Medway **NHS**
NHS Foundation Trust

PUBLIC MEETING OF THE TRUST BOARD
THURSDAY 28 APRIL 2016, 13.30 – 16.00
TRAFALGAR CONFERENCE SUITE, LEVEL 3 GREEN ZONE, MEDWAY MARITIME HOSPITAL

Item	Subject	Presenter	Format	Action
	Quality Insight : Home First Programme	TBC	Presentation	Noting
OPENING OF THE MEETING				
1.	Chair's welcome and apologies for absence	Chairman	Verbal	Noting
2.	Quorum	Chairman	Verbal	Noting
3.	Register of Interests	Chairman	Verbal	Noting
MEETING ADMINISTRATION				
4.	Minutes of the previous meeting held on 31 March 2016	Chairman	Paper	To approve
5.	Matters Arising Log	Chairman	Paper	To note
MAIN BUSINESS				
6.	Chair's Report	Chairman	Verbal	To note
7.	Chief Executive's Report	Chief Executive	Paper	To note
8.	CQC Review	Chief Executive	Verbal	To note
9.	Trust Recovery Plan	Chief Executive	Paper	To note
10.	Quality and Performance Reports a) Medical Director b) Director of Nursing c) Director of Workforce d) IQPR	Chief Quality Officer Medical Director Director of Nursing Director of Workforce	Paper	To discuss
11.	Finance Report - Further paper to follow	Finance Director	Paper	To note
12.	Clinical Governance Framework	Chief Quality Officer	Paper	To approve
13.	Vision & Values	Director of Workforce	Paper	To note
14.	Board Assurance Framework	Director Corporate Governance, Risk, Compliance & Legal	Paper	For assurance
15.	Return to Reporting	Chief Quality Officer	Verbal	To approve
16.	Q4 Monitor Submission	Finance Director	Paper	To note
FURTHER INFORMATION ITEMS				
17.	Communications Report	Communications Director	Paper	To note
18.	Performance Committee Report	Chairman	Verbal	To note
19.	Council of Governor's Update	Governor Representative	Verbal	To note
20.	Quality Assurance Committee Update	Ewan Carmichael	Paper	To note
AOB				
21.	AOB	Chairman	Verbal	Noting
CLOSE OF MEETING				
22.	Questions from members of the public relating to the Agenda	Chairman		
	Date of next meeting: Thursday 26 May 2016, Trafalgar Conference Suite, Level 3 Green Zone, Medway Maritime Hospital			

PUBLIC MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON THURSDAY, 31 MARCH 2016 AT 1.30PM IN TRAFALGAR CONFERENCE SUITE, LEVEL 3, GREEN ZONE, MEDWAY MARITIME HOSPITAL

Present: Mrs. S Winning, Chairman
                 Mrs. L Dwyer, Chief Executive

                 Dr P Bain, Chief Quality Officer
                 Ms. B Bradd, Director of Workforce
                 Mr. E Carmichael, Non-Executive Director
                 Mr. S Clark, Non-Executive Director
                 Dr. D Hamilton-Fairley, Medical Director
                 Ms. J Horne, Interim Deputy Director of Finance
                 Mr. T Moore, Non-Executive Director
                 Ms. J Palmer, Non-Executive Director
                 Mrs. K Rule, Director of Nursing
                 Ms. J Stephens, Non-Executive Director

In attendance: Ms. Y Ahmed, Deputy Director of Finance
                 Mrs. D King, Governor Representative
                 Mr. P Lehmann, Director of Communications
                 Mr. A Lindsay, General Manager, Cancer, Haematology & Pathology Programme
                 Mr. D Rice, Trust Secretary
                 Mr. M Wilde, Manager, Programme Management Office

Apologies: Mr. M Jamieson
                 Mr. D Cattell
                 Mrs. L Sheridan
                 Mrs L Stuart

Observers: Members of the public/staff/Governors (11)

QUALITY INSIGHT –   THE CANCER BOARD

Alistair Lindsay from the Cancer, Haematology & Pathology Programme gave a presentation on the Cancer Board and Cancer Services. The Cancer Board had been established in May 2015 and was chaired by the Trust Clinical Lead for Cancer who reported directly to the Chief Operating Officer. The Cancer Board was made up of the Trust Executive, Directors of Clinical Operations, operational management, tumour site clinical leads, commissioners and support services.

The Cancer Board was a forum for the discussion of cancer service developments to identify service gaps, issues and concerns and to oversee, receive assurance and agree recommendations or actions from external reviews or surveys.

The Board closely monitored waiting times and whether the requirement to start within 62 days had been complied with. In certain circumstances the Trust is unable to comply with the requirement and the patient was referred to another hospital. In the event that the other hospital is not meeting the 62

day requirement that becomes a breach for them rather than the Trust and it has to be closely monitored that the breach is allocated correctly.

The Cancer Board was now attended by almost all tumour site clinical leads and the management representatives. The membership had expanded to include senior commissioning representatives, public health, Macmillan GPs, Cancer Nurse specialists and patient representatives. It was a forum to discuss performance, remedial action plans together with Kent and Medway issues and suggested pathways to make the necessary improvements.

It was noted that at the Board's meeting in February there had been a presentation from NHSE Cancer Strategic Clinical Network. It was explained that "patient stories" were a standing item in all Directorate meetings to ensure that there was a clear focus on the patient experience rather than just ensuring that targets were being met. The patient stories encouraged discussion across a range of departments, services and healthcare partners. An example was cited where a UGI patient who was referred to multiple providers for a scan and because of cancelled appointments there had been a delay in their diagnosis and treatment. This led to a change in the patient pathway and the way scans were arranged.

Mr Lindsay explained the Cancer Waiting Times (CWT) Challenge. In April 2015 the Trust was the worse in the country in meeting the CWT standard of 93% of patients receiving an appointment within two weeks of a referral by a GP. The Trust's poor performance in CWT had been highlighted in the CQC report in August 2015 and therefore this became a focus for the remedial action plan. There had been a marked improvement and in January 2016 the two week wait statistic had exceeded the national standard at 95.77%. This achievement had been due to better management and escalating patients when there were delays and improved clinical engagement. A review was carried out to assess whether any of the previous delays had caused harm to any of the patients and it was concluded that they had not.

Mr Lindsay explained that there were aims to make further developments to improve training, breach reporting and analysis. There would be earlier escalation and efforts to move patients between trusts to reduce waiting times. The Trust was also working on a Cancer Strategy emphasising the need for earlier diagnosis and treatment, which was assisted by electronic referrals, followed by structured after-care support. These improvements would all ensure that the Trust met the criteria set out in the CWT Challenge.

There was a discussion about the transfer of cancer patients to other trusts to speed up their treatment and it was clarified that, this was done through a multi-disciplinary meeting held by video-conference, however, as there were monthly meetings this could lead to critical delays and this was being addressed.

There was a query about when the improvements would feed into the National Patient Survey. It was noted that the recent improvements would not impact the survey, however, subsequent surveys would show a significant improvement.

There was a discussion about whether the Cancer Board was helping with the issue of patients presenting themselves at GP's with suspected cancer symptoms. There were discussions between the Cancer Board and community regarding the national initiatives to ensure that the general public were aware of the potential cancer symptoms like blood in urine and which would assist with earlier presentations.

The Chairman thanked Mr Lindsay for his presentation which had been very informative.

16/03-01   WELCOME AND APOLOGIES FOR ABSENCE

The Chairman welcomed everyone to the meeting and in particular Yasmin Ahmed and Jacqui Horne who had recently joined the Finance Department. Apologies had been received from Martin Jamieson and Darren Cattell.

16/03-02   QUORUM

2.1   The Chairman confirmed that a quorum was present.

16/03-03   REGISTER OF INTERESTS

3.1   The table of directors interests was included in the board pack for information and the Board was asked to pass any amendments to the Trust Secretary.

16/03-04   MINUTES OF THE PREVIOUS MEETING

4.1   The minutes of the meeting held on 25 February 2016 were APPROVED as a true and accurate account of the meeting, subject to some minor amendments.

16/03-05   MATTERS ARISING – ACTION LOG   OUTSTANDING FOR UPDATING

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

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

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

16/03-06   CHAIRMAN'S REPORT

6.1   The Chairman reported that there had been contact with many external organisations since the last Board meeting and these included Medway Council, the Kent County Council Health Overview & Scrutiny Committee (HOSC), and Medway Council Health and Adult Social Care Overview and Scrutiny Committee (HASC) and that the Trust had been represented by both herself and the Chief Executive .

16/03-07   CHIEF EXECUTIVE'S REPORT

7.1   The Chief Executive presented her report. During the discussion that followed it was noted that:

- The Trust faced pressure from increased demand for its services which had a negative impact on achieving the desired performance targets. The performance for January 2016 with attendances numbering 8,997 and of those, the 4 hour access target had been breached for 1,814. It was noted that despite the increased number of attendances, the number of patients who were admitted to the hospital remained static.

- A nationally recognised Triage system had been introduced into ED with effect from 22 February 2016. This would ensure that all patients would have a senior assessment carried out within 15 minutes of arrival into the department and a treatment plan set and progressed. The Trust was satisfied that the Medical Model had been implemented successfully with the rate of discharge being at the expected level. The CQC had started their visit to the Trust that week with eleven members in their team inspecting all aspects of the hospital. Their initial findings were that the organisation was safer and they had witnessed higher levels of engagement by the staff. The Board was very grateful to the staff who had been helpful in their dealings with the CQC.

- The Junior Doctors Strike would end the following week and the Trust was well prepared and respected their right to strike whilst having to ensure that the Trust needed to offer a safe environment for care.

- The Non-Smoking Committee had started to meet with the aim of making the Trust site smoking free from the summer of 2016.

- Two new clinical directors had been appointed, Ben Stevens formerly from Homerton and James Lowell from GSTT and they completed the planned clinical structure.

- The Director of Strategy & Partnerships would be leaving the Trust that week and Pippa Bagnall would be taking over her responsibilities. The Board was very grateful to Lynne for all that she had achieved including opening up communications with the many partners of the Trust.

16/03-08   TRUST RECOVERY

The PMO Director joined the meeting.

8.1   The PMO Director explained that as part of the Recovery Plan there had been key initiatives including the launch of the Medical Model, Triage system and the setting up of the staff bank. The focus of the PMO over the last few months had been to instigate improvements and to prepare for the CQC visit in April. It was explained that the PMO focused on three business areas:

   a)   Organisation and workforce;
   b)   Clinical and operational excellence; and
   c)   Finance and information.

8.2   The PMO had six main improvement priorities for the Trust:

   a) Workforce; b) Data Quality;
   c) Emergency Pathway;
   d) Medical Model;
   e) Strategic Planning; ; and
   f) Nursing, Clinical & Corporate Governance.

8.3   There was a discussion about the actions that continued to be outstanding. It was explained that some items took longer to resolve than others for example the 4 hours treatment time in ED which given the increase in presentations to over 300 a day, made it difficult for changes to be implemented. Following the CQC inspection there had been 21 must and should do's which were set out in the report and these have been monitored on a weekly basis and measurable improvements have been made.

8.4   There was a discussion regarding safe-staffing and that the closure of an escalation ward would assist by redeploying the nurses to areas to which were short staffed. It was noted that matrons carried out two daily staff reviews and these were fed up to the Deputy of Nursing. There were more reports of nursing staff remaining with the Trust rather than leaving which was a positive change.

8.5   It was reported that the Home First Programme would assist with the levels of patients awaiting discharge. This had previously stood at 120 but recently this had fallen to around 85. .

8.6   The Board discussed the level of engagement and it was noted that after the last feedback session the CQC had noted that the staff were significantly more engaged and that in conversations with the inspectors the Trust staff were using the word "we" more frequently when explaining the workings of the Trust. There had been overwhelming

support for the Staff Open Day on 10 March when the restaurant had been full with staff listening and asking questions about the Trust's current situation.

16/03-09   INTEGRATED QUALITY & PERFORMANCE REPORT

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

9.2   The Board noted that there were no Serious Incidents (SI's) in ED for February and fewer incidents in deteriorating patients. More cases were being investigated where they related to inquests and there was currently a backlog of 18.   The incidents were being investigated more comprehensively with more involvement from the acute care team. The GSTT team had been helping in this area and junior doctors were participating on a specialist course to be able to investigate more effectively. The response times for cancer treatment had improved markedly so that now the Trust was one of the best performing in region. .

9.3   With the ending of the KMHIS contract the Trust was now managing its own technical support and development which comprised Clinical Systems support, Information technology and infrastructure, Business Intelligence and Information, Clinical Coding and Telecommunications and a team had been recruited and most posts would be filled by the beginning of April. It was expected that there would be a big improvement in the level of IT support for staff at the Trust as a result of this change.

9.4   The Medical Director reported that, following the implementation of the new Medical Model on 14 March, there had been an improvement in patient flow contributing to a reduction in admissions by 20% with 50% of patients being discharged within 48 hours, a reduction in outliers from 83 to 15 which had released pressure on surgery and two medical wards had been closed.

9.5   The Board noted that there had been an improvement in Patient Safety with the Trust's HSMR for the period from December 2014 to November 2015 falling to 106 from 120 for the same period for the previous year. The SMR for patients with primary diagnosis of Septicemia was at 113 being the lowest level it had been in the last two years and similarly for COPD this was currently 100 which was a 20 point reduction.   The SMR for patients with a primary diagnosis of heart failure was showing a reduction from 140 in early 2015 to just above 100 by November 2015 and compliance with the HF clinical care bundle was 90% which was above KSS peers.

9.6   There had been a "Sign up to Safety, One Year On" which was an educational day planned for 19 May where speakers including KSS PSC clinical leads, regional medical directors and the regional leads of the initiative were expected and all Trust staff were encouraged to attend.

9.7   In Clinical Effectiveness the new governance structures were settling down with particular progress being made in Clinical audit and NICE where dashboards were providing increased assurance on the progress of audits. There was also progress in improving reporting in Mortality and Morbidity.

9.8   On a national level the decision had been made to impose the new junior doctors' contract by August 2016. The Trust is required to implement this change and discussions were being held with Doctors in Training and Clinical Trust Fellows to resolve issues as they arose.

9.9   The Clinical Leadership Forum had been helpful in developing and engaging Clinical Directors and Specialty Leads but it was intending to broaden its approach by including

the leadership triumvirate of General Managers, Heads of Nursing/Therapies and Clinical Directors as well as Specialist Leads. Progress to date had been positive and a review would be carried out in May.

9.10 The Board noted that the Trust had one of the largest Research and Development (R&D) incomes standing at £1.6m outperforming other trusts within Kent, Surrey and Sussex. The study "Clinical implementation of cell free DNA testing in maternal blood in the first - trimester of pregnancy" was a major contributor in the year.   The Chairman requested that that the Board be provided with an update of the current R&D income and projects.

ACTION: **Diana Hamilton-Fairley to prepare a report explaining the significance of research and development income to the Trust.**

9.11 The Director of Nursing gave her report. She noted that in February there had been a reduction in complaints from 24% in December to 17% in February which demonstrated that more responsibility was being taken for complaints management and the improved quality of responses was leading to a reduction in the number of further complaints which had been the case previously when the initial responses had not be satisfactory.

9.12 The Board noted that in terms of clinical indicators there had been one Grade 4 pressure ulcer in the last month which had been treated as a serious incident.

9.13 In terms of Nursing and Midwifery Revalidation, there were 92 members of the due to revalidate in the first quarter of the year.   The 24 staff members who were due to revalidate in April 2016 had submitted their documentation.   Simone Hay had made a considerable effort regarding this project and this was welcomed by the Board.

9.14 The HR Director reported that recruitment remained the key priority for business critical posts noting the following:

- Progress had been made with regard to accelerating the appointment of staff after vacancies were advertised.
- Interest was shown by potential recruits at the Nursing Day and three more overseas nurses had been appointed taking the total to 13.
- There would be further interviews by skype at the end of April.
- Turnover of staff had fallen in the last six months and there were now more starters than leavers each month.
- The Trust's staff bank had gone live at the Easter weekend, and despite some initial teething problems it was working smoothly. This was helping with visibility across the Trust as to where there were significant staffing gaps.
- The Trust's anti-bullying programme was being reinvigorated and staff were being trained to listen when staff had issues that they wanted to report.
- The Board noted that the Clinical Leads were getting help with rostering and once this had become embedded it was suggested that this could be brought back to the Board for information.

9.15 Following discussion it was noted that the figure for RTT over 52 weeks, which stood at 10 was accurately recorded and the patient was tracked as soon as they came in to the Trust. This was an area of focus for the Trust over the coming months.

9.16 In response to a question about the progress in respect of the outsourcing of clinical activity that had been authorised by the Board it was confirmed that some activity had been outsourced and that a detailed analysis would be provided to the Board.

9.17 The Board discussed the progress of the new clinical directors and the Medical Director confirmed that they were proving to be a considerable asset to Trust and would be driving standards and be engaging with the Clinical Council.

9.18 It was noted that on the Nurse Staffing return the actual staff numbers were 6% behind. The Director of Nursing noted the concern and stated that the active policy of staff rotation and of reduction in bed numbers was designed to maintain safe-staffing on the wards.

16/03-10   FINANCE REPORT

10.1 The Deputy Director of Finance reported that the Trust's financial situation had been discussed in detail at the Performance Committee meeting held on 24 March.   In summary the Trust had reported a deficit of £5.6m for February 2016 (month 11) which was £1.7m adverse to the forecast and the deficit for the year was £53m year to date and this was likely to be £52.5m at the end of the financial year. This indicated that the financial situation was stable but not improving.

10.2 There was a discussion regarding the data under the year to date forecast which was down on last year and yet the activity in the hospital appeared to have increased. It was confirmed that the forecast would be reviewed for the next Board meeting.

10.4 The Board noted that the year to date forecast for the Trust stated that it faced penalties of £12m during the financial year. The fines for mixed sex accommodation would fall in the next financial year although it would be more difficult to reduce the fines due for not achieving the Referral to Treatment targets.

16/03-11   BOARD ASSURANCE FRAMEWORK

11.1 Board noted the papers regarding the review of the Corporate Risk Register and Board Assurance Framework prepared by Lynne Stuart (Director, Corporate Governance, Risk, Compliance & Legal). The intention was that there would be a new corporate risk register and the implementation plan was noted by the Board. There would also be Board discussions to ascertain the Trust's appetite for risk next month.

16/03-12   STAFF SURVEY & ACTION PLAN

12.1 The Board noted the report from the Director of Workforce regarding the results of the Staff Survey which had been completed by the staff between September and November 2015. It was noted that whilst other Trusts had fared better in the 2015 survey, the Trust's results were similar to the previous year. This suggested that the actions from the previous year had not been successfully favourably impacted. The Trusts' actions in the immediate term were as follows:

- An anti-bullying campaign to address concerns around bullying and harassment;
- Launching Vision and Values and "Our Behaviours";
- Leadership development program for all leaders;
- Working with Medway Council to improve the health and wellbeing of the Trust's staff; and
- Reviewing the appraisal process and increasing the opportunities for staff to access training and development.

12.2 All staff would be receiving a briefing from their line manager and each directorate would consider their specific findings in order to devise their own actions. The Directorates would be supported by the Learning and Development team to develop their pledges to help deliver their specific action plans.

12.3 There was a discussion regarding the current staff sentiment. In terms of bullying, the use of the bullying hot-line was being closely monitored to assess to what extent the service was being used and if particular areas of the hospital were heavier users than others. The HR ward rounds also provided greater visibility.   It was noted that the Security Committee was focusing on the security of both patients and staff.

12.4 Following discussion in respect of the planned improvement in the staff experience the Chief Executive proposed an item on the Board agenda to review the status on a quarterly basis.

ACTION: A workforce plan would be brought to the June Board meeting with a staff retention strategy to follow thereafter.

16/03-13   COMMUNICATIONS REPORT

13.1 The Board noted the Communications Report which included BBC coverage of the success of Womens and Childrens directorate and the Trusts' recent positive meetings with MPs. There was a discussion on the status of the new website and it was confirmed that a major revamp would be taking place over the next few months.

13.2 The Chairman commended the Communications team for the increased visibility across the Trust of banners and leaflets which demonstrated that the Trust was engaging more with staff and patients.

16/03-14 AUDIT COMMITTEE CHAIR'S REPORT

14.1 Mr Moore, on behalf of the Audit Committee Chairman, noted that at the last Audit Committee meeting there were two keys areas under discussion:

- The efficiency of Trauma & Orthopedics which was now under review by the Chief Executive and Diana Hamilton-Fairley and the Committee looked forward their response; and
- KPMG, the Trust's internal auditors, would be finalising a review on income recognition with the Director of Finance and this would be presented to the Board in due course.

14.2 The Chairman thanked Mr Moore for his report. It was noted that Stephen Clark would be taking over as Chairman of the Integrated Audit Committee following the close of the Trust's financial year 2015-2016.

16/03-15 CONTRACTS & INVESTMENTS COMMITTEE

15.1 The Committee Chairman noted that the Terms of Reference for the Committee were under review and would come to the Board for approval in due course.

16/03-16 QUALITY ASSURANCE COMMITTEE

16.1 The Committee Chairman noted that the Committee was formulating its working practices and had established a standardised report from the directorates and there was now increasing rigour in using this report which highlighted current issues.

16.2 The Patient Representative was investigating two major areas:

- "End of Life Care" on which there had been a report confirming that the Trust offered 5 day rather than 7 day care and this was due to the need for more staff.

- "Patient Experience" – some 8% of patients would not recommend the Trust to family and friends and there was still a backlog with dealing with complaints and the quality of the responses were variable, sometimes leading to further complaints being raised, where the first response was not deemed adequate by the complainant.

16.3 . The Director of Nursing noted that the Trust was carrying out a review of palliative care and explained that there was a 5 day service and weekends were covered by staff assisting via a phone line.

16.4 The Chairman noted that it would be helpful for the Board to have an idea of the volumes of complaints and if there were any recurring themes that could be addressed.

ACTION: Review of complaints received by the Trust for discussion at a future meeting.

16/01-17 COUNCIL OF GOVERNORS' UPDATE

17.1 It was noted that the next Council of Governors meeting would take place on 7 April at 4.00pm.

17.2 The Governor Representative queried the checks made by the Trust on agency staff. The HR Director noted that the Trust carried out thorough checks of CV's, registrations with regulated bodies, and if any individuals faced restrictions then they would not be recruited by the Trust.

17.3 The Governor Representative also noted that she had become aware that there were situations where patients were prepared for surgery and their operation had been cancelled at the last minute.   The Chairman suggested that individual cases would be investigated if the specific details were provided.

ACTION: The Director of Nursing agreed to investigate.
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16/01-18 ANY OTHER BUSINESS

18.1 Mr Clark noted that following a recent walk around the Surgical Directorate, he was impressed by the passion and enthusiasm of the department now had a better appreciation of the challenges the Trust faced in terms of Social Care provision in Medway.

16/01-19 QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

19.1 There was a query regarding Nelson Ward where, in a four bed bay, there were two male and two female patients. It was agreed that this would be investigated.

ACTION: The Director of Nursing agreed to investigate.

19.2 On the No-Smoking campaign it was noted how difficult it was to bring this in across the Trust site and it was suggested that there should be no-smoking champions. The first meeting of the No-Smoking Committee had taken place and it was intended that all members would be acting as champions and they would encourage other members of staff to also be champions.

19.3 It was queried what information was provided to patients about the services available to them while they were in the hospital.

ACTION: Review of the information provided to patients about the services available to them while they are the Trust.

19.3 A member of the public suggested that a customer satisfaction device could be placed in a prominent position in ED so that patients could express their views on the treatment they had received in the Trust.

16/01-20 DATE OF NEXT MEETING

The next meeting of the Trust Board will be held on Thursday 28 April 2016 in the Trafalgar Conference Suite, Level 3 Green Zone, Medway Maritime Hospital.

The meeting closed at 4:00pm

Shena Winning: Date:
Chair

Medway NHS
NHS Foundation Trust

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB-0280	25/06/15	9.20	To provide an update on the introduction of pain management audits at a future meeting	Medical Director	*20/10/15 - Pain management audit on post laparoscopic appendectomy completed in July with set of agreed actions to be implemented by end of October with re-audit in January 2016. Has now been included in the Annual audit plan*	Closed (green)
PUB-0306	24/9/15	9.7	To present a retention strategy to a future Trust Board meeting	Director of Workforce	To be added to the January Board agenda. 22/1/16 – Strategy to go to the Clinical Executive Group prior to Board. Proposal to be made after Workforce plan finalised at the **June 2016** Board meeting.	Open (red)
PUB-0307	24/9/15	9.12	To provide results of the analytical review of mortality data by Stethoscope to be presented to the October Trust Board meeting with monthly reports thereafter	Chief Quality Officer	26/10/15 - draft report from Stethoscope had been received the previous day and a review of the report was required before the outcome could be brought back to the **December Board meeting** 17/12/15 – to be provided at the January Board meeting 22/1/16 – appended to IQPR for January Board	Closed (green)
PUB-0316	26/10/15	14.5	To present the plans for implementing electronic patient records to a future Trust Board meeting.	Chief Quality Officer/ Director of Health Informatics	21/04/16 Aiming to present to the **August Board meeting**	Open (red)
PUB-0320	26/10/15	15.3	To present the outcome of the SI review in three months' time.	Chief Quality Officer	Discussed January Board	Closed (green
PUB-0321	26/10/15	15.23(i)	To look at including the compliance rate for completing the co-morbidities form in the divisional heatmap.	Chief Quality Officer	Under review. Aiming to cover in the Integrated Quality and Performance Report at the January 2016 meeting. A verbal update will be provided at the **March Board meeting**	Closed (green
PUB-0328	26/11/15	3.2	To share the NHS Providers document illustrating the impact of the extra NHS Funding with Board members as soon as available.	Chief Executive	24/03/16 – document still awaited.	Open (red)
PUB-0329	26/11/15	6.7	To present progress against the plan to reduce the number of patient falls at a future Board meeting.	Director of Nursing	17/12/15 – to be provided at the **March 2016** Board meeting.	Closed (green
PUB-0330	26/11/15	6.8	To produce a report to Board meeting in the New Year highlighting the new nurse revalidation process.	Director of Nursing	17/12/15 – to be presented at the **April 2016** Board meeting	Closed (green

PUB-0335	26/11/15	6.10.12	To review whether there was any correlation between medication errors and duty of candour and report to December Board	Chief Quality Officer	26/11/15 – update to be provided at the January 2016 Trust Board meeting. A verbal update will be provided at the March Board meeting	Closed (green)
PUB-0336	26/11/15	8.1	To report on the KPMG review of activity and income at the December board meeting	Director of Finance	26/11/15 – report to be presented at the January 2016 Trust Board meeting. Completed.	Closed (green)
PUB-0337	26/11/15	8.5.2	To ensure the weekly flash report is shared with Non-Executive Directors.	Chief Quality Officer	Completed	Closed (green)
PUB-0338	26/11/15	8.5.9	To provide an update at the December Board meeting of the internal audit reviews of the Trust's financial controls and financial planning.	Director of Finance	23/04/16 – Awaiting report from Audit Committee	Open (red)
PUB-0341	17/12/15	2.1	Martin Jamieson to provide details for the register of interests.	Martin Jamieson	29/03/16 see item 3 of agenda 31/03/16	Closed (green
PUB-0342	17/12/15	5.1	To circulate the NHS Provider's spending review and operational efficiency report to the Board when available	Chairman	29/03/16 – outstanding	Open (red)
PUB-0343	17/12/15	7.11	To review the waiting times of patients referred to MedOCC and report back at a future Board meeting.	Chief Quality Officer	21/1/16 - Verbal update this information is in ED Action Plan	Closed (green)
PUB-0344	28/01/16	2.1	To update the register of interests for new interests of Messrs Carmichael, Jamieson and Cattell	Company Secretary	29/03/16 – See item 3 of the agenda 31/03/16	Closed (green
PUB-0345	25/02/16	8.8	The Trust Secretary to circulate the non-executive directors with a schedule of dates of the Midwifery Quality Forums for 2016.	Company Secretary	29/03/16 – dates provided	Closed (green)
PUB-0346	25/02/16	11.2	The Digital Road Map would be brought to the August Board Meeting	Company Secretary	22/04/16 - To be presented at the ==August Trust Board meeting==	Open (red)
PUB –0347	25/02/16	15.1	To update the Board on public access of the GP unit at Estuary View, Whitstable	Chief Executive	31/03/16 - Verbal update at March meeting	Closed (green
PUB-0348	25/02/16	16.1	Staff Survey action plan to be discussed at the March Board Meeting	Chief Executive	29/03/16 – See item 13 of the agenda 31/03/16	Closed (green
PUB-0349	31/03/16	9.10	Update explaining the significance of research and development income to the Trust	Medical Director	22/04/16 – Report to be presented to a future Board meeting date to be confirmed	Open (red)
PUB-0350	31/03/16	10.13	Finance Department to prepare revised forecast for 2016-17 for Board approval	Director of Finance	22/04/16 – Revised Operating Plan submitted to NHS Improvement	Closed (green
PUB-0351	31/03/16	16.4	Review of complaints received by the Trust for discussion at a future meeting	Director of Nursing	22/04/16 Draft to be confirmed	Open (red)
PUB-0352	31/03/16	19.3	Review of information provided to patients about the services available to them while they are at the Trust	Director of Nursing / Comms	22/04/16 Review being carried out of information patients receive when they arrive	Open (red)

				Team	at the ward.	
PUB-0353	31/03/16	17.3	Director of Nursing to investigate patients that are prepared for surgery and their operation then cancelled at last minute	Director of Nursing		Open (red)
PUB-054	31/03/16	19.1	Director of Nursing to investigate Nelson Ward where in four bed bay, there were two male and two female patients	Director of Nursing		Open (red)

TRUST BOARD MEETING (PUBLIC) – 28 April 2016

Lead: Lesley Dwyer   **Name:**   **Lesley Dwyer**
                           Designation: **Chief Executive**

Chief Executive's Board Report (public) – April 2016

1.   **INTRODUCTION**

1.1   This report provides the Board with an update on key issues since the last meeting of the Board that are not covered elsewhere on the agenda.

2.   **PERFORMANCE**

2.1   For the month of March 2016, there was an increase of 15% from the previous March period in Emergency Department attendance with over 300 patients presenting each day (this also included weekends). To add to the challenges faced by our ED, there were regular surges of up to 400/presentation per day throughout the period. Ambulance attendances were up by 8.5% compared to last year, again with more than 100 ambulance arrivals/day.

2.2   Due to this activity performance has remained below target at 74.71% March with 23.22% of all presentations referred to Medoc. This was comparable to performance across the region and indicates the 'winter pressures' felt at this time of year. However, plans put in place to manage patients in the corridor and work in collaboration with SECAMB resulted in fewer patients experiencing this on a day to day basis in both total numbers and length of stay.

2.3   An audit of patients placed in the corridor against the re-defined suitability criteria prior to February 2016 identified the majority of patients not meeting this standard. Several safety measures were put in place to identify these patients earlier including changes in the Symphony patient tracking system. Compliance in the policy is now at 100% consistently. In addition a newly implemented Decision to Admit guideline has resulted in patients leaving the department several hours earlier leading to less use of the corridor.

2.4   A new Triage and assessment model at the ED "front door" was implemented at the end of February, with a focus on National Early Warning Scores (NEWS) as part of an assessment for key presentations. The last three weeks audits have evidenced that 100% of patients received NEWS scores at the appropriate time.

2.5   Recruitment initiatives within ED are proving successful, particularly those focused on newly qualified nurses and educational plans are being written to support their development.

2.6 The new Medical Model and Assessment Pathway went "live" on the 14 March. During the initial implementation phase additional clinical support via Guys and St Thomas' was provided to support our clinical staff. The new model and pathway has shown some early signs that flow is improving. Some very early positive changes in the indicators as of 31 March are:

- From an average admission rate of 350-400 per week

  o prior to the model the numbers of zero length of stay (this refers to patients with a less than 1 day length of stay) was 80/day: since 14 March this has increased to 120 per day
  o 24-48 hours Length of Stay (LOS) prior to the change was 80/day and now it is the same at 80 per day but fewer numbers are being admitted (so proportionally it is higher)
  o Admissions to the wards have decreased from 215 to 165 per week

- 46 beds have already closed on the back of this model (Dickens 23 beds, AMU 23 beds) with the assessment unit closing and remaining closed overnight since the second week. In addition we have managed to close the Discharge Lounge to overnight use and sustained this for the past two weeks.

2.7 By 11 March 2016, the merger between Dickens and Sapphire was completed, with the 23 beds on Dickens closing. Although we had always planned to close the escalation wards as soon as possible we needed to take this action now to address the concern we have in staffing wards with the appropriate numbers of trained nurses in order to ensure safety and maintain high quality care.

3. **'HOME FIRST'**

3.1 'Home First' was implemented on 4 April 2016. Home First is a multi-agency partnership initiative working across the whole health and social care system to reduce unnecessarily prolonged lengths of stay in hospital. Discharges are facilitated as soon as a patient becomes medically fit by the community teams providing a holistic assessment, equipment and on-going enablement in the patient's own home or intermediate care facility.

3.2 Home First will facilitate up to 35 discharges onto Pathway One per week including weekends.

3.3 It does this by providing:

- Single point of contact
- Coordinating discharges
- Coordinating packages of care
- Assessing the patient within two hours of returning home – therapy led
- Agreeing personalised enablement goals
- Providing equipment in the home within a further two hours
- Continually reviewing and reassessing the patient

3.4   In the first eight days (4 - 11 April 2016) 39 patients were discharged via Home First which is just under the target but very successful for the first week.

4.   **REMEDIAL ACTION PLAN (RAP) UPDATE**

4.1   Updates on the RAPs are as follows:

(a)   Imaging. A new 160 slice CT scanner became fully operational on 30 March and work is now beginning on identifying a site for the second scanner, which should be in operation by the end of 2016. A mobile MRI will be on site from 29 April allowing us to reduce waiting times, particularly for those patients on 2 Week Wait (WW) pathways. Reporting of CT and MRI continues to be monitored.

(b)   Cancer. There has been continued progress with completing the actions in the Cancer Remedial Action Plan (RAP) jointly with the CCG. The Trust continues to maintain compliance with the Cancer 2WW standard and trajectory. 2WW referrals continue to be monitored daily by the service teams to ensure that additional capacity can be provided to maintain the standard. There continues to be strong clinical engagement across specialities in reviewing and monitoring patients through their pathways. The number of 62 Day and 104 Day breach patients continues to reduce and the Trust is compliant with the recovery KPIs. Formal feedback has been received from the Cancer Intensive Support Team (IST) visit in February and the Trust has been signed off from formal intensive support. The original IST recommendations were incorporated into the Cancer RAP and so are being addressed through this.

(c)   Endoscopy and Referral to Treatment (RTT). The Trust is maintaining endoscopy capacity for patients on urgent or 2WW pathways. The service continues to identify and secure additional outsourced endoscopy capacity to further reduce waiting times for patients on routine pathways. The endoscopy operation transformation group is to be reconvened on 19 April to focus on preparation for the JAG visit in September. The Dermatology RTT position has continued to progress with an overall reduction of patients waiting over 40 weeks from 437 to 87. A comprehensive demand, capacity and financial model is in development which will detail the activity levels required to achieve compliance and sustainability with the RTT standards. The target date for delivery of the comprehensive plan is the end of May.

5.   **CARE QUALITY COMMISSION (CQC) UPDATE**

5.1   Following the CQC targeted inspection of the Trust at the end of March; at time of writing this report we do not have formal feedback. A verbal update will be provided if feedback is received prior to the Board meeting.

6.   **VISION AND VALUES**

6.1   This week we launched our Trust Vision and Values following a wide consultation with our staff and others. The feedback has been very positive and the embedding of these values is an important step in developing the

culture that will support Medway in providing the "Best of Care" through the "Best of People". Further information will be provided at agenda item 13.

7. **DEVELOPING THE TRUST STRATEGY**

7.1 <u>National Planning Guidance</u>:

(a) <u>Annual Operational Plan 2016/17</u>. The draft Annual Operational Plan was submitted on 18 April. The final version will be worked up by the Directors of Finance and Strategy and Partnerships over the next few weeks and finalised by mid-May. This plan underpins the Sustainability and Transformation Plan.

(b) <u>Kent and Medway Sustainability and Transformation Plan (STP)</u>.

(1) There are 44 STP geographical foot prints across the country. The chairs of each STP footprint have been selected and appointed by Simon Stevens. Glenn Douglas (Chief Executive of Maidstone and Tunbridge Wells NHS Trust) is the Chair for the Kent and Medway STP. The first checkpoint of the STP was completed using the nationally mandated template and submitted on 15 April. At this stage the document is considered to be work in progress and will be further developed by members of the Steering Group. The final draft of the submission will be completed by 27 May for sign off in June. It is possible that we may need to convene an additional Board meeting in order to sign off the STP within these tight timeframes.

(2) The meetings of the STP Steering Group will take place on the last Thursday of every month with a catch up teleconference on the second Thursday of the month.

(c) <u>Local Footprints for the Sustainability and Transformation Plans</u>

(1) Four local footprints have been identified and include:

DGS and Swale
Medway
East Kent
West Kent

(2) The CE and Director of Strategy and Partnerships will continue to attend meetings at both the DGS and Swale STP footprint (Chair, Patricia Davies) and the Medway STP (Chair, Caroline Selkirk).

(3) It has been agreed that there will be a consistent structure for each local footprint.

7.2   Strategic Intent

(a)   The Medway FT Strategic Intent is a high level description of how the organisation intends to deliver quality care within the financial organisational framework. There are four themes:

- Improving the health and wellbeing of the population of Medway
- Working in partnership with all key stakeholders including health and social care, local government, and the private and voluntary sectors
- Achieving clinical excellence and safety
- Clinical and Corporate Governance

(b)   In parallel with the launch of the Vision and Values, the Strategic Intent is being presented to key audiences within MFT including the Executive, Senior Management Teams, and the monthly Staff meetings. It is very important that all clinicians and managers are engaged in shaping our future as an important provider within the wider system.

(c)   Further opportunities will be identified to share our strategic intent with key stakeholders locally, across Kent Surrey and Sussex and nationally including NHS England, NHS Improvement, Public Health England and the CQC.

8.   **HEALTH INFORMATICS UPDATE**

8.1   The full Health Informatics update is included in the Public Trust Board agenda (Item 10).

8.2   The in-house IT Service Desk and core IT services was successfully transferred back into the Trust and launched on 31 March 2016. Trust staff now have access to a more agile and customer focused IT service.

9.   **CORPORATE GOVERNANCE**

9.1   Registration Authority (RA). Executive responsibility for RA has now moved from the Director of Corporate Governance, Compliance, Risk and Legal to the Chief Quality Officer.

9.2   Risk Management. Progress on the Risk Management Implementation Plan continues within the set timeframes.

9.3   Corporate Governance Directorate.

(a)   The Trust is currently rated "red" for Governance by the regulator, Monitor. In August 2015 the Trust was required to give Enforcement Undertakings to Monitor which included making significant improvements in corporate and clinical governance.

(b)   The Director of Corporate Governance, Compliance, Risk and Legal has recently commenced a consultation with directorate staff setting out proposals for a refreshed corporate governance directorate

structure which is considered fit for purpose to meet the improvements required.

10. **JUNIOR DOCTORS' INDUSTRIAL ACTION**

10.1   On 6 and 7 April 2016, some of the Trust's Junior Doctors participated in the industrial action as a result of the on-going dispute between the BMA and NHS. A total of 14 outpatient clinics were cancelled affecting 168 patients. We cancelled no elective (non-emergency) surgery but we did cancel 11 day cases for elective (non-emergency) surgery.

10.2   In preparation for the forthcoming two Industrial action days on 26 and 27 April, the Trust is expecting to cancel all non-elective in-patients and many outpatient clinics. These two days are different from the previous strike days because the doctors are engaged in a complete walk-out between the hours 08:00 and 17:00. However, this is mitigated to some extent because patients have not been booked into clinics or operations planned.

10.3   We have already held a number of meetings to plan for the next two action days in order that we can provide a safe service for our patients. We are working closely with our commissioners and local partners to ensure that the impact from such action is managed at a local system level. A meeting was held with a large number of junior doctors last week to discuss the upcoming strike, the Trust's mitigation plans and the issues in regard to the implementation of the new contract.

10.4   The Government has said that the new Junior Doctors' contracts will come into effect from 1 August 2016. The introduction of such a major contract reform will significantly change working patterns for doctors in training. It is important that we maintain an open dialogue with the junior doctors.

10.5   A phased implementation plan has been developed that will enable employers to introduce the new working patterns enshrined in the new contract more safely.

10.6   A Trust Implementation Group, chaired by the Medical Director, has been set up to consider all the issues associated with the introduction of a new junior doctors' contract, i.e. employment contracts, pay protection, rotas, associated costs, etc., An action plan is currently being devised with timelines.

11. **SMOKING**

11.1   Our Smoke-Free Committee continues to make plans for the site becoming smoke-free. It is currently considering what needs to be done in terms of training and education for staff, visitors and patients, what support needs to be offered, and what communications internally and externally is needed to underpin the initiative. The Committee is working closely with Medway Council's Public Health department on the plans.

11.2   The first key milestone is the removal of the smoking shelter nearest the main building, as part of the plans associated with the Emergency Department refurbishment. We are looking to put in place an intensive burst of activity in advance of this to ensure that the removal of the shelter does not lead to an increase in smoking near to the main entrance.

12. **HORIZON SCANNING**

12.1 The formal merger of Monitor and the Trust Development Authority to form NHS Improvement took place on 1 April 2016.

12.2 There has been the usual focus on the NHS in the media in recent weeks. Some of the key stories have been as follows:

(a) The junior doctors' strike continues to dominate the national media, as far as health issues are concerned. In recent days, there has been speculation as to whether Health Secretary Jeremy Hunt is moving away from "imposing" a new contract, in view of legal issues. However, under questioning in the House of Commons, the Secretary of State stated that he had not changed his position.

(b) There was significant coverage nationally of the NHS's A&E figures for February, which were billed as the "worst ever." Across England, 81% of patients were treated within four hours.

(c) More locally, there has been some coverage of the links being set up between the NHS in Kent and French hospitals. South Kent CCG sent their first patient to Calais Hospital for surgery this month under an agreement which had been signed in January.

(d) The EU referendum and its impact on the NHS has been making headlines with both "in" and "out" campaigns saying that a win for them would benefit the NHS. In advance of the referendum on, pre-election purdah rules apply, which means that there is likely to be a reduction in government announcements from 27 May.

13. **ORGANISATIONAL STRUCTURE**

13.1 In April, the Trust welcomed Ben Stevens, Director of Clinical Operations, Coordinated Surgical Directorate, and James Lowell, Director of Clinical Operations, Women's and Children's Directorate, to the Trust.

13.2 The Trust now has permanent Directors of Clinical Operations within each of the divisions, with Ben and James joining Margaret Dalziel, Director of Clinical Operations, Acute & Continuing Care Directorate.

13.3 We have also made a permanent appointment to the role of Director of Estates and Facilities with the appointment of Claire Lowe.

13.4 Over the coming weeks we will be recruiting to the permanent roles of Executive Director of Workforce and the Director of Nursing roles.

14. **ATTENDANCE AT CONFERENCE**

14.1 Dr Trisha Bain and myself attended the IHI BMJ Conference in Gothenburg 13 -15 April 2016. The theme of the conference was 'Change. Save. Sustain. In Partnership with Patients'.

14.2 We were joined by two of our ED consultants, Dr Ashike Choudhury, Dr Adebayo Da'Costa, and Anaesthetist, Dr Manisha Shah (who leads the

simulation training within the Trust). There were two posters (and another on which we collaborated) accepted for the conference and I have previously provided a link via the weekly newsletter to the short video that was made in ED regarding the program on which one of the posters was based.

14.3   We will be developing a paper which will be presented at an upcoming Grand Round, as well as a presentation at the May Board meeting on the conference and next steps.

15.   **EXECUTIVE ARRANGEMENTS**

15.1   During the month of April 2016, the following executives were on annual leave.

Trisha Bain, Chief Quality Officer	15 – 22 April 2016 (incl)
Darren Cattell, Director of Finance	1 – 13 April 2016 (incl)
Diana Hamilton-Fairley, Medical Director	13 – 20 April 2016 (incl)
Lynne Stuart, Director - Corporate Governance, Risk, Compliance & Legal	1 – 8 April 2016 (incl)

Title of meeting:	Trust Board	Date: 28/04/2016
Title of report:	Recovery Programme Status Update	Agenda item: 9
Reporting Officer:	Jane Rooney Programme Director	
Lead Director:	Jane Rooney	
FOI status:	This paper is disclosable under the FOI Act	

Report Summary:

Summary of the Recovery Programme progress includes

- An update on the improvements seen as the Medical Model entered its sixth week and information on the project evaluation process
- Information on the progress of the Emergency Pathway programme, the clinical launch of this programme and the implementation of the Home First Initiative
- The Deteriorating Patient Programme progess, implementation of the Safety Brief, Hospital at Night Handover and Intentional Hospital Rounding.
- Referral to Treatment describes the personnel changes and the planning work being carried out to identify outsourcing opportunities and planning for future management of demand
- Workforce gives an update on the Leadership Programme and the Temporary Staffing Service which has now gone live.
- Communications gives a round up of the current actions taking place to support the recovery programme including the publication of 'Our Medway' designed to ensure that staff in the wider community understand the achievements throughout the Trust
- CQC: Following the recent inspection the actions taken and the view going forward have detailed in the report. Final Feedback from CQC is anticipated imminently

Purpose: This paper is for

Assurance	x	Approval		Decision		Information	
							x

Recommendation:

No decisions are required—for information only

Strategic Objective Links:
1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment. 2. We will attract, retain and develop a first class workforce. 3. We will manage our resources prudently, efficiently and effectively. 4. In partnership, we will provide integrated care for the community.

Identified Risks and Risk Management Action:
Key risks to delivery of The Recovery Programme are detailed in Recovery Board Status Update Paper and were agreed as part of the CQC Quality Improvement Plan. Management actions are also detailed in this paper

Resource Implications:
All activities detailed within this paper are currently being carried out within existing resource.

Recovery Plan implications:
Does the subject matter support the Recovery Plan Yes: x   No: If yes, highlight which aspect of the Recovery Plan this recommendation aims to support. • Continuing to modernise our Emergency Department and pathway, reducing the time it takes for patients to be seen and assessed. • Improving patient safety and care by minimising the number of different doctors that patients see during their stay in hospital. • Accelerating our recruitment drive to employ the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interim and agency staff. • 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. • Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.

Recovery Plan Workstream					
Corporate Governance		Deteriorating patient	Yes	Referral management	Yes
Workforce	Yes	Nursing	Yes	Emergency pathway	Yes
Clinical leadership	Yes	Clinical governance	Yes	Medical model	Yes
Data quality		Finance	Yes		

Quality Impact Assessment:

Individual programmes detailed within this paper do have ongoing QIAs both during mobilisation and after implementation. No PIDs for approval are contained within this paper.

Yes:	No: x

If yes, attach the QIA as an appendice.
The paper will not be reviewed at the meeting if this is not attached.

If no, state why one is not required.
QIAs are carried out as part of the approved PIDs for each programme workstream

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Report History:

Monthly submission to the Trust Board

Next Steps and Further Reporting to the Board (if applicable):

No additional reporting to The Trust Board is anticipated at this time

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Appendices:

Recovery Plan Status Update to Board April 2016-appendix 1
Medical Model reporting to week 4-appendix 2

For further information or for any enquiries relating to this report please contact:
Jane Rooney Programme Director Jane.rooney3@nhs.net

Recovery Plan
Status Update to Board
April 2016

Contents

1. Highlights

The Recovery Plan continues to progress in line with the timeline previously agreed with the Trust Board.

There have been a number of important milestones in the last month, including:

- The Medical Model has now entered its sixth week and a positive impact is starting to be seen in some areas including length of stay.

- The Home First Initiative has been implemented

- The clinical launch of the Emergency Pathway Programme took place

- The substantive Director of Clinical Operations for Surgery joined the Trust and will oversee the Referral to Treatment (RTT-18 weeks) Pathway Programme working with and supported by the Project Management Team

- Care Quality Commission (CQC) field visits took place on March 29th and 30th. A subsequent feedback session took place on April 11th with the Trust Senior Management Team. Actions against the CQC action plan have continued to be progressed

- Communications activities have continued to ensure that staff, patients and stakeholders are sighted on the recovery programme.

2. Priority Programme Status

2.1 Medical Model

The Medical Model commenced operation on 14th March as planned and at the time of writing is in the 6th week of operation. There have been a number of improvements as a direct result of this implementation.

The key achievements have been captured and are attached as appendix 1 and there is a clear indication that further improvement is likely as the model matures. As with all major change projects, areas for improvement have been identified as part of the Plan Do Study Act (PDSA) process, these are also captured at appendix 1 and are being addressed through the Medical Model Programme team. A transition plan for the formal handover of the programme to The Trust operational team has been developed and will be signed off by the Programme Board and the Executive Committee during the next month

2.2 Emergency Pathway

The Emergency Pathway work is progressing well. The programme team structure is in place, with the Programme Board being chaired by the Medical Director and the 3 work streams being led by key operational and clinical staff.

The Programme Board has confirmed the aspirations and objectives for the work, and the Project Initiation Document has been agreed by the Executive Recovery Committee. The three work stream leads are currently scoping the key deliverables and these will be agreed in the next month.

There have been a number of achievements in the last 3 weeks.

- The Home First initiative commenced on the 4th April and in the first week exceeded the target number of patients expected to be discharged. It is run by the Community Trust and Social Care and allows patients to be sent home for their homecare assessments to be carried out.

- A clinical launch of the Emergency Pathway programme took place on the 19th April led by Dr Ian Sturgess (National Clinical Director ECIP programme) and presented the compelling case for change in the Emergency Department

- A KPI dashboard for the programme has been developed

Members of the National Emergency Care Improvement Programme (ECIP) have confirmed their ongoing support for this vital piece of work which is welcomed.

2.3 Deteriorating Patient

The Deteriorating Patient Programme continues to make good progress. The Acute Response Team was approved by the Executive Committee in March and a plan for recruitment and implementation has been developed. The key updates for the Deteriorating Patient Programme are as follows:

- Last Month an interim plan was presented to the Executive Recovery Committee to improve safety through the implementation of a Safety Brief, Hospital at Night Handover and Intentional Hospital Rounding. These are now in place and are being monitored and evaluated

- Professional standards for recognising and responding to unwell patients have now been developed and are awaiting final sign off

- A workshop for the development of an Avoidable Harm Strategy will be taking place on Monday 25th April

2.4 Referral to Treatment

Dedicated PMO support for the Referral to Treatment programme is in place and a full Project Initiation Document is being developed by the Project Management Office and the relevant operational teams. Plans for additional outsourcing of activity to supplement internal capacity are being progressed at pace with an expectation that these will be presented to the Trust Board in May. The Trust continues to develop its Referral to Treatment Time Trajectory as we progress towards meeting the national targets. This is being done in tandem with a significant piece of work to fully understand the internal demand and capacity within The Trust.

2.5 Workforce

The temporary staffing service has now gone live and a business evaluation process is being developed to assess the service before the end of May. A Leadership Programme for band 6 and 7 nurses is being developed and will take place over several sessions form May to December 2016, with support from Guys and St Thomas' Hospital.

The process for nurse recruitment has been improved to expedite the on-boarding of new nurses. The service is being benchmarked against other Trusts with a plan to constantly improve during 2016.

Over the coming weeks there will be further formal sign off of the remaining workforces project initiation documents

3. Communications

Weekly recovery plan newsletters focus on specific programmes (e.g. The Deteriorating Patient). Highlights include the publication of a weekly Recovery Plan newsletter, publication of two information cards focusing on core objectives of the Recovery Plan and informing staff and patients of CQC visit activity. A photo-journalist has been recruited and is producing a regular flow of good news stories highlighting the breadth of change and good practice occurring across the Trust – the first issue will be published in early May featuring 18 stories and more than 140 name-checked members of staff in the photos.

4. CQC Action Plan

The CQC Must Do/Should Do Action Plan which the Trust has been working through continues to be progressed. Currently of the 73 original actions, 36 are green, 33 are amber and 4 remain red.

The areas that remain red relate to staffing numbers (2 items), medicines management and complaints. Significant consideration has been given to the red areas and these are now in the early stages of having actions applied to resolve them.

The Trust is currently in the process of developing a plan around taking the regulatory framework compliance forward and making it part of business as usual.

5. Risks to delivery

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

Risk	Mitigant
Change is not sustained beyond the high visibility recovery period	Care is being taken to ensure ownership of change sits with the operational level of MFT. The PMO supports but does not lead clinicians, senior nurses and managers in planning, delivering and implementing change.
Resource constraints negatively impact pace and/or quality of change.	MFT has secured approval from Monitor to mobilise professional support for the PMO and has agreed to periodic resource reviews with Monitor's support to ensure the recovery programme is adequately resourced. The next resource review will occur in April as part of the finalisation of 2016/17 budgets with the Director of Finance.
Reporting and monitoring divert focus from the process of improvement and change.	MFT is pleased to have had the support of CQC and Monitor (amongst others) in planning the next stage of its recovery. Indications are that both CQC and Monitor appreciate the need for a core focus on delivery activities in the coming weeks. Appropriate, measured review and oversight arrangements have been put in place which, with support of the PMO, will minimise disruption to the core recovery activities.
Lack of staff buy-in to recovery	The Trust has recognised the need for strategic, targeted communications campaign to support the next stage of its recovery programme. The Trust's communications team have mobilised accordingly and a communications strategy is now being implemented to compliment the recovery activities.

Green: Planned, on track, delivered, stable
Amber: Off plan but recovery actions in place
Red: Overdue / not achieved

Summary Report

Workstream	Current	Previous	KPIs	Comments	CQC		
Medical Model	Green	Amber	Green	The Medical Model is now being refined to maximise efficiencies. Board Rounds are working well and flow is improving throughout the Trust.	(Red)	-	1 (-)
Emergency Pathway	Amber	Amber	Red	Home First initiative in place across the A&CC Directorate. This is in addition to the new triage model, frailty pathway improvements and new Decision to Admit process previously reported. Risk related to Data Analytics capacity and CSC engagement flagged, with mitigating actions underway.	(Red)	4(-)	2(-)
Deteriorating Patient	Amber	Amber	Amber	ART interim draft protocol developed. Planning underway for delivery phase of programme. Track and Trigger business case being further developed.	-	-	(green)
RTT	Amber	Amber	Amber	Continued improvement in waiting times helped by the procurement of a mobile MRI scanner to clear MRI waiting list back log.	-	4(-)	1 (-)
Workforce & Clinical Leadership	Green	Green	Amber	Start dates now agreed with 90% of nurses at offer stage. New Trust Vision and Values to be launched at open staff meeting on 25.4.16.	1 (-1)	5(+1)	5(-)
Others	Amber	Amber		N/A	4 (-)	19 (-)	26 (-)
Total					5 (-1)	32 (+1)	36 (-)

Fortnightly Highlight Report: 18.4.16

Work-stream: Medical Model	Reporting Period: W/E 15.04.16	Date Report Completed: 18.04.16

Current period RAG Status		Previous period RAG Status		KPI Trend		Must do actions completed this period	0

Key Achievements (Two Week Look Back)	Date	Two Week Look Ahead	Date	RAG Status
Medical Model implemented and flow now improving throughout the Trust	15/04	Finalise the other MDT room– one room now complete	29/04	
Lister Ward (AEC) now fully functioning – board rounds working well	15/04	Transition plan to ERC on 20/04 for approval	20/04	
All policies and procedures sent awaiting approval	29/03	Evaluation and PDSA cycles continue	29/04	
Data supplied for first 4 weeks of model implementation	14/04	Clinical challenge events planned and set up	06/05	
First PDSA review undertaken	12/04	Continue to plan for evaluation in May and June	29/04	
Phased transition plan completed	15/04	Data analysis required to produce reports	29/04	

Key Risks	Mitigation	Stakeholder Communication	Date
Sub optimum flow caused by late/failed discharge. Gaps on Jnr Dr rotas is causing some pressure on work plans	Bed management and site management review. Explore extending movement time for patients until 10pm	Junior Doctor workshop to discuss the model, identify JD issues and ideas. Explore how to take the model forward and how we present it to incoming Jnr Doctors	17/04/16
Management of patients staying longer than 48 hours on the AAW is requiring significant handoffs	Patients must be transferred from AAW after 48 hours. patients post 48 hours must stay with the Take GIM	Feedback to clinical teams on performance	17/04/16
Medical Model needs to be further embedded	Continue to reinforce the model and its principles with key stakeholder groups	Continued training and briefing for all staff. Daily basis through Ward Rounds & Board Rounds	Ongoing
Information flow is not yet available	Continued emphasis on gaining information	Ward Clerk training	24/03 & 4/04
Frailty changes have created additional patients for the Frailty Consultants to manage within Wakeley and Gundulph	Frailty Challenge through ECIP and GST T support. ECIP support into community this week		

Fortnightly Highlight Report: 18.4.16

Work-stream: Emergency Pathway	Reporting Period: W/E 15.04.16	Date Report Completed: 18.04.16

Current period RAG Status	🟧	Previous period RAG Status	🟧	KPI Trend	🟥	Must do actions completed this period	0

Key Achievements (Two Week Look Back)	Date	Two Week Look Ahead	Date	RAG Status
New Programme Director is now in post	04/04/16	ECIP-led Clinical Launch event held with Consultant body	19/04/16	🟩
Home First initiative commenced across A&CC Directorate	04/04/16	Draft 2 - EP Dashboard produced and populated with available data	29/04/16	🟧
EP Programme Board met and agreed requirements around bed occupancy and length of stay	12/04/16	Benchmarking LoS report completed. Capacity and Demand modelling underway	03/05/16	🟧
Stakeholder mapping exercise completed with PMO Communications Lead.	13/04/16	Revised Governance and reporting structure implemented across the Programme (with new Workstream Chairs)	03/05/16	🟧
Draft 1 - KPI dashboard produced and circulated for comment with EP Board Members	14/04/16	Site Operations Workshop to be held to review new Operations Model and Trust Concept of Operations	03/05/16	🟩
Workstream Chairs confirmed for all 3 workstreams	15/04/16	Revised Project Plan and Brief developed with Workstream Chairs.	03/05/16	🟧
External Discharge activity mapped with Workstream 3 (WS3) Chair to refine scope of WS3 deliverables	13/04/16			

Key Risks	Mitigation	Stakeholder Communication	Date
Lack of Data / Business Intelligence capacity	Scoping meeting held 13/04. Requirements to be reviewed by PMO Data Director and Head of Bus Intelligence	Consultant / Med Director meeting outlining key messages on the EP Programme	12/04/16
Co-ordinated Surgical Care Directorate not engaged with the Programme	Engage with new Director of Clinical Operations. Confirm Clinical Leadership for Workstreams	Trust Recovery Newsletter profiling programme to be completed and launched at the Staff Engagement Event (profiling EP and Trust Vision & Values together)	25/04/16
		Outline Programme Communications Strategy produced for review by EP Board	03/05/16
		Staff drop-in sessions to be planned to initiate	TBC

Fortnightly Highlight Report: 18.4.16

Work-stream: Deteriorating Patients		Reporting Period: W/E 15.4.16				Date Report Completed: 18.4.16	
Current period RAG Status		**Previous period RAG Status**		**KPI Trend**		**Must do actions completed this period**	**0**

Key Achievements (Two Week Look Back)	Date	Two Week Look Ahead	Date	RAG Status
The 'Recognising and Responding' sub-group meeting plan continues. Steering Group meeting and sign off of Terms of Reference	13.04.16	Changes to the process for the collection of Cardiac Arrest data	18.04.16	
CQC presentation and interviews completed with approval in principle regarding the project plan	28.03.16	Dashboard launch	02.05.16	
IHR and safety-briefs continue with monitoring plan in place	01.04.16	Support IT with the development of Track and Trigger business case to include financial benefits and efficiencies	22.04.16	
NEWS role out continues with development of Sepsis and AKI e-learning modules	28.03.16	Role and delivery plan of MFT support (Matrons) to be agreed/launched	25.04.16	
Agreement in principle of ART model of care	13.04.16	GSTT SNPs (x1 WTE) on night duty to develop night template/job plan	02.05.16	
Resource plan agreed for x1 WTE – Matrons and Critical Care Nurse Consultant	06.04.16	Review of IHR and Safety Briefs	02.05.16	

Key Risks	Mitigation	Stakeholder Communication	Date
Lack of clinical engagement in Medicine and ED	Director of Operations and ERC to be briefed	The next Improving our Hospital Newsletter is dedicated to DP	18.4.16
Clinical role of CSPs to be agreed in order to implement Acute Response Team Model as agreed by Executives	Discussions to commence with key directorate leads re roles and reporting lines.		
Medical cross cover at night	Medical director and key stakeholder meeting arranged		
Temporary staffing compliance with professional clinical standards	To be briefed as part of local induction on a shift by shift basis		

Fortnightly Highlight Report: 18.4.16

Work-stream: RTT		Reporting Period: W/E 15/04/2016				Date Report Completed: 18/04/2016		
Current period RAG Status		**Previous period RAG Status**		**KPI Trend**		**Must do actions completed this period**		0

Key Achievements (Two Week Look Back)	Date	Two Week Look Ahead	Date	RAG Status
Agreement to procure mobile MRI scanner to address the MRI waiting list backlog	08/04/2016	Complete draft RTT PID and action plan (revised deadline)	29/04/2016	
Substantive Director of Clinical Operations for Surgery is now in post	01/04/2016	Further reduction of endoscopy backlog for non-urgent patients	29/04/2016	
Capacity workshop with Medicine and Surgery (RTT Outsourcing)	06/04/2016	Draft Access Plan review meeting planned (MFT/CCG)	22/04/2016	
		Complete outsourcing plans for speciality sign-off (revised deadline)	18/05/2016	
		Cancer PTL (RTT) trajectory meeting planned with all specialities	28/04/2016	

Key Risks	Mitigation	Stakeholder Communication	Date
Endoscopy: Demand and capacity shows a weekly shortfall in steady state - 57 cases	Meetings being held with potential Endoscopy outsourcing partners	Weekly meetings with CCG Commissioners as part of the RAP process	Weekly meetings
Diagnostic RAP: Insufficient capacity for MRI demand	Business case for additional	Demand and Capacity planning meeting for Medicine and Surgery senior stakeholders	WE 22/04/2016
Operational management understanding of actions required for recovery trajectories	Sub-speciality level meetings ongoing with management and PMO to develop action plans		

Fortnightly Highlight Report: 18.4.16

Work-stream: Workforce & Clinical Leadership		Reporting Period: W/E 15.4.16				Date Report Completed: 18.4.16	
Current period RAG Status		**Previous period RAG Status**		**KPI Trend**		**Must do actions completed this period**	1

Key Achievements (Two Week Look Back)	Date	Two Week Look Ahead	Date	RAG Status
Leadership development programmes for Middle Managers designed and booked.	15/4/16	Launch of Trust Vision & Values to all staff	25/4/16	
All staff employed by temporary staffing service were paid on time	12/4/16	Anti-bullying Training for managers booked		
Start dates have been given to 90% of nurses at offer stage in the recruitment process	8/4/16	Anti-bullying Staff Workshops commence 20/4/16	20/4/16	
		Vision & Values briefing pack for managers available 25/4/16	25/4/16	
		Vision & Values Champions Breakfast booked	22/4/16	

Key Risks	Mitigation	Stakeholder Communication	Date
		Vision & Values comm's to senior managers	21/4/16
		Vision & Values all staff briefing	25/4/16

Fortnightly Highlight Report: 18.4.16

Four weeks into the new Medical Model

Achievements

- Successful ambulatory unit (incl: hot clinic; GP assessments; effective offloading of ED (860 pts in 1st 4 weeks); closing at night after 1st week.
- Functioning admission wards (>60% admissions: average LoS ↓ from >10.0 to <4 days with effective MDT board rounds): 6-9 admissions daily on each ward.
- 50% increase in Zero LoS
- 48hr discharge rate ↑ from 40 to 55%
- Dickens ward remains closed
- No ADL bedded patients
- Med outliers ↓ from 40-70 to 5-15pts
- Staff increasingly engaged
- Significant cost savings and opportunities for RTT

Ongoing Issues

- Benefit on 4hr target not yet evident: need to transfer out of ED earlier (i.e. clerking patients in admissions wards and not in ED)
- Need to increase number of patients going through admissions wards to ~90% of all medical admissions.
- Nursing: maintain adequate nursing numbers in admissions wards
- Junior doctors: need to improve team allocations and rotas (ongoing confusion)
- Base medical teams in admissions wards not ED (i.e. clerking…)
- Maintain senior attendance at board rounds
- Maintain rapid transfer to specialty wards at 48 hrs (particularly for COE / frailty, as small team)

Four weeks into the new medical model
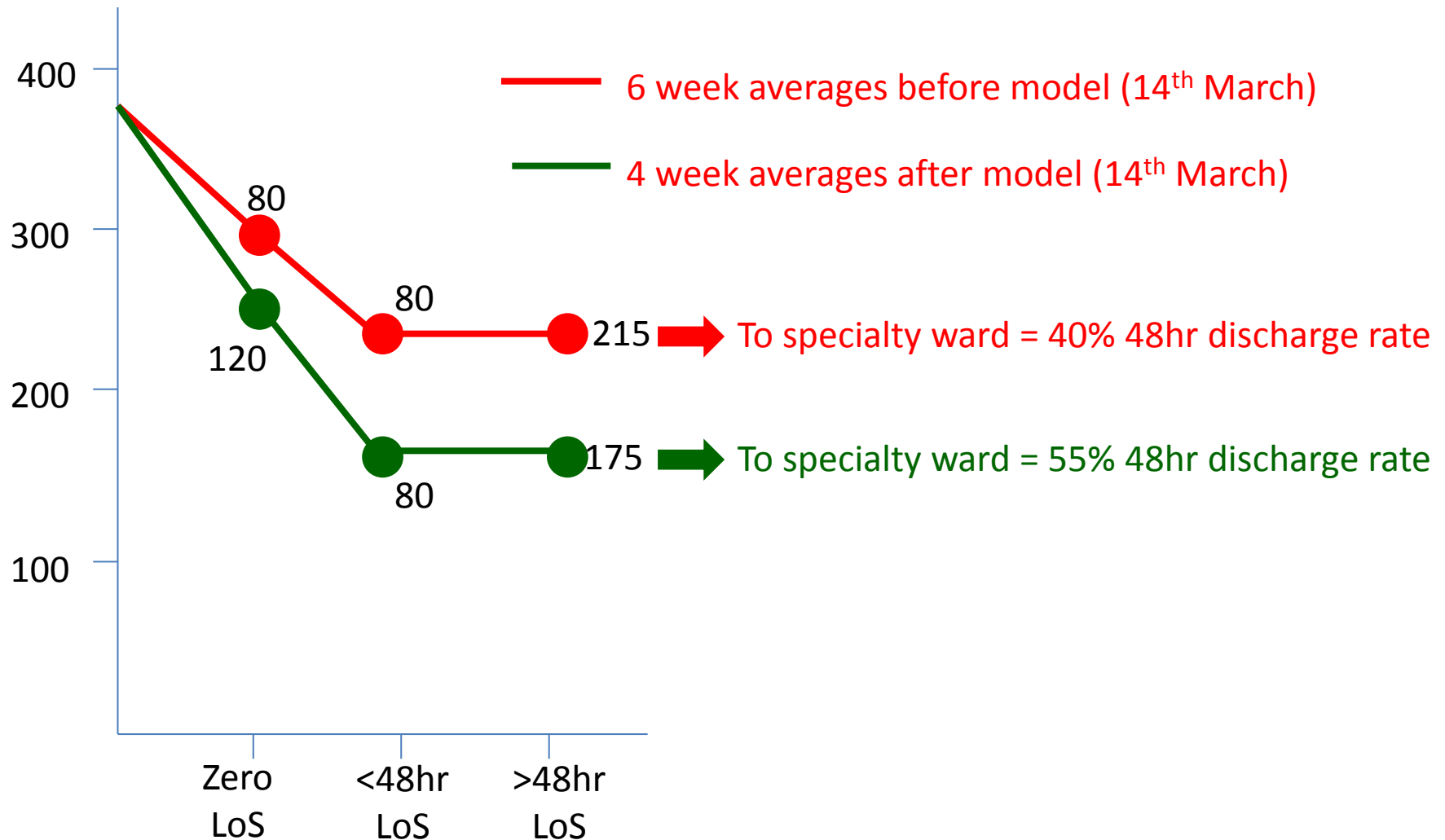
Key:

Not Met Target

Met Target

No Target

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Recovery Programme

Weekly KPI Dashboard
18th April 2016

CARING RESPECTING LISTENING LEARNING

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The Trust has failed to meet this trajectory in week 10, however there has been an improvement compared to previous weeks.

Week commencing 9th May, the Trust will implement an enhanced validation process to identify the cause of breaches and promote best practice.

1. 4 Hour Access Target

Percentage of patients waiting less than 4 hour access

- Actual
- Target

Medical model implemented

Impact of medical model will be noticed

This past week the Trust has seen a significant reduction to total time in ED.

Changes relating to the Emergency Pathway over the past 5 weeks will continue to have a positive effect on this indicator. In order of implementation, the main changes have been:

- New triage process
- DNA guidelines
- Board Rounds
- Medical Model
- Home First

2. Total Time in ED (80TH Percentile)

Total time in Emergency Department (80th Percentile)

- Actual
- Target

Week 1 = week beginning 8th February

Safe and Effective

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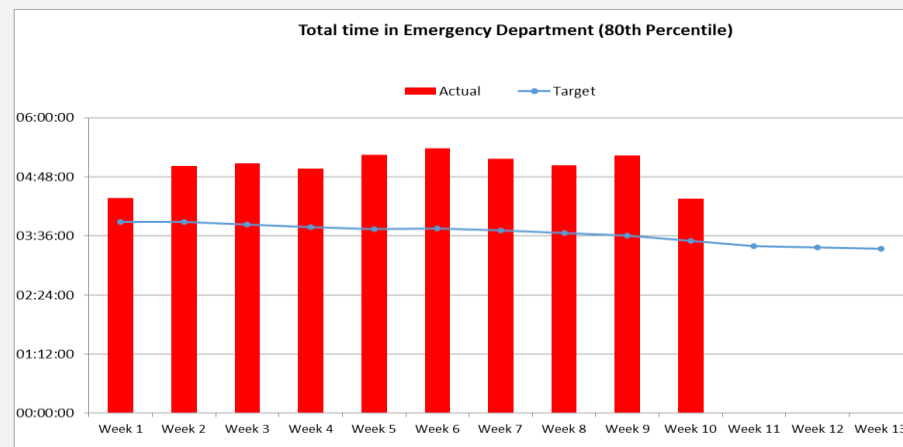
3. Total Time in ED (95TH Percentile)

The Trust has seen the best performance to date and is now meeting this target.

This is attributable to the cumulative effect of the new schemes and processes implemented over the past 5 weeks.

Total time in Emergency Department (95th Percentile)

Actual · Target
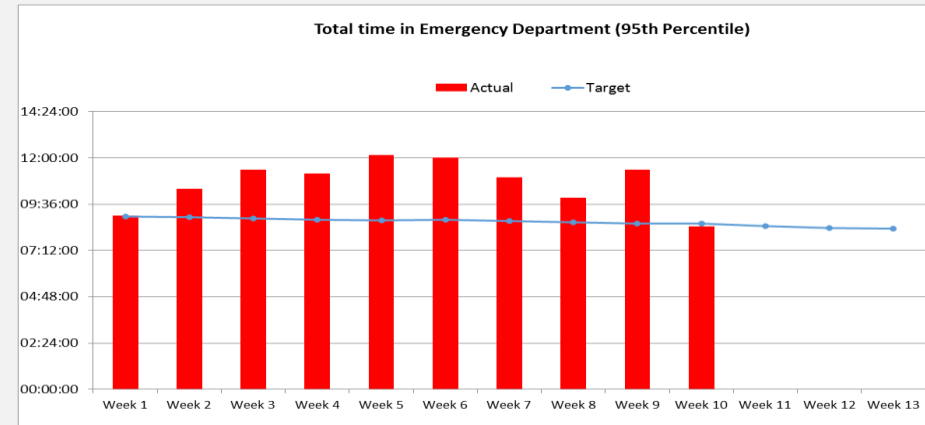
4. % of ambulance patients seen within 15 minutes

The Trust is now meeting this trajectory and performance has increased by 22% since Week 1. Senior clinical supervision and feedback have resulted in a steady improvement in performance.

This is complimented by the quality of the initial assessments which include formal triage and a weekly audited Plan of Care.
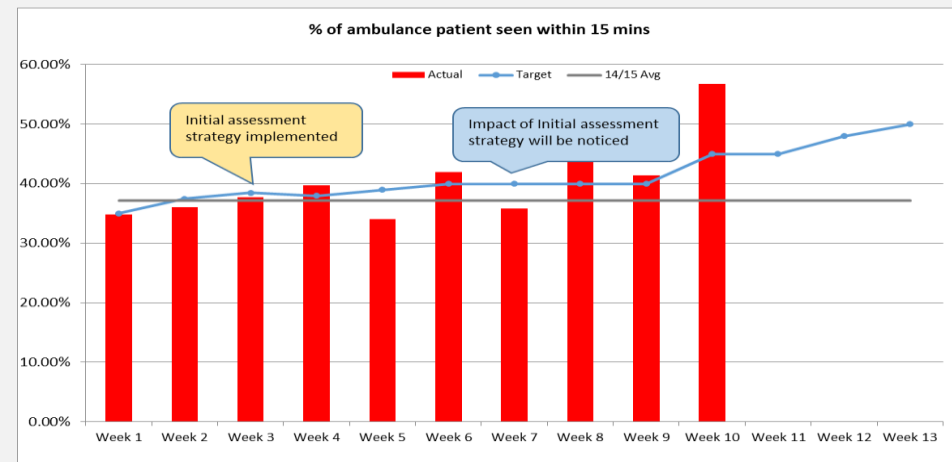
% of ambulance patient seen within 15 mins

Actual · Target · 14/15 Avg

Initial assessment strategy implemented

Impact of Initial assessment strategy will be noticed

Week 1 = week beginning 8th February

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NHS Foundation Trust

5. % of cohorted patients who comply with the clinical criteria

The Trust has met this trajectory for the 4th consecutive week. There has been a 58% improvement in flow since the introduction of the Medical Model and of the 'Decision to admit' Standard Operating Procedure (SOP).

Progress is being made in the major ED refurbishment scheme, with a business case expected to be presented to Board in May 2016.

% of cohorted patients who comply with the clinical criteria

Week 1 = week beginning 8th February

Safe and Effective

Medway **NHS**
NHS Foundation Trust

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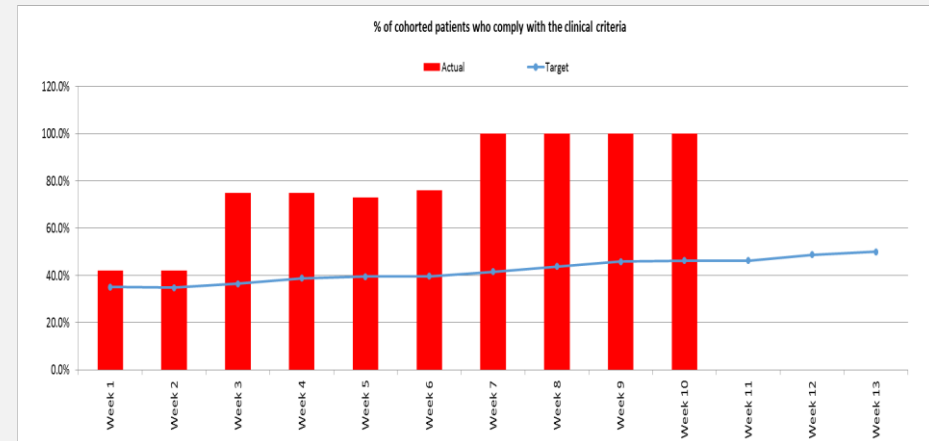
6. % Discharges from an acute bed pre noon

Week commencing 25th April the Trust introduces the initiative of identifying the 'Golden Patient' whereby eligible patients will be discharged before 9am on every ward) in order to increase early discharges. The Trust expects this initiative to help meet the set trajectory, whilst noting that the trajectory will be amended in the coming weeks.

% of discharges from an acute bed pre noon as % of total daily discharges

Legend: Actual, Target

Annotations: "Introduction of Board rounds", "Change reflects introduction of Board rounds"

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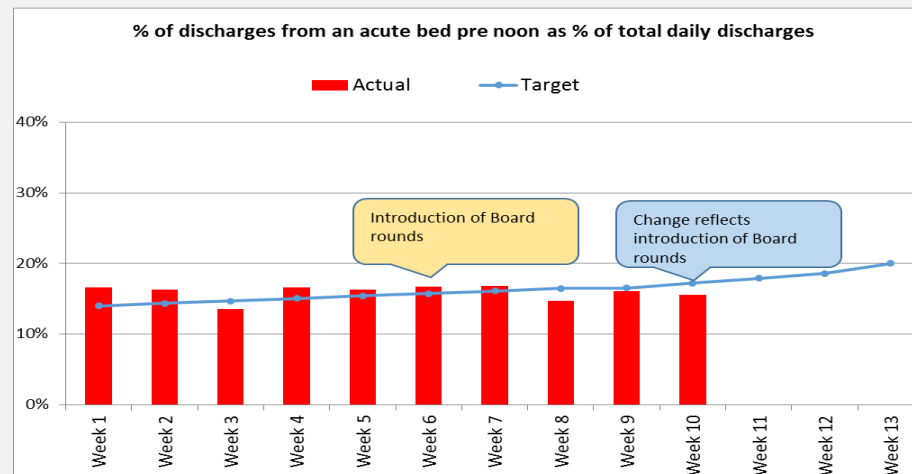
7. No. Medically Fit For Discharge LOS>7 Days

This indicator will be positively affected by the Home First initiative which was introduced in Week 9. It will take a number of weeks to embed this process with staff.

The number of DTOCs is slowly increasing and availability of community beds are becoming more challenging.

Medically Fit For Discharge LoS >7

Legend: Actual, Target

Week 1 = week beginning 8th February

Safe and Effective
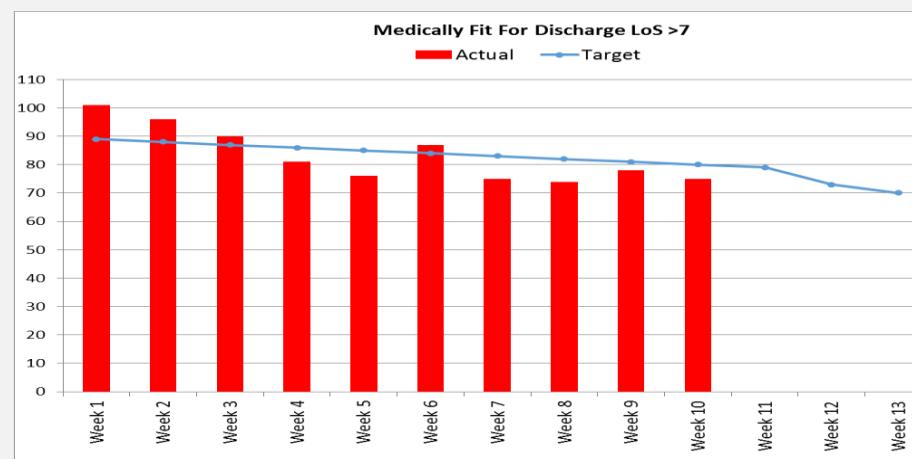
8. % Patients over 80 put on to frail pathway

The Medical Model continues to have a positive impact on ensuring frail elderly patients access this pathway at the beginning of their journey.

Performance has increased by 23% since Week 1 and over 100 bed days have been freed up per week.

The majority of other patients over the age of 80 are being cared for by a Geriatrician within the Care of the Elderly arena.

Please note this Indicator is reported a week in arrears.

% of admitted patients over 80 years of age put onto frail pathway

Actual — Target

Introduction of a specialist frailty nurse

Week 1 = week beginning 8th February

Medway **NHS**
NHS Foundation Trust
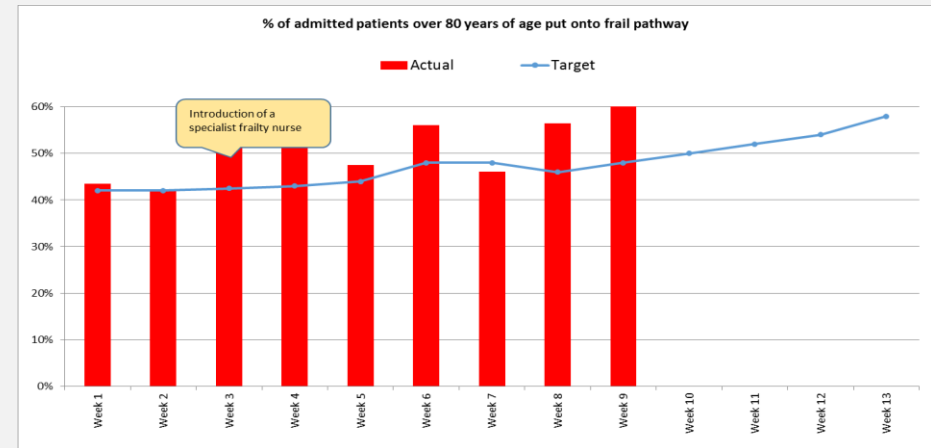
Safe and Effective

9. No. of SI's within ED Dept. including cohorted patients

There are 2 serious incidents being investigated following the initial Rapid Review, both will be notified as serious incidents as per protocol. Neither occurred within the 'corridor' area.

Number of SI's within ED Department
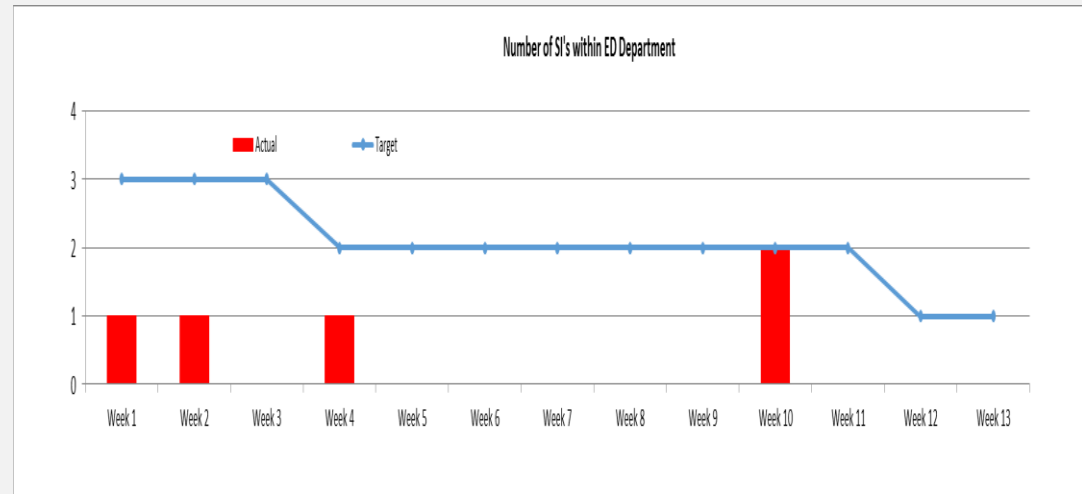
10. No. of Never Events

There have been zero declared
Never Events.

Week 1 = week beginning 8th February

Medway **NHS**
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This indicator is reported monthly, next report is due first week in May.

11. No. of wards <90% NEWS Compliance

Number of wards <90% NEWS compliance =>95% (excluding ED)

KPI to be reported on a monthly basis. March's data reported in Week 8

Week 8 zero wards were below 90% NEWS compliance
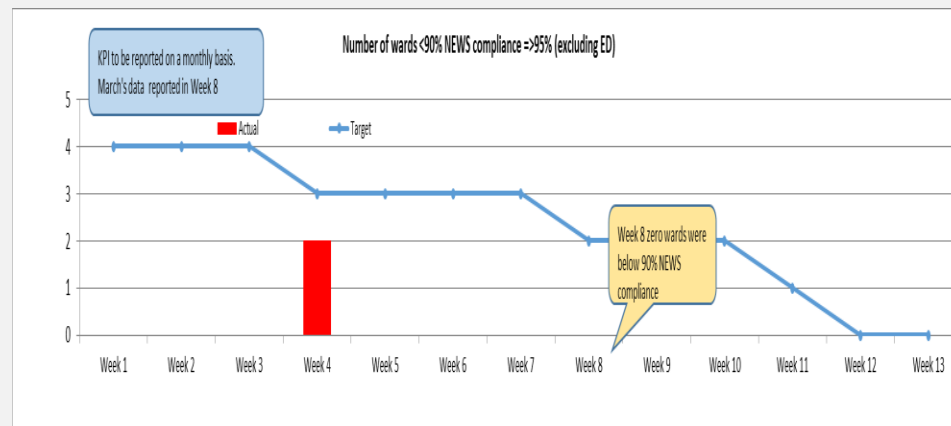
Fourth consecutive week of meeting this compliance target.

Senior team vigilance to continue until standardised practice becomes embedded.

12. NEWS Compliance for ED => 95%

% NEWS compliance for ED

Week 1 = week beginning 8th February

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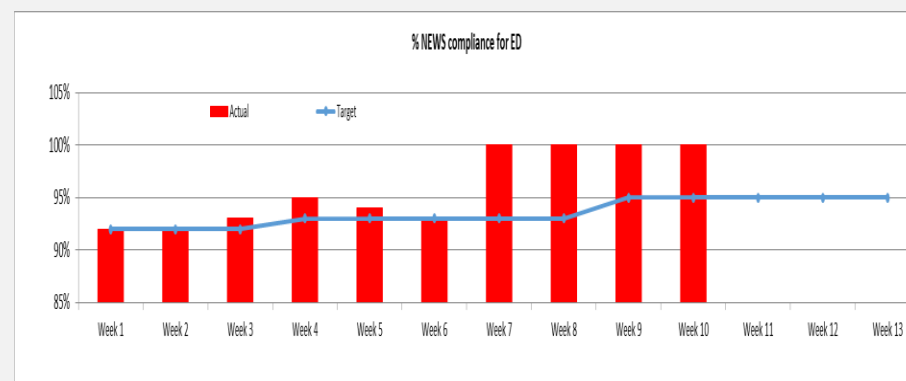
13. NEWS Compliance for Inpatient Wards =>95%

This indicator is reported monthly, next report due first week in May.

NEWS compliance for all Inpatient Wards => 95%

KPI to be reported on a monthly basis. March's data reported in Week 8

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14. Hospital Standardised Mortality Ratio (HSMR) (Rolling Year)
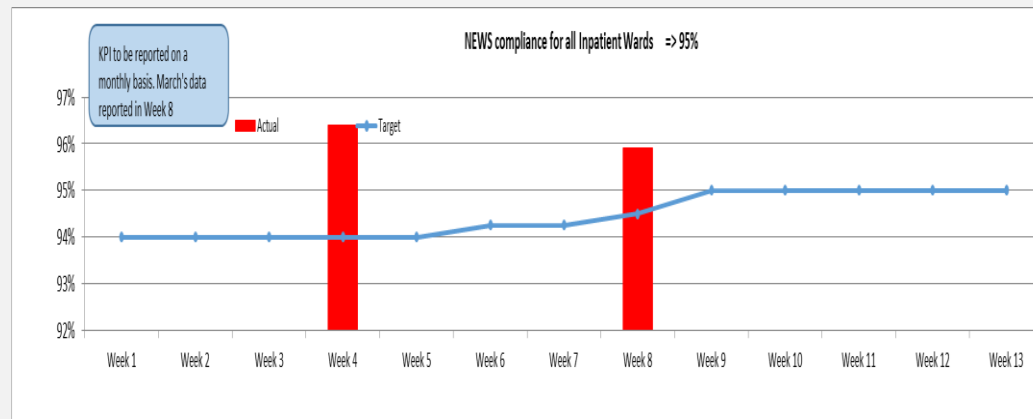
The Trust's updated HSMR position (October 2014 – November 2015) is 106.77 continuing the ongoing reduction that can be seen over the last year.

106.56 is significantly below the target set for the CQC indicator, which was to be at 109 until the end of March 2016.

Source: Dr Foster

HSMR 12 Month Rolling

Week 1 = week beginning 8th February

CARING   RESPECTING   LISTENING   LEARNING

Better care *together*

Caring
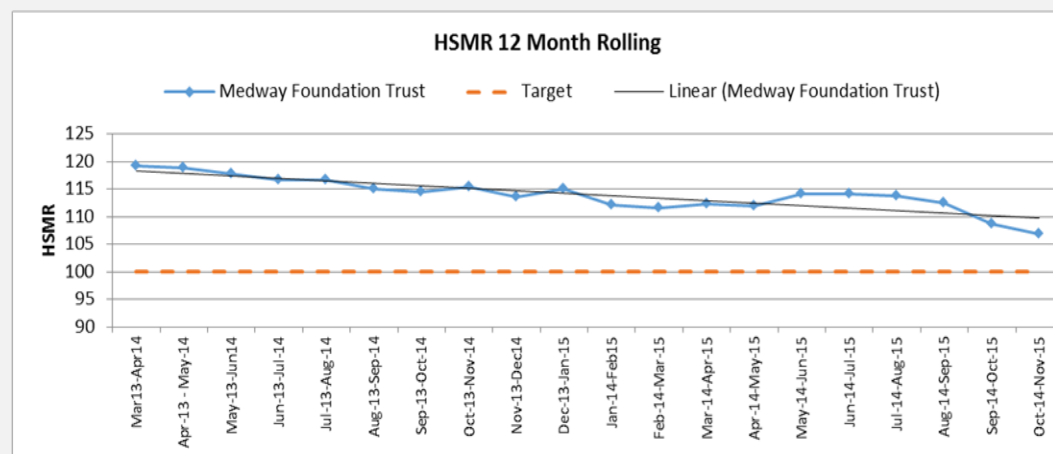
15. Reduction in Cardiac Arrests

The data collection methodology for this indicator has been reviewed as part of the Deteriorating Patient Programme.

The Deteriorating Patient workstream and dashboard is expected to be implemented in May.

Please note this indicator will be reported a week in arrears.
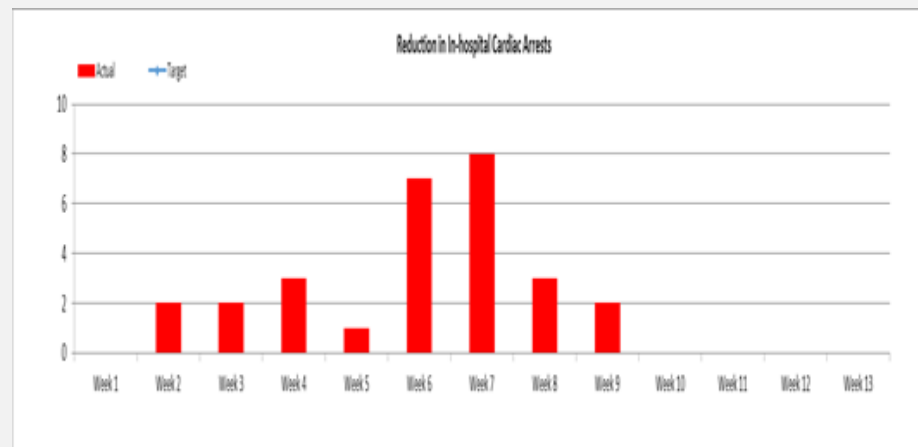
16. Total No. of times nurse: patient ratio on in-patient wards falls below 1:8

The Trust's overall fill rate of temporary shifts has increased by 2% since Week 9.

Further to this, March Vacancy figures for registered nurses show a drop of 2% on February 2016.

Week 1 = week beginning 8th February

Safe and Effective

17. % of Patients meeting Two week cancer target
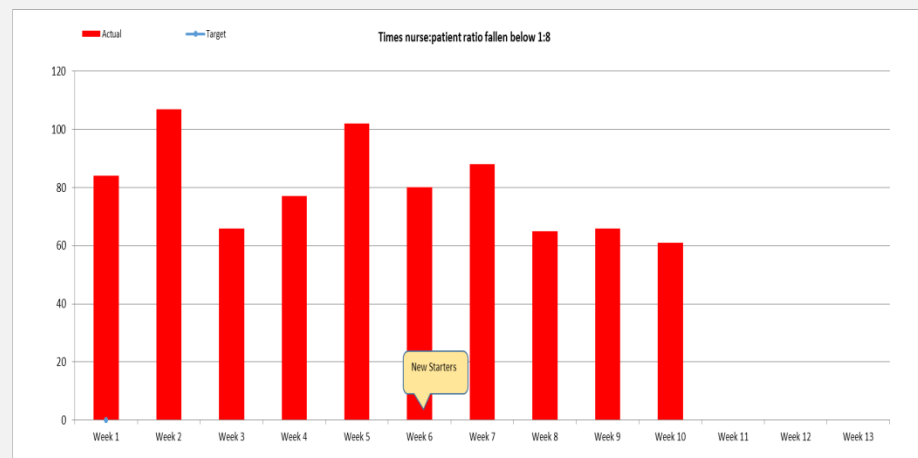
The Trust is currently not meeting this trajectory for Week 10. This is predominantly attributable to patient cancelled appointments and DNA's. This is linked to patient choice through the Easter holiday's.

Cancer 2 week wait

Easter holidays but still signed off monthly

18. % of PTLs signed by Clinician by Tumour Site
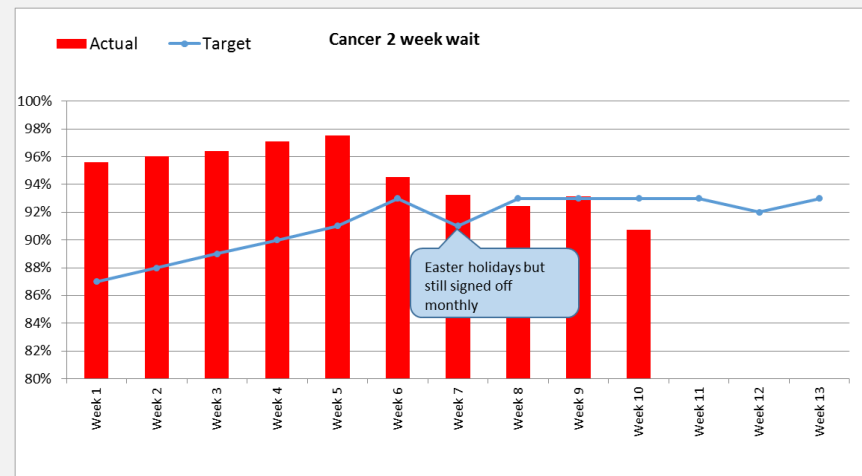
The Trust is not meeting this target in Week 10. This may be attributable to clinician leave over half term, despite having deputies in place.

It is anticipated that Week 11 will see a return to improved performance in line with the trajectory.

% of PTLs signed by clinician by tumour site
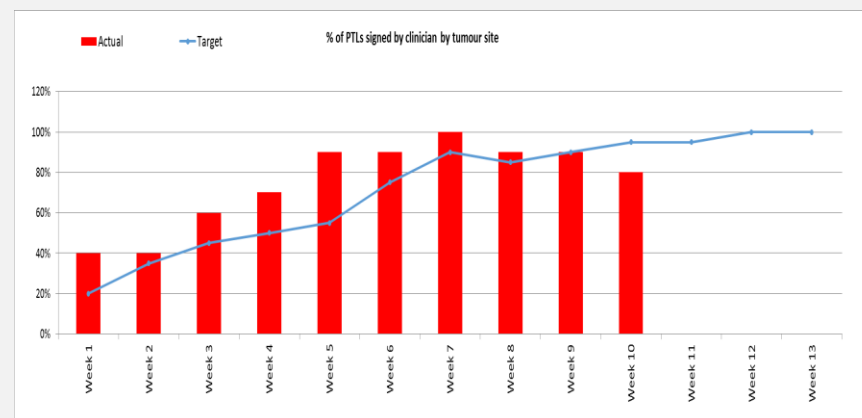
Week 1 = week beginning 8th February

20.% NEL inpatients discharged within 48 hours

The trajectory will be agreed this week with the operational lead as there is now 10 weeks worth of data.

Currently the performance is steady and is showing a decrease on the previous two weeks.

% NEL inpatients discharged within 48 hours

■ Actual

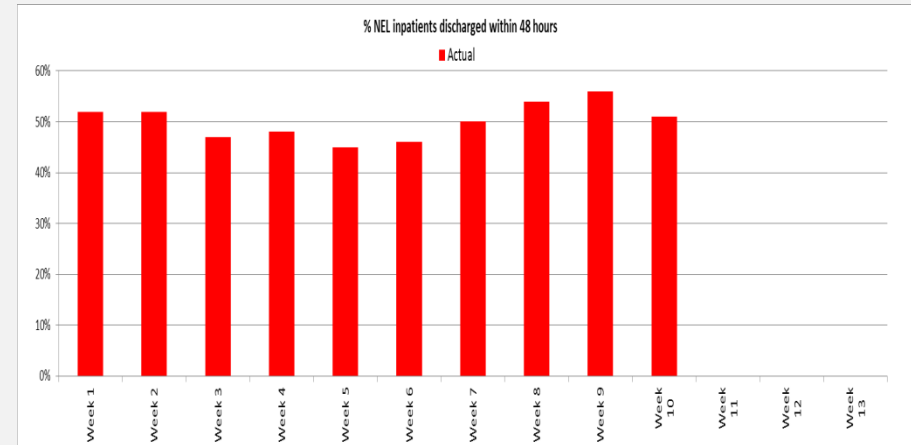| CQC Grouping	Measure	MFT Workstream	Lead	Baseline	April Target (per week unless stated)	Benchmark target	Actual/Target	Week 1 08-Feb	Week 2 15-Feb	Week 3 22-Feb	Week 4 29-Feb	Week 5 07-Mar	Week 6 14-Mar	Week 7 21-Mar	Week 8 28-Mar	Week 9 04-Apr	Week 10 11-Apr	Week 11 18-Apr	Week 12 25-Apr	Week 13 02-May
ED	1. 4 hour access target performance	Emergency Pathway	Director of Clinical Operations - Acute & Continuing Care	85.37%	88%	95%	Actual	78.4%	74.0%	73.72%	76.2%	74.1%	73.1%	74.5%	75.5%	73.9%	78.6%			
							Target	85.4%	82.6%	83.6%	84.2%	83.6%	82.3%	86.5%	88.6%	88.5%	88.0%	87.6%	88.0%	88.0%
	2. Total time in Emergency Department (80th percentile)	Emergency Pathway	Director of Clinical Operations - Acute & Continuing Care	03:52:45	03:20:00	03:00:00	Actual	04:22:23	05:01:20	05:04:00	04:57:48	05:15:00	05:22:49	05:10:00	05:01:52	05:13:36	04:21:00			
							Target	03:52:45	03:52:45	03:49:52	03:46:59	03:44:07	03:45:14	03:42:21	03:39:28	03:36:36	03:30:00	03:23:50	03:22:00	03:20:00
	3. Total time in Emergency Department (95th percentile)	Emergency Pathway	Director of Clinical Operations - Acute & Continuing Care	08:56:56	08:20:00	04:00:00	Actual	09:00:21	10:24:00	11:23:00	11:12:24	12:09:00	12:00:24	10:59:00	09:56:00	11:24:12	08:28:00			
							Target	08:56:56	08:56:00	08:51:41	08:47:22	08:46:00	08:48:00	08:43:41	08:39:22	08:35:02	08:35:00	08:29:00	08:22:00	08:20:00
	4. % of ambulance patients seen within 15 minutes	Emergency Pathway	Director of Clinical Operations - Acute & Continuing Care	37.20%	50%	70.00%	Actual	34.8%	36.0%	37.7%	39.70%	34.1%	41.9%	35.8%	46.9%	41.4%	56.8%			
							Target	35.0%	37.5%	38.5%	38.0%	39.0%	40.0%	40.0%	40.0%	40.0%	45.0%	45.0%	48.0%	50.0%
	5. % of cohorted patients who comply with the clinical criteria	Emergency Pathway	Director of Clinical Operations - Acute & Continuing Care	35%	50%	N/A	Actual	42.0%	42.0%	75.0%	75.0%	73.0%	76.0%	100%	100%	100%	100%			
							Target	35.00%	34.78%	36.34%	38.75%	39.43%	39.64%	41.50%	43.75%	45.76%	46.25%	46.15%	48.75%	50.00%
Flow	6. % of discharges from an acute bed pre noon as % of total daily discharges	Medical Model	Director of Clinical Operations - Acute & Continuing Care	14%	20%	40%	Actual	16.6%	16.3%	13.5%	16.6%	16.3%	16.7%	16.8%	14.7%	16.0%	15.6%			
							Target	14.0%	14.4%	14.7%	15.1%	15.4%	15.8%	16.1%	16.5%	16.5%	17.2%	17.9%	18.6%	20.0%
	7. Numbers of Medically Fit For Discharge LOS > 7 days	Medical Model	Director of Clinical Operations - Acute & Continuing Care	89	<70	N/A	Actual	101	96	90	81	76	87	75	74	78	75			
							Target	89	88	87	86	85	84	83	82	81	80	79	73	70
Frail Elderly	8. % of admitted patients over 80 years of age put onto frail pathway (reported 1 wk in arrears)	Emergency Pathway	Director of Clinical Operations - Acute & Continuing Care	42%	58%	N/A	Actual	43.53%	41.9%	52.3%	72.60%	47.56%	56.06%	46.05%	56.45%	66.67%				
							Target	42.0%	42.0%	42.5%	43.0%	44.0%	48.0%	48.0%	46.0%	48.0%	50.0%	52.0%	54.0%	58.0%
Deteriorating Patient	9. Number of serious incidents within ED department including any relating to cohorted patients	Emergency Pathway	Chief Quality Officer	3 per month	1 per month	0	Actual	1	1	0	1	0	0	0	0	0	2			
							Target	3	3	3	2	2	2	2	2	2	2	2	1	1
	10. Never Events	Emergency Pathway	Chief Quality Officer	0	0	0	Actual	0	0	0	0	0	0	0	0	0	0			
							Target	0	0	0	0	0	0	0	0	0	0	0	0	0
	11. Number of wards <90% NEWS compliance (excluding ED). This is reported Monthly	Deteriorating Patient	Medical Director/Director of Nursing	4	0	N/A	Actual						2		0					
							Target	4	4	4	3	3	3	3	2	2	2	1	0	0
	12. NEWS compliance for ED => 95%	Deteriorating Patient	Medical Director/Director of Nursing	92%	95%	95%	Actual	92.0%	92.0%	93.0%	95.0%	94.0%	93.0%	100.0%	100.0%	100.0%	100.0%			
							Target	92.0%	92.0%	92.0%	93.0%	93.0%	93.0%	93.0%	94.5%	95.0%	95.0%	95.0%	95.0%	95.0%
	13. NEWS compliance for all Inpatient Wards => 95%	Deteriorating Patient	Medical Director/Director of Nursing	94%	95%	N/A	Actual				96.40%				95.9%					
							Target	94.0%	94.0%	94.0%	94.0%	94.0%	94.3%	94.3%	94.5%	95.0%	95.0%	95.0%	95.0%	95.0%
	14. HSMR rolling monthly (over-arching KPI)	Deteriorating Patient	Medical Director/Director of Nursing	109 (per quarter)	106 (per quarter)	100	Actual	108.69	106.77	106.77	106.77	106.77	106.56	106.56	106.56	106.56	106.56			
							Target	109			109				108				107	106
	15. Reduction in In-hospital Cardiac Arrests (Reported 1 wk in arrears)	Deteriorating Patient	Medical Director/Director of Nursing				Actual		2	2	3	1	7	8	3	2				
							Target													
Safe Staffing	16. Total number of times nurse:patient ratio on in-patient wards falls below 1:8	Nursing	Director of Nursing	115	105	N/A	Actual	84	107	66	77	102	80	88	65	66	61			
							Target	Trust will define long-term trajectory target on completion of the current review period using data collected during this period												
RTT - Cancer	17. % of patients meeting two-week cancer target	RTT	Chief Quality Officer	85.23%	93%	93%	Actual	95.6%	96.0%	96.41%	97.09%	97.50%	94.55%	93.25%	92.45%	93.14%	90.71%			
							Target	87.0%	88.0%	89.0%	90.0%	91.0%	93.0%	91.0%	93.0%	93.0%	93.0%	93.0%	92.0%	93.0%
	18. % of PTLs signed by clinician by tumour site	RTT	Chief Quality Officer	20%	90%	100%	Actual	40.0%	40%	60%	70%	90%	90%	100%	90%	90%	80%			
							Target	20.0%	35.0%	45.0%	50.0%	55.0%	75.0%	90.0%	85.0%	90.0%	95.0%	95.0%	100.0%	100.0%
Frail Elderly	19. % of patients admitted to the frailty pathway seen by a Geriatrician within 14 hours (reported 1 wk in arrears)	Emergency Pathway	Director of Clinical Operations - Acute & Continuing Care				Actual										71.21%			
							Target	See definition page for update on this indicator. Data collection starts at Week 10												
Flow	20. % NEL inpatients discharged within 48 hours	Medical Model	Director of Clinical Operations - Acute & Continuing Care	50%		N/A	Actual	52%	52%	47%	48%	45%	46%	50%	54%	56%	51%			
							Target	Data has now been collated. Trajectory to be set in Week 11.												

Actuals for each week (weeks 1 to 13) will be populated on the trajectory graphs from week beginning 15th February for the previous week

Title of meeting:	Trust Board	Date: 28.4.2016
Title of report:	Quality and Performance updates	Agenda item:
Reporting Officer:	Dr Trisha Bain CQO	
Lead Directors:	Dr Diana Hamilton-Fairley/Dr Trisha Bain/Karen Rule/Rebecca Bradd	
FOI status:	*This paper is disclosable under the FOI Act;*	

Report Summary:

The reports included under this section of the Board agenda include: the IQPR report that identifies all KPIs discussed at the QIG. The four responsible officers reports will highlight any issues/progress from the IQPR, and progress against their own portfolios.

Purpose: This paper is for:

Assurance	√	Approval		Decision		Information	√

Recommendation:

The Board are asked to note the information within the portfolio reports and direct any questions to the responsible executive to provide views on their assurance in relation to the information and responses given..

Strategic Objective Links:

Highlight which strategic object(s) this recommendation aims to support.

1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment.
2. We will attract, retain and develop a first class workforce.
   .
3. We will provide high quality information and technology to support the delivery of care.

Identified Risks and Risk Management Action:

No major risk identified.

Resource Implications:

None

Recovery Plan implications:

Does the subject matter support the Recovery Plan

Yes: √	No:

If yes, highlight which aspect of the Recovery Plan this recommendation aims to support. [Delete those that are not applicable].

- Continuing to modernise our Emergency Department and pathway, reducing the time it takes for patients to be seen and assessed.

- Improving patient safety and care by minimising the number of different doctors that patients see during their stay in hospital.

- Accelerating our recruitment drive to employ the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interim and agency staff.

- 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.

- Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.

Recovery Plan Workstream [Highlight which workstream(s) the subject matter supports]		
Corporate Governance	Deteriorating patient	Referral management
Workforce	Nursing	Emergency pathway
Clinical leadership	Clinical goverance	Medical model
Data quality	Finance	

Quality Impact Assessment:

Does the subject matter require a QIA?

Yes:	No: √

If yes, attach the QIA as an appendice.
The paper will not be reviewed at the meeting if this is not attached.

If no, state why one is not required.

Report History:

Prevus discussions of the IQPR at March QIG

Next Steps and Further Reporting to the Board (if applicable):

No further reporting required unless requested by Board

Appendices:

Supporting information to the report should be listed here.

For further information or for any enquiries relating to this report please contact:
Dr Trisha Bain trisha.bain@nhs.net:

Quality and Health Informatics Update: April 2016

Background

The report highlights progress made within the Health Informatics remit over the last month in relation to:
- IQPR – KPI status
- KMHIS re-structuring and consultation
- Clinical Systems development : Bed Management, Order Comms, e-referral, EPR Digital Road Map
- Data Quality Programme
- Business Intelligence and Performance Framework
- Supporting Infrastructure
- Quality systems and processes

QUALITY AND HEALTH INFORMATICS: CURRENT STATUS

1. IQPR – KPI UPDATE

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

- Serious Incidents:

  There are a total of 36 cases currently open (as of 7/4/16).
  - 4 historical reports went to the CCG closure panel on 24 March 2016; feedback is awaited.
  - 32 cases remain open (10 are already for submission)
  - Of the 22 remaining, 14 are in date and all have investigators.
  - 1 case has gone to NHS England.
  - 7 SI are breaching, of which:
  - 2 cases are being considered for downgrading
  - 1 case is with Directorate for sign off
  - 3 are under investigation
  - 1 requires significant work.
- The chart below shows average SI breach days by month – to show the improvements seen since April 2015.

Average SI Breach Days by Month 2015/16
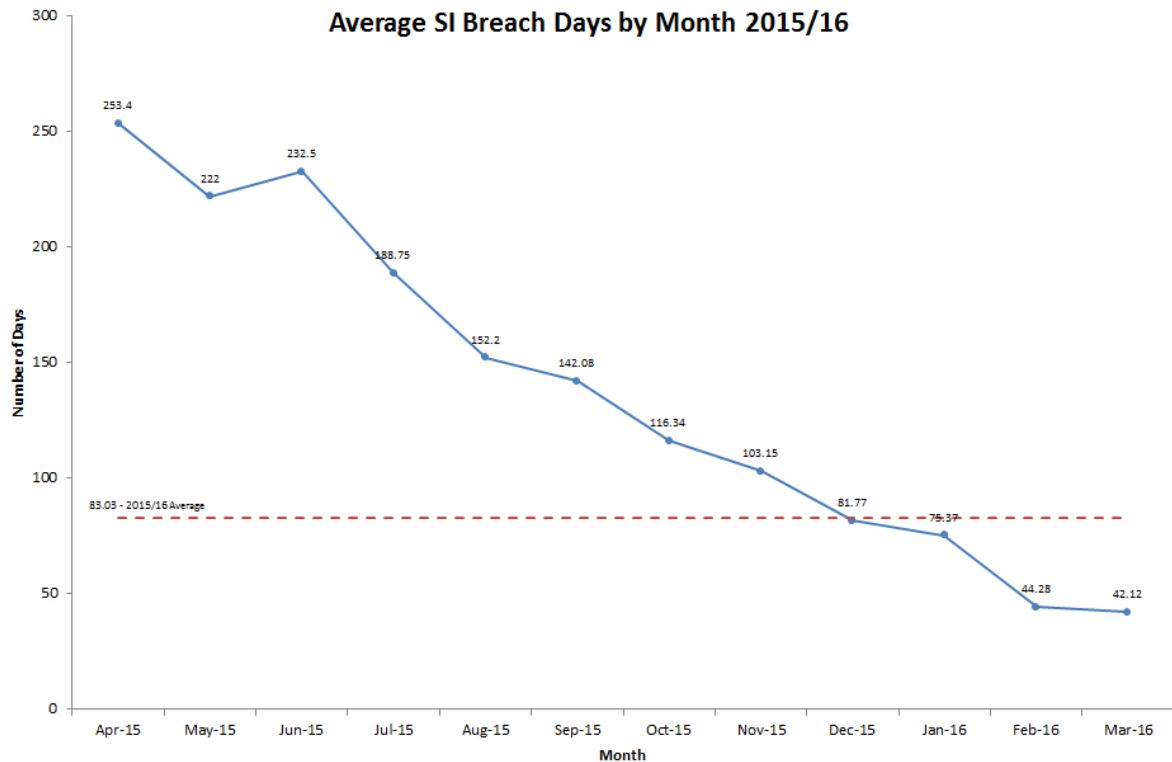
- The CCG have raised concerns re deadlines and issued a breach of contract.
- The Coroner has issued a Prevention of Future Deaths/Regulation 28. Our response and action plan are being completed.
- SI action plan, we are working towards closure of this historic action plan, with work being taken forward at the most appropriate group (e.g. medicines management group and deteriorating patient group).

- 2015/16 AKI and sepsis CQUIN:
  Total amount of CQUINs = £889,944.15
  Total amount achieved = £533,966.49

  2016/17 National CQUIN again includes sepsis. A business plan is being written to secure resources required.

- Datix incidents. Since February 2016, we have moved someone into the Patient Safety Team (PST) to lead on incident management and closure. The total incidents awaiting final approval include the total incidents awaiting final review and the total incidents overdue. The data shows a considerable improvement. At the beginning of the year in Jan 2016 there was a total of 2042 incidents, this reduced by 1655 by the end of Feb to 387.

- General progress with NICE compliance
  - Responses received and meetings held to discuss and provide evidence for several key historic guidelines (e.g. Ovarian and colorectal cancers, Acute Kidney Injury (AKI))
  - New processes for reviewing guidance and providing assurances on compliance introduced, including a 90 day response deadline for all

guidance, and publicised escalation process to ensure deadlines are met
- o New response forms developed to help evidence compliance. These forms are specific to the guidance types and work alongside the new processes
- o More collaborative working with Directorate governance co-ordinators to maximise engagement and communication

.

- Technical Appraisals
  - o 2 published
  - o 1 assessed as not applicable, 1 partially compliant (network guidelines need to be updated, but the treatment is considered for patients during MDT meetings)
  - o None outstanding – all responded within 90 days

- Quality Standards
  - o 4 published
  - o All outstanding currently – all distributed, responses due by the end of June 2016

- Clinical Guidelines
  - o 6 published
  - o 1 assessed as fully compliant (response received within 90 days)
  - o 5 currently under review – all distributed, responses due by the end of June 2016

- National Audit

- Results published:
  - o End of Life Care Audit results have been published; the Trust only met 2 of the eight organisational quality indicators, but in terms of the clinical audit we were either in line with national or better than national for 4 of the 5 Quality Indicators.
  - o National Lung Cancer Audit results have been published: Key findings 94.7% of patients were seen by a CNS compared to 77.5% nationally; active treatment rates lower than national at 45.9% compared to 57.6%

- Ongoing Audits:
  - o National Bowel Cancer Audit – Case submission now at 93% (case submission last year was 29%). Data collection for 2014/15 continues until June. We are starting to collect data for 2015/16 now.
  - o NELA – year to date mortality 8% (cf 10% in Year 2 and 17% in Year 1).

- Forthcoming Audits:
  - o National Smoking Cessation Audit – 100 cases required, data from April and May 2016. We will commence data collection in May with April patients to ensure a representative spread of cases.
  - o National Audit of Dementia – Organisational audit just opened.

CARING   RESPECTING   LISTENING   LEARNING   Better care *together*

2. HEALTH INFORMATICS: POST KMHIS DISSOLUTION

The newly integrated Health Informatics team, successfully launched the service desk and core IT support on the 31st March. The transfer from KMHIS ran smoothly as planned with good initial feedback from the user community. Final vacancies continue to be recruited to as we welcome the new staff that have transferred from the KMHIS.

Project closure and lessons learned will be completed in May.

3. CLINICAL SYSTEMS DEVELOPMENT

- The consultation and procurement process for the **electronic bed management system** has now concluded. The procurement includes a track and trigger system, selected by clinical teams. The business case will be presented to the Board in April. The roll-out will be agreed following project planning with the PMO to ensure that the project aligns to and does not conflict with the roll out of other significant change programmes.
- The **Order Comms** electronic ordering and test result system business case was approved at the March Board and is now out to procurement at the PQQ stage. Business change and interfacing work streams have commenced. The ability of GE to provide the requisite interfaces and data clean up to project timescales is currently a high project risk.
- **E-referral** For the initial specialties of breast surgery and gynaecology go live took place on the 11th April; the Trust alongside partners in Medway and Swale CCG's are now working toward raising the compliance toward the 100% electronic goal. Crucially this go live includes the rapid access, 2 week referrals for cancer in these specialties being made via electronic pathways; this mitigates the information governance and patient safety risks around the previous unsecured fax method.
- **Pan Kent PACS/RIS system :** the on-going issues in relation to GE RIS remain unresolved. Medium to longer term solutions are being explored. GE PACS is due to be upgraded 6/7 May. GE RIS upgrade postponed due to quantity and severity of issues found during testing. Issues continue to be escalated to the directors of GE in Europe.
- **Digital Roadmap/Strategy** Continues to be developed alongside partners in the local health economy.

4. DATA QUALITY AND SUPPORTING STRATEGIES

- The Data Quality and data warehouse project is now at the PID stage with resources being reviewed to take forward what will be a 12-18month

programme of work . The programme will focus on ensuring that data quality is 'owned' by the directorate and that this becomes an integral part of performance management frameworks. In parallel the data warehouse will be developed to provide standardised, real time reporting and 'one version of the truth' in terms of data analytics and reporting functionality.

- A significant amount of progress has been made in relation to 18 weeks RTT,in terms of validation of the backlog to an accurate >18 week position. Oasis PAS system development has ensured that issues in relation to accuracy of 'clock stops' for RTT has been resolved. However there is still a large proportion of data quality issues that relate to on-going 'user' error. Training is not currently keeping pace with the need and a case is being proposed to increase the number of MDT/Pathway co-ordinators using funded monies and/or validation team resources via the PMO RTT review.

5. BUSINESS INTELLIGENCE ; PERFORMANCE MANAGEMENT & ACCOUNTABILITY FRAMEWORK

- An information 'pack' is now available that includes quality, performance, finance (including CQUIN and CIPs). A standard summary and escalation sheet will be used at the performance meetings so that the focus is on risks to delivery. The information pack has now been used twice in the performance meetings.
- The BI team have met with General Managers to talk through the need for operational reporting and are currently building reports that will meet the needs of the Directorates at service level. The reports will be drillable to specialty, clinic and consultant level. Training will be provided on how to use them and the BI Business Partners will help with the interpretation of the data flowing from these.
- The clinical coding manager has spoken to the DQ User Group about the project to improve outpatient coding, which will provide more accurate data on activity and will also bring increased financial benefits. The project will be monitored through the DQ User Group.
- The DQ User Group are also monitoring a project around the outcome of clinics which is currently being trialled in Gynaecology. This will provide more timely, and therefore, more accurate data on the outcome of appointments and clinics and will help slightly improve income.

6. SUPPORTING INFRASTRUCTURE

- **Public and Patient Wi-Fi** has now been soft launched across the hospital, feedback is being sought and technical adjustments are being made before publicising the new service. The high quality firewalled connection out to the internet will allow patients to stream video to their bedside, for those that wish to do so on their personal devices.
- Wi-Fi provision in our staff residences is awaiting final connection; this is a key support measure to our retention of overseas staff that have come to work at Medway.

- Network cabling works continue in the main hospital building, the majority of the flood affected areas have now been moved to the new Network.
- The switch to all email users to **nhs.net** will be complete by late summer following an upgrade of the national system to NHS Mail2 provided by Accenture.
- We are currently working with the Medical Director to recruit a **Chief Clinical Information Officer** to work alongside the health informatics team to take forward the clinically focused and driven strategies.

7. QUALITY SYSTEMS AND PROCESSES

- Training for additional members of staff in RCA is being arranged with support from the GSTT team – dates are in place for April and June 2016.
- A trust-wide learning day is planned for May, a follow up event to the Trust Sign up to Safety initiative that will include learning from serious incidents.
- Newsletters have been well received that outline progress and learning from SI investigations and mortality reviews. An example is given as Appendix 1.
- A new tracking module has been developed to ensure the exact progress of SI investigations can be reported on and risks escalated.
- The Trust has been represented at the following Kent, Surrey and Sussex Academic Health Science Network events:
  - Improving Organisation Capability to undertake Safety and Quality Improvement – Introducing Front Line Safety Culture Assessment
  - Fractured Neck Of Femur collaborative
  - AKI collaborative
- The Quality Improvement Project Nurses are doing a rapid assessment of incidents involving deteriorating patients. This is added to the Datix so the handler has an objective overview and timeline. Feedback from ward staff has been positive as they see incidents being reviewed within a short timeframe and feel they are being taken seriously.
- The PST are also training staff to improve the quality and accuracy of information reported on Datix.
- The Trust's Hospital Standardised Mortality Ratio (HSMR) continues to demonstrate a downward trend and the most recently published value, for the period January 2015 – December 2015, is 106.6 and within confidence limits (LCL 100.78, UCL 112.59).
- The most recently published SHMI value, for the period October 2014 – December 2015, is 1.15 which whilst higher than expected is a reduction on previous periods and the lowest published value for the Trust since 2013. The Trust is optimistic that the SHMI will continue to demonstrate a reduction moving forward and aims to be within benchmarked limits by the end of 2016/17.
- Mortality and Morbidity Reviews continue to be undertaken within the Directorates and to date 502 completed forms have been received. It is hoped that the Mortality and Morbidity form will soon be made electronic, further improving completion rates however this is subject to approval by PCAB. The Trust's Mortality Learning Co-ordinator is now producing a Directorate Level

report to provide feedback in relation to review completion alongside current Trends and Themes which has been well received and moving forward will support with the production of a Monthly data pack for clinicians.

- Improving the understanding of mortality data amongst clinicians is key the Trust's reduction within the published mortality indicators, as such the Trust's Mortality and Learning Co-ordinator is working collaboratively with the newly appointed Head of Clinical Coding to support clinicians. A new deceased coding validation process went live on 1st April 2016 and the Clinical Coding Department have started to attend the diagnosis specific action groups that are ongoing within the Trust to see where improvements can be made that benefit both clinicians and the processes within the Clinical Coding Department.

- A GP is now attending the Trust Mortality and Morbidity meeting to allow feedback and collaborative working on any issues raised.

PATIENT SAFETY NEWS

April 2016

Learning from Simulation

On 2nd February, a multidisciplinary "in situ" simulation was run on Delivery Suite.
This involved a postnatal lady attending hospital 4 days after caesarean section with signs of sepsis, eventually progressing to septic shock. This further deteriorated to cardiac arrest.

We owe thanks to all of those who were involved!

Learning points, of which some seem obvious to many of us, taken from the session included:

- Use of the Critical Care Outreach Team bleep 725 with a deteriorating MEOWS
- The importance of leadership and effective and explicit communication skills, including SBAR to make sure that whole team shares same situation awareness
- It is essential that you state your name and your role when attending an emergency, where several disciplines are present
- Appropriate and efficient delegation and using all resources
- "Closing the loop" helps to avoid misunderstandings. This means that when a clinician gives you an instruction, you repeat the instruction back so they know you have understood what is expected of you. Once the task has been completed, you should communicate this back to the clinician who gave the original instruction. This informs the clinician that you have done the task.
- Once a crash call has been put out report this back to the team so everyone is aware that the task has been completed
- As it is unlikely that midwifery and some obstetric staff are ILS (intermediate life support) trained, ensure appropriate leadership in a cardiac arrest scenario is taken.

The importance of accurate and timely eDN especially for vulnerable, high risk patients

The Electronic Discharge Notification (eDN) system enables the production of discharge summaries and helps this Trust to ensure that they comply with the requirements for issuing discharge summaries to patients' GPs within 24 hours, ensuring patient care is transferred in a timely manner.

The eDN process enables staff to manage the list of patients requiring discharge summaries within each ward. For example the input of nursing and clinical information - including prescriptions, the recording of prescription workflow by pharmacy, and the printing and sending of the discharge summary itself.

GP's use these discharge summaries to follow up patients, identify what medicines have been altered, stopped and when to be restarted and if any blood tests are required so it is crucial that these are completed well.

Learning

Patient was admitted with overdose and self-discharged 8 days later against advice. The Mental Health team were involved in the patient's care. Following self-discharge there was a delay in the GP being notified for 12 days and he was a very vulnerable adult.

Key Issues
- *eDN should have been completed within 24hrs*
- *eDN was not issued for 12 days*
- *No consideration of safeguarding -given his high risk factors and vulnerability*

In-Patient Communication Sheet - Are you completing it!

A new 'In-patient Communication sheet' has been developed by the Endoscopy Unit in an attempt to improve the receiving of patients to the unit. This information sheet can ensure that the pre–checks and important information about the patient are recorded the day before the patients procedure. It also helps with the transportation of the patient to Endoscopy by giving information regarding their mobility, if they have oxygen, drip etc which will help prevent delays or issues for the patient when they are coming for a procedure.

Please help to improve the patients experience and smooth running of the department by making sure this is completed.

Thank you!

We are here to help you - Datix Reporting

It is everyone's responsibility to report incidents, especially those that involve Patient Safety. Organisations that report more incidents usually have a better and more effective safety culture. By reporting incidents we can learn how and why incidents happen and start to embed lessons through changes to practice, processes or systems. You can't learn and improve if you don't know what the problems are.

Listening to your feedback:-
- Unsure what should be reported
- Very time consuming - too many mandatory fields
- Which Directorate they work within
- How to categories incidents
- Receive no feedback on the outcome of incidents

What are we doing:-
- Making changes to Datix to make reporting easier
- Encouraging handlers/investigators to feedback to reporters when they close an incident
- Providing Datix training and looking at developing a training module to offer staff practical training completing datix reports
- Produced 'How to Guides' for categorising incidents and Levels of Harm
- Supporting staff when completing datix incidents
- Delivering Patient Safety Awareness training across the Trust

Make reporting matter!

To arrange training or if you just need support/advice when reporting incidents, please contact the Patient Safety team who will be happy to help you.

Patient Safety Team extn 5314

Sharing Lessons Learned

We have been asking staff to share any lessons learned from incidents and have heard from the Clinical Sister on Keats ward following a Serious Incident which occurred recently. A new initiative has been put in place for the safety of their patients and already these simple measures have now started to make a real difference.

'After our serious incident of an acquired grade four pressure sore, we took positive action. We have placed wipe boards in each bay and called them 'turn boards' Each patients next turn time is then put on the board, we have only had one acquired pressure sore in three weeks so they must be helping!

*Keep sharing! Keep learning! Keep improving patient safety!*

CARING RESPECTING LISTENING LEARNING

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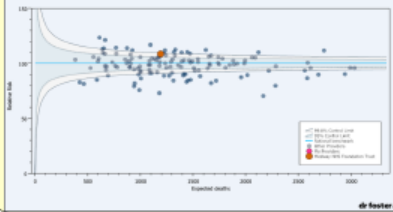
MORTALITY MATTERS

Medway **NHS**
NHS Foundation Trust

HSMR Update

The rolling year HSMR is currently **108.69** (Nov 14 - Oct 15). The data is presented in rolling year format as this minimises variation.

The Trust remains an outlier for both HSMR and SHMI, but progress has been made.
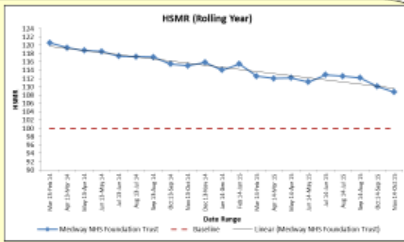
HSMR (Rolling Year)

HSMR BY PROVIDER (All acute non-specialist) for all admissions

There is clearly a downward trend in the rolling year HSMR, and a consistently decreasing position from our position in early 2014.

We need to continue the good work and raise awareness of Mortality across the Trust to ensure this continues.

Case Study
Midazolam Incident, November 2015

Summary:
A patient was prescribed and given 2.5mg of midazolam for agitation. Trust policy with regard to the prescribing and administration of midazolam on the wards states that it is for End of Life Care only. The prescription was made by a Trust SHO and administered by agency nurses.

Lessons Learned:
- Patient was admitted with confusion but no simple MCA was completed.
- Patient was made 'nil by mouth' but no MCA or Best Interest Decision was completed.
- No information is provided to agency nurses in the induction booklet with regard to any medications or any local policies with regard to restricted medications.
- It is unclear what information is provided to Junior Doctors about local policies with regard to restricted medications.
- The Safer Use of Midazolam Policy asks that if the prescription for Midazolam is a new one that the medical team review the prescription and consider an alternative agent – alternatives are suggested in the policy – this did not happen in this case.
- Reasons for obtaining medication from the Emergency Pharmacy were not documented in the notes by the nurses or the Site Practitioner.
- The Safer use of Midazolam policy asks that the Site Practitioner is the second checker when administering Midazolam – this did not happen in this case.
- The Trust Mental Capacity policy references the Restraint, Seclusion and Emergency Medication policy which went out of date in October 2012.

The Midazolam training module can be accessed here:
http://www.medway.nhs.uk/directorates-and-departments/patient-safety/lesson-of-the-month/december-2015/

Patient Safety Intranet Page

The Patient Safety page can be accessed directly via the link at the bottom of the staff intranet home page. Please take the time to have a look at this page and the sections within it, which are updated on a regular basis.

In particular, 'Lesson of the Month' is a page set up to encourage sharing of information and lesson learning across the Trust. Each month a key message or case study is published relating to incidents encountered during the clinical care of patients.

The 'Mortality Reduction Programme' section includes a number of graphs including the Trust's crude mortality and HSMR, which are updated regularly. Important documents can also be accessed, which include this newsletter, the most up to date Mortality review form, and the minutes template for use at specialty M&M meetings.

The Patient Safety page can be accessed via the home page, or at the following address:
http://www.medway.nhs.uk/directorates-and-departments/patient-safety/

Acute Deterioration Group

The Acute Deterioration Group (ADG) is a new group whose first formal meeting took place in January 2016. The purpose of the ADG is to ensure that the Trust has robust systems of monitoring, dealing with, and improving issues involving all aspects of deteriorating patients, and that the Trust has robust processes in place to ensure that it meets its regulatory requirements with regards to all aspects of patient deterioration.

Objectives/responsibilities include:
- Reviewing serious incidents and Datix incidents in relation to deteriorating patients.
- To respond to data trends from CCOT, Patient Safety Group and Mortality reviews with education and training objectives to improve care.
- Supporting and advising on the provision of training in NEWS, MMEOWS and PEWS scoring, escalation and audit in the Trust.

To help ensure all relevant incidents are identified...
- Please ensure details of incidents involving acute deterioration are included in Mortality review forms where appropriate. These cases will then be highlighted via the Mortality Learning Co-ordinator (Kim Watt).
- If applicable, when entering an incident onto Datix, please ensure you tick 'Yes' to the new question 'Did the incident relate to a deteriorating patient?'. This will ensure the Datix is automatically highlighted to members of the ADG.

The M&M Process

Why review deaths?

Mortality remains a major focus for the Trust and it is important that we not only review our mortalities, but also learn from them and put this learning into practice. Whilst nationally, those that die will account for 3% or less of those admitted to an acute hospital, concentrating on the learning from those deaths will inevitably impact positively on all patients. It is also possible to gain an understanding of the care delivered to those patients where death is expected and inevitable; a group which often does not receive optimal care in many organisations.

The Medway M&M Process

Mortality Review Forms	Specialty M&M Meetings	Trust M&M Meeting
Deaths are identified through a monthly data report which is distributed via the Mortality Learning Co-ordinator. Good practice and issues are identified using the review form.	Cases of interest/concern are discussed, and learning/actions highlighted. Minutes are taken using the agreed template. An overview of the actions, learning and issues identified is made available for the Trust M&M meeting.	Issues, learning and actions identified at specialty meetings are highlighted and reviewed. Actions are taken as appropriate and themes/trends identified to be fed back to specialties and shared throughout the Trust.

Specialty M&M Meetings

These meetings are an integral part of the M&M review process. They should be multidisciplinary in nature, and outputs must be recorded; especially conclusions about outstanding care and suboptimal care. The minutes template has been introduced to ensure this is happening, and data can be captured for the Trust M&M. There has been much improvement across the Trust with more specialty meetings taking place on a regular basis, and formal minutes now being produced as a result. The table below shows the areas previously identified as a concern, and where they are now.

Specialty	Oct-15	Nov-15	Dec-15	Jan-16	Comments/Actions
Gastroenterology	YY	Y	Canx	Canx	2016 Meeting schedule now confirmed. Minutes now being taken using the template.
Elderly Care/ Stroke	Canx	Y	Canx	YY	New meeting format now in place - future meetings should now be consistent and with minutes in the agreed template.
Diabetes	Canx	Y	Canx	Canx	Meetings set up in October but cancelled due to lack of consultant availability. Minutes to be taken at future meetings using the template.
ED	N	N	N	YY	Previous meetings on an informal basis. New meeting format now in place with regular monthly meetings scheduled - future meetings should be consistent and with minutes.
Surgical Directorate	N/A	Y	Y	Y	Meetings held regularly at audit afternoon but forms not previously completed and no minutes taken. Agreed at Governance meeting that forms will be completed and minutes taken from now on.

YY = Meeting took place and minutes received
Y = Meeting took place but no minutes taken/received
Canx = Meeting was cancelled
N/A = Meeting not scheduled
N = No formal Meeting took place

Trust M&M Meetings

The format of the Trust M&M meetings will be changing. Going forward, four specialty teams will attend each meeting – two of which will present. Team representatives must attend 4 meetings per year and present twice during that period.

Please send review forms and queries to:
met-tr.mortalitycoordinator@nhs.net
(Kim Watt, G027 Eliot Ward x3188)

Groups	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17
Diabetes / Haematology / Vascular / Neonates/paediatrics												
ICU/HDU / MHDU / Respiratory / Acute Medicine												
General Surgery / Trauma / Orthopaedics / ENT / Urology												
ED / Cardiology / Gastro / Elderly / Stroke												

CARING RESPECTING LISTENING LEARNING

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Medical Director Update: April 2016

Background

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

1. NEW MEDICAL MODEL

This is now in its 6th week and continues to need daily oversight but is becoming business as usual with benefit to all, most of all our patients.

- We have closed 46 beds - Dickens ward for safety reasons and taken all beds out of Lister ward so it can take patients from ED, act as a hot clinic for ED and other referrals and see all GP referrals. The unit has seen 876 patients, taken 20% of patients from ED with an admission rate of 10%.
- We have reduced the number of outlying patients by over a third and they are continuing to reduce.
- In terms of admissions to the wards, before the model was introduced the Trust admitted approximately 215 patients per week and this has reduced now to 165 patients per week.
- Before the model was introduced 40% of patients were discharged within 2 days. Since implementation of the model this has increased to 60%.
- The frailty pathway is also making a significant contribution.

2. PATIENT SAFETY

The Enhancing Quality and Recovery Programme (EQR)
A number of key clinical interventions are expected to occur when a patient is admitted across a pathway. This is called a "care bundle" which when performed consistently and fully, is clinically proven to improve patient outcomes.

The Trust has been involved in a total of ten clinical pathways and is currently in the early implementation stages for Emergency Laparotomy and fracture neck of femur pathways. The latter two will be key pathways for development going forward. Headlines for January to December 2015 include;

Enhancing Quality:

• **Heart failure, Community Acquired Pneumonia (CAP) and COPD**: heart failure care bundle delivery is significantly above KSS average. Admission rates, mortality and 30 day readmission rates are all in line with the region, with both admission and readmission having fallen compared to the previous report's time period (2014). For CAP, admission rates at MFT for pneumonia are significantly below the regional average. Crude In-hospital mortality and 30-day readmission rates are within the

average. Heart failure, pneumonia and COPD pathways all have significantly higher Length of Stay (LOS) than the regional average.

Enhancing Recovery:

• **Colorectal surgery, Gynaecology and Orthopaedic surgery**: All ER pathways have seen an improvement in care bundle delivery since start of the programme, particularly for Gynaecology and Orthopaedic where the Trust was already one of the highest performers across the region. Most consultants in Colorectal and Orthopaedics have LOS lower than the south of England average.

Key Areas for investigation and improvement: both heart failure and pneumonia pathways have a significantly higher LOS than the regional average which warrants further investigation. Also, admission rates for COPD are the highest in the KSS region. This links to the new medical model which has one of its main aims is to reduce LOS in hospital.

Notable achievements: MFT was a finalist for the 'Enhancing innovation through collaboration' and 'EQR team of the year' awards at the KSS AHSN Expo and Awards in 2016.

Medway NHS Foundation Trust

Notable Achievements

Finalist - Enhancing Innovation Through Collaboration Award

Finalist - EQR team of the year Award

 # patients benefitting from best practice, full-care bundles

	Actual at end 2014/15*1	Projected by end 2015/16*2
Pneumonia	2,069	2,276
Acute HF	758	1,063
ERP Orthopaedics	1,397	1,831
ERP Gynaecology	696	957
ERP Colorectal	189	257
Total	5,109	6,384
Additional Patients by end 2015/16		1,275

 # Current Quality Awarded & projected Quality Award for 2015/16

KSS Quality Award

Care Bundle Score	Category
90% - 100%	Excellence
70% - 89.99%	High performer
>50% - 69.99%	Moderate Achiever
0% - 50%	Improvement Needed

	2014/15 Quality Award	Projected Quality Award for 2015/16
Pneumonia	Improvement Needed	Moderate Achiever
Acute HF	High performer	Excellence
ERP Orthopaedics	High performer	Excellence
ERP Gynaecology	Excellence	Excellence
ERP Colorectal	Moderate Achiever	Moderate Achiever

*1 Actual from beginning of programme up to March 2015
*2 Projection up to March 2016

3. JUNIOR DOCTORS INDUSTRIAL ACTION

This was due to take place between the 26 & 27 April. Planning at a local level has taken place to ensure that contingency plans are in place to manage with a shortage of junior staff on the days of action.

4. CLINICAL EXCELLENCE AWARDS

The National Clinical Excellence Awards process is now open to eligible consultants. Individual applications require a citation from the Chief Executive.

5. MEDICAL EDUCATION

One of the Joint Directors of Medical Education, Dr Tariq Hussain, has resigned to take on a new challenge. Recruitment for two Deputy posts has commenced with

interviews due to take place in May 2016. We thank Tariq for his tremendous efforts to improve medical education at Medway.

The GMC trainee and trainers surveys are live. There are three patient safety areas highlighted by trainees to which a response is in progress. The recent HEKSS Visit reports for EM and Medicine have now been received, with responses in progress.

The next junior doctors' industrial action on 26th and 27th includes withholding emergency care. There are meetings planned with all junior doctors over the next few weeks to outline the impact of the new contract.

To increase opportunities for joint learning, a weekly Grand Round programme has been developed. Each Clinical area is developing a session to be delivered over the coming year. In addition Research & Development and the Medical Director's Office are running monthly educational events and Schwartz Round will continue monthly. Dr Bov Jani provided the first session of the new structure on April 15 when he delivered a presentation on "Well Being and Resilience" which provided valuable insights into the challenges of working in medicine and the importance of self-awareness and self-control in dealing with pressure.

6. RESEARCH & DEVEOPMENT

R&D statement for the Quality Accounts have been submitted.

The total number of patients that participated in research at the Trust within the Financial Year (FY) 2015/2016 was 8,958.

In the same period, a total of 147 projects were open. Most active specialities were (in order):
- Reproductive Health and Childbirth;
- Cancer;
- Critical Care;
- Cardiovascular Disease;
- Children;
- Renal Disorders;
- Infectious Diseases and Microbiology;
- Health Services and Delivery Research;
- Injuries and Emergencies;
- Respiratory Disorders;
- Haematology;
- Dermatology;
- Diabetes;
- Musculoskeletal Disorders;
- Stroke;
- Neurological Disorders;
- Genetics.

CARING   RESPECTING   LISTENING   LEARNING   Better care *together*

TRUST BOARD MEETING (PUBLIC)

Director of Nursing Report

A paper prepared by Laurel Neame Senior Matron Workforce and Education and Karen Rule, Director of Nursing and presented by Ms Karen Rule, Director of Nursing

March 2016

1. Safe staffing

The safe staffing report

- Brings to the attention of the Board any workforce issues across the inpatient ward areas during the month of March 2016.

- Provides the Board with an overview of nurse, midwifery staffing levels in inpatient areas as outlined in the Nurse Staff Guide 'How to ensure the right people, with the right skills are in the right place at the right time!' Published by the National Quality Board and the NHS Commissioning Board.

- The monthly UNIFY submission regarding fill rates for ward areas is attached as an appendix, supported by a number of quality metrics with an accompanying narrative. This data is now publicly available on the NHS Choices platform. The Trust is also displaying this information on its public facing webpage as well as displaying planned versus actual nursing and midwifery staffing numbers in clinical areas.

Key Points

- The information in the appendices relates to March 2016 fill rates, as per inpatient ward, for both registered and unregistered staff, broken down by day and night.

- The new Medical model was introduced 14 March 2016 aiming to improve the patient flow across the organisation, reducing the numbers of doctors each patient sees and improve standards of care. To facilitate this three wards changed their configuration and an escalation ward (Dickens) closed on 13 March.

- At the start of March there were two periods of red escalation due to high levels of activity. Response to this was in line with agreed escalation procedures. In the same period two wards were closed to admissions due to Norovirus.

- Meetings to discuss site safety, staffing and capacity are held three times each day to identify and escalate capacity and staffing challenges across the organisation. The expectation is that senior staff in attendance gain early visibility of organisational challenges and are able to put in place corrective action to ensure safe standards of care and to mitigate risk.

- A reporting system was implemented in March 2016 to improve the reporting levels of staffing levels below 1:8 minimum. Escalation of poor staffing levels now has a defined approach and reporting mechanism through to the Director of Nursing. This data is collected and reported on a weekly basis. The average number of breaches during March was 83.

- The in house temporary staffing bank went live on the 27 March 2016 following the trust's disengagement with NHSP.

Summary Points of Appendix One: Planned Vs Actual Nursing Hours

- The actual number of nursing hours worked was lower than the nursing hours planned on the nursing roster system by 10.9%. This is a 4.8% increase on previous month of February 2016, and reflects the decrease in the fill rate of temporary staff.

- Figure1 shows the overall fill rate. The fill rate is the lowest since December 2014 and is partially due to the transition from the use of NHSP to an in-house bank system. The IT infrastructure was not able to fully capture the booked shifts and therefore some of this data is not reflected in the fill rates. The bank team have provided assurance this is now resolved and all bookings will be captured for April 2016 shifts.

- In addition following introduction of the medical model several wards adjusted their staffing numbers. The healthroster team were not able to adjust the template therefore a manual calculation needed to be done to accurately reflect the actual staffing position against planned.

Figure One: Trust level: % Overall fill rate of nurse, midwifery and care staff - September 2014 – March 2016
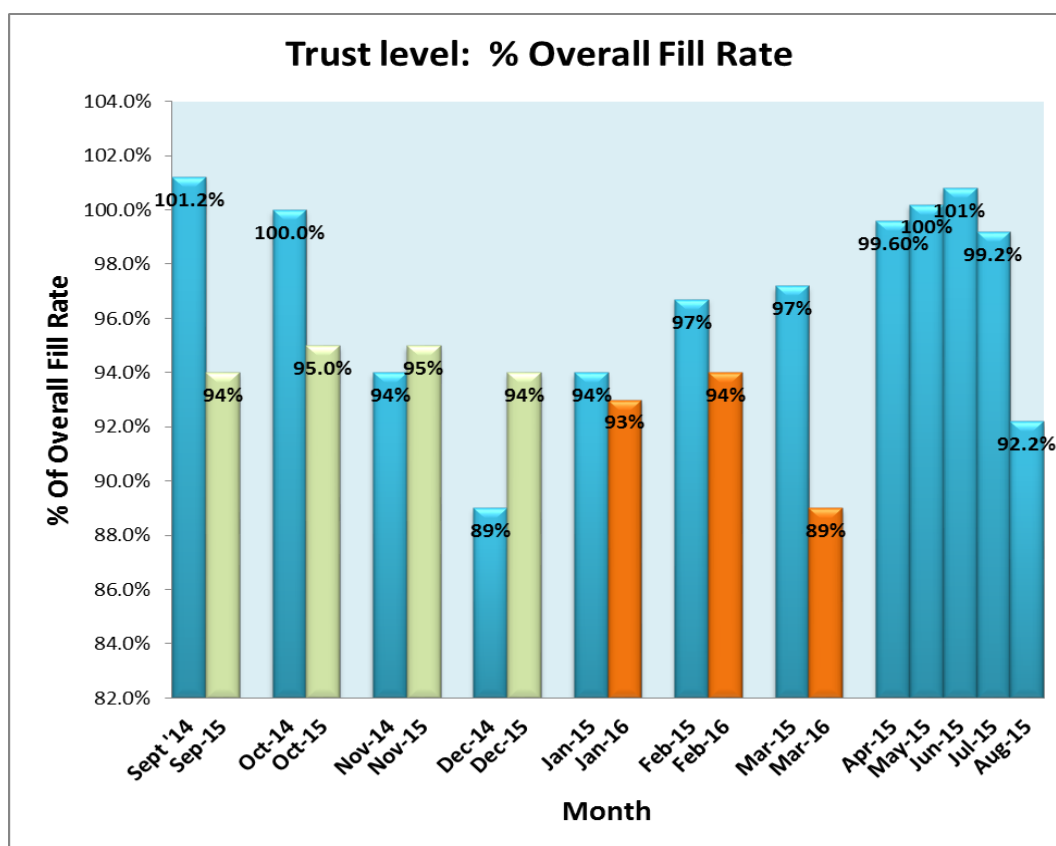
- As in previous months there were 26 wards that recorded a deficit of actual nursing hours against planned nursing hours.

- Fifteen of these wards recorded a deficit in actual hours against planned of more than 10%. The highest reporting wards remain the same as in previous months:

  Medical Wards include:
  o Gundolph (medical ward)
  o Wakeley, (medical ward)
  o Sapphire, (step down medical ward)
  o Will Adams, medical ward
  o Dickens(now closed)
  o AMU (now Ambulatory and a day facility with no inpatient beds) ,
  o Harvey (Stroke Unit)

- o   Milton (care of the elderly ward)
- o   Nelson, medical ward
- o   Tennyson (care of the elderly ward)
- o   Keats medical ward

Surgical Wards Include:
- o   Phoenix, (acute surgical ward)
- o   Kingfisher (surgical ward)
- o   Sunderland (23 hour surgical ward)

Women and Children include
- o   Neonatal Intensive Care Unit (NICCU)

- When staffing levels are lower than planned the staffing escalation procedure is followed and actions taken to mitigate risk. Actions include a review of acuity and dependency of our patients using the accredited Safer Nursing Care Tool (SNCT), review by a Matron of staffing alongside patient acuity, movement of staff across the Trust to cover vulnerable wards or departments and by Ward Sisters, Matrons and specialist nurses working clinically to deliver patient care.

- In the month of March two wards recorded higher actual nursing hours than planned. No wards used more than 10% of actual nursing hours above the planned.

- During March there were 49 formal escalations due to staffing issues. This remains on an upward trend however teams have been encouraged to document escalation concerns to ensure this information is captured.

- The Trust disengaged with NHS Professionals (NHSP) on the 26 March. During the period 1 – 26 March 24.9 % of all requested shifts to NHSP remained unfilled. This is an increase of 4.1% on February figures. This remains high and is in line with other months.

- The use of agency staff continued to be higher than that of NHSP staff. In March 2016 agency filled 44.8% of shifts whilst only 30.3% was filled by NHSP. This was comparable to the previous month; however agency fill rates were decreased by 3.9% from February. The top reason for booking temporary staff remains to cover vacancy (69%) followed by specialling (9 %) sickness (8 %) and escalation (8%). These figures remain in line with previous months.

Other workforce indicators

- The Registered Nurse Establishment for the Trust in March remains at 1371.06 WTE. The current registered nurse vacancy stands at 304.09WTE; this is a decrease of 18.68 WTE from February 2016 and represents a vacancy rate of 22% against the budgeted establishment. This does not take into account any maternity leave or any hours worked above contracted hours.

- The majority of Vacancies continue to be within the Acute and Continuing Care directorate (146.2 WTE) which equates to 27% of the registered nurse workforce; this is a 2% decrease on February 2016 figures. The Co-ordinated Surgical Care directorate has 64.41 WTE (22%) vacancy and the Women and Children's directorate has 83.95WTE (19%) vacancy. Both are 1% are lower than the previous month.

- The Clinical Support worker vacancy across the Trust stands at 79.07 WTE which equates to 14% vacancy rate. This is a 1% decrease on the previous months. Majority of these vacancies sit within the acute and continuing care division.

- 12.53 WTE Registered Nurses and Midwives commenced employment in the Trust against 7.9 WTE Registered Nurses and Midwives who left in March. This is the second consecutive month where we have had more RN and RM starting than leaving. There were 6.00 WTE clinical support workers who commenced employment against 7.86 WTE who left the organisation in March 2016.

Key workforce developments

- There are now 16 EU nurses working across the organisation. Three have received their professional registration, whilst the remaining nurses continue to work as Band 4 until they attain registration. A further nine nurses and three midwives arrive at the beginning of May. The ongoing recruitment of EU nurses continues with a series of skype interviews planned for the coming months and further oversea recruitment events planned for later in the year.

- There is continuing work with the recruitment team to look at innovate ways of increasing recruitment to nursing vacancies which remains a high priority for the Trust. There is ongoing work to ensure a seamless and quick process to decrease the time it takes to start work following interview.

- Assessment days continue to be held on a fortnightly basis and with approximately 6-8 nurses attending on each day.

- The rotational programme the Trust is now offering for newly qualified nurse is gaining interest and there are 6 nurses due to start this later in the year.

- The Clinical Practice team have commenced workshops with third year student's nurses around recruitment process, interview skills and completing applications to improve retention rates of the student nurses. Further open days are planned throughout the coming year.

- The trust disengaged with NHSP on the 26 March and booking of temporary staff was transferred to an in house bank. There is ongoing recruitment with the staff bank to reduce the reliance on Agency staff covering shifts.

Implications of current staffing position

- The Trust continues with a high level of activity and acuity demands, requiring high levels of nursing hours to deliver safe effective patient care. Staffing is one of the Trusts top 6 safety risks and stabilising and retaining the nursing and midwifery workforce in clinical areas remains a priority.

2. **Nursing and Midwifery Care Indicators**

   Safety thermometer

- Harm free care performance improved by 3% to 94% with a decrease in CAUTIs, pressure ulcers and falls.

   Falls

- There were 84 inpatient falls in March which has increased from previous months. Three falls resulted in moderate harm to patients with a fractured elbow, pubic ramus facture and a shaft of femur. Root cause analysis is being undertaken with each of these. Early analysis has highlighted the need for further training around falls assessment.

- The falls policy and associated protocols are under review and the Falls Strategy is being revised for 2016/2017.

   Pressure Ulcers

- In March there were six pressure ulcers graded 2 acquired in our wards. There was no grade 3 or 4 pressure ulcers reported.

- A review of pressure ulcer management is underway. An external peer review of policies and practices has been undertaken by a Consultant Nurse from Kings College Hospital London

Safeguarding

- The Trust recognises its safeguarding arrangements need strengthening and has implemented a safeguarding improvement plan.

- Posts in the Adult Safeguarding Team have been appointed to on fixed term and interim contracts and a substantive appointment has been made to the Learning Disability Nurse post.

- New reporting processes have been implemented and it is anticipated that reporting on safeguarding indicators will improve over the coming months.

Infection Prevention & Control (IPC)

- The Trust had 20 reportable Clostridium Difficile infections in 2015/2016, meeting the target of no more than 20 for the year. IPC targets remain unchanged for 2016/2017; zero MRSA bacteraemia and 20 Clostridium Difficile.

- The overall Trust compliance with hand hygiene was 99% but there are a number of areas where compliance is significantly below the 95% target. Enhanced measures have been put in place which includes weekly audits completed by the IPC team.

- A Link IPC network is due to be launched in April.

Patient experience

- The Trust is committed to making significant improvements in complaints management. A senior manager will be working with the Director of Nursing to implement an improvement plan.

- A target of 85% response rate (complaints responded to within 30 working days) has been agreed for 2016/2017 and a trajectory of improvement has been agreed. This target will replace the current indicator in the IQPR from April 2016.

Mixed Sex Accommodation

- There was a significant reduction in MSA breaches from 132 in February to 13 in March. This is due to the introduction of a new medical model and AMU becoming Lister Ambulatory Unit. Lister is closed overnight therefore eliminating mixed sex accommodation overnight.

- The Trust MSA target is zero breaches by July 2016. Following discussions with the CCG it is acknowledged that this is unrealistic, there are likely to be breaches for clinical reasons. The MSA improvement plan will be reviewed and a new target and trajectory agreed.

- In May responsibility for MSA will transfer from Acute & Continuing Care to the Director of Nursing.

3. **Recommendations:**

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

Appendices:

Appendix One – UNIFY data –March 2016

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

Title of meeting:	Board of Directors		**Date:** April 2016
Title of report:	Workforce Update		**Agenda item:**
Reporting Officer:	Rebecca Bradd		
Lead Director:	Rebecca Bradd, Acting Director of Workforce		
FOI status:	*This paper is disclosable under the FOI Act*		

Report Summary:
The report highlights progress made within the Workforce remit over the last month in relation to: • Staffing • Staff engagement and culture change • Workforce strategy development The Trust recognises that our workforce is our biggest enabler and inhibitor for recovery and change and that this is currently our biggest risk to delivery.

Purpose: This paper is for

Assurance	X	Approval		Decision		Information	X

Recommendation:
The Trust recognises current recruitment and retention strategies do not adequately address the urgent need for improvement in staffing levels. Improvements in leadership capability and staff engagement should improve retention and organisational performance and a robust Workforce and Organisational Development Strategy is required. Further updates regarding progress will be provided to the Board.

Strategic Objective Links:
1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment. 2. We will attract, retain and develop a first class workforce. 3. We will manage our resources prudently, efficiently and effectively.

Identified Risks and Risk Management Action:

Safe staffing levels is a significant risk and workforce planning and recruitment is being undertaken to minimise this risk. However it is recognised that recruitment to establishment levels will take some time.

Resource Implications:

n/a

Recovery Plan implications:

Does the subject matter support the Recovery Plan

Yes: X	No:

- Accelerating our recruitment drive to employ the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interim and agency staff.

- 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.

Recovery Plan Workstream		
Corporate Governance	Deteriorating patient	Referral management
Workforce X	Nursing	Emergency pathway
Clinical leadership	Clinical governance	Medical model
Data quality	Finance	

Quality Impact Assessment:

Does the subject matter require a QIA?

Yes:	No: X

Report History:

Workforce updates have previously been provided in the IQPR and Director of Workforce papers.

Next Steps and Further Reporting to the Board (if applicable):

Further updates will be provided to Board through the Workforce Updates paper.

Appendices:

n/a

For further information or for any enquiries relating to this report please contact:

Rebecca Bradd, Acting Director of Workforce rebecca.bradd@medway.nhs.uk

Workforce Update: April 2016

Background

The Trust and our external regulators have identified substantive staffing levels as an area requiring urgent improvement. This has resulted in a reliance on temporary staffing and agency expenditure. The Trust has recognised staffing as its highest risk to the organisation's ability to perform both in terms of delivery of high quality patient care and also in terms of its operational and financial performance.

The Trust has also, for the majority of the last eighteen months, had clinical escalation areas open to accommodate demand and this has stretched limited clinical staffing over a broader range of areas. The Trust took the decision to close one escalation ward in March due to staffing levels and this has remained closed as a result of changes to clinical practices as a result of the Medical Model.

There have been a number of activities undertaken by the Trust over the last financial year to support the recruitment to vacancies, and in particular to front line clinical vacancies, however the output of the recruitment activity has not been at the required level to make the operational impact needed and this, coupled with additional staffing requirements and a high level of turnover particularly over the first half of the financial year, has compounded the issue.

Staff engagement and culture were also identified as a concern within the last Care Quality Commission report in August 2015 and the results from the National Staff Survey undertaken between September 2015 and November 2015 presented to Trust Board last month also identified a lower staff engagement score of 3.66 for the Trust compared the national average of 3.79 (scored out of five).

For the future the Trust needs to develop a robust Workforce and Organisational Strategy and workforce modelling to ensure that these issues are addressed but also, and as importantly, to ensure that the organisational design and workforce profile supports the delivery of the Trust's strategic objectives and clinical strategy, ultimately improving the health and wellbeing of our local population.

This report provides the Trust's current status in terms of workforce and advises the Board on the next steps in terms of developing its Workforce and Organisational Strategy.

WORKFORCE: CURRENT STATUS

- ### STAFFING

Recruitment and retention has been particularly challenging particularly for business critical posts such as nursing, medical, pharmacist and physiotherapist roles.

There had also been a level of turnover in senior leadership and temporary management over the recent past. Following the clinical directorate restructure this has now significantly improved; a number of senior managerial and clinical leadership posts have been recruited to and the final two of the three substantive Directors of Clinical Operations have now started in post this month.

Nursing recruitment

Nursing recruitment activity continues with 12.53 WTE Registered Nurses and Midwives starting this month compared to 7.9 WTE Registered Nurses and Midwives who left in March. This is the second consecutive month where we have had more RN and RM starting than leaving reducing the registered nurse vacancy to 304.09 WTE with a vacancy rate of 22% against the budgeted establishment.

Recruitment to our nursing vacancies continues to make some progress with the fortnightly assessment days providing low but steady numbers into our pipeline. This is also supported through the open days which are held quarterly with the next scheduled on 21st May 2016.

The Trust commissioned 100 European nurses for 2016 and has 16 EU nurses already working across the organisation of which 3 are working as Band 5 registered nurses, whilst the remaining nurses work at Band 4 until they attain registration. A further cohort of 9 nurses and 3 midwives will arrive at the beginning of May. It is recognised that the Trust is behind trajectory for European recruitment and has been working closely with the recruitment agency to improve the marketing of the Trust. We have changed the recruitment strategy to include a series of skype interviews over the coming months as well as further overseas recruitment events planned for later in the year. It is recognised however that there is a significant likelihood that 100 will not be achieved in year and that the likelihood with the current projections is 50 nurses.

There is also a vacancy rate of 14% for Clinical Support workers (79.07 WTE) with the majority of these vacancies sitting within the Acute and Continuing Care directorate. The Trust has appointed 14 Clinical Support Workers last month for the Acute and Continuing Care Directorate and continues to have active campaigns to support the reduction in unqualified vacancy levels.

There is an acknowledgement that the current recruitment strategies are not achieving the required impact and although the vacancies are reducing this is more to do with improved retention over the last six months than the level of nursing recruitment. Alternatives in terms of recruitment and retention therefore need to be sought to address this gap in nursing staffing levels. These will include:

1. rotational programmes for newly qualified nurses due to start this later in the year
2. secondments/ rotations between NHS Trusts
3. engagement by the Clinical Practice team with third year student nurses around recruitment process, interview skills and completing applications to improve retention rates of the student nurses
4. recruitment to temporary nursing staff as part of the new temporary staffing service to reduce the reliance on agency staff covering shifts

5. rebranding of recruitment advertising and people documentation following the launch of the Vision and Values
6. offering support to UK based overseas nurses to complete the requirements for NMC registration
7. a review of the use of e rostering for nursing to maximise efficiency of the nursing workforce
8. improved attendance at recruitment events
9. development of educational, leadership and managerial programmes to improve leadership, capability, attraction and retention
10. developing work experience programmes to attract future workforce
11. engaging with students and visiting universities to attract future applicants
12. developing clinical support worker apprenticeship programmes and mapping current and future career nursing pathways to support the development of a robust workforce model
13. identifying current redesign and new clinical roles that support the delivery of patient care
14. consideration of recruitment into other overseas markets
15. engaging with our Higher Education Institutes and with Health Education Kent Surrey and Sussex to discuss the impact on nurse education and recruitment of the removal of the nursing bursary from September 2017.

Medical Staffing recruitment

Medical staffing vacancies have been identified as business critical posts; both at junior doctor and consultant level. There are particular challenges in recruiting to middle grades in medicine and consultant appointments (with one consultant post being advertised without applicants on three occasions).

There are 26 medical staff appointments offered in the pipeline. Interviews have been arranged for consultants in May and June for Haematology, Elderly Care, Dermatology, Anaesthetics and Medical Oncology.

There is an acknowledgement that for some vacancies the current recruitment strategies are not achieving the required impact and additional activity in terms of recruitment and retention is being undertaken. This includes:

1. Working with general recruitment on the use of social media and dedicated campaigns for hard to fill roles
2. Rebranding of recruitment advertising and people documentation following the launch of the Vision and Values
3. Supporting the further development and support of the Medical Training Initiative programmes
4. Consultant Job planning to ensure maximised efficiency and alignment to demand
5. Changes to targeted head hunting
6. Improved attendance at recruitment events
7. Developing links with physician associate programmes and mapping current and future career nursing pathways to support the development of a robust workforce model
8. Supporting the redesign of junior doctor rotas

9. Consideration of rotational posts

Pharmacy recruitment

Concerted recruitment activity over recent months has proven successful for pharmacists, in particular, with all vacancies now been appointed to; with some candidates already started and others with confirmed start dates.

Physiotherapists

We have advertised without success for Band 6 physiotherapists. The HR Business Partner and recruitment team have worked with the department in terms of a refreshed campaign in line with the Vision and Values and particularly focused on flexible working. Further updates will be provided regarding progress.

Accelerated recruitment

Between 1st October 2015 and 31st March 2016, the average time to recruit was 56.8 days, which is measured from the point of authorisation of the vacancy to the booked start date (not actual start date). Benchmarking against time to recruit is being undertaken against other NHS organisations as there is definite scope for improvement. Initial changes have already been made to the recruitment process this month following process mapping which includes changes to how offers are made.

The team will be working to improve the time to recruit through benchmarking and learning from the experience of other Trusts with streamlined recruitment processes in line with best practice. A target will be set in line with the benchmarking results for time to recruit and a plan put in place for improvement.

Temporary Staffing

The Temporary Staffing Service has now been operational for one month and the initial teething problems have on the whole been resolved.

The first week saw a rise in staffing demand which was difficult to meet, however this has now subsided and initial figures show improvement in the nursing shift fill in month.

The launch of the new service has allowed greater visibility into the Trust's staffing demands and this has resulted in a need to review a few priority areas such as bank only recruitment, last minute demand and agency booking behaviour. With the assistance of operational and Executive input, the team will be working cross-functionally with the wider HR team to initiate improvements to staffing levels.

Future and Developing Workforce

- Work experience

The Trust will be offering clinical and non-clinical work experience in the 1st week of June and 2nd week of July for local school students and has received a number of applications. Teams across the Trust will be providing a sponsor and a buddy for the week to ensure the individual has a good experience. The sponsor role is important to ensure that individuals have a positive experience and wish to return as an employee at a later date. This is the first step in the development of a rolling programme to showcase the Trust to our local students and potential future workforce.

- Apprenticeships

The Trust has also been developing Apprenticeships programmes through 2015. Currently we have 19 programmes running across Administration, Physiotherapy, Quality and Governance and Occupational Health. There is an addition to the programmes for substantive staff from April to include the Patient Service Centre, Pharmacy and others across NVQ's such as Customer Service and Administration and Leadership. Pathology is also developing an exciting programme with Canterbury College that will see our first new start apprentices in Microbiology. This will see us increase our programme delivery by between 14 and 20 apprenticeships by Quarter 2. The Trust is also looking at how we can map and develop our existing clinical support worker programme and align this with the apprenticeship agenda.

The Trust will be allocated an short term target for apprenticeships covering 1st April 2016 and 30th September 2016 based on 2.3% of total Band 1 to 9 headcount. This will be around 67 apprenticeships for the Trust.

With the introduction of the Enterprise Bill in the summer of 2016 the role of Apprenticeships will be given a legal status for both employment rights and Government legislation for Public Bodies. The Enterprise Bill legislation will introduce a legal requirement on the Trust to pay into the National Levy (0.5% of our PAYE bill) each year and this will then be drawn down using electronic voucher codes. There is still a significant amount of clarity that is still needed and further updates will be provided to Board in due course.

Retention

In March there were a number of retirements which increased the number of leavers. However with a continuing increase in starters, turnover has reduced further from 10.2% to 9.67%. Turnover for staff under one year's service remains high at 17%; however this is also on a downward trajectory.

The induction process is also under review and the first stage in the transformation was a radical overhaul of what is now known as Corporate Welcome (Trust first day induction) launched in March. Feedback has been very positive from delegates and while this is evolving, the basis of the new look Corporate Welcome is one of a genuine welcome to the organisation and has clear links to everyone's individual contribution to influencing a positive patient experience. The ultimate aim of the review is to have a more cohesive approach to induction which comprehensively links all aspects of the on boarding process in a seamless manner and is completed by local induction at the place of work, thus improving the experience for staff,

improving retention of staff within the first year, ensuring mandatory training compliance is achieved and finally improving local induction completion rates.

Our next First and Lasting Impressions events (an event for our new starters within few three months and one year) support the assessment of on boarding and will be refreshed at the end of May following our Vision and Values launch. These events provide us valuable insight to the experiences of our new colleagues and what we can do to provide appropriate support to them particularly within their first year. This information will be used in conjunction with feedback from leavers in addressing any issues.

There are a number of other activities being undertaken to improve retention including:
1. Enhanced Preceptorship - site dedicated Practice Development Nurses to support newly qualified nurses and overseas nurses on the wards.
2. Sponsorship of students to undertake their professional qualifications
3. New Leadership Programme being launched in May for senior leaders
4. Practical management workshops open to all staff starting June
5. Education Frameworks - mapping specialty specific development and education offerings, including University partnerships.
6. Career Pathways - ensure progressive career development pathways are identified for those within the Trust who seek advancement, including the identification and provision of professional and personal development required prepare individuals for their next role.

Recruitment and retention plan

Whilst it is recognised that there has been a number of initiatives to improve recruitment and retention, there is some way to go to deliver the required outputs to significantly improve our staffing levels.

The Trust is looking at other NHS and best practice organisations that have been successful in recruitment and retention to ensure that all appropriate activity is being undertaken and changes have already been identified to ensure that the activity is being supported by a streamlined recruitment, onboarding and developmental process.

The Trust will also be ensuring that staffing levels remain safe and will look to appropriately reduce clinical escalation areas when and where appropriate to maximise the utilisation of our clinical staffing.

- ## STAFF ENGAGEMENT AND CULTURE CHANGE

Staff engagement and culture were also identified as a concern within the last Care Quality Commission report in August 2015 and the results from the National Staff Survey undertaken between September 2015 and November 2015 presented to Trust Board last month also identified a lower staff engagement score of 3.66 for the Trust compared the national average of 3.79 (scored out of five).

It is recognised that staff engagement and the culture of the organisation are key to the delivery of the improvements required within the organisation and also how those improvements are sustained. There are a number of activities that have been undertaken this month to support this improvement.

Vision and Values

The Trust's new Vision and Values has been launched with a phased programme of communications this week to continue the Trust's commitment to cultural change and improving staff engagement. The launch follows the engagement of over 500 staff during the last year in its development.

This is an important milestone in our improvement in culture. Underpinning the Vision of 'Best of Care, Best of People' are a set of core Values and Behaviours that all staff will be expected to commit to and embed within their day to day practice. The Trust have identified a number of Champions who will role model the behaviours and support and embed the Vision and Values in their work place and in the wider organisation.

The behaviours will be integrated into a new appraisal process, management and leadership programmes, recruitment activity, the look and feel of our communications and all people policies and practices. This framework of expected behaviours has been simplified with behaviours for all staff at the first level and leaders, managers and specialists at the second level.

Over the next few months Values workshops will be undertaken with staff, further Champions be identified and developed and all people policies, practices and communications documentation will be refreshed to reflect our new Vision, Values and associated behaviours.

Leadership

Quality leadership is key to staff engagement and culture and it has been recognised that there was a developmental need in this area due to new multidisciplinary leadership teams and developing leaders.

The multidisciplinary Leadership Forum was launched on 30th March, with a good attendance of management triumvirates, and an output of a first draft of minimum standards of leadership compiled by triumvirates across the Directorates. Further marketing of the events will be used to engage more Senior Matrons and General Managers in future Forums.

Coaching with leadership of the clinical programmes and individual Clinical Directors has continued with written actions arising from each meeting. A list of staff wishing to be coached is being compiled and a coach matching exercise started using in house coaches. GSTT have also offered coaches from their database.

Small team management development sessions have started within priority areas e.g. at the request of the Chief Pharmacist, to address live issues with good progress achieved.

Bullying

The Respecting Others anti bullying campaign continues. Workplace Listeners training is being undertaken this month to support the internal staff who will listen to concerns and provide confidential advice and support for colleagues who feel they are being bullied.

The new behaviours being launched as part of the Trust's new Vision and Values will clearly identify the standards of behaviours required for both staff and managers. Awareness training for staff and briefing materials for managers will be distributed following the Vision and Values launch.

Staff Friends and Family

The Staff Friends and Family test for Quarter 4 has been undertaken in March 2016. All staff have been encouraged to complete the survey, which is available online and via a paper version, and in a postcard format. The closing date for this survey was 29th March 2016, with a response rate of 19% of all staff, a reduction from 23.1% for Quarter 2 2015. The results will be published by NHS England at the end of May.

The results will be provided to Board in May with an update regarding the Staff Survey action plan.

- ## WORKFORCE STRATEGY DEVELOPMENT

The Trust requires a robust Workforce and Organisational Development Strategy developed alongside robust workforce modelling to ensure that staffing, staff engagement and culture issues are addressed but also, and as importantly, to ensure that the organisational design and workforce profile supports the delivery of the Trust's strategic objectives, clinical strategy and supports the improvement in the health and wellbeing of our local population.

The development of the Strategy will be undertaken by a Workforce Group of senior leaders in the organisation with engagement of our staff side representatives and other relevant stakeholders and will be agreed by the Executives and presented to Board by June.

Title of meeting:	Board Meeting	Date: April 2016
Title of report:	Integrated Performance Report	Agenda item:
Reporting Officer:	Emma Birdsey, Senior Business Intelligence Analyst	
Lead Director:	Dr Trisha Bain CQO	
FOI status:	This paper is disclosable under the FOI Act	

Report Summary:
To inform/advise the Board of current performance across all functions and key performance indicators

Purpose: This paper is for

Assurance	✔	Approval		Decision		Information	✔

Recommendation:
Key Issues/Successes

Mortality - The SHMI figure is stable and showing a slight decrease from the last reportable period whilst higher than expected is a reduction on previous periods and the lowest published value for the Trust since 2013.

Cancer - The Trust maintained compliance with the 2 week wait standard across all tumour sites with the exception of brain. Overall 31 day first definitive treatment compliance is good with most tumour sites achieving the standard. However, the Trust failed to meet the standard as a result of insufficient urology surgical capacity.

A&E – Overall attendances continue to be high; March has been the busiest for the year by around 10%. It is anticipated that the combination of the new medical model and the implementation of the new Decision to Admit policy that performance will show an improvement.

SI's - There has been an increase in incident reporting with a significant increase in attributable incidents. The majority of the incidents are no and low harm. The top three categories of incidents are implementation of care which relate to pressure ulcers, Nutrition or delay and Delay, failure to monitor

Strategic Objective Links:

1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment.
2. We will attract, retain and develop a first class workforce.
3. We will manage our resources prudently, efficiently and effectively.
4. In partnership, we will provide integrated care for the community.
5. We will provide high quality information and technology to support the delivery of care.

Identified Risks and Risk Management Action:

N/A

Resource Implications:

N/A

Recovery Plan implications:

Does the subject matter support the Recovery Plan

Yes: ✓	No:

- Continuing to modernise our Emergency Department and pathway, reducing the time it takes for patients to be seen and assessed.

- Improving patient safety and care by minimising the number of different doctors that patients see during their stay in hospital.

- Accelerating our recruitment drive to employ the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interim and agency staff.

- 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.

- Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.

Recovery Plan Workstream		
Corporate Governance	Deteriorating patient	Referral management
Workforce	Nursing	Emergency pathway
Clinical leadership	Clinical goverance	Medical model
Data quality	Finance	

Quality Impact Assessment:

Does the subject matter require a QIA?

Yes:	No:	✓

If yes, attach the QIA as an appendice.
The paper will not be reviewed at the meeting if this is not attached.

If no, state why one is not required.
This is for Paper is for information only

Report History:

This paper has been to QIC and a finalised verison will go to Board.

Next Steps and Further Reporting to the Board (if applicable):

N/A

Appendices:
N/A

For further information or for any enquiries relating to this report please contact:
Emma Birdsey, Senior Business Intelligence Analyst, emma.birdsey@nhs.net Ext 3259

Medway **NHS**
NHS Foundation Trust

Integrated Quality and Performance Report

April 2016

Integrated Quality and Performance Report

April 2016

Contents and Key

Medway **NHS**
NHS Foundation Trust

Section	Content
Overview	Trust overview

Domain scorecards	1. Safe
	2. Effective
	3. Caring
	4. Responsive
	5. Well-led
	7. Enablers

Key to scorecard coding

Trust overview

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

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

Scorecards

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

Domain	Ref	Theme	Status			Alignment			Management			
			Number of indicators (reported)	% of indicators red	Outlook	18m plan	Monitor	Quality Metrics	Executive Lead	Priority last month ?	Priority this month?	Proposed update: CHAIR
18 Month Plan		18 Month Plan Update with specific project update this months - CQC Must Do's										
1. Safe	1.1	Patient safety - Incident reporting	21	10%	Escalate			✓	CN/MD	Yes	Yes	
	1.2	Patient safety - Safety Thermometer	5	60%	Escalate			✓	CN	Yes	Yes	
	1.3	Infection control and cleanliness	9	11%	Update			✓	CN	Yes	No	
	1.4	Mortality	7	71%	Escalate			✓	MD	Yes	Yes	
	1.5	Safe staffing	1	0%	Stable			✓	HR Dir	No	No	
2. Effective	2.1	CQUINs - National	6	0%	Stable				MD/CN	No	No	
	2.2	CQUINs - Local	7	14%	Stable			✓	CN	No	No	
	2.3	CQUINs - Contracting	4	0%	Stable				CN	No	No	
	2.5	Clinical best practice	4	75%	Escalate			✓	CQO/MD	No	Yes	
3. Caring	3.1	Admitted	4	75%	Escalate		✓	✓	CN	No	Yes	
	3.2	A&E	2	50%	Escalate		✓	✓	CN	No	Yes	
	3.3	Maternity FFT	2	0%	Stable			✓	CN	No	No	
	3.4	General patient and carers	2	100%	Escalate				CN	No	No	
4. Responsive	4.1	Elective treatment	4	100%	Escalate		✓		CQO	Yes	Yes	
	4.2	A&E	5	60%	Escalate		✓		MD	No	Yes	
	4.3	Cancer	9	56%	Escalate		✓		CQO	Yes	Yes	
	4.4	Diagnostics	2	50%	Escalate		✓		CQO	Yes	Yes	
	4.5	Stroke Services	8	63%	Escalate		✓		MD	Yes	Yes	
	4.6	Bed capacity and management	6	50%	Escalate		✓		CQO	No	Yes	
	4.7	Outpatient management	1	0%	Stable		✓		CQO	No	No	
5. Well-led	5.1	External assessments	2	100%	Escalate		✓		HR Dir	Yes	Yes	
	5.2	Staff experience	2	100%	Escalate			✓	HR Dir	No	No	
	5.3	Workforce indicators	15	27%	Stable				CEO/FD	Yes	No	
7. Enablers	7.1	Estates and Facilities	2	0%	Stable				CQO			
	7.2	Clinical Coding Information and IT	10	30%	Escalate				CQO		Yes	
	7.3	DQ Improvement	32	59%	Escalate				CQO		Yes	

Theme	Ref	Indicator	RAG Status	Number of m YTD at red	Escalation month	Monthly target	Jan-16	Feb-16	Mar-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor	Quality Account
1.1 Patient safety - incident reporting	1.1.1	Total patient safety incidents (attributable, 1 month in arrears)				N/A	269	268			365				
	1.1.3	Total serious incidents	G	5		5	3	7	5		5.1				
	1.1.21	Number of SI's breaching	R	3		0	14	18	20		15.7				
	1.1.4	Never events	G	1		0	0	0	0		0.1				✓
	1.1.5	Incidents resulting in unexpected death (1 month in arrears)				< 7	4	0			4.4				✓
	1.1.6	Incidents resulting in severe harm (per 1000 bed days) (1 month in arrears)				0.113	0.05	0.06			0.16				✓
	1.1.7	Incidents resulting in moderate harm (per 1000 bed days) (1 month in arrears)				1.871	1.1	1.0			1.5				✓
	1.1.8	Incidents resulting in low harm (per 1000 bed days) (1 month in arrears)				7.769	16.9	13.9			11.0				✓
	1.1.9	Incidents resulting in no harm (per 1000 bed days) (1 month in arrears)				18.2	25.0	20.7			21.4				✓
	1.1.10	Incidents with moderate or severe harm with duty of candour response **(will show percentage from Dec-15)**				100%	11%	18%			0.8				✓
	1.1.11	Safeguarding alerts reported (Children and Midwifery)	R			0	13	6	26		8.6				
	1.1.12	Safeguarding alerts reported (Adults)				0	12	6			11.9				
	1.1.13	Deprivation of Liberty - Applications Made and Accepted				N/A	1	1			5.5				
	1.1.14	Pressure ulcers (grade 2) attributable to trust	G	4	Jun-15	10	18	8	6		9.3				✓
	1.1.15	Pressure ulcers (grade 3&4)	G	8		0	0	1	0		0.6				✓
	1.1.16a	Administration or supply of a medicine from a clinical area		0		tbc	0.2	0.2	0.4		0.0				✓
	1.1.16b	Medication error during the prescription process				tbc	0.1	0.1	0.0						
	1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	G			0.2	0.1	0.0	0.2		0.1				
	1.1.18	Falls per 1000 bed days	G	4		6.63	3.97	3.76	4.86		5.1				
	1.1.19	Number of falls to fracture (per 1000 bed days)	G	1		0.2	0.1	0.0	0.2		0.1				
	1.1.20	Transfer of Care Concerns (TOCC) relating to pressure ulcers (reported 1 month in arrears)		2		3	0	3			2.4				
1.2 NHS Patient safety - safety thermometer	1.2.1	Proportion of Harm Free Care - point prevalence in month	R	4		95%	91%	91%	94%		91%				
	1.2.2	New VTEs - point prevalence in month	R	12		0.4%	1.4%	1.2%	0.8%		1.1%				
	1.2.3	CAUTIs - point prevalence in month	R	8	Jun-15	0.3%	1.8%	2.4%	0.4%		0.8%				
	1.2.4	New harms - point prevalence in month	G	11	Jun-15	2.2%	3.0%	2.9%	1.9%		3.2%				
	1.2.5	New Pressure ulcers - point prevalence in month	G	11	Jun-15	0.9%	1.2%	1.0%	0.6%		1.6%				

Theme	Ref	Indicator	RAG			Trend							Data Quality	Alignment		
			Status	Number of m YTD at red	Escalation month	Monthly target	Jan-16	Feb-16	Mar-16	12m Trend	YTD avg			18m plan	Monitor	Quality Account
1.3 Infection control and cleanliness	1.3.1	MRSA screening of admissions	G	7	Jun-15	*95%*	94%	100%	98%		94%		R			✓
	1.3.2	MRSA bacteraemia (trust – attributable)	G	5	Jun-15	*0*	1	0	0		1		R			
	1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	G	1	Jun-15	*2*	1	1	0		2		R			✓
	1.3.4	Hand Hygiene compliance	G	0		*95%*	98%	97%	99%		98%		R			
	1.3.5	Number of MSSA cases post 48 hours	G	0	Jul-15	*10*	0	0	2		1		R			
	1.3.6	Number of E-coli cases post 48 hours			Jun-15	*N/A*	3	1	3		3		R			
	1.3.7	Surgical Site Infection - Hip Replacement (reported 1 quarter in arrears)	G	0		*1.1%*		0.0%					G			
	1.3.8	Surgical Site Infection - Knee Replacement (reported 1 quarter in arrears)	R	0		*1.6%*		2.9%					G			
	1.3.9	Surgical Site Infection - Repair of neck of femur (reported 1 quarter in arrears)	G	0		*1.5%*		0.0%					G			
1.4 Mortality	1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	R	7		*100*		106.56			112.5					✓
	1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	R	1		*100*		115			115					✓
	1.4.3	Number of Deaths in low risk diagnosis groups (Quarter 2 15/16)	R	8	Jun-15	*0.65*	2	2	1		2.3					
	1.4.4	Crude Mortality (Quarter 3 15/16)			Jul-15	*N/A*	133	102	141		123					
1.4 Mortality	1.4.13	Septicaemia SMR (Rolling 12 Month)	R			*100*		106.36								
	1.4.15	Pneumonia SMR (Rolling 12 Month)	R			*100*		105.85								
	1.4.18	Congestive Cardiac Failure SMR (Rolling 12 Month)	G			*100*		95.97								
1.5 Safe Staffing	1.5.1	Safe Staffing – ratio of actual to planned nursing hours				*TBC*	93%	94%	89%		96%					

1.1 Safe - Incidents	Trends

There has been an increase in incident reporting with a significant increase in attributable incidents. The majority of the incidents are no and low harm.
The moderate and severe harm incident themes are :

ED handover – When transferring patients to Wards
Pressure Ulcers
Slips, Trips + Falls
Deteriorating patient

The top three categories of incidents are implementation of care which relate to pressure ulcers, Nutrition or delay and Delay, failure to monitor

Serious Incidents - Date Occurred
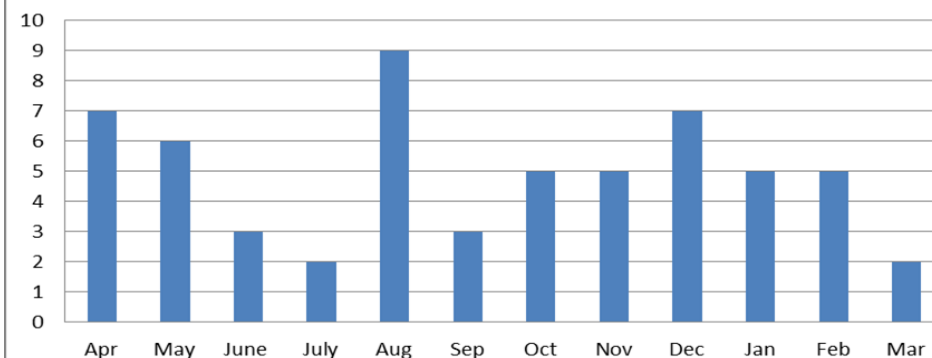
Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
7	6	3	2	9	3	5	5	7	5	5	2	59

Slips, trips and falls. There is a falls strategy in place and work continues to minimise the risks, the falls policy is being reviewed, bed rail assessment forms and the use of high low is being reviewed.
Medication incidents a detailed action plan is in place and ongoing audits are completed with actions to be implemented.

 Year end figures for SI's a total of 59 have occurred within 2015/16 of which 48 have been clinically related.The highest reported Sis have been related to falls to fracture , actions which have been taken are review of high low bed use age, risk assessment

There have been a total of 48 serious incidents which have related to clinical incidnets and 11 which were non clinical which include, black escalation, NICU and maternity closures and information governance incidents. Table below highlights the increase in the number of non clinical incidents in quarter 4.
Trust wide there are 36 serious incidents open of which 8 are breaching and a total of 13 are with the CCG for closure all of which were breaching. 15 serious incidents are in date and being investigated.

Serious Incidents - reported on STEIS
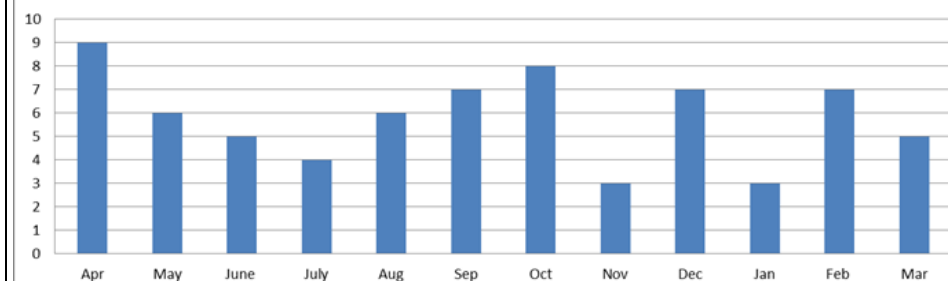
Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
9	6	5	4	6	7	8	3	7	3	7	5	70

1.1 Safe	
Trust wide there are 36 serious incidents open of which 8 are breaching and a total of 13 are with the CCG for closure all of which were breaching. 15 serious incidents are in date and being investigated. Actions: The SI monitoring group has introduced a quality assurance tool to monitor the standard of SI investigation. The group will be monitoring action plan progress and seeking assurance, trends identified will be included in the clinical audit plan. Risks to SI compliance will be raised and actioned. An escalation framework has been implemented and breaches against internal process timelines will be escalated to the Chief Quality Officer, Medical Director and Director of Nursing. Additional RCA training has been provided and further dates are in place for April and June 2016 to increase the number of investigators. Weekly progress reports are being provided to the Directorates to ensure risks can be mitigated, to ensure timely investigations are carried out A new tracking module has been developed to ensure the exact progress of SI investigations can be reported on and risks escalated.	

1.4 Safe - Mortality	Trends
The Trust's Hospital Standardised Mortality Ratio (HSMR) continues to demonstrate a downward trend and the most recently published value, for the period January 2015 – December 2015, is 106.6 and within confidence limits (LCL 100.78, UCL 112.59) as demonstrated by the funnel plot shown to the left. The most recently published SHMI value, for the period October 2014 – December 2015, is 1.15 which whilst higher than expected is a reduction on previous periods and the lowest published value for the Trust since 2013. The Trust is optimistic that the SHMI will continue to demonstrate a reduction moving forward and aims to be within benchmarked limits by the end of 2016/17. Mortality and Morbidity Reviews continue to be undertaken within the Directorates and to date 502 completed forms have been received. It is hoped that the Mortality and Morbidity form will soon be made electronic, further improving completion rates however this is subject to approval by PCAB. The Trust's Mortality Learning Co-ordinator is now producing a Directorate Level report to provide feedback in relation to review completion alongside current Trends and Themes which has been well received and moving forward will support with the production of a Monthly data pack for clinicians. Improving the understanding of mortality data amongst clinicians is key the Trust's reduction within the published mortality indicators, as such the Trust's Mortality and Learning Co-ordinator is working collaboratively with the newly appointed Head of Clinical Coding to support clinicians. A new deceased coding validation process went live on 1st April 2016 and the Clinical Coding Department have started to attend the diagnosis specific action groups that are ongoing within the Trust to see where improvements can be made that benefit both clinicians and the processes within the Clinical Coding Department.	

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Jan-16	Feb-16	Mar-16	12m Trend	Data Quality	18m plan	Monitor
			Status				**Trend**					**Alignment**	
2.1. CQUINs – national	2.1.1	AKI (Reported Quarterly) **Figures relate to Q3**	G	3		*15%*	35%	46%	45%				
	2.1.2	Sepsis (a) (Reported Quarterly)	G	1		*50%*	83%	79%	71%				
	2.1.3	Sepsis (b) (Baseline to be established to achieve CQUIN)	G			*0*	50%	71%	33%				
	2.1.4	Dementia – FAIR (Stage 1) (Reported a month in arrears)	G	1		*90%*	91.0%	97.4%					
	2.1.5	Dementia – FAIR (Stage 2) (Reported a month in arrears)	G	0		*90%*	95.0%	100.0%					
	2.1.6	Dementia – FAIR (Stage 3) (Reported a month in arrears)	G	0		*90%*	100.0%	94.1%					
2.2. CQUINs – local	2.2.1	Non elective LOS for in spells greater than 30days **Figures relate to Q3**				*N/A*		51.39					
	2.2.2	Braden/MUST including PU reduction		0		*82*	*Awaiting Month 9 results*						
	2.2.3	PU collaborative		0		*45%*	*Awaiting Month 9 results*						
	2.2.4	Complaints **(Figures relate to Q4)**				*65%*	8.0%						
	2.2.5	VTE collaborative		0		*100%*	*Awaiting Month 9 results*						
	2.2.6	Local FFT (ED positive/negative score improvement)	R	12		*85%*	72.3%	69.0%	69.0%				
	2.2.7	% of clients to be actively signposted for consultation with the specialist practitioner	G	1		*80%*	87.14%	52.07%	80.00%				
2.3. CQUINs – contracting	2.3.1	Hepatitis C Network (2 year CQUIN)				*Targets and processes agreed in August 2015, compliance will be reported once data is available.*							
	2.3.2	Neo-Natal term admissions											
	2.3.3	Pharmacy – SACT											
	2.3.4	Pharmacy – Oncotype DX											
2.4. Nice Compliance	2.4.1	NICE Technology Appraisals implemented					7	3	5				
	2.4.4	NICE Quality Standards escalated					7	1	10				
2.5. Clinical best practice	2.5.3	Emergency readmissions within 7 days	R	11		*4.6%*	5.4%	5.1%	6.1%				
	2.5.4	Emergency readmissions within 28 days	R	12		*4.9%*	13.4%	16.2%	11.6%				
	2.5.5	Elective surgical readmissions within 28 days	R	12		*0%*	4.2%	5.5%	3.3%				
	2.5.9	VTE screening (Quarter Behind)	G			*95%*		97.0%					

Theme	Ref	Indicator	Status			Trend						Alignment	
			Status	Number of m YTD at red	Escalation month	*Monthly target*	Jan-16	Feb-16	Mar-16	12m Trend	Data Quality	18m plan	Monitor
2.6. Best practice tarriff	2.6.0	FNOF: Time to surgery within 36 hours from arrival (1 month in arrears)					73.0%	77.0%					

* End of life pathway data is under review. Audit is currently underway by junior doctors.

3. Effective

Clinical Audit and NICE Compliance (CANC)

These meetings are currently established as the clinical audit leads meetings, the focus of the meetings are changing to include NICE guidance's compliance and a greater focus on the Clinical Audit Forward Plan and the Priority 1 & 2 'must do audits' (these are external and internal must do's).

The new terms of reference have been agreed, an audit and NICE dashboard is being developed. The group has appointed its Chairman and which Clinical Audit Leads will be representing the different programme of works within the directorates. However until these appointments have been agreed the group is continuing to work with the current Clinical Audit Leads. The leads will attend bi-monthly meetings and present twice yearly with formal reports to ensure compliance.

The CANC group will report back to QERC group.

NICE Guidelines

Following agreement from the Trust, a local timeframe has been set of 90 days for all NICE guidance's to be reviewed and a response received. The NICE Co-ordinator will escalate to the Directorates via reports to be added to directorate governance meetings, and escalate to the Medical Director and Chief Quality Officer when they are reaching 80 days and no response has been received. Currently 80% of TA have been reviewed within the 90 day time frame.

NICE Quality Standards

The NICE Coordinator will review the standards and collect any information/evidence in relation to the statements before discussing the outcome of the standards with the nominated leads and final sign off. This will enable the review to be completed within a timely manner and maximum efficiency. This process will be monitored and adjusted accordantly.

Bridging the gap between programme of works and the Directorates

The Head of Clinical Effectiveness or representative will attend the Directorates overarching governance meeting to report on audit & NICE activity and feedback any issues of concerns in relation to compliance of NICE or National 'must do' audits and ensure a feedback mechanism is in place to monitor action plans from completed audits.

2. Effective - CQUINs

2015/16 MFT CQUIN Schedule

	Ref.	Ref.	MFT value	(£)Value	Forecast as at M11	Forecast Amount
National	AKI	S1	0.25%	£444,972	50%	£222,486
National	Sepsis (a)	S2a	0.13%	£222,486	60%	£133,492
National	Sepsis (b)	S2b	0.13%	£222,486	85%	£189,113
National	Dementia - FAIR	S3a	0.15%	£266,983	100%	£266,983
National	Dementia - leadership/training	S3b	0.03%	£44,497	100%	£44,497
National	Dementia - carers	S3c	0.08%	£133,492	100%	£133,492
National	Imp diagnosis MH	S8	0.50%	£889,944	25%	£222,486
Local	non elective LOS	L1	0.18%	£320,380	84%	£269,119
Local	braden/must including PU reduction	L2	0.18%	£320,380	100%	£320,380
Local	PU Collab	L3	0.18%	£320,380	100%	£320,380
Local	Complaints	L4	0.18%	£320,380	40%	£128,152
Local	VTE Collab	L5	0.18%	£320,380	100%	£320,380
Local	Local FFT (ED positive/negative score improvement)	L6	0.18%	£320,380	100%	£320,380
Local	smoking at time of delivery	L7	0.17%	£302,581	100%	£302,581
	TOTAL		2.50%	£4,449,721	71.78%	£3,193,921
Specialised	Hepatitis C Network	S1	35.00%	£136,645	80%	£109,316
Specialised	Neo-Natal Term Admissions	S2	25.00%	£97,604	100%	£87,257
Specialised	Pharmacy - SACT	S3	25.00%	£97,604	100%	£109,072
Specialised	Pharmacy - Oncotype DX	S4	15.00%	£58,562	15%	£13,089
	TOTAL			£390,415	81.64%	£318,734
	Grand Total			£4,840,136	72.57%	£3,512,655

Domain 3: Caring

Medway NHS NHS Foundation Trust

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Jan-16	Feb-16	Mar-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor	Quality Account
3.1 Admitted	3.1.1	Friends and Family Test response rate	R	8	May-15	25%	24.9%	24.9%	25.5%		25%				
	3.1.2	Friends and Family Test % extremely likely/likely to recommend	R	2		83%	83.9%	84.8%	80.4%		84%				
	3.1.3	Mixed Sex Accommodation breaches	R	12	Jun-15	0	130	132	13		54.1				
	3.1.6	Dementia screening (% of patients over 75) (Reported 1 month in arrears)	G	1		90%	91.0%	97.4%			91%				
3.2 A&E	3.2.1	Friends and Family Test response rate	R	10	May-15	20%	16.2%	15.1%	16.2%		18%				
	3.2.2	Friends and Family Test % extremely likely/likely to recommend	G	0	May-15	65%	72.3%	69.0%	69.0%		73%				
3.3 Maternity	3.3.1	Friends and family test response rate	G	1		23%	47.4%	37.2%	37.1%		35%				
	3.3.2	Friends and family test % extremely likely/likely to recommend	G	0		79%	98.7%	100.0%	98.6%		99%				
3.4 General Patients and Carers	3.4.1	Number of Complaints	R	6	Jul-15	45	52	52	50		45				
	3.4.3	Number of complaint returners	R	2		↓	9.0	5.0	7.0		9.5				

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

3. Caring Commentary

Mixed Sex Accomodation

There were 13 MSA breaches in March, these breaches are those which are declarable where the patient no longer met the clinical need criteria to be in a mixed sex bay.
 The significant reduction is due to AMU changing its function on 14th March 2016 and becoming Lister Ward.

Mixed Sex Accommodation Breaches
Period: 12 month rolling

Theme	Ref	Indicator	Status			Trend							Alignment		
			Status	Number of m YTD at red	Escalation month	Monthly target	Jan-16	Feb-16	Mar-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor	Quality Account
4.1 Elective Treatment	4.1.1	RTT – Incomplete pathways (overall)	R	10	Jul-15	92%	68%	68%	68%		70%				
	4.1.2	RTT – Treatments over 52 weeks	R	10	Jul-15	0	3	5	19		8				
	4.1.3	RTT – Total complete pathways (non admitted)	R	10	Jul-15	95%	68.9%	71%	71%		75%				
	4.1.4	RTT –Total complete pathways (admitted)	R	10	Jul-15	90%	59.6%	54%	56%		58%				
4.2 A&E	4.2.1	Trolley wait >12 hours	G	0		0	0	0	0		0				
	4.2.2	Overall Time in A&E (95th percentile overall time in A&E Dept)	R	12	Jun-15	04:00	09:26:00	10:00:00	11:27:00		08:28:24				
	4.2.3	A&E stays less than 4 hours	R	12		95%	80%	76%	75%		85%				
	4.2.7	Ambulance handover time - within 15 minutes	R	1	0	70%	37.4%	36.8%	39.0%		42.0%				
	4.2.6	Patients left without being seen	R	12		0	3.6%	4.6%	4.3%		3%				
4.3 Cancer (reported 1 month in arrears)	4.3.1	Cancer – 2 week wait	G	7	Jun-15	93%	95.77%	96.42%			86%				
	4.3.2	Cancer – symptomatic breast	R	10	Jun-15	93%	88.24%	92.31%			83%				
	4.3.3	Cancer – 31 day first treatments	R	9	Jun-15	96%	90.84%	93.38%			93%				
	4.3.4	Cancer – 31 day subsequent treatments – surgical	R	8	Jun-15	94%	85.00%	83.33%			90%				
	4.3.5	Cancer – anti cancer drug treatment <31 days	G	3	Jun-15	97%	92.00%	100.00%			98%				
	4.3.7	Cancer – 62 day urgent GP referrals	R	8	Jun-15	85%	65.41%	75.41%			79%				
	4.3.8	Cancer – internal 62 day referrals	R	10	Jun-15	85%	71.43%	78.95%			71%				
	4.3.9	Cancer – 62 day screening	G	1	Jun-15	90%	92.86%	96.15%			96%				
4.4 Diagnostics	4.4.1	Diagnostic waits - under 6 weeks	R	12	Jun-15	100%	88.24%	90.71%	88.85%		93%				
	4.4.2	Diagnostic referral levels			Jun-15	N/A	6583	6507	7399		6894				

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Jan-16	Feb-16	Mar-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor	Quality Account
							Oct-15	Nov-15	Dec-15	For Stroke Only					
4.5 Stroke services *(one quarter in arrears)*	4.5.1	Stroke patients scanned within one hour of arrival	G	9	Jul-15	*50%*	38%	51%	57%		50%				
	4.5.2	Stroke patients scanned within twelve hours of arrival	G	6	Jul-15	*95%*	97%	100%	100%		97%				
	4.5.3	Patients admitted to a stroke unit within 4 hours of adm	R	9	Jul-15	*90%*	45%	38%	48%		41%				
	4.5.4	Patients with at least 90% of their stay on a stroke unit	R	9	Jul-15	*90%*	83%	74%	87%		78%				
	4.5.5	Patients receiving thrombolysis (RCP criteria)	G	3	Jul-15	*90%*	67%	100%	100%		90%				
	4.5.6	Patients that receive thrombolysis within one hour	R	9	Jul-15	*55%*	0%	0%	0%		8%				
	4.5.7	Patients seen by a stroke nurse within 24 hours	R	9	Jul-15	*95%*	91%	86%	78%		88%				
	4.5.8	Patients seen by a stroke consultant within 24 hours	R	9	Jul-15	*95%*	47%	43%	57%		55%				
4.6 Bed capacity and management	4.6.1	Average elective Length of Stay (Age 0 - 65)	G	0		*<5*	1.4	1.9	1.87		2.3				
	4.6.2	Average elective Length of Stay (Age > 65)	G	0		*<5*	2.6	3.1	4.37		3.7				
	4.6.3	Average non-elective Length of Stay (Age 0 - 65)	G	3		*<5*	1.9	1.1	2.1		1.3				
	4.6.4	Average non-elective Length of Stay (Age > 65)	R	3		*<5*	8.5	9.1	9.36		3.1				
	4.6.5	Discharges before noon	R	7	Aug-15	*25%*	17%	16%	15%		17%				
	4.6.6	Average occupancy	R	7		*90%*	98%	99%	97%		97%				
4.7 Outpatient Management	4.7.1	Did Not Attend rate	G	0	0	*10%*	9.3%	8.9%	8.8%		9%				

4.1 Responsive - RTT	Table
The non-admitted RTT backlog continues to shrink slowly, with most of the marginal headway being made in Dermatology, ENT, Colorectal Surgery and Urology. The admitted RTT backlog remains reasonably static with no particular specialties standing out. The improvements in the non-admitted RTT backlog should not be taken as a projection of overall future improvement as ¾ of the RTT backlog remains reasonably static or continues to worsen – whilst the position is improving, there is no room for a false sense of security. The RTT backlog & performance targets are now on a downwards trend, although the trust and CCG have agreed to move the compliance date to end March 2017, as per the tripartite requirements. The rate of backlog reduction does not look as fast as the rate of the target reduction, especially once we exclude the reduction yielded by the successful project to validate all patients in the backlog. There is a significant improvement required that still has no sound basis for delivery. The RTT backlog progress against target is shown below.	

4.3 Responsive - Cancer Waits	Table			

Cancer Performance

2 week wait standard - 93%				
Tumour Site	**Patients seen**	**Seen within 2 weeks**	**Breaches**	**Performance**
Leukaemia	1	1	0	100.00%
Brain	6	5	1	83.33%
Breast	145	144	1	99.31%
Children	8	8	0	100.00%
Gynaecology	59	59	0	100.00%
Haematology	4	4	0	100.00%
Head & Neck	106	103	3	97.17%
Lower GI	179	172	7	96.09%
Lung	14	14	0	100.00%
Other	1	1	0	100.00%
Skin	468	447	21	95.51%
Testicular	5	5	0	100.00%
Thyroid	4	4	0	100.00%
Upper GI	115	111	4	96.52%
Urology	114	107	7	93.86%
TOTAL	**1229**	**1185**	**44**	**96.42%**

2 week waits

The Trust maintained compliance with the 2 week wait standard across all tumour sites with the exception of brain (1 breach) which was a prisoner that HMP service declined the first offerred appointment and an alternative appointment was unable to be accomodated within 2 weeks.

Cancer Services will explore the potential of telephone/videoconferencing appointments with HMP and clinicians to improve compliance.

The Trust failed to meet the symptomatic breast standard with all breaches due to patient choice and a case of cancelled and declined appointments by the HMP service.

Cancer Services will explore the potential of telephone/videoconferencing appointments with HMP and clinicians to improve compliance.

2-WEEK WAIT (SYMPTOMATIC BREAST) - Target: 93%				
Breast Symptom	117	108	9	92.31%

31-DAY FIRST DEFINITIVE TREATMENT - Target: 96%				
Tumour Site	**Patients treated**	**Treated within 31 days**	**Breaches**	**Performance**
Breast	22	22	0	100.00%
Gynaecology	2	2	0	100.00%
Haematology	10	10	0	100.00%
Head & Neck	1	1	0	100.00%
Lower GI	12	12	0	100.00%
Lung	17	17	0	100.00%
Other	0	0	0	No patients
Skin	27	26	1	96.30%
Testicular	0	0	0	No patients
Thyroid	0	0	0	No patients
Upper GI	2	2	0	100.00%
Urology	43	35	8	81.40%
TOTAL	**136**	**127**	**9**	**93.38%**

31 day treatment

Overall 31 day first definitive treatment compliance is good with most tumour sites achieving the standard. However, the Trust failed to meet the standard as a result of insufficient urology surgical capacity. This lack of capacity is being reviewed by the Surgical Directorate and a corrective action plan will be developed.

31-DAY SUBSEQUENT TREATMENT - SURGERY - Target: 94%				
Tumour Site	**Patients treated**	**Treated within 31 days**	**Breaches**	**Performance**
Breast	10	8	2	80.00%
Gynaecology	1	1	0	100.00%
Head & Neck	0	0	0	No patients
Lower GI	0	0	0	No patients
Skin	10	9	1	90.00%
Thyroid	2	1	1	50.00%
Upper GI	0	0	0	No patients
Urology	7	6	1	85.71%
TOTAL	**30**	**25**	**5**	**83.33%**

4.3 Responsive - Cancer Waits	Table

62 Day Standard

The Trust failed to meet the 62 day GP referral standard across a number of the tumour sites. Pathway breaches were due to complex and multiple diagnostic pathways, patient choice and urology surgical capacity.

Work has been undertaken to review the current PTL backlogs across all tumour sites to produce a trajectory to recover a compliant position. Plans to reduce the backlogs in challenged tumour sites will be agreed with the Directorates and shared with the Trust Board, external partners and regulators.

The Trust was compliant with the 62 day screening standard.

There is no performamance standard for 62 day consultant upgrades but the 2 breaches were complex pathways with multiple diagnostics and referral to tertiary provider.

31-DAY SUBSEQUENT TREATMENT - DRUG TREATMENT - Target: 98%

Tumour Site	Patients treated	Treated within 31 days	Breaches	Performance
Breast	3	3	0	100%
Haematology	6	6	0	100%
Lower GI	0	0	0	No patients
Lung	2	2	0	100%
Urology	4	4	0	100%
TOTAL	15	15	0	100.00%

62-DAY STANDARD FROM GP REFERRAL - Target: 85%

Tumour Site	Patients treated	Treated within 62 days	Breaches	Performance
Breast	8	7	1	87.5%
Gynaecology	3.5	3.5	0	100.0%
Haematology	4.5	4.5	0	100.0%
Head & Neck	0.5	0.5	0	100.0%
Lower GI	8.5	0.5	8	5.9%
Lung	4.5	3.5	1	77.8%
Other	0	0	0	No patients
Skin	18	17	1	94.4%
Thyroid	0	0	0	No patients
Upper GI	1.5	0.5	1	33.3%
Urology	14	10.5	3.5	75.0%
TOTAL	63	47.5	15.5	75.40%

62-DAY SCREENING SERVICES - Target: 90%

Tumour Site	Patients treated	Treated within 62 days	Breaches	Performance
Breast	12.5	12.5	0	100.0%
Gynaecology	0	0	0	No patients
Lower GI	0.5	0	0.5	0.0%
TOTAL	13	12.5	0.5	96.15%

Tumour Site	Patients treated	Treated within 62 days	Breaches	Performance
Haematology	0	0	0	No patients
Head & Neck	0	0	0	No patients
Lower GI	0	0	0	No patients
Lung	8.5	6.5	2	76.5%
Skin	0	0	0	No patients
Thyroid	1	1	0	100.0%
Upper GI	0	0	0	No patients
TOTAL	9.5	7.5	2	78.95%

4.2 Responsive - A&E	Trends
Overall attendances continue to be high; March has been the busiest for the year by around 10%. There has been a 6% increase in attendances in 15/16 compared to the previous year, averaging an extra 500 per month. It is anticipated that the combination of the new medical model and the implementation of the new Decision to Admit policy that performance will show an improvement.	

A&E stays less than 4 hours
Period: 12 month rolling

Performance — Target

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Jan-16	Feb-16	Mar-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor	Quality Account
5.1 External assessments	5.1.1	Monitor governance rating	R	5	Jul-15	*3*	1	1	1		1				
	5.1.2	CQC rating	R	5	Jul-15	Good	Inadequate								
5.2 Staff experience (Figures for Q2)	5.2.1	Staff Friends and Family – Recommend as place to work	R			*62%*	48.8%								
	5.2.2	Staff Friends and Family – Recommend for care or treatment	R			*79%*	67.5%								
5.3 Workforce indicators	5.3.1	Vacancy rate - Medical (unfilled % of budgeted WTE)		3		*8%*	9.1%	8.8%			11%				
	5.3.2	Vacancy rate - Nursing (unfilled % of budgeted WTE)		3		*8%*	19.8%	19.6%			24%				
	5.3.3	Vacancy rate - Others (unfilled % of budgeted WTE)		3		*8%*	12.1%	11.2%			14%				
	5.3.4	Appraisals completed (% all staff)	R	5	Jun-15	*95%*	77.5%	74.4%	75.1%		73%				
	5.3.5	% of medical staff completing revalidation who were due to be re-validated within the month	G	0		*100%*	100%	100%	100%	To be validated					
	5.3.6	Mandatory training compliance	G	5	Jun-15	*80%*	83.8%	84.0%	84.6%		82%				
	5.3.7	Rolling annual turnover rate	R	5	Jun-15	*8%*	10.5%	10.2%	9.7%		11%				
	5.3.8	Overall Sickness rate		5		*3.0%*	3.9%	5.4%			3.9%				
	5.3.9	Sickness rate – Short term		2		*2.0%*	2.7%	2.5%			2.3%				
	5.3.10	Sickness rate – Long term		5		*1.0%*	1.2%	1.4%			1.5%				
	5.3.11	Temporary staff % of pay bill	R	5		*15%*	17.9%	19.4%			21%				
	5.3.12	Employee relations cases (excluding sickness)		5	Aug-15	*N/A*	41	49	61		45.7				
	5.3.13	Local Induction % Compliance	R			*80%*	56.8	52.1	50.72		56.01				
	5.3.14	Starters				*N/A*	65	74	72		77.8				
	5.3.15	Leavers				*N/A*	27	30	51.0		63.5				

For Well Led Commentary please see HR Exec Report

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Jan-16	Feb-16	Mar-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor	Quality Account
7.2 Clinical coding, information and IT* **(1 month in arrears)**	7.2.1	APC – NHS number completeness (1 month in arrears)	R	0		99%	98.8%	99.2%			98.3%		✓	✓	✓
	7.2.2	APC – Primary diagnosis (1 month in arrears)	G	0		96%	99.3%	98.8%			99.3%		✓	✓	✓
	7.2.3	APC – HRG4 (1 month in arrears)	G	0		96%	99.3%	98.7%			99.2%		✓	✓	✓
	7.2.4	OP – NHS number completeness (1 month in arrears)	G	0		99%	99.5%	99.4%			99.5%		✓	✓	✓
	7.2.5	OP – Primary procedure (1 month in arrears)	G	0		99%	100.0%	99.5%			100.0%		✓	✓	✓
	7.2.6	OP – HRG 4 (1 month in arrears)	G	0		98%	100.0%	97.5%			90.7%		✓	✓	✓
	7.2.7	A&E – NHS number completeness (1 month in arrears)	G	7	Jul-15	95%	93.6%	95.6%			92.4%		✓	✓	✓
	7.2.8	A&E – Attendance disposal (1 month in arrears)	R	7	Jul-15	99%	96.7%	97.8%			96.7%		✓	✓	✓
	7.2.9	A&E – HRG4 (1 month in arrears)	R	0		97%	100.0%	96.6%			86.5%		✓	✓	✓
7.3 Data quality improvement	7.3.8a	RTT large No. of patients with an unknown clock start	R	3		0	408	469	636		489.1		✓	✓	✓
	7.3.8b	RTT % of patients with an unknown clock start	R	3		0	1.0%	0.0%	2.0%		1.1%		✓	✓	✓
	7.3.9a	RTT No. cancelled referral, pathway still open	R	3		0	737	694	644		842.8		✓	✓	✓
	7.3.9b	RTT % cancelled referral, pathway still open	R	3		0	2.30%	2.10%	1.99%		2.7%		✓	✓	✓
	7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open	R	3		0	1355	1309	1051		1577.0		✓	✓	✓
	7.3.11a	RTT No. deceased patient with an open pathway	R	1		0	0	1	1		0.8		✓	✓	✓
	7.3.12a	A&E No. missing left department times	G	0		0	0	0	0		0.0		✓	✓	✓
	7.3.12b	A&E % missing left department times	G			0	0%	0%	0%		0.0%		✓	✓	✓
	7.3.13a	A&E No. missing breach reason on breached attendances	R	2		0	750	494	553		292.6		✓	✓	✓
	7.3.13b	A&E % missing breach reason on breached attendances	R	3		0	59.0%	77%	78%		77.6%		✓	✓	✓
	7.3.16	Cancer 2ww missing NHS number	G	0		0	0	0	0		0.0		✓	✓	✓
	7.3.17	Cancer 2ww invalid NHS Number	R	3		0	7	7	7		6.4		✓	✓	✓
	7.3.18	Cancer 2ww missing referral received date	G	0		0	0	0	0		0.0		✓	✓	✓
	7.3.19	Cancer 2ww missing urgent referral type	G	1		0	0	0	0		2.3		✓	✓	✓
	7.3.20	Cancer 2ww missing org code first seen	G	0		0	0	0	0		0.0		✓	✓	✓
	7.3.21	Cancer 2ww missing breach reason	R	3		0	5	16	28		13.1		✓	✓	✓
	7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex	R	2		0	4.00%	3.60%	2.97%		4%		✓	✓	✓
	7.3.23	Cancer 31 day missing NHS number	G	0		0	0	0	0		0.0		✓	✓	✓
	7.3.24	Cancer 31 day invalid NHS number	R	1		0	0	1	0		0.4		✓	✓	✓
	7.3.25	Cancer 31 day missing primary diagnosis	R	3		0	4	12	10		7.0		✓	✓	✓
	7.3.26	Cancer 31 day missing tumour laterality	R	3		0	4	10	9		6.6		✓	✓	✓
	7.3.27	Cancer 31 day missing decision to treat date	G	1		0	0	1	0		0.3		✓	✓	✓

Theme	Ref	Indicator	Status			Trend								Alignment			
			Status	Number of m YTD at red	Escalation month	Monthly target	Jan-16	Feb-16	Mar-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor		Quality Account
	7.3.28	Cancer 31 day missing org code for treatment	G	1		0	0	0	0		0.1		✓	✓		✓
	7.3.29	Cancer 31 day missing breach reason	R	3		0	6	12	7		5.0		✓	✓		✓
	7.3.30	Cancer 62 day missing NHS number	G	0		0	0	0	0		0.0		✓	✓		✓
	7.3.31	Cancer 62 day invalid NHS number	G	1		0	0	1	0		0.4		✓	✓		✓
	7.3.32	Cancer 62 day missing primary diagnosis	R	3		0	4	4	6		4.6		✓	✓		✓
	7.3.33	Cancer 62 day missing tumour laterality	R	3		0	4	4	4		4.4		✓	✓		✓
	7.3.34	Cancer 62 day missing decision to treat date	G	1		0	0	1	0		0.3		✓	✓		✓
	7.3.35	Cancer 62 day missing org code for treatment	G	0		0	0	0	0		0.0		✓	✓		✓
	7.3.36	Cancer 62 day missing breach reason	R	3		0	9	14	4		5.4		✓	✓		✓
	7.3.37	Cancer 62 day missing consultant upgrade	R	3		0	43	45	57		45.6		✓	✓		✓

Enablers
Estates Summary That key issues relating to Estates services are being maintained to the correct statutory and mandatory levels and where they are not being achieved an action plan is in place to achieve the necessary level. The primary elements requiring action have been highlighted, which are; Water Safety, Fire Safety and Electricity at work; In relation to Water Safety there has been a marked improvement in compliance that the Authorised Engineer's audit from 68% to 81%. In relation to Fire Safety an action plan with approved funding by the Trust is in place and the work is being carried out. In relation to Electricity at Work an Authorised Engineers report was recently carried out and an action plan is being developed. Need to improved Planned preventative maintenance items noted within the Water Risk Assessment 2013 as outstanding. Need for decant ward to enable completion of the Electricity at work items which are outstanding. Recruitment of staff to necessary levels and complete necessary PPM as indicated on Water Safety Plan. Deliver Fire Safety action plan Continue campaign for decant ward to enable Electricity at Works items to be completed (this needs to continue until bed pressures reach an appropriate level). Zero harm in relation to Water Safety, Fire Safety and Electricity at work.

Enablers
Data Quality The DQMG and DQUG are currently looking at the Data Quality Improvement Plan (DQIP) within the contract with Commissioners (CCG's and NHS England) to ensure that we are capturing areas where we want to improve DQ in the new financial year. The DQIP allows the Trust to set a timetable for achieving these DQ items and will focus any future project work through the DQ groups. The DQ User Group has been focussing on reporting back on a project which is monitoring the use of pathway co-ordinators inputting on to PAS the outcomes from clinics. This is monitoring whether the outcomes from the appointment are done in less time than they have been previously. There is currently an audit taking place for VTE and Cancer 62 day target, the results of which will be fed back through the DQ groups and recommendations carried out in due course. The results will also be communicated in a future Board update through this report. The DQ reports continue to go out to the services on a daily basis and work is on-going to priortise these and put fixes in place. The operational services will have instructions written up and another meeting to go over in-depth each DQ issue and how it can be fixed. This will lead to a greater knowledge of data entry processes and will enable some training to be written up for problem areas.

Mar-16 — Performance Review Scorecard - Executive Directorate Summary

Ref	Indicator	Units	Target	R/G	All areas Trust	Acute & Continuing Care Current Reporting Period	Acute & Continuing Care Previous Reporting Period	Trend	Co-ordinated Surgical Current Reporting Period	Co-ordinated Surgical Previous Reporting Period	Trend	Womens and Children Current Reporting Period	Womens and Children Previous Reporting Period	Trend
Safe														
1.1.3	Total Serious Incidents	Number	5	G	5	4	3		1	1		4	2	
1.1.4	Never Events	Number	0		0	0	0		0	0		0	0	
1.2.1	Proportion of harm free care - Point prevalence in month	Monthly %	95%	R	94.40%	94.98%	90.60%		97.00%	92.05%		94.98%	98.18%	
1.2.3	Pressure ulcers (grade 3&4)	Number	0	R	0	0	1		0	0		0	0	
1.2.5	Patient falls with moderate or severe harm	Cases	0		3	2	0		1	0		2	0	
1.3.1	MSRA screening of admissions	Number	95%	G	98%	98%	100%		97.17%	100.00%		97.86%	100.00%	
1.3.3	C-Diff acquisitions (Trust-attributable)	Number	0		0	0	1		0	0		0	0	
1.4.1	Hospital Standardised Mortality Ratio (HSMR) - Weekend **	Number	100		97.7	117.28	105.45		101.21	97.89		117.28	158.6	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI) ***	Number	100	R	115.3	115.3			115.3			115.3		
1.4.4	Crude Mortality	Number	N/A		0									
1.4.4	Deaths in Hospital	Number	N/A		144	121	98		20	21		121	1	
1.5.1	Safe staffing – ratio of actual to planned nursing hours	Ratio	0	G	0		0.94			0.95			0.96	
Effective														
2.2.1	Non elective Length of Stay	Cum ALOS	N/A		4.37	6.98	10.82		4.55	4.93		1.27	2.03	
2.2.4	Complaints	Number	N/A		50	26	28		17	3		7	3	
2.5.2	Number of day cases (Quality Account)	Number	N/A		1812	794	779		867	875		151	144	
2.5.3	Emergency readmissions within 7 days	Number	N/A		5.14%	5.89%	6.02%		4.36%	3.74%		5.15%	6.92%	
2.5.4	Emergency readmissions within 28 days	Number	10%	R	10.25%	12.54%	13.48%		7.94%	6.84%		10.21%	13.10%	
Caring														
3.1.3	Mixed sex accommodation breaches	Cases	0	R	13	13	132		0			0	0	
3.1.4	No. Patients cancelled on day of Surgery	Number			55	4	1		47	27		3	2	
3.1.5	Patients cancelled and not admitted within 28 days	Number	0		5	0	0		5	3		0	0	
3.1.6	Friends and Family Test response rate (Admitted)	Monthly %	40%		26%	22.20%	22.90%		27.10%	28.50%		23.98%	22.50%	
3.1.7	Friends and Family Test % recommend (Admitted)	Monthly %	83%		80%	74.90%	74.10%		77.00%	79.30%		82.47%	85.50%	

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

Ref	Indicator	Units	Target	R/G	All areas Trust	Current Reporting Period	Previous Reporting Period	Trend	Current Reporting Period	Previous Reporting Period	Trend	Current Reporting Period	Previous Reporting Period	Trend
Responsive														
4.1.1	RTT – Incomplete pathways (overall)	Monthly %	92%	R	67.94%	63.65%	63.26%		65.83%	66.19%		91.37%	90.87%	
4.1.2	RTT – Treatments over 52 weeks	Number	0	R	19	7	6		3	3		0	1	
4.1.3	RTT – Total complete pathways (non admitted)	Monthly %	95%	R	71.14%	57.38%	57.85%		72.12%	70.30%		94.85%	95.17%	
4.1.4	RTT –Total complete pathways (admitted)	Monthly %	90%	R	55.85%	56.67%	70.97%		43.40%	43.23%		87.79%	88.69%	
4.3.1	Cancer – 2 week wait ****	Quarterly %	93%	G	96.42%	95.72%	94.78%		96.75%	96.68%		100.00%	96.20%	
4.3.4	Cancer – 31 day subsequent treatments – surgical ****	Quarterly %	94%	G	83.33%	90.00%	93.75%		78.95%	79.17%		100.00%	No pts	
4.3.5	Cancer – secondary chemotherapy <31 days ****	Quarterly %	98%	G	100.00%	100.00%	90.91%		100.00%	92.86%		No pts	No pts	
4.3.7	Cancer – 62 day urgent GP referrals ****	Quarterly %	85%	G	75.40%	89.47%	81.54%		59.68%	50.75%		100.00%	No pats	
4.3.9	Cancer – 62 day screening ****	Quarterly %	98%	G	96.15%	No pts	No pts		96.15%	92.86%		No pts	No pts	
4.4.1	Diagnostic waits - Under 6 weeks	Monthly %	99%											
4.6.1	Average elective length of stay	Cum ALOS	<5	G	1.38	0.62	2.84		1.83	2.19		1.46	1.82	
4.6.3	Discharges before noon	Monthly %	25%	R	15.10%	14.90%			12.88%			18.16%		
4.7.2	Follow-up to new ratio	Ratio		R	2.10	2.73	2.85		1.89	1.95		1.53	1.65	
4.7.3	Did not attend rate	Monthly %	10%	G	8.80%	8.90%	8.50%		8.50%	8.90%		9.70%	9.80%	
4.7.5	Appointments cancelled by hospital 1-5 days' notice	Number		G		DQ - Under Review			DQ - Under Review			DQ - Under Review		
4.7.6	Appointments cancelled by hospital 1-6 weeks' notice	Number	10%			DQ - Under Review			DQ - Under Review			DQ - Under Review		
Well-Led														
5.3.4	Appraisals completed (% all staff)	Monthly %	95%	R	75%	73.97%	75.00%		73.46%	74.00%		70.22%	71.00%	
5.3.6	Mandatory training compliance	Monthly %	85%		85%	80.28%	80.00%		85.91%	84.00%		88.57%	87.00%	
5.3.7	Rolling annual turnover rate	Monthly %	8%	R	10%	13.01%	15.00%		9.96%	12.00%		7.86%	8.00%	
5.3.8	Overall Sickness rate	Monthly %	3%	G		3.83%			4.18%			0.03		
5.3.10	Temporary staff % of pay bill	Monthly %	15%			32.00%								
Enablers														
6.3.2	CIP variance to plan		95%											
6.4.1	NHS number completeness (Inpatients and Outpatients) *****	Monthly %	TBC		0.00%	99.57%								
6.4.2	Primary Diagnosis (Inpatients) *****	Monthly %	TBC		0.00%	94.23%								
6.4.5	Primary Procedure (Inpatients and Outpatients) **Under Review**		TBC			DQ - Under Review			DQ - Under Review			DQ - Under Review		
560	Elective activity vs profiled plan - cumulative variance	Cum var %	0%			Available from next month			Available from next month			Available from next month		
606T	New patients seen vs plan (all categories, in arrears)	Mthly var	0											
Income	Income against plan - var ytd (in arrears)	Cum £k	£0											
102	Overall budgetary variance	Mthly % var	£0											
Pay	Pay expenditure in month (neg=bad)	Mthly % var	0%			-874								
Non-pay	Non-pay expenditure in month (neg=bad)	Mthly % var	0%			-1066								
POC	Total Number Invoices with PO's	Mthly %	90%			Available from next month			Available from next month			Available from next month		

**   HSMR Weekend figures are based on a rolling 12 month period and are taken from Dr Foster
***   The SHMI indicator is only available at Trust Level and is taken from Dr Foster
****   Cancer figures are taken from Open Exeter and are 1 month in arrears
*****   Taken from SUS Data Quality Dashboards and are 1 month in arrears

Title of meeting:	Trust Board	Date: 28th April 2016
Title of report:	Month 12 Director of Finance Report	Agenda item: 11
Reporting Officer:	Yasmin Ahmed Deputy Director of Finance	
Lead Director:	Darren Cattell. Interim Director of Finance	
FOI status:	*This paper is disclosable under the FOI Act;*	

Report Summary:

This paper is a focused summary of the financial performance of the Trust as at M12.

This report is deliberately only focused on key indicators as the detail is still being worked through for the year end accounts preparation and our annual external audit.

As in previous years once the Accounts, Audit and Annual Report is completed this will be presented to the Audit Committee and the Trust Board for approval.

Purpose: This paper is for

Assurance	x	Approval		Decision		Information	

Recommendation:

The Board is asked to note the report.

Strategic Objective Links:

1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment.
2. We will attract, retain and develop a first class workforce.
3. We will manage our resources prudently, efficiently and effectively.
4. In partnership, we will provide integrated care for the community.
5. We will provide high quality information and technology to support the delivery of care.

Identified Risks and Risk Management Action:

The major risk is the previously identified risk of failure to achieve the financial plan targets

Resource Implications:
Summary report

Recovery Plan implications:

Yes:	No:

- Improving patient safety and care by minimising the number of different doctors that patients see during their stay in hospital.

- Accelerating our recruitment drive to employ the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interim and agency staff.

- 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.

- Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.

Recovery Plan Workstream		
Corporate Governance	Deteriorating patient	Referral management
Workforce	Nursing	Emergency pathway
Clinical leadership	Clinical goverance	Medical model
Data quality	Finance	

Quality Impact Assessment:

Yes:	No:

There is no general QIA requirement.

Report History:
The subject matter is reported every month to the Trust Board. The Executive Committee has received and noted this report. This report has been presented to the Performance Committee on the 25th April 2016.

Next Steps and Further Reporting to the Board (if applicable):
As above.

Appendices:
None

For further information or for any enquiries relating to this report please contact:
Darren Cattell, Interim Director of Finance. darrencattell@nhs.net

Finance Report For the Period 1st April 2015 to 31st March 2016 (Month 12)

1.0   Executive Summary

The draft financial performance for month 12 2015/16 is reported.

At the time of writing, the year-end process to produce the draft accounts is underway.

The deadline for submitting the draft accounts for audit is 22nd April 2016. The updated position will be reported to the May meeting, however, overall performance in not expected to differ from this report.

2.0   Draft Financial Performance

2.1   Draft financial performance for the 12 months ended 31st March 2016 is summarised in Table 1.

Table 1 Statement of Comprehensive Income

Statement of Comprehensive Income (SOCI)	2015/16 (£m)
Income:	
Clinical Income (inc. Drugs)	230.6
Other (inc. non NHS clinical income)	24.3
	254.9
Expenditure:	
Pay	-196.6
Drugs	-28.1
Other Non-Pay	-68.8
	-293.5
EBITDA:Surplus/ (Deficit)	**-£38.5**
Depreciation & Other	-9.8
Net Interest	-1.1
PDC Dividend	-3.1
	-14.0
Net Surplus/ (Deficit)	**-£52.5**

2.2   The income and expenditure position is in line with the forecast £52.5m deficit reported in the previous month. The position included improvements in additional income, the annual review of the land and buildings owned by the Trust resulting in a £0.4m benefit and a review of the useful lives of the Trust's medical equipment assets resulting in a reduction of depreciation of £0.7m.

2.3   The cash balance as at the end of March was £5.6m, which was higher than the planned level of £1.4m due to both the underspend in Capital expenditure, explained in 2.4, and additional cash receipts from our main Commissioner towards the end of March. During

2015/16 the Trust utilised the full £56.8m loan agreed with DH and in addition to this the Trust also obtained an additional £4.7m from the Department of Health in the form of a Working Capital Facility. Due to the additional cash holding the £4.7m working capital facility was repaid on the 11 April 2016.

2.4   Capital Expenditure

The capital expenditure position for the year amounted to £11.64m as shown below. This represents an under-shoot against the previous forecast out-turn (£19.5m) and reflects specific estates and IT infrastructure projects that are now due for completion in early 2016-17.

	£m
Estates and Site Infrastructure General	3.92
Information Technology	1.10
Medical and Surgical Equipment Programme	1.68
Specific Business cases, projects and contingency	1.44
Emergency Department	3.51
	11.64

2.5   Monitor Risk Rating 2015/16

The monitor risk rating is summarised in Table 2.

Table 2 – Monitor Risk Rating

	Plan	**Q1**	**Q2**	**Q3**	**Q4**
Under the risk assessment framework					
Continuity of Services	**1**	**1**	**1**	**1**	**1**
Governance	**Red**	**Red**	**Red**	**Red**	**Red**

Title of meeting:	Board Meeting	**Date:** 28.04.2016
Title of report:	Amended Clinical Governance committee structure	**Agenda item:**
Reporting Officer:	Dr Trisha Bain CQO	
Lead Director:	Dr Diana Hamilton-Fairley/Dr Trisha Bain	
FOI status:	*This paper is disclosable under the FOI Act;*	

Report Summary:

Following the initial implementation of clinical governance committees structure a 3 month review was conducted. The review highlighted the need to change some of the committees . The following changes were agreed and discussed at the Quality Improvement Group and with the responsible directors.

The changes are outlined in the pre and post diagrams in Appenidx 1 of this document. They are:

- The Infection Control Committee has moved from reporting to the patient experience committee to a position aligned with the patient experience, patient safety and clinical effectiveness committees. This reflects national recommendations.
- Likewise the Medicines Management Group has also been aligned in the same way due to the risk status of medicines management with the group chaired by the medical director.
- The clinical effectiveness committees sub groups have been reduced following discussions with the clinical leads, what was the clinical audit and improvement group is now merged with the clinical effectiveness group.
- Nutrition as a topic will be covered on the patient experience group agenda rather than having its own group.
- All committees have a reporting framework (see Appendix 2 as example from the clinical effectiveness group) and receive the integrated quality and performance dashboard for all of there meetings for discussion and relevant action. All of the KPIs are aggregated up to the Quality Improvement Group within the IQPR report.

Purpose: This paper is for:

Assurance		Approval	√	Decision		Information	

Recommendation:
The executive are asked to approve the final ammendments to the clinical governance framework prior to it going to the Board for final ratification.

Strategic Objective Links:
Highlight which strategic object(s) this recommendation aims to support.

1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment.
2. We will attract, retain and develop a first class workforce.
   .
3. We will provide high quality information and technology to support the delivery of care.

Identified Risks and Risk Management Action:
No major risk identified.

Resource Implications:
None

Recovery Plan implications:
Does the subject matter support the Recovery Plan

Yes: √	No:

If yes, highlight which aspect of the Recovery Plan this recommendation aims to support. [Delete those that are not applicable].

- Continuing to modernise our Emergency Department and pathway, reducing the time it takes for patients to be seen and assessed.

- Improving patient safety and care by minimising the number of different doctors that patients see during their stay in hospital.

- Accelerating our recruitment drive to employ the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interim and agency staff.

- 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.

- Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.

Recovery Plan Workstream [Highlight which workstream(s) the subject matter supports]		
Corporate Governance	Deteriorating patient	Referral management
Workforce	Nursing	Emergency pathway
Clinical leadership	Clinical goverance	Medical model

Data quality	Finance	

Quality Impact Assessment:

Yes:	No: √

If yes, attach the QIA as an appendice.
The paper will not be reviewed at the meeting if this is not attached.

If no, state why one is not required.

Report History:
Prevus ratification of the framework at the December 2015 Board

Next Steps and Further Reporting to the Board (if applicable):
No further reporting required

Appendices:
Appendix 1: Pre and post structures
Appendix 2 : Clincial effectivenss group/reporting structure as an example

For further information or for any enquiries relating to this report please contact:
Name, title and e-mail address:

Clinical Improvement Group
Lead CQC, MD, CN (rotational)

Clinical Effectiveness & Research
Lead Assoc. Medical Director
Dr Richard Leach

Meets Quarterly
- Dashboard etc
- Monitor sub groups
- PROMS
- Clinical Outcomes
- QI
- Research
- Trust wide audits

Mortality & Morbidity (MMCO)

Meets Monthly
- Mortality & morbidity
- End of life

Research Governance (RG)

Meets Quarterly
- Research
- Service Evaluations (requiring ethics approval)

Clinical Audit & NICE Compliance (CAN C)

Meets Bi Monthly
- Clinical Audit
- Clinical Guidelines & NICE Compliance
- National Reports
- Service Evaluations

Medway NHS Foundation Trust
Governance blueprint / structure map
Post March 2016

Medway NHS
NHS Foundation Trust

Quality Assurance Committee → **Board**

Clinical Council → **Clinical Executives Group**
Lead: Chief Executive → **Board**

Quality Improvement Group
Lead: CQO, MD, CN (rotational)

Patient Safety
Lead: Assoc. Medical Director
- Resuscitation & acute detrioration
- Transfusions and Thrombosis Committee
- Serious Incident Monitoring Group

Patient Experience
Lead: Head of patient experience
- EOL care group
- Clinical environment (PLACE)
- Patient feedback

Clinical effectiveness & research
Lead: Assoc. Medical Director
- Clinical guidelines, Clinical Audit, NICE & compliance
- Mortality & morbidity & Clinical Outcomes
- Research Governance

Medicines Management Committee
Lead: Chief Pharmacist/ Medical Director
- Non-medical prescribing
- Drugs & Therapeutics
  - Anti-microbial stewardship ← Safe Sedation

Children & Adult Safeguarding
Head of Safeguarding

Infection Prevention & Control
Lead: Director of Infection Prevention & Control
- Water Safety Group

Directorate level Governance Structure

Directorate

Directorate Quality & Governance Board

- Patient Experience
- Patient Safety
  - Medication Safety
  - Infection Control
- Clinical effectiveness & research
- Regulatory & standards

Legend
- Executive (green)
- Corporate (pink)
- Operational (blue)
- Assurance Committee (orange)

Key improvements
- Appropriate representation and membership
- Clear reporting lines
- Risk mitigation

Purpose
- Rationalisation
- Reduction in meetings
- Increase in appropriate escalation

```
┌─────────────────────────┐                    ┌──────────────────┐
│ Patient Safety          │───────────────────▶│ Patient safety   │
│ Lead: Assoc. Medical    │                    │ thermometer      │
│ Director                │                    │                  │
└─────────────────────────┘                    └──────────────────┘

┌─────────────────────────┐                    ┌──────────────────┐
│ Resuscitation & acute   │───────────────────▶│ AKI              │
│ detrioration            │                    │ Sepsis           │
│                         │                    │ HAP              │
└─────────────────────────┘                    └──────────────────┘

┌─────────────────────────┐
│ Transfusions and        │
│ Thrombosis Committee    │
└─────────────────────────┘

┌─────────────────────────┐                    ┌──────────────────┐
│ Serious Incidents       │───────────────────▶│ Never events     │
│                         │                    │ Falls            │
│                         │                    │ Pressure Ulcers  │
└─────────────────────────┘                    └──────────────────┘

┌─────────────────────────┐                    ┌──────────────────┐
│ Infection Prevention &  │───────────────────▶│ HCAI             │
│ Control                 │                    │                  │
└─────────────────────────┘                    └──────────────────┘

┌─────────────────────────┐
│ Drugs and theraputics   │
└─────────────────────────┘

┌─────────────┐
│ Safe sedation │
└─────────────┘

┌─────────────┐
│ Medication  │
│ safety      │
└─────────────┘

┌─────────────┐
│ Anti-microbial │
│ stewardship │
└─────────────┘

┌─────────────┐
│ Non-medical │
│ prescribing │
└─────────────┘

┌─────────────┐
│ Medical Gases │
└─────────────┘
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Medway NHS Foundation Trust
Governance blueprint / structure map
Pre March 2016

Medway **NHS**
NHS Foundation Trust

Quality Assurance Committee → **Board**

Clinical Council

Clinical Executives Group
Lead: Chief Executive

Quality Improvement Group
Lead: CQO, MD, CN (rotational)

Compliance & Risk Group
Lead: Director of Corporate Governance, Risk, Compliance & Legal

Patient Safety
Lead: Assoc. Medical Director

Patient Experience
Lead: Head of patient experience

Clinical effectiveness & research
Lead: Assoc. Medical Director

Regulatory & Standards
Lead: Head of Governance & risk

Resuscitation & acute detrioration

Nutrition

Patient feedback

Clinical guidelines, NICE & complicance

Medical devices/ contamination

Transfusions and Thrombosis Committee

Children & Adult Safeguarding

Clinical environment (place)

Mortality & morbidity & Clinical Outcomes

Capital Management Group incl security & H&S

Serious Incidents

EOL care group

Clinical Audit & Quality Improvement working group

External accreditation

Medicines Management Committee

Infection Prevention & Control

Research Governance

Information Governance / asset owners

Non-medical prescribing

Drugs & Therapeutics

Anti-microbial stewardship

Safe Sedation

Directorate level Governance Structure

Directorate

Directorate Quality & Governance Board

Patient Experience

Patient Safety

Clinical effectiveness & research

Regulatory & standards

Medication Safety

Key improvements
• Appropriate representation and membership
• Clear reporting lines
• Risk mitigation

Purpose
• Rationalisation
• Reduction in meetings
• Increase in appropriate escalation

Legend

■ Executive
■ Corporate
■ Operational
■ Task and finish groups

```
┌─────────────────────────────┐                    ┌──────────────────┐
│ Patient Safety              │───────────────────▶│ Patient safety   │
│ Lead: Assoc. Medical Director│                    │ thermometer      │
└─────────────────────────────┘                    └──────────────────┘

┌─────────────────────────────┐                    ┌──────────────────┐
│ Resuscitation & acute       │───────────────────▶│ AKI              │
│ detrioration                │                    │ Sepsis           │
└─────────────────────────────┘                    │ HAP              │
                                                    └──────────────────┘

┌─────────────────────────────┐
│ Transfusions and            │
│ Thrombosis Committee        │
└─────────────────────────────┘

┌─────────────────────────────┐                    ┌──────────────────┐
│ Serious Incidents           │───────────────────▶│ Never events     │
└─────────────────────────────┘                    │ Falls            │
                                                    │ Pressure Ulcers  │
                                                    └──────────────────┘

┌─────────────────────────────┐                    ┌──────────────────┐
│ Infection Prevention &      │───────────────────▶│ HCAI             │
│ Control                     │                    │                  │
└─────────────────────────────┘                    └──────────────────┘

┌─────────────────────────────┐
│ Drugs and theraputics       │
└─────────────────────────────┘

      ┌──────────────┐
      │ Safe sedation│
      └──────────────┘

      ┌──────────────┐
      │ Medication   │
      │ safety       │
      └──────────────┘

      ┌──────────────┐
      │ Anti-microbial│
      │ stewardship  │
      └──────────────┘

      ┌──────────────┐
      │ Non-medical  │
      │ prescribing  │
      └──────────────┘

      ┌──────────────┐
      │ Medical Gases│
      └──────────────┘
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Title of meeting:	Board of Directors		**Date:** April 2016
Title of report:	Vision and Values		**Agenda item:**
Reporting Officer:	Rebecca Bradd		
Lead Director:	Rebecca Bradd, Acting Director of Workforce		
FOI status:	*This paper is disclosable under the FOI Act*		

Report Summary:

The report presents the new Trust Vision, Values and associated behaviours.

Purpose: This paper is for

Assurance		Approval		Decision		Information	X

Recommendation:

The Board is asked to note the launch of new Vision and Values.

Strategic Objective Links:
1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment.
2. We will attract, retain and develop a first class workforce.
3. We will manage our resources prudently, efficiently and effectively.

Identified Risks and Risk Management Action:
It is important for all staff in the Trust to live and embed the new Vision and Values. The risk is that the Vision and Values are not embedded or have the required impact. This is mitigated through the launch and rollout programme.

Resource Implications:
n/a

Recovery Plan implications:
Does the subject matter support the Recovery Plan

Yes: X	No:

- Accelerating our recruitment drive to employ the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interim and agency staff.

- 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.

Recovery Plan Workstream		
Corporate Governance	Deteriorating patient	Referral management
Workforce X	Nursing	Emergency pathway
Clinical leadership	Clinical goverance	Medical model
Data quality	Finance	

Quality Impact Assessment:

Does the subject matter require a QIA?

Yes:	No: X

Report History:

The Vision and Values were endorsed at February Board.

Next Steps and Further Reporting to the Board (if applicable):

n/a

Appendices:

n/a

For further information or for any enquiries relating to this report please contact:

Rebecca Bradd, Acting Director of Workforce rebecca.bradd@medway.nhs.uk

Our vision

Our logo

Best of care

Best of people

Together

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Our values

Be the Best!...

…to make our Vision a reality

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Bold

We are Inspiring and Ambitious

Every Person Counts

We are Respectful and Supportive

Sharing and Open

We are Open and Speak Up

Together

We are Inclusive and Responsible

Values linked to behaviours

Values	Behaviours	
BOLD — We're inspiring and ambitious	Inspiring	Ambitious
EVERY PERSON COUNTS — We're respectful and supportive	Respectful	Supportive
SHARING & OPEN — We're open and speak up	Open	Speak Up
TOGETHER — We're inclusive and responsible	Inclusive	Responsible

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Living the Values…together

BOLD We are Inspiring and Ambitious	EVERY PERSON COUNTS We are Respectful and Supportive	SHARING & OPEN We are Open and Speak Up	TOGETHER We are Inclusive and Responsible
▪ We have high aspirations and want to be the best we can be ▪ We make the right decisions with our patients using evidence and best practice ▪ We share a common vision	▪ We treat everybody with respect ▪ We value the contribution of all staff ▪ We support & encourage each other to be our best	▪ We are open and transparent in all that we do ▪ We innovate, share and encourage creativity ▪ We are committed to learning and continuous improvement	▪ We deliver the best care for our patients together ▪ We work in partnership with our patients, families and our community ▪ We encourage team working to deliver the best outcomes ▪ We do what we say we will do

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Living the Values…for all

INSPIRING	RESPECTFUL	OPEN	INCLUSIVE
AMBITIOUS	**SUPPORTIVE**	**SPEAK UP**	**RESPONSIBLE**
- I strive to be the best - I have a "can do" attitude - I welcome and learn from challenges and opportunities - I make the right decisions using evidence and best practice - I am open to new ideas and willing to try new ways of working	- I respect others - I look for ways to create a positive experience for others - I support and encourage my colleagues to be the best - I treat others with kindness and address their concerns - I consider the impact of my actions on others - I challenge behaviour that is not in line with our values	- I communicate openly, honestly, effectively and often - I speak up when I see issues that affect the safety and well-being of others - I take action when I see something is wrong or can be improved - I reflect and share what I learn - I question, challenge and look for innovative solutions - I am committed to continuous learning and improvement	- I do what I say I will do - I am accountable and responsible for everything I do - I work in partnership to deliver the best care - I make a positive contribution to the success of the Trust - I prioritise my work effectively

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Living the Values…for leaders

INSPIRING	RESPECTFUL	OPEN	INCLUSIVE
AMBITIOUS	**SUPPORTIVE**	**SPEAK UP**	**RESPONSIBLE**
▪ I share a common vision to be the best ▪ I am bold in my aspirations and my decisions ▪ I lead by example and set clear objectives ▪ I make the right decisions using evidence and best practice ▪ I strive to be the best leader that I can be	▪ I am respectful in all my interactions ▪ I value and encourage other people's contribution ▪ I encourage and coach others to be the best they can be ▪ I take time to listen to ideas ▪ I am fair and consistent ▪ I look for ways to create a positive working experience for my team	▪ I act when there are issues that affect the safety and well-being of others ▪ I involve and empower my team to develop and deliver our objectives ▪ I explain the "why", not just the "what" ▪ I am consistent and constructive with my feedback ▪ I promote learning through innovation, best practice and change ▪ I seek feedback to help me be a better leader	▪ I deliver what I say I will ▪ I am accountable and responsible for our delivery ▪ I motivate others ▪ I give credit where it's due ▪ I make myself available for my team ▪ I involve our patients, staff and our community in decisions about the services we provide ▪ I delegate effectively to help people develop

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Recruitment & Policies

Vision, Values & Behaviours themes and imagery integrated into recruitment & policy activity and messages…
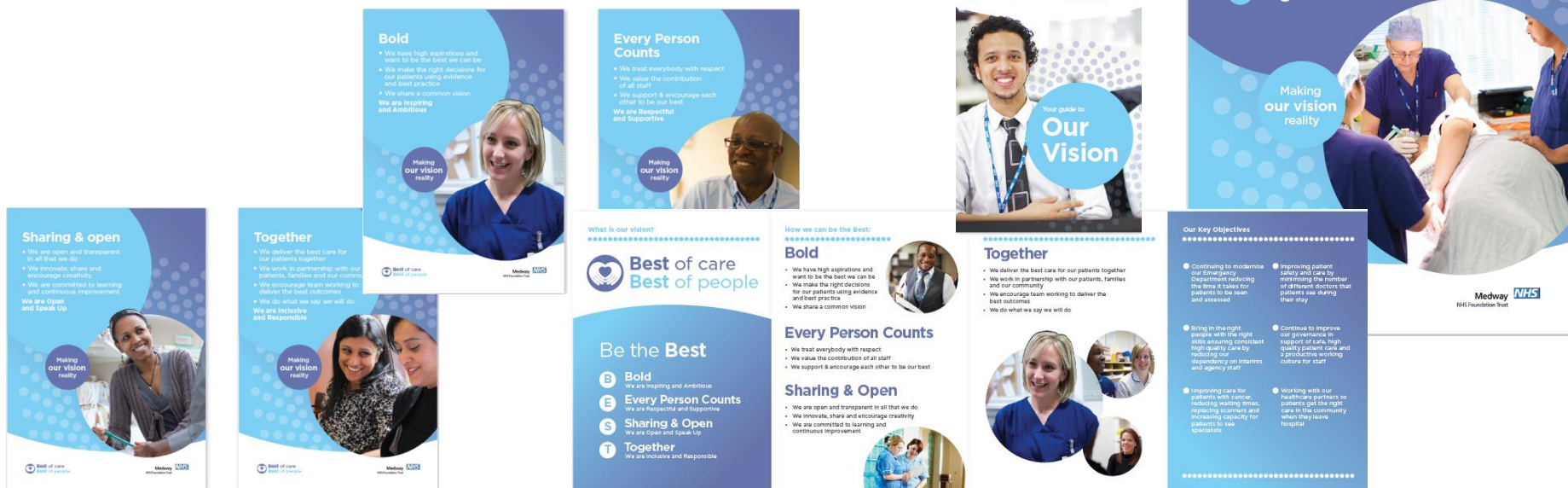
…helping us make our vision a reality:
Best of people

A new "appraisal" emphasis

That no longer focuses on the paperwork & "the event"…
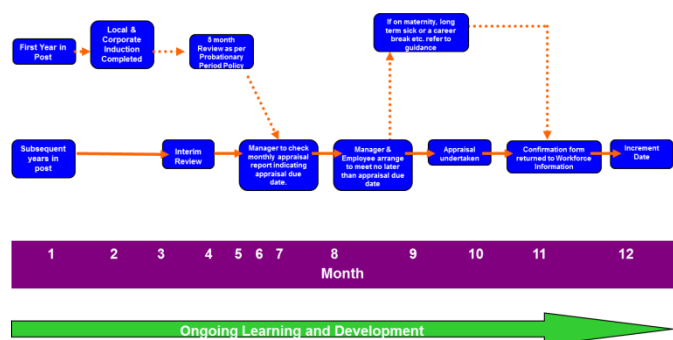
…and moves it to…

A two way conversation…
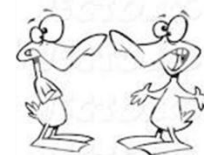
…with a common purpose

…enabling behavioural and attitudinal change genuinely connected to *Living our Values*

Leadership & Management Development Programmes

That integrate values & behaviours

INSPIRING	RESPECTFUL	OPEN	INCLUSIVE
AMBITIOUS	**SUPPORTIVE**	**SPEAK UP**	**RESPONSIBLE**
- I share a common vision to be the best - I am bold in my aspirations and my decisions - I lead by example and set clear objectives - I make the right decisions using evidence and best practice - I strive to be the best leader that I can be	- I am respectful in all my interactions - I value and encourage other people's contribution - I encourage and coach others to be the best they can be - I take time to listen to ideas - I am fair and consistent - I look for ways to create a positive working experience for my team	- I act when there are issues that affect the safety and well-being of others - I involve and empower my team to develop and deliver our objectives - I explain the "why", not just the "what" - I am consistent and constructive with my feedback - I promote learning through innovation, best practice and change - I seek feedback to help me be a better leader	- I deliver what I say I will - I am accountable and responsible for our delivery - I motivate others - I give credit where it's due - I make myself available for my team - I involve our patients, staff and our community in decisions about the services we provide - I delegate effectively to help people develop

…to help create inclusive and transformational Leaders *Living our Values*

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Personal Development Programmes

That integrate values & behaviours in every learning & development intervention…

INSPIRING	RESPECTFUL	OPEN	INCLUSIVE
AMBITIOUS	**SUPPORTIVE**	**SPEAK UP**	**RESPONSIBLE**
• I strive to be the best • I have a "can do" attitude • I welcome and learn from challenges and opportunities • I make the right decisions using evidence and best practice • I am open to new ideas and willing to try new ways of working	• I respect others • I look for ways to create a positive experience for others • I support and encourage my colleagues to be the best • I treat others with kindness and address their concerns • I consider the impact of my actions on others • I challenge behaviour that is not in line with our values	• I communicate openly, honestly, effectively and often • I speak up when I see issues that affect the safety and well-being of others • I take action when I see something is wrong or can be improved • I reflect and share what I learn • I question, challenge and look for innovative solutions • I am committed to continuous learning and improvement	• I do what I say I will do • I am accountable and responsible for everything I do • I work in partnership to deliver the best care • I make a positive contribution to the success of the Trust • I prioritise my work effectively

…to facilitate cultural change where everyone is *Living our Values* to achieve the Vision

Best of care
Best of people

Medway NHS
NHS Foundation Trust

Title of meeting:	Trust Board		Date: 28 April 2016
Title of report:	Combined Risk and Assurance Framework		Agenda item:
Reporting Officer:	Lynne Stuart		
Lead Director:	Lynne Stuart, Director of Corporate Governance, Risk, Compliance & Legal		
FOI status:	This paper is disclosable under the FOI Act		

Report Summary:
The Director of Corporate Governance, Risk, Compliance and Legal has collated a Combined Risk and Assurance Framework (CRAF) document which is attached for review. The document has been subject to the input, scrutiny and review of the Executive and is considered an accurate reflection of the Trust's strategic risks, controls, assurance and gaps. Whilst strategic risks, controls and assurances have been aligned to the Trust's strategic objectives, some additional objectives/principles have been drafted and placed below the yellow line. This is in recognition that the current stated strategic objectives are in need of updating and do not necessarily reflect organisational focus. The section related to Corporate Risks is not currently reflective of all corporate risks. This is due to deficiencies in the data on Datix, and the fact that not all directorates or corporate functions use Datix for risk registers (or may not have risk registers). The review and improvement process is still underway and embedded in the Risk Implementation Plan. As the Board's main focus is strategic the document is intended to support the Board in the following areas: • Clarifying risks that will compromise strategic objectives • Sense checking that the controls in place are still valid and resilient • Enabling the Board to affirm that assurance is in place and understand the reliability and trust that may be placed on the assurance • Recording gaps as a notification of the current state of play The document is intended as a stop-gap mechanism until a software based system for a Combined Risk and Assurance Framework is implemented as part of the Risk Management Improvement Plan. The output of the Board's risk appetite workshop and developing risk appetite statement will further support the integrity of the CRAF as well as supporting Board decision making on an ongoing basis.

Purpose: This paper is for

Assurance	✓	Approval		Decision		Information	

Recommendation:
The Board are requested to: • Review the Combined Risk and Assurance Framework and assess the adequacy of mitigating actions and controls. • Evaluate the assurance across all areas of principal risks • Consider the adequacy of plans to address gaps • Feedback on any omissions that have not been recorded

Strategic Objective Links:
Effective risk management and oversight of assurance and gaps supports delivery of all strategic objectives. 1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment. 2. We will attract, retain and develop a first class workforce. 3. We will manage our resources prudently, efficiently and effectively. 4. In partnership, we will provide integrated care for the community. 5. We will provide high quality information and technology to support the delivery of care.

Identified Risks and Risk Management Action:
There are deficiencies in the Trust's risk management arrangements which means that organisational oversight of risks is not assured. These deficiencies are being addressed through an implementation plan which commenced in March.

Resource Implications:
Not applicable

Recovery Plan implications:
Does the subject matter support the Recovery Plan Yes: ✓   No: • 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.

Recovery Plan Workstream		
Corporate Governance ✓	Deteriorating patient	Referral management
Workforce	Nursing	Emergency pathway
Clinical leadership	Clinical goverance	Medical model
Data quality	Finance	

Quality Impact Assessment:

Yes:	No: ✓

Not applicable.

Report History:

No previous history; this is the first time that the CRAF is presented to the Board.

Next Steps and Further Reporting to the Board (if applicable):

The updated CRAF will be reported to each Board meeting.

Appendices:

For further information or for any enquiries relating to this report please contact:
Lynne Stuart
Lynne.stuart@nhs.net

Mar-16

Strategic Objective	Strategic Risk	Risk Appetite (Impact x likelihood)	Impact - current	Likelihood - current	Risk Score - Current	Controls in place	Gaps	Assurance Providers — First Line (Business management)	Second Line (Corporate Oversight)	Third Line (Independent)	Risk Ref. No.	Date added to Risk Register	Description (there is a risk that...)	Risk Domain	Controls in place	Assurance	Exec Owner	Mgt Lead	Initial Risk Rating	Current Impact	Current Likelihood	Current Score	Actions (from Risk Register)	Target Rating (risk appetite)
We will deliver safe, effective care with an excellent patient experience in the most appropriate environment	Difficulty in filling consultant and nursing vacancies in ED, combined with high attendance rates and poor patient flow through the hospitals, leads to quality and safety failures in ED and harm to patients	4 (2 x 2)	4	4	16	CQC Action Plan (no. 21) - Review the environment within ED to meet patient demand effectively. CQC Action Plan (no. 25) Ensure that all patient records in ED are accurate to ensure a full chronology of their care has been recorded. CQC Action Plan (no.24) Ensure that staffing levels within adult ED meet patient demand. CQC Action Plan (no. 27) Take immediate action to improve patient flow. This must be achieved without impacting other services provided within the departments and have a risk balanced approach so not to impede on other services delivered.	Recruitment activity and resourcing initiatives are not having the required impact.	ED Strategy disseminated to staff and went live Feb 2016. It is anticipated that this will seen an improvement in 4 hour performance and non-admitted attendances. ED Remedial Action Plan in place. Actions include: Induction and competency training roll out in March 2016 for agency staff in ED; Rota put in place which allows for lead escalation/flow manager (went live Jan 2016); new leadership team has been established and is in place which includes a Clinical Lead, Lead Matron, Matron, Nurse Consultant and GM.	Performance against the Key Performance Indicators (KPIs) agreed within the Trust Recovery Plan which is reviewed and monitored at the weekly Executive Recovery Committee which reports direct to the Board, but with oversight by the Clinical Council on a monthly basis.	Weekly reporting on KPIs via a conference call with the CCG, Monitor and the CQC	87	10/03/2015	The level of vacancies remain high, particularly for nursing and medical staff	Well-led	Daily Matron Ward Rounds in place to monitor gaps. Identified issues escalated to the Site Manager (and Senior manager on-call out of hours).	Recruited to key posts within the recruitment team. Workforce plan developed to include recruitment/retention strategies. Introduction of TRAC recruitment system to streamline process. Working with procurement to secure overseas agency.	Medical Director	Margaret Dalziel	16	4	4	16	New assessment centre; nurses being recruited in reduced timeframe. Overseas recruitment events commenced in Nov 15.	3 x 3 = 9
	High vacancy rates within nursing means that existing staff resources are stretched beyond safe staffing levels resulting in poor patient care	4 (2 x 2)	4	4	16	CQC Action Plan (no. 48) - Ensure there are adequate numbers of nurses on duty at all times to meet its own needs assessment and national guidance. CQC Action Plan (no.69) Ensure theatre lists are staffed by appropriately competent staff at all times as outlined in national guidance to minimise the risk to patients. Buddying arrangements with GSTT. Chief Nurse in post. Medical Director in post (through GSTT buddying arrangement)	Recruitment activity and resourcing initiatives are not having the required impact.	Full N&M staffing / establishment review undertaken 90 wte new posts agreed for N&M. Staffing escalation policy in place, formal escalation of staffing concerns and action taken reported via DATIX. Three times daily review of staffing captured at site meetings. Senior Sister night rota for Medicine & Surgery implemented in December 2015. The need for this support is being reviewed weekly by DoN and Deputy DoNs. Following the review of the clinical site team and subsequent recruitment, this rota is no longer required. Three times overnight safety huddles taking place (Senior Sister, site practitioner and ED nurse in charge) - staffing and patient management discussed. DDoN for W&C has meet with Director of Nursing and workforce lead to agree establishment from April 2016 and agree timescale for establishment reviews. Maternity workforce review to commence in July 2016 for 3 months, analysis in October 2016 ready for Board paper in November 2016. No change to Gynae establishment required. Neonatal establishment awaiting BAPM review in line with acuity expected in April 2016. Paediatric acuity tool devised and piloted March and April 2016 review analysis in May 2016 for establishment agreement. Coordinated Surgical Care Directorate: Daily Directorate Safety Huddles with management team to plan days activity and discuss patient acuity. Senior Matron takes responsibility to mitigate any shortfall in staffing, actions include moving non ward based staff into clinical roles. A system has been implemented in conjunction with the Director of Nursing, to improve the formal escalation of any shortfall in staffing that cannot be resolved. Staffing is reported three times a day at the site safety meetings. Senior Night Nursing rota no longer in use which now allows for extended senior day time cover to ensure 8am-9pm cover 7 days a week. Ward Sisters and Matrons are still expected to undertake occasional night shifts to assure themselves of safe care out of hours	The Director of Nursing provides a monthly report to the Board which details the previous month's Unify data, areas of risk, mitigations in place and plans going forward.	Weekly reporting on KPIs via a conference call with the CCG, Monitor and the CQC. Published monthly Unify data	61	09/11/2012	The Trust has a poorer ratio of Registered to non registered nursing staff on a number of wards across the trust which leads to an inappropriate staffing and skill mix and over reliance on a temporary workforce and does not allow for a 1:8 or less ratio which may compromise patient safety and result in poor care.	Safe	1. Daily safety meetings in place with all matrons expected to review key safe staffing and ward safety concerns. 2. Weekly review of safe staffing. 3. E-rostering 26 wards across the Trust now live.	Nursing staff encouraged to report via DATIX-web when incidences may impact upon patient safety or reduced quality of care. Weekly management data on fill rates from NHSP. Recruitment drive being driven corporately.	Director of Nursing		16	4	4	16	New assessment centre; nurses being recruited in reduced timeframe. Overseas recruitment events commenced in Nov 15. Plans for transition NHSP staff across to an in-house bank are progressing at pace with a 'go live' date of 26 March 2016	2 x 3 = 6
	The hospital fails to improve its position as an outlier in mortality indicating that is causing harm to patients	4 (2 x 2)	5	3	15	Mortality Steering Group in place. Additional training given to Clinical Coding team to ensure correct coding. Thematic Mortality Dashboard		Monthly specialty reviews of mortality and morbidity commenced and through the revised directorate clinical governance arrangements , these reviews are now reporting to the Mortality Steering Group.	The Mortality Steering Group reports to the Quality Improvement Group indicating areas of progress and/ or deterioration. Latest HSMR = 106	Published HSMR and SHMI data	60	12/11/2012	There is a risk that the Trust will fail to resolve high HSMR issues resulting in reputational damage, loss of patient confidence and potential loss of licence	Safe			Medical Director		20	4	4	16	Trust review of mortality and morbidity in specialties where outcomes are below national averages. Priority areas - obstetrics, clinical haematology, general medicine, geriatric medicine, T&O. Mortality in these areas will receive a coding and clinical review where appropriate. Each speciality is holding Mortality and Morbidity review meetings.	
	The hospital fails to meet NHS Constitution targets (eg. Referral to treatment times, cancer 2 week waits etc.) resulting in potential harm to patients and/or poor patient experience	4 (2 x 2)	5	4	20	CQC Action Plan (no. 52) - Urgently review the two week cancer pathways for each speciality and ensure that there is clinical oversight of those patients waiting in order to mitigate the risks to those patients. Clinical Directors and structure in place. CQC Action Plan (no. 53) - Provide clinical oversight of patients waiting on incomplete pathways to ensure they are seen on a basis of clinical need in accordance with the trust Access Policy. CQC Action Plan (no.54) Ensure clinical oversight of activity provided and ensure appropriate audit trails and quality measurement tools are in place. CQC Action Plan (no.56) Review theatre start and finish times and staffing arrangements for over runs to ensure the department is working to maximum capacity to meet the demands of the service and to minimise the risk to patients from long referral to treatment times (RTT).	Clinical engagement and accountability is sub-optimal. Clinical leadership programme needs implementing to support Clinical Leaders fulfill their roles.	General Managers made accountable for ensuring that clinicians within their areas are updated with regular data concerning the number of patients on waiting lists and their waiting times to ensure clinical oversight. Enhanced patient tracking and improved data recording, reporting and monitoring implemented. Capacity and demand models developed for at risk, high demand specialties. Clinical oversight improved. Remedial action plan implemented. Weekly PTL lists are now being signed off by the key clinical lead for each tumour site	Performance against the Key Performance Indicators (KPIs) agreed within the Trust Recovery Plan which is reviewed and monitored at the weekly Executive Recovery Committee which reports direct to the Board, but with oversight by the Clinical Council on a monthly basis.	Weekly reporting on KPIs via a conference call with the CCG, Monitor and the CQC. Outcomes of external reviews (eg. Joint Accreditation Group - endoscopy); MHRA Inspections; CPA accreditation. For RTT the operating standard for all providers is 92% and any deviation below this must be specifically agreed with the provider regulator and commissioners	97	29/07/2015	There is a risk that increased waiting times across specialties, increasing numbers of cancelled operations and increased cancelled clinics will bring potential harm to waiting patients and further deterioration to cancer wait times, diagnostic access and RTT targets	Safe		Integrated Quality and Performance Report to Board	Chief Quality Officer		25	5	5	?	Remedial action plans for cancer, imaging, ED, RTT and endoscopy. Validation plan for pathways. Outsourcing.	4 x 4 = 16
	Failure to ensure that workforce is sufficiently trained: target of 95% of available workforce having completed mandatory training is not achieved resulting in patient harm and/or CQC action	4 (2 x 2)	2	3	6	CQC Action Plan (no. 62) Improve the completion of mandatory training rates. Acting Director of HR in post. Induction training; online system showing compliance rates; management oversight. CQC Action Plan (no. 65) Ensure that all staff understand their responsibilities under the Deprivation of Liberties Safeguards (DoLS) and discharge these in line with legal requirements	Substantive Director of HR to be appointed	Mandatory training data weekly monitoring. The mandatory training team are focusing on 'hotspots' in the organisation. These areas have been highlighted to the appropriate business partner for action, and as a result, the number of areas has decreased. The team will now be moving on to those areas with less than 75% compliance. We now have a weekly 'hotspot' league table which is shared with our HR colleagues. We can pinpoint the people and the topics which are creating difficulties. The HR IT training room is open every Friday for people to complete their mandatory training and updates where appropriate, with assistance from the mandatory training team. For new starters from other NHS Trusts, documentary evidence of previous training, if within our update schedule, is accepted as proof of compliance.	Performance against the Key Performance Indicators (KPIs) agreed within the Trust Recovery Plan which is reviewed and monitored at the weekly Executive Recovery Committee which reports direct to the Board, but with oversight by the Clinical Council on a monthly basis.		42	01/06/2013	The Trust will fail to meet the internal target of 95% of available workforce completing mandatory training	Well-led	Mandatory training action plan in place with weekly monitoring at mandatory training group meeting. Hot spots identified and circulated weekly to DoC Ops and Execs to improve compliance. Alternative training methods being developed including mandatory training booklet.		Director of HR	Tessa Honey	12	3	3	9		6

Strategic Objective	Strategic Risk	Risk Appetite (Impact x likelihood)	Impact - current	Likelihood - current	Risk Score - Current	Controls in place	Gaps	Assurance Providers First Line (Business management)	Second Line (Corporate Oversight)	Third Line (Independent)	Risk Ref. No.	Date added to Risk Register	Description (there is a risk that...)	Risk Domain	Controls in place	Assurance	Exec Owner	Mgt Lead	Initial Risk Rating	Current Impact	Current Likelihood	Current Score	Actions (from Risk Register)	Target Rating (risk appetite)
								Mar-16			**Organisational Risks (>15)**													
We will deliver safe, effective care with an excellent patient experience in the most appropriate environment	Patients are harmed because learning from serious incidents, complaints and feedback is not embedded in systems and processes	4 (2 x 2)	3	3	9	CQC Action Plan (no.8). SI Monitoring Group started Feb 2016. Ongoing monitoring via weekly harm free meetings which reviews mod/severe incidents. Patient safety awareness sessions being rolled out. Learning events commenced 2.2.2016 and will continue for all SIs. Process review of death certification process to link SIs with inquests. New report format in use for all SI investigations. Datix review underway. Specific controls are in place within the emergency department when the Trust and department capacity is escalating to red, as stated within the ED Improvement plan Quality Strategy Root Cause Analysis (RCA) training and process	Patient Safety Trainer is running a series of targeted sessions, particularly out of hours, focussing on temporary workers to ensure that all incidents are reported. Still delays in the completion of SI Investigations, with breach of 60 day statutory deadline No information on patient experience and feedback is reported to the Executive and information reported to the Board is restricted to statistics on the number of complaints.	Daily high level report of all incidents occuring the the preceding 24 hours issued to all directorate leadership teams. Patient Safety Team established under leadership of Medical Director, Chief Quality Officer and Chief Nurse Directorate governance meetings - Serious incidents are reported into the directorates at the monthly Directorate Governance Meeting CQUIN performance is reported by exception to the Quality Assurance Committee on a quarterly basis.	SI Monitoring Group - minutes reported to Patient Safety Committee Patient Experience Feedback Report to Quality Improvement Group (QIG) includes reporting on complaints (quarterly) Performance against the Key Performance Indicators (KPIs) agreed within the Trust Recovery Plan which is reviewed and monitored at the weekly Executive Recovery Committee which reports direct to the Board, but with oversight by the Clinical Council on a monthly basis. Directorate Report to Quality Improvement Group includes reporting on incidents, patient safety, alerts, complaints, risks Annual Quality Accounts	Monthly reporting via SI Action Plan Monitoring and closure group at North Kent CCG Learning From Mistakes League published by NHS Improvement (compiled from staff survey and NRLS data). Medway FT is ranked 226/230 with a categorisation of "Poor Reporting Culture" (March 2016)	90	08/05/2015	The time to process and close down Serious Incidents is in breach of mandatory time limits meaning that there are delays in embedding any learning and therefore the potential for patient harm exists.	Responsive		SI Monitoring Group review process and Terms of Reference	Chief Quality Officer	Debbie Brown	20	4	3	12	New clinical governance structure launched December 2015; training on RCA techniques and new documentation	4
We will attract, retain and develop a first class workforce	The CQC rating of the hospital as "Inadequate" overall may impact detrimentally on the Trust's ability to attract new staff resulting in the continuance of high vacancy rates and/or turnover	4 (2 x 2)	4	4	16	CQC Action Plan (no.71) Ensure all staff receive an annual appraisal and that there are arrangements for clinical supervision for those who require or request it. Four appraisal training workshops have been arranged, commencing 29 February 2016, and are currently advertised on the intranet. Head of Education has oversight of all arrangements for clinical supervision. Supervision - Clinical supervision is offered to all adult nursing students who attend placements in Medway, it is not mandatory but students are expected to attend. There is no formal supervision in place for the clinical staff on the wards, but Newly Qualified nurses receive supervision for the first six months during their preceptorship days, Midwifes have supervision included in their practice. Workforce plan developed to include recruitment/retention strategies. Introduction of TRAC recruitment system to streamline process. Acting Director of HR in post	Recruitment activity and resourcing initiatives are not having the required impact. Substantive Director of HR to be appointed	Appraisal rate on WIRED is 66.71% as at 12 February 2016.	Performance against the Key Performance Indicators (KPIs) agreed within the Trust Recovery Plan which is reviewed and monitored at the weekly Executive Recovery Committee which reports direct to the Board, but with oversight by the Clinical Council on a monthly basis.	Annual Local Authority Of Supervisors audit and report carried out on Midwifery supervision and reported to Quality Improvement Group Weekly reporting on KPIs via a conference call with the CCG, Monitor and the CQC	87	10/03/2015	The level of vacancies remain high, particularly for nursing and medical staff	Well-led	Daily Matron Ward Rounds in place to monitor gaps. Identified issues escalated to the Site Manager (and Senior manager on-call out of hours).	Recruited to key posts within the recruitment team. Workforce plan developed to include recruitment/retention strategies. Introduction of TRAC recruitment system to streamline process. Working with procurement to secure overseas agency.	Medical Director	Margaret Dalziell	16	4	4	16	New assessment centre; nurses being recruited in reduced timeframe. Overseas recruitment events commenced in Nov 15.	3 x 3 = 9
We will manage our resources prudently, efficiency and effectively.	The Trust fails to achieve its planned deficit reduction and budget for 2016/17 resulting in further licence conditions and potential regulatory action	9 (3 x 3)	4	3	12	Scheme of Delegation and authorisation levels Business planning process Interim Director of Finance appointed Budgetary Control Framework in place from April 2016 ensuring that budget holders have clear responsibilities and accountability and they are supported by training alongside robust budgets. National agency caps; monitoring by procurement team of contracts for agency workers Investments and Contracts Committee Performance Committee Cost Improvement Plans	Vacancies in Finance Team Poor governance and understanding of systems and processes by staff		Integrated Audit Committee oversight of financial governance systems Audit Committee oversight of bad debtors, SFIs, single tender waivers, losses	External audit of financial accounts and core financial systems	95	13.07.2015	Activity recording and billing does not satisfy CCG requirements resulting in inability to invoice for activity performed and loss of income	Responsive			Director of Finance		16	4	4	16	Action plan undertaken between finance and informatics to ensure all activity recorded and billable.	?
	The hospital is unable to operate without central funding (loans) which restricts the financial operation of the organisation and its autonomy which may impact on its ability to bring about required organisational changes	9 (3 x 3)	3	5	15	Loan Conditions			Monthly Finance Report to Board includes status report on compliance with Loan Terms from DH	NHS Improvement's monitoring of adherence to loan conditions														
In partnership we provide integrated care for the community.	If discharges of medically fit patients who require social care are not expedited in a timely manner, then operational capacity will be severely affected, four hour wait targets breached and with an adverse effect on patient care.	4 (2 x 2)	3	3	9	CQC Action Plan (no. 26) Improve the quality of discharge plans to decrease the number of delayed transfer of care Home to Assess programme underway. MFFD patients being monitored via weekly dashboard Programme to improve discharges before noon - trajectories set	Integrated Discharge Team not under full control of Trust. There's an internal team but the IDT is led by Medway Community Healthcare and not within the full control of the Trust	Location of Reports reviewed via : Shared Drive:NMAS, LOS, DTOC,three times daily site meetings	Performance against the Key Performance Indicators (KPIs) agreed within the Trust Recovery Plan which is reviewed and monitored at the weekly Executive Recovery Committee which reports direct to the Board, but with oversight by the Clinical Council on a monthly basis.	Weekly reporting on KPIs via a conference call with the CCG, Monitor and the CQC Health and Wellbeing Board Medway Council Overview and Scrutiny Committee														
We will provide high quality information and technology to support the delivery of care.	The financial position of the Trust means that there are insufficient resources for investment in required technology	9 (3 x 3)	4	3	12	Health Informatics Team in-house from April 2016 Informatics Programme Board (health economy forum) Chief Quality Officer - Executive Director with responsibility for informatics	Financial resources not sufficient for investment and catch up required Trust is lagging behind other Trusts in terms of innovation Digital footprint strategy is work in progress (CCG leading)	Corporate Informatics Group	Executive Committee and Clinical Executive Committee															

Medway NHS Foundation Trust Combined Risk and Assurance Framework — Mar-16

Strategic Objective	Strategic Risk	Risk Appetite (impact x likelihood)	Impact - current	Likelihood - current	Risk Score - Current	Controls in place	Gaps	First Line (Business management)	Second Line (Corporate Oversight)	Third Line (Independent)	Risk Ref. No.	Date added to Risk Register	Description (there is a risk that…)	Risk Domain	Controls in place	Assurance	Exec Owner	Mgt Lead	Initial Risk Rating	Current Impact	Current Likelihood	Current Score	Actions (from Risk Register)	Target Rating (risk appetite)
Additional strategic objectives/principles added below																								
Achieve compliance with mandatory and essential standards	The Trust is not compliant with legislation, CQC fundamental standards or NHS Improvement's licence conditions resulting in regulatory action being taken against the Trust with the potential to destabilise the Trust's recovery and improvement plans	4 (2 x 2)	4	3	12	Director of Corporate Governance, Compliance, Risk & Legal appointed Governance Manager in post with responsibility for ensuring that systems and processes for evidencing CQC compliance are in place. Governance team responsible for monitoring and tracking accreditation	Compliance and Risk Group needs to be established to provide a mechanism for holistically reviewing all compliance and providing onward assurance to the Board (ToR going to Exec Committee on 20.04.2016) Governance Team needs flexing/structuring to meet business needs There is no corporate oversight of CQC compliance on a cross-organisational basis (proposal for software based system was approved by Exec Committee on 20.04.2016) CQC Assurance - technology to support tracking and assurance is not in place; Trust is reliant on manual collection of data which is not reflective of current position	Director of Finance / Chief Exec are management leads for Monitor	Compliance and Risk Committee (not yet established)	Internal Audits Monitor assessment CQC Inspection Reports	74	Sep-15	The Trust has been found to be non compliant with the CQC Essential standards of quality and safety which impacts negatively on the experience and safety of patients and staff and increased the risk of CQC and NHSI intervention, loss of licence(s) and reputational damage.	Well-led					20	5	4	20	ED Action Plan in place and subject to daily monitoring. Cohorting procedure operational in ED to ensure a clear process is followed during periods of peak activity. Supported by the introduction of new Patient Safety Round documentation developed by Consultant Nurse in ED. Updated procedure out of hours to ensure that ED staff are supported overnight by Senior Nurse on-call and Site Team. Introduction of hot clinics for surgery, urology, cardiology and respiratory medicine are being supported through the ECIP partnership. Clinics enable ED to directly book patients for specialist review in hot clinic setting within 24/48 hrs.	2 x 2 = 4
											88	09/03/2015	There is a risk of non-conformity with statutory requirements relating to building and infrastructure due to a lack of corporate records which may present risks to health and safety of persons and risk of damage to assets.	Well-led			Director of Finance		25	4	4	16	New Estates and Facilities governance structure in place.	12
Rebuild patient and stakeholder confidence in the Trust	Confidence and trust in the services delivered are undermined by negative inspection reports and CQC "Inadequate" ratings	6 (3 x 2)	3	3	9	Communications team established Proactive stakeholder engagement programme in place with key political stakeholders. Healthwatch meetings with Chair / Chief Exec on a regular basis. Frequent updates on key Trust developments communicated to key stakeholders regularly Proactive media relations programme in place to publicise improvements in the hospital to reassure key stakeholders and the public Range of proactive public facing communications (eg. Improving	Board approved Communications Strategy is not in place (strategic intent work needed as a primary step before developing underpinning Comms Strategy)	Communications team provide media updates to all Board members on a daily basis.	Monthly Communications Report provided to the Board															
Ensure the Trust operates in accordance with its statutory framework and best practice principles of good governance and transparency	The Trust does not improve upon its Red Rating for Governance from its regulator and poor governance continues to impact detrimentally on patients and the organisation	4 (2 x 2)	4	3	12	CQC Action Plan (no.10) - Ensure that governance and risk management systems reflect current risks and services improve responsiveness to actions required within the risk register. Revised Risk Management Framework implementation plan rollout from March 2016 under leadership of Director of Corporate Governance. Special Measures regime requires publication of progress against action plans on NHS Choices and website. CQC will review the action plan to check it covers specific areas of improvement (A Guide to Special Measures)	Risk management processes are variable and inconsistent across the Trust; staff are not sufficiently trained in risk management; improvement plan will take 3-4 months to yield tangible results; Board has not defined risk appetite for the organisation No Board or sub committee oversight of NHS Choices submission	Executive Directors are aware of their individual areas of responsibility and update plans accordingly.	Audit Committee oversight of revised Risk Management Framework implementation Annual Governance Statement Monitor's Quality Governance Assurance Framework has been completed and presented to Board. This identified gaps and areas for improvement. Quarterly Monitor submission presented to Board for approval Chair and Chief Executive sign off NHS Choices submission	Monitor's "Risk Assessment Framework" guidance for trusts in complying with their continuity of service and governance licence conditions and FTs re expected to carry out an external review of governance every three years. External review due 2016/17. External Audit														
						CQC Action Plan (no.15) - Assure itself that staff understand the new Duty of Candour Regulations Being Open and Duty of Candour Policy in place with process documentation supporting; Staff training rolled out and ongoing.		SI Process has checklist for DoC Monitoring of the process at the weekly Harm Free meeting	SI Monitoring Group minutes	Reporting monthly to CQC in relation to DoC plus other compliance areas														
We will work in partnership with the wider health economy to ensure a sustainable future for our hospital	Other providers interests' may not be aligned and there may be resistance to change from within the organisation or the local authority	6 (2 x 3)	3	3	9	Engaging with partners and stakeholders around the new strategic intent Board to Board meetings with commissioners																		
Engage patients in the community in the planning, design, delivery and monitoring of services	The Trust is not aligned to the needs of the population that it serves because patient engagement is variable, non existent or not embedded across the organisation	6 (2 x 3)	2	4	8	CQC Action Plan (no. 62) Engage patients in the planning, design, delivery and monitoring of services Council of Governors is responsible for representing the interests of NHS FT members and the public in the governance of the NHS FT. Governors are responsible for regularly feeding back information about the trust, its vision and its performance to members and the public and the stakeholder organisations that either elected or appointed them (NHS FT Code of Governance)	No evidence of co-ordinated engagement strategy and workplan (work planned for May/June); no Board oversight of engagement activity; No equality and diversity lead or evidence of workplan Unclear what the mechanisms for Governor reporting are and how these feed into wider governance. There is limited reporting at Board/Committee level that demonstrates how they are fulfilling their duties	Company Secretary has responsibility for governor member arrangements Governors have a patient engagement group and a member engagement group. Patient engagement group is new and will start to reach out into the community to meet interested groups (from April 16)	Chair is responsible for the Council of Governors and reporting to the Board	Healthwatch reports CQC Inspection Reports														

Title of meeting:	PERFORMANCE MEETING	**Date:** 28th April 2016
Title of report:	Monitor M12 Submission 15/16	**Agenda item:**
Reporting Officer:	Steve Smith – Interim Financial Controller	
Lead Director:	Darren Cattell – Interim Director of Finance	
FOI status:	*This paper is disclosable under the FOI Act*	

Report Summary:

To inform the Board of the Monitor M12 Submission 15/16

The finances included in the month 12 submission are as per the monthly finance report presented to the Board so are not included separately here.

The proposed governance statements to report to Monitor are:

- **"Not confirmed"** for maintaining a financial sustainability risk rating of at least 3 over the next 12 months.
- **"Not confirmed"** for the capital expenditure not materially differing from the amended forecast in this financial year (there is no forecast in the month 12 submission)
- **"Not Confirmed"** for ongoing compliance with all existing targets in particular the A&E 4 hour waiting time targets and 18 weeks RTT.
- **"Confirmed"** that there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework, which have not already been reported.

The **change** in this quarters return is the "not confirmed" statement on Capital expenditure. This has moved from a "confirmed" statement in the previous quarters. The reason is a combination of planned delays in schemes eg the ED redevelopment, a planned re-phasing of certain schemes eg IT Order Comms and a number of schemes taking longer to prepare than planned eg Bed Tracker. This situation is not expected to reoccur.

Purpose: This paper is for:

Assurance		Approval	x	Decision		Information	

Recommendation:

The Board approve the Monitor Month 12 Submission 15/16

Strategic Objective Links:
Highlight which strategic object(s) this recommendation aims to support   We will manage our resources prudently, efficiently and effectively..

Identified Risks and Risk Management Action:
List the major risks identified and cross-reference to risk register, if appropriate. Include the risk of not adopting the recommendation. If not approved we will not comply with a statutory requirement

Resource Implications:
Outline the resources required to implement this recommendation. None further

Recovery Plan implications:
Does the subject matter support the Recovery Plan

Yes:	No: x

If yes, highlight which aspect of the Recovery Plan this recommendation aims to support.

- Continuing to modernise our Emergency Department and pathway, reducing the time it takes for patients to be seen and assessed.

- Improving patient safety and care by minimising the number of different doctors that patients see during their stay in hospital.

- Accelerating our recruitment drive to employ the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interim and agency staff.

- 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.

- Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.

- Working closely with our healthcare partners to ensure patients receive the right care in the community when they are ready to leave hospital. This will free up beds for people coming into the hospital.

Recovery Plan Workstream [Highlight which workstream(s) the subject matter supports]		
Corporate Governance	Deteriorating patient	Referral management
Workforce	Nursing	Emergency pathway
Clinical leadership	Clinical goverance	Medical model
Data quality	Finance	

Quality Impact Assessment:

Does the subject matter require a QIA?

Yes:	No: x

Report History:

Refer to previous reports presented on the same issue/item. If this paper has been considered by other committees the dates and name of the committee that considered it should be detailed. Performance Committee. Previous Monitor Submissions have been approved quarterly

Next Steps and Further Reporting to the Board (if applicable):

State whether this report needs to be referred to another meeting or requires additional monitoring. If the matter requires further Board monitoring state the timeline for further reporting.

None

Appendices:

Supporting information to the report should be listed here.

None although detail is available should the Board require it

For further information or for any enquiries relating to this report please contact:
Name, title and e-mail address: darrencattell@nhs.net

Title of meeting:	Board	Date: 28 / 4 / 2016
Title of report:	Communications Report	Agenda item:
Reporting Officer:	Paul Lehmann, Director of Communications	
Lead Director:	Paul Lehmann	
FOI status:	*This paper is disclosable under the FOI Act; <u>or</u>*	

Report Summary:

This paper outlines our communications activity over the last month, which have continued to focus on the Trust Recovery Plan.

Purpose: This paper is for:

Assurance		Approval		Decision		Information	X

Recommendation:

For information only.

Strategic Objective Links:

Highlight which strategic object(s) this recommendation aims to support.

Our activity supports the delivery of all of these:
1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment.
2. We will attract, retain and develop a first class workforce.
3. We will manage our resources prudently, efficiently and effectively.
4. In partnership, we will provide integrated care for the community.
5. We will provide high quality information and technology to support the delivery of

care.

| **Identified Risks and Risk Management Action:** |
| N/A |

| **Resource Implications:** |
| N/A |

Recovery Plan implications:

Does the subject matter support the Recovery Plan?

| Yes: x | No: |

Our activity supports the following public commitments and workstreams.

Public commitments

- Continuing to modernise our Emergency Department and pathway, reducing the time it takes for patients to be seen and assessed.

- Improving patient safety and care by minimising the number of different doctors that patients see during their stay in hospital.

- Accelerating our recruitment drive to employ the right people with the right skills. This will ensure consistent high quality care by reducing our dependency on interim and agency staff.

- 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.

- Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.

- Working closely with our healthcare partners to ensure patients receive the right care in the community, when they are ready to leave hospital. This will free up beds for people coming into the hospital

Recovery Plan Workstream		
Corporate Governance	Deteriorating patient	Referral management
Workforce	Nursing	Emergency pathway
Clinical leadership	Clinical governance	Medical model
Data quality	Finance	

Quality Impact Assessment:

Does the subject matter require a QIA?

Yes:	No:x

It does not require one because this is a report of communications activity for the period just gone – it does not relate directly to patient care

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Report History:

N/A – a communications report is presented to the Board each month.

Next Steps and Further Reporting to the Board (if applicable):

No further monitoring required

Appendices:

N/A

For further information or for any enquiries relating to this report please contact:

Paul Lehmann, Communications Director, paul.lehmann@medway.nhs.uk

Introduction

Our communications activity continues to focus on engaging staff in the recovery plan and demonstrating improvements to staff, stakeholders and the public.

Internal communications

The main focus in the past couple of weeks has been around the recent CQC fieldwork. We issued various pieces of communications to remind colleagues about the five domains, to reassure them that the purpose of the CQC's visit was to help us improve and to remind them on how to welcome the CQC in the event of an unannounced inspection. Following the fieldwork visit, we have been providing information about next steps, although we have not as yet been in a position to share feedback from the visit with staff.

The priority for the second half of April is launching the new vision and values; an all staff meeting is planned to introduce these, preceded a couple of days earlier by a senior managers' meeting. There will be a series of cascades following this, in which senior managers talk to their teams about the vision and values, what they mean for the team and the principles and behaviours associated with the values.

We will also shortly be producing a short digest of good news stories from colleagues around the Trust, which set out how staff in all areas are doing all they can to implement change.

Engagement with stakeholders and the public

This month has seen a stepping up of engagement with the public. The governors' held their first coffee morning for members of the public on 16 April. This was a great success with around 20-25 people attending, some with compliments, some with concerns and some with general feedback about the hospital. We sought to publicise the event in advance with local stakeholders, the Medway Messenger and social media in advance. The Chairman also put out her monthly letter to Foundation Trust members, focusing on the launch of the new medical model and Home First.

We remain in regular contact with local politicians to update them on progress and sent out a note to tell them about the Home First initiative.

The media

The main story in the media in the last month has been the case of Jessie Wilson, an elderly lady who waited in ED for 13 hours. The story was covered on the front page of the Metro and in some of the nationals. Our statement, in which we apologised and referred to the way in which the ED refurbishment will increase capacity, was widely covered.

On the proactive side, we have promoted the arrival of our new CT scanner. This was covered on the ITV Meridian website and in the Medway Messenger. The Medway Messenger continues to run its annual Hospital Hero feature, in which members of the public

can nominate wards or teams who have provided great treatment, with an overall winner being chosen later in the spring. We are working with the Messenger to publicise those teams nominated.

In the next few days, we are planning to promote the improvements for patients undergoing emergency surgery in the abdomen, and also the Home First initiative.

Social media

On social media, over the past 30 days we have engaged with 29,300 people on Twitter and 43,692 people on Facebook. We have gained 35 new followers on Twitter and 129 on our Facebook account, taking our total number of followers to 1,926 and 3,209 respectively. Key topics promoted on social over the last month were our Home First initiative and the promotion of smoking support available in the community and hospital. We continue to build relations with local and national health organisations, with our posts retweeted/shared by the Nursing and Midwifery Council, Healthwatch Medway, Medway Community Healthcare, NHS Medway CCG and A Better Medway.

The period ahead

The next major development will be publication of the findings from the CQC's fieldwork. We are working closely with the CQC and NHS Improvement to plan for this.

Title of meeting:	Quality Assurance Committee	**Date:** 28 April 16
Title of report:	**Chair's Report to the Trust Board:** **Qulaity Assurance Committee, held in Apr 2016**	**Agenda item:** 20
Reporting Officer:	E B CARMICHAEL	
Lead Director:	E B CARMICHAEL	
FOI status:	This paper is disclosable under the FOI Act;	

Report Summary:

The Committee heard reports from the Directorates and, while reporting is improving overall, there is still a tendency among the report drafters to be over-optimistic in anticipating progress. This is a feature we have previously reported on. In future the Committee will require the Quality Improvement Committee to provide an overview to add value.

The Committee then heard full reports on Medicines Management (specifically on 'Antimicrobial Stewardship') and on Mortality & Morbidity ('How can we be assured that mortality and morbidity are being monitored, reviewed and acted on?').

Antimicrobial Stewardship – Good processes are in place, with compliance improving, but not yet 100%.

Mortality & Morbidity (M&M) – Improved processes are in place, involving GPs also, but not all deaths are reviewed yet, and we must improve in recording cause of death.

The QAC workplan was reviewed and adjusted. Topics were agreed for the next two months. This may change, depending on CQC findings.

Purpose: This paper is for (please tick)

Assurance		Approval	X	Decision		Information	

Recommendations:

● The QIG should correct factual errors in Directorate reports and then provide an overview for the QAC.

● QAC members should see circulated the final Quality Account before it goes to Board.

● That the Trust's antibiotic stewardship measures should be followed rigorously.

- That the Trust's M&M processes should be followed, but that increased effort must be put into the correct recording of the cause of death.

Strategic Objective Links:

<mark>Highlight which strategic object(s) this recommendation aims to support.</mark>

1. We will deliver safe, effective care with an excellent patient experience in the most appropriate environment.
2. We will manage our resources prudently, efficiently and effectively.
3. In partnership, we will provide integrated care for the community.
4. We will provide high quality information and technology to support the delivery of care.

Identified Risks and Risk Management Action:

1. Reputational risk, if reporting of success is premature.
2. Risk to safety, if antimicrobial stewardship processes are not followed rogourously.
3. Risk to safety, if not all deaths are reviewed and/or correctly recorded.

Resource Implications:

<mark>Outline the resources required to implement this recommendation.</mark>

Use of current resources.

Recovery Plan implications:

<mark>Does the subject matter support the Recovery Plan</mark>

Yes: X	No:

If yes, <mark>highlight which aspect of the Recovery Plan this recommendation aims to support.</mark>

- 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.

Recovery Plan Workstream [<mark>Highlight which workstream(s) the subject matter supports</mark>]

Corporate Governance	Deteriorating patient X	Referral management
Workforce	Nursing	Emergency pathway
Clinical leadership X	Clinical goverance X	Medical model
Data quality	Finance	

Quality Impact Assessment:

<mark>Does the subject matter require a QIA?</mark>

Yes:	No: X

I consider that the Trust's processes in this regard are basically sound and that complimance, whilst not yet perfect, is improving

Report History:

The topic of over-optimistic reporting by report-drafters was previously raised in Jan 16.

Next Steps and Further Reporting to the Board (if applicable):

The topics will be kept under review by the QAC, and revisited periodically, depending on relative priorities.

Appendices:

Supporting information to the report should be listed here.

NONE

For further information or for any enquiries relating to this report please contact:
E B CARMICHAEL ewancarmichael@nhs.net