

MEETING IN PUBLIC OF THE TRUST BOARD
THURSDAY 2 MARCH 2017, 12.30pm – 3.00pm
BOARDROOM, POST GRADUATE CENTRE, MEDWAY MARITIME HOSPITAL

Time	Item	Subject	Presenter	Format	Action
12.30pm	1.	Patient Stories – working with patients to learn from their experiences	Heidi Butcher, Healthwatch Medway	Presentation	For Noting
OPENING OF THE MEETING					
1.00pm	2.	Chair’s Welcome	Chairman	Verbal	For Noting
	3.	Quorum	Chairman	Verbal	For Noting
	4.	Register of Interests	Chairman	Paper	For Noting
MEETING ADMINISTRATION					
1.05pm	5.	Minutes of the previous meeting held on 2 February 2017	Chairman	Paper	For Approval
	6.	Matters Arising Action Log	Chairman	Paper	For Noting
MAIN BUSINESS					
1.10pm	7.	Chair’s Report	Chairman	Verbal	For Noting
1.15pm	8.	Chief Executive’s Report	Chief Executive	Paper	For Noting
1.25pm	9.	STRATEGY a) Trust Recovery Update	Kevin Tallett	Paper	For Noting
1.45pm	10.	QUALITY a) IQPR	Director of Nursing & Medical Director	Paper	For Discussion
2pm	11.	PERFORMANCE a) Director of Nursing Report b) Finance Report c) Communications Report	Director of Nursing Director of Finance Director of Comms	Paper Paper Paper	For Discussion
2.20pm	12.	GOVERNANCE a) Corporate Governance Report	Director of Corporate Governance, Risk, Compliance & Legal	Paper	For Discussion
2.30pm	13.	PEOPLE a) Workforce Report	Director of HR & OD	Paper	For Discussion
REPORTS FROM BOARD COMMITTEES					
2.45pm	14.	Quality Assurance Committee Report	QAC Chair	Paper	For Noting
	15.	Finance Committee • Approval of TOR	Finance Chair	Paper	For Noting & Approval
	16.	Integrated Audit Committee	Audit Chair	Verbal	For Noting

AOB					
2.50pm	17.	AOB	Chairman	Verbal	For Noting
	18.	Questions from members of the public relating to the Agenda	Chairman	Verbal	For Discussion
CLOSE OF MEETING					
	19.	Date of next meeting: 6 th April 2017 Boardroom, Post Graduate Centre, Medway Maritime Hospital			

MEDWAY NHS FOUNDATION TRUST
REGISTER OF INTERESTS FOR BOARD MEMBERS

1.	Ewan Carmichael Non-Executive Director	<ul style="list-style-type: none"> • Timepathfinders Ltd • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
2.	Peter Carter Chairman	<ul style="list-style-type: none"> • Non-Executive Director NEAB; National Employees Advisory Board to the Armed Services • ALAMAC External Advisor to ALAMAC Company that works with a number of NHS Trusts • KPMG Occasional Consultant with KPMG • Hon Fellow at Royal College of General Practitioners
3.	Darren Cattell Interim Director of Finance	<ul style="list-style-type: none"> • Director and shareholder of Mill Street Consultancy Limited • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
4.	Stephen Clark Non-Executive Director	<ul style="list-style-type: none"> • Pro-Chancellor and chair of Governors Canterbury Christ Church University • Deputy Chairman Marshalls Charity • Chairman 3H Fund Charity • Non-Executive Director Nutmeg Savings and Investments • Member Strategy Board Henley Business School • Business mentor Leadership Exchange Scheme with Metropolitan Police • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Access Bank UK Limited – Non Executive Director
5.	Lesley Dwyer Chief Executive	<ul style="list-style-type: none"> • Member of the Corporate Trustees of Medway NHS Foundation Trust Charitable Funds
6.	Diana Hamilton-Fairley Medical Director	<ul style="list-style-type: none"> • Director of Education Transformation at Guy's and St. Thomas' Hospitals NHS FT • Member of London Clinical Senate Council • Elected Fellows Representative for London South for RCOG • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
7.	Anthony Moore Non-Executive Director	<ul style="list-style-type: none"> • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds

8.	Joanne Palmer Non-Executive Director	<ul style="list-style-type: none"> • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Lloyds Bank (Fountainbridge 1) Limited • Lloyds Bank (Fountainbridge 2) Limited • Halifax Premises Limited • Gresham Nominee1 Limited • Gresham Nominee 2 Limited • Lloyds Commercial Properties Limited • Lloyds Bank Properties Limited • Lloyds Commercial Property Investments Limited • Target Corporate Services Limited
9.	Karen Rule Chief Nurse Designate	<ul style="list-style-type: none"> • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
10.	Jan Stephens Non Executive Director	<ul style="list-style-type: none"> • Trustee of Medway Youth Trust • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
11.	David Rice Company Secretary	<ul style="list-style-type: none"> • Director and shareholder of Shooters Hill Management Co Limited

Meeting in Public

**Board of Directors Meeting in Public on 02/02/2017 held Trust Boardroom,
Postgraduate Center, Medway Maritime Hospital**

Members:	Name:	Job Title:	Initial
	Dr P Carter	Chairman	PC
	Mrs L Dwyer	Chief Executive	LD
	Mr D Cattell	Interim Finance Director	DC
	Mr J Devine	Director of Workforce	JD
	Dr D Hamilton-Fairley	Medical Director	DHF
	Mr T Moore	Non-Executive Director	TM
	Mrs J Palmer	Non-Executive Director	JP
	Mrs K Rule	Director of Nursing	KR
	Mrs J Stephens	Non-Executive Director	JS
Attendees:	Ms G Alexander	Director of Communications	GA
	Mr B Best	General Manager	BB
	Ms H Butcher	Healthwatch Medway	HB
	Mr P Christian	Medilead (Observer)	PC
	Ms. C Lowe	Director of Estates and Facilities	CL
	Mr J Lowell	Director of Clinical Operations, Women's and Children's Directorate	JL
	Mr W Neville	Fire Adviser	WN
	Prof. M Sheriff	Consultant	MS
	Mr B Stevens	Director of Clinical Operations, Co-ordinated Surgical Directorate	BS
	Mrs L Stuart	Director of Corporate Governance, Risk, Compliance and Legal	LS
	Mr K Tallett	Director of PMO	KT
	Mr D Rice	Trust Secretary	DR
Apologies:	Mr E Carmichael	Non-Executive Director	EC

	Mr S Clark	Non-Executive Director	SC
Observers:	Mrs D King	Governor Board Representative	DK
	Members of the public/staff/Governors (9)		

Items were taken out of order but the minutes correspond to the order on the agenda.

QUALITY INSIGHT – HEALTHWATCH

The Chairman welcomed HB from Healthwatch Medway (“Healthwatch”) to the meeting. GA explained that a programme of “patient stories” were being developed for future Trust Board meetings and the views of the Board were sought as to how this should be structured. This represented an opportunity for the Board to explore the experiences of both staff and patients. Following a presentation by HB on the work of Healthwatch, there were a number of questions and views from the attendees at the meeting.

LS queried whether the “patient stories” would be cases that had been resolved or were they still ongoing at the time of being presented to the Board. HB noted that they could be either resolved or ongoing cases.

DK commented that the presentation would be very helpful for the Governors and suggested that it could be included at a future Council of Governors meeting. DK queried where the work of Healthwatch fitted with that of the Patient Liaison Service (PALS). It was confirmed that many cases dealt with by Healthwatch would be passed directly to the clinical directorates without any involvement of PALS.

JS commented that the importance of “patient stories” was what the Trust learnt and whether it would make a difference to procedures and processes in the future.

DHF commented that the confidentiality of the patient and members of staff should be respected at all times and advanced notice provided to ensure that the background to the cases could be fully researched before the specifics of the case were delivered to the Board.

JP commented that there were a number of similar initiatives with the review of Serious Incidents and the Patient Experience and warned that the Trust needed to ensure that these were appropriately focused and did not duplicate.

PC thanked HB for the presentation noting that the Board was supportive of the “Patient Story” initiative provided the anonymity of patients and staff were respected at all times and they should not duplicate the existing processes already in place at the Trust. HB thanked the Chairman noting that Healthwatch Cumbria was citing the relationship between Healthwatch Medway and the Trust as an exemplar for other trusts.

1. Welcome and Apologies for Absence

- 1.1 The Chairman welcomed everyone to the meeting including Peter Christian, a neonatal registrar from Medilead who was currently shadowing the Chief Executive. Apologies had been received from Ewan Carmichael and Stephen Clark.

2. Quorum

- 2.1 The Chairman confirmed that a quorum was present.

3. 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.

4. Minutes of the Previous Meeting

- 4.1 The minutes of the meeting held on 24 November 2016 were **APPROVED** for signature as a true and accurate account of the meeting subject to minor amendments.

5. Matters Arising – Action Log

- 5.1 The Board of Directors RECEIVED the Action Log which was noted and updated accordingly.
- 5.2 The Chairman referred to paragraph 17.4 of the minutes on Risk Appetite and requested that the Director of Corporate Governance, Compliance, Risk and Legal hold a follow up session for the Board.

ACTION: LS to arrange for a follow up session on risk for the Board.

6. Chairman's Report

- 6.1 The Chairman noted that he had visited a considerable number of wards since joining the Trust. He cited a visit to the Coronary Care Unit where he had met two patients who were ready to be discharged and they were fulsome in their praise for the treatment they had received at the Trust. The Chairman added, however, that where patients raised concerns he was not confident that they were always addressed in an appropriate and timely manner.
- 6.2 The Chairman praised the commitment of the clinical staff and especially those who had worked over the Christmas and New Year period when the Trust had been under considerable pressure. The enthusiasm of staff had been inspirational and many demonstrated how rewarding and satisfying they found their roles.
- 6.3 The Chairman commented that he had attended meetings with NHSI and had contact with local MPs and fellow Board members. Overall the Chairman considered that the Trust was making significant improvements and that it was performing better than it had been for a number of years.

7. Chief Executive's Report

- 7.1 The Chief Executive presented her report which was taken as read and it was noted that:
- The Trust continued to face unprecedented demand but staff morale was good.
 - Following the CQC inspection in November it was anticipated that the draft report would be issued following the Chair's meeting with Ted Baker

and Alan Thorne from the CQC with the final report released early to mid-March.

- The Staff Survey results were currently embargoed but over 2,000 members of staff took part which was the highest response rate at Medway in over 5 years and full details would be presented to the Trust Board in February.
- On executive recruitment Diana Hamilton-Fairley had been appointed as substantive Medical Director and recruitment of a substantive Finance Director would be made in March.

7.2 JS noted that following the November 2016 CQC inspection there had been seven recommendations and queried the status. KR commented that the Trust was confident that evidence could be provided to confirm that these recommendations had been addressed and, following some GAP analysis, these would be reviewed at the Quality Improvement Group and the CCQ Quality Meeting.

8. Strategy

8.1 Trust Recovery Plan – Phase 3

8.1.1 The Chairman welcomed Kevin Tallett, Director of the PMO to the meeting.

8.1.2 The paper was taken as read. KT noted that the continued pressure at the Trust had led to a slight slowdown in activities within the PMO. The final report from the CQC would provide a focus on the areas that needed improvement although many of the matters included in the initial findings letter had been well known and were in the course of being addressed, for example the care of children in adult post-operative recovery areas. BS added that this specific issue would be resolved in the next few days with a proposed medium and long term solution which would be communicated to the CQC.

8.1.3 KT noted that at the time of the inspection the CQC had not raised any “red flags” during the visit or in the 10 day period afterwards.

8.1.4 KT explained that the work of the PMO could be categorised into three stages:

- Stage 1 - the preparation for the CQC visit which had received the staff focus
- Stage 2 – working to the improve flow and operational performance
- Stage 3 – ensuring that the Trust was delivering good value for money

8.1.5 KT explained that Phase 3 would show a move away from recovery into a transformational phase. This would involve a review of Phase 2 of the recovery, the implementation of an integrated model and engagement with external stakeholders.

8.1.6 TM commented that there was clarity regarding the Financial Recovery Plan in whether there were similar milestones for the Trust Recovery. KT noted the comment and hoped to address the issue by the end of March, depending on agreeing the Trust strategy and programme scope.

ACTION: Trust Recovery milestones to be determined by KT.

- 8.1.7. LD explained that the Executive would be focusing on compliance with the 4 hour target, RTT and the cultural change required at the Trust.
- 8.1.8. PC emphasised that the Trust's focus was predicated on the outcome of the CQC inspection as there could be clear instructions about the areas that required immediate attention. The Trust also had to consider which partners the Trust wanted to develop closer links with and also any wider STP considerations.
- 8.1.9 JS queried the status of the "transforming outpatients" project which had been a priority in early 2016. KT explained that this was being followed up by the PMO and progress was expected to have been made by the end of March 2017. LD explained that there had been a deliberate decision to not include the outpatient's project within Phase 1 of the Recovery Plan as it needed to be rebuilt.
- 8.1.10 There was a discussion about the "Perfect Week" which had run between Monday 9th January through to Sunday 15th January. The Perfect Week is aimed at reducing days that are of no value for the patient as they are not receiving treatment that will lead to their discharge from the hospital. The initiative had continued for a further 3 weeks, however, this placed additional pressure on staff.
- 8.1.11 DC noted that new processes based on models used at other trusts would be introduced in the coming weeks at the "front" and "back" doors to improve patient flow.
- 8.1.12 Following a question from TM, there was a discussion about whether more regular monitoring could help review imperfections in the system. LD agreed that the "Perfect Week" had helped analyse problem areas and added that the Trust chaired the A&E Delivery Board which reviewed the areas that needed improvement.

8.2 Robotic Surgical System

- 8.2.1 The Chairman welcomed Professor Martin Sheriff and Benn Best to the meeting.
- 8.2.2 MS gave a presentation to support the business case to seek approval to purchase and implement the Robotic Surgical System ("the System").
- 8.2.3 The System would be used initially for urology procedures and then expanded to other disciplines particularly colorectal and gynaecology. The objective is to ensure that the Trust was offering the latest innovative technology to drive positive patient outcomes and secure future sustainability of the West Kent Urology Cancer Centre (WKUCC).
- 8.2.4 WKUCC has an established national and international reputation in complex laparoscopic urological surgery which has several advantages including smaller incisions, reduced post-operative pain, faster mobilisation and early discharge.

MS noted, as an international trainer himself, that it took considerable time to train surgeons in laparoscopic skills and experienced surgeons were difficult to retain. However, it was easier to train surgeons in the robotic technique than the laparoscopic surgery. There was full clinical support for the proposal.

- 8.2.5 Robotic surgery had, over the past 20 years become the most common method of treatment. In the UK approximately 80% of all prostatectomies were carried out using the robot technique. The acquisition of the robot would ensure the future viability of WKUCC, enhancing the Trust's reputation and status as a centre of excellence.
- 8.2.6 The robotic system would generate cost savings and increase the numbers of both NHS and private patients that could be treated. In terms of financing, leasing of the robotic system was deemed preferable and this was forecast to generate a surplus of £735k after five years.
- 8.2.7 There was clarification that the appropriate governance procedures had been followed with two reviews by the Executive team and a further review by the Finance Committee which had fully supported the proposal.
- 8.2.8 JS queried the strategic aspects of the proposal and LD confirmed that this was an integral part of the establishing a centre of excellence which was an expectation of the public. MS added that the robotic system was well established and in its 4th generation and there was over ten years of clinical data to support the stated benefits.
- 8.2.9 DHF supported the proposal and expected other specialties to find applications for Robotic surgery. DHF agreed with the leasing proposal as this provided flexibility for the future.
- 8.2.10 The Chairman thanked MS for his informative presentation and confirmed that the Board **APPROVED** the Robotic Surgical System business case.

9. Quality – IQPD

- 9.1 DC gave an overview noting that the increase in attendances at ED had led to operational pressures, a pause on elective surgery and an increase in the number of 12 hour breaches.
- 9.2 BS gave an overview of ED noted that despite the increased number of attendances at ED the Trust had been able to “step up” to ensure that safety was ensured at all times which demonstrated how the Trust had improved.
- 9.3 JL noted that whilst nationally there had been a 3% increase in attendances, at MFT these had risen by 18%. On unplanned care there were a number of actions which would be developed to improve the Trust's Opal 4 status.
- 9.4 JS noted that the IQPD referred to there being 11% of emergency readmissions within 28 days. On the basis that there were 4,800 admissions this appeared a high percentage.

ACTION: Clinical Operations to investigate the process to avoid re-admissions.

- 9.5 JP noted that despite the 18% increase in the numbers of attendees the proportion of admissions had remained stable. LD commented that some 27% of those admitted were in the 75 plus age group.
- 9.6 KR noted that the CDiff trajectory of 20 for the year to 31 March 2016 had been breached which would lead to a financial penalty being imposed on the Trust. The situation was being reviewed and positive actions would be implemented.

10. Performance

10.1 Clinical Operations Report

- 10.1.1 BS referring to the IQPD noted that RTT performance had fallen slightly in December due to the pause in elective surgery and was below the challenging trajectory. In order to support the emergency flow through the site, the Trust was engaging with partners in the independent sector to undertake a proportion of the elective surgery.
- 10.1.2 The increase in attendances had also placed additional pressure on MRI and CT scanners and the independent sector were assisting with mobile scanning equipment.
- 10.1.3 JS queried the use of the term “insourcing” and BS explained that it was when a company undertakes a specific activity using the Trust’s own facilities.
- 10.1.4 JS queried when the elective work would recommence. BS clarified that cancer diagnoses and urgent cases were continuing to be carried out but the broader elective work would not resume until the Perfect Week had been completed. NHSI had been informed that the Trust had fulfilled that condition.
- 10.1.5 There was a discussion regarding cases where surgery had been cancelled and possible repercussions for the patients. BS clarified that all decisions were clinically led and surgery was only delayed when it would not have an impact on a patient’s outcome. If the Trust could not perform urgent surgery they would be referred to the independent sector as had been the case for some cancer patients.

10.2 Finance Report

- 10.2.1 DC explained that the Trust delivered an “in month” performance in line with the plan, however, there was an Elective income shortfall of between £250-£300k per week and this was risk for the forecast position. This matter was discussed by the Finance Committee and requested that the Board should be aware that the deficit would not be greater than the Control Total of £46.7m but it would be larger than the stretch financial plan target of £43.8m. DC noted that the Executive were committed to achieving the Control Total.
- 10.2.2 DC commented that the Finance Committee had been made aware that some of the CIP targets had slipped which had been due the external pressure placed on the hospital which had required escalation areas to be kept open to cope with the increase in ED attendances.
- 10.2.3 The original plan for 2016-17 had outlined a total capital spend of £28.2m of which £11.8m related to the ED refurbishment. The revised forecast for the current year now showed a total forecast spend in year of £18m. This was due

to the phasing of the ED refurbishment project and also the Bed Management scheme, the latter of which was dependent on borrowing from the Department of Health which imposed conditions relating to the use of agency staff.

- 10.2.4 The 2017-19 Contract with Commissioners had been approved and signed whilst an update on the contract for 2016-17 was expected in the near future, although that included a potential £900,000 shortfall for the Trust.
- 10.2.5 The Chairman noted that, whilst the Trust's deficit was a concern, all NHS Trusts faced serious financial difficulties.
- 10.2.6 JS noted that the Board had been informed that the CIPs were back ended to the second half of the financial year which was difficult to achieve due to winter pressures and queried whether this could have been predicted.
- 10.2.7 TM noted that the Finance Committee had discussed the issue of the "elective pause" as unless this was resumed in the next few weeks it could place further pressure on achieving the control total, however, DC confirmed that the risk was to the "stretch total" rather than the "control total".
- 10.2.8 LD commented that the "control total" would be at risk if the elective work did not resume in the short term. LD noted that day surgery areas were still in use as escalation areas due to the high demand.

10.3 Communications Report

- 10.3.1 GA noted that there was increasing stability with the Communications team with a move away from interim to substantive staff.
- 10.3.2 The Trusts' communications needed to be aligned with the strategic objectives and priorities of the Trust to ensure that good relationships were built with stakeholders. There was a need for clarity of messaging together with an understanding of how to best reach the various interested groups.
- 10.3.3 Engaging with staff had featured a "theme of the week" for staff messages. A key message is sent to staff mid-week, supported in the Chief Executive's weekly message on Friday. During January the messages have supported the "Perfect Week" activity which aimed to improve hospital flow.
- 10.3.4 Community Engagement would include a membership stand in the main entrance to the hospital in February to encourage members of the public to become members of the Trust.
- 10.3.5 The Communications team was preparing communications in readiness for the release of the CQC report which was due to be published in March.
- 10.3.6 JS queried why two public events had been arranged for the same day; the Vascular Network and the Members Informatics presentation both being on 7 February, however, it was noted that the Vascular Network was not open to members of the public.

10.4 Fire Safety Update

- 10.4.1. The Chairman welcomed Claire Lowe, Director of Estates and Facilities and Wayne Neville, Fire Adviser to the meeting.
- 10.4.2. DC noted that there had been media coverage about the Trust's fire safety arrangements and CL and WN would provide the Board with an update.
- 10.4.3. CL explained that Bill Scott had been an Interim Fire Adviser and made a considerable contribution to the Trust. Mr Scott's replacement was WN and a fire adviser had also been appointed recently.
- 10.4.4 CL explained that she had been interviewed on BBC News following some adverse press comment that the Trust site was allegedly unsafe with no testing of systems or evacuation exercises. This was not the correct as the Trust was safer, regarding fire safety, than it had been in the last five years. This was to a large extent due to the work of Mr Scott who developed a good relationship with Kent Fire & Rescue Service and a number of target objectives had in fact been resolved sooner than had been expected.
- 10.4.5 The negative media coverage had been turned around with the BBC requesting a positive story about fire safety improvements where a "live drill" would be filmed. The filming would also cover the ED improvements and the modular construction.
- 10.4.6 Fire Safety training was now bespoke to the specific areas that staff were working rather than being generic in nature. Specific improvement measures were being made included ensuring sufficient evacuation lifts and the provision for the movement of bariatric patients.
- 10.4.7 LS noted that the agreed fire safety actions would be overseen by the Health and Fire Safety Committee.
- 10.4.8 Following a question from JS there was a discussion regarding whether all the actions could be achieved and it was agreed that the plan was prudent and had been developed in conjunction with the Kent Fire & Rescue Service.
- 10.4.9 TM queried the numbers of staff who were trained and WN confirmed that the aim was for 95% to ensure that there were sufficiently trained staff for all wards.
- 10.4.10 JP noted that at the last inspection the CQC had been impressed with the management of the estate and the fire safety measures in place.
- 10.4.11 The Board thanked CL was thanked for her television interview and Bill Scott for his contribution.

- 10.5 JS queried whether under the new style of papers whether the Medical Director's Report would be discontinued as she had found this very helpful. After a short discussion it was agreed that the Medical Director's Report in some form should be retained.

11. Governance

Corporate Governance Report

- 11.1 The paper was taken as read. The Director of Corporate Governance, Compliance, Risk and Legal explained that a Health & Safety audit had been arranged to carry out a full health and safety compliance assessment between January and March and a report would follow in April.
- 11.2 A “Well Lead” review, which is a mandatory requirement, will be carried out in February and March and a report would be available in April. This exercise would involve a review of Board and Board Committee conduct and there would be a discussion with the Chair as to the best way of feeding back the findings to the Board. This would be fed into the Governance Statement to be included in the Annual Report and Accounts for 2015/16. LD noted that the Trust had discussed the timing of the review with NHSI and it was agreed that it could be carried out in 2017. DK queried whether the Governors would be asked for their views on whether the Trust was well lead. It was confirmed that the Lead Governor would be interviewed and LS would check if the other Governors would be asked for their comments. It was subsequently confirmed that the Lead Governor would be responsible for feeding back comments as part of the “Well Lead” review.

Corporate Risk Register & Board Assurance Framework

- 11.3 LS noted that the Board could be assured that there was a structured approach to managing risk across the Trust. The Board Assurance Framework (“BAF”) was in a narrative format which the Board found easier to understand. The Executive analysed the BAF in advance of it being presented to the Board for their review of the mitigating actions. It was noted that the innovation and digital technology would be added to the BAF.
- 11.4 JS queried if there was a move to service line reporting how this would be embedded at the Trust. DC responded that the move would allow greater responsibility by the directorates and, in order to develop the approach, there would be a scoping document together with an action plan and this would feed into the Recovery Plan. It was proposed that Womens and Childrens would be the pilot directorate for this initiative.

Complaints Management

- 11.5 LS updated the Board on the new Corporate Policy for Complaints Management which allowed the directorates to manage their complaints and, depending on their seriousness, the Chief Executive would no longer need to sign off all complaints. LS noted that the complaints policy had been discussed at a meeting of QAC held in January.
- 11.5 JS raised the matter of PALS ability to reimburse car parking fees to patients where their clinics had overrun. It was agreed that the policy would not impact on this matter.
- 11.6 After discussion the Board **APPROVED** the Complaints Management Policy.

12. People

Workforce Report

- 12.1 The Board took the paper as read. JD highlighted the following from the report:
- 12.1.1 Nurse recruitment – a dedicated nurse recruitment campaign had started in January 2017 which included the review of incentives and analysis of exit data to understand why individuals leave the Trust and if this is more prevalent in specific areas of the hospital;
 - 12.1.2 Staff turnover – generally this has reduced or remained the same across the Trust, however, nursing turnover indicates more leavers than starters this year which would be alleviated by the overseas recruitment drive;
 - 12.1.3 Agency spend – there would be greater oversight with centralised bookings for temporary workers (including agency) and a revised authorisation process to ensure compliance with the NHSI limits; and
 - 12.1.4 Workforce Strategy – this was under development and will be completed by March 2017.

Safe Staffing

- 12.2 The Board took the paper as read. DHF highlighted the following from the report:
- 12.2.1 There had been a slight rise in HMSR of 1% but, given the additional pressure placed on the hospital, it was not unexpected and not deemed significant.
 - 12.2.2 25 Serious Incidents would be signed off in the next couple of weeks.

13. Quality Assurance Committee Report

- 13.1 The Board noted the report.

14. Integrated Audit Committee

- 14.1 The Board noted the report.

15. Quit Smoking – making care more effective

- 15.1 Following a joint Medway CCG, Medway Hospital, Medway Council proposal to the Medway Health & Well-Being Board earlier this year, work had progressed to develop ways to enable more members of the public to quit smoking to improve the effectiveness of the care they receive.
- 15.2 JS commented that she had been involved as a non-executive representative on the Stop Smoking Committee with Andrew Burnett. JS added that the Medway CCG had asked MFT to endorse its adoption.
- 15.3 LD noted that whilst this was not a Trust policy it had been approved by the Executive last year. DHF noted that the policy had been supported by the Clinical Council. It was therefore **AGREED** to be endorsed and adopted as a clinical policy.

14. Questions from the Governor Representative

- 14.1 Mrs King requested that it would be helpful if the Trust Board papers could be uploaded to the website a few days before the meeting to allow Governors sufficient time to read them. DR noted that the papers had been uploaded on Monday 31st January but the Trust would endeavour to make them available as soon as they had been published.
- 14.2 Mrs King commented that she had received some very positive feedback from patients attending ED and they were particularly impressed that there had been a doctor on hand directing attendees to the most appropriate areas for care.
- 14.3 Mrs King sought clarity on the arrangements for transgender members of staff and patients.

ACTION: JD and JL to provide Governors with information on the arrangements for transgender members of staff and patients at the Trust.

15. Questions from the members of the public

- 15.1 Mrs Coussens commented that Mr and Mrs Roper had attended ED recently and were impressed with the care they had received.
- 15.2 Mr Stephens asked if there was a correlation between the pause on elective work and the increase in attendances at A&E. BS responded that there was no evidence of a correlation adding that those patients whose surgery was delayed were closely monitored to ensure that there they did not deteriorate further while waiting for operations.
- 15.3 Mr Stephens asked if patients whose operations were cancelled were offered any form of counselling. DHF explained that patients are contacted in person and if they need any further help they can approach PALS or the Trust Chaplain. KR added that the cancellation of operations are subject to a team decision and that often the consultant will contact the patient concerned.
- 15.4 Mr Stephens commented that he found the infographics in the IQPD helpful and asked if there was a method for the reader to 'drill down' into the supporting information if they required further clarification of the statistics.

ACTION: DC and GA agreed to investigate if drilled down information could be provided on the infographics in the IQPR.

- 15.5 Mr Stephens commented that there was a reduction in community beds in the Medway area and was concerned if patients were moved from Medway to Swale. PC noted that the health and social care system often operated in 'silos' and there needed to be a more joined up approach. PC added that there was also a wider issue of preventative healthcare to reduce the number of attendees at hospitals. PC added that he considered the treatment of Medway based patients in Swale to be perfectly acceptable given that it was a very short distance from Medway. LD noted that there were not many community beds and the closure of St Barts had been detrimental. The Trust had helped Medway Community Health by providing nurses where the community beds could not be staffed. LD added that the STP initiative was expected to address this area

- 15.6 Mrs Bouttell queried whether when compared to national data, Medway had more the deaths from smoking. DHF responded that the Medway did have above average rates of lung disease, lung cancer and pulmonary conditions.

16. Any other business

The Chairman noted that the Trust had shortlisted candidates for the position of Chairman and interviews would be held at the end of February.

The Chairman also added that he was holding regular meetings with the Lead Governor and that she was doing a good job at representing local interests.

17. Date of next meeting

The next meeting of the Trust Board will be held on Thursday 2 March 2017 in the Boardroom, Postgraduate Centre, Medway Maritime Hospital.

The meeting closed at 3.40 pm

Peter Carter:
Chair

Date:

PUBLIC BOARD ACTION LOG

ITEM 06

Bd/17/01

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB-0364	28/07/16	13.1	People & Organisational Development Strategy to be brought back before the next Performance meeting with any comments to be provided to the Acting Director of Workforce prior to the meeting	Director of Workforce	23/09/16 – New Director of Workforce to progress, April 2017 meeting.	Open (red)
PUB – 0365	02/02/17	5.3	LS to arrange for a follow up session on risk.	Director of Corporate Governance, Risk, Compliance & Legal	02/03/17 - To be addressed as part of a Board development plan following the appointment of the new Chair.	Open (red)
PUB – 0366	02/02/17	8.1.6	Trust Recovery milestones to be determined by KT.	PMO Director	02/03/17 – To be addressed by the end of March after the Trust Strategy has been agreed.	Open (red)
PUB-0367	02/02/17	9.4	Clinical Operations to Investigate the process to avoid re-admissions.	Clinical Operations	02/03/17 – To be addressed in the IQPR discussion, under item 10.	Open (red)
PUB – 0368	02/02/17	14.3	JD and JL to provide the Governors with information on the arrangement for transgender members of staff and patients.	Director of Workforce & Director of Women's and Children	02/03/17 – Following the appointment of the Head of Equality and Diversity in March, a presentation will be provided to the April COG.	Open (red)
PUB - 0369	02/02/17	15.4	DC and GA agreed to investigate if drilled down information could be provided on the infographics in the IQPR.	Director of Finance & Director of Communications	02/03/17 – There will be development work to link reporting once the Trust website is set up.	Open (red)

Chief Executive's Report – February 2017

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

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

1. Opening Summary

As you will read from the Board papers, it continues to be a challenging time following the winter period at Medway. Like most NHS Trusts, we are starting to see a return to previous figures in regard to demand for our services, particularly in the emergency department. Despite this our performance has only recently shown signs of improvement against the 4 hour target and we continue to have large numbers of patients who no longer require acute care in our beds.

As referenced in the last month's report we continue to work in collaboration with our partner organisations in shaping new models of care to better manage flow across the hospital, and across the local health economy. Our two priorities are to establish a Clinical Control Centre to provide the co-ordination for both admission and discharge and the second is to rapidly develop a front door model based on hospital avoidance and diversion back to primary care.

2. At and Around Medway

- CQC Inspection Outcome - Medway NHS Foundation Trust

We are expecting our draft report for factual accuracy checking soon after the 6th March and have been advised that the report will be publically released on the 17th March. Until such time it will remain embargoed.

We will be holding the required Quality Summit with CQC, other NHS regulators and local health and system partners on the same day.

Communication plans are underway so that our staff and key stakeholders are informed of the outcome and recommendations just prior to the release of the report.

- NHS Staff Survey

By way of update we have been informed that the national results will be released on the 7 March. We are anticipating that the report will show considerable improvement and that in many areas we will be amongst the top Trusts.

- Kent, Surrey and Sussex Leadership and Innovation Awards

We have been shortlisted in three categories, which will be awarded at a ceremony on 1 March 2017, in:

- Quality and Safety: for our Patient Safety Improvement Excellence programme
- Team Outstanding Achievements – Business Professionals: for our HR & OD team
- Excellence in Out of Hospital Care: for our Proactive Assessment Clinic for the Elderly (PACE)

- Brexit and EU staff

Following on from last month's report outlining how we are supporting our EU staff, a "love your EU worker" morning was held in the restaurant on Valentine's day. The event was well attended, and a number of EU staff who feel vulnerable and concerned about the changes fed back that they feel well supported by the Trust.

- Nurse Recruitment in the Philippines

As reported in this month's Workforce report our recruitment activity is underway both in Europe and the Philippines. On the 20 March a contingent of Medway staff will fly to Manila and undertake a week of interviews. As well as recruiting over 100 nurses they have an added task which is to develop a lasting relationship and pipeline of recruitment so that our future workforce requirements are sustained.

Karen Rule our Director of Nursing will lead the contingent with Dr Peter Carter joining them for 4 days to develop the ongoing the relationship. Peter understands the Philippine system very well and has many key contacts for us to pursue.

- Accreditation and other inspection visits

This month we received an "inspection visit" from the South East Coast Trauma Network, following on from the peer review undertaken in September 2016.

The visit focussed on the changes that we had implemented – including the recruitment of an additional TARN coordinator and rehabilitation physiotherapist – to address the concerns they had identified previously. The feedback on the day confirmed that we had addressed their previous concerns.

The overall feedback we received after their visit to the Emergency Department was really positive overall, and they commended the work of our team – even suggesting that we should be sharing our good practice to help other trusts.

- Carter Efficiency: Getting it Right the First Time (GIRFT)

GIRFT is a quality improvement initiative commissioned by the Department of Health that reviews the performance of individual surgical specialities against a range of national benchmarks. The methodology has two main components: the clinical leadership of change, with peer to peer engagement and discussion; and the provision of a benchmark data pack that forms the basis of this peer to peer discussion.

To date Medway has had reviews in Orthopaedics, Spinal Services and most recently Urology Services with reviews for ENT and General Surgery to follow.

The orthopaedic and spinal reviews have highlighted areas where efficiency may be identified, particularly linked to the types of procedure being undertaken and the non-pay cost associated with them. The urology review feedback presented on Friday 24th February by the national lead described a highly performing flagship Urology service. Opportunities in kidney stone work were identified and will be taken forward by the department.

- Sustainability & Transformation Programme (STP)

The Trust continues, with representation, to support the Kent and Medway STP across a number of workstreams including finance, workforce and the hospital care programme.

Information sessions for Non Executive Directors are underway and we continue to contribute to the development of a clinical strategy across the Kent system.

A separate report by the King's Fund says politicians should back changes to NHS services outlined in sustainability and transformation plans (STPs) when the evidence shows they will benefit patients. The analysis says STPs could help to move more care closer to home, but it warns against cutting hospital beds without first investing in suitable support in the community.

3. Away from Medway

a) Government and Policy

- Ministerial appointment

Lord O'Shaughnessy has been appointed as a minister at the Department of Health. He takes on the role of parliamentary under-secretary of state, as well as becoming a government whip. He is a former Downing Street aide, and was director of policy for David Cameron from May 2010 to October 2011.

The role was previously held by Lord Prior, who was moved to be parliamentary under-secretary at the Department for Business, Energy and Industrial Strategy.

- Parliamentary & Health Service Ombudsman appointment

The new Parliamentary and Health Service Ombudsman (PHSO) has been named as Rob Behrens. The PHSO holds government to account by considering complaints that government departments, public bodies or the NHS in England 'have not acted properly or fairly or have provided a poor service.'

Rob Behrens previously worked as the independent adjudicator for higher education in England and Wales and is currently a senior adviser to the European Network for Ombudsmen in Higher Education.

- Redundancies at the Department of Health

More than 500 civil servants working for the Department of Health are to leave their jobs as part of a plan to reduce running costs by 30 per cent over five years. A total of 538 employees are to take voluntary redundancy over a period of months. Staff will be relocated from three existing offices to new premises in central London.

- Care Quality Commission inspection approach

The Care Quality Commission has completed its consultation into how it regulates NHS trusts and foundation trusts in the future. The CQC will begin rollout of its new inspection approach from April 2017.

The CQC's new regulation regime is intended to offer a more targeted and tailored approach to inspections, with previous ratings helping to determine how often trusts are re-inspected.

- Healthcare charges for overseas visitors

The Department of Health has announced new regulations requiring all hospitals to check upfront whether patients are eligible for free NHS treatment.

The regulations are intended to ensure the cost of health treatments provided to patients not ordinarily resident in the UK is recovered.

Legal changes will require all hospitals to establish whether patients are eligible for free treatment, and to charge upfront those who are not eligible, for any non-urgent, planned care.

The law will change from April 2017 and this will play a role in meeting the government's ambition to recover up to £500 million a year from overseas visitors who are not eligible for free care.

The new measures will also require hospitals and NHS bodies to identify and flag a patient's chargeable status so that other parts of the NHS can more easily recoup costs from overseas visitors wherever charges apply.

b) Service provision and quality

- Safe, Sustainable and Productive Staffing

NHS Improvement has launched draft improvement resources for setting staffing in learning disability services and acute adult inpatient services, following its consultation which closed in February. These have been launched for comment and align with the National Quality Board's (NQB) improvement resource "Supporting NHS providers to deliver the right staff, with the right skills, in the right place at the right time - safe, sustainable and productive staffing", published in July 2016.

The draft adult in patient resource can be accessed via the following link:

<https://improvement.nhs.uk/resources/safe-staffing-improvement-resources-adult-inpatient-acutecare/> along with the opportunity to give feedback via an online survey.

The development of further setting-specific safe, sustainable and productive staffing improvement resources to help providers of NHS services implement NQB's expectations, are being led nationally by NHS Improvement and will cover:

- Mental health services
- Maternity services
- Children's services
- Urgent and emergency care
- Community nursing

The Board will receive further updates on progress with relevant resources in the next Nursing & Midwifery Safe Staffing paper, scheduled for April 2017.

- CQC review: Learning, Candour and Accountability (December 2016)

This review of the way NHS Trusts review and investigate the deaths of patients in England has been carried out in response to the very low number of deaths that were investigated in Southern Health's learning disability and mental health for older people's services, the most high profile of which was the death of 18 year old Conor Sparrowhawk.

The review reports on the processes and systems NHS trusts need to have in place to learn from problems in care before the death of a patient.

Information was gathered from data supplied by NHS Trusts and from visits to a sample of Trusts including 4 acute trusts. The Trust was not one of those visited by the CQC for this report.

Information was also gained from surveys of families and carers and listening events.

Overall the report describes inconsistencies in the way the health system identifies, investigates and learns from deaths in healthcare. It is particularly critical of the lack of importance given to the views and concerns of families and carers of those who have died.

The seven key recommendations from the report are:

1. Learning from deaths needs much greater priority across the health and social care system.
2. Healthcare providers should have a consistent approach to identifying and reporting, investigating and learning from the deaths of people using their services, and when appropriate, sharing

this information with other services involved in a patient's care before their death.

3. Bereaved relatives and carers must be treated as equal partners and receive honest and caring responses from health and social care providers with full explanation of processes of investigation, and accurate explanation of the reasons the person died and response to all the concerns they have raised.
4. The deaths of people with a learning disability or severe mental illness should receive the appropriate attention at a local and national level.
5. Systems and processes should be developed and implemented to ensure that all providers are aware when a patient dies and that information from reviews and investigations is collected in a standardised way.
6. Investigation should focus on system analysis rather than individual errors and should be undertaken by staff who have had specialist training to do so and time protected in order that the investigations identify missed opportunities to improve care.
7. To ensure that learning from deaths is given sufficient priority at a local level, provider boards and clinical commissioning groups must take action without delay on this report and implement national guidance when this becomes available.

- GP and 7 Day Services

GP surgeries have been told they must open seven days a week, offering extended hours from 8am to 8pm unless they can prove that there is not demand in their area.

The Prime Minister has said that a major package of government funding will be 'contingent' on such a move. Surgeries may be asked to use an appointments tool to submit data to the Government on the exact number and type of appointments being offered to patients. GPs will also be asked to ensure more patients are able to book appointments online.

This is important context for Medway given that 38% of our local GPs are at or near retirement age.

- 111 Services review

A report by the Nuffield Trust health think-tank has found that the NHS 111 service in England is sending not just an increasing number, but also an increasing proportion, of the people who call it to A&E departments and to ambulances.

The report draws on data from NHS England's weekly winter operational updates. It finds that over the three years the service has been running, the number of people calling who have either been advised to go to their local A&E or been sent by ambulance has increased from around 150,000 a month to more than 200,000, with the proportion of callers rising from 18/19 per cent to 20/22 per cent. This represents an increase of around 20,000 people a month.

Surveys of callers appear to show that even higher numbers would have opted for these emergency services if they hadn't been able to call 111.

c) Public Sector Finances

- Carter reviews

More than 20 trusts have been chosen to be part of a new NHS efficiency review led by Lord Carter.

The Labour peer and a team from NHS Improvement will look into organisational productivity and performance at 23 mental health and community service organisations.

NHS Improvement has said the review will follow a similar structure and methodology to Lord Carter's previous analysis of acute hospital productivity last year.

4. And Finally

I would like to take the opportunity to advise that Margaret Dalziel, Director of Clinical Operations, Acute and Continuing Care has accepted a new role in Cornwall which she will take up at the end of April. Whilst we are very sad to lose someone like Margaret, we know that our loss is Cornwall's gain and Margaret leaves behind a strong legacy of exceptional leadership and the knowledge that our services are better and safer due to her efforts.

Interviews for the permanent Finance Director take place the first week of March. We have had strong interest in the role and are confident of being able to make an appointment.

- End

Report to the Board of Directors

Board Date: February 2017

Title of Report	Trust Recovery Programme Update
Presented by	Kevin Tallett
Lead Director	Kevin Tallett, PMO Director
Committees or Groups who have considered this report	Executive Recovery Group
Executive Summary	<p>The purpose of this report is to update the Board on progress of the Trust Recovery Programme, identify key risks and discuss next steps.</p> <p>Key points to note are:</p> <ol style="list-style-type: none"> 1. The draft CQC report is due to be received on 7 March for factual accuracy checks. The report will be issued publicly on 16 March and the Quality Summit will be held on 17 March. Following which an Improvement Plan for any actions arising will be produced and agreed. 2. The Planned Care programme has made progress in work stream 1 across the areas of Enhanced Recovery, Pre-assessment, High Dependency Unit, Pre-operative care Unit and Day Surgery. In work stream 2 progress has been made with CEPOD booking/escalation, Paediatric Recovery, Recruitment & Retention, Theatre Scheduling and Enhanced Recovery. In work stream 3 work has continued on Recovery, Post-Operative Optimisation and Supporting early Discharge. 3. The Deteriorating Patient programme has continued to focus on the recruitment for the Acute Response team, Safety Briefings and Safety Campaigns with Safety Tuesdays. 4. The Unplanned Care programme has continued with its close down activities, as the key actions are now all being picked up under the work being done to improve flow and reduce attendances/admissions via the Emergency Department. The key initiatives are to implement a new 'front door' model (using the Barking and Havering model) which is focussed on diverting patients from the ED and a new 'back door' model (using the Oxford University Hospital model) which is focussed on patient flow and discharge. This includes implementation of a new Clinical Control Centre operation that aims to give the patient the shortest, safest journey through their hospital stay. The team are supporting delivery of this using Agile methods to deliver

	<p>the new capability in just 3 weeks.</p> <ol style="list-style-type: none"> 5. The Workforce programme has required little PMO support over the last month while initiatives across the function were reviewed and consolidated ready for Phase 3. The main focus has continued to be on Recruitment building on the developments made over the last 3 months. The Trusts social media presence is continuing to develop and a new campaign to recruit nurses locally and nationally commenced on 20 February. EU and International recruitment work is on-going with a big push on recruiting nurses from the Philippines planned for March. 6. The Transforming Outpatients programme is developing a handover plan to Phase 3 confirming which activities will be within scope and identifying any that can be handed over to business as usual initiatives. The programme has not made the expected progress and will need to be re-energised under Phase 3. 7. Good work has continued with Cost Improvement Plans under the Financial Recovery programme delivering £9.2m against a full year target of £12.6m at month 10. Work on income has identified a potential opportunity of £8m. The Carter Model Hospital work was temporarily delayed during Perfect Week but is re-commencing during March. Lastly, the programme continues to collaborate with the STP Productivity work stream. 8. The Health Informatics programme has a key deliverable this month in the Bed Management system which is integral to improving flow and operations. 9. The Transforming Care programme has been revitalised following a slow down over Christmas and the New Year. A number of activities have been completed and a revised plan produced. The programme will focus on a series of trust wide Awareness Campaigns, development of revised discharge training material and development of an approach to get further Non executive involvement and support of the programme. Last month saw the launch of the 'Funky Zimmers' an awareness to reduce the risk of falls. 10. Early work has started on defining scope of the Trust Improvement Programme Phase 3.
Resource Implications	Resource new PMO team and approve budget for 2017/18. This will be subject to separate process.
Risk and Assurance	Risks have been identified and mitigated as far as possible. The replacement of the current PMO team has not yet been mitigated but work is in progress by the Chief Executive to do so.
Legal Implications/Regulatory	Key vehicle for removing the Trust from Special Measures

Requirements	
Recovery Plan Implication	Fully aligned
Quality Impact Assessment	Covered by individual programmes
Recommendation	The board are asked to discuss and note the report
Purpose & Actions required by the Board :	<div>Approval</div> <input data-bbox="596 629 641 680" type="checkbox"/> <div>Assurance</div> <input checked="" data-bbox="791 629 836 680" type="checkbox"/> <div>Discussion</div> <input checked="" data-bbox="1003 629 1048 680" type="checkbox"/> <div>Noting</div> <input data-bbox="1209 629 1254 680" type="checkbox"/>

Trust Recovery Programme Update – February 2017

1. EXECUTIVE SUMMARY

1. The draft CQC report is due to be received on 7 March for factual accuracy checks. The report will be issued publicly on 16 March (embargoed until midnight) and the Quality Summit will be held on 17 March. Following which an Improvement Plan for any actions arising will be produced and agreed.
2. The Planned Care programme has made progress in work stream 1 across the areas of Enhanced Recovery, Pre-assessment, High Dependency Unit, Pre-operative care Unit and Day Surgery. In work stream 2 progress has been made with CEPOD booking/escalation, Paediatric Recovery, Recruitment & Retention, Theatre Scheduling and Enhanced Recovery. In work stream 3 work has continued on Recovery, Post-Operative Optimisation and Supporting early Discharge.
3. The Deteriorating Patient programme has continued to focus on the recruitment for the Acute Response team, Safety Briefings and Safety Campaigns with Safety Tuesdays.
4. The Unplanned Care programme has continued with its close down activities, as the key actions are now all being picked up under the work being done to improve flow and reduce attendances/admissions via the Emergency Department. The key initiatives are to implement a new 'front door' model (using the Barking and Havering model) which is focussed on diverting patients from the ED and a new 'back door' model (using the Oxford University Hospital model) which is focussed on patient flow and discharge. This includes implementation of a new Clinical Control Centre operation that aims to give the patient the shortest, safest journey through their hospital stay. The team are supporting delivery of this using Agile methods to deliver the new capability.
5. The workforce programme has required little PMO support over the last month while initiatives across the function were reviewed and consolidated ready for Phase 3. The main focus has continued to be on Recruitment, building on the developments made over the last 3 months. The Trusts social media presence is continuing to develop and a new campaign to recruit nurses locally and nationally commenced on 20 February. EU and International recruitment work is on-going with a big push on recruiting nurses from the Philippines planned for March.
6. The Transforming Outpatients programme is developing a handover plan to Phase 3 confirming which activities will be within scope and identifying any that

can be handed over to business as usual initiatives. The programme has not made the expected progress and will need to be re-energised under Phase 3.

7. Good work has continued with Cost Improvement Plans under the Financial Recovery programme delivering £9.2m against a full year target of £12.6m at month 10. Work on income has identified a potential opportunity of £8m. The Carter Model Hospital work was temporarily delayed during Perfect Week but is re-commencing during March. Lastly, the programme continues to collaborate with the STP Productivity work stream.
8. The Health Informatics programme has a key deliverable this month in the Bed Management system which is integral to improving flow and operations.
9. The Transforming Care programme has been revitalised following a slow down over Christmas and the New Year. A number of activities have been completed and a revised plan produced. The programme will focus on a series of trust wide Awareness Campaigns, development of revised discharge training material and development of an approach to get further Non executive involvement and support of the programme. Last month saw the launch of the 'Funky Zimmers' an awareness to reduce the risk of falls.
10. Early work has started on defining scope of the Trust Improvement Programme Phase 3.

1. GOVERNANCE & STANDARDS PROGRAMME

The focus of the programme has been on preparation for publication of the CQC report and the Quality Summit which will follow immediately behind. The Trust welcomed Professor Ted Baker, Deputy Chief Inspector of Hospitals and Alan Thorne, Head of Hospital Inspections who met with the Chair together with the Chief Executive and Medical Director. The pair visited the Emergency department, Lister ward and Wakeley ward. This was a planned visit following our inspection last November and was the first time he had returned to the Trust since the August 2015 inspection.

The draft CQC Report will be received on the 7th March and after an initial review by the Chief Executive, we will start a tightly controlled process of reviewing the report for factual accuracy. The Quality Summit date has been set for the 17th March which reduces the window for factual accuracy checking. So, the intention is to drive a quick paced turnaround of any issues daily. The report will be published by CQC on 16th March, embargoed until midnight.

The Quality Summit will follow the same style format as last time with a two part agenda. The first element being, for the CQC, is to present the inspection key findings and the Trust response to the findings. The second element will be workshop format led

by NHSI to examine the results through a series of lenses linked to the Trust strategic objectives.

Following receipt of the report and the Quality Summit a CQC Improvement Plan will be produced and will drive actions to resolve the issues raised. This will fit under the umbrella of Phase 3 of the Trust Improvement Programme continuing our journey of *Aiming For Best*.

2. PLANNED CARE PROGRAMME

The Planned Surgical Care Programme continues. Task and Finish Groups have been defined for all work streams and work has commenced on a number of them.

Workstream 1 - Pre-theatre:

- Enhanced Recovery – Colorectal pathway work is underway with urology and gynaecology to follow
- Pre-assessment – The new results management process was implemented on 15th February and will be audited for effectiveness. Workup of operational process has commenced with evaluation of best practice models as a priority
- High Dependency Unit bookings – Initial meeting held and action plan developed. Next meeting in three weeks
- Pre-Operative Care Unit – work yet to initiate
- Day Surgery – Work has commenced on the Day Surgery operational policy and theatre scheduling with the anticipation that a full day surgery service will commence post March

Workstream 2 – Peri-Operative

- CEPOD Booking Policy / Escalation Policy – Both policies have been reviewed with a re-launch planned
- Paediatric Recovery – visit from GSTT specialist team has been undertaken. There has been a review of the paediatric recovery processes at other similar Trusts. A final report with recommendations has been delivered to the Trust
- Recruitment and retention – work has commenced in developing a training and development approach
- Theatre scheduling – Review and revision of the theatre booking and scheduling process has commenced in preparation of the surgery re-launch
- Enhanced Recovery – work has commenced with Rohit Jain to improve the peri-operative orthopaedic processes with a view to extending the approach to other surgical specialities

Workstream 3 – Post Operative

- Recovery – work is progressing well with good engagement from recovery staff, therapies, post op ward staff and the anaesthetic team
- Post op optimisation – A visit to One Ashford to review their post-operative approach has re-energised the task and finish group and slow progress is being made
- Supported early discharge – this piece of work has been slow to commence with engagement from all groups being less than ideal.

3. DETERIORATING PATIENT

- The Acute Response Team recruitment drive continues. The Senior Matron – ART has been appointed to and confirms the leadership post for the team. The post holder will be in place from April. The recruitment strategy has been ramped up to fill the remaining Band 7 and 8a posts. The new combined advert is live on NHS Jobs, and social media platforms. For posts recruited to in March or April, candidates will be eligible for a recruitment and retention premium as part of a Trust-wide bid. There are also plans in place to expedite the recruitment process to ensure that the vacancies are filled effectively and at pace.
- The *Improving Safety* briefing, issue 3, was published and cascaded within clinical areas.
- The Improving Safety campaign carries on with 'Safety Tuesdays' which sees the DPP team visit clinical areas and engage with front-line staff about the initiatives and processes relating to '*recognising, responding, reporting*' and with regular updates at identified meetings and forums across the Trust.
- The follow-up DPP Link Nurse event will be held at the end of February. This event aims to recruit a DPP champion in each of the clinical inpatient areas. The second session will provide an update in relation to developments on areas identified for improvement.

4. UNPLANNED CARE PROGRAMME

Closedown activities have continued for the four work streams with the outstanding deliverables being identified with recommendations for next steps, which will either be inclusion in the Trust Improvement Programme (Phase 3) or to be absorbed into business as usual activities.

The main area under consideration is further work on the embedding of the Medical Model to ensure long term benefits are not lost. A gap analysis has been produced outlining next steps, with further work required to develop a plan to implement.

The Medway & Swale A&E delivery board (LAEDB) agreed on 26 Jan to implement step changes to the system-wide processes for managing unplanned care demand, in relation to:

- Expanding the clinical support for care homes (to reduce ED demand and improve discharge processes);
- Improving Primary Care services at the ED front door (to improve ED demand management); and
- Introducing integrated, system-wide patient 'case management' processes from Decision To Admit (to improve internal flow, discharges and system capacity utilisation).

Clinical Control Centre:

Following the Perfect Week initiative, the programme is actively supporting the development and implementation of a new Clinical Control Centre (CCC). The CCC is based on a 'back door' model implemented at Oxford University Hospital with a 'front door' process included based on a model implemented at Barking, Dagenham, Havering and Redbridge University Hospitals. Both of which are examples of the Trust using best practice to drive improvement without re-invention.

The Clinical Control Centre will enable operational efficiency and high-quality patient journeys with one cohesive team, without boundaries, ensuring that all key individuals and teams are working together to offer a smooth pathway from admission to discharge. The target launch date for the CCC is mid-March, with an iterative approach being used. Following launch, continuous improvements and learnings will be applied to maximise efficiency ensuring that the CCC remains fit for purpose as it expands to cover the Coordinated Surgery directorate once it settles down and the new Bed Management system is available for the Surgery directorate in late March.

5. WORKFORCE PROGRAMME

"The Workforce workstream has required little in the way of PMO support this month. Planned improvement initiatives across the function have been collated to provide a consolidated view and from here any projects, going forwards, requiring PMO support can be identified and progressed.

The significant activity stream of recruitment is continuing to build upon the developments made over the previous months. January saw a good number of nurses join the Trust and the pipeline of new arrivals looks positive.

General Recruitment

The Recruitment Team are continuing to develop the Trust's social media presence and have recently engaged with TMP Worldwide, a recruitment specialist, to launch a new campaign targeted locally and nationally for nurses. This campaign runs from the 20th February and will hold a large number of benefits for any new staff members to the Trust.

Some of the benefits include:

- £3000 Recruitment & Retention bonus (paid at intervals over a 26 month period)
- Preceptorships
- Personal 1-2-1 support for revalidation
- Cycle to Work to scheme
- Flexible Working Hours
- Relocation Loan Scheme
- Onsite Nursery
- Access to a wide range of training and development opportunities

This TMP Worldwide campaign, like previous campaigns, will run over the 3 month period, and will include: Radio advertisement, engagement on Spotify, a supplement advertisement in The Guardian, KM newspaper advertisement and potentially a new billboard campaign if the appropriate sites can be agreed within these timescales.

The Trust's recruitment team are continuing to hold open days with the aim of attracting the best candidates and promoting the Trust as an employer of choice. The Recruitment Team are holding Nursing Assessment Days which include: Hospital Tours, Team Meetings, Occupational Health appointments and ID appointments with the aim to reduce our time to recruit and also increase candidate engagement to the Trust.

EU and International Recruitment

There is an ongoing recruitment campaign of EU nurses through the Medacs contract; the next date for Skype interviews is 23rd March. This aims to appoint a minimum of 15 new nurses to the Trust. It is likely that two further skype interview dates between March – May will be required to ensure that the Trust stays on target under this agreement.

The Trust is positively considering the renewal of the contract with Medacs for the continued supply of international nurses.

In other international recruitment, the Trust appointed 8 NICU nurses from the Philippines in October and they are expected to arrive in August 2017.

The Trust has engaged with Harvey Nash to recruit 120 nurses from the Philippines across all disciplines. Trust delegates are due to fly out to the Philippines to conduct over 500 interviews week commencing the 20th March 2017."

6. TRANSFORMING OUTPATIENTS

As Phase Two of the Trust transformation programme comes to completion, a handover of the Transforming Outpatients programme is being developed by the PMO. This will confirm the actions that, going forward, will now be Business as Usual (BAU), change management and/or are transformational and will be picked up and re-energised under Phase 3:

Reducing patient visits.

- This workstream is primarily about improving outpatient efficiency and will be taken forward as a BAU function under the three directorates.

External outpatient models.

- This workstream continues to make progress under the MaSCOE programme which is being managed by Swale and Medway CCGs.

Accurate RTT data

- The formation of a Trust Data Quality team is complete and all actions have been delivered. The management of RTT data quality is now the responsibility of the Directorates and any concerns with data quality is now monitored and discussed at the Trust PTL and data quality meetings.

Reconfiguration of the Trusts Outpatient administration functions

- Further meetings are planned for February to agree the future structure for this project as it contains a mix of actions that are BAU, service improvement and transformational.

7. FINANCIAL RECOVERY PROGRAMME

The Financial Recovery Plan is progressing to plan looking at both deliveries in year and for the coming years. The focus of the plan is around four key areas:

1. CIPs 2016/17

The benefits realised on CIPs to Month 10 is £9.2m against the full year target of £12.6m. This does not include a saving against the PMO budget of an estimated

£200k which is to be signed off by the PMO director before the end of March. The forecast to year end, including the £200k PMO saving, is currently £10.7m.

Income non cash releasing savings over and above the £10.7m have started to materialise. To date the benefits are £1.3m with an anticipated value to year end of £2.2m.

The total cash releasing and non-cash releasing CIP delivery for 2016/17 is forecast to be £13.2m.

Governance is underway for the 17/18 CIP programme and due for completion the end of February the validation covers QIAs and Project briefs/Project Initiation Documents.

There are over 100 schemes in the Pipeline, they are working through the gateway of Project, QIA and Financial validation before they are approved for financial release.

2. Income

There has been work undertaken to validate income that has not been claimed by the trust or related to incorrect penalties. Currently there are 23 projects representing potential income opportunities of approximately £8m of which it is expected £2m will be validated in the financial year 16/17 with the majority of the benefit being taken in 2017/18.

Approval has been given for a project manager to deliver the validation and transfer methods to directorates for income lost schemes.

3. Carter Model Hospital

Work was temporarily stopped on the Carter validation of medical to help in the management of the Perfect Week for the Trust and to work on the development of a Trust Elective Management Strategy. This work will be resumed during March. Work has continued on Corporate Carter delivery.

4. Sustainability & Transformation Plan

We continue to work with the STP on future opportunities through the newly formed productivity work stream.

We are in the process of concluding negotiations on both Pathology and Laundry services working in collaboration with DVH and MTW respectively, both of these collaborative pieces of work will run in our Cater work stream and also form future blueprints for the STP.

5. HEALTH INFORMATICS PROGRAMME

Electronic Order Comms Programme

- The Order Comms Project team have paused work on the Pathology work streams pending the Board's decision in regard to the North Kent Pathology Service. Contingency options are being prepared in the event that the outcome is a decision not to merge with D&G.
- The PAS/RIS interface work originally has now been approved by the County Wide Group (KMMIC) and is scheduled for 18th March 2017.

Bed Management and Electronic Observations

- At time of submission the team are preparing for go-live in Acute and Continuing Care (ACC) on the morning of Wednesday 22nd February 2017.
- The project team has been increased in the short term to enable the Phase 2 deployment to Surgical on Monday 20th March, a full two weeks earlier than initially planned.
- Women and Children's (W&C) will be due to go-live in early May.

Electronic Document Management (EDM)

- The full Invitation to Tender (ITT) has now closed with 6 suppliers responding. These 6 have been invited to demonstrate their solutions on 27th and 28th February. This will then complete the scoring of supplier responses in order for the full business case to be prepared for recommendations to the Executive and the Board in March/April.

E-Referral

- A briefing and options paper has been circulated to key decision makers ahead of internal discussions during w/c 20th February. A significant change of operational approach and engagement is required in order to comply with the CQUIN targets for 17/18.

Mobile Interoperability Gateway (MIG)

- MIG Web Viewer (Also known as the Summary Record Viewer or SRV) has now been successfully deployed to the Emergency Department (in addition to 3 other critical areas). The team are liaising with Information Governance and Pharmacy to determine how Pharmacy could also be linked to the MIG.
- A purchase order to integrate MIG with Symphony in ED has also now been raised.

Child Protection Information Standards (CP-IS)

- The team are launching the CP-IS flags within the Telelogic (outpatient) system. This is a first of type nationally which means that NHS Digital are heavily engaged with the deployment. The solution will also then be flagged within the ED on Symphony during Q1/Q2 of 17/18.

Oasis PAS upgrade to version 2016.1

- The upgrade and additional software patch (CU6) have all been successfully deployed. This has enabled more intelligent messaging and interfacing into and out of PAS to other key systems, such as the new Bed Management System.

Maternity Solution

- The Tender Phase of the project has now commenced, with supplier responses being required by 27th February. Supplier demonstrations are being planned for 2nd to 9th March, in order to complete response scoring and present a business case with recommendations to the Executive and the Board in March/April.

NHS Mail 2

- The HI team are liaising with Accenture (NHS Digital's scheme provider) to migrate all medway.nhs.uk users to nhs.net mail accounts in Q1 17/18.

Other Programmes

- Chemotherapy E-Prescribing has is unlikely to meet the March 31st deadline, (issues with haematology) – it is anticipated that a mid-May date is achievable. The project board will be revising the consequent potential financial impact to the Trust.
- Symphony Upgrade – The HI team have issued a Purchase order to EMIS (Supplier of Symphony) upgrade the version of Symphony, add in an SSRS reporting module, Integrate the MIG and integrate the CP-IS flags. This it anticipated to occur during Q1 17/18.
- E-Prescribing – Pharmacy and HI PMO are awaiting a proposal from an E-Prescribing specialist to inform the scope of the programme and prepare a business case.
- Digital Dictation and Voice Transcription – this requires a full scope and business case to be prepared for the 17/18 financial year. It is anticipated to achieve this successfully, including all functionality benefits, Trust wide will involve an 18 month deployment.
- Dr Doctor – A business case was submitted to the Executive Group on 15th February. This will be submitted to Board for approval following financial verification.

- Check In Kiosks – Planning for this phase of PAS linked functionality will start once Bed Management has gone live and will be commencing deployment in Green Zone for the W&C Directorate.
- Integration Programme – interfacing work with other IT systems will recommence after the go live of the Bed Management solution.

6. TRANSFORMING CARE PROGRAMME

The programme has been revitalised following the 'slow down' over the Christmas/New Year period. A number of activities have been completed across various work streams and the overall programme plan updated to reflect revised timelines.

One of the key activities over the next few months will be the development of a Trust Wide 'awareness' week campaign for each workstream to highlight the changes and activities that are being/have been implemented, to engage staff and ensure understanding of new process, procedures and ways of working.

Another area of key focus is the development of revised Discharge training materials, to ensure that all staff across the Trust understand the processes, options and their roles and responsibilities that support the Discharge Process.

Further area of focus last month include the launch of 'Funky Zimmers' raising awareness and increasing the use of Zimmer frames, thus helping to reduce the risk of falls. Following the recent implementation of Houdini assessment for management of continence a review and awareness survey has been completed, with results available shortly.

The development of an approach to get further Non- Executive Director involvement and support of the programme has started.

Finally, a review of the programme has commenced as part of the handover to business as usual in quarter 2 later this year and the change of the Operational Lead.

7. TRUST IMPROVEMENT PROGRAMME PHASE 3

Early work has started on defining the next phase of the programme with a move away from a focus on Recovery to one of Improvement. Specifically the following actions are planned take place between now and the end of March:

- Review Phase 2 of the programme to determine what we set out to deliver, what has been delivered up to this point and what will then go forwards under the programme umbrella, move to a business as usual initiative or is no longer needed and can stop.
- Identify the Improvement Actions that arise from our CQC Report and Quality Summit and include these in the programme scope where appropriate.
- Engage with key stakeholders to define key transformation activities.
- Scope the high level programme and define governance arrangements.

Following this, during April, the activity will focus on:

- Gaining approval for Phase 3.
- Launching the programme.

8. RISKS TO DELIVERY

The Trust Recovery Programme has reached a key point in its current form. The excellent work done in preparing for the CQC Inspection has established a solid platform from which to build. The biggest risk to the programme is not to take the opportunity to re-focus the improvement journey into one of transformation and culture change. This work is on-going and a paper will be presented to Board in March or April.

The current PMO team will be leaving the Trust at the end of March and to ensure a smooth handover and transition it is important to identify the new team quickly. All of the current work including methods and tools will be packaged up appropriately.

The Board are asked to note progress.

Kevin Tallett

Report to the Board of Directors

Board Date : 2nd March 2017

Title of Report	Integrated Quality Performance Report
Presented by	Executive Directors
Lead Reporting Director	Darren Cattell Director of Finance, however Executive Team accountability
Committees or Groups who have considered this report	Quality Assurance Committee Quality Improvement Committee
Executive Summary	<p>To inform Board Members of January's performance across all functions and key performance indicators. Key points are:</p> <ul style="list-style-type: none"> • The Trust did not achieve the four hour ED target for January. In number terms, performance has dropped from 73.67% in December to 71.96% in January however this is against the backdrop of continued flow pressures. <ul style="list-style-type: none"> ○ Emergency Department (ED) attendances running 1% above last January's levels. This is a 9% decrease on November's figure however the acuity of Patients has increased as we have admitted 20.4% of Patients in January when compared to 19.8% in December. ○ Flow issues caused by our inability to discharge Patients and particularly in outliers, where at the peak the number of outliers was up to 90 Patients. ○ Bed occupancy again increased by 2% to 96.49% • Nationally, ED attendances across England have risen by 4.5% and emergency admissions via ED by 3.5% in the past 12 months. We still report an increase of over 10%. • During this operational pressure, the Trust reported 16 12 hour breaches in January, this compares to 3 in the whole of 2015 and 48 in the whole of 2016 • HSMR remains on the same downward longer term trend line as previously reported and within benchmarked norms. This demonstrates a more consistent system of care within the Trust which is being maintained. • This month saw a 68% increase in the number of Mixed Sex Accommodation breaches, these totalled 37 in January and were due to the Emergency Admission pressures. • RTT performance remains steady at 77.02% of patients

	<p>seen within 18 weeks. However there has been a four-fold (5-20) increase in number of Patients waiting longer than 52 weeks for treatment. All Patients are regularly reviewed by the clinical teams to manage clinical risk.</p> <ul style="list-style-type: none"> • Cancer targets have not all been achieved however on a positive note, the 2 week wait performance improved by 6% to 96.49%. The performance for the two week wait for Breast Symptomatic was below target for the first time in three months. The 31 day wait for subsequent cancer surgery target is now at 100% of Patients receive their surgery. • Diagnostic Target to see 99% of patients within 6 weeks of request has not been met. Performance in January is 90.84%, an improvement of 1.65%. • In January, the number of C-difficile cases reported was 7. This means we have now exceeded our annual target with two months left in the year. The ACC Directorate is undertaking a root cause analysis. • There were 39 open SIs, a decrease of 30 on December with 49 breaching timescales. Plans to close 21 by 31st March are in place • There were a higher number of falls in January (103) when compared to December (72) • 67 complaints were reported in month, an increase of 91% from the 35 in November • 85% of our staff have now had an appraisal, slightly down on last month by 2% • 70% of our staff have successfully completed Mandatory Training, just dropping from 71% from last month.
Resource Implications	STF funding at risk for under performance
Risk and Assurance	See report
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	Supports the Recovery Plan in the following areas: Workforce, Data Quality, Nursing, Finance
Quality Impact Assessment	See report as appropriate
Recommendation	The Board is asked to note performance

Purpose & Actions required by the Board :	Approval <input type="checkbox"/>	Assurance <input type="checkbox"/>	Discussion <input type="checkbox"/>	Noting <input checked="" type="checkbox"/>
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Integrated Quality and Performance Report




February 2017

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



Contents

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

+ 9088

Patients visited our ED , which is a 9% decrease on the previous month, with **71.96%** seen within 4 hours, compared to **73.61%** . **1855** Patients were admitted, with an increased conversion rate of 20.4% compared to 19.8% in December

3251 Patients arrived at ED via ambulance which is over a **9%** decrease on last month



29.9%

Of ambulance patients were seen in under 15 minutes

There were **4948** total patient admissions **4909** patients were discharged. Bed Occupancy increased by 2.07% in January to 96.49%



23850



Patients attended an outpatient appointment with 9.5% DNA rate which is a decrease of 0.6% on last month

January's Story....

434 Babies were delivered in the month of January (40 more than December) with Emergency C-Section rate reducing by **0.7%** from previous month to **16.6%**



HSMR has slightly decreased from previous month to 101.4 - a slight decrease on last months although on downward trend

There were 103 total falls in January, compared to 72 in December



85% of staff have had an appraisal which is a **2%** decrease on the previous month.



● C-diff Acquisitions

As at 31 December the *C.diff* target was on trajectory; 15 cases against a trajectory of 20. In January 2017 there were seven cases, the highest number of cases since April 2016 taking the count to 22 cases. 20 out of 22 cases involve Acute and Continuing Care (ACC) patients.

Main themes and trends from post infection reviews are:

Inappropriate antimicrobial prescribing and poor antimicrobial stewardship secondary to poor diagnoses

Timeliness of stool samples

Delay in isolation (due to black escalation)

A SWARM event will be held in March to identify incidental and direct learning from the C Diff breaches in January. The Trust is working with the CCG to identify the financial penalty that will be attributed to the C Diff breaches, an update will be given next month.

● Pressure Ulcers

An action learning set has been established with a spotlight on the top 5 wards with the highest number of pressure ulcers; Gundulph, Will Adams, Byron Milton and Phoenix. This action set is one part of a comprehensive tissue viability trust wide improvement plan. A pressure ulcer grand SWARM will be held on 23 February 2017 and the outputs will feed into the tissue viability trust wide improvement plan.

Incidents

A high incident reporting rate is indicative of an organisation with an open and transparent reporting culture. All staff are encouraged to continue reporting incidents; the focus for the coming months will be on developing a framework around learning the lessons and demonstrating improvements.

Serious Incidents

See attached slide plus include the following narrative:

The Never Event SWARM was held on 10 January 2017; the final report is with the Directorate for review and sign off.

● Mortality

The Trust's position within the published mortality indicator, the Hospital Standardised Mortality Ratio (HSMR) continues to sit just above the baseline of 100. The latest HSMR value for the rolling 12 month period (November 2015 – October 2016) is 101.4 (Figure 1).

Figure 1

The HSMR has stabilised over the last year with a fluctuation around 101 to October 2016 (Figure 2). This demonstrates a more consistent system of care within the Trust which is being maintained.

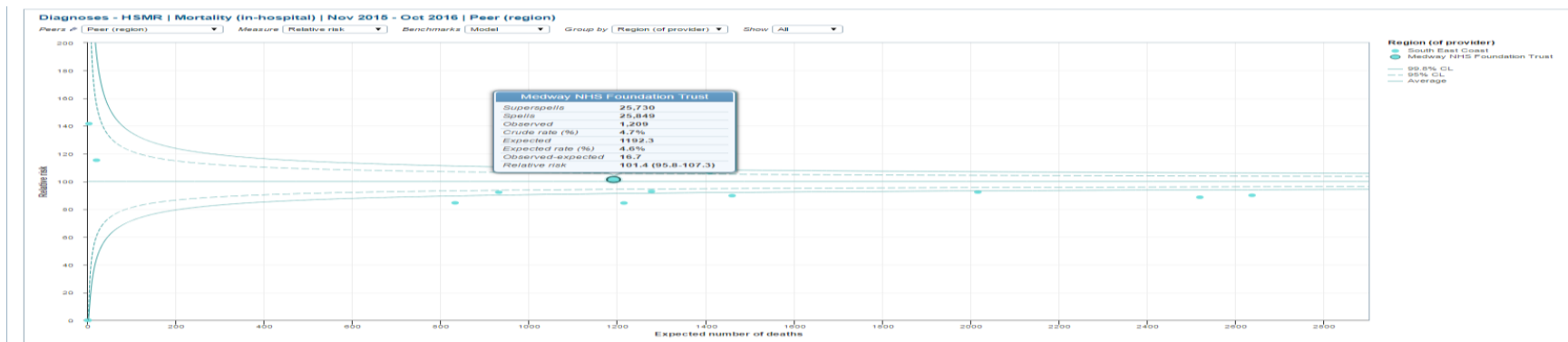
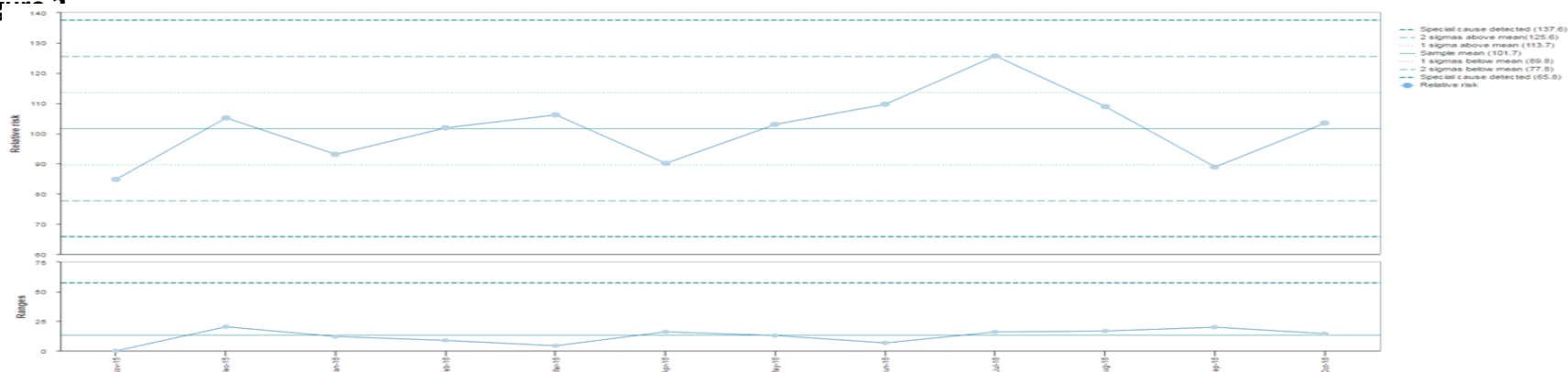


Figure 2



Weekend mortality has been identified as an area for review with a 'deep dive' review of mortalities from a Saturday and Sunday as day of discharge together with a subsequent improvement plan.

CQUIN - Please find attached an update on the CQUINs on Page 10.

- The percentage of patients who would recommend ED has improved by 8.1% from previous month. This is a good improvement during a period of continued pressure on emergency services.
- The number of complaints increased in January 2017 compared to the previous month. This is not unusual as individuals often do not wish to pursue complaints in the run up to Christmas and prefer to wait until the new year. Whilst complaint responses within 30 days are still below the Trust target, the performance in the second half of the year is significantly better than the first part of the year. Work on embedding new processes still continues with clinical directorates. Complaints turnaround times have been impacted since December by operational pressures in the Trust.

ED

- Performance against the 4 hour target was 71.96%, despite a 9% decrease of attendances from December. However, the critical nature of presentations was noted, with a decrease in availability and access to Critical Care beds, fewer patients suitable to be seen in minors (non-admitted pathway), and a higher acuity of patients admitted, resulting in significant impact on flow. At the peak, in the second week of January, there were up to 90 medical outliers across the Hospital; all escalation areas were in full use, including the theatre recovery area, with patients unable to be placed into a surgical inpatient bed following emergency surgery. Very little elective activity has taken place during January regardless of the Perfect Week which ran through the first week of January in order to create capacity. The bed occupancy rate for adult inpatient beds has been at over 100% throughout January as no escalation beds have closed, and outliers remain at above 40.

The flow indicators in ED were significantly challenged with increased delays at both the 80th and 95th percentile, with a total of 16 reportable 12 hour breaches across 5 different days in the month. This was all due to the lack of availability of inpatient beds, with the Trust in Black escalation.

Throughout the period, MFT remained one of the highest performers in the region in relation to ambulance handover time compliance, and worked collaboratively with SECamb to mitigate the risk of Immediate Handover which occurred frequently due to surge pressures on both systems.

● RTT

RTT performance is 77.02% an increase of 0.01% on the previous month. Elective activity has been cancelled in order to support the management of emergency demand. In agreement with the CCG and NHSi, based on current performance the trajectory to the end of 16/17 has been revised. The management of elective activity is being supported through further use of the independent sector.

● Cancer

December's performance against the cancer waiting time standards is improved on the previous month with compliance across all standards with the exception of the 62 day screening standard which is below trajectory although improved on November's performance.

2WW – Trust has achieved the GP 2 week wait and 2 week wait symptomatic breast standard.

31D - The Trust achieved the first definitive and subsequent surgical and drug treatment standards.

● **62D** – The Trust failed to achieve compliance with the GP 62 day referral standard but achieved compliance with the screening and Consultant upgrade standards.

The reasons for GP 62 day referral standard performance of 77.97% were varied due to complex pathways requiring additional diagnostic tests and involvement of local and tertiary providers and patient choice/cancellation delays

The skin pathway is being reviewed to ensure earlier referral to treatment provider where possible

Performance improvement plans are also in place for urology & lower GI tumour sites

Well Led Page 12

There has been a slight increase in the sickness absence rate, although this remains below the target of 4%. The HR Business Partners will shortly be based within their respective clinical directorates, and therefore better placed to manage a range of indicators including absence and turnover.

We saw the highest number of starters in January for some months, which includes the efforts made to transfer agency workers on to the Trust payroll via either the in-house bank, or fixed term contracts. This is important as we look to continue the work to reduce our reliance on temporary staffing spend & usage.

Actions

- Work with directorates to continue the work in challenging the usage of agency workers, and those working above the NHSI price cap
- Launch the UK nurse campaign as we work toward reducing the vacancy rate across key groups and bandings

Enablers Page 13

The data quality team continue to complete the RTT validation on a daily basis. The unknown clocks report has recently been handed back to the service teams. The duplicate pathways report is now also validated by the patient service centre for those records where the error originates from the PSC. The data quality team continue to validate the remaining duplicate pathways.

It has been identified within the Trust that the review lists on APAS have now become unmanageable due to the incorrect use of the system’s partial booking facility and users booking patient appointments outside of this process.

The data quality team are working through the follow up review lists specialty by specialty. On completion of the validation, the management of the lists will continue with the service teams. We are currently working on Neurology and neuro-otology which has 5782 patients in total.

Serious Incident Current Position

As at 31 January 2017 there are a total of 88 open Serious Incidents (SIs) (an increase of 19 from December) key issues of note are as follows:

- Open SIs within allocated timeframe – **39**
- Open SIs breaching the allocated timeframe – **49**
- 21 SIs were submitted for closure at the February CCG SI Panel – confirmation has been received that all **21 SIs will be closed** during February
- A Falls SWARM learning event was held in January 2017 – The aggregate report has now been drafted and will result in the **closure of 19 SIs** (14 breaching and 5 within allocated timeframe)

Remedial Actions:

- A Pressure Ulcer SWARM learning event will be held on 23 February 2017 - Agreement has been received from the CCG to submit an aggregate report which will result in **the closure of 10 SIs** (7 breaching and 3 within allocated timeframe)
- ED are currently finalising the investigation into **nine** 12-hour trolley breaches (2 breaching and 7 within allocated timeframe)
- In addition to the 21 SIs submitted, it is anticipated that **a further of 38 SI investigations will be submitted for closure** by the end of February 2017

3. Safe

3. Safe

	Monthly Target	RAG	Trend						Alignment		
		Status	Nov-16	Dec-16	Jan-17	Movement	YTD avg	Data Quality	Carrier	SOF	Quality Account / COLUMN
1.1.3.2	Potential under-reporting of patient safety incidents (Quarterly)		Information on NRLS under review from DOH.								
1.1.4	Never events	0	G	0.00	1.00	0.00	↓	0.1			✓
1.1.4.1	Never Events - Incidence Rate	0.00%	G	0.00%	0.04%	0.00%	↓	0.0		✓	
1.1.5	Incidents resulting in death (1 month in arrears)	0	R	1.00	7.00		↑	4.0			✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days) (1 month in arrears)	0.11	R	0.60	0.39		↓	0.22			✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days) (1 month in arrears)	1.87	R	1.61	1.95		↑	1.7			✓
1.1.10	Incidents with moderate or severe harm with duty of candour response (1 month in arrears)	100%	R	47.0%	58.5%		↑	0.2			✓
1.1.14	Pressure ulcers (grade 2) attributable to trust	10	R	17.00	12.00	13.00	↑	9.7			✓
1.1.15	Pressure ulcers (grade 3&4)	0	G	2.00	4.00	0.00	↓	1.0			✓
1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.00	0.00	0.00	↔	0.0		✓	
1.1.21	% Duty of Candour with first letter	Datix system being reconfigured to allow accurate data capture.									
1.2.2	New VTEs - point prevalence in month	0.36%	R	0.4%	0.39%	0.62%	↑	0.6%		✓	
1.2.7	Emergency c-section rate	<15%	R	18.3%	17.3%	16.6%	↓				
1.3.1	MRSA screening of admissions	95%	R	93.0%	84.1%	89.5%	↑	94%			✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	G	0.00	0.00	0.00	↔	1		✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	R	1.00	1.00	7.00	↑	1		✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	R	101.4			↓	102.8		✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	R	103.4			↔			✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	100	R	110			↔	115		✓	✓
Commentary			Actions								
Please see Executive Summary			Please see Executive Summary								

4. Effective

2.5.4	Emergency Readmissions within 28 days
2.6	Discharges before noon

Monthly Target	Status	Trend						Alignment			
	Status	Nov-16	Dec-16	Jan-17	Movement	YTD avg	Data Quality	Center	SDF	Quality Account /	CQUIN
5%	R	7%	11%	17%	↑	11%			✓		
25%	R	12%	16%	14%	↓	12%			✓	✓	

CQUIN											
Ref.	November Status	December Status	Nov-16				Dec-16				
NHS Staff and Wellbeing Physical, Mental & Physio			On target				Next reporting period is Q4				
NHS Staff and Wellbeing food			The Baseline review is presently being undertaken. Some indicators are already achieved. Staff Menu to be reviewed shortly to introduce healthier options. High Risk remains with "League of Friends" shops within the hospital as their products do not meet the set criteria.				Next reporting period is Q4				
NHS Staff and Wellbeing flu							MFT has submitted data on the ImmForm website. CQUIN target date is 31st December 2016, and final data for December 2016 was submitted on ImmForm on 12th January 2017. An additional 4 eligible immunisations were provided in quarter 3, but are not included in the ImmForm data as forms were not received by 31st December. Actual Imms Given: Eligible Staff = 3,2017. Received flu vaccine = 2,407. % = 75.05%. Reported on ImmForm: Received flu vaccine: 2,403.				
Sepsis 2a			There is a large amount of audits which are required for this CQUIN, and so in order to support nursing staff who are completing the audits, a business case for additional support is with Execs. Audits have been				Q3 report submitted. Awaiting reconciliation.				
Sepsis 2b											
Antimicrobial Resistance 5a - reduction							On target to deliver. Bal and Prina (CCG pharmacist) confirmed with Busola that Q2 has been met. Awaiting reconciliation for Q3				
Antimicrobial Resistance 5b - review							On target to deliver. Bal and Prina (CCG pharmacist) confirmed with Busola that Q2 has been met. Awaiting reconciliation for Q3				
Joint Formulary			On target to deliver				On target to deliver. Bal and Prina (CCG pharmacist) confirmed with Busola that Q2 has been met. Awaiting reconciliation for Q3				
Medicines Reconciliation			On target to deliver				On target to deliver. Bal and Prina (CCG pharmacist) confirmed with Busola that Q2 has been met. Awaiting reconciliation for Q3				
Review of patients on Oral Nutritional Supplements			On target to deliver				On target to deliver. Bal and Prina (CCG pharmacist) confirmed with Busola that Q2 has been met. Awaiting reconciliation for Q3				
Reduction in Community Acquired Pressure Ulcers			On target to deliver. However, investigations are not being completed in a timely manner and so there is currently about 20 investigations outstanding. A new process is being written and this will be in place by				Q3 target achieved.				
Discharge Before Midday			Target for Q3 is 30%. For October, reporting 14%				Target for Q3 is 30%. MFT achieved 14% discharges before midday in Q3.				
Paediatric outpatient referral management system			On target. GPs have started to refer electronically for general paediatrics.				E-referral is functioning and referrals are being electronically received into the department since September 2016.				
Development of Electronic Discharge Note			On target to deliver. Received confirmation from CCG that achieved Q1 and Q2 milestone. Q2 reconciliation is yet to be completed.				As previously agreed with the CCG, the Ante-natal and Post-natal revised templates went "live" on 5th December 2016 as planned. A meeting was held with the CCG on the 9th December 2016 to confirm this and that further templates will "go live" in Q4 as agreed. MFT and CCG have agreed to revalidate the baseline				
Paediatric asthma and wheeze pathway			Asthma nurse is engaging with families and re-training families on the use of inhaler and identifying other attributing factors to asthma. We have a dedicated asthma trained nurse until the end of December.				Data submitted for Q3.				
Optimal Device			Data for Q1 and Q2 submitted to NHSE. Awaiting reconciliation				Data for Q3 submitted to NHSE. Awaiting reconciliation for Q1, Q2 and Q3.				
Adult Critical Care Timely Discharge			Data for Q1 and Q2 submitted to NHSE. For Q2, 25% discharged within 4 hours, 32% discharged between 4 and 24 hours, 43% discharged after 24 hours. Awaiting reconciliation.				Data for Q3 submitted to NHSE. For Q3, 25% discharged within 4 hours, 45% discharged between 4 and 24 hours, 30% discharged after 24 hours. Awaiting reconciliation for Q1, Q2 and Q3				
Increase take up of School Immunisation			The action plan to increase uptake of school aged immunisations has been submitted to the PHE Screening & Immunisation Team (SIT) who are monitoring this on behalf of NHSE. Following a teleconference on 02.11.16 with the SIT and the NHSE commissioner it was agreed that there needs to be some further additions to the plan, and this will be re-submitted in the next two weeks.				The action plan to increase uptake of school aged immunisations has been submitted to Public Health.				

5. Caring

		Monthly Target	RAG Status	Trend						Alignment		
				Nov-16	Dec-16	Jan-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / ColUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	83%	G	84.6%	85.8%	88.0%	↑	85%		✓		
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	65%	G	77.8%	70.5%	78.6%	↑	75%		✓		
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	79%	R	99.5%	98.1%	98.5%	↑	99%		✓		
3.1.3	Mixed Sex Accommodation breaches	15	R	10.00	22.00	37.00	↑	25.7		✓		
3.4.1	Number of Complaints	45	R	51.00	35.00	67.00	↑	46		✓		
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	85%	R	51.0%				16%		✓		
3.4.3	Number of complaint returners	↓	G	11.00	7.00	7.00	↔	6.6		✓		

Commentary	Actions
<p>The % of patients who would recommend ED has improved by 8.1% from previous month. This is a good improvement during a period of continued pressure on emergency services.</p> <p>The number of complaints increased in January 2017 compared to the previous month. This is not unusual as individuals often do not wish to pursue complaints in the run up to Christmas and prefer to wait until the new year. Whilst complaint responses within 30 days are still below the Trust target, the performance in the second half of the year is significantly better than the first part of the year. Work on embedding new processes still continues with clinical directorates. Complaints turnaround times have been impacted since December by operational pressures in the Trust.</p>	<p>Work on embedding new processes still continues with clinical directorates.</p>

6. Responsive

	Monthly Target	Status	Trend						Alignment		
			Nov-16	Dec-16	Jan-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
4.1.1	RTT – Incomplete pathways (overall)	92%	R	78.52%	77.01%	77.02%	↑	76.54%		✓	
4.1.2	RTT - Treatment Over 52 Weeks	0	R	14	9	20	↑	17			
4.2.3	A&E 4 hour target	95%	R	77.02%	73.61%	71.96%	↓	80.50%		✓	
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	R	71.35%	77.97%		↑	79%		✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	90%	G	100.00%	100.00%		↔	81%		✓	
4.4.1	Diagnostic waits - under 6 weeks (1 month in arrears)	99%	R	90.50%	89.19%	90.84%	↓	92%		✓	
4.5.8	Patients seen by a stroke consultant within 24 hours (Jun to Aug figures reported)	95%	R	45.00%	45.00%	47.00%	↑	55%			✓
4.6.1	Average elective Length of Stay	<5	G	2.36	3.65	3.50	↓	2.3			✓
4.6.2	Average non-elective Length of Stay	<5	R	6.86	7.70	6.89	↓	3.7			✓
4.6.6	Average occupancy	90%	R	94.35%	94.43%	96.49%	↑	92%			✓

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

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

7. Well led

		Monthly Target	Status	Trend						Alignment		
			Status	Nov-16	Dec-16	Jan-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CoUM
5.2.1	Staff Friends and Family – Recommend as place to work (Quarterly)	62%	R	57.7%			↔	48.8%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	79%	R	73.1%			↔	67.5%			✓	
5.3.7	Rolling annual turnover rate	8%	R	8.9%	9.4%	10.0%	↑	9%			✓	
5.3.7.1	Executive Team Turnover Rate	TBA		0.0%	7.1%	0.0%	↓	0%			✓	
5.3.8	Overall Sickness rate	4.0%	G	3.91%	3.89%	3.92%	↑	3.9%				
5.3.9	Sickness rate – Short term	2.0%	R	2.7%	2.7%			2.8%			✓	
5.3.10	Sickness rate – Long term	1.0%	R	1.2%	1.2%			1.1%			✓	
5.3.11	Temporary staff % of pay bill	15%	G	25.0%	23.1%			23.4%			✓	
5.3.14	Starters	N/A		49	33	89	↑	87.7				
5.3.15	Leavers	N/A		22	47	46	↓	70.9				

Commentary	Actions
<p>Recruitment and Retention continues to be a Trust priority and our overseas nursing campaign has progressed with Trust managers visiting the Philippines in March to interview 500 potential nurses for the Trust.</p> <p>We saw a big increase in new starters to the Trust in January and further work continues to look at retention and exit interview data. Exit interviews are carried out on line now and our first data is expected end March 2017.</p> <p>We continue to work with our agencies to ensure we work within price caps and we have 20 agency workers in the process of converting to the staff bank. Work continues to convert interims to fixed term or bank working.</p>	<ul style="list-style-type: none"> - Working with agencies to ensure we work within price caps - Continue to work to convert interims to fixed term or bank working

8. Enablers

		Monthly Target	Status	Trend						Alignment			
			Status	Nov-16	Dec-16	Jan-17	Movement	YTD avg	Data Quality	Center	SDF	Regulatory Account /	COUN
7.2.1	APC – NHS number completeness (2 month in arrears)	99%	R	99.2%				98.8%				✓	
7.2.8	A&E – Attendance disposal (2 month in arrears)	99%	R	97.9%				96.2%				✓	
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	11	R	83	68		↓	51.0		✓		✓	
7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	0	R	0	0		↔	0.0					
7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	99.25	R	325	226		↓	438.7		✓		✓	
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	1%	G	1.3%	0.9%		↓	1.6%		✓		✓	
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	103.50	G	126	35		↓	461.17					
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	0.00	R	0.00	10.00		↑	3.83					
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	949	R	2157	2638		↑	1123.0		✓		✓	
7.3.13b	A&E % missing breach reason on breached attendances (1 month in arrears)	50%	R	100.0%	100.0%		↔	82.1%		✓		✓	
7.3.17	Cancer 2ww invalid NHS Number (1 month in arrears)	0.25	G	8	0		↓	5.3		✓		✓	
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	13.25	G	8	2		↓	32.6		✓		✓	
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	0.01	G	0	0		↔	4%		✓		✓	
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	2	G	0	0		↔	9.6		✓		✓	
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	1.25	G	0	1		↑	3.6		✓		✓	
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	1.25	G	1	0		↓	5.6		✓		✓	
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	1	R	5	7		↑	6.4		✓		✓	

Commentary	Actions
<p>The data quality team continue to complete the RTT validation on a daily basis. The unknown clocks report has recently been handed back to the service teams. The duplicate pathways report is now also validated by the patient service centre for those records where the error originates from the PSC. The data quality team continue to validate the remaining duplicate pathways.</p> <p>It has been identified within the Trust that the review lists on APAS have now become unmanageable due to the incorrect use of the system's partial booking facility and users booking patient appointments outside of this process.</p> <p>The data quality team are working through the follow up review lists specialty by specialty. On completion of the validation, the management of the lists will continue with the service teams. We are currently working on Neurology and neuro-otology which has 5782 patients on them in total.</p>	

Report to the Trust Board

Board Date : 2nd March 2017

Title of Report	Nursing, Midwifery and care staff workforce update – January 2017
Presented by	Karen McIntyre – Deputy Director of Nursing
Lead Director	Karen Rule – Director of Nursing
Committees or Groups who have considered this report	Not Applicable
Executive Summary	<p>Key points are :</p> <ul style="list-style-type: none"> • Planned v actual – 11.6% above planned establishment • High level of acuity with escalation beds open • High number of vulnerable patients requiring 1.1 care • Care Hours per Patient Day consistent trend with previous months.
Resource Implications	Staff costs exceed established budget
Risk and Assurance	Trust Board to note the information provided in this report
Legal Implications/Regulatory Requirements	Not Applicable
Recovery Plan Implication	Recruitment and retention plans
Quality Impact Assessment	Not Applicable
Recommendation	Future nursing and midwifery safe staffing report will form part of the Integrated Quality and Performance Report
Purpose & Actions required by the Board :	<p>Approval Assurance Discussion Noting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/></p>

Nursing and Midwifery Safe Staffing Report – February 2017

A paper prepared by Zoe Andrews Senior -Matron Workforce and presented by Mrs Karen McIntyre, Deputy Director of Nursing on behalf of Karen Rule, Director of Nursing.

1. INTRODUCTION

1.1. The purpose of this paper is to:

- Provide an overview of the nursing and midwifery staffing levels and to highlight any workforce issues identified across the inpatient ward areas during the month of January 2017.
- Highlight any specific areas of concern or risk related to the nursing and midwifery workforce in the delivery of safe care.
- 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!' Published by the National Quality Board and the NHS Commissioning Board.
- This paper is to be read in conjunction with the Integrated Quality and Performance Report.

2. UPDATE

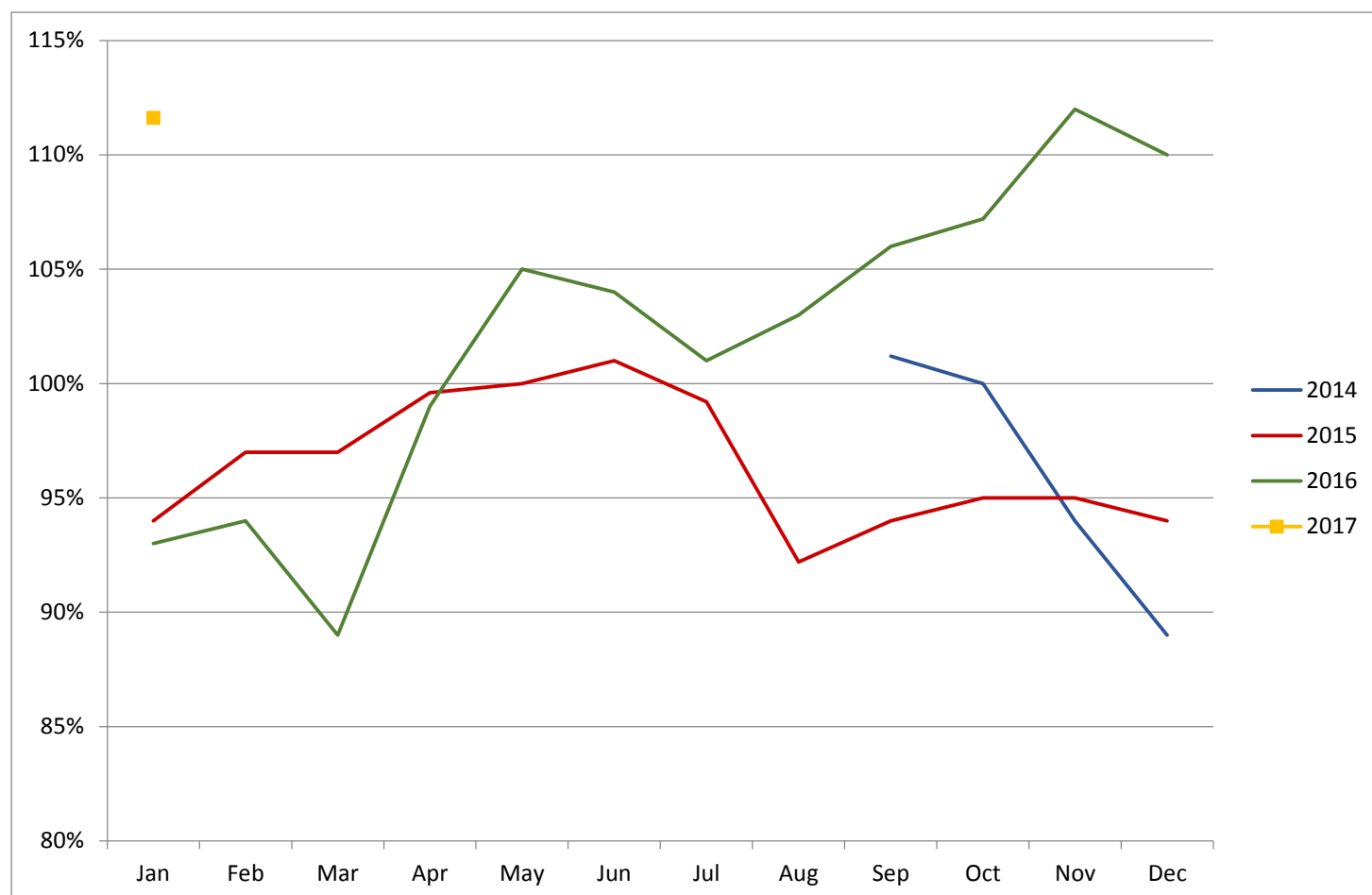
2.1. Recruitment

2.2. Refer to the workforce report.

3. MONTHLY DATA / SAFE STAFFING LEVELS

3.1. The actual hours worked was 11.6% above the planned hours. This is a slight increase from December which was at 10%. Figure one shows the accumulative overall fill rates as per month. The underlying reason behind this increase is due to the continuing high levels of activity across the trust necessitating the use of extra beds in line with the escalation procedure and a subsequent increase in staff to maintain patient safety. This also reflects the need to support many complex patients who need constant 1:1 supervision in order to maintain patient safety.

Figure 1 Overall fill Rate September 2014- January 2017



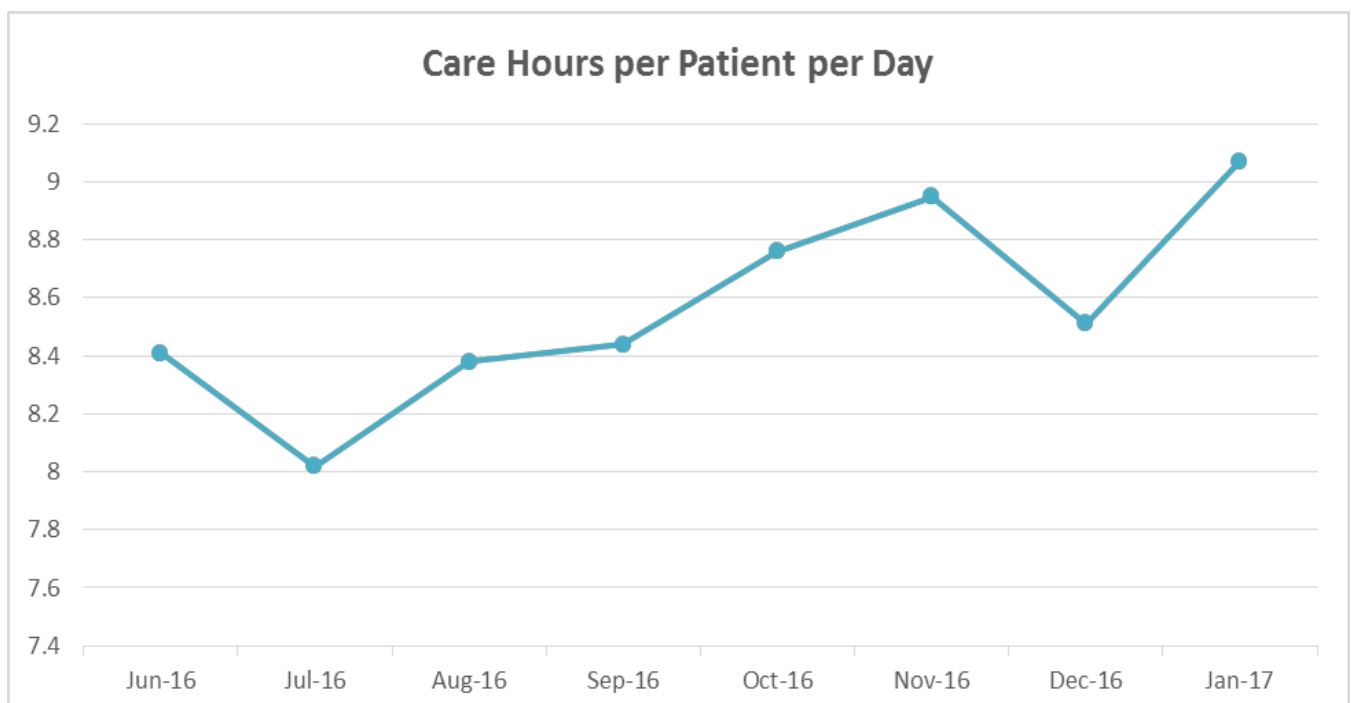
- 3.2. January has seen 8 wards utilised over 10% or more actual hours than they had planned, a reduction from December, with five wards recording over 40% above their planned hours. Sapphire ward has seen an increase in staff utilisation up to 100% above their planned activity of trained nurses. The Matron and senior sister are now using a more rigorous process to assess the mental health needs of the patients and together with the temporary staff bank are now utilising a CSW role to care for patients with more complex needs where appropriate.
- 3.3. Arethusa ward and McCulloch ward recorded the highest % above their planned for the month at 141% and 156% for Co Ordinated care. McCulloch ward had an increase in the number of patients with tracheostomies and an increase in the need for 1:1 care for a particular Medical patient. Sapphire and Byron ward for Acute and Continuing care had the highest % above planned, Sapphire as previously mentioned and Byron with 154% due to an increased need for 1:1 care.

- 3.4. Victory (cohort MRSA ward) recorded 75% above their planned for untrained staff, this is due to the utilization of CSWs for the night shifts to support the need for 1:1 care for some of their patients.
- 3.5. With the successful recruitment of CSWs to the Trusts staff bank, the plan going forward is to adopt a more robust assessment process for the ordering of registered mental health nurses. To adopt a systems whereby a pool of higher trained CSWs are available to cover 1:1 shifts caring for patients with greater needs.

CHPPD data

- 3.6. In response to the Carter review all Trusts are required to submit care hours per patient day (CHPPD) data. The overall figure for November is 9.79 this remains consistent with the data since reporting started earlier in the year. There remains a wide variance with the figures across wards and departments, with the Critical Care areas, The Birth Place and Delivery suite recording higher care hour's. Analysis of the data since recording starting shows that CHPPD data of individual wards and departments have been consistent. Please see figure 2 for the Trust overall CHPPD data

Figure 2 Overall Trust Score for Care hours per patient per day



4. HARM TO PATIENTS / PATIENT SAFETY

- 4.1. Falls data and Pressure data is included in the Integrated Quality and Performance Report.

Complaints

- 4.2. The Trust received ten complaints in January which related to nursing care issues only. In addition to this there were a further three complaints where nursing care issues were raised although this was not the main subject of the complaint. Please refer to the Integrated Quality and Performance Report.

5. RECOMMENDATIONS

- 5.1. The Board of Directors are asked to note the information contained in this summary report.
- 5.2. Future nursing workforce reports will form part of the Integrated Quality and Performance Report.

6. APPENDICES

- 6.1. Appendix One – UNIFY data – January 2017
- 6.2. Appendix Two – Nursing, Midwifery and Care Staff Return – January 2017

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

Org: RPA Medway NHS Foundation Trust
Period: January_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				Day		Night		Day		Night		Care Hours Per Patient Day (CHPPD)								
	Hospital Site Details		Ward name	Main 2 Specialities on each ward		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		Speciality 1	Speciality 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		1863.5	2,629	1,070	1,466	1,353	2,182	1,023	1,353	141.1%	136.9%	161.2%	132.3%	817	5.9	3.4	9.3
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Bronte WARD	340 - RESPIRATORY MEDICINE		1456	1,408	1,116	1,147	1,081	1,091	729	787	96.7%	102.7%	101.0%	108.0%	558	4.5	3.5	7.9
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Byron	430 - GERIATRIC MEDICINE		1404.5	2,156	1,100	1,359	1,035	1,841	1,029	1,330	153.5%	123.5%	177.9%	129.2%	752	5.3	3.6	8.9
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	CCU	320 - CARDIOLOGY		721.65	710	-	-	702	717	-	-	98.4%	-	102.2%	-	138	10.3	0.0	10.3
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Delivery	501 - OBSTETRICS		2969	2,895	606	535	2,976	2,934	516	480	97.5%	88.3%	98.6%	93.0%	0	-	-	-
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Dolphin (Paeds)	420 - PAEDIATRICS		3177.75	3,127	668	1,245	2,484	2,544	345	402	98.4%	186.3%	102.4%	116.4%	376	15.1	4.4	19.5
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Gundulph	300 - GENERAL MEDICINE		1889.5	1,771	1,679	1,284	1,331	1,354	1,353	1,278	93.8%	76.5%	101.7%	94.5%	734	4.3	3.5	7.7
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Harvey	328-STROKE MEDICINE		1185.75	1,402	1,638	1,398	1,035	1,250	1,046	1,031	118.3%	85.3%	120.8%	98.5%	763	3.5	3.2	6.7
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3550.5	3,789	-	-	3,123	3,487	-	-	106.7%	-	111.6%	-	275	26.5	0.0	26.5
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Keats	301 - GASTROENTEROLOGY	307-DIABETIC MEDICINE	1481.5	1,717	1,184	1,354	1,012	1,553	1,023	1,188	115.9%	114.4%	153.5%	116.2%	724	4.5	3.5	8.0
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Kent	501 - OBSTETRICS		1081.25	1,095	463	509	732	721	684	612	101.2%	110.0%	98.5%	89.5%	490	3.7	2.3	6.0
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Kingfisher SAU	100 - GENERAL SURGERY		1926.5	1,700	1,619	1,368	1,353	1,310	682	671	88.2%	84.5%	96.8%	98.4%	724	4.2	2.8	7.0
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Lawrence	823 - HAEMATOLOGY		1106.75	1,076	881	939	698	733	698	731	97.2%	106.6%	105.1%	104.8%	487	3.7	3.4	7.1
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	McCulloch	100 - GENERAL SURGERY		1439.5	2,252	1,074	1,510	1,012	1,821	1,023	1,409	156.4%	140.5%	179.9%	137.7%	924	4.4	3.2	7.6
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Medical HDU	192 - CRITICAL CARE MEDICINE		1438.5	1,347	353	337	1,070	1,050	357	351	93.6%	95.6%	98.1%	98.4%	176	13.6	3.9	17.5
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Milton	430 - GERIATRIC MEDICINE		1672.5	2,445	1,294	2,047	1,012	1,900	1,046	1,594	146.2%	158.2%	187.7%	152.4%	804	5.4	4.5	9.9
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Nelson	320 - CARDIOLOGY		1572.75	1,198	1,240	1,443	990	923	682	1,015	76.2%	116.3%	93.2%	148.8%	744	2.9	3.3	6.2
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	NICU	422-NEONATOLOGY		3604.75	3,712	423	138	3,565	3,613	-	-	103.0%	32.6%	101.3%	-	0	-	-	-
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Ocelot	502 - GYNAECOLOGY		909	928	525	877	745	794	384	780	102.1%	167.0%	106.6%	203.0%	357	4.8	4.6	9.5
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Pearl	501 - OBSTETRICS		1178	1,257	794	647	1,116	1,072	372	312	106.7%	81.4%	96.0%	83.9%	438	5.3	2.2	7.5
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Pembroke	110 - TRAUMA & ORTHOPAEDICS		1515	1,398	1,186	1,411	1,023	1,276	1,012	1,277	92.3%	118.9%	124.7%	126.1%	828	3.2	3.2	6.5
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Phoenix	100 - GENERAL SURGERY		1834.6	1,957	1,480	1,583	1,353	1,645	1,331	1,397	106.7%	107.0%	121.6%	105.0%	937	3.8	3.2	7.0
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Sapphire Ward	300 - GENERAL MEDICINE		1204.5	2,407	2,449	1,965	1,023	2,127	1,340	1,329	199.8%	80.2%	207.9%	99.2%	868	5.2	3.8	9.0
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	SDCC	100 - GENERAL SURGERY		2031	2,003	1,570	1,030	638	1,224	638	693	98.6%	65.6%	191.9%	108.6%	657	4.9	2.6	7.5
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Surgical HDU	192 - CRITICAL CARE MEDICINE		2136.6	2,110	381	343	1,694	1,811	-	11	98.8%	90.0%	106.9%	-	305	12.9	1.2	14.0
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Tennyson	430 - GERIATRIC MEDICINE		1583.666667	1,227	1,184	1,391	1,046	1,103	1,035	1,202	77.4%	117.5%	105.4%	116.1%	826	2.8	3.1	6.0
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	The Birth Place	501 - OBSTETRICS		1104.5	1,084	372	372	1,116	1,107	372	360	98.1%	100.0%	99.2%	96.8%	0	-	-	-
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Victory	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1134.916667	1,485	821	986	1,011	1,055	682	1,197	130.9%	120.1%	104.4%	175.4%	520	4.9	4.2	9.1
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Wakeley	300 - GENERAL MEDICINE		1948.5	1,626	1,586	1,530	1,328	1,350	1,373	1,286	83.4%	96.5%	101.7%	93.7%	766	3.9	3.7	7.6
	RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Will Adams	301 - GASTROENTEROLOGY	307-DIABETIC MEDICINE	1551.966667	1,662	1,150	1,343	1,023	1,330	1,012	1,487	107.1%	116.8%	130.0%	146.9%	806	3.7	3.5	7.2

Fill rate indicator return																																			
Staffing: nursing, midwifery and care staff																																			
Jan-16																																			
			Day				Night				Day		Night		Quality Metrics / Actual Incidents						Associate Chief Nurse (Divisional) review				Internal KPIs				Care Hours Per Patient Day (CHPPD)						
			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 with/moderate to severe harm	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 %	Difference total Actual vs Planned %	Cumulative count over the month of patients at 23:59 each day	Registered midwives / Nurses	Care Staff	Overall				
Directorate	WARD	Beds																																	
Acute & Continuing Care	Bronte Ward	18	1456	1408	1116	1147	1081	1091	729	787	97%	103%	101%	106%	0	0	0	1	0		Bronte is always over 100% as it is staffed to ensure there is cover for the NIV patients who are nursed on the ward		4,382	4,432	101%	51	1%	558	4.48	3.46	7.94				
Acute & Continuing Care	Byron Ward	26	1405	2156	1100	1359	1035	1841	1029	1330	154%	123%	178%	129%	0	0	0	0	1		Above due to RMN's		4,569	6,686	146%	2,117	46%	752	5.32	3.57	8.89				
Acute & Continuing Care	CCU	4	722	710	0	0	702	717	0	0	98%		102%		0	0	0	0	0				1,423	1,427	100%	4	0%	138	10.34	0.00	10.34				
	Gundulph																																		
Acute & Continuing Care		25	1890	1771	1679	1284	1331	1354	1353	1278	94%	76%	102%	94%	0	0	0	0	1				6,252	5,687	91%	-	565	-9%	734	4.26	3.49	7.75			
	Harvey Ward																				Harvey has required additional support to manage the dependency of patients. They have needed a tracheostomy trained nurse to support 2 patients across the month. Staff on the ward have been undergoing competencies, however due to annual leave there has been a reduced number of substantive staff available to cover the shifts. The Senior Sister and the Matron have worked clinically to support the ward and Critical care have supported the ward.		4,905	5,081	104%	176	4%	763	3.48	3.18	6.66				
Acute & Continuing Care		24	1186	1402	1638	1398	1035	1250	1046	1031	118%	85%	121%	99%	5	1	0	0	0				4,905	5,081	104%	176	4%	763	3.48	3.18	6.66				
Acute & Continuing Care	Keats Ward	27	1482	1717	1184	1354	1012	1553	1023	1188	116%	114%	153%	116%	1	0	0	1	0		Above due to RMN's		4,700	5,812	124%	1,112	24%	724	4.52	3.51	8.03				
Acute & Continuing Care	Lawrence Ward	19	1107	1076	881	939	698	733	698	731	97%	107%	105%	105%	0	0	0	0	0		There is a shortfall in the number of trained chemotherapy nurses. The Senior Sister, the PDN and the Clinical Lead support the ward when there is a shortfall in specific staff.		3,383	3,479	103%	97	3%	487	3.71	3.43	7.14				
Acute & Continuing Care	Milton Ward	27	1673	2445	1294	2047	1012	1900	1046	1594	146%	158%	188%	152%	0	1	0	0	0		Above due to RMN's		5,025	7,986	159%	2,962	59%	804	5.40	4.53	9.93				
	Nelson Ward																				Nelson ward has had some sickness and staff leaving over January. They have also had new starters who are working in a super numary capacity, so although they are on the ward and supporting the patients they are not reflected in the safe care numbers. The Senior Sister works clinically to support the new staff and the ward at times of great pressure		4,485	4,578	102%	93	2%	744	2.85	3.30	6.15				
Acute & Continuing Care		24	1573	1198	1240	1443	990	923	682	1015	76%	116%	93%	149%	0	0	0	0	0				4,485	4,578	102%	93	2%	744	2.85	3.30	6.15				
	Sapphire Ward																				Sapphire Ward continues to function on mainly agency staff, however these staff are block booked and are integrated as part of the team. There has been at times over the month, gaps between the hours of 5 and 8 pm. When this happens, the patinet acuity is reviewed and if needed the late bleep holder will support the ward		6,017	7,828	130%	1,811	30%	868	5.22	3.79	9.02				
Acute & Continuing Care		28	1205	2407	2449	1965	1023	2127	1340	1329	200%	80%	208%	99%	0	0	0	0	0				6,017	7,828	130%	1,811	30%	868	5.22	3.79	9.02				
Acute & Continuing Care	Tennyson Ward	27	1584	1227	1184	1391	1046	1103	1035	1202	77%	117%	105%	116%	0	0	0	0	0		Above due to RMN's		4,849	4,921	101%	73	1%	826	2.82	3.14	5.96				
	Wakeley Ward																				There continues to be a number of shifts unfilled by agency/staff bank. Matrons, working with the Senior Sister to review the week going forward and escalating to bank as an area of high risk. However there has remained a poor fill rate. The ward is working at a 1-8 at most times but due to the high turnover of patients daily there should be a higher RN/patient ratio. Staff moved to accommodate from areas where staffing is at a rate above a 1.8.		6,234	5,792	93%	-	442	-7%	766	3.88	3.68	7.56			
Acute & Continuing Care		25	1949	1626	1586	1530	1328	1350	1373	1286	83%	96%	102%	94%	0	1	0	0	0				6,234	5,792	93%	-	442	-7%	766	3.88	3.68	7.56			
Acute & Continuing Care	Will Adams Ward	26	1552	1662	1150	1343	1023	1330	1012	1487	107%	117%	130%	147%	1	1	0	0	1		Above due to RMN's		4,736	5,822	123%	1,085	23%	806	3.71	3.51	7.22				
Co-ordinated Surgical	Arethusa Ward	27	1864	2629	1070	1466	1353	2182	1023	1353	141%	137%	161%	132%	0	1	1	0	0		Due to patientswho had greater care needs an increase in staff was required to minimise the risk		5,310	7,629	144%	2,319	44%	817	5.89	3.45	9.34				
																					Critical Care staffing was increased due to level 2 and leve. 3 patients being cared for in other clinical areas		6,674	7,276	109%	602	9%	275	26.46	0.00	26.46				
Co-ordinated Surgical	ICU	9	3551	3789	0	0	3123	3487	0	0	107%		112%		0	1	0	0	0				6,674	7,276	109%	602	9%	275	26.46	0.00	26.46				
Co-ordinated Surgical	Kingfisher SAU	14	1927	1700	1619	1368	1353	1310	682	671	88%	85%	97%	98%	1	0	1	0	0		Due to the Surgical assessment area being used as a bedded area, staff can be used flexibly within the directorate		5,580	5,048	90%	-	532	-10%	724	4.16	2.82	6.97			
Co-ordinated Surgical	McCulloch Ward	24	1440	2252	1074	1510	1012	1821	1023	1409	156%	141%	180%	138%	0	1	0	0	0		A number of patients were vulnerable and this increased the need for one to one nursing to minimise the risk		4,549	6,991	154%	2,442	54%	924	4.41	3.16	7.57				
Co-ordinated Surgical	Medical HDU	6	1439	1347	353	337	1070	1050	357	351	94%	96%	98%	98%	0	0	0	0	0		Staffing ratios are acceptable for level of patients nursed within this area		3,217	3,084	96%	-	133	-4%	176	13.61	3.91	17.52			
Co-ordinated Surgical	Pembroke Ward	27	1515	1398	1186	1411	1023	1276	1012	1277	92%	119%	125%	126%	0	0	0	0	0		Staff within the orthopaedic wards work flexibly to ensure safe staffing		4,736	5,361	113%	625	13%	828	3.23	3.25	6.47				
Co-ordinated Surgical	Phoenix Ward	30	1835	1957	1480	1583	1353	1645	1331	1397	107%	107%	122%	105%	0	4	0	0	1		A number of patients were vulnerable and this increased the need for one to one nursing to minimise the risk		5,999	6,583	110%	583	10%	937	3.84	3.18	7.03				
Co-ordinated Surgical	SDCC	26	2031	2003	1570	1030	638	1224	638	693	99%	66%	192%	109%	3	0	0	0	0		Due to operational pressures 12 unfunded beds are open		4,877	4,950	101%	73	1%	657	4.91	2.62	7.53				
Co-ordinated Surgical	Surgical HDU	10	2137	2110	381	343	1694	1811	0	11	99%	90%	107%		0	0	0	0	0		Staffing ratios are acceptable for level of patients nursed within this area		4,211	4,274	101%	63	1%	305	12.86	1.16	14.01				
Co-ordinated Surgical	Victory Ward	18	1135	1485	821	986	1011	1055	682	1197	131%	120%	104%	175%	1	0	0	0	0		A number of patients were vulnerable and this increased the need for one to one nursing to minimise the risk		3,649	4,723	129%	1,074	29%	520	4.89	4.20	9.08				
Women & Childrens	Delivery Suite	15	2969	2895	606	535	2976	2934	516	480	98%	88%	99%	93%	3	0	0	0	1		Staff moved across the unit to meet the acuity		7,067	6,843	97%	-	223	-3%	0						
Women & Childrens	Kent Ward	24	1081	1095	463	509	732	721	684	612	101%	110%	98%	89%	0	0	0	0	0		Stafff moved across the unit to meet the acuit		2,960	2,937	99%	-	23	-1%	0						
Women & Childrens	NICU	25	3605	3712	423	138	3565	3613	0	0	103%	33%	101%		2	0	0	0	0		staffing levels safe for this unit		7,593	7,463	98%	-	130	-2%	0						
Women & Childrens	Ocelot Ward	12	909	928	525	877	745	794	384	780	102%	167%	107%	203%	0	0	0	0	0		Extra HCA booked to support medical outliers		2,563	3,378	132%	816	32%	357	4.82	4.64	9.46				
Women & Childrens	Dolphin (Paeds)	34	3178	3127	668	1245	2484	2544	345	402	98%	186%	102%	116%	0	0	0	0	0		staffing levels safe for this unit		6,675	7,317	110%	643	10%	376	15.08	4.38	19.46				
Women & Childrens	Pearl Ward	23	1178	1257	794	647	1116	1072	372	312	107%	81%	96%	84%	2	0	0	0	0		Staff moved across the unit to meet the acuit		3,460	3,287	95%	-	173	-5%	438	5.32	2.19	7.51			
Women & Childrens	The Birth Place	9	1105	1084	372	372	1116	1																											

Board Report

Report date: 2nd March 2017

Title of Report	Report of the Director of Finance
Presented by	Darren Cattell, Director of Finance
Lead Director	Darren Cattell, Director of Finance
Committees or Groups who have considered this report	Executive Group Finance Committee
Executive Summary	<p>The Finance Committee considered this report on the 23rd February 2017.</p> <p>For Board assurance, the Chair of the Finance Committee has provided a summary of the key finance related issues discussed and agreed at the meeting elsewhere on this agenda.</p> <p>This report outlines;</p> <ol style="list-style-type: none"> 1. Summary Trust financial performance for M10, January 2017 2. End of year risk to Income and Expenditure Forecast 3. Capital reforecast 4. CIP update 5. Update on 2017-19 Contracting with Commissioners 6. Update on Corporate Services Consolidation (Back office) under the Productivity work stream of the STP 7. Update on 2016-17 CCG contract <p>1.Trust Financial Performance</p> <p>The key drivers for the months financial performance are outlined in the IQPR on this agenda and are the same as reported in previous months:</p> <ul style="list-style-type: none"> • Emergency Department (ED) attendances and subsequent admissions running above planned and previous months levels • Elective Patient activity pause and the loss of income/contribution • High cost Agency staff, particularly Doctors and Nurses and high volume Agency usage for Admin and Clerical staff

Key points on the financials are:

- In summary the Trust delivered an in month performance **out of line** with the plan for the first time. Year to date this is a value of a £320k deficit above the plan of the £36m deficit.
- The Elective income shortfall is between £250-£300k per week so for January the impact of this was £1m
- Additional Emergency activity is at a premium (Agency) cost. In addition income for this activity is only seen at 70% of tariff, a loss of c£0.4m however emergency income has been higher than expected for January and more than offsets the lack of elective income.
- With the above in month broadly compensating events, simply the variance to plan was made up of two factors
 - Agency costs in the Acute and Continuing Care Directorate (£400k)
 - Unachieved CIPs in the Coordinated Surgical Care Directorate (£200k)
- Both clinical Directorates have been asked to produce a recovery plan to be presented at the next Directorate PRM

2. End of year risk to forecast

- In month, for the first time this financial year the Trust has reported a non achievement of the phasing of the £43.8m deficit plan.
- The risk to achievement of the year end financial plan is now real for the reasons outlined above.
- At M10, the Executive report that the forecast for the end of year is a deficit of between £44.4m and £46.6m.
- The main reasons for this are
 - Net estimated impact of elective pause (c£1.0m)
 - Loss of mediation on contract dispute (£0.8m)
- The most likely forecast based on what we know at month 9 is a deficit of c£2.4m above the stretch target of £43.8m
- This is still within the Control Total and the **Finance Committee agreed that the Control Total is the ABSOLUTE must achievement for the Trust.**
- The Executive Team will refine the forecast each month now until the year end and report this to the Finance Committee and the Board.
- **Recovery actions are being agreed, these were discussed at the Finance Committee and include;**
 - Immediate elective IP activity outsourcing
 - Plan to return to a 75% level of internal elective activity
 - Immediate enhanced ERoster controls
 - Staff wte review in key staff groups
 - Medium to long term refinement of bed base

3. Capital Reforecast

- At M9 the Executive undertook a revised forecast for capital spend for the year ending 2016-17.
- This was reported to the Finance Committee where it was supported and this was reported to the February Board.
- In summary this was a forecast spend of c£18m against an original plan of c£28m.
- Members will recall the major reasons for the variances were explained
- The Executive have reviewed this forecast and presented this to the Finance Committee and assurance was provided that **this was still the most realistic forecast** following operational input into planned spending levels
- The Finance Committee were assured that capital cash was available to finance this planned spending level
- The Finance Committee will review this forecast at the next meeting and a further update will be provided to the Board

4. CIP performance update

- The Finance Committee received a report that outlined the current end of year forecast on CIP achievement is £10.9m against a plan of £12.6m
- It was explained that this number was expected to increase over the last few weeks of the year as more schemes were realised
- The FD explained that there was a remaining inflation reserve that could be used to offset any CIP shortfall at year end
- The Finance Committee stated that CIP performance was stronger than in previous years and were assured that any shortfall would be managed in year
- The Finance Committee requested an update on 2017-18 CIP planning at the next meeting.
- The current forecast end of year CIP performance is outlined in the appendices.

5. Update on 2017-19 Contracting with Commissioners

- The Trust continues to progress the jointly agreed action orientated work plan with the CCG
- Progress is slower than we expected with this and this has been escalated to the CCG to ensure the right and appropriate decision makers are available
- Financial risk for 2017-18 is currently being quantified and will be reported to the Finance Committee as part of the requested Business Planning update.

6. Update on Corporate Services (Back Office) under STP

- Progress continues to be made;
 - Establishment of a financial investment and savings framework across the STP footprint
 - Setting up of “project structures and resources” to take forward key initiatives

	<ul style="list-style-type: none"> ○ Productivity analysis completed and work streams identified ○ Corporate Services consolidation continues although progress is a little slower than expected <p>7. Update on 2016-17 CCG contract</p> <ul style="list-style-type: none"> • The CEO has signed the 2016-17 CCG contract having come under increasing pressure from all stakeholders • The funding for the one outstanding issue has still not been agreed to the Trusts satisfaction but will be considered by the Trust and the CCG as part the end of year settlement process. It will also be taken forward under commissioning clarity into the 2017-19 contract. The contracting team are in discussion with the responsible operational team and are constructing a case to present to the CCG and NHSE.
Resource Implications	As outlined
Risk and Assurance	<ul style="list-style-type: none"> • The high level of ED demand is creating multiple knock on adverse effects on the Trust's financial position such as the reliance on premium rate agency staff at short notice, the displacement of elective capacity by emergency patients, the increase in non-elective admissions which attract only a marginal tariff and additional unexpected demand pressures on achieving both our ED access and RTT targets. This is likely to lead to financial risk in achieving the Sustainability and Transformation Fund (STF), the financial plan stretch target deficit as well as a number of key quality standards. The Board is asked to note that mitigating work continues with the CCGs to identify actions to reduce the demand impact, however currently the impact is low. The financial risk to the end of year plan is high and likely as outlined in the report. Executive Director Colleagues continue to manage the quality risks on a daily basis, this is reported elsewhere on this agenda. • A number of Trust Directorates/Services are financially performing ahead of plan. A smaller number are not. The risk is currently mitigated by other areas where they are ahead of plan. The Board is asked to note those areas behind plan have been agreed with Directorates as part of the PRM process and a rectification plan for each is being prepared. • In Q4 the financial risk associated with a lack of full CIP plans will rise. A CIP forecast has been produced and corrective actions expected. All CIP actions will be subject to a full Quality Impact Analysis (QIA)

	<p>process. The monthly reforecast exercise will continue to highlight any CIP shortfall in the report to the Board.</p> <ul style="list-style-type: none"> • A current reputational and financial risk is the Agency cost above cap and outside of framework. Our current usage and cost is above expected levels. This remains a high and likely risk to our loan conditions. The Board is asked to note that mitigation includes close working with NHSI in the short term to agree improvement actions.. Short term control and reporting actions have commenced including enhanced controls under ERostering our Nurse staffing rostering system. An update on the recruitment and retention actions is provided in the HRDs report. All actions will be subject to a full QIA process. • A rising risk to report is a lack of formal agreement to payment to all activity performed by the Trust due to a lack of contract agreement with the North Kent Commissioners. The Board is asked to note that the Executive continue to work closely with Commissioners to mitigate this risk by agreeing payment plans for activity. • Inefficient use of Trust resources remains a risk due to assurance gaps in the financial controls environment. The Board is asked to note that work has already commenced to enhance the financial controls environment as part of the Trust Financial Recovery Plan and will further roll out through the Winter 2016. • Trust infrastructure and estate remains a risk due to age and condition. The Board is asked to note that improvements have already commenced on both minor and major works, including ED. Operational staff are involved in these improvements, communications have been increased to outline timescales for the improvements. Risk assessments are now completed for areas and action plans are being developed.
Legal Implications/Regulatory Requirements	<p>Lack of achievement of the agreed control total will lead to Further Regulatory actions.</p> <p>Inappropriate Estate and insufficient Facilities lead to higher than acceptable risk to Patients, visitors and staff and could lead to further regulatory action.</p>
Recovery Plan Implication	<p>Financial Recovery is one of the nine programmes of Phase 2</p>

	Recovery.
Quality Impact Assessment	All actions will follow an appropriate QIA process
Recommendation	The Board is asked to note the report
Purpose & Actions required by the Board :	<div>Approval</div> <input type="checkbox"/> <div>Assurance</div> <input type="checkbox"/> <div>Discussion</div> <input type="checkbox"/> <div>Noting</div> <input checked="" type="checkbox"/>

Finance Report - APPENDICES

Month 10

2016/17

Finance Report for January 2016

1. Liquidity

- a. Cash Flow
- b. Loan Conditions

2. Financial Performance

- a. Consolidated I&E
- b. Run Rate Analysis - Financial
- c. Clinical Activity
- d. Clinical Income
- e. Workforce
- f. Run rate analysis Pay

3. Balance Sheet

- a. Balance Sheet
- c. Creditors

4. Capital

- a. Capital Summa

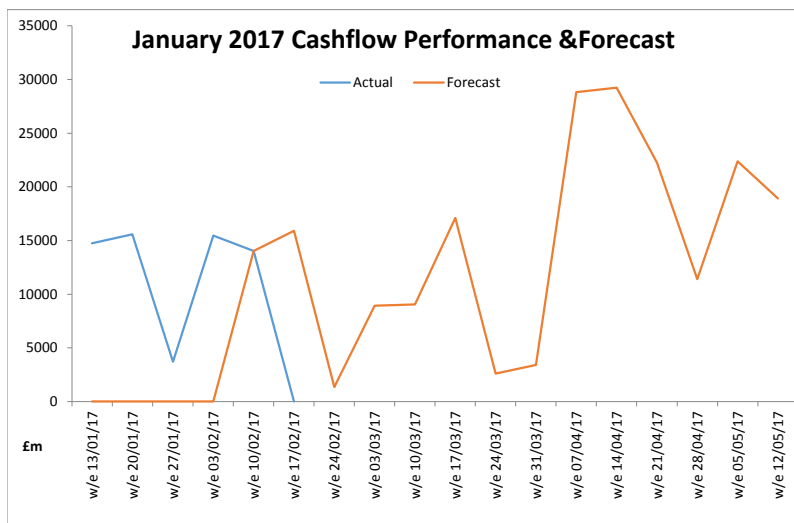
2. Liquidity

1a. Cash Flow

14 Week Forecast

£m	Actual				Forecast													
	w/e 13/01/17	w/e 20/01/17	w/e 27/01/17	w/e 03/02/17	w/e 10/02/17	w/e 17/02/17	w/e 24/02/17	w/e 03/03/17	w/e 10/03/17	w/e 17/03/17	w/e 24/03/17	w/e 31/03/17	w/e 07/04/17	w/e 14/04/17	w/e 21/04/17	w/e 28/04/17	w/e 05/05/17	w/e 12/05/17
BANK BALANCE B/FWD	14.64	14.75	15.57	3.71	15.46	14.04	17.60	3.58	4.16	3.69	15.75	0.87	1.43	27.11	27.62	20.51	9.65	21.23
Receipts																		
NHS Contract Income	3.07	1.84	0.13	14.29	0.88	3.10	0.49	2.90	0.11	4.48	0.00	0.85	28.76	3.88	0.00	0.00	14.62	0.00
Other	0.38	2.26	0.24	0.37	0.59	1.48	0.30	0.35	0.72	1.39	0.30	0.30	0.20	0.76	1.95	0.25	0.25	0.67
Total receipts	3.45	4.10	0.38	14.67	1.47	4.57	0.79	3.25	0.83	5.87	0.30	1.15	28.96	4.64	1.95	0.25	14.87	0.67
Payments																		
Pay Expenditure (excl. Agency)	0.00	(5.94)	(7.80)	(0.02)	0.00	(2.22)	(11.60)	(0.03)	0.00	(2.19)	(11.56)	(0.03)	0.00	0.00	(5.92)	(7.85)	0.00	0.00
Non Pay Expenditure	(3.34)	(3.61)	(4.43)	(0.71)	(2.89)	(2.05)	(3.20)	(0.69)	(2.65)	(2.65)	(3.18)	0.16	(3.28)	(4.12)	(3.15)	(3.26)	(3.28)	(4.12)
Capital Expenditure	0.00	0.00	0.00	(2.20)	0.00	0.00	0.00	(1.96)	0.00	0.00	0.00	(1.51)	0.00	0.00	0.00	0.00	0.00	0.00
Total payments	(3.34)	(9.55)	(12.23)	(2.92)	(2.89)	(4.27)	(14.80)	(2.68)	(2.65)	(4.83)	(14.74)	(1.39)	(3.28)	(4.12)	(9.07)	(11.11)	(3.28)	(4.12)
Net Receipts/ (Payments)	0.11	(5.45)	(11.86)	11.75	(1.42)	0.31	(14.02)	0.58	(1.82)	1.04	(14.44)	(0.24)	25.68	0.51	(7.12)	(10.86)	11.58	(3.46)
Funding Flows																		
FTFF/DOH - Revenue	0.00	6.27	0.00	0.00	0.00	3.25	0.00	0.00	0.00	6.14	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FTFF/DOH - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.85	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
STF Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	4.20	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.35	0.92	0.00	0.80	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.43)	(0.44)	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	(0.65)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	0.00	6.27	0.00	0.00	0.00	3.25	0.00	0.00	1.35	11.02	(0.44)	0.80	0.00	0.00	0.00	0.00	0.00	0.00
BANK BALANCE C/FWD	14.75	15.57	3.71	15.46	14.04	17.60	3.58	4.16	3.69	15.75	0.87	1.43	27.11	27.62	20.51	9.65	21.23	17.78

Fig1. Cashflow Forecast



Commentary

The opening cash balance for January 2017 was £1.64m, closing balance was £3.5m. This cash holding exceeds the minimum liquidity level (£1.4m) required by DH by £2.1m. The excess cash balance is mainly due to a higher loan drawdown in the month, which has not been fully utilised to settle creditors. Processes are currently being reviewed to ensure the cash holding is similar to the required level of £1.4m.

The graph shows actual cashflow for January and projected weekly cashflow for up to and including 12 May 2017

Receipts in the month were £23.3m and loans & funding received was £6.3m, therefore total cash inflows for January was £29.6m. Payments, including capital in the month were £27.7m.











The Trust has received £37.2m of deficit loan funding YTD which includes £21.3m working capital facility recently converted to a lower interest rate loan and £15.9m in uncommitted loans. As the Trust is permitted to drawdown up the level of the deficit this leaves £9.4m remaining, this will be fully utilised in February and March. In addition to the deficit loan the Trust has also received £3.7m STF YTD, the total funding is expected to be £9.4m. £4.2m of this will be received in March, the remaining balance relates to an underpayment for Q1 & Q2 which has been successfully appealed. Confirmation on when payment is expected has been requested.

Monthly payments for 16/17 have averaged at £26.9m, 55% relating to payroll costs. £8.4m per month for direct salary payments and £5.9m employer costs. Monthly receipts (excluding loans & STF) for 16/17 have averaged at £23m, it should be noted that this includes a double contract payment from the main CCGs in April but monthly payments at 15/16 contract rates due to the 2016/17 contract not being agreed. YTD the monthly shortfall has therefore averaged at £3.9m.

As we draw close to the financial year end and to the limit of the deficit loan the March cashflow forecast is tight and payments will need to be managed carefully to maintain the £1.4m required by DH at the end of the year. In addition the timely conclusion of year-end settlements with the Commissioners will help the cash position.

1b. 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 reported a V3 plan on 29 June in line with new control totals. NHSI/DH are aware of revenue and capital funding required in 16/17			Trust is reporting an operating deficit within V3 of the plan
8 – 2	Agency nursing procured through approved frameworks and within maximum cap	Immediately	Notice given to agencies breaching the cap. Action plan in place to substitute the non-framework agency nurses with bank and framework workers.			All non-framework usage to be eliminated by 1st April 2017.
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			Review due to finish by end of February 2017.
8 – 5	Review / benchmarking of Estates and Facilities costs	31st May 2017	In progress			We are benchmarking via the annual ERIC return as well as against live information on the Model Hospital portal.
8 – 6	Produce an Estates strategy	Summer 2017	In progress			Estates strategy is moving at pace but is an emerging and changing strategy and 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 now been engaged to undertake a review of processes and will be at the Trust during November 2016
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	On-going			

2. Financial Performance

2a. Consolidated Income & Expenditure

Consolidated I&E (January 2017)

	Current Month			Year to Date			Annual		
	Actual	Plan	Variance	Actual	Plan	Variance	Forecast	Plan	Variance
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical income	19,642	18,530	1,112	189,787	186,582	3,205	226,751	222,722	4,029
High Cost Drugs	1,809	1,770	39	17,327	17,260	67	21,016	20,785	231
STF Income	700	700	0	7,404	7,000	404	9,400	8,400	1,000
Other Operating Income	2,344	1,985	359	20,339	19,769	570	24,488	23,729	759
Total Revenue	24,495	22,985	1,511	234,857	230,611	4,246	281,655	275,636	6,019
Expenditure									
Substantive	-13,784	-15,711	1,927	-136,583	-156,549	19,967	-164,231	-187,959	23,728
Bank	-712	-140	-572	-6,721	-2,888	-3,832	-8,005	-3,224	-4,781
Agency	-3,936	-1,261	-2,675	-33,090	-14,021	-19,069	-39,751	-16,652	-23,099
Total Pay	-18,432	-17,112	-1,320	-176,393	-173,459	-2,934	-211,987	-207,834	-4,153
Clinical supplies	-2,923	-2,783	-141	-31,084	-28,748	-2,336	-37,595	-34,309	-3,286
Drugs	-2,497	-2,714	217	-25,009	-25,274	265	-30,060	-29,898	-162
Consultancy	-145	-18	-127	-462	-911	449	-692	-939	247
Other non pay	-3,086	-2,697	-389	-27,666	-27,556	-110	-32,851	-33,474	623
Total Non Pay	-8,651	-8,211	-440	-84,221	-82,490	-1,731	-101,198	-98,620	-2,578
Total Expenditure	-27,083	-25,323	-1,760	-260,614	-255,949	-4,665	-313,185	-306,454	-6,731
EBITDA	-2,589	-2,338	-250	-25,757	-25,338	-419	-31,530	-30,819	-711
	-11%	-10%	-17%	-11%	-11%	-10%	-11%	-11%	-12%
Post EBITDA									
Depreciation	-770	-792	22	-8,067	-8,084	17	-9,693	-9,693	0
Interest	-198	-197	-1	-1,541	-1,619	78	-2,021	-2,021	0
Dividend	-119	-109	-10	-1,170	-1,089	-81	-1,307	-1,307	0
Profit on sale of asset	0	0	0	85	0	85	85	0	85
	-1,087	-1,098	11	-10,693	-10,792	99	-12,936	-13,020	84
Net (Surplus) / Deficit	-3,676	-3,436	-240	-36,450	-36,130	-320	-44,467	-43,839	-628
Adjustments (donations/asset disposal)	22	13	9	-165	129	-294	-170	153	-323
Net (Deficit) Adjusted	-3,654	-3,423	-231	-36,615	-36,001	-614	-44,637	-43,686	-951

Please note, the adjusted deficit reflects the Trusts performance against the NHSi control totals.

Commentary
Net (Surplus) / Deficit and Forecast Outturn
The Trust reported a £3.7m deficit in month 10, adverse to plan by £0.2m. As at month 10 the Trust's annual forecast deficit for the year remains at the same level reported in month 9 at £44.5m. The FOT is £0.6m adverse to plan but remains below the Trust's control total of £46.6m (CT) and assumes additional funding from NHSi of £1m as the forecast is to deliver £1m better than our CT. A detailed forecast outturn (FOT) has been prepared and the Trust is required to closely monitor the FOT for the remainder of the year due to the material income risks. Worse case FOT assuming STF is not received, arbitration and contract challenges not successful is £4.2m adverse to plan. Best case FOT is £2.8m favourable to plan assuming an improved position is achieved on clinical income.
Clinical Income
A&E attendances continue with high volumes month on month, seeing a 12% increase compared to January 2016. The YTD comparison between 16/17 and 15/16 is a13% increase. EL & DC activity during January has significantly reduced from November due to high levels of emergency demand. There has also been an acuity change within A&E from minor injuries to more complex presentations. Excess bed days have continued to under perform against plan due to the impact of the medical model and the reduction of length of stay within the emergency pathway.
Meetings are scheduled with Commissioners to negotiate year-end settlements.
Other Operating Income
Other income YTD is favourable to plan mainly due to increased activity in the A&CC Directorate (increased pathology tests to other providers) and W&C Directorate for additional care packages.
Pay
Pay expenditure is £1.3m adverse to plan in month mainly due to CIP non delivery, agency costs due to increased acuity of patients and pending recruitment and enhancements paid relating to the previous months holiday period. YTD is adverse by £2.9m mainly due to CIP non delivery and premium agency costs. The agency improvement plan is in the process of being developed and the Trust is required to closely monitor expenditure over the remainder of the year.
Non Pay
Clinical supplies in month are adverse to plan mainly due to increased activity offset by CIP delivery. YTD is adverse to plan mainly due to external outsourcing to improve RTT performance, additional expenditure on supplies due to increased activity offset by CIP delivery. Expenditure on drugs is favourable to plan in month and YTD mainly due to CIP delivery and reduced planned activity.
CIP
The Trust has delivered £9.1m CIP as per plan and the FOT assumes £12.6m delivery as per plan.
Directorate Reports
The income and expenditure position by Directorate is detailed later in the report.
Risks and Mitigations
There is a risk of continuing reduced planned elective and day case activity due to the pressure of emergency flows during winter months which has already resulted in a substantial reduction in clinical income during December and January. The revised FOT assumes income levels similar to January adjusted for working days. Directorate recovery plans are being monitored at the PRIM. A high level of CIP remains unidentified in the Surgical and Estates and Facilities Directorates and continues to be challenged at the PRIM. This is mitigated by increased CIP delivery on drugs and clinical supplies, underspends in other areas and reserves.
Sustainability & Transformation funding will be contingent upon achievement of the agreed performance trajectories. The Trust is currently not meeting the agreed A&E, RTT and Cancer improvement trajectory but as per the STF guidance the growth has been raised with the CCG and an appeal sent to NHSi for Q1 and Q2.
The clinical income contract with the main Commissioners is yet to be finalised. Arbitration papers have been submitted to NHSi and the Trust awaits the outcome.

2b. Run Rate Analysis - Financial

Analysis of 15 monthly performance - Financials

	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue															
Clinical income	17.3	16.7	16.8	16.9	21.9	16.9	16.9	22.1	19.2	17.9	19.3	19.9	19.5	18.4	19.6
High Cost Drugs	1.6	1.7	1.7	1.7	1.7	1.8	1.6	1.8	1.7	1.6	2.0	1.8	1.7	1.5	1.8
STF Income						0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7
Other Operating Income	2.0	1.9	1.9	2.4	2.0	1.9	2.1	2.3	2.1	2.0	2.2	2.0	1.8	2.1	2.3
Total Revenue	20.8	20.3	20.4	20.9	25.6	21.4	21.3	26.9	23.7	22.2	24.2	24.4	23.6	22.6	24.5
Expenditure															
Substantive	-12.9	-12.8	-13.1	-13.1	-12.9	-13.5	-13.5	-13.7	-13.6	-13.7	-13.7	-13.6	-14.0	-13.6	-13.8
Bank	-0.6	-0.6	-0.6	-0.6	-0.8	-0.6	-0.5	-0.6	-0.8	-0.7	-0.6	-0.6	-0.9	-0.8	-0.7
Agency	-2.4	-3.6	-2.7	-3.0	-2.8	-2.6	-2.8	-3.6	-2.8	-3.1	-3.6	-3.5	-3.8	-3.5	-3.9
Total Pay	-15.8	-17.0	-16.4	-16.7	-16.5	-16.8	-16.8	-17.9	-17.2	-17.5	-17.9	-17.7	-18.6	-17.9	-18.4
Clinical supplies	-2.9	-3.0	-2.7	-3.1	-3.6	-3.2	-3.4	-3.4	-3.4	-3.3	-3.2	-2.8	-2.7	-2.8	-2.9
Drugs	-2.4	-2.4	-2.4	-2.4	-2.6	-2.7	-2.9	-2.7	-2.5	-2.7	-2.8	-2.5	-2.1	-1.7	-2.5
Consultancy	-0.1	-0.1	-0.2	-0.2	-0.1	0.0	-0.1	0.0	-0.1	0.0	-0.1	0.0	0.1	0.0	-0.1
Other non pay	-2.5	-2.7	-2.9	-2.8	-2.7	-2.9	-2.4	-2.9	-2.6	-2.6	-2.4	-2.9	-3.0	-3.0	-3.1
Total Non Pay	-7.9	-8.3	-8.1	-8.5	-9.0	-8.8	-8.8	-9.0	-8.6	-8.6	-8.5	-8.2	-7.8	-7.4	-8.7
Total Expenditure	-23.8	-25.4	-24.5	-25.2	-25.5	-25.6	-25.6	-26.9	-25.8	-26.1	-26.4	-25.9	-26.4	-25.3	-27.1
EBITDA	-3.0	-5.1	-4.1	-4.3	0.1	-4.2	-4.3	0.0	-2.1	-3.9	-2.2	-1.5	-2.8	-2.7	-2.6
Post EBITDA															
Depreciation	-0.9	-0.9	-0.9	-0.9	-0.3	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.9	-0.8	-0.8
Interest	-0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
Dividend	-0.3	-0.3	-0.3	-0.3	0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Fixed Asset Impairment	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Profit on sale of asset	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0
	-1.3	-1.3	-1.3	-1.3	0.0	-1.0	-1.0	-1.0	-1.0	-1.1	-1.1	-1.0	-1.2	-1.1	-1.1
Net Surplus / (Deficit)	-4.3	-6.3	-5.4	-5.6	0.1	-5.3	-5.3	-1.0	-3.1	-5.0	-3.3	-2.5	-3.9	-3.8	-3.7
Revaluation Gain	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus / (Deficit)	-4.3	-6.3	-5.4	-5.6	0.4	-5.3	-5.3	-0.9	-3.1	-5.0	-3.1	-2.4	-3.9	-3.8	-3.7

2c. Clinical Activity

Clinical Activity by Point of Delivery (January 2017)

	Current Month			Prior Year In Month	Year to Date			Prior Year YTD
	Actual	Plan	Variance	Actual	Actual	Plan	Variance	Actual
PBR								
Elective Day Case	1,712	1,707	5	1,684	18,931	17,738	1,193	16,392
Elective Inpatient	323	600	-277	581	5,769	6,132	-363	5,843
Non Elective Inpatient	3,700	4,417	-717	4,333	39,581	39,642	-61	38,881
Excess Bed Days	1,820	1,536	284	1,536	16,203	20,568	-4,365	20,397
Outpatients	27,518	26,346	1,172	26,128	290,903	281,275	9,628	270,868
A&E (includes MEDOC)	9,554	8,775	779	6,591	96,289	87,612	8,677	65,775
Maternity Pathway	1,002	955	47	955	9,103	9,033	70	9,014
Direct Access Radiology	0	5,288	-5,288	2,073	0	43,479	-43,479	17,337
Adult Critical Care	878	912	-34	912	8,148	8,457	-309	8,457
Chemotherapy	606	804	-198	804	8,345	8,082	263	8,082
Total PBR	47,113	51,340	-4,227	45,597	493,272	522,018	-28,746	461,046
Non PBR								
Direct Access	197,058	193,361	3,697	99,092	2,052,803	1,842,707	210,096	940,774
Paediatric & Neonatal Critical Care	912	1,071	-159	1,035	9,775	9,701	74	9,389
Excluded Devices	101	80	21	95	966	733	233	825
Other cost per case	2,626	3,358	-732	6,016	24,698	30,447	-5,749	60,424
Total Non PBR	200,697	197,870	2,828	106,238	2,088,242	1,883,588	204,654	1,011,412

Commentary

A&E attendances continue with high volumes month on month, seeing a 12% increase in Jan 17 compared to Jan 16. There are fewer minor injuries appearing because of national publicity about attending A&Es, but these are replaced by A&E patients with a higher level of acuity. The YTD comparison between 16/17 and 15/16 is a 13% increase.

Elective day cases are only over performing in month by 5 spells while inpatients are under performing in month by 277 spells, however this is offset by overperformance in outpatients and increased emergency work.

Excess bed days have continued to under perform against plan due to the impact of the medical model and the reduction of length of stay within the emergency pathway.



2d. Clinical Income

Clinical Income by Point of Delivery (January 2017)

	Current Month			Prior Year In Month	Year to Date			Prior Year YTD
	Actual £m	Plan £m	Variance £m		Actual £m	Plan £m	Variance £m	
PBR								
Elective Day Case	1.38	1.29	0.09	1.25	14.63	13.63	1.00	12.21
Elective Inpatient	0.77	1.62	-0.85	1.51	15.10	16.66	-1.56	15.18
Non Elective Inpatient	7.01	6.44	0.57	6.30	66.42	64.59	1.83	63.23
Emergency Readmissions	-0.19	-0.19	0.00	0.00	-1.93	-1.93	0.00	-2.02
Emergency Marginal rate	-0.40	-0.27	-0.13	-0.22	-2.95	-2.65	-0.30	-2.68
Excess Bed Days	0.40	0.37	0.03	0.36	3.74	4.94	-1.20	4.83
Outpatients	3.36	3.40	-0.04	3.28	35.62	35.60	0.02	33.78
A&E	0.97	0.84	0.13	0.82	9.80	8.47	1.33	8.25
Maternity Pathway	1.09	0.96	0.13	0.98	9.37	9.00	0.37	9.13
Direct Access Radiology	0.00	0.21	-0.21	0.15	0.00	1.79	-1.79	1.26
Adult Critical Care	0.91	0.93	-0.02	0.92	8.36	8.70	-0.34	8.60
Chemotherapy	0.10	0.11	-0.01	0.11	1.23	1.14	0.09	1.12
Total PBR	15.40	15.71	-0.31	15.46	159.39	159.94	-0.55	152.89
Non PBR								
High Cost Drugs	1.81	1.77	0.04	2.03	17.33	17.26	0.07	16.44
Direct Access	0.69	0.50	0.19	0.54	7.29	4.92	2.37	5.34
Paediatric & Neonatal Critical Care	0.74	0.95	-0.21	0.83	7.86	7.84	0.02	6.78
Excluded Devices	0.17	0.21	-0.04	0.20	1.84	1.92	-0.08	1.84
Other cost per case	0.28	0.28	0.00	0.27	2.66	2.93	-0.27	2.93
Block contracts	0.75	0.66	0.09	0.78	7.68	7.79	-0.11	7.85
Outpatient efficiencies	0.00	-0.23	0.23	-0.21	-1.21	-2.27	1.06	-1.97
Total Non PBR	4.44	4.14	0.30	4.44	43.45	40.39	3.06	39.21
CQUIN	0.45	0.37	0.08	0.28	4.26	3.70	0.56	2.90
Contract Penalties	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.26
Other Income Adjustments	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Sustainability & transformation Funding	0.70	0.70	0.00	0.00	7.40	7.00	0.40	0.00
Other Non-Contracted Income	0.05	0.05	0.00	0.00	0.50	0.52	-0.02	0.00
Provision	-0.19	-0.08	-0.11	-0.21	-1.55	-1.09	-0.46	-0.38
Prior Month Adjustments	1.31	0.00	1.31	0.00	0.00	0.00	0.00	0.00
Others (RTA & Overseas)	-0.01	0.00	-0.01	0.00	1.06	0.00	1.06	0.00
Total	22.15	20.89	1.26	19.97	214.51	210.46	4.05	191.36

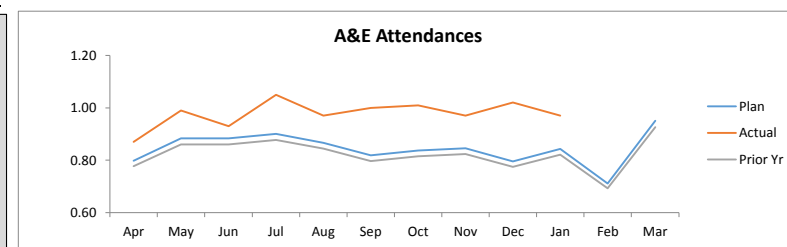
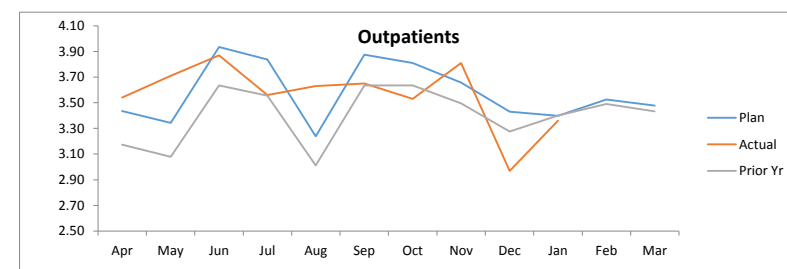
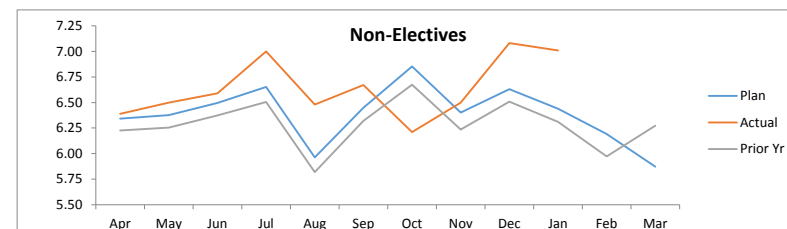
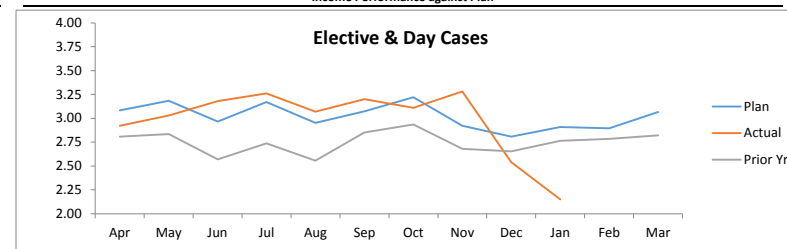
Commentary

A&E income is over performing in month 10 by £127k and is over performing YTD by £1323k.

Non elective income is over performing in month mainly in General Medicine, Cardiology and Paediatrics . Whilst non elective activity has increased it attracts a lower tariff compared to planned care and is subject to the marginal rate cap.

The contract with the main commissioners remains pending agreement and arbitration papers have been submitted to NHSi and the Trust is awaiting the outcome. Contract penalties have not been applied in line with the Trust's acceptance and sign up to the Sustainability & Transformation Fund, however future period Sustainability & Transformation funding will be contingent upon achievement of the agreed performance trajectories. There are currently risks on achieving the A&E, RTT and Cancer trajectories which the Trust will be appealing against. Traditional contract penalties will not be applied in line with NHS Improvement guidance.

Income Performance against Plan



2e. Workforce

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual WTE	Plan WTE	Variance WTE	Actual £m	Plan £m	Variance £m	Actual £m	Actual £m	Plan £m	Variance £m	Actual £m
Substantive	Consultants	179	216	-37	2.40	2.71	-0.31	2.25	23.72	26.63	-2.91	22.47
	Junior Medical	321	371	-50	2.01	2.20	-0.20	1.95	19.45	21.21	-1.77	17.38
	Nurses & Midwives	1118	1487	-369	3.91	5.01	-1.10	3.71	39.27	49.96	-10.69	37.59
	Scientific, Therapeutic & Technical	448	506	-58	1.40	1.54	-0.14	1.35	13.84	15.12	-1.28	13.32
	Healthcare Assts, etc.	455	547	-92	1.02	1.09	-0.07	0.91	9.63	10.92	-1.28	8.93
	Executives	5	9	-4	2.06	2.42	-0.36	1.80	20.25	23.92	-3.68	17.89
	Chair & NEDs	6	7	-1	0.01	0.01	-0.01	0.01	0.11	0.13	-0.02	0.11
	Admin & Clerical	812	956	-144	0.09	0.14	-0.04	0.09	1.17	1.36	-0.19	1.30
	Other Non Clinical	433	486	-53	0.89	0.89	0.01	0.83	9.14	8.57	0.58	8.37
	Pay Reserves	0	0	0	0.00	-0.29	0.29	0.02	0.00	-1.27	1.27	0.02
Substantive Total		3777	4586	-809	13.78	15.71	-1.93	12.93	136.58	156.55	-19.97	127.39
Agency	Consultants	19	0	19	0.41	0.08	0.33	0.18	3.37	0.78	2.6	1.97
	Junior Medical	62	0	62	0.61	0.49	0.13	0.70	6.03	4.46	1.6	7.01
	Nurses & Midwives	487	0	487	1.82	0.32	1.50	0.94	13.75	4.54	9.2	11.49
	Scientific, Therapeutic & Technical	50	0	50	0.21	0.08	0.13	0.39	2.54	1.00	1.5	3.61
	Healthcare Assts, etc.	82	0	82	0.31	0.00	0.31	0.02	1.29	0.00	1.3	0.35
	Admin & Clerical	51	14	37	0.49	0.25	0.24	0.31	4.94	2.94	2.0	3.08
	Other Non Clinical	45	0	45	0.08	0.03	0.05	0.14	1.16	0.30	0.9	1.40
	Agency Total	795	14	781	3.94	1.26	2.68	2.69	33.09	14.02	19.07	28.91
Bank	Nurses & Midwives	39	0	39	0.20	0.12	0.08	0.18	2.29	1.23	1.1	1.71
	Scientific, Therapeutic & Technical	6	0	6	0.02	0.01	0.01	0.03	0.52	0.08	0.4	0.39
	Healthcare Assts, etc.	121	0	121	0.30	0.05	0.25	0.27	2.50	0.53	2.0	2.33
	Admin & Clerical	67	1	66	0.12	-0.09	0.21	0.10	1.01	0.67	0.3	1.08
	Other Non Clinical	41	15	26	0.07	0.04	0.03	0.02	0.40	0.37	0.0	0.27
	Bank Total	274	16	258	0.71	0.13	0.58	0.61	6.72	2.89	3.83	5.79
Workforce Total		4846	4616	230	18.43	17.10	1.32	16.22	176.39	173.46	2.93	162.09

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual WTE	Plan WTE	Variance WTE	Actual £m	Plan £m	Variance £m	Actual £m	Actual £m	Plan £m	Variance £m	Actual £m
Staff Group:												
Consultants		198	216	-18	2.81	2.79	0.02	2.43	27.09	27.41	-0.32	24.45
Junior Medical		383	371	12	2.62	2.69	-0.07	2.64	25.47	25.67	-0.20	24.39
Nurses & Midwives		1,644	1,487	156	5.93	5.45	0.49	4.83	55.31	55.73	-0.42	50.80
Scientific, Therapeutic & Technical		504	506	-3	1.63	1.63	0.00	1.78	16.91	16.20	0.71	17.32
Healthcare Assts, etc.		658	547	111	1.63	1.14	0.49	1.20	13.43	11.45	1.97	11.61
Executives		5	9	-4	2.06	2.42	-0.36	1.80	20.25	23.92	-3.68	17.89
Chair & NEDs		6	7	-1	0.01	0.01	-0.01	0.01	0.11	0.13	-0.02	0.11
Admin & Clerical		930	971	-41	0.70	0.30	0.40	0.51	7.11	4.97	2.14	5.46
Other Non Clinical		519	501	18	1.04	0.96	0.08	0.99	10.71	9.23	1.47	10.04
Pay Reserves		0	0	0	0.00	-0.29	0.29	0.02	0.00	-1.27	1.27	0.02
Workforce Total		4,846	4,616	230	18.43	17.11	1.32	16.22	176.39	173.46	2.93	162.09

Commentary:

Pay expenditure is overspent compared to plan in month by £0.73m mainly due to CIP and premium agency costs. Increases on prior year in month expenditure are mainly due to increments, inflationary and national insurance increases of 3.3%.

The pay run rate increased mainly due to agency expenditure of £0.4m as emergency demand pressures continue with acuity of patients increasing. Substantive pay also increased by £0.2m mainly due to enhancements paid relating to the Christmas period.

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.

2f. Run Rate Analysis - WTE / £

Analysis of 15 monthly performance - WTE

		Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	182	180	180	178	179	178	181	179	177	179	179	180	181	180	179
	Junior Medical	325	322	319	324	326	321	311	322	307	335	334	328	329	327	321
	Nurses & Midwives	1,088	1,076	1,066	1,077	1,102	1,110	1,107	1,105	1,089	1,084	1,097	1,105	1,106	1,098	1,118
	Scientific, Therapeutic & Technical	450	453	450	448	453	464	466	460	452	451	456	442	446	450	448
	Healthcare Assts, etc	465	472	465	466	477	471	465	457	461	450	457	458	459	463	455
	Executives	5	4	4	5	6	7	7	7	7	7	8	8	10	6	5
	Chair & NECs	6	7	7	7	7	7	7	7	7	7	7	6	6	6	6
	Admin & Clerical	754	750	750	768	779	794	800	801	802	801	809	808	809	809	812
	Other Non Clinical	419	425	417	422	420	443	435	451	467	464	458	464	458	434	433
	Substantive Total	3,694	3,689	3,658	3,658	3,749	3,795	3,779	3,789	3,768	3,778	3,805	3,801	3,804	3,772	3,777
Agency	Consultants	11	10	8	11	14	10	13	14	16	19	25	20	18	18	19
	Junior Medical	64	54	59	51	59	50	52	51	54	59	65	68	61	70	62
	Nurses & Midwives	100	271	200	245	159	168	224	330	201	254	340	324	364	290	487
	Scientific, Therapeutic & Technical	54	54	52	55	49	44	52	61	55	61	28	35	54	63	50
	Healthcare Assts, etc	6	17	10	8	42	9	31	46	26	44	63	49	57	45	82
	Admin & Clerical	27	41	32	39	52	40	41	61	58	30	22	22	57	57	51
	Other Non Clinical	41	-	48	53	73	57	45	36	35	35	35	44	45	45	45
	Agency Total	303	447	409	409	448	360	458	598	444	502	578	562	656	588	795
Bank	Nurses & Midwives	43	41	47	49	92	58	58	46	51	47	44	53	57	57	39
	Scientific, Therapeutic & Technical	11	9	10	10	10	4	4	28	27	18	17	18	20	21	6
	Healthcare Assts, etc	113	105	118	108	91	91	91	153	120	117	108	114	124	127	121
	Admin & Clerical	49	47	48	50	42	36	36	19	62	106	51	59	78	59	67
	Other Non Clinical	12	13	9	11	10	3	3	1	4	9	3	13	45	40	41
	Bank Total	228	215	232	232	245	192	192	247	264	297	223	257	324	304	274
Workforce Total		4,225	4,351	4,299	4,299	4,442	4,347	4,429	4,634	4,476	4,577	4,606	4,619	4,784	4,664	4,846

Analysis of 15 monthly performance - £

		Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.29	2.29	2.29	2.23	2.26	2.31	2.37	2.33	2.38	2.33	2.30	2.48	2.48	2.34	2.40
	Junior Medical	1.79	1.75	1.95	1.93	1.81	1.86	1.83	1.91	1.88	1.99	1.95	1.96	2.10	1.95	2.01
	Nurses & Midwives	3.71	3.74	3.74	3.77	3.73	3.97	3.95	4.00	3.89	3.91	3.92	3.92	3.91	3.89	3.91
	Scientific, Therapeutic & Technical	1.38	1.35	1.36	1.35	1.32	1.45	1.43	1.42	1.38	1.38	1.42	1.18	1.39	1.40	1.40
	Healthcare Assts, etc	0.92	0.93	0.95	0.95	0.94	0.99	0.95	0.97	0.96	0.94	0.97	0.94	0.96	0.94	1.02
	Executives	1.77	1.78	0.09	0.19	0.06	1.98	2.01	2.00	2.01	2.01	2.02	2.03	2.04	2.08	2.06
	Chair & NECs	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.02	-	0.01
	Admin & Clerical	0.13	0.13	1.82	1.83	1.91	0.11	0.11	0.13	0.15	0.12	0.13	0.10	0.10	0.12	0.09
	Other Non Clinical	0.83	0.83	0.83	0.84	0.82	0.91	0.87	0.91	0.93	0.96	0.94	0.93	0.96	0.85	0.89
	Substantive Total	12.83	12.81	13.04	13.04	12.83	13.59	13.52	13.69	13.59	13.65	13.67	13.56	13.96	13.57	13.78
Agency	Consultants	0.11	0.24	0.18	0.24	0.29	0.24	0.26	0.31	0.37	0.37	0.44	0.31	0.29	0.37	0.41
	Junior Medical	0.66	0.84	0.70	0.59	0.60	0.66	0.54	0.50	0.56	0.60	0.64	0.57	0.62	0.72	0.61
	Nurses & Midwives	0.88	1.66	0.94	1.34	0.80	0.72	0.96	1.68	1.01	1.18	1.58	1.56	1.81	1.43	1.82
	Scientific, Therapeutic & Technical	0.39	0.36	0.39	0.32	0.25	0.28	0.28	0.31	0.27	0.26	0.14	0.24	0.29	0.25	0.21
	Healthcare Assts, etc	0.03	0.05	0.02	0.02	0.06	0.04	0.08	0.12	0.06	0.11	0.16	0.12	0.15	0.13	0.31
	Admin & Clerical	0.20	0.34	0.31	0.34	0.55	0.53	0.50	0.50	0.40	0.52	0.42	0.56	0.52	0.50	0.49
	Other Non Clinical	0.13	0.14	0.14	0.14	0.20	0.15	0.14	0.13	0.14	0.09	0.17	0.10	0.08	0.09	0.08
	Agency Total	2.39	3.63	2.68	2.68	2.76	2.63	2.76	3.55	2.81	3.13	3.55	3.47	3.76	3.49	3.94
Bank	Nurses & Midwives	0.17	0.16	0.19	0.19	0.38	0.20	0.24	0.22	0.30	0.17	0.16	0.10	0.27	0.31	0.20
	Scientific, Therapeutic & Technical	0.04	0.03	0.03	0.04	0.04	0.00	0.01	0.10	0.08	0.06	0.06	0.06	0.06	0.07	0.02
	Healthcare Assts, etc	0.25	0.23	0.28	0.24	0.20	0.22	0.22	0.29	0.28	0.26	0.24	0.26	0.28	0.27	0.30
	Admin & Clerical	0.12	0.11	0.11	0.12	0.10	0.14	0.07	-0.05	0.13	0.21	0.09	0.05	0.14	0.11	0.12
	Other Non Clinical	0.03	0.04	0.02	0.03	0.02	0.03	0.01	0.00	-	0.02	0.01	0.09	0.10	0.09	0.07
	Bank Total	0.60	0.58	0.63	0.63	0.75	0.59	0.54	0.56	0.79	0.72	0.57	0.55	0.85	0.85	0.71
Workforce Total		15.82	17.02	16.35	16.35	16.34	16.81	16.82	17.80	17.19	17.50	17.79	17.58	18.58	17.91	18.43

3. Balance Sheet

3a. Balance Sheet

	Last Month	Current Month		
	Actual	Actual	Plan	Variance
	£m	£m	£m	£m
Non current Assets				
Property, Plant and Equipment	170.2	170.1	181.0	-10.9
Non NHS trade receivables	0.6	0.6	0.5	0.1
Non current Assets Sub Total	170.8	170.7	181.5	-10.8
Current Assets				
Inventories	6.8	6.5	6.4	0.2
Trade receivables	38.7	39.4	23.1	16.3
Other receivables	2.0	1.8	-1.3	3.2
Other current assets	4.9	4.8	1.3	3.5
Cash at bank	1.7	3.5	1.7	1.8
Current Assets Sub Total	54.0	56.0	31.1	24.9
Current Liabilities				
Trade payables	-19.5	-17.7	-15.9	-1.8
Other payables	-26.8	-28.6	-17.9	-10.7
Borrowings	-1.0	-1.0	-1.2	0.2
Provisions	0.0	-0.1	-0.1	0.0
Other liabilities	-18.2	-17.5	-4.6	-12.9
Sub Total Current Liabilities	-65.5	-64.9	-39.6	-25.3
Net Current Assets	-11.5	-8.9	-8.5	-0.4
Non Current Liabilities				
Borrowings	-116.1	-122.4	-129.0	6.6
Provisions	-0.9	-0.9	-0.9	0.0
Other liabilities	0.1	0.0	0.0	0.0
Sub Total Non Current Liabilities	-116.9	-123.2	-129.8	6.6
Net Assets Employed	42.3	38.7	43.3	-4.6
Taxpayers' and Others' Equity				
Public Dividend Capital	132.2	132.2	136.5	-4.3
Retained Earnings	-122.2	-125.8	-125.5	-0.3
Revaluation Reserve	32.3	32.3	32.3	0.0
	42.3	38.7	43.3	-4.6

Commentary

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

4. Capital

4a.Capital Summary

Capital Programme Summary

Expenditure

Recurrent Estates & Site Infrastructure
IM&T
Medical & Surgical Equipment
Specific Business Cases
Transform Projects (ED/AAU)

Total

Current Month		
Actual	Plan	Variance
£m	£m	£m
-0.16	0.43	-0.58
-0.01	0.78	-0.78
0.07	0.12	-0.05
-0.26	0.46	-0.72
1.00	1.06	-0.06
0.64	2.84	-2.20

Year to Date (YTD)		
Actual	Plan	Variance
£m	£m	£m
3.01	4.26	-1.25
2.60	5.01	-2.41
1.39	1.26	0.13
1.22	3.13	-1.91
3.98	9.33	-5.35
12.20	22.98	-10.78

Revised Annual Forecast		
Original	Forecast	Forecast
Plan	Out-turn	Variance
£m	£m	£m
5.06	4.03	1.04
5.90	3.21	2.69
1.52	1.52	0.00
3.88	1.70	2.18
11.84	7.54	4.30
28.20	18.00	10.20

Commentary

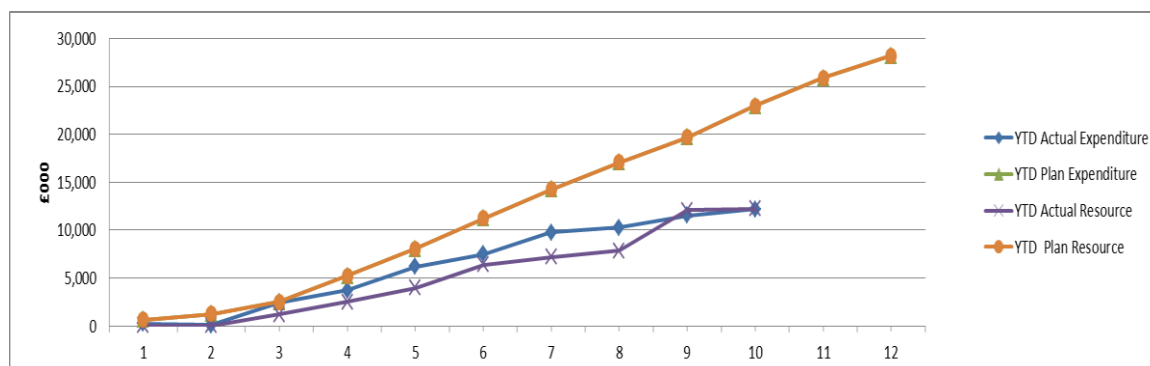
As at Month 10 the Capital programme shows a net undershoot YTD against the original control total amounting to £10.7m. This is in line with the latest forecast for the year end position recently reported to the DH. It should be noted that this undershoot will consist principally of projects that were to have been funded by external loans which will therefore be carried forward to 2017-18 in order to finance the re-phased programmes.

The next page 5b provides more detail on both the actual expenditure and forecast out-turn for each programme and the principal forecast variances are considered as follows:

- ED Refurbishment £4.3m; The project was subsequently commenced in October 2016 with a programme that has revised the original phasing.
- IT Projects £2.69m; This consists principally of Telephony project (£1m) and Electronic Data management (£700k) each of which have been re-phased operationally into 2017-18.
- Other variances relate to Bed management (£200k) and electronic order communications (£300k) which has been impacted by the timetable for the joint pathology project with Dartford and Gravesham NHST.
- Specific Business cases £2.1m variance consisting principally of 2nd CT Scanner (£1m) Medical HDU design (£0.3m) GS1 Inventory (£0.25m). These projects have been re-phased into coming months as a result of operational constraints or efficiencies.
- Estates Infrastructure works £1m variance. This has arisen partly as a result of the legal administration of one of the Trust's principal contractors. The progress of other works projects have been affected directly by the need to gain access to busy clinical areas.
- Medical Equipment. Whilst this is forecast to achieve the original plan the Trust is progressing the delivery of around £600k orders before the year end.

Whilst any change to the original phasing of a capital programme may present a risk, it should be noted that in this instance all changes have been discussed and agreed with the relevant clinical or operational teams and where necessary mitigating actions put in place. Slippages this year have principally arisen as a result of over optimistic planning or necessary constraints upon access to busy clinical areas.

Capital Monthly Profile



Report to the Board of Directors

Board Date: 2 March 2017

Title of Report	Communications report
Presented by	Glynis Alexander
Lead Director	Director of Communications
Committees or Groups who have considered this report	Not applicable
Executive Summary	<p>The purpose of this report is to summarise the communications highlights of the last month.</p> <p>There are currently two areas of focus for internal communications and staff engagement – the forthcoming publication of our CQC report, and initiatives to improve flow and cope with demand in the hospital.</p> <p>We continue to seek opportunities for positive coverage in the media, and through social media, and are very successful at this. However, there are times when we need to respond to reports of care falling short of our usual standards. In the past month we have seen a mix of positive and negative coverage.</p> <p>We are keen to develop our stakeholder engagement with patients and public, as well as our governors and members. A number of events have taken place with more planned. As well as face-to-face engagement we use a full range of communication channels.</p>
Resource Implications	None
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA

Recovery Plan Implication	The Communications Team's work is aligned with the recovery plan.
Quality Impact Assessment	NA
Recommendation	For noting by the Board
Purpose & Actions required by the Board :	<div>Approval</div> <input type="checkbox"/> <div>Assurance</div> <input type="checkbox"/> <div>Discussion</div> <input type="checkbox"/> <div>Noting</div> <input checked="" type="checkbox"/>

Communications report – March 2017

1. EXECUTIVE SUMMARY

- 1.1. There are currently two areas of focus for internal communications and staff engagement – the forthcoming publication of our CQC report, and initiatives to improve flow and cope with demand in the hospital.
- 1.2. We continue to seek opportunities for positive coverage in the media, and through social media, and are very successful at this. However, there are times when we need to respond to reports of care falling short of our usual standards. In the past month we have seen a mix of positive and negative coverage.
- 1.3. We are keen to develop our stakeholder engagement with patients and public, as well as our governors and members. A number of events have taken place with more planned. As well as face-to-face engagement we use a full range of communication channels.

2. ENGAGING COLLEAGUES

- 2.1. We recognise that our senior managers have a vital role to play in making sure all our staff are kept well informed and have a chance to feed in their views about what works well and where improvements can be made. In February we held a very successful meeting with our senior managers where we discussed how we will continue Medway's improvement journey following publication of the Care Quality Commission's report. There was a concerted view that our improvements need to continue at pace, and that this is not dependent on the outcome of the CQC inspection. We will, of course, be engaging further with our senior managers and all our staff as we prepare for the publication of our CQC report.
- 2.2. The engagement of our staff is essential to improve flow in the hospital. The introduction of a Clinical Control Centre is intended to ensure a high quality emergency care pathway, including timely discharge, and to make sure that increased pressure does not impact on planned care. Our communications to support this are therefore aimed at targeting messages at the appropriate staff group, at the right time, so they understand how they can play a part in this important improvement project.
- 2.3. Meanwhile, we continue to engage all staff in key developments, through our 'themes of the week' which focus on safety and good practice messages, weekly emails from the Chief Executive, and at face-to-face opportunities. For example, our HR team held a drop-in session in the staff restaurant, when a

large number of EU staff visited their stall to find out more about what Brexit may mean for them. We recognise that this is an unsettling time for staff from mainland Europe, and have reassured them that we will keep them informed as more details become available.

- 2.4. We are now looking forward to sharing the results of the staff survey when they are published on 7 March. After this, an action plan will be produced to ensure we respond to feedback from our staff.
- 2.5. We are also working on communications to support the introduction of our electronic bed management system, a much improvement procurement process, and a promotional campaign for the 'hello my name is...' initiative. We will be encouraging nominations in our Staff Excellence Awards.

3. MEDIA

- 3.1 It is always disappointing to hear of poor care or patient experience through the media. However, there are occasions when this happens, and one such incident concerned a dementia patient who, despite the best efforts of staff, left our emergency department while arrangements were being made for his safe return to his nursing home. We have apologised to the patient's family, and we are currently looking into the incident so that we can ensure we learn from it.
- 3.2 We also received media coverage about the tragic death of a premature baby. A full review was carried out to examine the circumstances of her death, following concerns expressed by her patients. We are confident that as a Trust we did absolutely everything we could have. We conveyed our condolences to the family during this very difficult time.
- 3.3 In Sheppey there was an article alleging poor care of a patient who died in January. A statement from the Trust Chief Executive expressed concerns, saying the issues raised were completely unacceptable and not representative of care provided at the hospital. She apologised to the patient's widow, and said action has already been taken to address some of the issues raised.
- 3.4 The i newspaper ran a feature on STPs. Regrettably, the information about the Kent and Medway STP – which was not checked – was almost entirely wrong. The article incorrectly stated that trauma and maternity is to be located at a single acute hospital, with A&E and planned care at two hospitals and that services including, renal, urology and hyper-acute stroke care were to be moved to a single site, which is not the case. The newspaper printed a retraction the following day.
- 3.5 On a positive note, the Trust's Stop Smoking campaign received praise from Duncan Selbie, Chief Executive of Public Health England. There was also coverage of the Trust's partnership with the University of Greenwich to develop energy-saving strategies, as well as numerous articles about positive

developments. Recognition of excellent patient care has been seen in several letters published in our local papers.

- 3.6 Building management magazine BIM Today published a piece on Smart Asset Management and the use of data to support effective building management. The article included a quote from Trust Head of Estates Claire Lowe, explaining the role of effective estate management in helping to deliver efficiencies on the Trust site, as well as better patient experience.

4. SOCIAL MEDIA

- 4.1 Over the past 30 days we have engaged with 26,400 people on Twitter and 31,385 people on Facebook. We have gained 41 new followers on Twitter and 65 on our Facebook account, taking our total number of followers to 2,543 and 4,029 respectively. Key topics over the last month were Stay Well This Winter and alternative services to visiting A&E.
- 4.2 We continue to connect with local and national health organisations and stakeholders with our posts retweeted/shared by a number of followers, including NHS Million, local CCGs and Healthwatch Medway.

5. STAKEHOLDER ENGAGEMENT

- 5.1 Following the launch of consultation about the Medway Local Plan, and subsequent headlines about the possible relocation or redevelopment of the hospital, members of the Executive invited senior planning representatives from Medway Council to discuss proposals contained in the plan. They set out the council's vision for future development across Medway, aimed at creating economic success and sustainability, addressing inequalities in health and promoting healthier lives, and enhancing the natural environment. The future of the hospital and its location rightly considered as part of the 20-year vision for Medway. The Local Plan will continue through its various stages, with further opportunities for comment along the way.
- 5.2 We held an event for our members with a focus on new technology. The session looked at how we will deliver healthcare more innovatively in the future and step into the digital age. Members heard how a new bed management system will offer real-time, digital intelligence on which patients are where, within the hospital. In practical terms, this will be made possible through the use of 42-inch digital whiteboards on the wards. These will allow clinical staff to identify what bed space is available for patients, offering clinicians and service managers a real-time source of information as to where any one patient is at any time. A programme of events for members has been planned for the rest of the year.

- 5.3 Our members receive a regular email from the Chairman providing updates on the Trust's progress and developments.
- 5.4 Once our CQC report is received we will update our governors and members. Engaging with them will be essential as we enter the next phase of our improvement journey.

6. COMMUNITY ENGAGEMENT

- 6.1 Discussions have been taking place with health and social care partners about how we will engage our local communities in the Sustainability and Transformation Plan. An update on progress has been prepared, and plans are underway to begin conversations with members of the public across Medway and Swale about why changes will be needed to ensure patients receive the best possible care in future, and what options might be considered. These conversations are taking place across Kent and Medway.
- 6.2 In early February there was a patient engagement event as part of the Kent and Medway review of vascular services. Around 20 patients attend a meeting at Medway Maritime Hospital, with patients from the east of the Kent attending a similar event in Canterbury. Patients, some of whom were involved in earlier events as part of the review, were asked for their views on a potential new model for vascular services, which would see one arterial centre for Kent and Medway, with other centres for day surgery and outpatients. They considered the importance of specialist care, travel times, and the need for care closer to home wherever possible.
- 6.3 Healthwatch Medway is working with the Trust to share patient experience with our Board so that we can ensure improvements in care are made where they are needed, as well as to hear what works well for patients. Patients who have agreed to share their experiences will be supported by Healthwatch to create a narrative, along with recommendations about what could be done differently. By presenting these as Board meetings we will know that opportunities for improvement are considered at the most senior level.

Report to the Board of Directors

Board Date: 2 March 2017

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

Corporate Governance Report – 2 March 2017

1. EXECUTIVE SUMMARY

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

2. CARE QUALITY COMMISSION

Inspection

- 2.1. The Trust has continued to receive further data requests from the CQC Maternity inspection team and has responded to these requests within the timescales set. The data requests have ranged from how the service is meeting the trust's targets on post-partum haemorrhage to specific support for teenage mums, smoking, vulnerable women, alcohol and drugs.
- 2.2. Professor Ted Baker, Deputy Chief Inspector of Hospitals, and Alan Thorne, Head of Hospital Inspections, paid a follow up visit to the Trust on 15 February and spent time in the Emergency Department observing the improvements and talking with a wide range of staff. In addition they had a detailed conversation with the Chief Executive and Chair.
- 2.3. The corporate governance team and the PMO continue to work closely in preparing for the publication of the CQC Quality Report and the subsequent Quality Summit.

Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)

- 2.4. The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R 2000) is legislation aimed at the protection of patients against the hazards associated with ionising radiation. The CQC enforce IR(ME)R by a variety of mechanisms including developing programmes of assessment and inspection of organisations using medical exposures. The Trust is obliged to submit notifications of exposures 'much greater than intended' (MGTI), to the CQC which they investigate in every case.
- 2.5. A CQC specialist inspector (IR(Me)R), visited the Imaging Department on 17 February to follow up on the action that the Trust has taken in response to the four CT incidents which were reported in June 2016, and investigated as a Serious Incident. Feedback from the inspector indicated that the incidents had been thoroughly investigated and measures put in place to reduce the likelihood of similar events happening in future.

2.6. A formal response will be issued to the Chief Executive advising as to the closure of these notifications in due course.

Proposed CQC Regulatory Framework changes

2.7. The way the CQC will regulate from April 2017 is changing, including how they might change their approach to rating all services. The new Regulatory Framework publication is soon due to be published now that the consultation period has ended.

2.8. In brief, the CQC is proposing to undertake on-site inspections at least annually for trusts rated as inadequate, 3 yearly for those rated as requiring improvement and 5 yearly for those rated good and outstanding with table top reviews in between. The CQC will undertake these inspections focusing on the well led domain along with either one other domain or one core service based on a risk assessment and will provide an overarching trust rating; they will continue to recommend the special measures regime for any quality breaches.

2.9. The CQC is also proposing broader and more in-depth Key Lines of Enquiry (KLOE) within the well led domain, similar to those assessed against now, plus what had been in the Quality Governance Assurance Framework previously. A 3 yearly external assurance review will also be required (as is the case now). In addition, it is proposed that NHSI will undertake an inspection of Use of Resources and will make a recommendation for a rating to the CQC (so the Trust will have 6 ratings instead of 5).

2.10. More detail regarding these changes, and what these mean for the Trust, will be brought to the attention of the Board when the CQC publishes the new Regulatory Framework.

Internal Compliance Monitoring

2.11. There is a rolling programme of internal compliance monitoring against the Regulatory Fundamental Standards and earlier this month a full review of the following standards and supporting evidence took place:-

Reg	Standard	Executive	Compliance status	Action
5	Fit and proper persons: Directors	David Rice	Good	Upload recent F&PP checks for JD; DHF; PC; AG
6	Service provider requirements in relation to a Nominated	David Rice	Good	No changes

Reg	Standard	Executive	Compliance status	Action
	Individual			
10	Dignity and respect	Glynis Alexander	Requires Improvement	<p>Patients may not always be asked how they would prefer to be addressed and staff may not always think to question patients if they are happy with the sex of the nurse caring for them. Patient assessment documentation is currently being reviewed and a comment to this effect will be added. Some wards can be too strict on visiting times – this is being reviewed and will be incorporated into ‘John’s campaign’ from Feb 2017</p>
15	Premises and equipment	Darren Cattell	Requires Improvement	<p>The outcomes of an equipment training logs audit showed some areas had not adequately maintained their records and this is being corrected with the support of the new clinical equipment trainer who came into post at the end of January 2017.</p> <p>On-going action in relation to the separation of child-adult mix in theatre recovery.</p>

3. RISK AND REGULATION QUALITY ASSURANCE

Audit

- 3.1. The audit of the Trust's Risk Management framework by internal auditors KPMG is due to be completed. The initial verbal feedback is positive and the draft report is awaited.

4. HEALTH AND SAFETY

External Compliance Assessment

- 4.1. The Health and Safety compliance assessment previously notified to the Board is currently in progress and due for completion on 31 March 2017.

5. DOCUMENTATION MANAGEMENT

Corporate Policies

- 5.1. Streamlining all of the Trust's policies and procedural documents continues. The table below shows the status of the 17 corporate policies:-

Corporate Policy	Document Owner	Status
Complaints	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet
Duty of Candour	Medical Director	Approved; Available on intranet
Emergency Preparedness, Resilience and Response	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet
Estates, Facilities and Security	Director of Finance	Approved; Available on intranet
Finance	Director of Finance	Approved; Available on intranet
Fire Safety	Director of Finance	Approved; Available on intranet

Corporate Policy	Document Owner	Status
Health and Safety	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet
HR	Director of Workforce and OD	There are a number of SOPS and related documents however there is currently no overarching Corporate HR Policy. A meeting with the Deputy Director of Workforce and OD has taken place to commence this work.
Information Governance	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet
Medicines Management	Medical Director	First draft written. A framework of SOPs is currently being developed and these will be reviewed against the 'Marsden Manual' once received
Patient Care and Management	Director of Nursing	First draft written. Awaiting implementation of the 'Marsden Manual'; the draft policy will be reviewed against the 'Marsden Manual' once received.
Risk Management	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet
Safeguarding	Director of Nursing	The Trust follows Kent & Medway Adult Safeguarding policies and protocols however a corporate policy stating this, and identifying roles and responsibilities, is underway.
Serious Incidents	Medical Director	Approved; Available on

Corporate Policy	Document Owner	Status
		intranet
Standards of Business Conduct	Company Secretary	First draft written
Violence, Aggression and Disruptive Behaviour	Security Director (currently Director of Finance)	Approved; Available on intranet

6. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

Multi-Agency Training

- 6.1. The Trust was invited to participate in a Multi-Agency Disaster Victim Identification/ Mass Fatalities Exercise on 9 February. The Trust Human Tissue Act Designated Individual and Mortuary Manager were identified to play as parties in the Local Health Resilience Partnership Mass Fatalities Plan, which was reported to have been a very informative and interesting day and highlighted the Trust's role as part of the multi-agency response.

7. GOVERNANCE

Corporate Governance Review of the Effectiveness of the Clinical Governance Framework

- 7.1. The report on the review of the governance and effectiveness of the Trust's Clinical Governance Framework (excluding Directorates' governance) has now been submitted to the CEO, Director of Nursing and Medical Director for consideration.
- 7.2. A review of the effectiveness of the governance arrangements of the Acute and Continuing Care Directorate, is underway and recommendations are being fed back.
- 7.3. A training programme and a suite of resource documents and templates are being prepared by the Head of Integrated Governance and the Director of Governance, Risk, Compliance and Legal to help support the Chairs and Administrators of these Groups in understanding the importance of their respective roles and in fulfilling their functions more effectively; the outcome being to provide greater first and second level assurance to the Board on the quality and safety of patient care.

External Governance review

- 7.4. Under NHSI's Risk Assessment Framework and in line with the Code of Governance for Foundation Trusts, FTs are expected to carry out an external review of their governance every three years. NHSI have previously agreed that the Trust could postpone their review until the early part of 2017 (the previous review having been undertaken in September 2013). The Trust is currently sourcing an external reviewer to undertake this work. It is anticipated that the review will be undertaken on the basis of the revised regulatory framework referenced in section 2.7 – 2.10 above.

8. INFORMATION GOVERNANCE

- 8.1. A comprehensive update on Information Governance will be provided in the SIRO's half yearly report to the Board in April.

Report to the Board of Directors

Board Date : February 2017

Title of Report	Workforce Report
Presented by	James Devine, Executive Director HR & OD
Lead Director	James Devine, Executive Director HR & OD
Committees or Groups who have considered this report	n/a
Executive Summary	<p>This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the hospital.</p> <p>As seen from the Trust risk register, recruitment and retention remain the areas of significant focus. This report provides an updated position with regard to the nursing recruitment and retention position; whilst acknowledging further work is required on this area, the increased efforts over recent months show an improving position with the highest number of starters for some months. This will support the reduction and reliance on temporary staffing usage & expenditure</p> <p>The international recruitment plan for nursing was presented in the previous Trust Board paper. This work commences on 20 March 2017, with the aim of recruiting around 120 qualified nurses, with primarily senior nursing colleagues undertaking interviews. In addition, the UK based nurse recruitment plan launches at the end of February 2017 with advertising in a range of print, online and social media platforms. This being a collaborative piece of work between the HR&OD and the nursing directorates.</p> <p>This report also summarises the position with regard to temporary staffing usage, and the extensive work undertaken to better manage this, particularly around the use of non-clinical agency interims. This has resulted in a significantly improved position.</p> <p>Other updates provided include progress on the development of our 2 year workforce strategy, the NHS Staff Survey, the Equality & Inclusion agenda, and supporting our EU staff.</p>
Resource Implications	None

Risk and Assurance	<ul style="list-style-type: none"> • Nurse Recruitment • Temporary Staffing Spend <p>The following activities are in place to mitigate this through:</p> <ol style="list-style-type: none"> 1. Targeted campaign to attract local and national nurses 2. Update on overseas campaign 3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway
Legal Implications/Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators.
Recovery Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan.
Quality Impact Assessment	n/a
Recommendation	Information
Purpose & Actions required by the Board :	<div> <div>Approval <input type="checkbox"/></div> <div>Assurance <input type="checkbox"/></div> <div>Discussion <input checked="" type="checkbox"/></div> <div>Noting <input checked="" type="checkbox"/></div> </div>

WORKFORCE REPORT – FEBRUARY 2017

TRUST BOARD MEETING

1. Introduction

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

2. Nurse Recruitment

- 2.1 The enhanced activity with regard to nurse recruitment has continued since the last paper presented to the Trust Board
- 2.2 The international campaigns in both Europe and the Philippines remain on track, with the UK campaign launching at the end of February 2017. On the latter, the Trust has partnered with award winning media company TMP Worldwide (TMPW) who work with many NHS Trusts across the country on providing expert resourcing campaigns.
- 2.3 The recruitment plans highlighted in earlier Trust Board papers are now beginning to show dividends with a higher number of qualified nurses and Clinical Support Workers starting in January 2017 than in previous months. This improved position is supported by a lower number of leavers. The table below summarises the position on starters and leavers for January 2017.

Role	Starters	Leavers
Qualified Nurses	21	10
Clinical Support Workers	20	7

3. Directorate Metrics

- 3.1 The table below shows performance across five core indicators by directorate. Turnover, at 9% YTD, remains slightly above the tolerance level of 8%. Sickness absence remains slightly below the tolerance level of 4% at 3.9% YTD. On turnover particularly, a more detailed analysis will be provided in the next Board paper following the launch of the new online exit interview which was launched in December 2016.

- 3.2 Whilst both appraisal and mandatory training rates have reduced since the last reporting period, the HR Business Partners are working with directorates to devise robust plans which better support the achievement review approach as opposed to an annual appraisal system which was replaced in 2016. The Learning & Development team are also working with subject matter experts to undertake a training needs analysis to review the staff groups required to undertake training (and levels), and the frequency requirements. It is anticipated that this work will be complete before the next workforce paper is presented to the Trust Board

• Indicator	Acute & Continuing Care (FTE)	Trend from previous month	Co-ordinated Surgical (FTE)	Trend from previous month	Women & Children (FTE)	Trend from previous month	Corporate (FTE)	Trend from previous month
Turnover rate (8%)	10%	↓	10%	↑	9%	↔	15%	↑
Sickness rate (4%)	4%	↔	4%	↔	4%	↔	2%	↔
Vacancy rate	18%	↑	22%	↔	11%	↔	14%	↓
Appraisal (95%)	86%	↓	78%	↓	90%	↓	89%	↓
Mandatory Training (95%)	73%	↓	75%	↓	80%	↓	51%	↓

4. Temporary Staffing

- 4.1 Agency spend remained high in January, with a similar number of requests as those seen in December 2016. Some of this can be attributed to the recent centralising of all bookings, however, further work is currently being undertaken on reviewing areas of continued reliance on temporary staffing, with dedicated support from HR Business Partners to devise plans to recruit on a substantive basis.
- 4.2 Requests for temporary staffing to cover nursing and doctor vacancies reflected past trend in January 2017; however positively, there was a slight increase in the fill rate; 81% of nursing requests, and 84% medical locum requests were covered.
- 4.3 During January 2017, in order to comply with the NHS Improvement rules, all directorates attended a challenge session with the Chief Executive and Executive Director of HR&OD, to discuss levels of agency usage, with particular focus on the usage of non-clinical agency workers earning above the price cap set by NHS Improvement.

- 4.4 As a result, the Trust has been able to report that there are now only 2 non-clinical interim agency workers earning in excess of the value that, if very senior managers (VSM), would require approval from NHS Improvement.
- 4.5 A number of agency workers have reduced rates to now comply with the NHSI price cap, with a further 14 agency workers having either joined or are in the process of joining the Trusts in-house bank (resulting in the removal of agency premium). Where negotiation has resulted in both parties not being able to agree rates that sit within the price cap, we have issued notice that their placements will end.
- 4.6 With regard to clinical agency usage, the Temporary Staffing Service have been working in collaboration with directorate teams to convert agency workers, to in-house bank (resulting in the removal of agency premium). As a result, 8 agency medical locums; 10 agency CSWs; and 28 agency registered nurses have joined or are in the process of joining the bank.

5. Other Workforce Updates

5.1 Update on Equality and Inclusion

Previous papers to the Trust Board have summarised the work required on the development of an Equality Delivery Scheme (EDS), with an initial indicative timeframe for completion of March 2017.

The main purpose of the EDS is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED).

This is an important, and significant piece of work. As a result of a paper submitted by the Director of HR&OD in January 2017, the Executive Team approved the appointment of a Head of Equality & Inclusion, with interviews for the role taking place at the end of February 2017.

5.2 Update on Workforce Strategy

Progress on the development of a 2 year workforce strategy remains on track, with this being presented to the Trust Board at the next meeting.

5.3 Update on NHS Staff Survey

The results of the NHS Staff Survey are currently under embargo until 07 March 2017. A presentation summarising our results will be presented at the next Trust Board meeting.

5.4 Supporting our EU Staff

In recognising the vulnerability many of our staff from the EU are feeling following the outcome of the EU referendum vote in the UK, we have recently undertaken Q&A sessions. These have been well attended, with our HR team supporting staff with applications for residency and/or providing information. This work was undertaken in partnership with the Communications Team.

- End

Quality Assurance Committee (QAC) Chair's Report
16 February 2017

I would describe this as a moderate meeting of the QAC. Some important topics, with Board-level relevance, were covered. However, yet again some of the papers were only made available on the morning of the meeting, significantly reducing any value which members might obtain from them. The CEO has undertaken to apply close personal attention to this issue.

Prior to the meeting, Lynne Stuart gave an introduction on the Trust's developing approach to risk, to those members of QAC who are not part of the executive team. The session was well received. A critical part of this process, adding value, is identifying the senior accountable risk owner.

We heard the quarterly report from the Women and Children's Directorate. Particular effort has gone into the Directorate's compliance with Duty of Candour. It has been identified that incorrect grading of incidents is a recurring theme, with effort now being put into standardizing grading and reducing inconsistencies. Grading is now a routine part of clinical meetings.

We examined the Integrated Quality and Performance Report (the title having reverted back from 'Dashboard'). As agreed at the last QAC, this is taken one month in arrears. The Hospital Standardised Mortality Ratio, while showing moderate variation, continues to hover in a much-improved bracket. The introduction of Acute Response Teams will bear further fruit, but may take about three months to show statistically. One Never Event occurred in the period being looked at (December 2016), in interventional radiology, which is being taken forward as a Serious Incident. As at December, the risk of breaching the ceiling of 20 C.Diff cases was high (see current position under QIG, below).

Michelle Woodward briefed QAC on the approach to producing the Quality Account (required by 30 June), and also the Quality Report (which will be a sub-section of the Trust Annual Report). It was agreed that absolute clarity of deadlines for the Board and for NEDs was required. The discussion reopened the consideration of the QAC's own self-assessment summary, and it was decided to take the advice of the Governance team (to be reported next month).

Denise Thompson presented on Clinical Effectiveness, and on the audit programme, some of which is mandated nationally. However, the scale of effort going into the many (344 projects on the audit database) audits, renders it difficult to grasp what is important. It was agreed that the Board ought to be helped to understand what it is signing up to, and where the value lies for the Trust. The Committee asked whether an emerging significant problem could be flagged up so that it was not lost in the background process. Whilst audits are not deemed finished until they have been presented to an audience, we are probably not capturing where there is a risk. QAC asked for more information on closure of feedback loops.

QAC received a comprehensive update on a Falls 'Swarm' ahead of schedule (it had been forecast for March). 20 SIs were reviewed (4 patients had died within 2 weeks of the incidents), looking at Root Cause Analysis and common themes. This was a valuable presentation, highlighting the importance of a multi-disciplinary approach.

The report from the Quality Improvement Group (QIG) was discussed and one matter was escalated. The Trust has now breached the C.Diff target of having no more than 20 cases in the year. The main outcome is that a Trust antimicrobial stewardship (a topic which QAC has previously examined) improvement plan must be developed.

The minutes (some in draft) of many Trust clinical groups were provided for noting. The

Committee had previously asked for these on a regular basis, but their late arrival caused us to question whether we could do anything meaningful with them. We shall keep this under review.

In March, in addition to standing agenda items, QAC will: reconsider the self-assessment summary of its own effectiveness, in the light of advice from the governance team; receive an overview of preparation for the Quality Account; receive an update on Safeguarding; review the Deteriorating Patient and take the Leach paper on Mortality. Looking ahead to April, our programme may alter significantly as a result of CQC, but I would anticipate hearing about the Board Assurance Framework and looking at audit feedback loops..

E B Carmichael
Non-Executive Director; Chair, Quality Assurance Committee
16 February 2017

Key Issues Report

From a meeting of Finance Committee held on 23/02/2017

1

Report to: Board of Directors

Date of meeting: 02/03/2017

Presented by: Tony Moore Chair Finance Committee

Prepared by: Tony Moore Chair Finance Committee

Matters for escalation

1. Risk to planned year end forecast identified following elective pause, contract mediation outcome and CIP achievement. Control Total achievement absolute requirement confirmed by the Executive and supported by Finance Committee
2. An emerging risk has been identified relating to the achievement of the agreed target and improvement trajectory for our elective patients waiting longer than eighteen weeks. Specifically the Finance Committee considered whether the current mitigation of outsourcing Patient activity was at the levels required. Further work to provide this assurance was requested of the operational teams

Other matters considered by the group:

1. Month 10 financial performance including Capital forecast
2. CIP performance ytd and forecast including risk and mitigations
3. Financial Recovery Plan development status and next step timescales
4. STP finance update
5. Business Cases
 - a. North Kent Pathology Service commercial review – this was supported for Board approval
 - b. ED – assurance received over project management
6. Contracts Database from Procurement
7. Business Planning – an update on progress would be provided at the next meeting
8. Board Assurance Framework

Key issues report

Key decisions made/ actions identified:

1. North Kent Pathology Service Business Case supported for Board approval
2. An update on 2017-18 Business Planning would be presented to the next Finance Committee in advance of the next Board meeting

Risks:

The Finance section of the Board Assurance Framework was considered. All risks apart from two were considered by the Committee under the agenda. An update on the two remaining risks was provided by the FD

1. Patient Level Costing requirement - Business Case approved by the Executive Group and implementation plan being prepared
2. Finance Staff recruitment plans

Assurance:

Assurance was provided on;

1. Financial reporting including CIPs, Capital and Cash management
2. Risk identification and risk management under the Board Assurance Framework was covered
3. Development and timescales of the FRP (to be presented to the Board at the next meeting)
4. Due Diligence on behalf of the Board for the commercial questions raised on the North Kent Pathology Service
5. ED project governance

Key Issues Report

Attendance Log: shade out dates when member was not in post/not a member. Put x for any meetings missed regardless of reason and use ✓ to mark attendance. Only members (as laid out in the terms of reference) need to be included – not attendees.

Name and Job Title of Member	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Insert name and job title												
Tony Moore NED Chair										Y	Y	
Jo Palmer, NED										Y	X	
Stephen Clark NED										X	X	
Lesley Dwyer CEO										X	Y	
Darren Cattell Finance Director										Y	Y	
James Devine, Director of Workforce & OD										Y	X	
Glynis Alexander Director of Communications										Y	X	

Minutes

of the Finance Committee held on Thursday, 26 January 2017 at 15.00 hrs
in the Trust Boardroom.

Members

Name:	Job Title:	Initial
Tony Moore	Non-Executive Director (Chairman)	TM
Jo Palmer	Non-Executive Director	JP
Glynis Alexander	Director of Communications	GA
Darren Cattell	Interim Director of Finance	DC
James Devine	Director of HR	JD

In attendance:

Name:	Job Title:	Initial
Maadh Aldourhi	Consultant Haematologist	MA
Margaret Dalziel	Director of Clinical Operations – Acute & Continuing Care	MD
Benn Best	General Manager- Coordinated Surgical Directorate	BB
Jacqui Horne	Interim Deputy Director of Finance	JH
Alistair Lindsay	General Manager, Cancer, Haematology & Pathology Programme (Item 5 only)	AL
David Rice	Trust Secretary	DR
Adrian Stolton	Assistant Director of Finance	AS

1. Chairman's Welcome, Apologies and Introductions

The Chairman welcomed members and the attendees to the meeting. There were no apologies.

2. Quorum

It was confirmed that the meeting was quorate.

3. Minutes of previous meetings

It was agreed that the minutes of meeting of the Investments and Contracts Committee (which had been merged into the new Finance Committee held on 1 December 2016) were approved as an accurate record of the matters discussed.

4. Terms of Reference for the Finance Committee

4.1 The Chairman suggested that the terms of reference should not be too prescriptive in order to allow the Committee some flexibility. There was a discussion about the role of the Committee and it was agreed that its role was not to approve proposals but should be seen as a “sounding board” for the directorates. There was discussion about whether the STP was a matter to be referred to the Board or whether it should be considered first at the Finance Committee.

Action: To discuss with the Board whether matters relating to the STP should be reviewed by the Finance Committee before being presented to the Board.	
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5. Review of Finance Report for the Trust Board 2 February 2017

5.1 The Director Finance suggested that he would ask a variety of personnel from the Finance Department to present the Finance Report to give the Committee exposure to the team.

5.2 TM suggested that the role of the Committee was to review the financial detail, whilst the Board could take a broader view, in the knowledge that the Committee had carried out a thorough review.

5.3 JP commented that the Executive had a duty to ensure that “bad news” should be highlighted to the Committee rather than being hidden in the back pages.

5.4 The Committee turned the pages on the Finance Report and probed areas of concern. DC explained that the pressure on ED at the Trust was having a serious financial impact due to the fall in elective surgery. The “elective pause” which had started on 19 December was causing a negative impact of around £1m a month. The A&E Delivery Board would decide when elective work could recommence.

5.5 There was a discussion around outsourcing and JP queried whether the Trust had considered using other providers’ facilities but staffed by our own surgeons. This would seem a better approach for patients too as they would have the continuity of the same consultant overseeing their specific case. There was clarification that there was outsourcing of work but not staff at the current time.

5.6 JP also suggested that, to reduce the waiting lists, patients could be moved to beds within the health community and they could be staffed by the Trust's own nurses. GA noted that this approach would be well received by the public.

5.7 TM queried whether the Trust had stopped dispensing drugs which patients could buy cheaply elsewhere. JH explained that there was a collaborative approach to buying drugs across Kent and this would "go live" from 1 April 2017. There was a move towards the use of generic drugs where possible and the cost benefits and 2-3 weeks supplies of drugs would be provided instead of 6 weeks as had previously been the case. Consideration was also being given to having a commercial pharmacy on site. TM commented that the Board should be made aware of these initiatives.

5.8 DC explained that there was a Hospital Patient Strategic Initiative which would be launched from 1 April 2017 which was a part of the Carter guidelines.

Action: The Board to be made aware of the various initiatives regarding the procurement of drugs.
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DC

5.9 JH noted that the STP had a number of workstreams and the pharmaceutical strategy had both financial and medical aspects. The Committee were encouraged by the various initiatives under the STP but clarity was required about its implications and what further actions were being taken by the Trust and how they were allocated across the Executive.

5.10 The Committee discussed the agency cap and DC noted that, for the first time, 8% of agency staff were paid below the agency cap.

6. Capital Expenditure

6.1 AS explained that the purpose of the report was to inform the Committee of the revised forecast for capital spend for the year ending 2016-17. The original plan for 2016-17 estimated a total capital spend of £28.2m of which £11.8m related to the ED refurbishment. The revised forecast for the current year showed a total forecast spend in year of £17.9m (of which £7.4m related to the ED refurbishment).

6.2 TM asked if there was capability within the capital budget to do what was expected and DC confirmed that this was included as a part of the revised program for 2016-17.

6.3 JP queried the reference to "restrictions upon capital funding" which were likely to continue into 2017-18 and AS confirmed that indications were that there would be less

capital available in future and that consideration would need to be given as to the most efficient way to purchase capital equipment. DC noted that the Trust could consider alternative ways of funding capital expenditure which could for example include joint arrangements with local universities; this would need to be part of a wider Estates Strategy.

7. CIP Review

7.1 JH gave an overview of the Cost Improvement Plan (CIP) Delivery at Month 9 and explained the governance surrounding which involved rigorous validation including sign off by the directorate before an idea could be formally recognised as a CIP. There were currently around 160 ideas which could potentially become CIPs.

7.2 TM queried the lead in time from the initial idea becoming a recognised CIP which would generate cost benefits. JH explained that this could, in some cases, happen within the course of a week, however, the potential benefit was monitored closely before it was deemed to be a workable CIP.

7.3 There was a discussion around whether “improved income”, i.e. receiving money for activity which had previously not been paid for, could be justifiably treated as a CIP. The improving situation with income recognition showed the Trust’s improving financial awareness and accounted for some £10m of the existing deficit.

8. Risk to financial reforecast to 31 March 2017

8.1 The Committee noted the report.

9. Financial Recovery Plan

9.1 The Financial Recovery Plan was presented to the Finance Committee for review.

10. Business Case – Robotic Surgery

10.1 The Chairman welcomed Ben Stevens and Benn Best to the meeting.

10.2 BB provided a background to support the business case to purchase and implement the Robotic Surgical System.

10.3 The System would be used initially for urology procedures and then expanded to other disciplines particularly colorectal and gynaecology. The objective is to ensure that the Trust is offering the latest innovative technology to drive positive patient outcomes and secure future sustainability of the West Kent Urology Cancer Centre (WKUCC).

10.4 WKUCC has an established national and international reputation in complex laparoscopic urological surgery which has several advantages including smaller incisions, reduced post-operative pain, faster mobilisation and early discharge. It was

difficult to train and recruit surgeons in laparoscopic surgery and easier to teach them how to perform the robotic technique.

10.5 BS explained how robotic surgery over the past 20 years and is now the most common method of treatment. In the UK approximately 80% of all prostatectomies were carried out using the robot technique and this was 90% in the US. The acquisition of the robot would ensure the future viability of WKUCC, enhancing the Trust's reputation and status as a center of excellence.

10.6 JP queried whether the business case was in line with STP strategy and whether once acquired the service could move to another trust. BS noted that the STP was in its early stages and even if the service did move the equipment could be moved to another site.

10.7 The robotic system would generate cost savings and increase the numbers of both NHS and private patients that could be treated. In terms of financing, leasing of the robotic system was deemed preferable and this was forecast to generate a surplus of £735k after five years.

10.8 TM queried whether this type of surgery was a core competency for the Trust and whether the leasing costs would be satisfied by the increased patient flow. DC confirmed that the volume of patients would increase and the length of their stay at the Trust would reduce. The Trust's commissioners were in favour of the proposal.

10.9 JP suggested that the Trust should approach the private sector to see if additional operations could be directed to the Trust if it had the robotic system.

10.10 The proposal would be presented to the Trust Board for approval the following week.

11. Business Case – Additional Surgical Capacity

11.1 BS explained that there was a backlog of between 30 and 40 patients who were medically fit for discharge which was creating a risk for the Trust in delivering its RTT targets.

11.2 TM explained that there had been an outsourcing plan last year but RTT did not improve. It was necessary to understand why RTT was worsening.

11.3 DC suggested that the Trust needed to support a revised outsourcing plan of 75% of the elective work, which the Board had previously approved, on the basis of ensuring quality care for patients.

11.4 JP suggested that the Board be kept up-to-date regarding outsourcing with an explanation of the background to the underlying problem.

12. Business Case – Pathology Update

12.1 The Chairman welcomed the MD, MA and AL to the meeting.

12.2 MD explained that the Board had been advised that the Pathology Integration would realise an estimated financial benefit of £1.3m in year 1 and £1.7m in year 2. The full business case revision now indicated a reduction in financial benefits to £0.8m in year 1, £1.1m in year 2 and £1.2m in year 3 and these amounts would be shared between MFT and Dartford & Gravesham (DGT) NHS Trust.

12.3 There had been consideration of the following three main areas:

- **Political**- integration of pathology services was integral to the productivity and efficiency savings required by the Carter Report;
- **Clinical**- consultant and laboratory staff are prepared for the integration and further delays would affect other critical projects like the MFT order comms;
- **Financial**- expected savings, whilst not at the level reported to the Board in June 2016.

12.4 DC explained that the original split had been more in DGT's favour and this had been adjusted more fairly. In addition the Finance Director at DGT had indicated further leeway in the amount offered to MFT.

12.5 There was a discussion about the space created at MFT if the integration went ahead, however, this would be subject to a review by the Estates Department.

12.6 TM commented that he considered that the idea of a sharing capacity appeared a sensible proposal, however, more work needed to be carried out to clarify the financial benefits between Dartford and Medway.

12.7 It was suggested that further work should be carried out on the proposal and a decision as to whether to proceed to Board would be taken on Monday 30th January.

Action: For further work to be carried out to ensure that there were appropriate financial benefits for the Pathology Business case.	DC
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13. Board Assurance Framework & Risks not covered elsewhere on the agenda

The Committee noted the paper and this would be discussed in detail at the next meeting.

14. Proposal to Implement the “Best Choices” Scheme

14.1 JD explained that the Best Choices scheme allowed members of staff to leave the Trust by way of a mutually agreed resignation; such schemes are widely used to reduce headcount. It was for the directorate concerned to decide whether the posts affected should be removed. The key points of the scheme were as follows:

- Payments made to employees were around 50% lower than via a redundancy programme
- Notice payments were not applicable
- The scheme would be run for a 6 to 8 week period in the first quarter of the new financial year in order to maximize the monetary benefit to the Trust
- Payments are capped at a maximum of one year's salary and cannot be greater than £80,000
- There were two lines of scrutiny, the first being by the line manager concerned.

14.2 GA noted that the scheme made sense given the Trust's financial position and the scheme was completely voluntary. GA queried why a voluntary redundancy scheme could not be used and JD confirmed that unions preferred the mutual resignation scheme. DC noted that once the scheme had been approved by NHSI the auditors should be informed in order that a provision could be made in the accounts for the year ending 31 March 2016.

14.3 The Committee was in favour of the proposal and thanked JD for his report.

15. Date and Time of Next Meeting

The next meeting will be held on Thursday, 23 February 2017, 12.30 – 15.00 hrs in the Trust Boardroom.

Signed by Chair:

Tony Moore

Date:

Report to the Board of Directors

Board Date: 2 March 2017

Title of Report	Finance Committee - Terms of Reference
Presented by	David Rice, Company Secretary
Lead Director	David Rice, Company Secretary
Committees or Groups who have considered this report	Finance Committee
Executive Summary	The purpose of this report is to present the Terms of Reference for approval by the Board. The terms of reference have been reviewed by the Finance Committee.
Resource Implications	None.
Risk and Assurance	Not applicable.
Legal Implications/Regulatory Requirements	Not applicable.
Recovery Plan Implication	Not applicable.
Quality Impact Assessment	Not applicable for this particular paper.
Recommendation	The Finance Committee is asked to review the revised terms of reference.
Next Steps	The terms of reference will be formally adopted and uploaded to the Trust website.
Purpose & Actions required by the Board :	<div> Approval <input checked="" type="checkbox"/> Assurance <input type="checkbox"/> Discussion <input type="checkbox"/> Noting <input type="checkbox"/> </div>

Terms of Reference

Finance Committee

1. Purpose

- 1.1. To assure the Trust Board on the review and scrutiny of its financial planning and performance and to scrutinise major business cases and oversee major capital projects.

2. Constitution

- 2.1. The Finance Committee is established on the authority of the Trust Board.

3. Authority

- 3.1. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Finance Committee
- 3.2. The Finance Committee is also authorised to implement any activities which are in line with its terms of reference.

4. Accountability

- 4.1. The Committee will report to the Trust Board monthly.
- 4.2. The Committee will provide a report to the Council of Governors periodically/as requested.

5. Chairperson

- 5.1. The Chair of the Committee will be the chosen and appointed by the Trust Board from among the Non-Executives Directors (NEDs); the Deputy Chair will be one of the other NED members.

6. Membership

- NED (Chair)
- Two NEDs
- Director of Finance
- Director of Workforce and OD
- Director of Communications

In attendance:

Company Secretary (or member of the secretariat) as minute taker

7. Attendance is expected from:

- 7.1. There is a requirement for members to attend at least 75% of all meetings in one calendar year.
- 7.2. The following staff will be expected to attend regularly

7.2.1. Executive Directors

Terms of Reference

7.2.2. Divisional Representatives

7.2.3. Clinical Council representative

7.3. The following are welcome to attend:

7.3.1. Trust Chief Executive

7.4. Other staff may be requested to attend at the invitation of the Chair.

8. Quorum

8.1. Meetings will be quorate when at least two members, one non-executive and one executive.

9. Frequency

9.1. The meetings will be held monthly. This will be kept under quarterly review.

10. Key responsibilities

10.1. Responsibilities : To enable the Trust Board to obtain assurance that :

10.1.1. There is scrutiny of the Trust's financial performance against plans agreed by the Trust Board.

10.1.2. There is oversight of financial planning in the short and long term.

10.1.3. There is review of areas of unmitigated financial risk through the Board Assurance process.

10.1.4. There is scrutiny of major business cases, service developments and proposed investment decisions in excess of £1m on behalf of the Board.

10.2. To provide a written or verbal report to the Trust Board that provides this assurance and highlights any areas that are of concern.

10.3. Duties : all Finance Committee meetings will include the following standing items:

10.3.1. Review of the monthly Finance Report.

10.3.2. Review of Financial Recovery Plan.

10.3.3. Review of Capital Programme.

10.3.4. Review of CIP.

10.3.5. Review of business cases for service developments/changes/contracts in excess of £1m.

10.3.6. Review of contracts due to be awarded in excess of £1m.

10.4. Committee papers will be published at least 5 working days before the date of the Committee.

Committee minutes will be produced within 5 working days.

Terms of Reference

11. Process for Monitoring compliance with Terms of Reference

11.1. The Finance Committee will monitor its performance against its TOR quarterly.

12. Review Date

12.1. All Terms of Reference should be reviewed annually.