCGs, any adjustments that are required following completion of negotiations will be retrospectively applied through the income contingency.

Other Income

Other income is favourable to plan mainly due to apprenticeship funding received in the workforce department.

Pay

Pay is favourable to plan mainly due to vacancies in the Directorates although expenditure has increased in agency compared to month 1 due to updated (catch up) agency usage information being received relating to month 1 for the Acute and Continuing Care Directorate.

Non Pay

Clinical supplies in month and YTD is adverse to plan mainly due to external outsourcing to improve RTT performance. A budget transfer is pending approval which will reduce this overspend and will match planned income levels.

Risks and Mitigations

A high level of unidentified CIP is reported by the Directorates and is being reviewed and challenged at the PRM. As at month 2 £7.2m of the £12.6m (57%) remains unidentified with the plan assuming delivery from month 7. The clinical income contract with the main Commissioners is yet to be finalised. An arbitration process may need to be followed to ensure resolution.

3b. Run Rate Analysis - Financial

Anaylsis of 12 monthly performance - Financials

	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue												
Clinical income	15.8	18.1	18.0	17.1	17.1	17.3	16.7	16.8	16.9	21.9	17.6	17.6
High Cost Drugs	1.4	1.8	1.5	1.6	1.7	1.6	1.7	1.7	1.7	1.7	1.8	1.6
Other Operating Income	2.1	2.2	1.9	1.9	2.0	2.0	1.9	1.9	2.4	2.0	1.9	2.1
Total Revenue	**19.4**	**22.1**	**21.4**	**20.5**	**20.8**	**20.8**	**20.3**	**20.4**	**20.9**	**25.6**	**21.4**	**21.4**
Expenditure												
Substantive	-12.7	-12.4	-12.5	-12.7	-12.5	-12.6	-12.5	-12.8	-12.9	-12.6	-13.3	-13.3
Bank	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.8	-0.6	-0.5
Locum	-0.2	-0.3	-0.3	-0.2	-0.3	-0.3	-0.3	-0.3	-0.2	-0.3	-0.2	-0.2
Agency	-2.5	-3.2	-3.3	-2.9	-3.0	-2.4	-3.6	-2.7	-3.0	-2.8	-2.6	-2.8
Total Pay	**-16.0**	**-16.4**	**-16.6**	**-16.4**	**-16.4**	**-15.8**	**-17.0**	**-16.3**	**-16.7**	**-16.3**	**-16.8**	**-16.8**
Clinical supplies	-2.3	-2.7	-2.8	-2.8	-2.8	-2.9	-3.0	-2.7	-3.1	-3.6	-3.2	-3.4
Drugs	-2.0	-2.5	-2.2	-2.3	-2.5	-2.4	-2.4	-2.4	-2.4	-2.6	-2.7	-2.9
Consultancy	-0.1	-0.2	-0.2	-0.3	-0.1	-0.1	-0.1	-0.2	-0.2	-0.1	0.0	-0.1
Other non pay	-2.7	-2.8	-2.9	-2.8	-2.9	-2.5	-2.7	-2.9	-2.8	-2.7	-2.9	-2.4
Total Non Pay	**-7.1**	**-8.1**	**-8.2**	**-8.1**	**-8.4**	**-7.9**	**-8.3**	**-8.1**	**-8.5**	**-9.1**	**-8.8**	**-8.8**
Total Expenditure	**-23.1**	**-24.5**	**-24.7**	**-24.5**	**-24.8**	**-23.7**	**-25.3**	**-24.5**	**-25.2**	**-25.5**	**-25.6**	**-25.6**
EBITDA	**-3.7**	**-2.4**	**-3.3**	**-4.0**	**-4.0**	**-2.9**	**-5.0**	**-4.0**	**-4.3**	**0.1**	**-4.3**	**-4.2**
Post EBITDA												
Depreciation	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.3	-0.8	-0.8
Interest	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Dividend	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	0.2	-0.1	-0.1
Fixed Asset Impairment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0
	-1.3	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**0.0**	**-1.0**	**-1.0**
Net Surplus / (Deficit)	**-5.0**	**-3.7**	**-4.6**	**-5.3**	**-5.3**	**-4.2**	**-6.3**	**-5.3**	**-5.6**	**0.1**	**-5.3**	**-5.3**
Revaluation Gain	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0
Net Surplus / (Deficit)	**-5.0**	**-3.7**	**-4.6**	**-5.3**	**-5.3**	**-4.2**	**-6.3**	**-5.3**	**-5.6**	**0.4**	**-5.3**	**-5.3**

3c. Clinical Activity

Clinical Activity by Point of Delivery (May 2016)

	Current Month			Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
PBR								
Elective Day Case	1,896	1,903	- 7	1,659	3,803	3,717	86	3,321
Elective Inpatient	566	621	- 55	714	1,191	1,252	- 61	1,360
Non Elective Inpatient	3,862	3,960	- 98	3,308	7,622	7,795	- 173	6,540
Excess Bed Days	1,025	1,691	- 666	1,825	2,380	4,001	- 1,621	3,801
Outpatients	29,114	26,815	2,299	25,212	57,878	54,241	3,637	50,333
A&E	7,644	6,818	826	6,815	14,449	12,982	1,467	12,973
Maternity Pathway	836	844	- 8	893	1,704	1,749	- 45	1,794
Direct Access Radiology	5,697	4,887	810	1,769	12,518	9,835	2,683	3,541
Adult Critical Care	841	759	82	851	1,533	1,618	- 85	1,587
Chemotherapy	796	765	31	2,089	1,683	1,583	100	3,614
Total PBR	**52,277**	**49,063**	**3,214**	**45,134**	**104,761**	**98,773**	**5,988**	**88,865**
Non PBR								
Direct Access	182,878	169,595	13,283	90,231	383,048	337,444	45,604	180,321
Paediatric & Neonatal Critical Care	919	955	- 36	913	1,962	1,891	71	1,776
Excluded Devices	81	80	1	67	160	159	1	144
Other cost per case	8,122	5,204	2,918	5,170	10,599	10,690	- 91	10,403
Total Non PBR	**192,000**	**175,834**	**16,166**	**96,381**	**395,769**	**350,184**	**45,585**	**192,644**

Commentary

A&E attendances are significantly above plan in month & YTD, this is driven by the recent surge in attendances where average daily attendances has risen from circa 200 per day to 250 per day, with some days having seen over 300 attendances per day for a sustained period. Questions have been raised with Commissioners to assist in understanding the increase.

Non-Elective Activity is close to planned volumes in the majority of specialties although T&O is below plan by 75 spells. However following the introduction of the medical model, there has been a marginal shift of long-stay activity and short-stay activity to same day emergency care, which reflects the new pathways and intention to discharge patients the same day to avoid the overnight stay and relieve pressure on bed capacity.

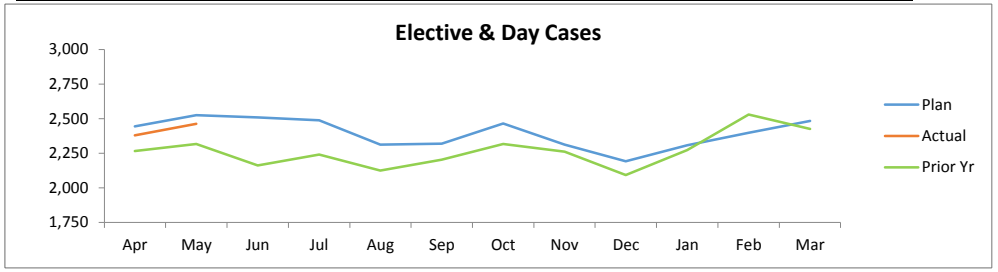
Adult critical care days were above plan in Month 2, reducing the under performance in month 1.

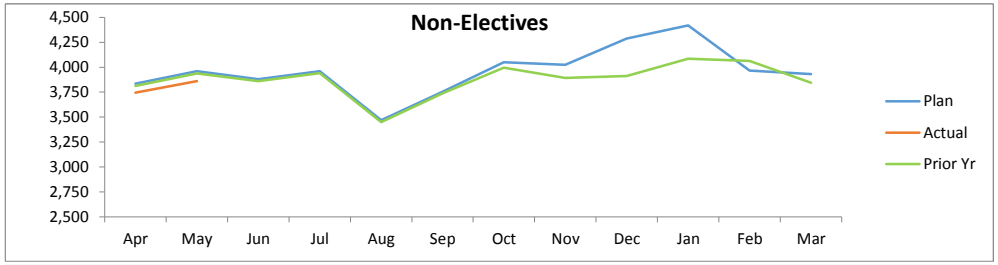
Elective Day cases & Inpatients are below plan in month by 62 spells mainly due to reduced T&O. Year to date is slightly above plan due to the increase in additional sessions within the Trust.

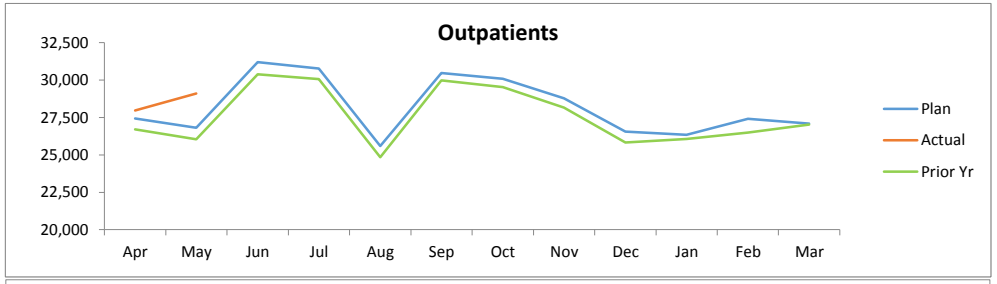
Direct Access Pathology activity & pricing is yet to be agreed in the contract with the CCG's, once this has been agreed prior periods will be retrospectively adjusted.

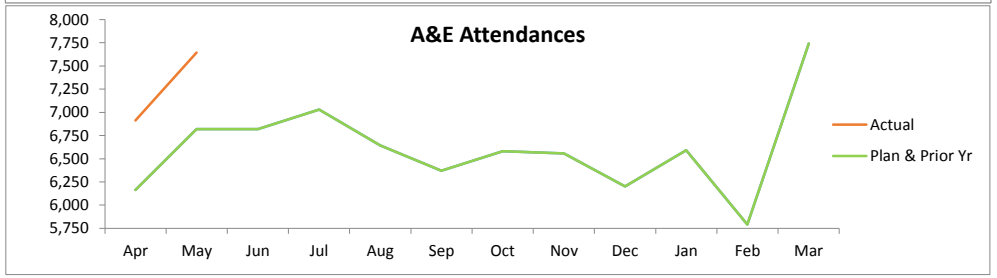
The Clinical Directorates will be asked to review staff (consultant) mix between OPs and Theatre sessions.

Activity Performance against Plan









3d. Clinical Income

Clinical Income by Point of Delivery (May 2016)

	Current Month			Prior Year In Month	Year to Date			Prior Year YTD
	Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Actual* £m
PBR								
Elective Day Case	1.41	1.45	-0.05	1.31	2.77	2.81	-0.04	2.62
Elective Inpatient	1.52	1.73	-0.21	1.97	3.14	3.46	-0.32	3.72
Non Elective Inpatient	6.40	6.38	0.02	5.78	12.77	12.72	0.05	11.40
Emergency Readmissions	-0.19	-0.19	0.00	-0.19	-0.39	-0.39	0.00	-0.38
Emergency Marginal rate	-0.22	-0.27	0.04	-0.10	-0.45	-0.53	0.08	-0.20
Excess Bed Days	0.25	0.40	-0.15	0.43	0.57	0.95	-0.39	0.89
Outpatients	3.60	3.34	0.26	3.45	7.11	6.78	0.33	6.92
A&E	0.97	0.88	0.09	0.87	1.84	1.68	0.16	1.62
Maternity Pathway	0.77	0.84	-0.07	1.03	1.61	1.76	-0.15	1.84
Direct Access Radiology	0.23	0.18	0.05	0.14	0.49	0.37	0.12	0.24
Adult Critical Care	0.87	0.78	0.09	0.83	1.56	1.61	-0.05	1.55
Chemotherapy	0.11	0.11	0.01	0.13	0.23	0.22	0.01	0.23
Total PBR	**15.70**	**15.63**	**0.07**	**15.65**	**31.25**	**31.44**	**-0.19**	**30.46**
Non PBR								
High Cost Drugs	1.62	1.53	0.10	1.36	3.42	3.33	0.10	3.09
Direct Access	0.38	0.47	-0.09	0.52	0.82	0.94	-0.12	1.02
Paediatric & Neonatal Critical Care	0.83	0.73	0.10	0.64	1.77	1.48	0.30	1.24
Excluded Devices	0.18	0.17	0.01	0.15	0.33	0.38	-0.05	0.33
Other cost per case	0.28	0.28	-0.00	0.28	0.54	0.54	-0.00	0.50
Block contracts	0.77	0.77	0.00	0.51	1.55	1.55	0.00	1.29
Outpatient efficiencies	-0.18	-0.23	0.05	-0.16	-0.42	-0.45	0.04	-0.33
Total Non PBR	**3.88**	**3.72**	**0.16**	**3.31**	**8.01**	**7.76**	**0.25**	**7.15**
CQUIN	0.34	0.35	-0.01	0.35	0.69	0.71	-0.02	0.68
Contract Penalties	-0.41	-0.39	-0.02	0.00	-0.82	-0.78	-0.04	0.00
Other Income Adjustments:	-0.31	-0.11	-0.20	-0.01	-0.60	-0.40	-0.20	0.02
Other Non-Contracted Income	0.05	0.05	0.01	0.09	0.12	0.10	0.03	0.28
Prior Month Adjustments	-0.02	0.62	-0.64	0.00	0.00	0.00	0.00	0.00
Total	**19.24**	**19.88**	**- 0.64**	**19.39**	**38.65**	**38.82**	**- 0.17**	**38.59**

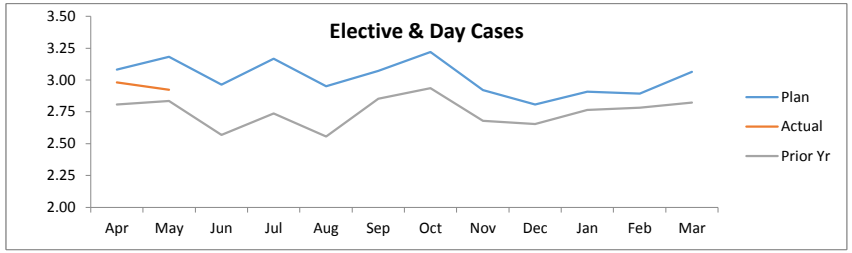
Commentary

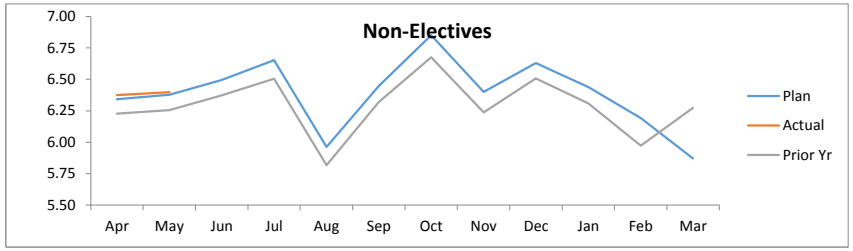
The financial plan has been updated to reflect the latest Trust position. The year to date position is £0.17m below plan at m onth 2.

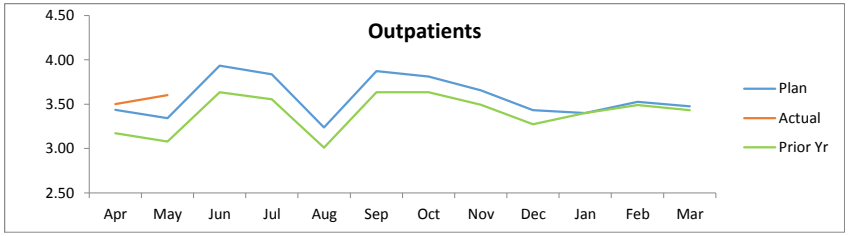
Elective income is below plan mainly due to reduced T&O activity. Non Electives overall are largely on plan both in month and year to date.

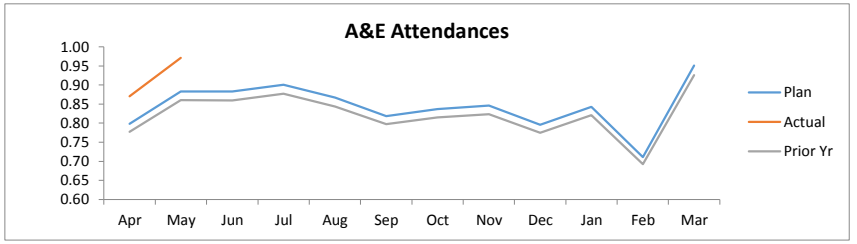
Contract negotiations are close to completion with CCGs and adjustments that are required following completion of negotiation s will be retrospectively applied in Month 3.

Income Performance against Plan









3e. Workforce

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
		WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Substantive	Consultants	157	183	-26	2.14	2.28	-0.13	2.04	4.21	4.56	-0.35	4.14
	Junior Medical	309	365	-56	1.82	2.04	-0.23	1.69	3.66	4.08	-0.42	3.37
	Nurses & Midwives	1,107	1,448	-341	3.95	4.90	-0.91	3.89	7.93	9.74	-1.81	7.82
	Scientific, Therapeutic & Technical	466	506	-41	1.43	1.49	-0.06	1.30	2.88	2.97	-0.09	2.60
	Healthcare Assts, etc.	465	544	-79	0.95	1.07	-0.12	0.96	1.94	2.14	-0.20	1.90
	Executives	7	9	-2	2.01	2.30	-0.30	1.83	3.99	4.62	-0.63	3.65
	Chair & NEDs	7	7	0	0.01	0.01	0.00	0.01	0.03	0.03	0.00	0.02
	Admin & Clerical	800	931	-131	0.11	0.14	-0.03	0.14	0.21	0.27	-0.06	0.27
	Other Non Clinical	435	494	-59	0.87	0.86	0.01	0.83	1.77	1.73	0.04	1.66
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	-0.03	0.03	0.00
	Substantive Total	**3,753**	**4,487**	**-735**	**13.29**	**15.09**	**-1.77**	**12.69**	**26.62**	**30.11**	**-3.49**	**25.43**
Agency	Consultants	13	0	13	0.26	0.11	0.15	0.11	0.51	0.22	0.30	0.38
	Junior Medical	52	0	52	0.54	0.46	0.08	0.68	1.20	0.91	0.30	1.38
	Nurses & Midwives	224	0	224	0.96	0.66	0.30	1.00	1.68	1.31	0.40	1.98
	Scientific, Therapeutic & Technical	52	0	52	0.28	0.12	0.16	0.25	0.56	0.23	0.30	0.56
	Healthcare Assts, etc.	31	0	31	0.08	0.00	0.08	0.03	0.12	0.00	0.10	0.07
	Admin & Clerical	41	8	34	0.50	0.34	0.16	0.39	1.03	0.69	0.30	0.75
	Other Non Clinical	45	0	1	0.14	0.15	-0.01	0.12	0.29	0.31	0.00	0.24
	Agency Total	**458**	**8**	**407**	**2.76**	**1.84**	**0.92**	**2.58**	**5.39**	**3.67**	**1.70**	**5.36**
Bank	Nurses & Midwives	58	0	58	0.24	0.14	0.09	0.25	0.43	0.28	0.20	0.49
	Scientific, Therapeutic & Technical	4	0	4	0.01	0.01	0.00	0.04	0.01	0.02	0.00	0.08
	Healthcare Assts, etc.	91	0	91	0.22	0.06	0.16	0.25	0.44	0.13	0.30	0.46
	Admin & Clerical	36	1	35	0.07	0.02	0.05	0.11	0.21	0.04	0.20	0.21
	Other Non Clinical	3	0	3	0.01	0.03	-0.02	0.02	0.04	0.05	0.00	0.05
	Bank Total	**192**	**1**	**191**	**0.55**	**0.26**	**0.28**	**0.67**	**1.13**	**0.52**	**0.70**	**1.29**
Locum	Consultants	24	24	1	0.23	0.24	-0.01	0.26	0.47	0.48	0.00	0.51
	Junior Medical	2	2	0	0.01	0.01	0.00	0.00	0.02	0.02	0.00	0.01
	Locum Total	**26**	**26**	**1**	**0.24**	**0.25**	**-0.01**	**0.26**	**0.49**	**0.50**	**0.00**	**0.52**
	Workforce Total	**4,429**	**4,522**	**-136**	**16.84**	**17.44**	**-0.58**	**16.20**	**33.63**	**34.80**	**-1.09**	**32.60**

Commentary:

Pay expenditure is underspent compared to plan in month by £0.60m mainly due to vacancies. Increases on prior year in month expenditure are mainly due to increments, inflationary and national insurance increases of 3.3%.

Establishments have been set based on a run rate basis including vacancies and agreed opening budgets with Directorates. Further in year reviews are planned in all three clinical directorates to confirm required staffing levels following the demand and capacity analysis.

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.

	Current Month						Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
Staff Group:	WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Consultants	194	207	-12	2.63	2.63	0.01	2.41	5.19	5.26	-0.05	5.03
Junior Medical	363	367	-4	2.37	2.51	-0.15	2.37	4.88	5.01	-0.12	4.76
Nurses & Midwives	1,389	1,448	-59	5.15	5.70	-0.52	5.14	10.04	11.33	-1.21	10.29
Scientific, Therapeutic & Technical	522	506	15	1.72	1.62	0.10	1.59	3.45	3.22	0.21	3.24
Healthcare Assts, etc.	587	544	43	1.25	1.13	0.12	1.24	2.50	2.27	0.20	2.43
Executives	7	9	-2	2.01	2.30	-0.30	1.83	3.99	4.62	-0.63	3.65
Chair & NEDs	7	7	0	0.01	0.01	0.00	0.01	0.03	0.03	0.00	0.02
Admin & Clerical	877	940	-62	0.68	0.50	0.18	0.64	1.45	1.00	0.44	1.23
Other Non Clinical	483	494	-55	1.02	1.04	-0.02	0.97	2.10	2.09	0.04	1.95
Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	-0.03	0.03	0.00
Workforce Total	**4,429**	**4,522**	**-136**	**16.84**	**17.44**	**-0.58**	**16.20**	**33.63**	**34.80**	**-1.09**	**37.44**

3f. Run Rate Analysis - WTE

Anaylsis of 12 monthly performance - WTE

		May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	155	153	152	154	155	155	157	155	155	153	153	153	157
	Junior Medical	303	302	294	311	312	315	323	320	317	322	324	319	309
	Nurses & Midwives	1,127	1,116	1,091	1,064	1,076	1,075	1,088	1,076	1,066	1,077	1,102	1,110	1,107
	Scientific, Therapeutic & Technical	425	416	416	433	446	452	450	453	450	448	453	464	466
	Healthcare Assts, etc	484	490	477	485	473	468	465	472	465	466	477	471	465
	Executives	5	7	8	6	7	6	5	4	4	5	6	7	7
	Chair & NEDs	5	4	5	5	7	6	6	7	7	7	7	7	7
	Admin & Clerical	749	754	747	751	752	756	754	750	750	768	779	794	800
	Other Non Clinical	403	425	426	427	436	427	419	425	417	422	420	443	435
	Substantive Total	**3,656**	**3,666**	**3,615**	**3,636**	**3,664**	**3,649**	**3,657**	**3,652**	**3,631**	**3,668**	**3,721**	**3,768**	**3,752**
Agency	Consultants	10	5	9	10	14	13	11	10	8	11	14	10	13
	Junior Medical	62	51	70	62	57	53	64	54	59	51	59	50	52
	Nurses & Midwives	168	176	220	197	216	214	100	271	200	245	159	168	224
	Scientific, Therapeutic & Technical	35	49	62	57	52	56	54	54	52	55	49	44	52
	Healthcare Assts, etc	10	15	8	9	20	16	6	17	10	8	42	- 9	31
	Admin & Clerical	30	32	43	30	41	45	27	41	32	39	52	40	41
	Other Non Clinical	33	54	62	52	77	41	41	-	48	53	73	57	45
	Agency Total	**349**	**382**	**473**	**417**	**477**	**438**	**302**	**448**	**409**	**462**	**448**	**360**	**458**
Bank	Nurses & Midwives	69	59	48	42	46	45	43	41	47	49	92	58	58
	Scientific, Therapeutic & Technical	8	11	10	12	12	10	11	9	10	10	10	4	4
	Healthcare Assts, etc	104	101	107	119	104	120	113	105	118	108	91	91	91
	Admin & Clerical	45	42	49	41	46	46	49	47	48	50	42	36	36
	Other Non Clinical	11	11	14	12	12	11	12	13	9	11	10	3	3
	Bank Total	**237**	**224**	**228**	**226**	**220**	**233**	**227**	**216**	**233**	**228**	**246**	**192**	**192**
Locum	Consultants	26	27	26	25	26	26	25	25	25	25	26	25	24
	Junior Medical	2	2	2	2	2	2	2	2	2	2	2	2	2
	Locum Total	**28**	**28**	**28**	**26**	**27**	**28**	**27**	**26**	**26**	**27**	**28**	**27**	**26**
	Workforce Total	**4,270**	**4,299**	**4,344**	**4,306**	**4,388**	**4,347**	**4,214**	**4,342**	**4,299**	**4,385**	**4,443**	**4,347**	**4,428**

4. Balance Sheet

Medway NHS
NHS Foundation Trust

4a. Balance Sheet

	Last Month	Current Month		
	Actual	Actual	Plan	Variance
	£m	£m	£m	£m
Non current Assets	**165.7**	**165.9**	**166.8**	**-0.9**
Current Assets				
Inventories	6.4	6.5	6.4	0.1
Trade receivables	12.4	15.4	18.5	-3.1
Other receivables	2.2	1.8	2.2	-0.4
Other current assets	5.8	7.2	2.2	5.0
Cash at bank	14.4	9.2	1.5	7.7
Current Assets Sub Total	**41.2**	**40.1**	**30.8**	**9.3**
Current Liabilities				
Trade payables	-21.2	-19.8	-17.5	-2.3
Other payables	-15.2	-21.3	-14.4	-6.9
Borrowings	-1.1	-1.0	-1.1	0.1
Provisions	-0.1	-0.1	-0.1	0.0
Other liabilities	-16.1	-16.1	-17.1	1.1
Sub Total Current Liabilities	**-53.7**	**-58.3**	**-50.2**	**-8.1**
Net Current Assets	**-12.6**	**-18.2**	**-19.4**	**1.3**
Non Current Liabilities				
Borrowings	-85.7	-85.7	-85.4	-0.3
Provisions	-0.8	-0.8	-0.8	0.0
Other liabilities	0.4	0.7	0.5	0.2
Sub Total Non Current Liabilities	**-86.1**	**-85.9**	**-85.7**	**-0.1**
Net Assets Employed	**67.0**	**61.8**	**61.6**	**0.2**
Taxpayers' and Others' Equity				
Public Dividend Capital	129.5	129.5	129.5	0.0
Retained Earnings	-94.7	-100.0	-100.2	0.2
Revaluation Reserve	32.3	32.3	32.3	0.0
	67.0	**61.8**	**61.6**	**0.2**

Commentary

For the commentary relating to the balance sheet please refer to section 5a for Capital, 2a for Cashflow, 4b for debtors and 4c for creditors.

4b. Debtors

Aged Debtors

	Total	Current	31 - 60 Days	61- 90 Days	91- 180 Days	181 - 365 Days	12 - 18 Months	18 - 24 Months	2 - 3 Years	3 + Years
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS										
Medway CCG	1.00	0.36	0.01	0.41	0.06	0.02	0.01	0.00	0.13	0.01
Swale CCG	0.78	(0.19)	(0.00)	0.71	0.22	0.01	0.01	0.02	0.00	0.00
Dartford & Gravesham CCG	0.94	0.16	0.21	0.22	(0.04)	0.24	0.10	0.00	0.06	0.00
Other CCGs	1.92	0.68	0.02	0.36	0.27	0.39	0.08	0.04	0.06	0.00
NHS England	0.18	0.00	0.00	0.00	0.14	0.00	0.02	0.00	0.02	0.00
Other	3.13	0.38	0.20	0.40	0.97	0.64	0.29	0.05	0.11	0.10
Partially Completed Spells and Overperformance	6.55	6.55	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total NHS	**14.50**	**7.94**	**0.43**	**2.09**	**1.62**	**1.31**	**0.51**	**0.11**	**0.38**	**0.11**
Non NHS										
Nursery	0.06	0.02	0.01	0.00	0.01	0.01	0.01	0.00	0.01	0.00
Payroll	0.15	(0.00)	0.00	(0.00)	0.01	0.04	0.02	0.01	0.01	0.06
Overseas patients	0.29	0.01	0.01	0.01	0.03	0.08	0.06	0.03	0.05	0.02
Medway Comm Healthcare	0.29	0.09	0.02	0.05	0.05	0.03	0.02	(0.00)	0.02	0.02
Other	1.00	0.33	0.22	0.06	0.21	0.07	0.06	0.02	0.04	0.01
Total Non NHS	**1.79**	**0.44**	**0.25**	**0.12**	**0.30**	**0.22**	**0.17**	**0.06**	**0.13**	**0.11**
Bad debt provision	**(0.90)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.02)**	**(0.17)**	**(0.50)**	**(0.21)**
Total Debtors	**15.38**	**8.39**	**0.68**	**2.21**	**1.92**	**1.53**	**0.65**	**0.00**	**0.00**	**0.00**

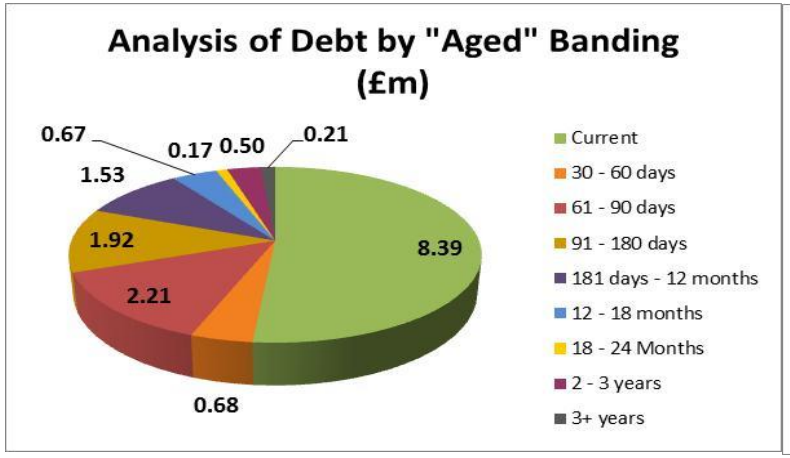
Commentary

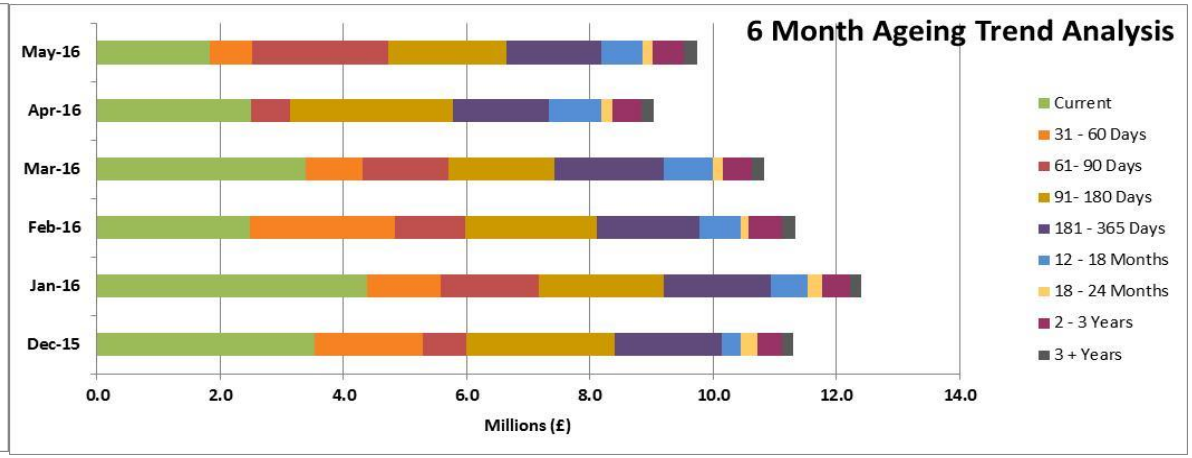
The Gross Trade Receivables Debt outstanding to the trust as at 31 May 2016 is £16.29m (£15.38m Net). In accordance with Trust policy the Bad Debt provision is shown separately.

The 1+ Year ageing categories in this table have now been aligned with the Trust's Bad Debt provision policy.

The Pie chart shows the value of Debt outstanding by Ageing Category. Current Debt (ie less than 30 days) stands at 51.5% of total receivables, with a further 29.6% of receivables for categories up to 6 months overdue; the remaining 18.9% of debt is over 6 months old.

The Bar Chart below illustrates the trends of each ageing category over the last 6 months. It is noted that April's 61-90 Day Ageing category included an unallocated £1.33m receipt for Medway CCG - that has since been allocated. The movement in ageing of Swale CCG debt is being monitored & reviewed with the income team.





** Please note that the above graphs are based on invoiced debt only and exclude analysis relating to partially completed spells and provisions for bad debt included in the table above.

4c. Creditors

Aged Creditors

	Total	Current	30 to 60	61 to 90	Over 90	Over 120
	£m	£m	£m	£m	£m	£m
NHS						
NHS Business Services Authority	0.72	0.36	0.12	0.12	0.12	0.00
Dartford and Gravesham	1.19	0.18	0.18	0.02	0.23	0.58
National Blood	0.03	0.01	0.01	0.00	0.00	0.00
Other	0.99	0.08	(0.30)	0.36	0.12	0.74
NHS Pension Scheme	2.17	2.17	0.00	0.00	0.00	0.00
Total NHS	5.11	2.80	0.01	0.50	0.48	1.32
Non NHS						
NHS Professionals	0.09	0.00	0.00	0.00	0.00	0.09
NHS Supply Chain	0.87	0.49	0.38	0.00	0.00	0.00
Johnson and Johnson	0.17	0.05	0.09	0.03	0.00	0.00
Other	13.59	4.46	6.80	1.31	0.44	0.57
Total Non NHS	14.72	5.00	7.27	1.35	0.44	0.66
Total Creditors	**19.82**	**7.79**	**7.29**	**1.85**	**0.92**	**1.98**

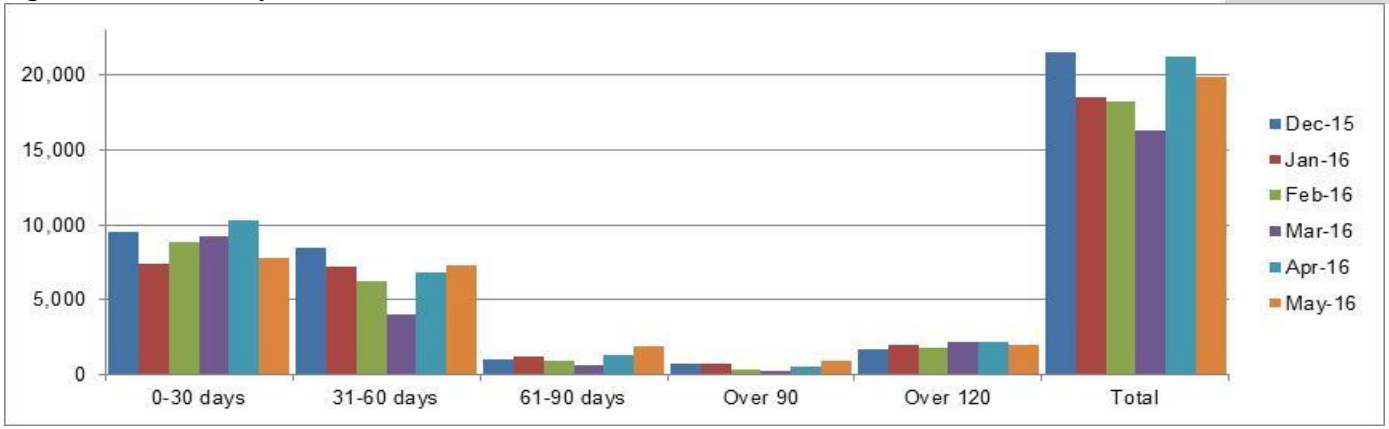
Commentary

The key NHS and Non NHS trade creditors are shown in the table to the left. Trade Creditors are now at £19.82m.

It is noted that Creditor Ageing has declined slightly and this is due to issues with regard to agency invoicing and the internal bank. Whilst the new processes are bedding in a number of invoices are being rejected by the internal bank as they do not match backing data. These invoices remain on our Creditors ledger and continue to age until the issues are resolved and the invoices are paid.

The Trust has continues to maintain payments for all approved invoices between 45 and 60 days from the invoice date. The Trust continues to work through and resolve the NHSP legacy issues and is actively working towards clearing the agency debt directly with suppliers.

Aged Creditor Monthly Profile



5. Capital

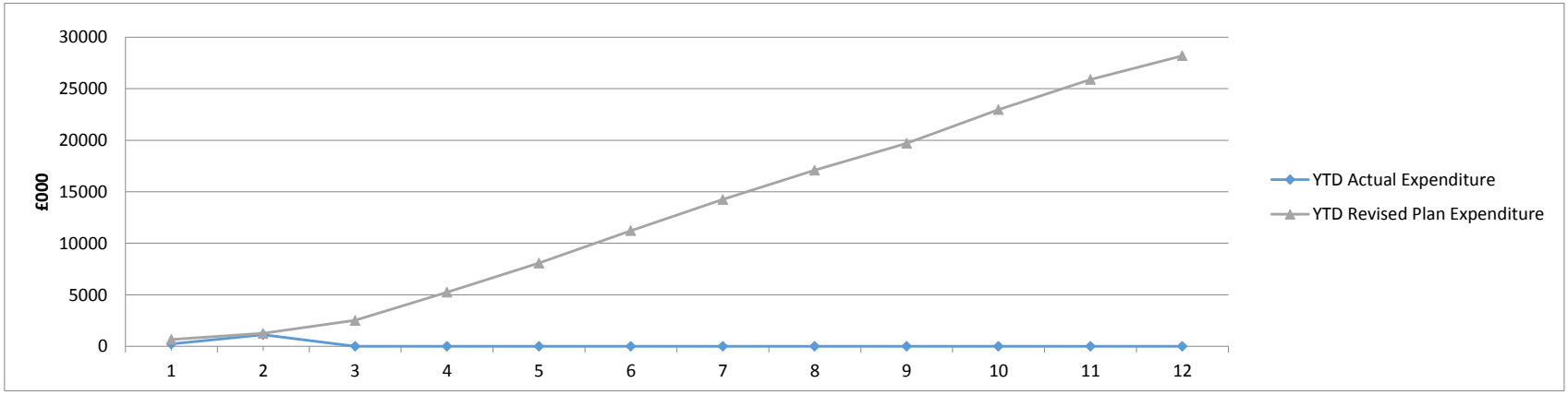
5a.Capital

Capital Programme Summary

	Current Month			Year to Date			Annual
	Actual	Plan	Variance	Actual	Plan	Variance	Plan
	£m	£m	£m	£m	£m	£m	£m
Expenditure							
Recurrent Estates & Site Infrastructure	0.18	0.14	0.05	0.28	0.22	0.06	5.06
IM&T	0.15	0.05	0.11	0.23	0.13	0.10	5.9
Medical & Surgical Equipment	0.03	0.00	0.03	0.02	0.00	0.02	1.52
Specific Business Cases	0.08	0.02	0.06	0.16	0.52	-0.36	3.88
Transform Projects (ED/AAU)	0.44	0.38	0.06	0.43	0.38	0.04	11.84
Total	**0.88**	**0.58**	**0.30**	**1.12**	**1.25**	**-0.13**	**28.20**

Commentary
To date only marginal variances have occurred across the programme as a result of minor timing differences. The programme is currently the subject of discussions with NHSI with regard to agreement of the external financing requirement.

Capital Monthly Profile



Medway NHS
NHS Foundation Trust

Report to the Board of Directors
Board Date: Thursday 30 June 2016

Title of Report	Medical Appraisal and Revalidation Annual Report
Reporting Officer	Dr Kirtida Mukherjee
Lead Director	Dr Diana Hamilton-Fairley
Responsible Sub-Committee	Executive Group
Executive Summary	To provide the Trust Board with an annual report on medical appraisal and revalidation for the appraisal year ending 31 March 2016
Risk and Assurance	Not Applicable
Legal Implications/Regulatory Requirements	Responsible Officer Regulations
Recovery Plan Implication	Not Applicable
Quality Impact Assessment	Not Applicable
Purpose & Actions required by the Board: • **Approval**	To provide the Trust Board with an annual report on medical appraisal and revalidation for the appraisal year ending 31 March 2016 The Board is requested to approve the report following which the Chair/CEO will be required to sign off the Designated Body Statement of Compliance for submission to NHS England
Recommendation	Approval of the revalidation report and Statement of Compliance report.

Medical Appraisal and Revalidation Annual Report: June 2016

1. Executive Summary

For the appraisal year 1 April 2015 – 31 March 2016, there were 308 doctors who had a prescribed connection with the Trust. At 31 March 2016, 277 doctors (90%) had a completed appraisal. The appraisal rate was lowest amongst the Trust Doctors who are usually short term fixed appointments. For the majority of these doctors this is their first post in the UK and they have only been in post for a relatively short period of time. This meant that a full appraisal was not possible as they did not have adequate time and opportunity to provide the relevant supporting information required for appraisal.

2. Purpose of the Report

Medical revalidation is a legal requirement which applies to all licensed doctors listed on the General Medical Council (GMC) register. Its purpose is to improve patient care by bringing all licensed doctors into a governed system that prioritises professional development and strengthens personal accountability.

This report gives the Trust Board an annual report on completion of the annual medical appraisals and the number of revalidation recommendations made for the year ending 31 March 2016.

The Board is asked to approve this report so that the CEO can sign the Statement of Compliance which is a statutory requirement.

3. Background

Medical Revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

The Trust has a statutory duty to support Dr Diana Hamilton-Fairley the Responsible Officer (RO) in discharging her duties under the Responsible Officer Regulations (2010 as amended in 2013) and it is expected that the Board will oversee compliance by:

- ensuring there is a process for monitoring the frequency and quality of medical appraisals;
- checking there are effective systems in place for monitoring the conduct and performance of doctors;
- confirming that feedback from patients is sought periodically so that their views can inform the appraisal and revalidation process for doctors;
- ensuring that appropriate pre-employment background checks are carried out to ensure that medical practitioners have qualifications, experience and knowledge of the English language appropriate to the work performed.

4. Governance Arrangements

All Consultants, Specialty Doctors and doctors not n a formal training programme are required to use the e-appraisal system currently in operation in the Trust for completion of their annual appraisals. The e-appraisal system operates on a traffic light system in relation to both completion of the annual appraisal and the revalidation due date. This is monitored on a daily basis by the Medical Director's office to ensure that progress in meeting these deadlines is being maintained.

The Human Resources Department/Medical Staffing provides the Medical Director's office with a weekly list of all new non-training doctors together with a list of those non-training doctors who have left the Trust. Doctors are then added or deleted from the e-appraisal system and the GMC list as necessary to ensure the list of doctors with a prescribed connection to the Trust is as up to date as possible. All new doctors are given information on appointment explaining the requirements of appraisal and revalidation and are also contacted by the Medical Director's office and informed of the process for ensuring their annual appraisal (or before the end of their fixed term period with the Trust, whichever is the earlier) is completed.

The Deputy RO and/or Senior Medical Appraiser provided a series of sessions to inform all new non-training doctors on the requirements for medical appraisal and revalidation. These sessions have been very well attended by over 70 doctors in 2015-16.

The RO, in conjunction with the Deputy RO and Senior Medical Appraiser, is responsible for reviewing all appraisals submitted by the appraisers for review and for making recommendations to the GMC for revalidation and renewal of a doctor's licence to practise.

The Medical Revalidation Governance Group has been formed. The main aim of this Group is to discuss all revalidation submissions to ensure that a consistent approach is taken in relation to all revalidation submissions made by the RO. This Group currently meets monthly; however, this may meet less frequently depending on the number of recommendations that are required. A non-executive director is part of this Group and undertakes a random audit of the appraisals of doctors due to have a revalidation recommendation to provide assurance on the process.

5. Policy and Guidance

The Trust has a Medical Appraisal and Revalidation Policy and a Remediation of Medical Staff Policy and Procedure. These are updated regularly to ensure all recent amendments to the RO regulations and guidance are included.

6. Medical Appraisal

(i) Appraisal and Revalidation Performance Data

- As on 31 March 2016 there were 308 non-training doctors who had a prescribed connection with the Trust
- 277 non-training doctors had completed their appraisal for the period 1 April 2015 to 31 March 2016. This equates to an overall 90% compliance.

	No. of doctors with a	Number and percentage of

	prescribed connection with the Trust	completed appraisals for MFT
Consultants	182	176 (97%)
Specialty Doctors	52	51 (98%)
Trust Doctors and Locums	71	47 (72%)
TOTAL	305	274 (90%)*

Approved Missed or Incomplete Appraisals

30 doctors were reported as approved missed or incomplete appraisals out of which:

6 were Consultants:

- 2 appraisals relate to doctors on maternity leave.
- 1 incomplete appraisal was due to long term sick leave.
- 2 appraisee were new starters more than 3 months from appraisal due date*.
- 1 doctor is retiring.

1 Specialty Doctor:

- Was granted a postponement for personal reasons.

23 Trust Doctors and Locums out of which:

17 were new starters more than 3 months from their appraisal due date*.

- 4 were within the 9-15months of their start date but the appraisal meeting did not take place within the reporting period.
- 1 was granted a postponement for personal reasons.
- 1 appraisal was within the 9-15months of the last appraisal but the doctor left the Trust shortly before the appraisal meeting could take place.

Unapproved Missed or Incomplete Appraisals

1 doctor was reported as an unapproved missed or incomplete appraisal:

- The doctor left the Trust before completing appraisal.

*If we discounted the 19 new starters in the table above who were not due to have an annual appraisal by 31/03/16 as they had been working in the Trust for less than six months, the appraisal rate would have been 96%. However, using NHS England's definition, these doctors are considered as missed appraisals. In view of this, we are intending to ask all Trust Doctors to have an initial appraisal with their nominated appraiser within the first three months of their commencement date to ensure they understand what supporting evidence they will be required to collect for their appraisal and revalidation and agree a PDP for them to work towards. This will attempt to ensure that all doctors have an initial or full appraisal by the end of the appraisal year and thus increase the Trust's compliance rate.

(ii) Appraisers

The Trust currently has 60 medical appraisers who have undertaken the approved appraisal training for enhanced medical appraisals. Three Appraiser update sessions took place November 2015 to January 2016; all Appraisers were required to attend one of these sessions.

(iii) 360 Multi Source Feedback

360 multi-source feedback (MSF) is a core component of appraisal for feedback on a doctor's performance which can help in effective development of personal, team and service practice; the Trust has a programme with an external provider to ensure that all non-training doctors undertake a 360 MSF with both patients and colleagues to support their appraisal and revalidation. This must be undertaken at least once on a 5 year revalidation cycle and must be within 3 years of the revalidation date. The Trust sets a minimum requirement of 15 responses for each MSF undertaken, which are anonymous and aggregated and any comments made are non-attributable. Colleague feedback reports are available for roles which include: Doctor as Clinician, Doctor as Educator, Doctor as appraiser and Doctor as Medical Manager. The responses are collated by our external provider and the 360 report is analysed against a national mean standard. Once received, the report is uploaded as supporting information on e-appraisal. The doctor is asked to reflect on the results and if necessary, have a Personal Development Plan based on 360 multisource feedback. All MSF reports are reviewed, upon which the appraiser and/or RO can request MSF to be repeated if deemed necessary.

(iv) Quality Assurance

Our e-appraisal system now incorporates an appraisee checklist of all supporting evidence covering the whole scope of practice. This must be completed before the appraisee can submit the appraisal to the Appraiser. In addition the Appraiser must complete the Appraiser checklist before submission to the RO for review. This reduces the occasions when the RO or Senior Medical Appraiser has to refer back an appraisal due to missing or incomplete supporting evidence.

From July 2016, the GMC requires that all doctors who undertake a recognised educational role (educational supervisors and clinical supervisors), must provide evidence as part of the appraisal process, of their ongoing professional development against the seven domains agreed by the GMC and Academy of Medical Educators "Framework for Supervisors" (2010). This has now been incorporated into our e-appraisal system and is already in process to enable us to be ahead of this deadline.

Appraisers are required to check compliance against the previous year's PDP and agree a new PDP with the appraisee. The appraiser then completes the appraisal summary and appraisal output declarations before submitting the appraisal electronically to the RO for review.

To provide assurance on the quality of the appraisals, the Deputy RO and Senior Appraiser review all appraisal forms with all supporting evidence and if any evidence is deemed missing or incomplete, the appraisal is referred back for correction and re-submission.

To enhance the level of assurance and provide evidence which challenges the system or the decision-making, all designated bodies are required to undergo a process to validate the status of their revalidation systems at least once in every 5-year revalidation cycle. This may be carried out by audits commissioned by the designated body, their regulators, peers or higher-level RO. NHS England last undertook an audit of the Trust's appraisal and revalidation process with particular emphasis on the core standards of the Framework of Quality Assurance in October 2014.

The Trust has recently arranged training for Case Investigators and Case Manager Training and now has 24 trained Case Investigators and 15 trained Case Managers. The Revalidation Governance Group, chaired by the Responsible officer, continues to meet every month with a Non-executive Director as a member of the group. Work to ensure there is a robust incident reporting process to support the RO in making revalidation recommendations continues, although challenges around this process continue. However, this is an area of development that many other Trusts continue to experience.

(v) Access, security and confidentiality

All non-training doctors are required to use the e-appraisal system as their appraisal portfolio. All doctors have their individual login and password to access the system and only the appraiser and RO and Revalidation team can view the appraisal record and documents. The doctors are informed who can view the appraisal folders. The doctors themselves can then choose who else they may wish to share their appraisal folder with once this has been reviewed by the RO i.e. private organisations for which they undertake clinical work.

(vi) Clinical Governance

It is recognised that the Trust needs to improve the access of clinical data for individual doctors to support the appraisal process. The RO/Deputy RO and Senior Appraiser continue to liaise with our Governance Data Analyst, Complaints and Datix team to ensure that individual doctors have access to clinical incidents, complaints and their individual activity data to support the appraisal process. The Healthcare Evaluation Data (HED) system is used to provide an overview of individual consultant performance, the local specialty peer performance and the national specialty peer performance.

7. Revalidation Recommendations

For the year ending 31 March 2016 there were 103 doctors due to revalidate.
The recommendations made were as follows:-

	Recommendation Type	
93	Revalidate – positive recommendation	
9*	Defer – Insufficient evidence for a recommendation to revalidate **5* were *subsequently revalidated during the reporting year after submitting required evidence*	

1	On Hold - pending an investigation by the GMC	
0	Missed or late recommendations	
103	Total	

8. Recruitment and engagement background checks

A Standing Operating Procedure (SOP) with the Human Resources Department is in place to ensure that all the necessary pre and post-employment checks have been undertaken for all doctors. This also applies to locum appointments. Where relevant, Medical Practice Information Transfer (MPIT) forms are used for all incoming non training doctors for RO to RO transfer of information.

9. Responding to Concerns and Remediation

There is a Remediation of Medical Staff Policy which is available on the Hospital Intranet. This was updated in January 2015. Any concerns raised are discussed to the Decision Making Group (DMG). No one currently requires remedial training.

10. Risk and Issues

The lack of a centralised reporting system around complaints within the Trust excludes the reporting of individual doctors to support the Revalidation and Appraisal process.

11. Improvements and Next Steps

Improvements made since last annual report include:-

- E-appraisal software has been developed to update the appraisee and appraiser checklist to further improve the quality of appraisal evidence.
- A new Educator module has been developed and incorporated from May 2015 into the e-appraisal form for all 2015-2016 appraisals to satisfy GMC requirements for appraisal of educational roles.
- Easy access links to supporting documentation for doctors available via Hospital Intranet – reviewed and updated accordingly. A link to the NHS England Appraisal Training video has also been added.
- Monthly meetings with the Decision Making Group (DMG) are held to review conduct, capability and health issues relating to doctors to ensure RO is fully informed.
- Quarterly meetings with the GMC Liaison Officer/Medical Director (RO) and Deputy RO to discuss and update on all on-going GMC complaints and disciplinary issues continue.
- Monthly (or as deemed appropriate) Revalidation Governance Group meetings chaired by RO to discuss all doctors due for revalidation recommendation continue with a Non-executive Director as an active member of the group to provide governance and quality assurance.
- Attendance at RO regional network meetings.
- Head of Medical Director services appointed in March 2015 is now well established in post.
- New post of Revalidation Officer; commenced July 2015.

- Electronic appraisal system now ensures that reminders are sent to all doctors at 4, 2 and 1 monthly intervals.
- GMC sends communication to all doctors 4 months in advance of doctors revalidation due date.
- Coaching sessions are available for individual doctors regarding the appraisal process and system.

Next Steps

- Training for 6 – 8 new Appraisers is scheduled for September 2016.
- Appraiser update sessions are planned for October 2016 and January 2017 and further sessions will be scheduled going forward.
- Appraisal information workshops for non-training Trust Doctors are planned for June 2016 and further sessions will be scheduled during the year.
- Clinical Directors will be sent a monthly list showing all the doctors for whom an appraisal is required. This will detail the month the appraisal is due, name of appraiser and date of Revalidation and will be updated using the traffic light system.
- The Trust should be able to provide clinical data around complaints of clinical performance to the individual clinician to ensure a robust appraisal system. This should be available to be incorporated into the appraisal system to support the Revalidation and Appraisal process.
- Quality audit tool to be piloted to provide assurance on appraisal outputs, feedback to the individual appraiser and to provide evidence for appraiser development
- Appraisals moved forward to ensure that no appraisals are scheduled for February and March unless there are exceptional circumstances. This should improve future compliance rates.
- ESR Interface with the electronic appraisal system for starters and leavers.

12. Recommendations

The Board is asked to approve this report and for the Chairman/CEO to sign off the Statement of Compliance confirming that the Trust, as a Designated Body, is in compliance with the regulation.

Appendix 1: Annual Organisation Audit (AOA) End of Year Questionnaire 2015-16

NHS England

Annual Organisational Audit (AOA)

End of year questionnaire 2015-16

NHS England INFORMATION READER BOX		
Directorate		
Medical	Commissioning Operations	Patients and Information
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

Publications Gateway Reference:	**04543**
Document Purpose	Resources
Document Name	Annual Organisational Audit Annex C (end of year questionnaire)
Author	Gary Cooper
Publication Date	18 March 2016
Target Audience	Medical Directors, NHS England Regional Directors, GPs
Additional Circulation List	
Description	
Cross Reference	A Framework for Quality Assurance for Responsible Officers & Revalidation April 2014 Gateway ref 01142
Superseded Docs (if applicable)	2014/15 AOA cleared with Publications Gateway Reference 02945
Action Required	
Timing / Deadlines (if applicable)	
Contact Details for further information	Gary Cooper Professional Standards Team Quarry house Leeds LS2 7UE

Document Status

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Annual Organisational Audit (AOA)

End of year questionnaire 2015-16

Version number: 3.0

First published: 4 April 2014

Updated: 24 March 2015 & 18 March 2016

Prepared by: Gary Cooper, Project Manager for Quality Assurance, NHS England

Classification: OFFICIAL

“The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.”

Promoting equality and addressing health inequalities are at the heart of NHS England’s values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it; and

Given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities.

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Contents

1 Introduction

The Framework of Quality Assurance (FQA) and the monitoring processes within it are designed to support all responsible officers in fulfilling their statutory duty, providing a means by which they can demonstrate the effectiveness of the systems they oversee. It has been carefully crafted to ensure that administrative burden is minimised, whilst still driving learning and sharing of best practice. Each element of the FQA process will feed in to a comprehensive report from the national-level responsible officer to Ministers and the public, capturing the state of play in implementing medical revalidation across the country.

The reporting processes are intended to be streamlined, coherent and integrated, ensuring that information is captured to contribute to local processes, whilst simultaneously providing the required assurance. The process will be reviewed and revised on a regular basis.

The AOA (Annex C) is a standardised template for all responsible officers to complete and return to their higher-level responsible officer. AOAs from all designated bodies will be collated to provide an overarching status report of implementation across England. Where small designated bodies are concerned, or where types of organisation are small in number, these will be appropriately grouped to ensure that data is not identifiable to the level of the individual.

The AOA has been simplified and shortened considerably from its predecessor, (ORSA), with a focus on what is happening, with what outcome, along with an assessment of the designated body's organisational capacity to ensure a robust consistent system of revalidation. Learning from the experience of ORSA, the AOA has been designed to reduce the administrative burden upon organisations and to be of maximum help to responsible officers in fulfilling their obligations.

The aims of the annual organisational audit exercise are to:

- gain an understanding of the progress that organisations have made during 2015/16;
- provide a tool that helps responsible officers assure themselves and their boards/management bodies that the systems underpinning the recommendations they make to the General Medical Council (GMC) on doctors' fitness to practise, the arrangements for medical appraisal and responding to concerns, are in place;
- provide a mechanism for assuring NHS England (as the Senior Responsible Owner for medical revalidation in England), the England Revalidation Implementation Board (ERIB) and the GMC that systems for evaluating doctors' fitness to practice are in place, functioning, effective and consistent.

This AOA exercise is divided into five sections:

Section 1: The Designated Body and the Responsible Officer

Section 2: Appraisal

Section 3: Monitoring Performance and Responding to Concerns

Section 4: Recruitment and Engagement

Section 5: Additional Comments

The questionnaire should be completed by the responsible officer on behalf of the designated body, though the input of information to the questionnaire may be appropriately delegated. The questionnaire should be completed **during April and May 2016** for the year ending 31 March 2016. The deadline for submission will be detailed in an email containing the link to the electronic version of the form, which will be sent after 31 March 2016.

Whilst NHS England is a single designated body, for the purpose of this audit, the national and regional offices of NHS England should answer as a 'designated body' in their own right.

Following completion of this AOA exercise, designated bodies should:

- consider using the information gathered to produce a status report and to conduct a review of their organisations' developmental needs.
- complete a statement of compliance and submit it to NHS England by the 30th September 2016.

The audit process will also enable designated bodies to provide assurance that they are fulfilling their statutory obligations and their systems are sufficiently effective to support the responsible officer's recommendations.

For further information, references and resources see pages 30-31
and www.england.nhs.uk/revalidation

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2 Guidance for submission

Guidance for submission:

- Several questions require a ‘Yes’ or ‘No’ answer. In order to answer ‘Yes’, you must be able to answer ‘Yes’ to all of the statements listed under ‘to answer ‘Yes’’
- Please do not use this version of the questionnaire to submit your designated body’s response.
- You will receive an email with an electronic link to a unique version of this form for your designated body.
- You should only use the link received from NHS England by email, as it is unique to your organisation.
- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference, the second button will take you to the electronic form for submission.
- Submissions can only be received electronically via the link. Please do not complete hardcopies or email copies of the document.
- The form must be completed in its entirety prior to submission; it cannot be part-completed and saved for later submission.
- Once the ‘submit’ button has been pressed, the information will be sent to a central database, collated by NHS England.
- A copy of the completed submission will be automatically sent to the responsible officer.
- Please be advised that Questions 1.1-1.3 may have been automatically populated with information previously held on record by NHS England. The submitter has a responsibility to check that the information is correct and should update the information if required, before submitting the form.

3 Section 1 – The Designated Body and the Responsible Officer

Section 1	The Designated Body and the Responsible Officer	
1.1	**Name of designated body:** Medway NHS Foundation Trust	
	Address line 1 Windmill Road	
	Address line 2	
	Address line 3	
	Address line 4	
	City Gillingham	
	County Kent	Postcode ME7 5NY
	Responsible officer: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	GMC registered last name ***** Phone *****
	Medical Director: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Medical Director ☐ GMC registered last name ***** Phone *****
	Clinical Appraisal Lead: Title ***** GMC registered first name ***** GMC reference number ***** Email *****	No Clinical Appraisal Lead ☐ GMC registered last name ***** Phone *****
	Chief executive (or equivalent): Title ***** First name ***** GMC reference number (if applicable) Email *****	Last name ***** Phone *****

1.2	**Type/sector of designated body:** (tick one)	NHS	Acute hospital/secondary care foundation trust	☑
			Acute hospital/secondary care non-foundation trust	☐
			Mental health foundation trust	☐
			Mental health non-foundation trust	☐
			Other NHS foundation trust (care trust, ambulance trust, etc)	☐
			Other NHS non-foundation trust (care trust, ambulance trust, etc)	☐
			Special health authorities (NHS Litigation Authority, NHS Trust Development Authority, NHS Blood and Transplant, etc)	☐
		NHS England	NHS England (local office)	☐
			NHS England (regional office)	☐
			NHS England (national office)	☐
		Independent / non-NHS sector (tick one)	Independent healthcare provider	☐
			Locum agency	☐
			Faculty/professional body (FPH, FOM, FPM, IDF, etc)	☐
			Academic or research organisation	☐
			Government department, non-departmental public body or executive agency	☐
			Armed Forces	☐
			Hospice	☐
			Charity/voluntary sector organisation	☐
			Other non-NHS (please enter type)	☐

1.3	**The responsible officer's higher level responsible officer is based at:** [tick one]	NHS England North	☐
		NHS England Midlands and East	☐
		NHS England London	☐
		NHS England South	☑
		NHS England (National)	☐
		Department of Health NHS	☐
		Faculty of Medical Leadership and Management - for NHS England (national office) only	☐
		Other (Is a suitable person)	☐
1.4	**A responsible officer has been nominated/appointed in compliance with the regulations.** To answer 'Yes': • The responsible officer has been a medical practitioner fully registered under the Medical Act 1983 throughout the previous five years and continues to be fully registered whilst undertaking the role of responsible officer. • There is evidence of formal nomination/appointment by board or executive of each organisation for which the responsible officer undertakes the role.		☑ Yes ☐ No

1.5	**Where a Conflict of Interest or Appearance of Bias has been identified and agreed with the higher level responsible officer; has an alternative responsible officer been appointed?** (Please note that in The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013), an alternative responsible officer is referred to as a second responsible officer) To answer 'Yes': The designated body has nominated an alternative responsible officer in all cases where there is a conflict of interest or appearance of bias between the responsible officer and a doctor with whom the designated body has a prescribed connection. To answer 'No': A potential conflict of interest or appearance of bias has been identified, but an alternative responsible officer has not been appointed. To answer 'N/a': No cases of conflict of interest or appearance of bias have been identified. Additional guidance Each designated body will have one responsible officer but the regulations allow for an alternative responsible officer to be nominated or appointed where a conflict of interest or appearance of bias exists between the responsible officer and a doctor with whom the designated body has a prescribed connection. This will cover the uncommon situations where close family or business relationships exist, or where there has been longstanding interpersonal animosity. In order to ensure consistent thresholds and a common approach to this, potential conflict of interest or appearance of bias should be agreed with the higher level responsible officer. An alternative responsible officer should then be nominated or appointed by the designated body and will require training and support in the same way as the first responsible officer. To ensure there is no conflict of interest or appearance of bias, the alternative responsible officer should be an external appointment and will usually be a current experienced responsible officer from the same region. Further guidance is available in *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).	☐ Yes ☐ No ☑ N/A

1.6	**In the opinion of the responsible officer, sufficient funds, capacity and other resources have been provided by the designated body to enable them to carry out the responsibilities of the role.** Each designated body must provide the responsible officer with sufficient funding and other resources necessary to fulfil their statutory responsibilities. This may include sufficient time to perform the role, administrative and management support, information management and training. The responsible officer may wish to delegate some of the duties of the role to an associate or deputy responsible officer. It is important that those people acting on behalf of the responsible officer only act within the scope of their authority. Where some or all of the functions are commissioned externally, the designated body must be satisfied that all statutory responsibilities are fulfilled.	☑ Yes ☐ No
1.7	**The responsible officer is appropriately trained and remains up to date and fit to practise in the role of responsible officer.** To answer 'Yes': • Appropriate recognised introductory training has been undertaken. • Appropriate ongoing training and development is undertaken in agreement with the responsible officer's appraiser. • The responsible officer has made themselves known to the higher level responsible officer. • The responsible officer is engaged in the regional responsible officer network. • The responsible officer is actively involved in peer review for the purposes of calibrating their decision-making processes and organisational systems. • The responsible officer includes relevant supporting information relating to their responsible officer role in their appraisal and revalidation portfolio including the results of the Annual Organisational Audit and the resulting action plan.	☑ Yes ☐ No

1.8	**The responsible officer ensures that accurate records are kept of all relevant information, actions and decisions relating to the responsible officer role.** The responsible officer records should include appraisal records, fitness to practise evaluations, investigation and management of concerns, processes relating to 'new starters', etc.	☑ Yes ☐ No
1.9	**The responsible officer ensures that the designated body's medical revalidation policies and procedures are in accordance with equality and diversity legislation.** To answer 'Yes': • An evaluation of the fairness of the organisation's policies has been performed (for example, an equality impact assessment).	☑ Yes ☐ No
1.10	**The responsible officer makes timely recommendations to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and the GMC Responsible Officer Protocol.** To answer 'Yes': • The designated body's board report contains explanations for all missed and late recommendations, and reasons for deferral submissions.	☑ Yes ☐ No
1.11	**The governance systems (including clinical governance where appropriate) are subject to external or independent review.** Most designated bodies will be subject to external or independent review by a regulator. Designated bodies which are healthcare providers are subject to review by the national healthcare regulators (the Care Quality Commission or Monitor). Where designated bodies will not be regulated or overseen by an external regulator (for example locum agencies and organisations which are not healthcare providers), an alternative external or independent review process should be agreed with the higher level responsible officer.	☑ Yes ☐ No

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1.12	**The designated body has commissioned or undertaken an independent review* of its processes relating to appraisal and revalidation.** **(*including peer review, internal audit or an externally commissioned assessment)**	☑ Yes ☐ No

4 Section 2 – Appraisal

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2016 should be included. Where the answer is 'nil' please enter '0'. **See guidance notes on pages 16-18 for assistance completing this table**		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	182	124	52	6	0	182
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	52	31	20	1	0	52
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	71	27	20	23	1	71
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	3	3	0	0	0	3
2.1.7	**TOTAL** (this cell will sum automatically 2.1.1 – 2.1.6).	308	185	92	30	1	308

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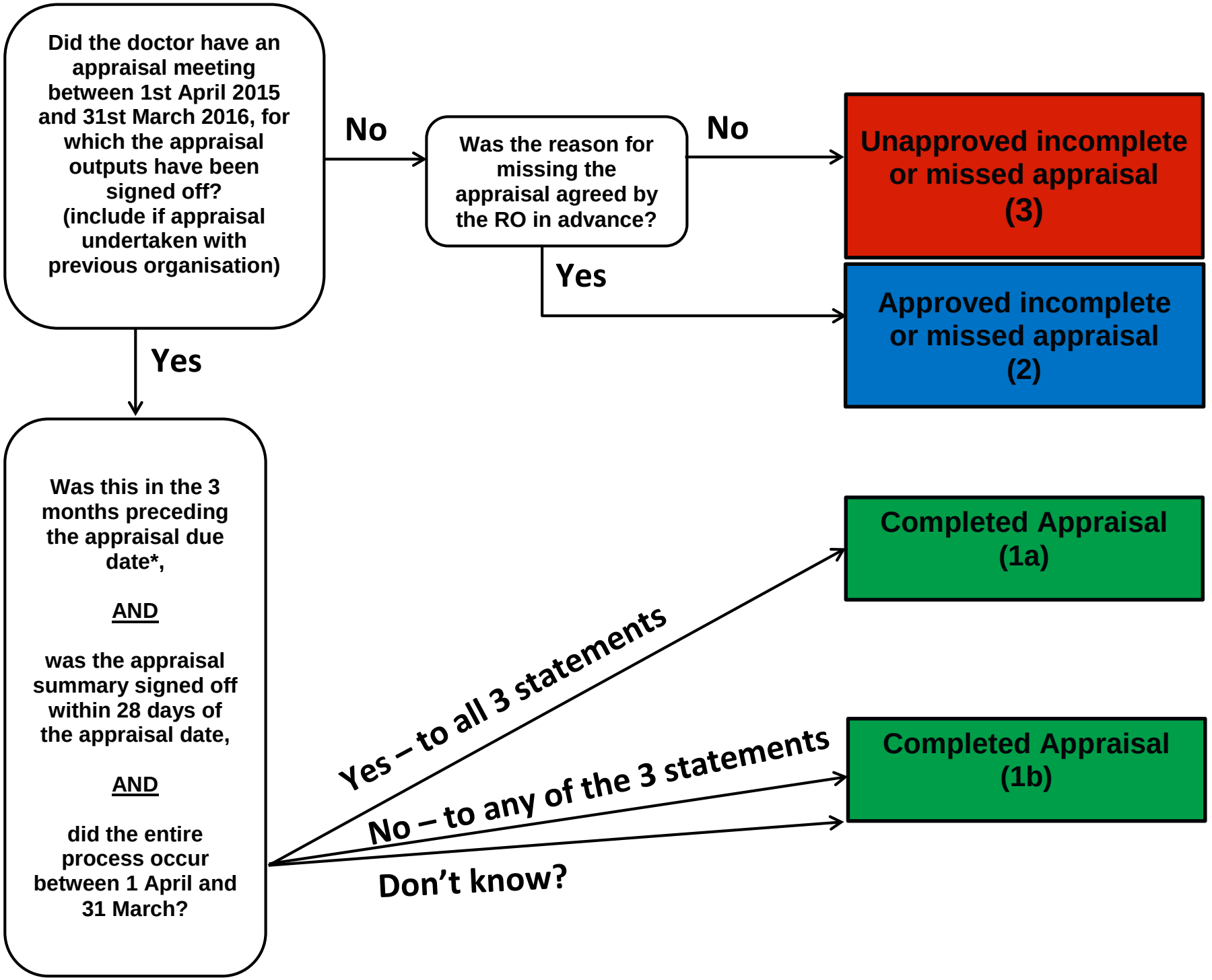

Did the doctor have an appraisal meeting between 1st April 2015 and 31st March 2016, for which the appraisal outputs have been signed off? (include if appraisal undertaken with previous organisation)
No
Was the reason for missing the appraisal agreed by the RO in advance?
No
Unapproved incomplete or missed appraisal (3)
Yes
Approved incomplete or missed appraisal (2)
Yes
Was this in the 3 months preceding the appraisal due date*,
AND
was the appraisal summary signed off within 28 days of the appraisal date,
AND
did the entire process occur between 1 April and 31 March?
Yes – to all 3 statements
Completed Appraisal (1a)
No – to any of the 3 statements
Completed Appraisal (1b)
Don't know?

2.1	**Column - Number of Prescribed Connections:** **Number of doctors with whom the designated body has a prescribed connection as at 31 March 2016** The responsible officer should keep an accurate record of all doctors with whom the designated body has a prescribed connection and must be satisfied that the doctors have correctly identified their prescribed connection. Detailed advice on prescribed connections is contained in the responsible officer regulations and guidance and further advice can be obtained from the GMC and the higher level responsible officer. The categories of doctor relate to current roles and job titles rather than qualifications or previous roles. The number of individual doctors in each category should be entered in this column. Where a doctor has more than one role in the same designated body a decision should be made about which category they belong to, based on the amount of work they do in each role. Each doctor should be included in only one category. For a doctor who has recently completed training, if they have attained CCT, then they should be counted as a prescribed connection. If CCT has not yet been awarded, they should be counted as a prescribed connection within the LETB AOA return. **Column - Measure 1a Completed medical appraisal:** A *Category 1a completed annual medical appraisal* is one where the appraisal meeting has taken place in the three months preceding the agreed appraisal due date*, the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor within 28 days of the appraisal meeting, and the entire process occurred between 1 April and 31 March. For doctors who have recently completed training, it should be noted that their final ACRP equates to an appraisal in this context. **Column - Measure 1b Completed medical appraisal:** A *Category 1b completed annual medical appraisal* is one in which the appraisal meeting took place in the appraisal year between 1 April and 31 March, and the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor, but one or more of the following apply: - the appraisal did not take place in the window of three months preceding the appraisal due date; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor between 1 April and 28 April of the following appraisal year; - the outputs of appraisal have been agreed and signed-off by the appraiser and the doctor more than 28 days after the appraisal meeting. However, in the judgement of the responsible officer the appraisal has been satisfactorily completed to the standard required to support an effective revalidation recommendation.	

	Where the organisational information systems of the designated body do not permit the parameters of a *Category 1a completed annual medical appraisal* to be confirmed with confidence, the appraisal should be counted as a *Category 1b completed annual medical appraisal*. **Column - Measure 2: Approved incomplete or missed appraisal:** An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. **Column - Measure 3: Unapproved incomplete or missed appraisal:** An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*. **Column Total:** Total of columns 1a+1b+2+3. The total should be equal to that in the first column (Number of Prescribed Connections), the number of doctors with a prescribed connection to the designated body at 31 March 2016. * Appraisal due date: A doctor should have a set date by which their appraisal should normally take place every year (the 'appraisal due date'). The appraisal due date should remain the same each year unless changed by agreement with the doctor's responsible officer. Where a doctor does not have a clearly established appraisal due date, the next appraisal should take place by the last day of the twelfth month after the preceding appraisal. This should then by default become their appraisal due date from that point on. For a designated body which uses an 'appraisal month' for appraisal scheduling, a doctor's appraisal due date is the last day of their appraisal month. For more detail on setting a doctor's appraisal due date see the Medical Appraisal Logistics Handbook (NHS England, 2015)	

2.2	**Every doctor with a prescribed connection to the designated body with a missed or incomplete medical appraisal has an explanation recorded** If all appraisals are in Categories 1a and/or 1b, please answer N/A. To answer Yes: • The responsible officer ensures accurate records are kept of all relevant actions and decisions relating to the responsible officer role. • The designated body's annual report contains an audit of all missed or incomplete appraisals (approved and unapproved) for the appraisal year 2015/16 including the explanations and agreed postponements. • Recommendations and improvements from the audit are enacted. Additional guidance: A missed or incomplete appraisal, whether approved or unapproved, is an important occurrence which could indicate a problem with the designated body's appraisal system or non-engagement with appraisal by an individual doctor which will need to be followed up. Measure 2: Approved incomplete or missed appraisal: An a*pproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, but the responsible officer has given approval to the postponement or cancellation of the appraisal. The designated body must be able to produce documentation in support of the decision to approve the postponement or cancellation of the appraisal in order for it to be counted as an *Approved incomplete or missed annual medical appraisal*. Measure 3: Unapproved incomplete or missed appraisal: An *Unapproved incomplete or missed annual medical appraisal* is one where the appraisal has not been completed according to the parameters of either a *Category 1a or 1b completed annual medical appraisal*, and the responsible officer has not given approval to the postponement or cancellation of the appraisal. Where the organisational information systems of the designated body do not retain documentation in support of a decision to approve the postponement or cancellation of an appraisal, the appraisal should be counted as an *Unapproved incomplete or missed annual medical appraisal*.	☑ Yes ☐ No ☐ N/A

2.3	**There is a medical appraisal policy, with core content which is compliant with national guidance, that has been ratified by the designated body's board (or an equivalent governance or executive group)** To answer 'Yes': • The policy is compliant with national guidance, such as *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014), *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010), *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014). • The policy has been ratified by the designated body's board or an equivalent governance or executive group.	☑ Yes ☐ No
2.4	**There is a mechanism for quality assuring an appropriate sample of the inputs and outputs of the medical appraisal process to ensure that they comply with GMC requirements and other national guidance, and the outcomes are recorded in the annual report template.** To answer 'Yes': • The appraisal inputs comply with the requirements in *Supporting Information for Appraisal and Revalidation* (GMC, 2012) and *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013), which are: o Personal information. o Scope and nature of work. o Supporting information: 1. Continuing professional development, 2. Quality improvement activity, 3. Significant events, 4. Feedback from colleagues, 5. Feedback from patients, 6. Review of complaints and compliments. o Review of last year's PDP. o Achievements, challenges and aspirations. • The appraisal outputs comply with the requirements in the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) which are: o Summary of appraisal, o Appraiser's statement, o Post-appraisal sign-off by doctor and appraiser.	☑ Yes ☐ No

Please do not use this version of the form to submit your response.

	Additional guidance: Quality assurance is an integral part of the role of the responsible officer. The standards for the inputs and outputs of appraisal are detailed in *Supporting Information for Appraisal and Revalidation* (GMC, 2012), *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013) and the *Medical Appraisal Guide* (NHS Revalidation Support Team, 2014) and the responsible officer must be assured that these standards are being met consistently. The methodology for quality assurance should be outlined in the designated body's appraisal policy and include a sampling process. Quality assurance activities can be undertaken by those acting on behalf of the responsible officer with appropriate delegated authority.	
2.5	**There is a process in place for the responsible officer to ensure that key items of information (such as specific complaints, significant events and outlying clinical outcomes) are included in the appraisal portfolio and discussed at the appraisal meeting, so that development needs are identified.** To answer 'Yes': • There is a written description within the appraisal policy of the process for ensuring that key items of supporting information are included in the doctor's portfolio and discussed at appraisal. • There is a process in place to ensure that where a request has been made by the responsible officer to include a key item of supporting information in the appraisal portfolio, the appraisal portfolio and summary are checked after completion to ensure this has happened. Additional guidance: It is important that issues and concerns about performance or conduct are addressed at the time they arise. The appraisal meeting is not usually the most appropriate setting for dealing with concerns and in most cases these are dealt with outside the appraisal process in a clinical governance setting. Learning by individuals from such events is an important part of resolving concerns and the appraisal meeting is usually the most appropriate setting to ensure this is planned and prioritised. In a small proportion of cases, the responsible officer may therefore wish to ensure certain key items of supporting information are included in the doctor's portfolio and discussed at appraisal so that development needs are identified and addressed. In these circumstances the responsible officer may require the doctor to include certain key items of supporting information in the portfolio for discussion at appraisal and may need to check in the appraisal summary that the discussion has taken place. The method of sharing key items of supporting information should be described in the appraisal policy. It is important that information is shared in compliance with principles of information governance and security. For further detail, see *Information Management for Revalidation in England* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.6	**The responsible officer ensures that the designated body has access to sufficient numbers of trained appraisers to carry out annual medical appraisals for all doctors with whom it has a prescribed connection** To answer 'Yes': The responsible officer ensures that: • Medical appraisers are recruited and selected in accordance with national guidance. • In the opinion of the responsible officer, the number of appropriately trained medical appraisers to doctors being appraised is between 1:5 and 1:20. • In the opinion of the responsible officer, the number of trained appraisers is sufficient for the needs of the designated body. Additional guidance: It is important that the designated body's appraiser workforce is sufficient to provide the number of appraisals needed each year. This assessment may depend on total number of doctors who have a prescribed connection, geographical spread, speciality spread, conflicts of interest and other factors. Depending on the needs of the designated body, doctors from a variety of backgrounds should be considered for the role of appraiser. This includes locums and salaried general practitioners in primary care settings and staff and associate specialist doctors in secondary care settings. An appropriate specialty mix is important though it is not possible for every doctor to have an appraiser from the same specialty. Appraisers should participate in an initial training programme before starting to perform appraisals. The training for medical appraisers should include: • Core appraisal skills and skills required to promote quality improvement and the professional development of the doctor • Skills relating to medical appraisal for revalidation and a clear understanding of how to apply professional judgement in appraisal • Skills that enable the doctor to be an effective appraiser in the setting within which they work, including both local context and any specialty specific elements. Further guidance on the recruitment and training of medical appraisers is available; see *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

2.7	**Medical appraisers are supported in their role to calibrate and quality assure their appraisal practice.** To answer 'Yes': The responsible officer ensures that: • Medical appraisers have completed a suitable training programme, with core content compliant with national guidance (Quality Assurance of Medical Appraisers), including equality and diversity and information governance, before starting to perform appraisals. • All appraisers have access to medical leadership and support. • There is a system in place to obtain feedback on the appraisal process from doctors being appraised. • Medical appraisers participate in ongoing performance review and training/development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers). Additional guidance: Further guidance on the support for medical appraisers is available in *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014).	☑ Yes ☐ No

5 Section 3 – Monitoring Performance and Responding to Concerns

Section 3	Monitoring Performance and Responding to Concerns	
3.1	**There is a system for monitoring the fitness to practise of doctors with whom the designated body has a prescribed connection**. To answer 'Yes': • Relevant information (including clinical outcomes, reports of external reviews of service for example Royal College reviews, governance reviews, Care Quality Commission reports, etc.) is collected to monitor the doctor's fitness to practise and is shared with the doctor for their portfolio. • Relevant information is shared with other organisations in which a doctor works, where necessary. • There is a system for linking complaints, significant events/clinical incidents/SUIs to individual doctors. • Where a doctor is subject to conditions imposed by, or undertakings agreed with the GMC, the responsible officer monitors compliance with those conditions or undertakings. • The responsible officer identifies any issues arising from this information, such as variations in individual performance, and ensures that the designated body takes steps to address such issues. • The quality of the data used to monitor individuals and teams is reviewed. • Advice is taken from GMC employer liaison advisers, National Clinical Assessment Service, local expert resources, specialty and Royal College advisers where appropriate. Additional guidance: Where detailed information can be collected which relates to the practice of an individual doctor, it is important to include it in the annual appraisal process. In many situations, due to the nature of the doctor's work, the collection of detailed information which relates directly to the practice of an individual doctor may not be possible. In these situations, team-based or service-level information should be monitored. The types of information available will be dependent on the setting and the role of the doctor and will include clinical outcome data, audit, complaints, significant events and patient safety issues. An explanation should be sought where an indication of outlying	☑ Yes ☐ No

	quality or practice is discovered. The information/data used for this purpose should be kept under review so that the most appropriate information is collected and the quality of the data (for example, coding accuracy) is improved. In primary care settings this type of information is not always routinely collected from general practitioners or practices and new arrangements may need to be put in place to ensure the responsible officer receives relevant fitness to practise information. In order to monitor the conduct and fitness to practise of trainees, arrangements will need to be agreed between the local education and training board and the trainee's clinical attachments to ensure relevant information is available in both settings.	
3.2	**The responsible officer ensures that a responding to concerns policy is in place (which includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns) which is ratified by the designated body's board (or an equivalent governance or executive group)**. To answer 'Yes': • A policy for responding to concerns, which complies with the responsible officer regulations, has been ratified by the designated body's board (or an equivalent governance or executive group). Additional guidance: It is the responsibility of the responsible officer to respond appropriately when unacceptable variation in individual practice is identified or when concerns exist about the fitness to practise of doctors with whom the designated body has a prescribed connection. The designated body should establish a procedure for initiating and managing investigations. National guidance is available in the following key documents: • *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003). • The National Health Service (Performers Lists) (England) Regulations 2013. • *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010). The responsible officer regulations outline the following responsibilities: • Ensuring that there are formal procedures in place for colleagues to raise concerns. • Ensuring there is a process established for initiating and managing investigations of capability, conduct,	☑ Yes ☐ No

	health and fitness to practise concerns which complies with national guidance, such as *How to conduct a local performance investigation* (National Clinical Assessment Service, 2010).
	• Ensuring investigators are appropriately qualified.
	• Ensuring that there is an agreed mechanism for assessing the level of concern that takes into account the risk to patients.
	• Ensuring all relevant information is taken into account and that factors relating to capability, conduct, health and fitness to practise are considered.
	• Ensuring that there is a mechanism to seek advice from expert resources, including: GMC employer liaison advisers, the National Clinical Assessment Service, specialty and royal college advisers, regional networks, legal advisers, human resources staff and occupational health.
	• Taking any steps necessary to protect patients.
	• Where appropriate, referring a doctor to the GMC.
	• Where necessary, making a recommendation to the designated body that the doctor should be suspended or have conditions or restrictions placed on their practice.
	• Sharing relevant information relating to a doctor's fitness to practise with other parties, in particular the new responsible officer should the doctor change their prescribed connection.
	• Ensuring that a doctor who is subject to these procedures is kept informed about progress and that the doctor's comments are taken into account where appropriate.
	• Appropriate records are maintained by the responsible officer of all fitness to practise information
	• Ensuring that appropriate measures are taken to address concerns, including but not limited to:
	  • Requiring the doctor to undergo training or retraining,
	  • Offering rehabilitation services,
	  • Providing opportunities to increase the doctor's work experience,
	  • Addressing any systemic issues within the designated body which may contribute to the concerns identified.
	• Ensuring that any necessary further monitoring of the doctor's conduct, performance or fitness to practise is carried out.	

3.3	**The board (or an equivalent governance or executive group) receives an annual report detailing the number and type of concerns and their outcome.**	☑ Yes ☐ No

3.4	**The designated body has arrangements in place to access sufficient trained case investigators and case managers.** To answer 'Yes': The responsible officer ensures that: • Case investigators and case managers are recruited and selected in accordance with national guidance *Supporting Doctors to Provide Safer Healthcare, Responding to concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013). • Case investigators and case managers have completed a suitable training programme, with essential core content (see guidance documents above). • Personnel involved in responding to concerns have sufficient time to undertake their responsibilities • Individuals (such as case investigators, case managers) and teams involved in responding to concerns participate in ongoing performance review and training/development activities, to include peer review and calibration (see guidance documents above). Additional guidance The standards for training for case investigators and case managers are contained in *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014) and *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014). Case investigators or case managers may be within the designated body or commissioned externally.	☑ Yes ☐ No

6 Section 4 – Recruitment and Engagement

Section 4	Recruitment and Engagement	
4.1	**There is a process in place for obtaining relevant information when the designated body enters into a contract of employment or for the provision of services with doctors (including locums).** In situations where the doctor has moved to a new designated body without a contract of employment, or for the provision of services (for example, through membership of a faculty) the information needs to be available to the new responsible officer as soon as possible after the prescribed connection commences. This will usually involve a formal request for information from the previous responsible officer. Additional guidance The regulations give explicit responsibilities to the responsible officer when a designated body enters into a contract of employment or for the provision of services with a doctor. These responsibilities are to ensure the doctor is sufficiently qualified and experienced to carry out the role. All new doctors are covered under this duty even if the doctor's prescribed connection remains with another designated body. This applies to locum agency contracts and also to the granting of practising privileges by independent health providers. The prospective responsible officer must: • Ensure doctors have qualifications and experience appropriate to the work to be performed, • Ensure that appropriate references are obtained and checked, • Take any steps necessary to verify the identity of doctors, • Ensure that doctors have sufficient knowledge of the English language for the work to be performed, and • For NHS England regional teams, manage admission to the medical performers list in accordance with the regulations. It is also important that the following information is available: • GMC information: fitness to practise investigations, conditions or restrictions, revalidation due date, • Disclosure and Barring Service check (although delays may prevent these being available to the responsible officer before the starting date in every case), and	☑ Yes ☐ No

	• Gender and ethnicity data (to monitor fairness and equality; providing this information is not mandatory). It may be helpful to obtain a structured reference from the current responsible officer which complies with GMC guidance on writing references and includes relevant factual information relating to: • The doctor's competence, performance or conduct, • Appraisal dates in the current revalidation cycle, and, • Local fitness to practise investigations, local conditions or restrictions on the doctor's practice, unresolved fitness to practise concerns. See *Good Medical Practice: Supplementary Guidance: Writing References* (GMC, 2007) and paragraph 19 of *Good Medical Practice* (GMC, 2013) for further details.	

7 Section 5 – Comments

Section 5	Comments	
5.1	In relation to the figures for appraisals (2.1) we would make the following comments:- 2.1.1 - Of the 6 doctors (in Category 2) 2 appraisals relate to doctors on maternity leave. 1 appraisal was due to long term sick leave. 2 appraisals were new starters more than 3 months from appraisal due date. 1 doctor is retiring. 2.1.2 - The doctor (in Category 2) was an approved postponement for personal reasons. 2.1.5 - Of the 23 doctors (in Category 2) 17 were new starters more than 3 months from appraisal due date. 4 were within the 9-15months of their start date but the appraisal meeting did not take place by 31/3/15. These have since been completed. 1 was an approved postponement for personal reasons. 1 appraisals was within the 9-15months of the last appraisal but the doctor left the Trust shortly before the appraisal meeting could take place. 2.1.5 - The doctor (in Category 3) left the Trust without undertaking appraisal.	

Please do not use this version of the form to submit your response.

8 Reference

Sources used in preparing this document

1. The Medical Profession (Responsible Officers) Regulations 2010 (Her Majesty's Stationery Office, 2013)
2. The Medical Profession (Responsible Officers) (Amendment) Regulations 2013 (Her Majesty's Stationery Office, 2013)
3. The Medical Act 1983 (Her Majesty's Stationery Office, 1983)
4. *Maintaining High Professional Standards in the Modern NHS* (Department of Health, 2003)
5. The National Health Service (Performers Lists) (England) Regulations 2013
6. *The Role of the Responsible Officer: Closing the Gap in Medical Regulation, Responsible Officer Guidance* (Department of Health, 2010)
7. *Appraisal Guidance for Consultants* (Department of Health, 2001)
8. *Appraisal Guidance for General Practitioners* (Department of Health, 2004)
9. *Revalidation: A Statement of Intent* (GMC and others, 2010)
10. *Good Medical Practice* (GMC, 2013)
11. *Good Medical Practice Framework for Appraisal and Revalidation* (GMC, 2013)
12. *Good Medical Practice: Supplementary Guidance - Writing References* (GMC, 2012)
13. *Guidance on Colleague and Patient Questionnaires* (GMC, 2012)
14. *Supporting Information for Appraisal and Revalidation* (GMC, 2012)
15. *Effective Governance to Support Medical Revalidation: A Handbook for Boards and Governing Bodies* (GMC, 2013)
16. *Making Revalidation Recommendations: The GMC Responsible Officer Protocol – Guide for Responsible Officers* (GMC, 2012)
17. *The Medical Appraisal Guide* (NHS Revalidation Support Team, 2014)
18. *Quality Assurance of Medical Appraisers* (NHS Revalidation Support Team, 2014)
19. *Providing a Professional Appraisal* (NHS Revalidation Support Team, 2012)
20. *Information Management for Medical Revalidation in England* (NHS Revalidation Support Team, 2014)
21. *Supporting Doctors to Provide Safer Healthcare: Responding to Concerns about a Doctor's Practice* (NHS Revalidation Support Team, 2013)
22. *Guidance for Recruiting for the Delivery of Case Investigator Training* (NHS Revalidation Support Team, 2014)
23. *Guidance for Recruiting for the Delivery of Case Manager Training* (NHS Revalidation Support Team, 2014).
24. *Responsible Officer Conflict of Interest or Appearance of Bias: Request to Appoint and Alternative Responsible Officer* (NHS Revalidation Support Team, 2014).
25. *Guide to Independent Sector Appraisal for Doctors Employed by the NHS and Who Have Practising Privileges at Independent Hospitals: Whole Practice Appraisal* (British Medical Association and Independent Healthcare Forum, 2004)
26. *Joint University and NHS Appraisal Scheme for Clinical Academic Staff* (Universities and Colleges Employers Association, 2002)
27. *Preparing for the Introduction of Medical Revalidation: a Guide for Independent Sector Leaders in England* (GMC and Independent Healthcare Advisory Services, 2011)

28. *How to Conduct a Local Performance Investigation* (National Clinical Assessment Service, 2010)
29. *Use of NHS Exclusion and Suspension from Work amongst Doctors and Dentists 2011/12* (National Clinical Assessment Service, 2011)
30. *Return to Practice Guidance* (Academy of Medical Royal Colleges, 2012)
31. *Medical Appraisal Logistics Handbook (NHS England, 2015)*

Designated Body Statement of Compliance – 2015-16

The Trust Board management team of Medway NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   CONFIRMED

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   CONFIRMED

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   CONFIRMED

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   CONFIRMED

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   CONFIRMED

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   CONFIRMED

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   CONFIRMED

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   CONFIRMED

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

   CONFIRMED

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

    CONFIRMED

Signed on behalf of the designated body

Name: Lesley Dwyer Signed: _____

Chief Executive of Medway NHS Foundation Trust

Date: Thursday 30 June 2016

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Medway NHS
NHS Foundation Trust

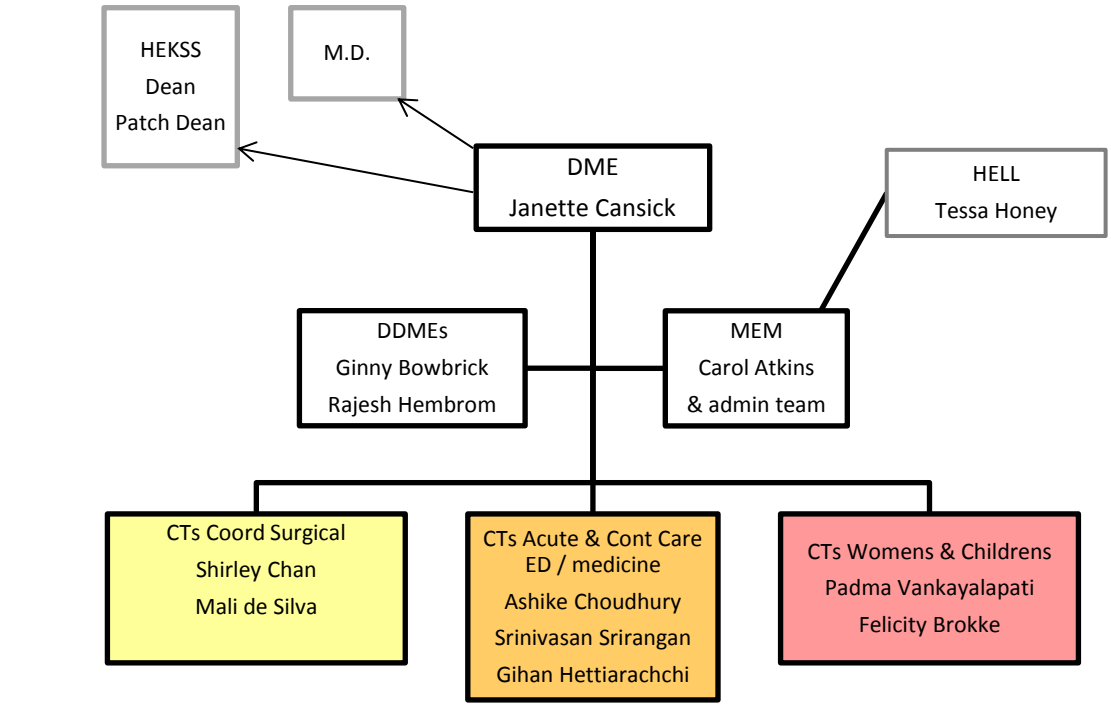
Report to the Board of Directors

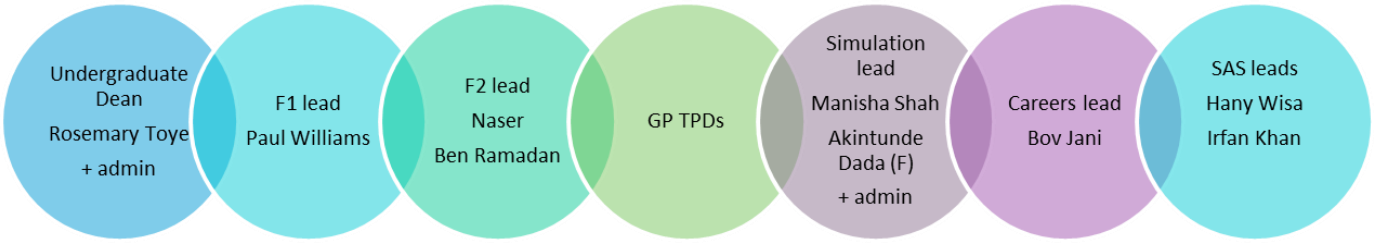
Board Date: June 2016

Title of Report	Medical Education Report
Reporting Officer	Dr Janette Cansick, Director of Medical Education Carol Atkins, Medical Education Manager
Lead Director	Dr Hamilton-Fairley
Responsible Sub-Committee	Local Academic Board
Executive Summary	To inform/advise the Board of: 1. The development of the structure of Medical Education 2. Update on priorities presented to Board in October 2015 3. Initial results of GMC National Training Survey 2016 4. Key results of recent HEKSS Schools Visits 5. SWOT analysis of the activity of Medical Education 6. Medical education strategy MFT has 1 DME supported by 2 recently appointed deputies and MEM to oversee medical training, with leads within different programmes and specialties to oversee delivery. DMEs are accountable to MD and HEKSS Dean. Enhancing trainee voice has been a priority. Significant successes have been seen in terms of improvements in medicine, leading to 4 new posts, and improved trainee feedback. In addition, 5 Physician Associates students will be training in Trust from January 2017. There are ongoing patient safety concerns being reported via GMC trainee survey and HEKSS visits particularly within medicine and ED, although recent trainee feedback is positive following the introduction of the medical model and emergency pathway. Rota gaps, however, remain a significant concern. SWOT analysis is provided, with an update on October 2015 priorities. From this a medical education vision and purpose, with priorities and strategy is presented. Junior doctor morale is particularly low, locally following the CQC report and significant changes in Trust and nationally as a result of the uncertainties around the JD contract with industrial action. Difficulties in IT remains' a concern and is prominent in trainee feedback. Early progress is being made in obtaining oversight of the PGME

	budget but this needs protection.
Risk and Assurance	Clinical Risks ☒, Finance & Performance risks ☒, Reputation risks ☒ Governance risks ☒ Monitor risks☒
Legal Implications/Regulatory Requirements	
Recovery Plan Implication	
Quality Impact Assessment	
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	The Board is requested to: 1. Receive this paper as an update in the structure, strengths and weaknesses in medical education 2. Consider and support the improvement of junior doctor morale 3. Consider and address the risks identified within training notably: a. Junior doctor morale b. Ongoing IT issues c. Oversight and protection of PGME budget d. Educational Supervisors' job planning e. Tensions in the interface between service and education
Recommendation	

STRUCTURE OF MEDICAL EDUCATION





Recent Appointments

Dr Tariq Hussain finished as joint DME in April 2016 and two deputies have taken his place – Miss Ginny Bowbrick and Dr Rajesh Hembrom.

In addition the following appointments have also been made:

Dr Paul Williams – F1 lead

Drs Hany Wisa and Irfan Khan – joint SAS leads (development lead and article 14 mentor respectively)

Inter-professional Education

There is a move towards encouraging multi-professional education where possible, and is being driven forward by simulation. The Faculty of Education meeting will be co-chaired by DME and Tessa Honey (Head of Education, Learning and Leadership). There is joint working started on developing an education strategy for the Trust. Library services and pharmacy continue to report into Local Academic Board.

Local Academic Board

This continues to meet three times a year drawing together reports from all areas of medical education, with joint learning. Trainees provide feedback and the GMC survey results and HEKSS visits are discussed. Minutes are available if required.

October 2015 Board Report – Update on Progress

We have prioritised above all promoting trainee voice, opportunities for them to air their views – us to listen, to harness ideas and enable change. This has been meetings for all junior doctors, with MD and CEO in attendance, trainee in action groups, particular meetings set up to discuss particular difficulties, 1 to 1 meetings with trainees where needed.

In October we identified our priorities as investment in trainees and educational supervisor, with plans to drive forward the following areas:

1. Information Technology
   The WiFi is now available across the Trust, and developments including Technology-enhanced Learning and the Faculty of Education website remain goals

2. Multi-Professional Learning
   We remain committed to embed education and learning throughout the organisation's service delivery with a focus on patient centred care and trainee centred education. Progress has been made with multi-professional in situ simulation now occurring regularly in many areas; this continues to be improved on by the simulation team. As stated above, there is joint working on developing opportunities for multi-professional learning, and in order to develop a Trust education strategy.

3. Improved training numbers
   Following improvements noted by HEKSS during LEP visit to medicine, we successfully bid for 3 new CMTs and 1 ACCS from August 2016. There are plans to introduce radiology trainees into the Trust from 2017. With further investment in training and education across the Trust, there is scope to increase middle grade training posts, particularly in Medicine.

4. Improved educational supervisors (ES) standards and investment in ES time
   The Trust job planning document is clear on ES time, and there is now commitment for ES to be adequately job planned, although this is yet to be reality in some departments. There is a monthly educational supervisor programme to improve skills and there will be essential update half days in October.

We have now progressed to write a medical education strategy.

GMC National Trainee Survey

Highlights from the 2015 GMC survey were reported in the Board report in October. Full 2016 results will be published in July.

There have been one immediate and five non-immediate patient safety concerns identified, and one undermining and bullying concern raised.

The immediate patient safety concern related to a trainee report of resuscitation trolleys being poorly stocked on medical wards. This has been resolved and currently weekly audits of all resuscitation trolleys are occurring.

One non-immediate patient safety concern related to paediatric surgical cover, and the rest were related to flow in ED and medicine, and poor staffing.

These patient safety issues have been previously recognised, and the majority had already been rectified.

HEKSS to LEP Visits

HEKSS have changed their policy from routine visits to reactive visits, so currently there are no upcoming visits planned.

Following the CQC report, HEKSS undertook a visit to medicine and ED on 29th February. Despite the significant service pressures in ED, good quality of training has been maintained, and this is reflected in very few requirements for change. In medicine, improvements were noted and this led to us securing 4 new training posts in medicine from August 2016.

The areas of concern raised by trainees and trainers have been addressed and are being monitored. There were patient safety concerns such as delays in seeing medical referrals for several hours, not all patients having named consultant, outlying medical patients being lost. These have all significantly improved / resolved with the introduction of the medical model and emergency pathway. Other issues such as inappropriate tasks being performed by doctors at night will be improved by the hospital at night and deteriorating patient program.

Another significant area of concern was lack of feedback to trainees who fill in datix reports, leading to them stopping filling in datix. Work has been done with the datix department to improve this and PGME will now be able to monitor this; an audit is currently in process.

The Trust has responded to HEKSS and updates will continue to be provided via the monthly board report on progress.

SWOT Analysis May 2016:

Strengths

- Relationship with both MD and Dean / patch Dean at HEKSS
- Faculty complete, with two DDMEs appointed and strong MEM
- Enhanced trainee voice
- Simulation
- Trainees in need of support (Foundation prize)
- Wifi
- Secured 4 new trainees (3 CMT, 1 ACCS) August 2016; 3 radiology trainees from August 2017
- Secured placements for 5 Physician Associate students
- Busy DGH with committed consultants
- Job planning for educational supervisors
- Medilead project

Weaknesses

- Financial accountability – budget statements not accurate (Tariff, SIFT funding)
- I.T.
- Interprofessional working
- Induction
- Datix reporting feedback
- Undermining & bullying
- General trainee morale
- Reputation
- Release of foundation F2 doctors to teaching

Opportunities

- Strengthen relationship with CDs and Directors of Operations
- Interprofessional working – faculty of education; educational structure
- Human Factors – multiprofessional working to develop training and excellence in delivery across the Trust
- Finances – working group set up with Isla, Tessa Honey, MEM and DME
- I.T. – educational webpage, technology-enhanced learning
- Developmemt of supervisors
- Guardian / junior doctor fora
- Physicians associates

Threats

- Junior doctors' morale - CQC (patient safety), rota gaps, undermining & bullying, junior doctors' contract
- Trainee vacancies & recruitment
- Reputation
- Protection of tariff and SIFT funding

Medway NHS
NHS Foundation Trust

Medical Education Strategy June 2016

Vision:

To design, develop and deliver the best education and training to enable and empower trainees to be the best doctors to deliver the best care to patients.

Purpose:

1. Support delivery of best education and training programmes in all departments and Directorates
2. Achieve high quality outcomes by improving links with Directorates, innovating through training leads and engaging trainees and trainers
3. Assess and respond to workforce requirements, to support service and provide best training opportunities
4. Empower trainers to perform their best in supervision and delivery of training
5. Enable and empower every trainee to be their best and achieve success

Strategy:

1. Provide best education and training – focus on induction and morale
2. Strengthen interprofessional working
3. Establish clear oversight of the budget
4. Development and innovation in use of I.T. for training
5. Improvement in quality of educational supervision
6. Development of training establishment
7. Reduction in undermining and bullying

Medway NHS
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Report to the Board of Directors

Board Date : 30 June 2016

Title of Report	Communications Report
Reporting Officer	Paul Lehmann
Lead Director	Director of Communications
Responsible Sub-Committee	N/A
Executive Summary	This paper summarises the communications highlights of the last month. Key points to note include: - The Secretary of State's visit - Coverage on the BBC of the work taking place in our theatres - Internal launch of the second phase of our recovery programme
Risk and Assurance	N/A
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	Almost everything the communications team does is in support of the recovery plan.
Quality Impact Assessment	N/A
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Information
Recommendation	The Board is requested to note this paper

Medway NHS
NHS Foundation Trust

Communications Report : June 2016

Introduction

We have had another good month, with some positive media coverage and the beginning of staff engagement around the next phase of our recovery.

SECRETARY OF STATE'S VISIT

The Secretary of State for Health, Jeremy Hunt, visited the Trust on 10 June, accompanied by Gillingham and Rainham MP Rehman Chishti. Mr Hunt met the Chairman, Chief Executive and members of the leadership team, walked around the Emergency Department and Lister Ward to see recent improvements and the impact of the medical model, and then spoke to members of the clinical council. He spoke to a patient while he was on Lister Ward, who was complimentary about her experience of care, and to a number of members of staff on his walkaround.

MEDIA

We have had two notable highlights with the media over the last month.

On 16 June, BBC South East broadcast a special feature from their health correspondent, Mark Norman. The feature was a behind the scenes look at the work of our theatres and surgical teams, including consultants Neil Kukreja and Sarah Hare. The idea of the feature was to highlight the multidisciplinary approach to improving health outcomes for our surgical patients. As part of the filming, the Press Office, along with Neil and Sarah, identified a patient to film with who was undergoing keyhole surgery for bowel cancer. Mark Norman filmed the safety briefing with the team, as well as the entire operation. We're especially pleased that BBC South East captured the strong ethic of teamwork that has helped improve performance in our Surgical Directorate.

Meanwhile, the HSJ did some filming of the medical model in action, as part of a feature they are doing on how the NHS can reap the benefits of more standardised care. They filmed on Lister Ward and interviewed clinical director Sandip Banerjee. The footage should go online in the next couple of weeks.

On a reactive level, we received enquiries from the Health Service Journal about two separate issues: our revised financial position for the last quarter of 2015/2016 and the Adult Inpatient Survey that was carried out by the Care Quality Commission in July 2015, which revealed we were the second lowest-scored Trust in the country at that time. We provided responses on both issues. In addition, the Medway Messenger contacted us about a 92 year old patient who came in a month early for her surgical appointment because of an admin error. Again, we provided a formal response to this enquiry.

ENGAGING STAFF IN THE SECOND PHASE OF THE RECOVERY PROGRAMME

We are just beginning to engage staff in the next phase of the recovery programme. We are calling this phase “Aiming for Best” and it has kicked off with an introductory email to all staff from the Chief Executive, outlining the eight new programmes and a briefing for senior managers. A meeting to which all staff are invited will take place in the coming days.

Earlier in the month, we produced a magazine for staff called “Our Medway,” the essence of which is staff telling their stories to the rest of the staff. Feedback to the magazine was good and we will fold more of these types of staff stories into our other internal communications channels.

Executive visibility is a key feature of our internal communications activities and we have recently undertaken another round of executive visits to the frontline. All the executives are due to do a “working with you” session, shadowing colleagues on the frontline, in the week of the Board meeting.

KEEPING OUT LOCAL POLITICIANS INFORMED

As well as joining us for the Secretary of State’s visit, Rehman Chishti, together with Kelly Tolhurst, joined us for the Clinical Trials Day on 6 June at which we showcased some of the research and development we are doing, that was discussed at the last Board.

We welcomed two of the local councillors for this ward, Clive Johnson and Naushabah Khan, to see the improvements we are making to the ED. Neither had been here for over a year, so it was good to bring them up to speed on the work we are doing.

We have also kept local stakeholders informed of our plans to go smoke-free.

SOCIAL MEDIA

On social media, over the past 30 days we have engaged with 46,200 people on Twitter and 14,391 people on Facebook. We have gained 174 new followers on Twitter and 544 on our Facebook account, taking our total number of followers to 2,061 and 3,566 respectively. Key topics over the last month were clinical research and the visit from Jeremy Hunt. Our posts were retweeted/shared by BBC South East, A Better Medway, NHS Medway CCG and local charities such as Medway Carers’ Support.

WHAT’S COMING UP?

A number of other initiatives are in train or about to start:

- I am pleased to say that we are re-starting work to revamp our **public website**. This will have a number of benefits, perhaps the most important being to boost our chances of attracting good recruits.

- Our **Annual Report and Accounts** will be laid in Parliament in the next few days and published. We are doing a short, digestible version of the report for stakeholders and members of the public who are interested.
- We are pulling together a **community engagement** strategy which we hope to bring to the Board shortly.
- The next edition of **News@Medway** will hit the stands at the beginning of July – issues covered include the Secretary of State's visit, the vision and values, Celebrating Excellence Awards and profiles of the staff governors.