Medway **NHS**
NHS Foundation Trust

PUBLIC MEETING OF THE TRUST BOARD
THURSDAY 26 MAY 2016, 13.30 – 16.00
TRAFALGAR CONFERENCE SUITE, LEVEL 3 GREEN ZONE, MEDWAY MARITIME HOSPITAL

Time	Item	Subject	Presenter	Format	Action
		Quality Insight : International Forum	Dr Ashike Choudhury	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	Paper	Noting
**MEETING ADMINISTRATION**				
	4.	Minutes of the previous meeting held on 28 April 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.	Trust Recovery Plan	Chief Executive	Paper	To note
	9.	Quality & Performance Reports : a) Chief Quality Officer b) Clinical Operations Report c) Medical Director d) Director of Nursing e) Director of Workforce f) IQPR Report	Chief Quality Officer Ben Stevens Medical Director Director of Nursing Director of Workforce	Paper	To discuss
	10	Finance Report	Finance Director	Paper	To note
	11	Strategy	Director of Strategy & Partnerships	Paper	For information
	12	Emergency Preparedness, Resilience and Response Group Annual Report	Director Corporate Governance, Risk, Compliance & Legal	Paper	For Assurance
	13	Research and Development Annual Board Reports	Medical Director	Paper	To note
**FURTHER INFORMATION ITEMS**				
	14	Communications Report	Communications Director	Paper	To note
	15	Performance Committee Report	Chairman	Verbal	To note
	16	Audit Committee Report	Audit Chairman	Verbal	To note
	17	Charitable Funds Committee	Charity Funds Chairman	Verbal	To note
	18	Quality Assurance Committee Report	Jan Stephens	Paper	To note
**AOB**				
	19	AOB	Chairman	Verbal	Noting
	20	Questions from members of the public relating to the Agenda	Chairman		
**CLOSE OF MEETING**				
		Date of next meeting: Thursday 30 June 2016, Trafalgar Conference Suite, Level 3 Green Zone, Medway Maritime Hospital			

Medway NHS Foundation Trust

MEDWAY NHS FOUNDATION TRUST

REGISTER OF INTERESTS FOR BOARD MEMBERS

1.	Patricia Bain Director of Health Informatics	• Director of Qualitas Independent Consultancy Ltd • Specialist Advisor CQC • Associate Consultant Capsticks Legal • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
2.	Rebecca Bradd Director of Workforce	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
3.	Ewan Carmichael Non-Executive Director	• Timepathfinders Ltd • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
4.	Darren Cattell Interim Director of Finance	• Director and shareholder of Mill Street Consultancy Limited • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
5.	Stephen Clark Non-Executive Director	• Pro-Chancellor and chair of Governors Canterbury Christ Church University • Deputy Chairman Marshalls Charity • Chairman 3H Fund Charity • Non-Executive Director Nutmeg Savings and Investments • Member Strategy Board Henley Business School • Business mentor Leadership Exchange Scheme with Metropolitan Police • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
6.	Lesley Dwyer Chief Executive	• Member of the Corporate Trustees of Medway NHS Foundation Trust Charitable Funds
7.	Diana Hamilton-Fairley Medical Director	• Director of Education Transformation at Guy's and St. Thomas' Hospitals NHS FT • Member of London Clinical Senate Council • Elected Fellows Representative for London South for RCOG • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
8.	Martin Jamieson Non-Executive Director	• Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Director, Lightpoint Medical Ltd • Senior Adviser, ArchiMed Private Equity • Non-Executive Director – C-Major Ltd • Strategic Planning Consultant, Rocket Medical Pl • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
9.	Anthony Moore Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
10.	Joanne Palmer Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
11.	Karen Rule Chief Nurse Designate	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
12.	Jan Stephens	• Trustee of Medway Youth Trust

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

PUBLIC MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON THURSDAY, 28 APRIL 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
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: Mrs. D King, Governor Representative
Mrs. M Dalziel, Director of Clinical Operations, Acute & Continuing Care Directorate
Mr. P Lehmann, Director of Communications
Mr. J Lowell, Director of Clinical Operations, Women's & Children's Directorate
Ms. A Gibson, Lead Matron for Discharge
Mr. D Rice, Trust Secretary
Mr. B Stevens, Director of Clinical Operations, Coordinated Surgical Directorate

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

QUALITY INSIGHT –   HOME FIRST PROGRAMME

Amanda Gibson gave a presentation on the Home First Programme. The aim of Home First is to speed up hospital discharge times and improve patient outcomes. It supports patients who may need assistance through care packages at home by arranging an independence programme.   The programme included an assessment of needs, setting of goals and the provision of support at home to promote independence and reduce the need for ongoing long term care in the future. The Trust and the Social Care Partner's pledge was to:

- Minimise a patient's acute hospital length of stay;
- Maximise independence through enablement;
- Support care at home or closer to home; and
- To make no decision about long term care in an acute setting.

The advantages of the scheme were as follows:

- Patients would be assessed in their own familiar environment which leads to more accurate assessments;
- Avoidance of processes and delays in the discharge process;
- A reduction in the length of a hospital stay;
- A reduction in the risks associated with vulnerable patients remaining in the hospital environment;
- Improved discharge rates on the wards;
- Freeing up of hospital beds reducing medical outliers; and

- Improved patient flow through the hospital.

There were distinct pathways depending upon the different circumstances of the patient :

- Pathway Zero – these patients were deemed to not require further support and were discharged and any care packages could be resumed accordingly;
- Pathway One – where patients were medically fit but needed further support which would be assessed by an occupational therapist within two hours of the patient returning home;
- Pathway Two - the patient is medically fit but requires further assessment or rehabilitation and it would be unsafe for them to be left between visits;
- Pathway Three – where the patient is unable to live independently at home and requires long term social support or placement or the patient is in the terminal phase of an illness.

Ms Gibson noted that the intention was to remove 35 patients from the system but to date the current total was 111 and so it had been considered a highly successful scheme. The Chairman queried if there had been any patient feedback on the initiative and Ms Gibson noted that there had not but there had been positive reports in the media which followed patients who had been discharged under the scheme. The scheme had been received approval from care homes and the details were presented to the Health & Wellbeing Board.

The Chairman thanked Ms Gibson for her presentation and congratulated her on the development of the scheme.

16/04-01   WELCOME AND APOLOGIES FOR ABSENCE

1.1   The Chairman welcomed everyone to the meeting and in particular Margaret Dalziel, James Lowell and Ben Stevens, the clinical directors of operation who were in attendance. Apologies had been received from Martin Jamieson.

16/04-02   QUORUM

2.1   The Chairman confirmed that a quorum was present.

16/04-03   REGISTER OF INTERESTS

3.1   The Chairman noted that the register of interests had not changed since that included in the previous board pack and if there were any changes required to be made they should be passed to the Trust Secretary.

16/04-04   MINUTES OF THE PREVIOUS MEETING

4.1   The minutes of the meeting held on 31 March February 2016 were APPROVED as a true and accurate account of the meeting, subject to some minor amendments.

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

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

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

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

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

Action number PUB 0349 - Report on the significance of Research & Development income to the Trust to be presented to the May Board Meeting.

Action number PUB 0351 – Review of complaints is now included on a monthly basis in the Nursing Report.

Action number PUB 0352 – Review of information of services available at the Trust provided to patients on arrival was under review by the Director of Nursing.

Action number PUB 0353 – Patients prepared for surgery and operations cancelled at the last minute was a multifactorial problem across the NHS and any specific cases could be investigated by the Trust.

Action number PUB 0354 – Following a review the mixed sex bay in Nelson Ward was confirmed as a breach. This was due to pressure on the cardiology department but was not expected to be repeated.

16/04-06   CHAIRMAN'S REPORT

6.1   The Chairman explained that following their inspection in April, the CQC had been encouraged to find that the Trust had demonstrated that it made significant improvements. There had been support from the Trust's stakeholders and local politicians and the staff deserved congratulations for their continued effort and assistance during the recent CQC visit. The improvements had been demonstrated with the publication of the SMR data for the year to the end of January 2016 which shows an improvement and now stood at 102.76.

6.2   The Chairman noted that at the Performance meeting held earlier that day, there had been discussions of the Trust's Annual plan to ensure that it is a sustainable organisation for the future. The Kent & Medway Sustainability & Transformation Plan (STP) had also been discussed and the Trust was required to submit a final version by 25 June 2016 and would be brought back for the May Board meeting

6.3   At the private board meeting it had been agreed to resume the reporting of RTT (Referral to Treatment) performance.

6.4   The Chairman noted that at the private board meeting there had been an update on the redevelopment of ED and that the Board had approved the appointment of the preferred bidder for the planning of majors and resus phase which had been paused whilst the redesign process had begun. The redevelopment would require a reconfiguration of the road layout and work on this would commence later in May.

6.5   There had also been a case responded to under Regulation 28, details of which could not be disclosed at the public meeting due to confidentiality.

6.6   The Chairman reported that the Governors had hosted two coffee mornings one on 16 and one on 23 April at Medway and the Sittingbourne Memorial Hospital respectively to engage with the community. The events had been very successful with over thirty members of the public attending the event at Medway and ten at Sittingbourne. Members of the Trust and the general public had attended and had expressed their support for the Trust citing examples of good care that had been received and suggesting where improvements could be made. The Chairman thanked the Governors for successfully engaging with the community and looked forward to further events in the future.

16/04-07   CHIEF EXECUTIVE'S REPORT

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

- During the month of March 2016, there was an increase of 15% from the previous March period in Emergency Department attendances with over 300 patients presenting each day including weekends. Ambulance attendances had increased by 8.5% compared to last year with more than 100 ambulances arriving per day. In maternity the Trust was now responsible for more than 5000 deliveries per annum.

- There was a gradual easing of the reliance on agency as recruitment of substantive staff was increasing. An update was provided on the Remedial Action Plan (RAP):

- a new 160 slice CT scanner had become fully operational on 30 March and a second scanner should be in place by the end of 2016 and a mobile MRI will be on site from 29 April reducing waiting times, particularly for those on a 2 Week Wait pathways;

- The Trust had launched its Vision and Values following a wide consultation with staff. Feedback had been very positive with and the values would be become embedded with a series of future initiatives.

- On 6 and 7 April some of the Junior Doctors from the Trust had taken part in the industrial action as a result of the on-going dispute between the BMA and NHS. The Trust's priority was to maintain a safe environment for care during the action. With the introduction of the new contracts coming into effect from 1 August 2016, the Trust was maintaining an open dialogue with the Junior Doctors.

- The Non-Smoking Committee continued to make plans for the site to become smoke-free by October 2016 and the first key milestone would be the removal of the smoking shelter near the main building which coincided with the ED refurbishment which required the widening of the road.

- Following the recent CQC visit on 29/30 March, the Trust had received a letter noting that there had been substantial improvements under the new leadership with greater staff engagement, and increased patient safety.

- The Trust would be holding the first Quality Oversight Committee (the "Committee) on 29 April at which the CCG and NHS Improvement would attend. The monthly meetings would ensure that the Trust was maintaining its level of improvement. The CQC would carry out a further inspection in November 2016. The Board would be kept informed of any outcomes from the Committee in due course.

16/04-08   TRUST RECOVERY

8.1   The Board noted the Recovery Plan Update and associated papers. The Chief Executive noted that the Trust had been requested to report its progress with the 20 KPI's on a weekly basis for twelve weeks and that there were two weeks remaining for this level of reporting. After these twelve weeks the recovery plan would enter a phase of consolidation by building capability for sustained improvement and a revised Recovery Plan would be prepared which would be presented to the May Board meeting.

8.2   The Chief Executive highlighted that the four hours access target statistics showed continued improvement and the Trust now had the second best performing ED in Kent. There was a discussion regarding the performance target which had been agreed with the CQC to be at 90% for the Trust, which was below the 95% national level. The reduced target was due to the 10% increase in attendances to the Trust over the last year; the average being around 300 attendances a day although on some days these reached 400.

16/01-09   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 36 Serious Incidents (SI's) currently open as at 7 April 2016. The average SI breach days by month had improved from 253 as at April 2015 to 42 at March 2016 and it was expected that this would fall to 10 in the subsequent six months.

9.3   There had been an improvement in the reporting of Datix incidents with a member of staff having been moved into the Patient Safety Team to lead on incident management and closure. At the beginning of the year in January 2016 there were a total of 2,042 incidents outstanding and this had been reduced to 387 by the end of February. It was stressed that agency staff were trained to be able to report incidents.

9.4   The Medical Director reported that the new medical model was now in its sixth week and was becoming "business as usual". This had led to the closure of 46 beds and a reduction in the number of outlying patients by over a third. There was a fall in the number of admissions to wards from 215 patients per week to 165. There had also been an increase in the percentage of patients discharged within 2 hours from 40%, before the model had been introduced, to 60% since implementation.

9.5   On Research and Development there were some 147 projects open for the financial year, and a full list of these would be prepared for the May Board meeting.

ACTION : Diana Hamilton-Fairley to prepare a report explaining the significance of research and development to the Trust for the May meeting.

9.6   The Director of Nursing gave her report stating that following the introduction of the Medical Model patient flow across the organisation had improved and the number of doctors a patient sees had reduced improving standard of care. To facilitate this three wards had changed their configuration and an escalation ward (Dickens) had been closed on 13 March.

9.7   The Board noted that in terms of clinical indicators during March there had been six pressure ulcers graded 2; there were no grade 3 or 4 pressure ulcers reported. There was currently a review of pressure ulcer management and an external peer review of policies and practices had been undertaken by a Consultant Nurse from Kings College Hospital London.

9.8   Safe guarding was an area which was in need of strengthening and an plan had been implemented.   Posts in the Adult Safeguarding Team had been appointed to on fixed term and interim contracts and a substantive appointment had been made to the Learning Disability Nurse post.

9.9   The Trust had 20 reportable Clostridium Difficile infections in 2015/16 which met the target of no more than 20 for the year. Whilst there were a number of areas where compliance was below the 95% target, plans have been put in place, including weekly audits completed by the IPC team, in order to comply with the trajectories agreed with NHS Improvement.

9.10   There was a significant reduction in Mixed Sex Accommodation breaches from 132 in February to 13 in March. This had been due to the introduction of the Medical Model which resulted in Lister Ward being closed at night therefore eliminating mixed sex accommodation overnight. There was a target for zero MSA breaches by July 2016,

however, this has been discussed with the CQC as being unrealistic as there were likely to be breaches for clinical reasons. The MSA improvement plan will be reviewed and a new target and trajectory will be agreed,

9.11   The Director of Nursing reported that the Medway & Swale CCG was leading the development of an End of Life Strategy and that she would be representing the Trust.

9.12   There was a discussion regarding the 22% vacancy rate in the Co-ordinated Surgical Care directorate and whether this included those nurses on maternity leave. It was noted that there would be more visibility on this area when the Nursing and Midwifery scorecard was produced.

9.13   The Director of Workforce reported that the Trust's new Vision and Values had been launched with a phased programme of communications to demonstrate the Trust's commitment to cultural change.

9.14   On recruitment the Trust had commissioned 100 European nurses for 2016, however, the Trust was behind the trajectory and has been working closely with the recruitment agency to improve the marketing of the hospital. Recruitment methods now include skype interviews and there were other recruitment events planned for later in the year. However, it was recognised that it would be unlikely that the target of 100 would be achieved in the year and that 50 was a more realistic figure.

9.15   Between 1 October 2015 and 31 March 2016, the average time to recruit was 56.8 days, which was measured from the point of authorisation of the vacancy to the booked start date. The Trust was benchmarking this recruitment period as there was scope for it to be improved. A target will be set in line with the results of the benchmarking and a plan put in place for improvement.

9.16   There was a discussion regarding the turnover of staff under one year's service which stood at 17% and whether there could be more information to understand the figure. The HR department was following up on this area with a more rigorous exit interview procedure.

9.17   The Trust had been developing an apprenticeship programme. This could encourage those who were not taken on for the degree course in nursing and this should be followed up with local schools, colleges and universities. It was confirmed that there were three partner governors from local universities who were working on having closer links with the Trust. Generally there was positive feedback from those apprentices on placement and they wanted to return to both midwifery and nursing.

16/04-10   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 earlier that day. In summary the Trust had reported a deficit of £52.5m for the 12 months ended 31 March 2016. The cash balance was higher than expected as the capital expenditure had been lower than planned and payments had been received in March from the CCG. The addition cash had been used to repay some of the NHS loan.

10.2   There was a discussion regarding how the Trust's CQUIN targets and how they related to quality improvements in the organisation and how some targets were negotiable and others were not. It was noted that for the forthcoming negotiations the Trust would be in a stronger position with all the necessary information being made available at the required time.

10.3   The Finance Director referred the Board to the 2015/2016 Income & Expenditure Performance and in particular the bridge from the Original Plan (£22.5m) to the

Reforecast (£52.5m). The bridge highlighted the deteriorating financial performance of the Trust which was mainly due to the following factors:

- ED resource to support 95% 4 hour target and ambulance handover time;
- A failure to increase net substantive nurses in post despite strong recruitment;
- Non-delivery of the CIP due to operational pressures on capacity
- Opening of two step down wards, largely staffed by agency to improve Patient flow
- Due to non-elective demand there was a shift away from "profitable" elective work
- Contract performance penalties (cancer waiting times, ED 4 hour, Ambulance handovers, MRSA, CDiff, MSA and RTT.

10.4 It was noted that a robust plan would be built for the future which would take account of efficiency savings and this would be monitored by the new operational teams.

10.5 There was a query regarding the increase in non-elective patients compared to last year and the Finance Director agreed to check the numbers provided.

ACTION: To check the increase in non-elective patient compared to last year.

16/04-11   CLINICAL GOVERNANCE FRAMEWORK

11.1 The Chief Quality Officer reported that a 3 month review, following the initial implementation of the clinical governance committee structure, had been conducted. There was an ongoing review which was being carried out by the Director of Corporate Governance, Compliance, Risk & Legal. The Board approved the current structure.

16/04-12   VISION & VALUES

12.1 The Board noted the new Trust Vision & Values which had been launched successfully earlier that week. The next stage was for them to become embedded into the Trusts working practices.

16/04-13   BOARD ASSURANCE FRAMEWORK

13.1 Board noted the papers regarding the review of the Corporate Risk Register and Board Assurance Framework prepared by Lynne Stuart. The intention was that there would be a new corporate risk register and the implementation plan which had been presented to the Audit Committee was noted by the Board. There would also be Board discussions to ascertain the Trust's appetite for risk.

16/04-14   RETURN TO REPORTING

14.1 Further to a discussion at the private board meeting the Chairman explained that following a period of not reporting RTT performance it was intended to return to reporting in the month of June which would relate to the data for May.

16/04-15   Q4 MONITOR SUBMISSION 2015/16

15.1 The Finance Director reported that the month 12 submission to Monitor was due and required the approval of the Board. The only change to this month's return was that the statement on Capital expenditure is not confirmed (it was confirmed in the previous quarters.) The reason for the non-confirmation was a combination of planned delays in schemes such as the ED redevelopment, a re-phasing of certain schemes eg IT Order Comms and other schemes which had taken longer to prepare than planned.

15.2 The Board APPROVED the Monitor Month 12 Submission 2015/16.

16/04-16   COMMUNICATIONS REPORT

16.1   The Board noted the Communications Report which explained that the main focus in the last few weeks had been in relation to the recent CQC visit. The Chief Executive had been giving radio and television interviews to provide information on the improvements at the Trust which had been recognised by the CQC. There had also been coverage on ED and the new CT scanner.

16.2 The Communications team had also been involved in launching the new vision and values. Following a successful launch to the staff, there would be a series of cascades where senior managers talked to their teams about how the vision and values should become established behaviours across the Trust. The Chairman thanked the Communications team for their contribution to rolling out the vision and values.

16/04-17   PERFORMANCE COMMITTEE REPORT

17.1   The Chairman noted that there had been a meeting of the Performance Committee held earlier in the day when an analysis of the Trust's finances, the Recovery Project, and Strategy were discussed in detail.

16/04-18 COUNCIL OF GOVERNORS' UPDATE

18.1   Mrs King was pleased that the Trust had been able to demonstrate improvements since the last CQC visit and that the staff were more engaged in helping the Trust in its recovery plan.

18.2   Mrs King highlighted a concern regarding the Trust's communication with young patients who often felt that clinicians talked to their parents rather than directly to them as individuals.

18.3   Mrs King noted that the Governors were discussing how to engage directly with women and specific ethnic groups to understand their health needs and to investigate how the Trust could address these issues.

16/04-19 QUALITY ASSURANCE COMMITTEE

19.1 The Chairman of the Quality Assurance Committee noted that reporting was improving overall however, the authors of the reports needed to avoid being over-optimistic in anticipating the progress that had been made.

19.2 For Mortality & Morbidity and Antimicrobial Stewardship improved processes were in place and with improved levels of compliance. The Trust's M&M processes needed to be followed and it was necessary for increased effort to be made into the correct recording of causes of death.

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16/04-20 QUESTIONS FROM MEMBERS OF THE PUBLIC RELATING TO THE AGENDA

20.1 There was a question regarding whether a Costa Coffee would be opening on the site and it was confirmed that there were currently no plans.

20.2 There was also a query whether the wifi at the Trust would be capable to deal with the increased demand from patients streaming data. It was confirmed that this was an area that under review as a part of a wider project investigating the Trust's digital road map.

16/04-21 DATE OF NEXT MEETING

The next meeting of the Trust Board will be held on Thursday 26 May 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-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-0316	26/10/15	14.5	To present the plans for implementing electronic patient records to a future Trust Board meeting.	Chief Quality Officer/ Director of Health Informatics	21/04/16 Aiming to present to the **August Board meeting**	Open (red)
PUB-0338	26/11/15	8.5.9	To provide an update at the December Board meeting of the internal audit reviews of the Trust's financial controls and financial planning.	Director of Finance	23/04/16 – Awaiting report from Audit Committee	Open (red)
PUB-0346	25/02/16	11.2	The Digital Road Map would be brought to the August Board Meeting	Company Secretary	22/04/16 - To be presented at the **August Trust Board meeting**	Open (red)
PUB-0349	31/03/16	9.10	Update explaining the significance of research and development income to the Trust	Medical Director	22/04/16 – See item 13 on May agenda	Open (red)
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	20/05/16 Multifactoral problem across the NHS. Individual cases can be investigated if details provided	Closed (green)
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	20/05/16 Following investigation breach due to pressure on cardiology dept. It was not expected to be repeated	Closed (green)
PUB-055	28/04/16	9.5	Diana Hamilton-Fairley to prepare a report explaining the significance of research and development to the Trust for the May meeting	Medical Director	20/05/16 See Item 13 on May Board agenda	Open (red)
PUB-056	28/04/16	10.5	To check the increase in non-elective patient compared to last year	Finance Director	20/05/16 Finance Director to provide verbal update at May meeting	Open (red)

Report to the Board of Directors

Board Date: 26 May 2016

Title of Report	Chief Executive's Report
Reporting Officer	Lesley Dwyer
Lead Director	Lesley Dwyer
Responsible Sub-Committee	
Executive Summary	The Chief Executive's report provides the Board with an update on key issues since the last meeting of the Board that are not covered elsewhere on the agenda. This month, the Directors of Clinical Operations are presenting a separate report, Clinical Operations Report, and this report is listed as item 9 on the Public Trust Board agenda.
Risk and Assurance	Detailed within the report.
Legal Implications/Regulatory Requirements	
Recovery Plan Implication	The contents of this report supports the recovery plan.
Quality Impact Assessment	Not Required.
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	The Board are asked to note the information within the Chief Executive and Executive portfolio reports and direct any questions to the responsible executive to provide further information.
Recommendation	The Board are asked to note the information contained within the Chief Executive's report

Chief Executive's Report: May 2016

Background

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

1. PERFORMANCE

(a) The clinical operations performance is detailed at Item 9 on the Public Trust Board agenda and will be presented by the Directors of Clinical Operations.

(b) Remedial Action Plans: Update provided by Ben Stevens, Director of Clinical Operations, Coordinated Surgical Directorate.

    (1) Imaging. Waiting times for CT and Ultrasound continue to fall and the use of an onsite mobile MRI scanner is helping to reduce the wait for many MRI examinations. Two week wait patients for Ultrasound can now be seen within a week of the request being received; however this is dependent upon the ability to contact patients by phone. Work is about to begin on reducing the number of DNAs (Did Not Attend) within each service and this in turn should further help to reduce waiting times.

    (2) Cancer. The Cancer RAP actions continue to be completed or progressed with six outstanding actions. Regular meetings are in place with commissioners to agree remedial actions and evidence of completion.

    (3) Endoscopy and Referral to Treatment (RTT).

        (i) The Trust is maintaining endoscopy capacity for patients on urgent or 2WW (2 week wait) pathways. The service continues to identify and secure additional endoscopy capacity to further reduce waiting times for patients on routine pathways. It is expected that an agreement for an in source model will be agreed by 27 May 2016.

        (ii) The size of the waiting list continues to fall including a reduction in the size of the backlog. This is as a result of validation and a focus on delivering the required activity levels.

2. CARE QUALITY COMMISSION (CQC)

(a) Single Quality Oversight Committee.

Following the recent CQC process and visit the Trust requested that a Single Quality Oversight Committee be established to provide a collaborative approach between the Trust and regulators to support the next phase of the recovery plan. The group will

meet each month, thereby consolidating other regulatory meetings and forums. The group is chaired by the Regional Director of NHS Improvement.

(b)   <u>CQC Assessment of Children Looked After and Safeguarding</u>

Update provided by Karen McIntyre, Deputy Director of Nursing, Women's & Children's Directorate:

A joint assessment of Children Looked After and Safeguarding held from 22 – 26 February 2016 by the CQC and led by Medway Clinical Commissioning Group (CCG), highlighted the following:

- Areas of good practice commended for the Trust, particularly for Looked After Team processes and maternity Multi-Disciplinary Team (MDT).
- Recommendations for all providers: the Trust, Medway CCG. Kent and Medway NHS and Social Care Partnership Trust, Kent Community Health, Medway Community Healthcare
- Our recommendations centre on ED processes/systems, ie flagging mechanisms, documentation of processes, review of resources of children's team, training and effective MDT.

All actions to be incorporated into the Trust wide safeguarding action plan

3.   CORPORATE GOVERNANCE

Update provided by Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal.

(a)   <u>Risk Management Improvements</u>

(1)   The Director of Corporate Governance, Risk, Compliance and Legal has chaired the second Risk Governance Group which meets monthly to improve the processes within the organisation to address risk management at directorate and corporate function levels. The purpose of the meeting is to ensure organisation wide engagement in the risk management improvement process.

(2)   The Trust will be rolling out a new risk management system Risk Assure, to replace Datix, which will enable a more compatible model for the organisation. System configuration is underway and roll out is planned to commence late June using the clean data that has been derived through the engagement and support of the Corporate Governance Team.

(3)   Initially a desktop review and review of directorate and corporate function risks was commenced in March 2016 by the interim risk manager to ensure risk registers were fit for purpose and clean data could then be transferred from Datix to the new system Risk Assure. As there are departments that currently keep excel spreadsheets and did not use the Datix management system this makes the organisation vulnerable in terms of not having access to a transparent risk register and awareness of all its risks from all departments and specialties.

(4)   It was found that registers had a significant number of risks and further exploration resulted in the identification of issues as opposed to risks. Challenge of risks that were on the register for a substantial amount of time of more than two years indicated that staff did not understand the rationale for a risk register and demonstrated risk aversion, when the risk was of minimal impact and consequence. This was articulated as a fear of being blamed if the risk was not on the risk register.

(5)   Directorates were encouraged to review their risk registers with the interim risk manager. There has been good uptake across most areas of the Trust, but not all, and there needs to be more engagement and understanding of risk for staff to ensure they accurately reflect the current risks.

(6)   Risk description, grading, evaluation and monitoring of risks including action plans for risks is not evident from the information reviewed.   Risk registers would appear at times to be used as a mechanism for highlighting issues and enabling the securing of funding for equipment nearing the end of its shelf life or securing additional resource, without reviewing the risk and controls that need to be in place. There appears to be a disparity between staff understanding the mechanisms the Trust already has in place for managing operational activities on a daily basis and how the risk register may not be the correct mechanism for highlighting and resolving issues within departments.

(7)   It is evident that there needs to be systematic education and training of all staff in risk identification and management. We are developing this training offering and initially ensuring that the governance leads are trained via their Risk Governance Group involvement.

(b)   Emergency Preparedness, Response and Resilience.

The Director of Corporate Governance, Risk, Compliance and Legal attended NHS England's Local Health Resilience Partnership meeting on 28 April as the Trust's Accountable Emergency Officer representative. The NHS England/CCG led assurance process for MFT is likely to be light touch in 2016/17 as they are confident in MFT's EPRR arrangements (based on 2015/16 results) and wish to focus on providers that have not previously been subject to an assurance process or have poor results from 2015/16.

(c)   CQC Assurance.

The Trust has approved the implementation of CQC Assure, a software based system for collating and tracking compliance with CQC fundamental standards. System configuration work is currently underway.

4.   DEVELOPING THE TRUST STRATEGY

A report on the development of the Trust's Strategy is included on the Public Trust Board agenda (item 11).

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5.   JUNIOR DOCTORS' INDUSTRIAL ACTION

Update provided by Rebecca Bradd, Acting Director of Workforce

(a)   Many of you will have seen the recent news that the Department of Health have agreed to pause the introduction of the new junior doctors' contract to allow for an eight day negotiating period with the BMA. At the time of writing the Trust had been asked to cease activity on the introduction of the contract to honour the commitments that have been made to allow further negotiations to take place.

(b)   An announcement was made on 18 May 2016 that an agreement had been reached by the British Medical Association Junior Doctors Committee, NHS Employers and the Secretary of State for Health, of negotiated terms which, subject to a referendum of relevant BMA members, will form the basis of a new contract in 2016.

(c)   Further updates will be provided as further information becomes available.

6.   HORIZON SCANNING

Update provided by Paul Lehmann, Director of Communications.

The main health issue in the news has been the junior doctors' strike. Away from that, other issues covered have been:

- The problems at Southern Health, the recent CQC report on performance there, and the pressure on the chief executive Katrina Percy
- A report by the Parliamentary and Health Service Ombudsman which found that too many patients are discharged from hospitals inappropriately early, and with too little support for the patients in the community
- The publication of national statistics which suggest that the NHS is struggling to cope with what has been called the busiest year in its history. More people are waiting for elective operations than at any time since 2007
- The Daily Telegraph reported that the NHS has stopped the imposition of fines on providers who receive financial support and breach waiting time targets. However, going forward, trusts who do receive support will be subject to strict performance criteria.

7.   SMOKING

Update provided by Paul Lehmann, Director of Communications.

(a)   We continue to make plans towards making the site smoke-free. We are now looking towards a go live date of October, to coincide with the national stop smoking "Stoptober" drive.

(b)   Our plans include ensuring that nicotine replacement therapy is available to all wards, ensuring that ward-based staff are trained to have early conversations with patients after they arrive to tell them that they cannot smoke in the hospital and do

not encourage patients to go outside for a cigarette, installing large, highly visible signs and increasing security presence. We are also considering what support and guidance managers can give to staff members who smoke and what sanctions should be applied to staff who are caught smoking on Trust property.

(c)   Medway Council's Health and Wellbeing Board recently approved an increase in the council's activity to promote smoking cessation, and council officers are being extremely supportive in working up training packages for staff among other activities.

(d)   One change to the plan from my report last month is around the removal of the smoking shelter nearest the Postgraduate Centre: we had planned to move this in late June, but because of changes in the plans for the ED roadworks, we will now remove both shelters at the time that we go live as a smoke-free site in October.

8.   ORGANISATIONAL STRUCTURE

The process of recruiting to the permanent roles of Director of Communications and Director of Nursing is currently underway and interviews are tentatively scheduled for June 2016.

9.   EXECUTIVE ARRANGEMENTS

During the month of May 2016, the following executives were on annual leave:

Rebecca Bradd, Acting Director of Workforce	12 – 16 May 2016 (incl)
Paul Lehmann, Director of Communications	3 – 6 May 2016 (incl)
Karen Rule, Director of Nursing	9 – 13 May 2016 (incl)

Report to the Board of Directors

Board Date : 26 May 2016

Title of Report	Recovery Programme Status Update
Reporting Officer	Jane Rooney, Programme Director
Lead Director	Lesley Dwyer, Chief Executive
Responsible Sub-Committee	Executive Group
Executive Summary	The attached papers provides both a summary of the current Recovery Programme and an outline of the future direction of ongoing recovery and transformation. The current program progress includes: - An update on the improvements recognised through the Medical Model as it entered its ninth week and information on the project evaluation process - An update on the progress of the Emergency Pathway Programme (EP), the clinical launch of this programme and the implementation of the Home First initiative - An update on the Deteriorating Patient Programme (DP) progress, implementation of the Safety Brief, Hospital at Night Handover and Intentional Hospital Rounding - An update on Referral to Treatment (RTT) personnel changes and the planning work being carried out to identify outsourcing/insourcing opportunities and planning for future management of demand - An update on Workforce providing an update on the Leadership Programme and the Temporary Staffing Service which has now gone live - An update on 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 An update on CQC following the recent inspection, the actions taken and the view going forward.
Risk and Assurance	Key risks to delivery of The Recovery Programme are detailed in Recovery Board Status Update Paper and were agreed as part of the CQC Quality Improvement Plan. Management actions are also detailed in this paper.
Legal Implications/Regulatory Requirements	

Recovery Plan Implication	Yes • 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
Quality Impact Assessment	No
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Assurance Information
Recommendation	Board to note the progress of the current recovery program and discuss the future direction of the ongoing recovery and transformation required.

**Trust Recovery Plan
Status Update to Board**

May 2016

Contents

1. HIGHLIGHTS

The Recovery Plan continues to make progress in line with the timeline previously agreed with the Trust Board. There have been a number of significant milestones in the last month, including:

- The Medical Model has now entered its 9th week and is reducing patients length of time in ED
- The Emergency Pathway Programme is now fully mobilised across all relevant workstreams. Bed modelling project has commenced to review capacity and demand across all directorates
- The Deteriorating Patient Programme is making steady progress and Intentional Hospital Rounding is now fully operational. The Track and Trigger Business case has been approved at the Trust ERC and the Business Case will now go to Trust Board for approval
- The Trust's trajectory for RTT is showing improvement.   A mobile MRI Scanner is now on site to help clear the backlog and improve patient safety and a business case to increase Endoscopy capacity has also been submitted for approval
- Communications have finalised the first issue of 'Our Medway' which will be published on week commencing 23 May. Featuring 17 stories and 185 name-checked members of staff, it will highlight the breadth of change and good practice occurring across the Trust

2. PRIORITY PROGRAMME STATUS

2.1 Medical Model
The Medical Model has been in operation since 14 March as planned, and is currently in Week 9 of operation. The PDSA is now in its 2nd cycle which will result in further development of the model. There have been a number of demonstrable improvements seen since its implementation. Key highlights of the last month are:
- The number of patients arriving by ambulance and being seen within 15 minutes has almost doubled since Week 1
- The number of patients being seen within 4 hours is increasing and the total time that patients are spending in the Emergency Department (ED) is decreasing
- Handoffs between consultants and nursing staff have decreased
- There has been a significant reduction in the number of patients being nursed in the corridor
- Consultants have now agreed to change the General Internal Medicine (GIM) rota to a full week of on-call cover
- Stretch targets are now being implemented for wards to expedite discharge improvements

2.2 Emergency Pathway
The Programme is fully mobilised across all Directorates and all relevant workstreams have cross-organisational involvement from statutory sector partners. The Board structure, governance and reporting processes are embedded and a formal set of impact metrics are now being monitored on a monthly basis. Workstreams are meeting fortnightly to track and monitor delivery and impact. Key Highlights for the past month include:
- The first draft of the Trust Daily Concept of Operations has been circulated to Programme Board members laying out the processes, practice and performance required to efficiently run the daily flow of patient activity across the Trust

- The Bed Modelling process has commenced across the Directorates to review the capacity and demand requirements for the Trust
- Within the Emergency Department (ED) a targeted validation process has commenced to better understand why patients have extended stays in the Department and escalate or cascade actions to improve the length of stay in ED. In addition, new practices relating to Nurse Handover and Decision processes to Admit (DTA) have been implemented to ensure consistency
- The Home First initiative, operational since the 4th April, has seen 85 patients referred via the supported early discharge pathway in the first month. There has also been a corresponding positive impact on the number of medically fit patients in hospital over seven(7) days

2.3 Deteriorating Patient

The Deteriorating Programme continues to make excellent progress. Key highlights of the past month are:
- Intentional Hospital Rounding is now operational and the additional support from the GSTT Senior Nurse Practitioners in the Site team out of hours has resulted in the development of Safety Checks. These have been introduced to provide assurance that patient safety and outcomes, by way of recognition and response to unwell patients, are optimised
- The Sepsis and AKI e-Learning modules have undergone a scrutiny process to ensure that they are appropriate for use at Medway
- The Track and Trigger Business case has been approved at the Trust ERC and the Business Case will now go to Trust Board for approval. This is a significant milestone for the programme
- A trial for the 'Avoidable Harm Project' has commenced. Results will inform the final draft of the protocol
- The Programme Board met and agreed the Communication Strategy in relation to Recognising and Responding to Unwell Patients Policy and Professional Standards. These will formally go to Clinical Council for approval and sign-off
- Collaborative working across Directorates has resulted in Women and Children's developing Professional Standards for Maternity and Paediatrics. These will sit alongside the Professional Standards for Adults and will jointly go to clinical council for approval

2.4 Referral to Treatment

The PMO continues to support the Trusts trajectory for Referral to Treatment Time (RTT). Key highlights of the last month are:
- Support is also being given to the Trusts plan to return to RTT reporting with a project to address data quality issues in the Trusts waiting lists. The project will cover all specialities through increased waiting list validation, intensive RT**T** training and administration process improvements
- The Validation Team has increased to help expedite progress
- The Trust now has increased MRI capacity onsite which is helping to clear the backlog and improve patient safety
- A business case for additional Endoscopy capacity has been presented for approval
- A further 2 business cases for Surgery & Cardiology outsourcing are being developed, based on the recent demand and capacity review

2.5 Workforce

The Temporary Staffing Service went live on 26 March and we are monitoring the fill rates on a continuous basis; the current fill rate is 80%. We have benchmarked our time to recruit and have a target of 40 days. The highlights of the last month are:

- The Clinical Leadership forum has been expanded to include the leadership trios in directorates (Clinical Director, General Manager & Matron) plus the service Heads. This is a group of c40 people
- A full programme of staff developmental events is in place until the end of 2016, supplemented by breakfast and supper meetings to address particular issues, such as bullying & personal leadership skills
- Two cohorts of a new management development programme are currently being recruited through an application process. There are 12 places on each cohort, and the 3 day programme over 8 weeks addresses the skills required to be an effective manager in MFT. It is aimed at a multidisciplinary group at Bands 6 and 7, and their equivalents
- A full programme of bite size workshops to address key leadership skills
- The vision and values were successfully launched and work is continuing to embed the resulting behaviours

3. COMMUNICATIONS

The first issue of 'Our Medway' 24-page staff magazine will be published on week commencing 23 May. Featuring 17 stories and 185 named members of staff, it will highlight the breadth of change and good practice occurring across the Trust; it will also enable staff to feel more part of the organisation they work for and inspire them to share their own stories.

It is planned to distribute the new publication not only to the staff, but also to key external stakeholders including the CCGs, CQC, Monitor, NHSE, Local Healthwatch and local MPs. The Trust Recovery Plan (TRP) newsletter, 'Improving our hospital', continues to update staff on the progress of the TRP programmes.

Specific programme communications plans have been developed in support of Deteriorating Patient and Emergency Pathway and agreed by the Programme Boards. These plans will be rolled out from late May/early June. Planning is in hand to begin promoting the new programme structure to staff once formally agreed by the Board.

4. CQC ACTION PLAN

The PMO continues to support the Trust's CQC Action Plan. Following the fieldwork inspection carried out on 29-30 March 2016, the Chief Inspector of Hospitals, Sir Mike Richards, published a letter to the Health Secretary, setting out the CQC's findings. In summary, the CQC found signs of considerable improvement since their last inspection of the hospital in August 2015. Specifically, they found that:

- The hospital was safer for patients
- Leadership had improved
- Staff engagement among senior and middle managers had improved although low staffing levels are impacting on the morale of frontline staff

The CQC Must Do/Should Do Action Plan which the Trust has been working through continues to be progressed. The status of all 73 actions being:

- 48 - Green
- 20 - Amber
- 5 - Red

The areas that remain Red relate to staffing numbers (2), medicines management, patient transport service 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 CQC is scheduled to revisit the Trust in November 2016. 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, whilst preparing for the CQC inspection in November.

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

Moving Forward:

Projects and Recovery to Programmes and Transformational Change

Context

- Agreement of programmes and KPIs that will move us out of special measures by Nov 2016 and aiming for "good" at next inspection

- Develop driver diagrams and plans

- In parallel, plan to move from local modelling to transformational change programmes aligned to strategic direction i.e. unplanned care, STP

- Alignment to strategic direction of travel required

- Alignment and development of business intelligence and reporting

- Building capacity and capability for continuous improvement, involving 'experts'

- Continual review and re-assessment points

Best of care
Best of people

Next 6 months: Suggested Programmes

Our overarching programme aim :   ***Provide Best of Care***

Trust wide:

- Out of special measures and aiming for "good" following 2016 Inspection by implementing and embedding CQC standards, highly reliable systems and processes
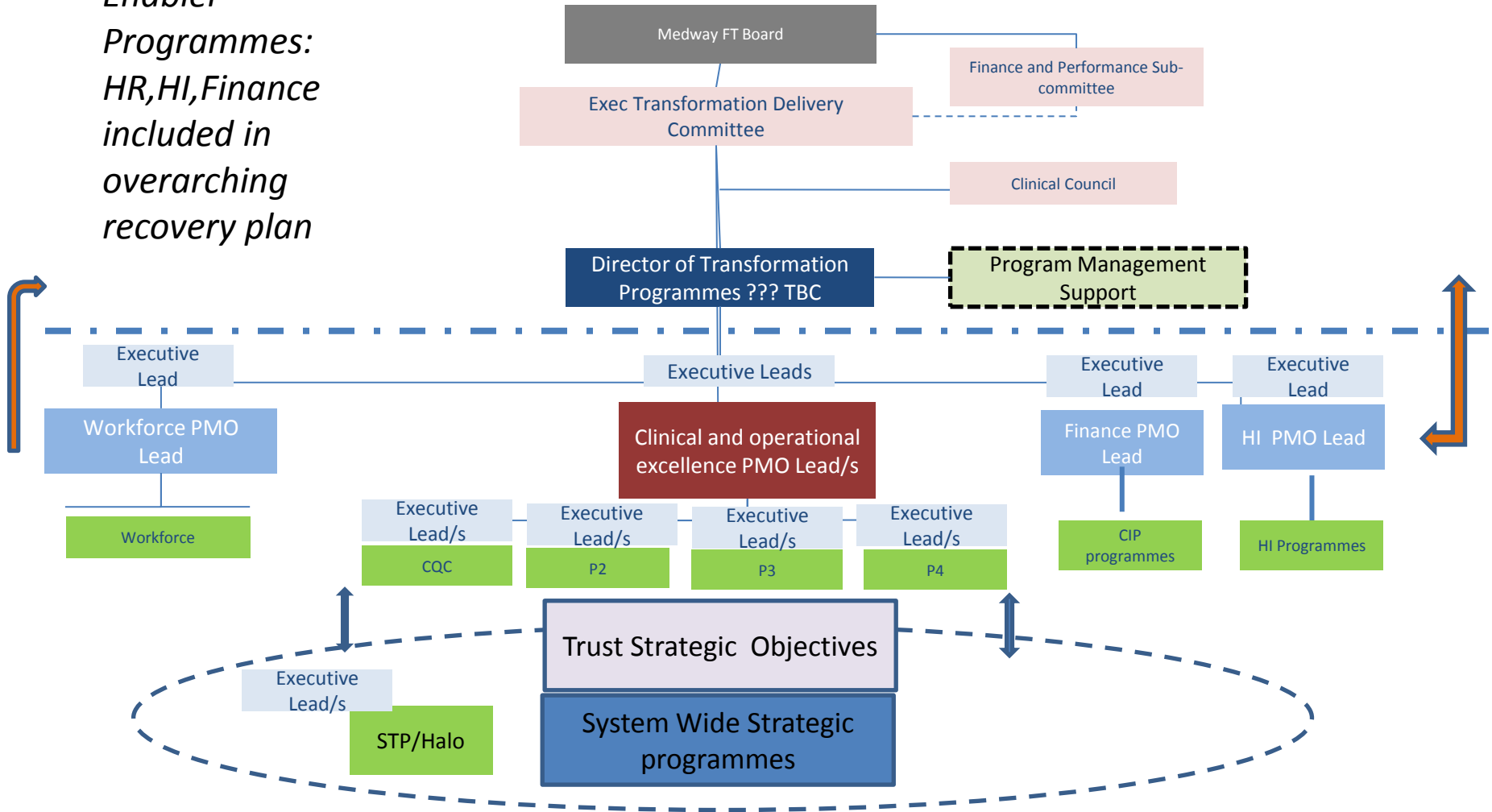
Unplanned care:

- Reduce the number of deaths per week by 5, by 31 December 2016
- Improved quality and position on critical Medicines Optimisation by October 2016
- Reduced number of o/night beds occupied by unplanned patients by 50 by October 2016
- Increase the income per bed day by (TBA%) by October 2016

Planned Care

- Achieve non-acute patient point of contact outside of hospital setting for 2 LTC pathways by OCT 2016 (i.e. Respiratory, Gastro) and by 5 pathways by July 2017
- Increased theatre efficiency by 4 per day by December 2016
- Improve baseline contributions by 10% by December 2016

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Stage 3: Develop and agree Revised PMO structure and delivery model

Enabler Programmes: HR,HI,Finance included in overarching recovery plan

Medway FT Board

Finance and Performance Sub-committee

Exec Transformation Delivery Committee

Clinical Council

Director of Transformation Programmes ??? TBC

Program Management Support

Executive Lead

Executive Leads

Executive Lead

Executive Lead

Workforce PMO Lead

Clinical and operational excellence PMO Lead/s

Finance PMO Lead

HI PMO Lead

Workforce

Executive Lead/s — CQC

Executive Lead/s — P2

Executive Lead/s — P3

Executive Lead/s — P4

CIP programmes

HI Programmes

Executive Lead/s — STP/Halo

Trust Strategic Objectives

System Wide Strategic programmes

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4

Opportunities and priorities going forward

- Strengthened buddying arrangements both tactically and strategically with GSTT
- Working collaboratively with other external organisations i.e. Halo, ECIP, Advisory Group
- Opportunity to work with IHI
- Develop breadth of recovery programme and measures
- Agree Improvement Methodology and key work streams in line with strategic and corporate objectives

Report to the Board of Directors

Board Date : 26 May 2016

Title of Report	Quality and Health Informatics Update (inc IQPR)
Reporting Officer	Chief Quality Officer
Lead Director	Director of Health Informatics and Associate Director Quality Improvement
Responsible Sub-Committee	Quality Assurance Committee
Executive Summary	The report highlights the progress in the quality and health informatics directorate functions over the month of May. A verbal update will be given in relation to any relevant KPIs within the IQPR by the CQO at the Board.
Risk and Assurance	n/a
Legal Implications/Regulatory Requirements	
Recovery Plan Implication	• Continuing the work to improve our corporate and clinical governance, which will support both safe and high quality patient care and a productive working culture for staff. • Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.
Quality Impact Assessment	N/A
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Assurance Information
Recommendation	The board is asked to review the information within the update and IQPR and to ask any further questions, make any relevant comments to provide assurance that the functions are delivering to expected standards.

Quality and Health Informatics Update: May 2016

Background

The report highlights progress made within the Health Informatics remit over the last month in relation to:
- IQPR – KPI status
- Clinical Systems development :
- Data Quality Programme
- Business Intelligence and Performance Framework
- Supporting Infrastructure
- Quality systems and processes

QUALITY AND HEALTH INFORMATICS: CURRENT STATUS

1. IQPR – KPI UPDATE

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

Serious Incidents:

Position as of 11th May

2 new SI's for May involving pressure ulcer and a fall.

34 cases open
15 are in date
12 sent to CCG for closure
 7 awaiting closure by directorates

A meeting was held with CCG and all concerns addressed and resolved. A formal contract closure is now being requested.

Actions taken to reduce the risk of breaching:

- Investigators to be agreed and signed off by the directorate to ensure investigators workload allows the time and support to undertake the investigation.

- Business partner model for each directorate from the PST to support the assigned investigators
- New tracking system has been developed with a dashboard to provide the directorates with the details of SI investigation progress - to be cascaded weekly from 16th May
- Additional RCA training to be delivered by GSTT and workshops for existing investigators to run routinely
- Trajectory has been set to reduce the breach time and number of SI reports breaching
- Serious incident policy has been updated for approval -responsibilities have been strengthened
- Escalation framework has been put in place – SI monitoring group to enact

In addition for the future to assure sustainability:

Competency based training matrix for investigators is to be developed to ensure high quality investigations, competent investigators, this will support succession planning and development of investigators.

Learning events continue, newsletter published and a magazine article on the PST and the importance of patient safety is to be published.

- SI action plan, CCG agreed to close all areas on historic action plan, with work being taken forward at the most appropriate group (e.g. medicines management group and deteriorating patient group) at the next closure panel.

- Datix incidents. We continue to work with GSTT and are developing Datix to be more user friendly with a range of reports for end users.

Clinical Effectiveness Update

- 2016/17 National CQUIN again includes sepsis. A business plan has been written to secure resources required. A new sepsis screening tool for paediatric patients was discussed at a recent meeting and will be going to their next governance meeting for approval. New resources are being developed in line with new NICE guidelines for sepsis

- To assist with our monitoring work, the department has launched two new databases, one for NICE compliance and one for registered clinical effectiveness projects. We are now able to monitor compliance with NICE and progress of audit projects more efficiently. The systems also provide a robust method for recording evidence of actions and compliance. Reporting functionality is currently in development, and we hope to have this completed by the end of June.

- The annual Clinical Audit and Quality Improvement Awards are coming up on 09 June; we are currently promoting the event and sending out application packs.

- NELA contacted the Trust to advise that we are one of the top five most improved sites for Consultant Surgeon Presence in Theatre nationally.

- A trust-wide learning day is on May 19th, a follow up event to the Trust Sign up to Safety initiative that will include learning from serious incidents.

- The Trust's Hospital Standardised Mortality Ratio (HSMR) continues to demonstrate a downward trend and for the latest 12 month period that can be reported (February 2015 – January 2016) is **102.76** (LCL 97.07, UCL 108.70).

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

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2. HEALTH INFORMATICS:

2A CLINICAL SYSTEMS DEVELOPMENT

- The consultation and procurement process for the **electronic bed management system** has now concluded with the view that Hospedia is the system that will provide all appropriate functions for clinical and operational staff. The procurement process will now start with a view to havig a fully functioning system by end of the year.
- **Chemotherapy E-prescribing** : Issue shave arisen with the implementation of this system due to initial under resourcing of the project. A business case was presented to the Executive team and resource now beign identified to ensure that this project will delvier without any further financial support.
- **E-prescribing Trust wide** is currently being scoped and project manager and SRO assigned. Full implementation of the system is not expected until next year.
- **Digital Road map** – We continue to work with the CCG on the system wide development of the digital road map. We have also involved the Advisory Board to ensure that we develop a strategy that is based on best international and national evidence. The **next clinical council** agenda will be focused on the digital road map and recruitment of clinical health informatics leads.
- **EPR –** is part of the digital strategy and the approach will be strengthened by working closely with the strengthened and more experienced Allscripts (Oasis) team. The timeline will be presented along with the digital strategy in August Board.

- **Oasis PAS Upgrade :** Oasis PAS has now been taken over by Allscripts – the company have suggested that we upgrade our current PAS (implemented just over a year ago) to provide better functionality. However this would mean delaying bed management and order comms projects until this has been completed. We are currently working with Allscripts to ensure that the system is upgraded at an appropriate time without detriment to our current programmes of work.

2B DATA QUALITY AND SUPPORTING STRATEGIES

- We have just received a 'positive assurance' in the draft KPMG report on the quality account indicators ; 62 day cancer waiting times, urgent referrals, screening and VTE risk assessment compliance. This is an excellent objective assessment and alongside our improvement with the data quality relating to 18 weeks – is testament to the hard work of may Trust staff.
- NHSE, CCG and NHSI will be assessing our systems and processes relating to 18 week reporting and management on May 26th. Following this assessment our commissioners and stakeholders will agree or not with the Trusts request to return to reporting in the next few months..

2C BUSINESS INTELLIGENCE ; PERFORMANCE MANAGEMENT & ACCOUNTABILITY FRAMEWORK

- A new Model Hospitla Lean dashboard has been developed and will be produced for the weekly and monthly executive meetings.
- All KPIs related to the recovery programmes will now include the methodology used within the Lord Carter recommendations
- AN action plan outlining our current progress against the Lord Carter recommendations is being developed and will be provided at the next Board.
- The Medical Director is working with the quality analysts to produce a consultant pack which will be available to all consultants on a monthly basis to identify areas of improvement and also to investigate any potential data quality issues to ensure their data is recorded accurately.
- The Head of Clinical Coding continues to work on improving the coding in relation to mortality and data more generally , action plans are in place to ensure systematic reviews are undertaken within the coding team working closely with clinicians
- In addition, the clinical coding manager will work with the finance team to take forward a plan of work to improve outpatient coding, this will provide more accurate data on activity and will also bring increased financial benefits.

2D SUPPORTING INFRASTRUCTURE

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- Remote access is now available to trust staff and patients and public via the **wi-fi system**.
- 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.

Report to the Board of Directors

Board Date: 26th May 2016

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

RTT Update – April Position

Summary of April position

- The Trust is not currently reporting externally for RTT.   Planned return to reporting is in June.
- The total incomplete waiting list size reduced by approximately 1000 patients across the month of April. The reduction has been achieved through the effective validation and a focus on delivering additional capacity.
- Incomplete performance in April is around69%
- The current backlog size is below trajectory. This is predominantly as a result of validation and therefore the rate of backlog reduction is expected to slow down.
- Cardiology performance remains a risk due to the lack of available capacity and limited outsource options.
- Additional validation work is being undertaken in preparation for the return to reporting.
- A revised PTL meeting has been implemented with good representation from all specialities in attendance.
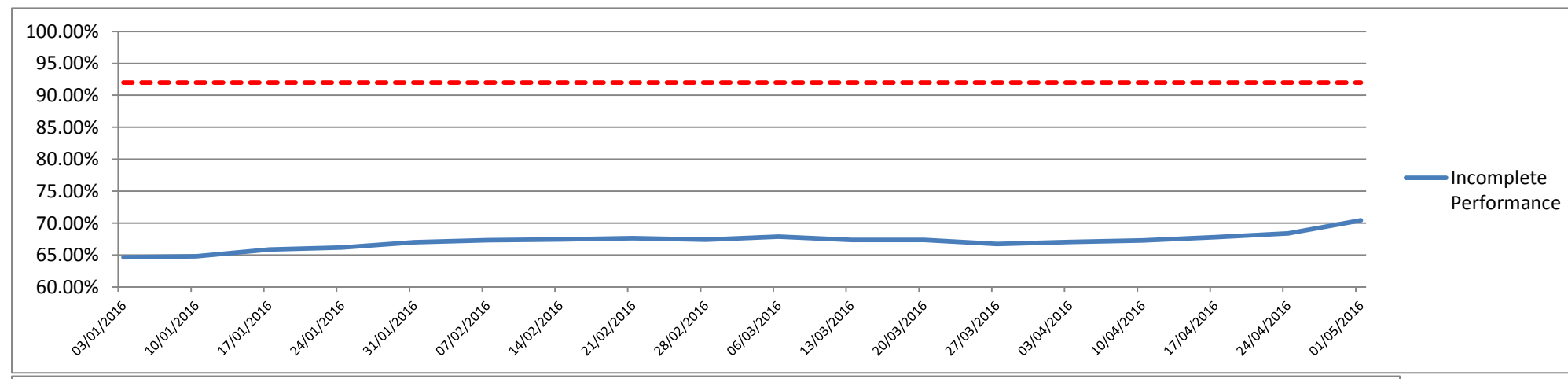
Total Waiting List Size
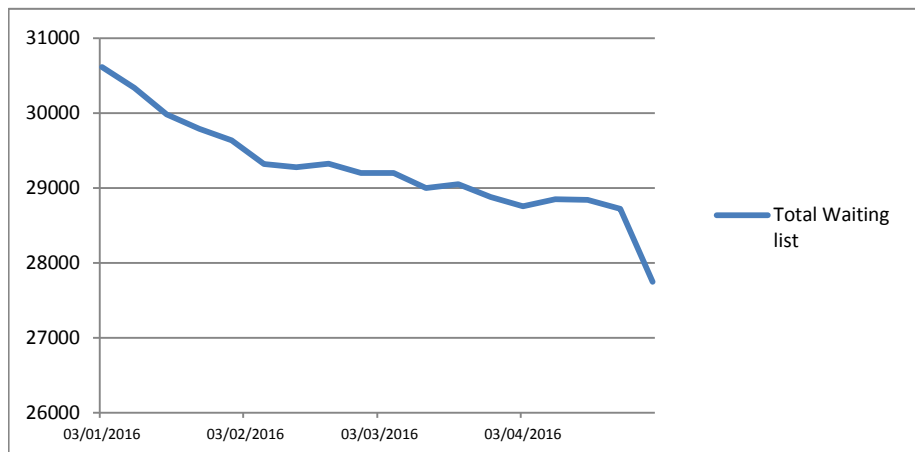
Backlog Trajectory
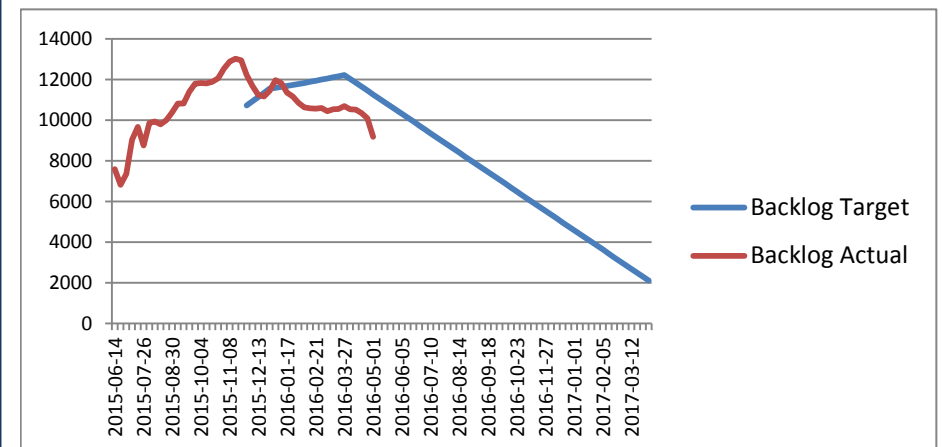
Incomplete Performance
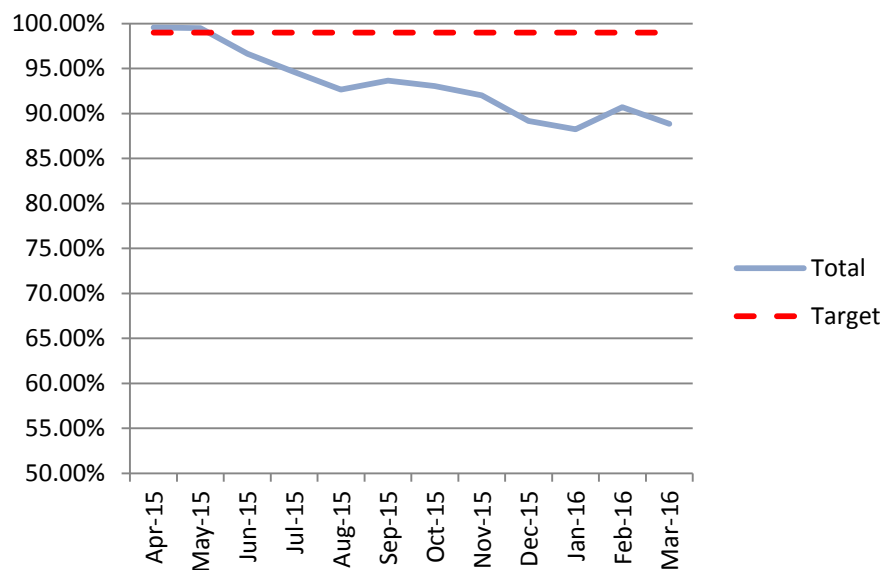

18 week RTT Sustainability Plan

- Demand & Capacity modelling has been completed across all specialities. The models and assumptions will now be shared with the clinical teams.
- Work will be undertaken in the speciality teams to identify additional internal capacity opportunities.
- Additional outsource capacity is being progressed with contracts with Ashford one due for sign off imminently.
- The PID is in development for the surgical pathway programme which will have a focus on improving efficiency and productivity through theatres.
- An access board will commence I May to provide single oversight for RTT, Diagnostics and Cancer performance.

Diagnostic Update – March Position

Summary of March position

- The Trust achieved a performance of 88.85% for diagnostic tests completed within 6 weeks.
- The national target for diagnostics is 99% of diagnostic tests to be completed within 6 weeks.
- The three poorest performing areas are flexi sigmoidoscopy, gastroscopy and colonoscopy due to the shortfall in endoscopy capacity at Medway.
- MRI is the biggest risk for imaging diagnostics however a mobile MRI scanner is now on site to support backlog clearance. A reduction in the waiting times for MRI has already been observed.

Trust Performance – Diagnostic 6 Week Target

Modality Performance
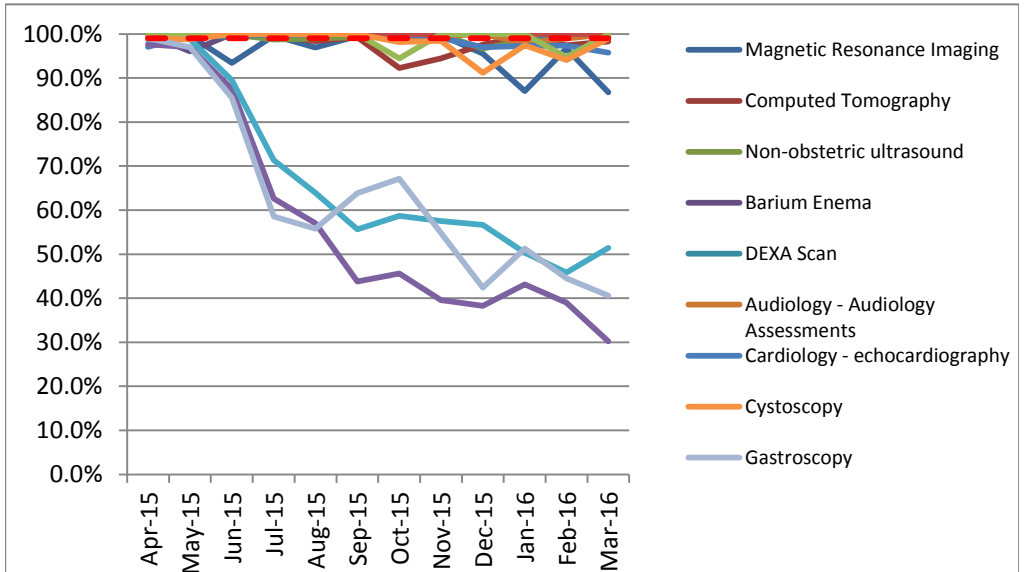
Diagnostic Sustainability Plan

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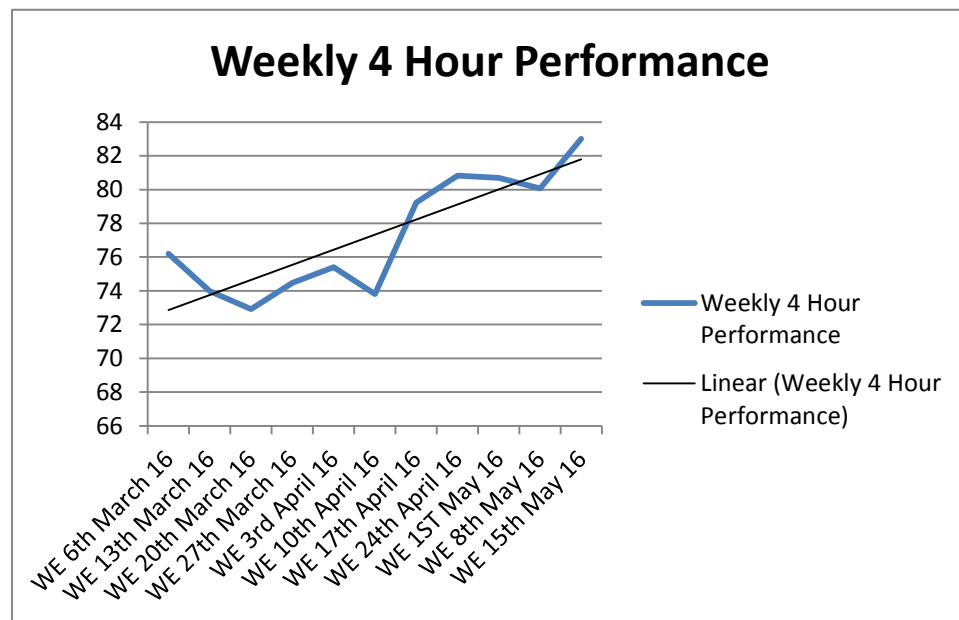- A strategic review of all areas within imaging is planned for completion by the end of 2016.

ED Update – April 2016 Position

Summary of April position

April saw a 12% reduction in total attenders on the previous month. The reduction in ambulance attenders was less marked at 7.5%. Emergency Admissions were 5.8% less than the previous month but 4.6% more than February. As a result of some of the activity markers reducing, 4 Hour performance has improved month on month from February and sits at 77.81% for April. 1062 patients saw their care managed in the corridor for all or part of their stay in April; this was 24% less than March and the second lowest number this year. Consistently just over 23 % of ED presentations were streamed to MEDDOC month on month over the last 3.

Access target Performance (95%)

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

Weekly 4 Hour Performance

Legend:
— Weekly 4 Hour Performance
— Linear (Weekly 4 Hour Performance)

X-axis categories: WE 6th March 16, WE 13th March 16, WE 20th March 16, WE 27th March 16, WE 3rd April 16, WE 10th April 16, WE 17th April 16, WE 24th April 16, WE 1ST May 16, WE 8th May 16, WE 15th May 16

Quality indicators

Clinical markers performing well with 100% NEWS compliance and 100% of patients in the corridor are meeting the acceptable clinical criteria. This is recorded through snapshot audits covering all times of day and night.

Ambulance Performance – Medway saw 3115 conveyances in April, the second highest in the sector and almost 12% above the next highest. 54.5% of patients were handed over within 15 minutes, with several weeks above the 12 week trajectory. This is 3rd in the sector with Medway seeing 178% more than the highest performer (1997 more). 30 minute performance was 9%, the highest in the sector was 25.3%, 60 minutes was 2.1%, DVH were highest with over 10%, 90 minutes were 1% and 120 minutes 0.5% (14 patients)
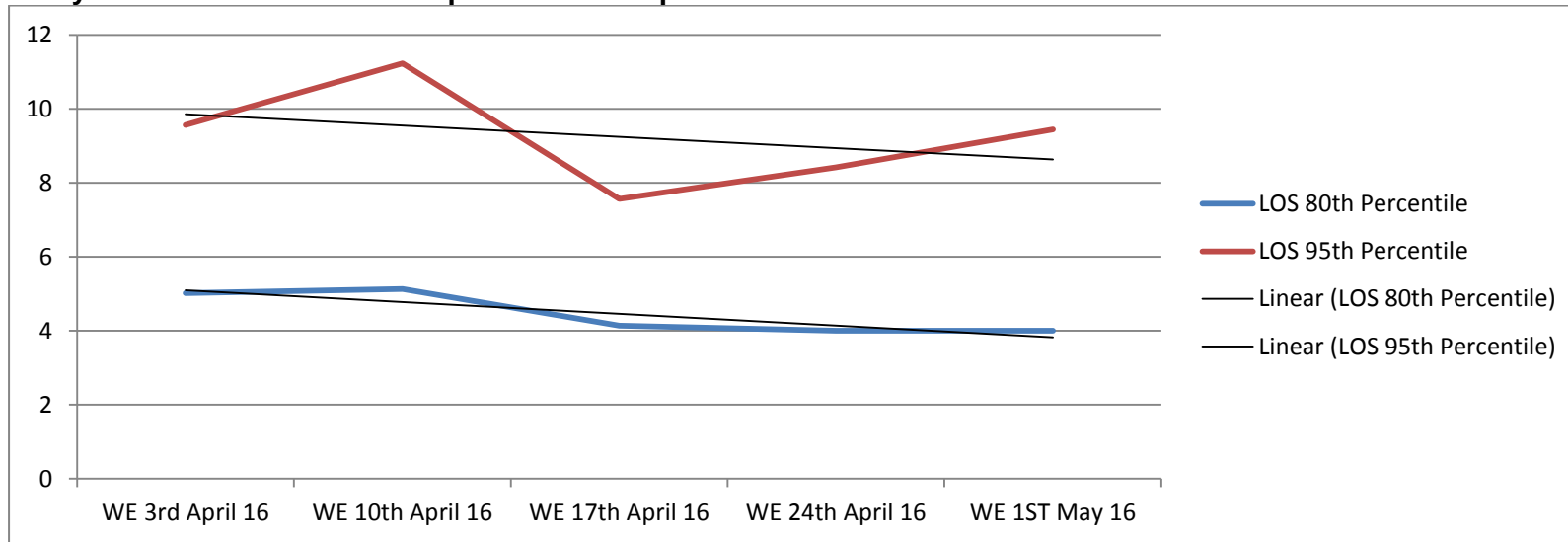
Through Audit, we know 100% of patients in the corridor are clinically appropriate to be there. There is a robust process in place to manage this and the snapshot audit covers all times of the day and night.

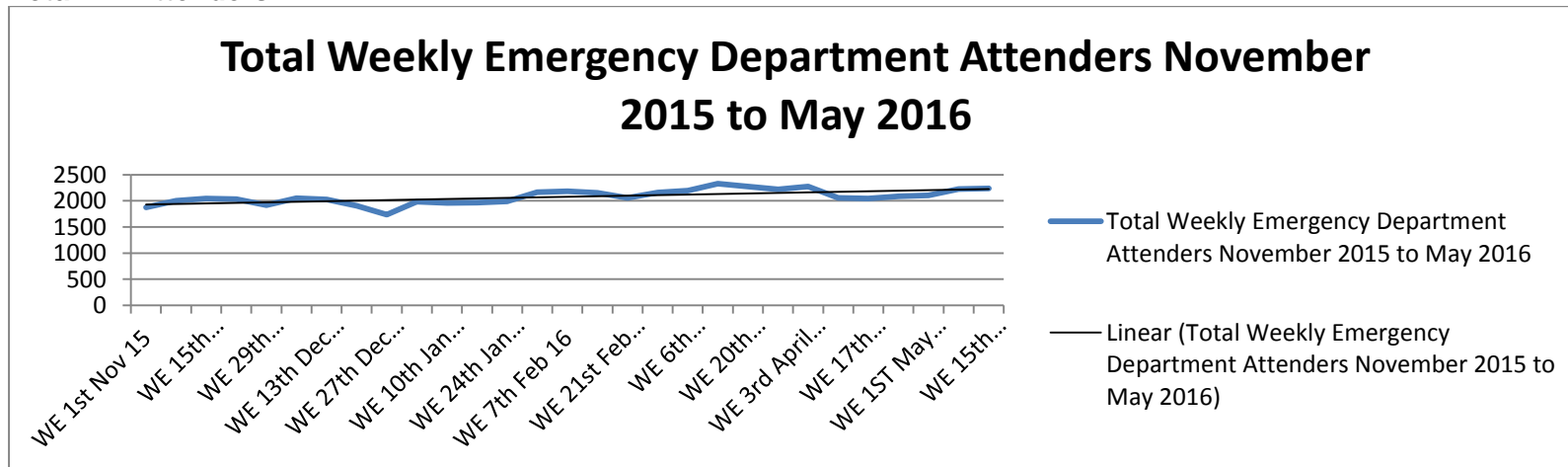Measurement of the LOS in ED shows an improving trend at the 80th and 95th percentile

DTA process is monitored throughout the day and night to ensure this decision happens as early as possible.

Daily breach validation looks at all key points in the patient's journey to determine primary and secondary causations to clearly defined measurements of time to all measurable points such as 1st assessment, DTA, referral, interventions and LOS in the department
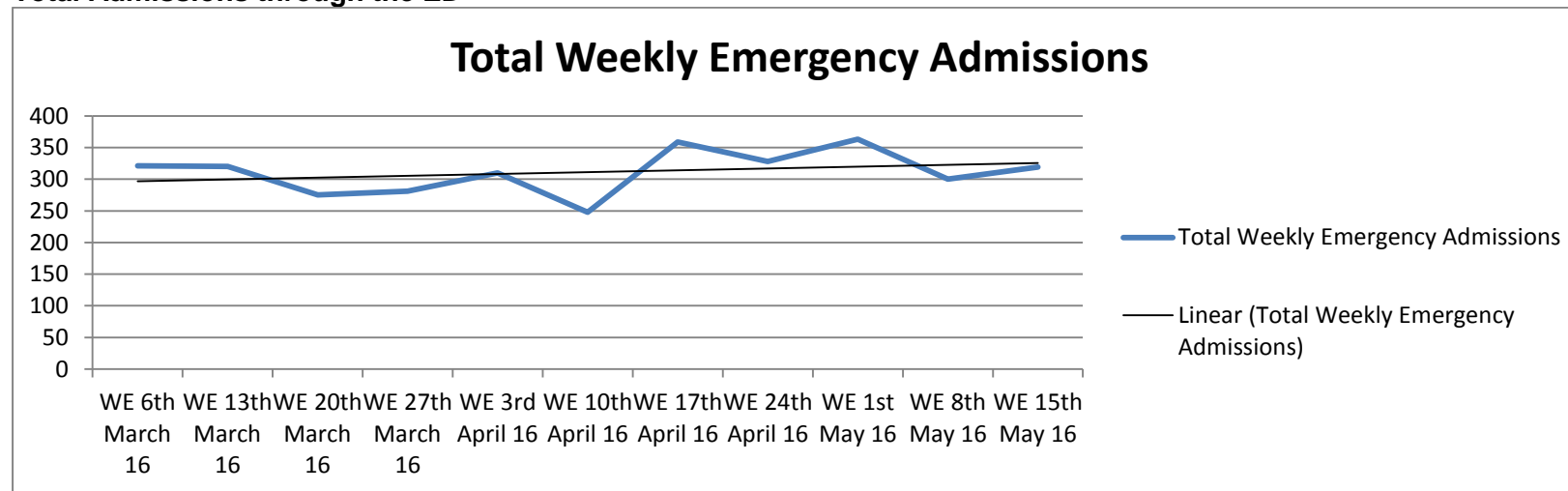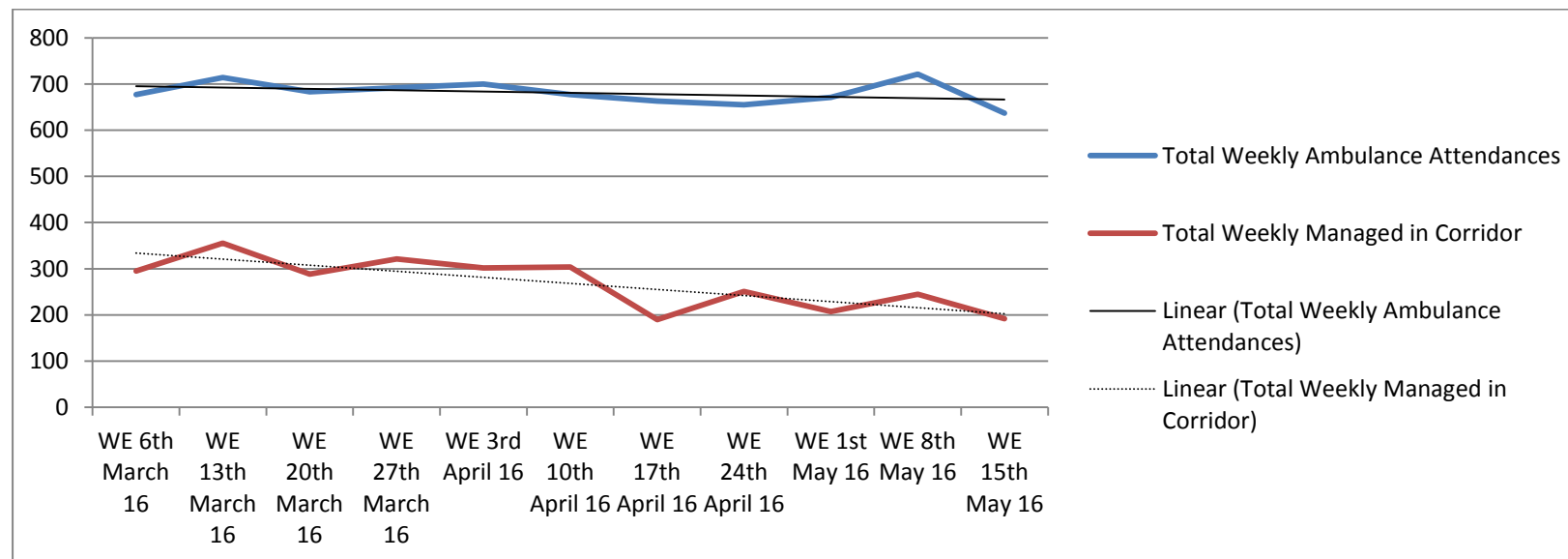
Analysis of LOS at 80th and 95th percentile for April:

Total ED Attenders:

Total Weekly Emergency Department Attenders November 2015 to May 2016

Total Admissions through the ED

Total Weekly Emergency Admissions

Legend:
- Total Weekly Emergency Admissions
- Linear (Total Weekly Emergency Admissions)

X-axis: WE 6th March 16, WE 13th March 16, WE 20th March 16, WE 27th March 16, WE 3rd April 16, WE 10th April 16, WE 17th April 16, WE 24th April 16, WE 1st May 16, WE 8th May 16, WE 15th May 16

SECAmb attenders matched to corridor use:

Legend:
- Total Weekly Ambulance Attendances
- Total Weekly Managed in Corridor
- Linear (Total Weekly Ambulance Attendances)
- Linear (Total Weekly Managed in Corridor)

X-axis: WE 6th March 16, WE 13th March 16, WE 20th March 16, WE 27th March 16, WE 3rd April 16, WE 10th April 16, WE 17th April 16, WE 24th April 16, WE 1st May 16, WE 8th May 16, WE 15th May 16

ED Improvement Plan

Integrated Health Projects were successful in the tender for the ED build. This is being managed by PM21+. Phasing options are on the table:

Option	Cost	Completion of new majors	Project completion	Benefits
Current design	£17.4M	Nov 17	Mar 18	Potential time to include for any unknowns that occur
Double shifting	£17.7M	Aug 17	Dec 17	Saves 12 weeks, although noise maybe an issue
Modular	£17.7M	Aug 17	Dec 17	Saves 12 weeks on programme and reduced construction traffic
Alternative phasing inc modular new build	£17.5M	Dec 16	Aug 17	New majors department for Dec 16

With all phases, there will be loss of CDU function for prolonged periods.

Site/Flow Update – April 2016 Position

Summary of April position

The site continues to experience delays in progressing patients through the department once speciality referral takes place and a DTA is in place. In response, a DTA SOP was put in place allowing a much earlier decision to admit when it was clear admission was necessary. This has been successful in managing patients through the emergency pathway much quicker than would previously been expected. We have measured this at the 80th and 95th percentiles. The 80th percentile could, in part, be considered a good measure of the non-admitted pathway. This has improved from 5 hours 08 in March to 4 hours 32 for April. At the 95th percentile, a good measure in part of the admitted pathway, it has improved from 11 hours 27 to 9 hours 33. While an improvement, there is still some way to go however the trajectory is improving. Long delays are evident for some particular pathways such as patients under the care of IDT and mental health presentations, particularly admissions. Trust Escalation was predominately Amber with some Red. Most days saw multiple DTA's in the ED awaiting placement. Lister Assessment Centre saw an average of 35 patients a day. An average of 17 a day went through the GPAU with 10 of those admitted, AEC saw an average of 18 a day with only an average of 1 a day admitted. Of the total numbers through LAC, an average of 10 a day were pulled from the ED with an average of 4 a day admitted.

Hospital @ Night progress

This is being addressed through the PMO within the deteriorating patient group as well as through the ART team work. Intentional rounding and safety briefs are in place and managed by the site team. Further work is being done to develop the site team further with an away day planned in May to go through, amongst other things, leadership and their position within the organisation, particularly out of hours

Quality indicators

MSA - There were no mixed sex breaches recorded outside of excluded areas for April 2016

All site flow meetings are recorded in a template that allows audit of flow, surges, response, actions and the ability to develop learning and improvement.

Emergency Pathway Programme update

The Programme has fully mobilised across all Directorates and all relevant workstreams have cross-organisational involvement from statutory sector partners. The Board structure, governance and reporting processes are embedded and a formal set of impact metrics are now being monitored on a monthly basis. Workstreams are meeting fortnightly to track and monitor delivery and impact.

Key Highlights for the past month include:

- The first draft of the Trust Daily Concept of Operations has been circulated to Programme Board members laying out the processes, practice and performance required to efficiently run the daily flow of patient activity across the Site;
- The Bed Modelling process has commenced across the Directorates to review the capacity and demand requirements for the site;
- Within the Emergency Department (ED) a targeted validation process has commenced to better understand why patients have extended stays in the Department and escalate or cascade actions to improve the length of stay in ED. In addition, new practices relating to Nurse Handover and Decision processes to Admit (DTA)
- The Home First initiative, operational since the 4th April, has seen 85 patients referred via the supported early discharge pathway in the first month. There has also been a corresponding positive impact on the number of medically fit patients in hospital over seven(7) days

Cancer Update – April 2016 Position

Summary of validated March Open Exeter position

2WW – Trust maintained compliance with the 2 week wait standard but failed symptomatic breast. Breast breaches were predominantly as a result of capacity issues and a short notice clinic move that booked patients declined. The remainder of breaches were as a result of patient choice.

31D - The Trust failed to achieve the first definitive treatment standard. Breast has issues with service capacity and cover of consultant leave, urology breaches are as a result of MTW surgeon availability and skin breaches were due to patient's cancelling planned treatment dates. The Trust was compliant with the subsequent drug treatment standard.

62D – The Trust failed to achieve the GP referral standard but performance was improved on the previous two months, breaches were varied and due to complex pathways, delays due to patient choice, endoscopy capacity and late referrals from other Trusts. The Trust also failed to achieve the screening standard due to the issues in breast and complex pathways with multiple diagnostic tests in lower GI.

The Trust is seeking to agree changes with commissioners to the Trust access policy criteria and adjustments for patients who are unavailable or cancel appointments in line with other providers in the region.

Cancer Waiting Time Summary Performance

	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
2WW cancer	93%	58.47%	67.93%	88.79%	94.38%	91.61%	84.44%	82.14%	85.23%	87.43%	95.77%	96.42%	94.06%
2WW symptomatic breast	93%	70.10%	72.73%	87.88%	100.00%	85.71%	64.18%	77.59%	83.70%	90.40%	88.24%	92.31%	81.42%
31D first treatment	96%	91.11%	97.35%	97.48%	95.49%	91.01%	92.16%	92.91%	92.20%	94.12%	90.84%	93.38%	89.31%
31D sub treatment surgery	94%	100.00%	95.83%	88.00%	90.32%	84.62%	90.70%	88.00%	94.44%	87.50%	85.00%	83.33%	82.86%
31D sub treatment drug	98%	100.00%	100.00%	100.00%	100.00%	100.00%	95.45%	100.00%	100.00%	88.24%	92.00%	100.00%	100.00%
62D GP referral	85%	69.47%	75.68%	87.50%	76.56%	86.25%	75.00%	77.56%	87.73%	83.33%	65.41%	75.40%	83.02%
62D screening	90%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	93.55%	87.50%	90.63%	92.86%	96.15%	72.73%
62D consultant upgrade	n/a	76.92%	81.25%	60.00%	75.00%	84.62%	40.00%	50.00%	100.00%	64.29%	71.43%	78.95%	71.43%

Cancer Remedial Action Plan

The Cancer Remedial Action Plan actions continue to be completed or progressed with currently 6 outstanding actions. Regular meetings are in place with commissioners to agree updates to the RAP and evidence of action completion. The outstanding actions are as follows;

- Re-establishing tumour site Local Implementation Group meetings
- Developing & documenting MDT Coordinator induction & training (2 actions)
- Evidencing operational KPI performance
- Ensuring clinical authorisation of data entered in MDT meetings
- Evidencing sufficient MDT Coordinator resources for service delivery

The Trust is developing an ongoing Cancer Improvement Plan which will incorporate recommendations or best practice from reports, audits, National guidance and other providers to continually improve and develop cancer service provision and performance.

Report to the Board of Directors

Board Date : 26 May 2016

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

Medical Director Update: May 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 10th week and continues to need daily oversight but is becoming business as usual with benefit to all, most of all our patients.

The key development since the last report has been the introduction of a "Physician of the Week" scheme which will provide for increased continuity of care of patients.

The Associate Medical Director is also engaging with Junior Doctors to ensure their role within the model is developed to increase alignment of the medical workforce.

2. PATIENT SAFETY

On the 19 May a special event to mark the one year anniversary of the Trust's participation in the national Sign up to Safety initiative took place.

The event focussed on the work that has been carried out to improve patient safety at the Trust over the last 12 months, as well as plans for the future. Speakers, included

- Nigel Acheson - Regional Medical Director and Higher Level Responsible Officer (South), NHS England
- Tony Kelly – Associate Medical Director for Quality and Innovation, Brighton and Sussex University Hospitals.

3. JUNIOR DOCTORS CONTRACT

Work on implementing the contract has been put on hold whilst the employer and junior doctor's representatives returned to the negotiating table. Next steps will be clearer following the outcome of those discussions.

4. MEDICAL EDUCATION

In the light of Dr Hussein taking up a new position the role of Director of Medical Education has been revised to enable two Deputy Medical Directors to be appointed to support Dr Janette Cansick, the Director of Medical Education.

The two appointees are Dr Virginia Bowbrick and Dr Rajesh Hembrom. They bring with them a broad range of medical and education skills.

The Director of Medical Education team is now made up of consultants from all three Directorates providing a broad range of expertise to support our HEKSS trainees.

The GMC trainee survey has now closed. There have been immediate and non-immediate patient safety issues as well as one non-immediate undermining and bullying concern to address.

A full annual report of progress in Medical Education will be provided to the Board meeting in June.

5. RESEARCH & DEVEOPMENT

The Research Governance Group met on 5th April 2016.

The key issues discussed:

- Terms of Reference (TOR) approved.
- R&D Quality Accounts approved.
- Two historic studies which were conducted without formal Trust approval were discussed and reported as breaches of governance. No further action required.
- A study by Prof Kanegaonkar which does not require ethical approval (as involves only staff) has been considered and approved.
- Service Improvement issues with Pharmacy and Finance discussed and areas for change identified.

The Research & Development Annual Review is being presented to the Board this month.

6   MEDICAL REVALIDATION

Medical Revalidation team are preparing the Annual Audit of Compliance which needs to be submitted by the end of May 2016 and will provide a full report to the Board in June 2016. The team have recently completed an update s

7   LEADERSHIP DEVELOPMENT

Clinical Directors, Specialist Leads and Senior Managers completed in-house training in Case Investigation and Case Management in a continued initiative to develop the capacity of our medical workforce to manage performance and development within their clinical areas.

Report to the Board of Directors

Board Date: 26 May 2016

Title of Report	Director of Nursing Update
Reporting Officer	Karen Rule, Director of Nursing
Lead Director	Karen Rule, Director of Nursing
Responsible Sub-Committee	N/A
Executive Summary	Safe staffing - The Trust continues with a high level of activity and acuity demands, requiring high levels of nursing hours to deliver safe effective patient care. Nursing & Midwifery Care Indicators - There was an improvement in Harm Free Care performance in April. Infection Prevention & Control – see below Dementia & Delirium – 2015/2016 CQUINS achieved. End of Life Care – Good progress is being made against the EOLC Improvement plan. The results of the national End of Life Care Audit: Dying in Hospital has been published. Actions have already been incorporated into the Trust EOLC Improvement Plan. Patient experience – The % of patients who would recommend ED significantly improved in April, 75.3% compared to 69% the previous month. Assurance – The Perfect Ward and Super 7 audits are beginning to provide valuable information in relation to standards of patient care.
Risk and Assurance	Staffing levels remains a Trust quality risk. Actions to mitigate the risk of current staffing levels are in place and embedded. Stabilising and retaining the nursing and midwifery workforce in clinical areas is a priority as we move through 2016.
Legal Implications/Regulatory Requirements	Infection Prevention & Control – Regulation 28 of the Coroners (Investigations) Regulations 2013 Report, to prevent future deaths, was received by the trust. All necessary actions have bene or are being taken.
Recovery Plan Implication	Nil to note
Quality Impact Assessment	N/A
Purpose & Actions	The purpose of this report is to provide the Board with

required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	• An overview of nurse, midwifery staffing levels in inpatient areas as outlined in the Nurse Staff Guide 'How to ensure the right people, with the right skills are in the right place at the right time!' • An overview of key work and achievements relating to the portfolio held by the Director of Nursing
Recommendation	The Board of Directors is asked to note the information contained in this report and the actions that are in place.

Director of Nursing Update: May 2016

Safe Staffing

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

Key Points:

- The information in the appendices relates to April 2016 fill rates, as per inpatient ward, for both registered and unregistered staff, broken down by day and night.
- At the start of April there were two periods of red escalation due to high levels of activity. Response to this was in line with agreed escalation procedures.
- Meetings to discuss site safety, staffing and capacity are held three times each day to identify and escalate capacity and staffing challenges across the organisation. The expectation is that senior staff in attendance gain early visibility of organisational challenges and are able to put in place corrective action to ensure safe standards of care and to mitigate risk.
- A reporting system implemented in February 2016 to improve the reporting levels of staffing levels that fall 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 April was 55. This is a decrease of 34% on the numbers reported in March 2016

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 0.6%. This is a 10.3% decrease on previous month of March 2016. This change reflects the increase in the fill rate of temporary staff, as well as additional beds that were opened due to escalation and the requirement for extra staff for 1:1 specialling.
- Figure1 shows overall fill rate. This fill rate is the highest since October 2014 and is the first full month of reporting since the in house temporary staffing service was operational. The IT system used by the temporary staffing service is now able to fully capture all the booked shifts for April.

Figure One: Trust level: % Overall fill rate of nurse, midwifery and care staff - September 2014 – April 2016
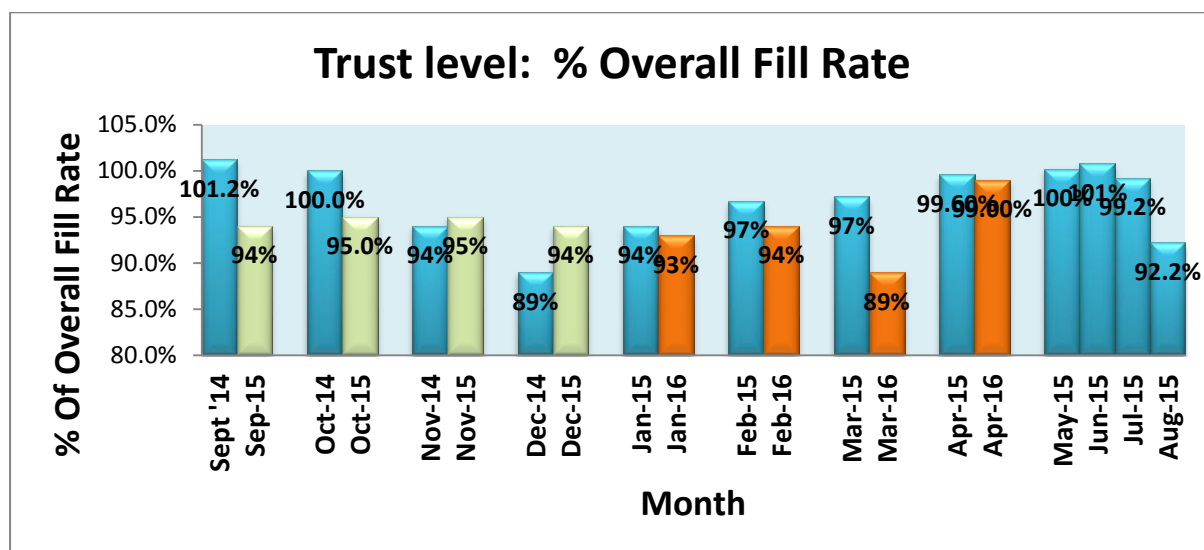
- Since the introduction of the medical model two wards have yet to have their establishment agreed, so the health roster team were not able to adjust their staffing template a manual calculation was done to ensure the figures accurately reflected the actual staffing position against planned.
- There were sixteen wards which recorded a deficit of actual nursing hours against planned nursing hours. Three ward deficit in actual hours against planned of more than 10%. The highest reporting wards remain the same as in previous month:
  - **Medical Wards include:**
    - o Tennyson (care of the elderly ward)
  - **Surgical Wards Include:**
    - o Phoenix, (acute surgical ward)
    - o Sunderland (23 hour surgical ward)

- When staffing levels are lower than planned the staffing escalation procedure is followed and actions taken to mitigate risk. Actions will include a review of acuity and dependency of our patients using the accredited Safer Nursing Care Tool (SNCT), review by a Matron of staffing alongside patient acuity, movement of staff across the Trust to cover vulnerable wards or departments and by Ward Sisters, Matrons and specialist nurses working clinically to deliver patient care.
- In April 2016 11 wards recorded higher actual nursing hours than planned. Three wards Will Adams (general medical ward) Ocelot (gynaecology ward) and Byron (care of the elderly ward) used more than 10% actual nursing hours above the planned.
- During April there were 49 formal escalations due to staffing issues. This is consistent with the previous month. Teams have been encouraged to document escalation concerns to ensure this information is captured.
- April is the first month of reporting since the in house temporary staffing went live. In April 23.2% of all requested shifts remained unfilled. This is a decrease of 1.7% on March figures. The use of agency continues to be higher, with 48% of shifts filled by agency against 28.8% filled by bank staff. This is consistent with previous months. The top

reason for booking temporary staff remains to cover vacancy (73%) followed by specialling (9%) escalation (8%) and sickness (7%) These figures remain in line with previous months.

Other workforce indicators

- 4.87 WTE Registered Nurses and Midwives and an additional 6.0WTE newly qualified nurses who are waiting for professional registration to be attained commenced employment in the Trust against 7.15 WTE Registered Nurses and Midwives who left in April. This is the third consecutive month where we have had more registered nurses and Midwives starting than leaving.
- There were 3.8 WTE clinical support workers who commenced employment against 7.77 WTE who left the organisation in April 2016.

Key other workforce developments

- **EU- Nurses** - There are now 13 EU nurses working across the Trust as in the last month 3 nurses have resigned their positions and decided to return home. Ongoing recruitment continues and further skype interviews have been held.   Professional registration with the NMC remains a challenge and to date only three have attained registration. The Nurses are being supported with English which will involve a study day and a period of ongoing support via an on line network to support the nurses with their conversational English. A further 5 Registered Nurses and 3 Midwives will join the Trust at the start of May.
- **Recruitment –** This continues to be a high priority for the Trust. Recruitment Assessment days continue, attendance remains stable and numbers are increasing slowly. There is ongoing work to ensure a seamless and quick process to decrease the time it takes to start work following interview.
- The Emergency Department held a study morning for the third year nursing students in April; attendance was good with around 16 students nurses, two have subsequently attended the nursing assessment day and been given a conditional offer of employment for September 2016 dependant on successful completion of their training. There are plans to hold further similar events for student nurses in the future.
- A further recruitment open day is planned for the 21st May 2016.
- Work has started around interviewing third year students in their final placement. Emails will be sent out containing a link to the application form and information on our preceptorship programme, help to complete the application forms has been offered by the team in HR. Completed application forms received by 11th May2016 will be invited to an assessment day on Monday 16th May 2016. This day will include a talk by the clinical practice team on preceptorship and the support for nurses new to the trust.
- **Temporary staffing Service –** The temporary staffing service is now fully operational and a recruitment initiative is now underway to recruit both registered and unregistered nurses to the bank and reduce the reliance on agency staff.
- **Care hours per patient per day (CHPPD) –** Following the Carter review a recommendation was made that from May 2016 this will become the principle measure of nursing and healthcare support workers deployment on inpatients wards. This will

enable the Trust to ensure that the right staff skill mix is in the right place at the right time. This data will be reported on from May 2016

- **Revalidation** - went live on 1st April 2016. 46 members of staff have successfully revalidated in April and May. The table below shows the current number of staff per directorate who are due to revalidate in the next six months:

	Women's and Children	Co –ordinated Surgery	Acute and Continuing care	Others	**Total**
June	3	8	6	1	**18**
July	19	7	2	1	**29**
August	13	4	10		**27**
September	36	38	33	5	**112**
October	6	8	4	1	**19**
November	8	8	4		**20**
December	4	4	4		**12**
Totals	**89**	**77**	**63**	**8**	**237**

- Staff and managers of those due to revalidate from August onwards are currently being contacted. Revalidation workshops are held twice a month. There is a continued interest in the workshops and to date over 133 members of staff have accessed them. Revalidation is also on the agenda at ward and department meetings. Staff that have gone through the process are also starting to support colleagues in their areas who are yet to complete.
- Future reporting of compliance with revalidation will be by exception.
- **RePAIR project** - Health Education England (HEE) is undertaking a project about reducing pre-registration attrition and improving retention (RePAIR). The trust is part of the operation group meetings. As part of this project the academic researcher is holding two focus groups with second year students nurse and midwives along with mentors at the trust on the 3rd June. Students are currently being identified with support from the university involved. The practice placement facilitators within nursing and midwifery are identifying relevant mentors.

Implications:

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

Nursing & Midwifery Care Indicators

Falls

- There were 73 inpatient falls in April which is decrease on the previous month. None of these falls resulted in either a moderate or severe harm.

  Q4 15/16 summary
- Quarter 4 has seen the lowest recorded number of falls since 2014. The Trust has been consistently below the national mean rate of falls resulting in moderate/severe harm or death (0.19) this quarter. There has been a 64% reduction in falls with fracture since Q2 this year.
- 105 staff members including members of the multidisciplinary team and student nurses have received falls prevention training this quarter including the CRASH falls bundle.
- The slips, trips and falls policy has been updated and following input from stakeholders will be re-presented for approval at the Nursing/Midwifery Strategy Group in May.

Pressure Ulcers

- In April there were eight pressure ulcers graded 2 were acquired in our wards. There were no grade 3 or 4 pressure ulcers reported in April 2016.
  Q4 15/16 summary
- There has been a 28% reduction in the total number of Pressure Ulcer incidents in the Trust and a 44% reduction in grade 2 pressure ulcer incidents compared to the same quarter last year.
- 37% of the Pressure ulcer incidents in quarter 4 were on patients who were at the end of life. Review of these incidents is underway, but no definitive trends/themes have emerged.
- In 2015/16 the Trust had three CQUINS relating to Pressure Ulcers -
    - o Collaborative working with Medway Community healthcare to reduce transfer of care concerns relating to Pressure ulcers.
    - o A targets of 20% reduction of avoidable grade 2 pressure ulcers
    - o Following audit in quarter 4 80% of patients risk assessed as needing equipment had the equipment in place at the time of audit.

- The quarter 4 reports have been submitted, demonstrating achievement against all CQUIN targets.

Safety Thermometer

- Harm free care performance improved by 1% to 95%

Infection Prevention & Control

- The Trust did not meet the target for MRSA screening, reporting 94% compliance. Focus for review and improvement is within co-ordinated surgical care and maternity
- In March 2016 a Regulation 28 of the Coroners (Investigations) Regulations 2013 Report, to prevent future deaths, was received by the trust following the death of an MRSA case.

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- o **IPC Matters arising from Regulation 28**
  - – The patient's history of MRSA was not established prior to surgery as per trust policy, despite opportunities in three different hospital departments to obtain this information from the patient or their family
  - – Prophylactic Teicoplanin was not provided pre- or post-operatively as per trust policy for a trauma patient, knowing that the results of an MRSA screen would not have been available at the time of surgery (MRSA –ve written on pre-op form without undertaking the appropriate checks)

- o **IPC Actions from Regulation 28:**
  - – New admission / transfer assessment documentation of patient infection status including MRSA launches April 2016.
  - – Infection prevention and control team to audit assessment completion on a monthly basis as well as when undertaking individual patient reviews and disseminate results monthly.
  - – During initial roll out period random audits of new admissions via emergency department, SAU, and Lister and assessment wards to be carried out by IPCT and actions taken dependent upon outcome
  - – Staff education and training and support for new process provided by infection prevention and control team

- Infection control issues raised within this case had already been addressed as part of the MRSA remedial action plan.
- **2015/2016 Annual Infection Prevention and Control Report –** This report is due to be presented to the IPC Committee in May. Highlight messages are as follows;
  - o The key challenges this year have once again been the increase in number of Clostridium difficile cases, since last year especially in the first quarter. As reported last month the Trust trajectory of 20 was achieved.
  - o The Trust did not have any major issues with diarrhoea and vomiting due to Norovirus this year. There were only two occasions when wards had to be closed. One ward in September and two in March (see below). Both wards were decluttered and deep cleaned prior to reopening. Despite bed pressures the team were supported by the Trust to ensure patient safety. This is a great achievement especially as there were numerous outbreaks in the wider health economy. Early risk assessment and prompt isolation is key to this success.
  - o The trust saw an increase in the number of attributable cases of MRSA bacteraemia this year. As a result a contract performance meeting was held with the CCG and a MRSA remedial action plan was implemented in February 2016 which was based upon the already existing health care associated action plan in the trust.
  - o There was a 40.6% reduction in the number of cases of post 48 hours MRSA acquisitions from last year. The majority of these cases were in the medical division and is consistent with the layout of the wards in B and C block.
- **Hand Hygiene -** The basic building block for all infection prevention strategies continues to be compliance with effective hand hygiene.
  - o The IPCT launched a new 'hands aware safe to care' slogan for the trust and changed all of its hand sanitiser boards on the wards.

Best of care
Best of people

- A new a hologram prompting visitors to the trust to clean their hands and remind them about basic infection control was placed in the two main access areas to the hospital to which there has been a very positive response. In fact over two litres of alcohol hand rub is used every day at the front entrance alone.
- Weekly or monthly hand hygiene audits are undertaken in all clinical areas by the matrons or other trained auditors. A new simplified hand hygiene audit tool based upon the World Health Organisations 'five moments for hand hygiene' was introduced in 2015. As part of the audit, any omissions / non-compliance issues are fed back to the individuals at the time of the audit, and results fed back to the wards/teams as part of the IPCT monthly statistics for action. These results are then displayed publically in all clinical areas. Areas achieving 95% or above, continue to be audited monthly; any area not achieving this will be audited weekly for the next month. If there has been an infection control incident during the previous month, hand hygiene audits will be undertaken by the IPCT which then gives external assurance that hand hygiene audits are undertaken effectively.
- Some areas have not achieved the standards required; however overall, the trust has seen an increase in compliance scores this year.

Dementia and Delirium

- On the 9 February 2016 the Dementia and Delirium Team undertook the quarterly census of the number of adult in-patients with a diagnosis of dementia, suspected dementia and delirium (without dementia):
  - 82 people with a diagnosis of dementia

  - 23 people with suspected dementia

  - 14 people with a delirium (without dementia)

- This accounts for 20% of adult in-patient beds.
- For the year 2015 / 16 there were >3,278 admissions of people living with dementia and people with delirium on admission.
- The Trust has achieved the 90% target for all three stages of the FAIRI (Find, Assess, Investigate, Refer, Inform) component of the National Dementia CQUIN.
- The League of Friends has funded the purchase of six Digital Reminiscence Therapy systems. Further information will be communicated more widely when these have been received by the Trust.

End of Life Care

- Work continues to deliver the End of Life Care Improvement plan. Recent achievements include

- A new End of Life Care policy has been written encompassing Neonates, Paediatrics and Adults. Standard Operating Procedures (SOP's) include guidelines for care after death, the 5 End of Life priorities, safe transfer of care and personal care of the deceased. These will be all available on the intranet (Q-pulse) under the End of Life Care Section.
- The policy and SOP's are to be presented to the End Of Life Steering Group in June for approval.
- Review of EOLC incidents is an agenda item for the End of Life Care Steering Group. Learning from incidents and complaints is shared with ward staff and an action plan will be developed with the Ward Manager and End of Life Care CNS.
- Relatives that have either raised a complaint or a concern are contacted by the CNS to discuss their experience.
- The Anticipatory Medication algorithm has been revised and approved by the CQC.

- **National End of Life Care Audit: Dying in Hospital –** The results of this national audit have been published. The sample period was 01-31 May 2015 and included all adult inpatient deaths where the patient had been admitted for > 4 hours.
- The sample size for Medway Foundation Trust was 80.
- The results are presented below

Quality indicators

Quality Indicator	Medway (n=80)	National (n=9302)
Documented recognition that the patient would probably die in the coming hours or days	85%	83%
Documented evidence that the patient's imminent death was discussed with those important to them	83%	79%
Documented evidence that patient had the opportunity to share any concerns	93%	84%
Documented evidence that the needs of those important to the patient were asked about	61%	56%
Documented evidence of a holistic care assessment of patient's needs for an individual plan of care in last 24 hours of life	60%	66%

Quality Indicator	
Lay member of Trust Board with responsibility for End of Life Care	
Bereaved relatives/friends views obtained within last two financial years	
In house training for medical staff covering communication during the last hours or days of life	
Formal in-house training specifically including communication skills for care in the last hours/days of life for:	
Medical Staff	
Registered Nursing Staff	
Non-registered Nursing Staff	
Allied Health Professionals	
Access to Specialist Palliative Care from 9am – 5pm, Monday – Sunday	
One or more End of Life Care Facilitators Employed	

Recognition of Dying

	Medway (n=72)	National (n=7707)
It was recognised that the patient would probably die in the coming hours or days (excluding unexpected deaths)	94%	93%
A senior clinician was involved in the recognition of dying	88%	76%
The recognition that the patient was thought to be dying was regularly reviewed	81%	91%

Communication

	Medway (n=80)	National (n=9302)
The patient's imminent death was discussed with them	26%	23%
If no discussion took place, a reason was documented	85%	81%
The patient's imminent death was discussed with those important to them	96%	95%
If no discussion took place, a reason was documented	67%	51%

Involving the dying person and their loved ones in decision making

	Medway (n=80)	National (n=9302)
A DNACPR order was in place at time of death	96%	94%
A senior doctor discussed CPR with the patient	33%	36%
If no discussion took place, a reason was documented	80%	76%
The CPR decision was discussed with those important to the patient during the last episode of care	81% (n=79)	82% (n=8925)
Patients were able to express their concerns	86% (n=44)	67% (n=4411)
Patients were able to have questions about their concerns answered	92%	97%
Those important to the patient had the opportunity to discuss the patient's condition with a senior healthcare professional	75% (n=79)	83% (n=8934)

Medical interventions

	Medway (n=80)	National (n=9302)
An implanted defibrillator was deactivated in the last 24 hours of life	33%	11%
The patient had assisted ventilation at the time of death	14%	11%
The patient had dialysis at the time of death	1.7%	1%

Needs of families and others

	Medway (n=80)	National (n=9302)
The patient's needs were discussed with their loved ones	46% (n=74)	41% (n=8656)
The needs of those important to the patient were asked about	61% (n=79)	55% (n=9080)
Those important to the patient were notified of the patient's imminent death	65%	84%
Those important to the patient were present at the time of death	84% (n=49)	66% (n=6797)
Support was offered to those important to the patient immediately after death	35%	65% (n=9077)

Individual plan of care

	Medway (n=80)	National (n=9302)
Documented evidence of a holistic care assessment of patient's needs for an individual plan of care in last 24 hours of life	60%	66%
The patient was reviewed by a member of the specialist palliative care team	51%	31%
A specialist palliative care review occurred in the last 24 hours of life	36%	23%

Symptom control in the last 24 hours of life

Noisy breathing/death rattle (National n=3704; Medway n=42): Medway 83%, National 62%
Pain (National n=4891; Medway n=46): Medway 89%, National 79%
Nausea/vomiting (National n=2659; Medway n=12): Medway 92%, National 55%
Dyspnoea/breathing difficulty (National n=4656; Medway n=36): Medway 78%, National 68%
Agitation/delirium (Natioanl n=4836; Medway n=45): Medway 78%, National 72%
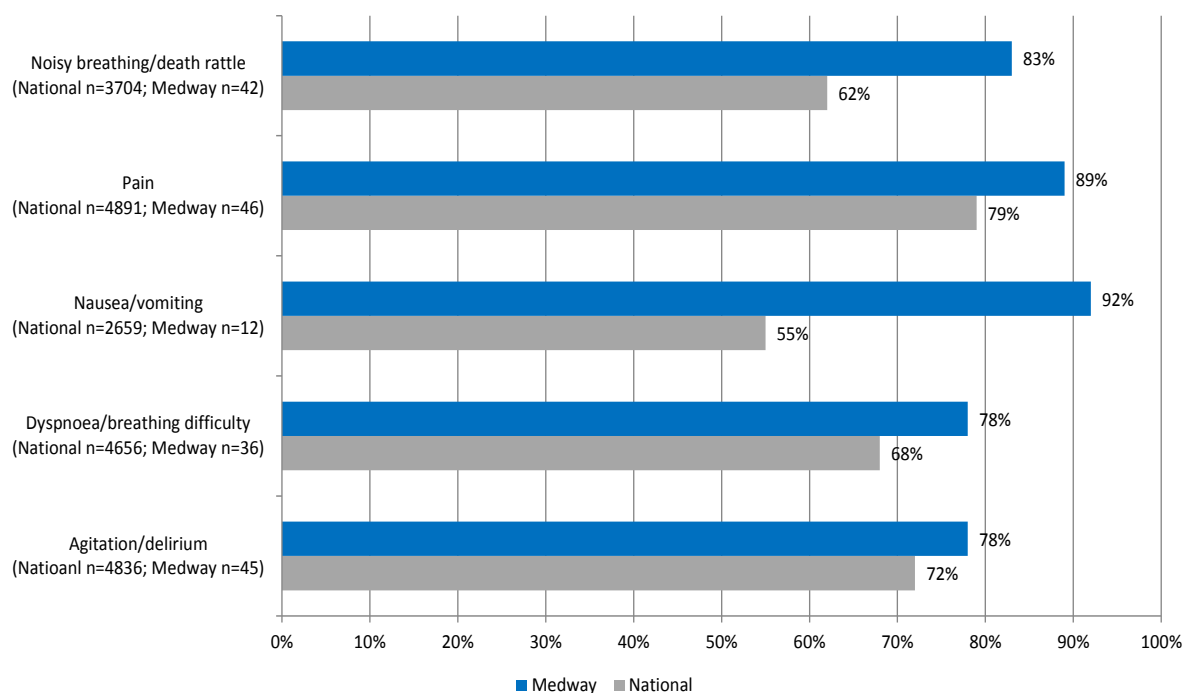
■ Medway ■ National

Drinking and assisted hydration

	Medway (n=80)	National (n=9302)
The patient's ability to drink was assessed in the last 24 hours of life	49%	67%
The patient was drinking in the last 24 hours of life	21%	39%
The patient was supported to drink in the last 24 hours of life	20%	45%
Drinking and the need for assisted hydration was discussed with the patient	13%	18%
If no discussion took place, a reason was documented	66%	79%
Drinking and the need for assisted hydration was discussed with those important to the patient	38%	39%
If no discussion took place, a reason was documented	8%	15%

Eating and assisted nutrition

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	Medway (n=80)	National (n=9302)
The patient's ability to eat was assessed in the last 24 hours of life	40%	61%
The patient was eating in the last 24 hours of life	9%	26%
The patient was supported to eat in the last 24 hours of life	8%	36%
The patient's need for clinically assisted nutrition was assessed in the final admission	40%	34%

- The Trust will use the audit results to continue to develop the End of Life Care Service and bring it into line with national performance standards.
- Actions had already been incorporated into the Trust EOLC Improvement Plan. Specific action related to the audit results include:
  - The Comfort Plan for the Dying Patient will be relaunched – currently this is poorly completed. The new plan will be amended in line with the findings of the audit.
  - The Preferred Priorities for Care (PPC) is being commenced – this was developed in the community and has been adapted for hospital use. A generic email will enable these to be shared across primary and secondary care.
  - Education for all professionals to be rolled out including ward based teaching, highlighting key issues.
  - Communications Skills study sessions currently being developed, based on advanced communication skills and aimed at all bands of staff.
- The End of Life Care for patients at Medway Maritime Hospital has improved, but there is still much to achieve. Review and governance structures are more robust and having a designated nurse specialist provides consistency in communication and training. Partnership working with the Palliative Care Team is becoming stronger and new End of Life care networks are evolving across the region. The Trust will be participating in a Medway EOLC workshop on 5 May 2016.

Patient Experience

- The Friends and Family Test remains our real time barometer for patient comments alongside our other indicators of quality.
- The results for 'would recommend' ED significantly improved in April from 69% to 75.3%. This is most likely due to the continuing success of the ED team to deliver improvements in patient safety and experience within the department.
- The Annual Complaints report is being finalised and will be published in due course.
- **Patient information -** The quality of the Trusts information provided to patients is continually being monitored to ensure our patients receive up to date information. Departments and authors are being advised when their information is due to expire so that they can review and amend where necessary.
- In order to ensure accurate information and the importance of the regulatory framework for patient information a proactive approach is being taken. Meetings are

Best of care
Best of people

now being attended by the patient information coordinator to highlight this. Directorates will have to look at their expired leaflets and update accordingly. Language and explanations need to be in plain English.

- The focus in the previous quarter has been to update the Pre Admissions booklet to ensure all the information is relevant to patients who are coming in for treatment or for an operation. Also our maternity discharge booklet has been updated.
- The contract for our bedside folders is under review.
- The patient information racks on the wards and outpatient waiting areas are regularly reviewed to ensure our patients are receiving the most up to date information.

Assurance

Perfect Ward

- In April 21 inspections were undertaken across 21 areas.
- The average score across the organisation was 83%.
- Three inspections undertaken on a weekend.
- Most inspections were carried out between the hours of 9am and 7pm.
  The top 5 scores were
  o Do they feel confident escalating concerns of any nature? **100%**
  o 2Are all staff bare below the elbow? **100%**
  o 3Alcohol gel readily available? **100%**
  o 4All staff wear name badge & ID pass? **95%**
  o 5All fire extinguishers correctly mounted? **95%**
  The lowest 5 scores were
  o All patients have an up-to-date EDD? **38%**
  o (At mealtimes) is the red tray system in place? **29%**
  o You're challenged if not bare below the elbow? **29%**
  o Has the ward sister / charge nurse ever been counted in the clinical numbers this week? **10%**
  o Can staff describe a change in practice or learning from a complaint or incident? **0%**
- Ward specific actions are agreed with the Senior Sisters and monitored by the Matrons.
- We continue to work with the developers of the Perfect Ward App to refine the reports. It is hoped that from June we will be able to present results in graph form.

Super 7 Audits

- Most wards completed a web based Super 7 audit in April.
- Work is ongoing to refine the reporting so it is not possible to provide a graphic of results. The two screen shots below show how the results are currently presented. The first screen shot shows the overall score for each of the seven elements of the audit. The second screen shot shows the detailed results for one of the seven elements.

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MUST				
Assessment	Score	Yes	No	N/A
Does the patient have the appropriate care plan in place (MUST of 1 or above or general concern for the patients nutritional needs)	99	57%	0%	42%
Has a must been completed within 48 hours of admission?	100	100%	0%	0%
Has a referral to the dietitian been completed (MUST of 2 or above)	99	42%	0%	57%
Has the food diary been completed fully?	57	0%	42%	57%
Has the must score and weight been recorded correctly as per policy and has it been calculated correctly?	100	100%	0%	0%
Is the patient on the appropriate intervention eg. reg jug red tray red mat food diary based on the assessment of the patient?	99	28%	0%	71%

- Once we have completed a full quarter of audits we will be able to produce graphs showing trends over time.

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 –April 2016

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

Report to the Board of Directors

Board Date: May 2016

Title of Report	Workforce Update
Reporting Officer	Rebecca Bradd
Lead Director	Rebecca Bradd, Acting Director of Workforce
Responsible Sub-Committee	Executive
Executive Summary	The report highlights progress made within the Workforce remit over the last month in relation to: • Staffing • Staff engagement and culture change • Workforce strategy development
Risk and Assurance	Safe staffing levels is a significant risk and workforce planning and recruitment is being undertaken to minimise this risk. The Trust recognises current recruitment and retention strategies do not adequately address the urgent need for improvement in staffing levels and are 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. Improvements in leadership capability and staff engagement should improve retention and organisational performance.
Legal Implications/Regulatory Requirements	Staffing levels, staff engagement, leadership and culture have been identified as areas of urgent improvement by the Trust and our regulators.
Recovery Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery of the Recovery plan.
Quality Impact Assessment	n/a
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Information
Recommendation	n/a

Workforce Update: May 2016

Summary

A detailed summary was provided in last month's Workforce update in relation to the Trust's position and actions in terms of staffing, staff engagement and culture change and workforce strategy development. In this month's update progress is provided in relation to the following areas:

- Staffing
- Staff engagement and culture change
- Workforce strategy development

WORKFORCE: CURRENT STATUS

• STAFFING

As detailed in April's workforce update there are a number of actions being undertaken to address the staffing gap with a particular focus on:

- recruitment to business critical posts including nursing, medical, pharmacy and physiotherapists
- accelerating the recruitment process
- temporary staffing
- future workforce
- retention

This month's report focuses on updates in month.

Vacancy rates

The workforce budgets have been reviewed for 2016/17 and reset at outturn as part of business planning and have resulted in some changes to the number of vacancies and resulting vacancy rates. The vacancy rates can be seen in the table below.

Current position (April 2016)	Budget (wte)	M1 Actual (wte)	Variance (wte)	Vacancy rate (%)
Admin & Clerical	923.33	795.05	-128.28	**14%**
Consultants	184.61	153.21	-31.4	**17%**
Healthcare Assts, etc	553.27	471.09	-82.18	**15%**
Junior Medical	372.43	319.22	-53.21	**14%**
Nurses & Midwives	1474.81	1113.05	-361.76	**25%**
Other Non Clinical	494.85	442.66	-52.19	**11%**
Scientific, Therapeutic & Technical	514.13	463.53	-50.6	**10%**
Total	**4533.43**	**3770.81**	**-762.62**	**16.8%**

Business critical posts

4.87 wte Nurses and Midwives and an additional 6 wte newly qualified nurses who are waiting for professional registration to be attained commenced employment in the Trust against 7.15 wte Registered Nurses and Midwives who left in April. There were 3.8 WTE clinical support workers who commenced employment against 7.77 WTE who left the organisation in April 2016.

4 substantive Consultants were appointed this month; 2 Consultant Haematologists and 2 Consultant Radiologists.

In addition, two Pharmacy vacancies were appointed in April.

Accelerated recruitment

The team is 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.

Benchmarking has been undertaken against other local Trusts and in comparison to the Pan-London group. Our average time to recruit is 56.8 days, which is in the mid-range compared to other Trusts. However, by optimising the use of TRAC, the electronic recruitment package, some London Trusts have reduced their time to recruit to 30 days. We are investigating how we can use TRAC more effectively to reduce our target time initially to recruit to 40 days. A plan is in place to achieve this improvement.

Temporary Staffing

April is the first full month of reporting since the Temporary Staffing Service went live. The figures for nursing are as follows –

Date	Skill Set	Shifts Filled	Shifts Unfilled	Total Requests
28.03.16 - 03.04.16	RN	206 (78%)	57 (22%)	263
	CSW	340 (72%)	132 (28%)	472
04.04.16 - 10.04.16	RN	207 (87%)	31 (13%)	238
	CSW	323 (93%)	25 (7%)	348
11.04.16 - 17.04.16	RN	218 (87%)	34 (13%)	252
	CSW	396 (93%)	31 (7%)	427
18.04.16 - 24.04.16	RN	190 (89%)	23 (11%)	213
	CSW	390 (93%)	30 (7%)	420
25.04.16 - 01.05.16	RN	222 (93%)	16 (7%)	238
	CSW	377 (91%)	37 (9%)	415

Retention

In April turnover has remained at a similar level than last month (9.66% compared to 9.67% last month). Turnover for staff under one year's service remains high at 17%; however this is also on a downward trajectory with 79.78 wte leavers (planned and

unplanned) within the last 6 months compared to 243.72 wte leavers (planned and unplanned) overall in the last year.

A First and Lasting Impressions event is being held on 27th May (an event for our new starters within few three months and one year) to support the assessment of on boarding. 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.

Recruitment and retention plan

The Trust has been looking at other NHS and best practice organisations that have been successful in recruitment and retention to ensure that all appropriate activity is being undertaken 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

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.

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 held on 10th May 2016 focused on Respecting Others. The first two cohorts of the Management Development programme and a programme of Bitesize sessions commence in June.

Bullying

The Every Person Counts (Respecting others) anti bullying campaign continues. Awareness training for staff have commenced this month and briefing materials for managers has been distributed following the launch of the new behaviours as part of the Trust's new Vision and Values.

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 for the Trust for Quarter 4 were:

	Response Rate (%)	How likely are you to recommend this organisation to friends and family if they needed care or treatment?	How likely are you to recommend this organisation to friends and family as a place to work?
Medway NHS Foundation Trust	19%	66%	52%

- **WORKFORCE STRATEGY DEVELOPMENT**

Workforce is a critical enabler for the delivery of the Trust's objectives, its recovery and an improvement in organisational performance. Priority workforce programmes for the next six months have been agreed as part of the Recovery Plan by the Executive including:
- Workforce modelling
- Staffing recruitment and retention plan
- Temporary staffing plan
- Staff engagement and culture change
- Workforce informatics

These programmes will form the foundation of the Workforce and Organisational development Strategy to be presented to Board in June.

Integrated Quality and Performance Report

May 2016

Integrated Quality and Performance Report

May 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

Executive Summary

SAFE

Safety Incidents

Total reported patient safety incidents continue to decline with the previous 7 months data all below the baseline (average) of 352. This indicates a statistically significant change in the system. This could indicate either a reduction in actual incidents or a decrease in reporting.

Total Patient Safety Incidents (attributable)

216

Legend: Series1, Mean, LCL, UCL
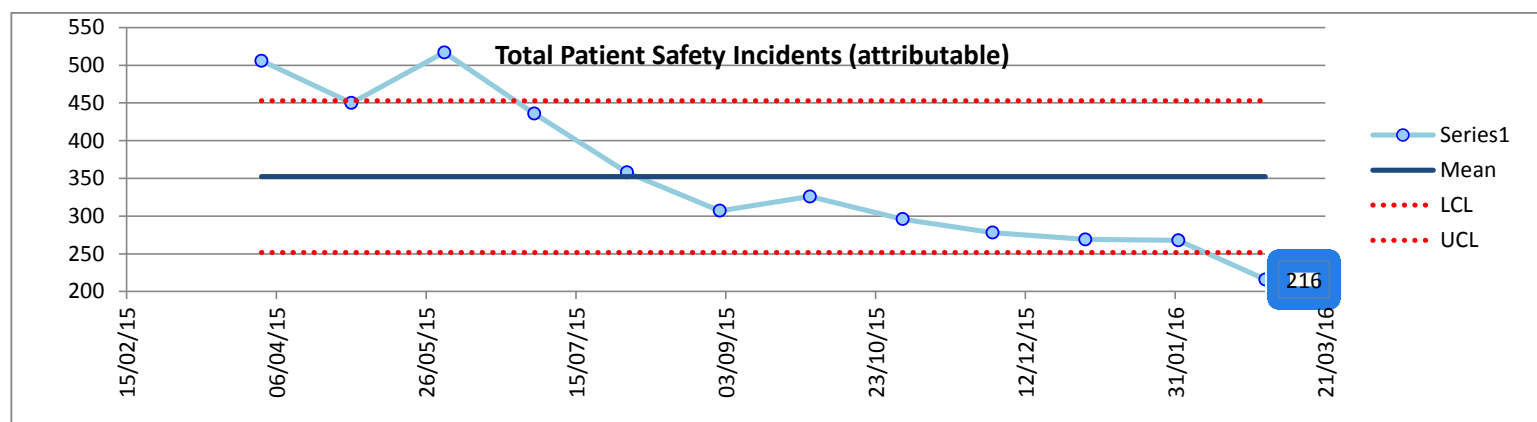
Mortality

The Trust continues to improve its position within the published mortality indicators, the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). The HSMR for the latest reportable period (February 2015 – January 2016) is 102.76 which is within the expected range (LCL 97.07, UCL 108.70) as seen in the funnel plot graph to the right.

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

dr foster.
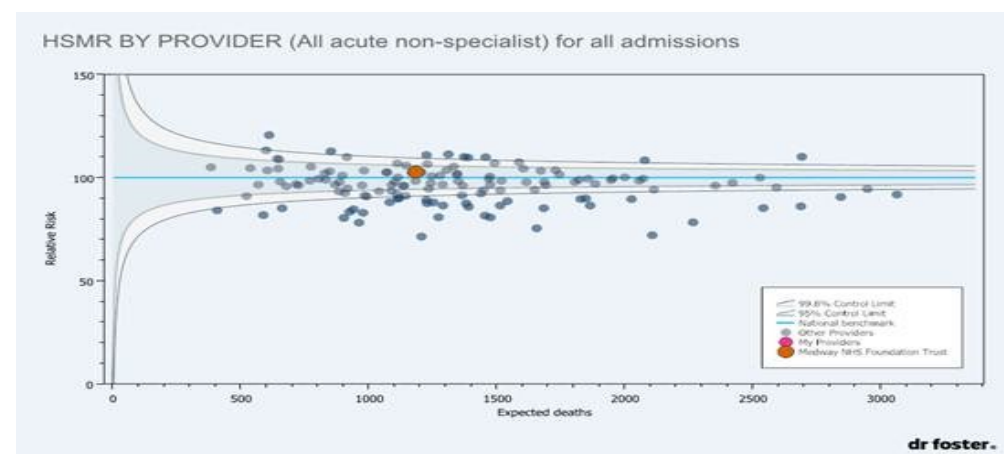
Executive Summary

EFFECTIVE

CQUIN
The CQUINs in the effective dashboard are still measuring the 2015/16 schemes.
During April the Trust has received all National, Local, Specialised and Public Health CQUIN Schemes. These are currently being reviewed and discussed both internally and externally before being submitted for approval by senior executives.

Emergency readmissions
Emergency readmissions within 7 days is achieving target for the second time this year. The new medical model was implemented in March 2016 alongside improved ward rounds during the night to identify patients for discharge the next day, this will have had a positive impact on patients being discharged correctly and therefore the readmission rate.

CARING

Mixed Sex Accommodation
Dramatic reduction in Mixed Sex Accommodation (MSA) breaches from 132 breaches in February to 0 breaches in April. This is due to the introduction of the Medical Model and the change in the way that the AMU (Lister Ward) is used with closure at night.

Mixed Sex Accommodation breaches

Legend:
- Series1
- Mean
- LCL
- UCL
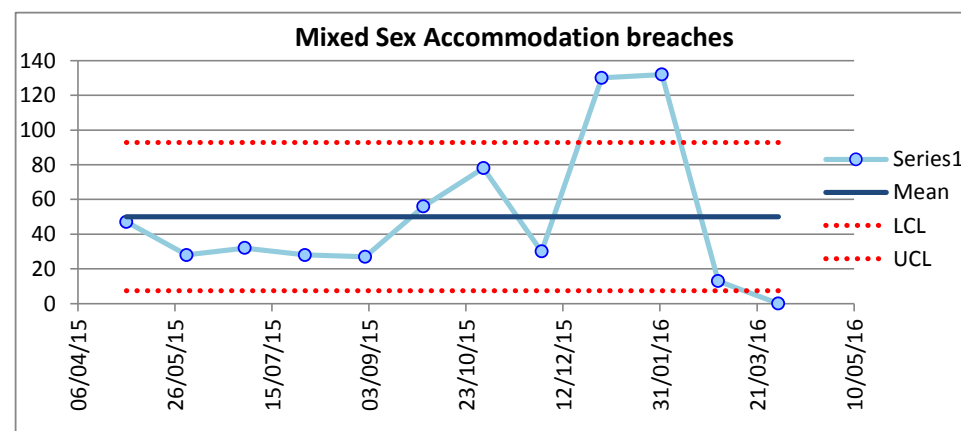
Executive Summary

RESPONSIVE

A&E 4 Hour Target

The % of patients waiting less than 4 hours in A&E has been above the current baseline (average) for the past 5 weeks which is a good indication of improvement. There is still some way to go to meet the national target of 95%.

A new validation process has identified that a significant number of breaches are caused by patients waiting for mental health placements, patients waiting for inpatient beds and internal delays for intervention within ED. A meeting has been setup with KPMT to address the Length of Stay (LOS) of patients with mental health needs as these can exceed 3 to 4 days on a regular basis.

Percentage of patients waiting less than 4 hour access

Actual — Mean ····· LCL ····· UCL

5 points above the mean - 2 more points will result in a special cause RUN = Statistically significant Improvement

Cancer 2 week wait

The Trust maintained compliance with the 2 week wait standard across most tumour sites. Breast breaches were predominantly as a result of capacity issues and a short notice clinic move that booked patients declined. The remainder of breaches were as a result of patient choice.

Cancer – 2 week wait

94%

Series1
Mean
····· LCL
····· UCL
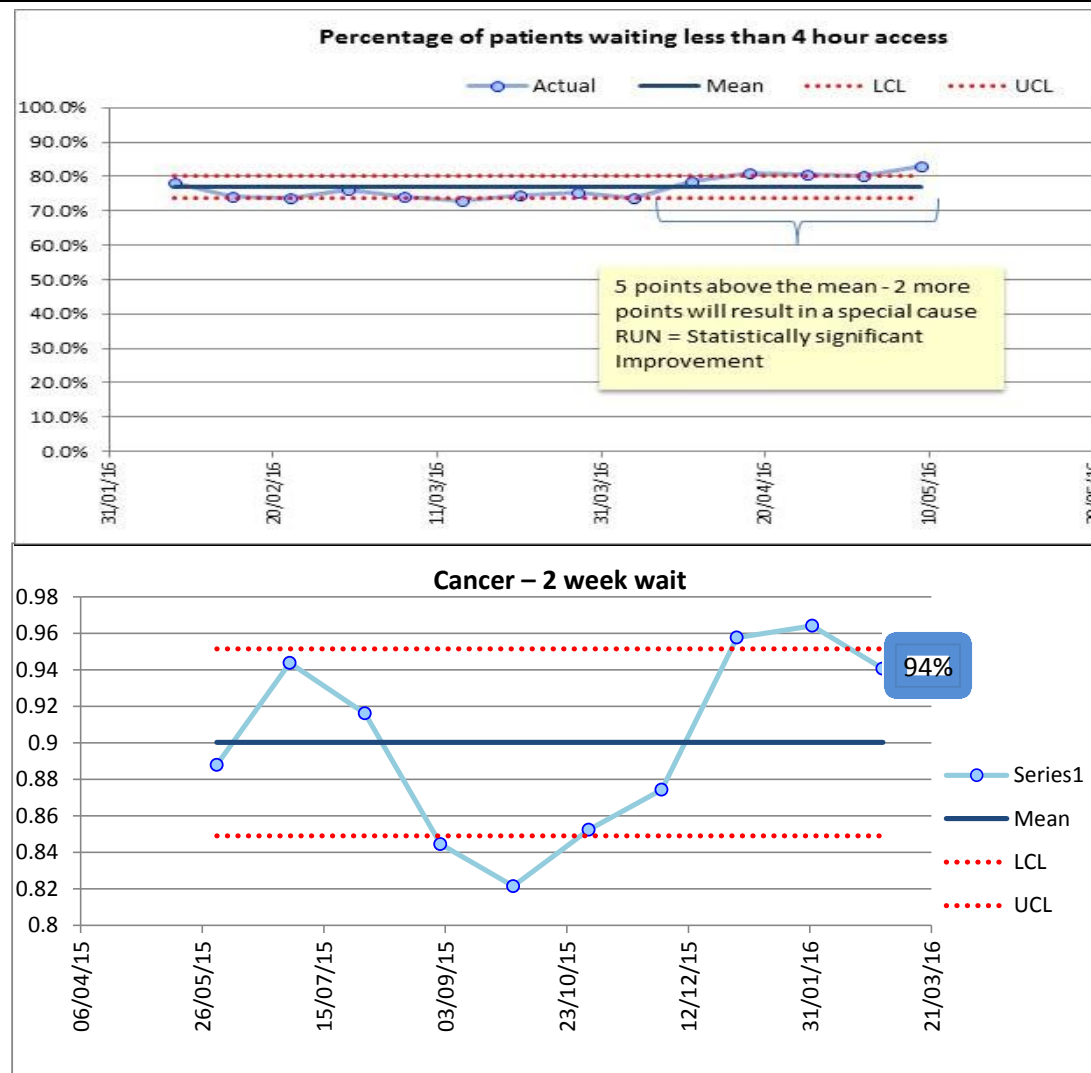
WELL LED

Staffing

Turnover remains below 10% and the trend of more starters than leavers continues. Temporary staff are being provided by the new in-house system which is allowing more visibility of demand and issues relating to availability of workers to cover shifts.

Net Difference: Starters and Leavers

ENABLERS

Data Quality

The VTE and Cancer 62 day target data quality audit has been completed, the results of which will be fed back through the DQ groups and recommendations carried out in due course.

The lilac outcome form has been agreed in the data quality user group and will have been approved by the data quality management group by the time this report is being seen. This vastly improves the lilac form to include outcomes which were missing or unclear. This will lead to better data quality in the inputting of the data on to PAS.

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Feb-16	Mar-16	Apr-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*	268	216			352				
	1.1.3	Total serious incidents	G	5		*5*	7	5	3		5.1				
	1.1.21	Number of SI's breaching	R	3		*0*	18	20	21		16.4				
	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*	0	4			4.3				✓
	1.1.6	Incidents resulting in severe harm (per 1000 bed days) (1 month in arrears)				*0.113*	0.06	0.06			0.15				✓
	1.1.7	Incidents resulting in moderate harm (per 1000 bed days) (1 month in arrears)				*1.871*	1.0	1.0			1.5				✓
	1.1.8	Incidents resulting in low harm (per 1000 bed days) (1 month in arrears)				*7.769*	13.9	11.2			11.0				✓
	1.1.9	Incidents resulting in no harm (per 1000 bed days) (1 month in arrears)				*18.2*	20.7	20.8			21.4				✓
	1.1.10	Incidents with moderate or severe harm with duty of candour response **(will show percentage from Dec-15)**				*100%*	18%	28%			0.7				✓
	1.1.11	Safeguarding alerts reported (Children and Midwifery)	R			*0*	6	26	21		8.6				
	1.1.12	Safeguarding alerts reported (Adults)				*0*	6	#N/A			11.3				
	1.1.13	Deprivation of Liberty - Applications Made and Accepted				*N/A*	1	#N/A			5.5				
	1.1.14	Pressure ulcers (grade 2) attributable to trust	G	4	Jun-15	*10*	8	6	8		9.3				✓
	1.1.15	Pressure ulcers (grade 3&4)	G	8		*0*	1	0	0		0.6				✓
	1.1.16a	Administration or supply of a medicine from a clinical area		0		*tbc*	0.2	0.4	#N/A		0.0				✓
	1.1.16b	Medication error during the prescription process				*tbc*	0.1	0.0	#N/A						
	1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	G			*0.2*	0.0	0.2	0.0		0.1				
	1.1.18	Falls per 1000 bed days	G	4		*6.63*	3.76	4.86	4.12		5.1				
	1.1.19	Number of falls to fracture (per 1000 bed days)	G	1		*0.2*	0.0	0.2	0.0		0.1				
	1.1.20	Transfer of Care Concerns (TOCC) relating to pressure ulcers (reported 1 month in arrears)		2		*3*	3	3			2.4				
1.2 NHS Patient safety - safety thermometer	1.2.1	Proportion of Harm Free Care - point prevalence in month	G	4		*95%*	91%	94%	95%		91%				
	1.2.2	New VTEs - point prevalence in month	R	12		*0.4%*	1.2%	0.8%	0.6%		1.1%				
	1.2.3	CAUTIs - point prevalence in month	R	8	Jun-15	*0.3%*	2.4%	0.4%	1.4%		0.8%				
	1.2.4	New harms - point prevalence in month	G	11	Jun-15	*2.2%*	2.9%	1.9%	1.9%		3.2%				
	1.2.5	New Pressure ulcers - point prevalence in month	G	11	Jun-15	*0.9%*	1.0%	0.6%	0.2%		1.6%				

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Feb-16	Mar-16	Apr-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor	Quality Account
			RAG			**Trend**							**Alignment**		
1.3 Infection control and cleanliness	1.3.1	MRSA screening of admissions	R	7	Jun-15	95%	100%	98%	94%		94%	R			✓
	1.3.2	MRSA bacteraemia (trust – attributable)	G	5	Jun-15	0	0	0	0		1	R			
	1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	G	1	Jun-15	2	1	0	0		2	R			✓
	1.3.4	Hand Hygiene compliance	G	0		95%	97%	99%	95%		98%	R			
	1.3.5	Number of MSSA cases post 48 hours	G	0	Jul-15	10	0	2	0		1	R			
	1.3.6	Number of E-coli cases post 48 hours			Jun-15	N/A	1	3	2		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	8		100		102.76			111.3				✓
	1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	R	5		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		124				
1.4 Mortality	1.4.13	Septicaemia SMR (Rolling 12 Month)	R			100		100.82							
	1.4.15	Pneumonia SMR (Rolling 12 Month)	G			100		99.61							
	1.4.18	Congestive Cardiac Failure SMR (Rolling 12 Month)	G			100		84.52							
1.5 Safe Staffing	1.5.1	Safe Staffing – ratio of actual to planned nursing hours				TBC	94%	89%	99%		96%				

1.1 Safe - Incidents	Trends

There were no never events reports and 3 serious incidents were reported on steis in April- 1 fall to fracture, and 2 relating to a delay in treatment.

There was a total of 34 serious incidents open of which 21 were breaching and 13 were in date.

Breach breakdown:
5 reports had been declined by the CCG and have been resubmitted for the May closure
9 reports were with the Directorates for sign off
1 report was with the executive team for sign off
6 breaching reports were still under investigation.

Actions to mitigate the breach rates:
SI process is to change in May , Directorates will be assigning investigators and manging the process to ensure compliance with the SI timeframe with support from PST.
Trajectory is to be set to ensure all breached investigations are completed and the Trust has no breaching investigations by Quarter 3.
A baseline assessment of investigators across the trust has been undertaken and a training needs analysis is to be completed in May and RCA training is being delivered throughout quarter 2.
A dashboard tracking the SI process is being shared with all directorates on a weekly basis.
Monthly meetings with the CCG have commenced to support with resolving issues to ensure timely closure of serious incidents.

Serious Incidents - reported on STEIS
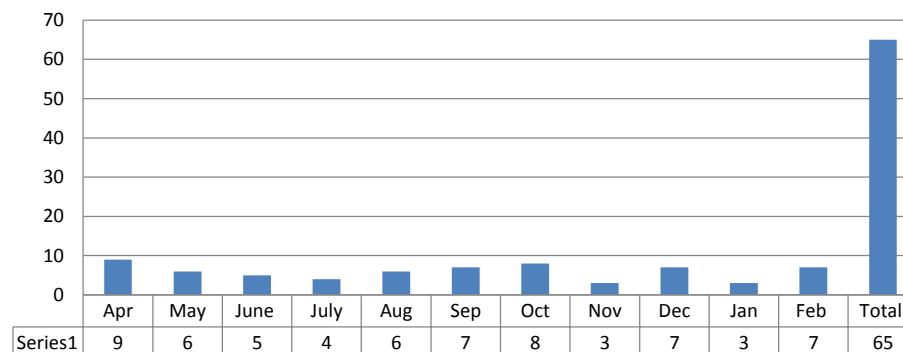
	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Total
Series1	9	6	5	4	6	7	8	3	7	3	7	65

1.4 Safe - Mortality	**Trends**
The Trust continues to improve its position within the published mortality indicators, the Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). The HSMR for the latest reportable period (February 2015 – January 2016) is 102.76 which is within the expected range (LCL 97.07, UCL 108.70) as shown in Figure 1. The SHMI for the latest reportable period (October 2014 – September 2015) is 1.15 which is an improvement, but is still outside the expected range (LCL 0.90, UCL 1.11) as shown in figure 2.	Figure 1 HSMR BY PROVIDER (All acute non-specialist) for all admissions Figure 2 SHMI BY PROVIDER (All acute non-specialist) for all admissions
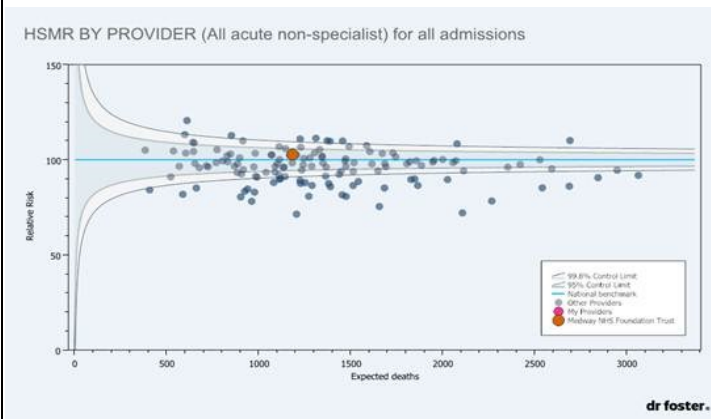
1.4 Safe - Mortality	Trends
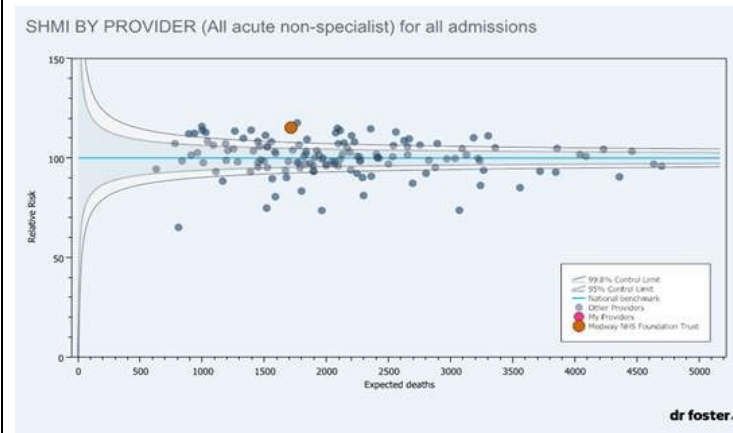
1.4 Safe - Mortality

Specialty M&M Meetings:

In the majority of cases, meetings are now taking place as planned and minutes are being taken on the agreed template. Some meetings were cancelled in March and April due to junior doctor strikes or lack of consultant Reviews.

Figure 3 shows the M&M meetings which have taken place for each specialty and whether minutes have been received.

Trends

Figure 3

	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Medicine							
ED				green	pink	orange	orange
Acute	green	green	green	green	green	pink	pink
Cardio	green	green	green	green	green	green	pink
Diabetes	pink	orange	pink	pink	green	green	pink
Elderly/Stroke	pink	orange	green	green	green	green	green
Gastro	green	orange	orange	pink	green	green	green
Haematology			green				
Respiratory	orange	green	pink	green	green	green	green
CC							
ICU/SHDU	green	green	green	green	pink	green	green
MHDU	green		green		orange		
Surgery Audit Afternoon		orange	orange	orange		pink	orange

Key	
	No meeting scheduled (e.g. less frequent than monthly)
green	Meeting took place, minutes received on template
orange	Meeting took place, minutes not received/incomplete/not on template
pink	Meeting cancelled

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Feb-16	Mar-16	Apr-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%*	97.4%	94.9%					
	2.1.5	Dementia – FAIR (Stage 2) (Reported a month in arrears)	G	0		*90%*	100.0%	96.9%					
	2.1.6	Dementia – FAIR (Stage 3) (Reported a month in arrears)	G	0		*90%*	94.1%	100.0%					
2.2. CQUINs – local	2.2.1	Non elective LOS for in spells greater than 30 days **Figures relate to Q3**				*N/A*		51.39					
	2.2.2	Braden/MUST including PU reduction		0		*82*	*Awaiting Month 10 results*						
	2.2.3	PU collaborative		0		*45%*	*Awaiting Month 10 results*						
	2.2.4	Complaints **Figures relate to Q4**				*65%*	8.0%						
	2.2.5	VTE collaborative		0		*100%*	*Awaiting Month 10 results*						
	2.2.6	Local FFT (ED positive/negative score improvement)		12		*85%*	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)											
	2.3.2	Neo-Natal term admissions				*Targets and processes agreed in August 2015, compliance will be reported once data is available.*							
	2.3.3	Pharmacy – SACT											
	2.3.4	Pharmacy – Oncotype DX											
2.4. Nice Compliance	2.4.1	NICE Technology Appraisals implemented					3	5	4				
	2.4.4	NICE Quality Standards escalated					1	10	18				
2.5. Clinical best practice	2.5.3	Emergency readmissions within 7 days	G	11		*4.6%*	5.1%	6.1%	4.5%				
	2.5.4	Emergency readmissions within 28 days	R	12		*4.9%*	16.2%	11.6%	10.1%				
	2.5.5	Elective surgical readmissions within 28 days	R	12		*0%*	5.5%	3.3%	0.7%				
	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	Feb-16	Mar-16	Apr-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)					77.0%	74.8%					

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

3. Effective

The CQUINs in the effective dashboard are still reflective of the 2015/16 schemes. This is due to the 2016/17 schemes being agreed through the contract process currently taking place.

During April the Trust has received all National, Local, Specialised and Public Health CQUIN Schemes. These are currently being reviewed and discussed both internally and externally before being submitted for approval by senior executives. The schemes are as follows and a monthly report will be submitted regarding performance at the end of Quarter 1 and monthly thereafter. The current challenge that the Trust faces is to ensure that the schemes are realistic and achievable and to ensure that a baseline is agreed with each of the agencies during Q1.

Ref.	Ref.	MFT value	Value
NHS Staff and Wellbeing – Staff Survey	1a	0.25%	£450,000.00
NHS Staff and Wellbeing – Healthy Food	1b	0.25%	£450,000.00
NHS Staff and Wellbeing – Flu Vaccinations	1c	0.25%	£450,000.00
Identification and Early Treatment of Sepsis – Treatment in ED	2a	0.13%	£225,000.00
Identification and Early Treatment of Sepsis – Treatment in acute inpatient settings	2b	0.13%	£225,000.00
Antimicrobial Resistance – Reduction in Antibiotic Consumption	5a	0.20%	£360,000.00
Antimicrobial Resistance – Empiric Review of Antibiotic Consumption	5b	0.05%	£90,000.00
TOTAL		1.25%	£2,250,000.00
LOCAL CQUIN VALUE		1.25%	

Ref.	Ref.	MFT value	Value
Reduction in Community Acquired Pressure Ulcers	8	0.14%	£250,000.00
Formulary adherence – Percentage reduction in the number of hospital FP10 prescriptions issued by the Trust.	13	0.14%	£250,000.00
Discharges before midday	16	0.14%	£250,000.00
Blood Transfusion clinical Review *(Still to be confirmed but unlikely to be agreed)*	12	0.14%	£250,000.00
Medication Safety Thermometer	15	0.14%	£250,000.00
Effective review of patients on Oral Nutritional Supplements (ONS) in the hospital prior to discharge.	14	0.14%	£250,000.00
Paediatric outpatient referral management system	2	0.14%	£250,000.00
Development of electronic clinical communications to GPs, including a standard template for the Electronic Discharge Note	DG3	0.14%	£250,000.00
Paediatric asthma and wheeze pathway	3	0.14%	£250,000.00
TOTAL		1.25%	£2,250,000.00
NHS ENGLAND CQUIN VALUE		2.00%	£16,018,000.00 (Indicative)

Ref.	Ref.	MFT value	
Activation system for Patients with Long Term Conditions *(Unlikely to remain as patient cohort too small)*	GE2	0.21%	£32,836.90
Optimal Device – (ICD's)	GE4	0.13%	£21,464.12
Adult Critical Care Timely Discharge	TR1	1.66%	£266,058.98
TOTAL		2.00%	£320,360.00
NHS ENGLAND (PUBLIC HEALTH) CQUIN VALUE		2.50%	£212,957.00 (Indicative)

Ref.	Ref.	MFT value	
Increase Take Up of School Immunisations		2.50%	£5,323.93
Grand Total			£4,825,683.93

3. Effective

Clinical Audit & NICE Compliance (CANC) group

This a is re-energized Clinical Audit Leads (CAL) group which supports the new governance structure within the directorates; the group will not only focus on Clinical Audit, but the outcomes and implementation of action plans. The group will also focus on NICE guidance and compliance. The purpose of the Clinical Audit & NICE Compliance Group (CAN C) is to provide assurance to the Clinical Effectiveness & Research (CER) & Quality Improvement Group (GIG) that evidence-based practice (particularly NICE guidance) has been implemented

NICE Guidelines

The risk to the Trust for a delay in responding to the outstanding guidance is that we are unable to confirm that we are providing up to date evidence based care, we are also unable to currently provide our Commissioners with an up to date position against NICE guidance and therefore run the risk of becoming an outlier against this measure. The NICE Co-ordinator will continue to follow up responses with the identified leads and escalate when necessary.

As part of our local requirements, the Trust needs to provide internal assurance reports of evidence of actions taken against any new NICE guidance within three months of publication. In order to achieve this, the Clinical Effectiveness Department requires the support of designated clinicians and the Directorates in returning completed NICE responses within the timescale. Where a response has not yet been received this has been escalated to the Directorates / Medical Director / Quality Officer / Clinical Directors / Governance Leads and QIG and CANC, the Clinical Effectiveness Department will continue to follow up.

Currently for 2016-17 50% of the applicable TAs have been reviewed within the 90 day time frame. The remaining 50% are still within the 90 day deadline, and are being escalated to Specialty, Program, Directorate and Board level.

NICE Quality Standards

The NICE Co-ordinator 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. The current response rate for 2016-17 is 50%, but with 2 months remaining until the 90 day deadline. The historic Quality Standards continue to be escalated.

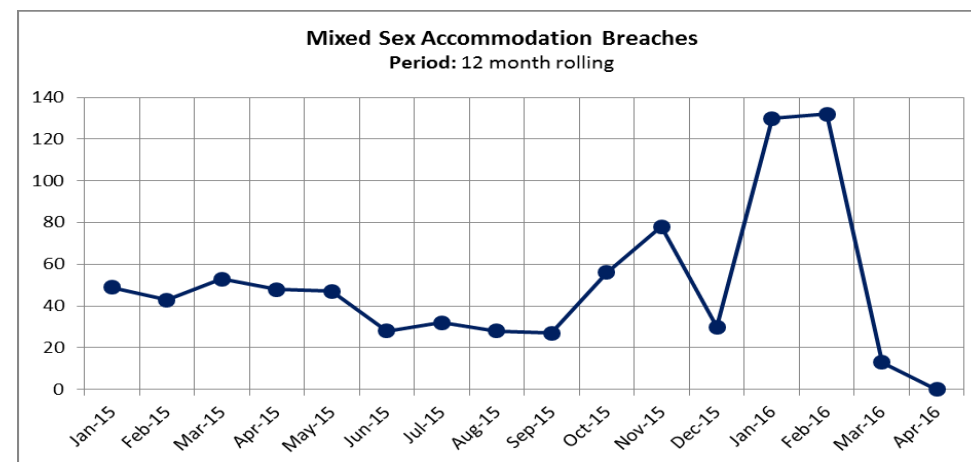**Meeting with Regional NICE Implementation Consultant**

The NICE Co-ordinator invited the regional Implementation Consultant, Jane Moore, to MFT to discuss the current processes and tools in place and given and further advice. Jane provided ideas on how to implement some of the toolkits produced by NICE. She was impressed with the work that is ongoing around the NICE guidance and the processes that have been introduced. Jane has agreed to return to the Trust in 12 months to see how things have progressed.

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Feb-16	Mar-16	Apr-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%	25.5%	24.5%		25%				
	3.1.2	Friends and Family Test % extremely likely/likely to recommend	G	2		83%	84.8%	80.4%	83.9%		84%				
	3.1.3	Mixed Sex Accommodation breaches	G	12	Jun-15	0	132	13	0		54.1				
	3.1.6	Dementia screening (% of patients over 75) (Reported 1 month in arrears)	G	1		90%	97.4%	94.9%			92%				
3.2 A&E	3.2.1	Friends and Family Test response rate	R	10	May-15	20%	15.1%	16.2%	15.6%		18%				
	3.2.2	Friends and Family Test % extremely likely/likely to recommend	G	0	May-15	65%	69.0%	69.0%	75.3%		73%				
3.3 Maternity	3.3.1	Friends and family test response rate	G	1		23%	37.2%	37.1%	54.2%		35%				
	3.3.2	Friends and family test % extremely likely/likely to recommend	G	0		79%	100.0%	98.6%	99.0%		99%				
3.4 General Patients and Carers	3.4.1	Number of Complaints	R	6	Jul-15	45	52	50	50		45				
	3.4.3	Number of complaint returners	R	2		↓	5.0	7.0	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

With the introduction of the Medical Model, and change of use of the AMU (now Lister Ward), which now closes at night the MSA situation has improved greatly as predicted. We have also reiterated the importance of ensuring patients do not have to experience mixed sex accommodation during their stay in our hospital.

Mixed Sex Accommodation Breaches
Period: 12 month rolling

Integrated Quality and Performance Report

Domain 4: Responsive

May 2016

Medway **NHS**
NHS Foundation Trust

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Feb-16	Mar-16	Apr-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor	Quality Account
4.1 Elective Treatment (reported 1 month in arrears)	4.1.1	RTT – Incomplete pathways (overall)	R	10	Jul-15	92%	68.03%	67.94%			70.00%				
	4.1.2	RTT – Treatments over 52 weeks	R	10	Jul-15	0	5	19			8				
	4.1.3	RTT – Total complete pathways (non admitted)	R	10	Jul-15	95%	71.30%	71.14%			74.61%				
	4.1.4	RTT –Total complete pathways (admitted)	R	10	Jul-15	90%	54.24%	56.30%			57.82%				
4.2 A&E	4.2.1	Trolley wait >12 hours	R	0		0	0	0	2		0				
	4.2.2	Overall Time in A&E (95th percentile overall time in A&E Dept)	R	12	Jun-15	04:00	10:00:00	11:27:00	09:33:09		08:28:24				
	4.2.3	A&E stays less than 4 hours	R	12		95%	76.08%	74.71%	77.81%		84.98%				
	4.2.7	Ambulance handover time - within 15 minutes	R	1	0	70%	36.8%	39.0%	54.5%		42.0%				
	4.2.6	Patients left without being seen	G	12		5%	4.59%	4.27%	3.62%		3.23%				
4.3 Cancer (reported 1 month in arrears)	4.3.1	Cancer – 2 week wait	G	7	Jun-15	93%	96.42%	94.06%			87%				
	4.3.2	Cancer – symptomatic breast	R	11	Jun-15	93%	92.31%	81.42%			83%				
	4.3.3	Cancer – 31 day first treatments	R	10	Jun-15	96%	93.38%	89.31%			93%				
	4.3.4	Cancer – 31 day subsequent treatments – surgical	R	9	Jun-15	94%	83.33%	82.86%			89%				
	4.3.5	Cancer – anti cancer drug treatment <31 days	G	3	Jun-15	97%	100.00%	100.00%			98%				
	4.3.7	Cancer – 62 day urgent GP referrals	R	9	Jun-15	85%	75.41%	83.02%			79%				
	4.3.8	Cancer – internal 62 day referrals	R	11	Jun-15	85%	78.95%	71.43%			71%				
	4.3.9	Cancer – 62 day screening	R	2	Jun-15	90%	96.15%	72.73%			94%				
4.4 Diagnostics (reported 1 month in arrears)	4.4.1	Diagnostic waits - under 6 weeks	R	12	Jun-15	100%	90.71%	88.85%	#N/A		93%				
	4.4.2	Diagnostic referral levels			Jun-15	N/A	6507	7399	#N/A		6894				

Theme	Ref	Indicator	Status											Alignment		
			Status	Number of m YTD at red	Escalation month	Monthly target	Feb-16	Mar-16	Apr-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*	1.9	1.9	1.86		2.3				
	4.6.2	Average elective Length of Stay (Age > 65)	R	0		*<5*	3.1	4.4	6.25		3.7				
	4.6.3	Average non-elective Length of Stay (Age 0 - 65)	G	3		*<5*	1.1	2.1	3.42		1.3				
	4.6.4	Average non-elective Length of Stay (Age > 65)	R	3		*<5*	9.1	9.4	10.79		3.1				
	4.6.5	Discharges before noon	R	7	Aug-15	*25%*	16%	15%	14%		17%				
	4.6.6	Average occupancy	R	7		*90%*	98.57%	97.15%	#N/A		97%				
4.7 Outpatient Management	4.7.1	Did Not Attend rate	G	0	0	*10%*	8.9%	8.8%	8.7%		9%				

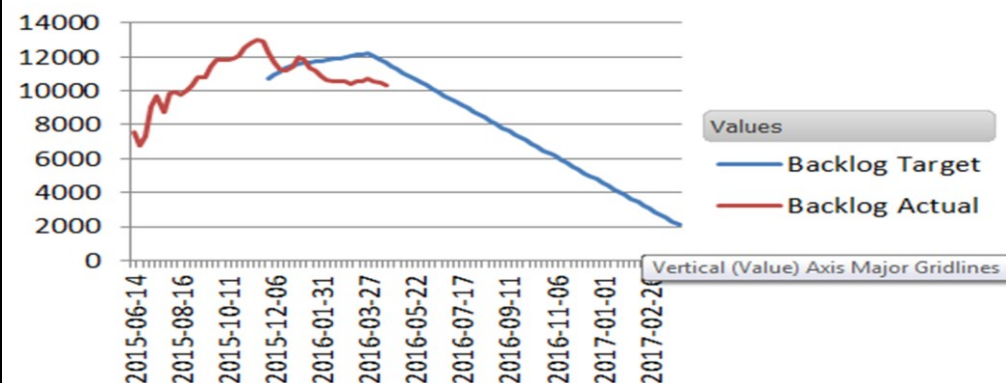| 4.1 Responsive - RTT	Table
Please note due to moving to 1 month in arrears reporting for RTT KPI's commentary and graph are still for March 2016. The non-admitted RTT backlog continues to shrink slowly, with most of the marginal headway being made in Dermatology, ENT, Colorectal Surgery and Urology. 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

The Trust maintained compliance with the 2 week wait standard across most tumour sites. Breast breaches were predominantly as a result of capacity issues and a short notice clinic move that booked patients declined. The remainder of breaches were as a result of patient choice.

The Trust failed to achieve the symptomatic breast standard and breaches were predominantly as a result of capacity issues and a short notice clinic move that booked patients declined. The remainder of breaches were as a result of patient choice and 2 prison delays.

The Trust failed to achieve the 31 day first definitive standard. Breast had 10 breaches as a result of issues of service capacity and pathway flow and cross cover of consultant leave discussions are planned on ensuring cross cover in job planning to prevent reoccurrence.

The LGI patient required joint operation with Gynae consultant and the Skin patient cancelled a minor operation. The Urology breaches are all patients referred from MTW and the MTW surgeons were unavailable to treat within breach date.

The Trust failed to meet the 31 day subsequent surgery treatment standard, Breast was due to capacity/consultant leave and the requirement for a joint operation which was difficult to schedule. The Skin breaches were due to patient choice and cancelled operations.

2 week wait standard - 93%

Tumour Site	Patients seen	Seen within 2 weeks	Breaches	Performance
Leukaemia	0	0	0	No patients
Brain	10	9	1	90.00%
Breast	199	168	31	84.42%
Children	7	6	1	85.71%
Gynaecology	86	84	2	97.67%
Haematology	5	5	0	100.00%
Head & Neck	82	81	1	98.78%
Lower GI	134	134	3	97.81%
Lung	14	14	0	100.00%
Other	0	0	0	No patients
Skin	519	486	33	93.64%
Testicular	7	7	0	100.00%
Thyroid	11	11	0	100.00%
Upper GI	107	106	1	99.07%
Urology	130	125	5	96.15%
TOTAL	**1314**	**1236**	**78**	**94.06%**

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

Breast Symptom	113	92	21	81.42%

31-DAY FIRST DEFINITIVE TREATMENT - Target: 96%

Tumour Site	Patients treated	Treated within 31 days	Breaches	Performance
Breast	32	22	10	68.75%
Gynaecology	4	4	0	100%
Haematology	19	19	0	100.00%
Head & Neck	0	0	0	No patients
Lower GI	11	10	1	90.91%
Lung	22	22	0	100.00%
Other	0	0	0	No patients
Skin	31	30	1	96.77%
Testicular	0	0	0	No patients
Thyroid	1	1	0	100.00%
Upper GI	4	4	0	100.00%
Urology	35	30	5	85.71%
TOTAL	**159**	**142**	**17**	**89.31%**

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

Tumour Site	Patients treated	Treated within 31 days	Breaches	Performance
Breast	11	9	2	81.82%
Gynaecology	0	0	0	No patients
Head & Neck	0	0	0	No patients
Lower GI	0	0	0	No patients
Skin	12	8	4	66.67%
Thyroid	0	0	0	No patients
Upper GI	1	1	0	100.00%
Urology	11	11	0	100.00%
TOTAL	**35**	**29**	**6**	**82.86%**

4.3 Responsive - Cancer Waits	Table

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

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

Tumour Site	Patients treated	Treated within 31 days	Breaches	Performance
Breast	3	3	0	100%
Haematology	12	12	0	100%
Lower GI	0	0	0	No patients
Lung	3	3	0	100%
Urology	6	6	0	100%
TOTAL	24	24	0	100.00%

The Trust failed to meet the 62 day GP referral standard across a number of the tumour sites. Pathway breaches were varied and due to complex pathways, delays due to patient choice, endoscopy capacity and late referrals from other Trusts.

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

Tumour Site	Patients treated	Treated within 62 days	Breaches	Performance
Breast	8.5	7.5	1	88.2%
Gynaecology	3.5	3	0.5	85.7%
Haematology	8	6	2	75.0%
Head & Neck	0.5	0	0.5	0.0%
Lower GI	5	3	2	60.0%
Lung	7	5.5	1.5	78.6%
Other	0.5	0	0.5	0.0%
Skin	28	27	1	96.4%
Thyroid	0	0	0	No patients
Upper GI	2.5	0.5	2	20.0%
Urology	16	13.5	2.5	84.4%
TOTAL	80	66.0	13.5	83.02%

The Trust failed to meet the 62 day screening standard. Breast was due to capacity/consultant leave issues and the Lower GI breaches were due to complex pathways with multiple diagnostic tests and biopsies.

62-DAY SCREENING SERVICES - Target: 90%

Tumour Site	Patients treated	Treated within 62 days	Breaches	Performance
Breast	19	15	4	79.0%
Gynaecology	0	0	0	No patients
Lower GI	3	1	2	33.3%
TOTAL	22	16	6	72.73%

There is no performance standard for 62 day consultant upgrades. The Gynae patient was referred to a specialist centre late in the pathway and further tests required before specialist MDT agreed treatment plan. One Lung patient was referred late and unable to be treated within breach date and the other had inconclusive biopsies and multiple MDMs and diagnostics before a decision to treat.

Tumour Site	Patients treated	Treated within 62 days	Breaches	Performance
Gynaecology	0.5	0	0.5	0.00%
Haematology	1	1	0	100.0%
Head & Neck	0	0	0	No patients
Lower GI	0	0	0	No patients
Lung	5.5	4	1.5	72.7%
Skin	0	0	0	No patients
Thyroid	0	0	0	No patients
Upper GI	0	0	0	No patients
TOTAL	7.0	5.0	2	71.43%

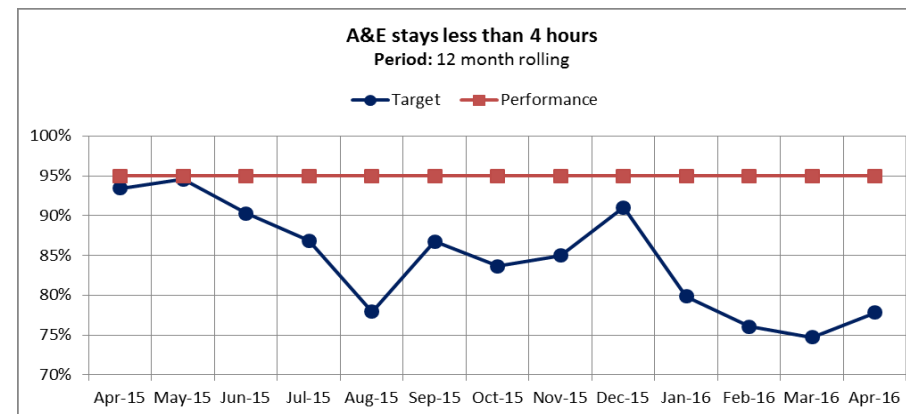| 4.2 Responsive - A&E	Trends
April saw a 12% reduction in total attenders on the previous month. The reduction in ambulance attenders was less marked at 7.5%. Emergency Admissions were 5.8% less than the previous month but 4.6% more than February. As a result of some of the activity markers reducing, 4 Hour performance has improved month on month from February and sits at 77.81% for April. 1062 patients saw their care managed in the corridor for all or part of their stay in April, this was 24% less than March and the second lowest number this year. Consistently just over 23 % of ED presentations were streamed to MEDDOC over the last 3 months.	**A&E stays less than 4 hours** **Period:** 12 month rolling ──Target ──Performance

Theme	Ref	Indicator	Status			Monthly target	Feb-16	Mar-16	Apr-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor	Quality Account
			Status	Number of m YTD at red	Escalation month										
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)	R	3		*8%*	8.8%				11%				
	5.3.2	Vacancy rate - Nursing (unfilled % of budgeted WTE)	R	3		*8%*	19.6%				24%				
	5.3.3	Vacancy rate - Others (unfilled % of budgeted WTE)	R	3		*8%*	11.2%				14%				
	5.3.4	Appraisals completed (% all staff)	R	5	Jun-15	*95%*	74.4%	75.1%	72.5%		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%*	84.0%	84.6%	84.3%		82%				
	5.3.7	Rolling annual turnover rate	R	5	Jun-15	*8%*	10.2%	9.7%	9.7%		11%				
	5.3.8	Overall Sickness rate	R	5		*3.0%*	5.4%	3.9%	3.9%		3.9%				
	5.3.9	Sickness rate – Short term	R	2		*2.0%*	2.5%	2.6%	2.6%		2.4%				
	5.3.10	Sickness rate – Long term	R	5		*1.0%*	1.4%	1.3%	1.3%		1.4%				
	5.3.11	Temporary staff % of pay bill	R	5		*15%*	19.4%				21%				
	5.3.12	Employee relations cases (excluding sickness)		5	Aug-15	*N/A*	49	61	61		47.091				
	5.3.13	Local Induction % Compliance	G			*80%*	52.12%	50.72%	49.66%		55.22%				
	5.3.14	Starters				*N/A*	74	72	69		77				
	5.3.15	Leavers				*N/A*	30	51	45.0		61.818				

5. Well-Led

Recruitment and retention remain the priority for the organisation and as such a detailed workforce report will be the focus for the 2nd planned Single Oversight Committee, which will meet at the end of May 2016. In relation to the identified business critical posts, further cohorts of overseas nurses have started, including midwives from Italy, and the next Open Day will be held on 21st May.
Turnover remains below 10% and the trend of more starters than leavers continues. Temporary staff are being provided by the new in-house system which is allowing more visibility of demand and issues relating to availability of workers to cover shifts.

Mandatory training remains constant and appraisal is decreasing in compliance rates. Appraisals are being held back to be reported unless all statutory and mandatory training has been completed and housekeeping is a particular hotspot for this.

The new vision and values launch has actions to support implementation throughout recruitment, policies and training, including clinical leadership, management development and 'bite-size' learning opportunities.

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Feb-16	Mar-16	Apr-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%*	99.2%	98.8%			98.4%			✓	✓	✓
	7.2.2	APC – Primary diagnosis (1 month in arrears)	G	0		*96%*	98.8%	99.8%			99.3%			✓	✓	✓
	7.2.3	APC – HRG4 (1 month in arrears)	G	0		*96%*	98.7%	99.8%			99.3%			✓	✓	✓
	7.2.4	OP – NHS number completeness (1 month in arrears)	G	0		*99%*	99.4%	99.5%			99.5%			✓	✓	✓
	7.2.5	OP – Primary procedure (1 month in arrears)	G	0		*99%*	99.5%	100.0%			100.0%			✓	✓	✓
	7.2.6	OP – HRG 4 (1 month in arrears)	G	0		*98%*	97.5%	100.0%			91.5%			✓	✓	✓
	7.2.7	A&E – NHS number completeness (1 month in arrears)	R	7	Jul-15	*95%*	95.6%	93.6%			92.5%			✓	✓	✓
	7.2.8	A&E – Attendance disposal (1 month in arrears)	R	7	Jul-15	*99%*	97.8%	96.5%			96.7%			✓	✓	✓
	7.2.9	A&E – HRG4 (1 month in arrears)	R	0		*97%*	96.6%	100.0%			87.6%			✓	✓	✓
7.3 Data quality improvement	7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	R	3		*0*	469	482			469.9		✓	✓		✓
	7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	R	3		*0*	0.0%	2.0%			1.1%		✓	✓		✓
	7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	R	3		*0*	737	694			842.8		✓	✓		✓
	7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	R	3		*0*	2.30%	2.10%			2.7%		✓	✓		✓
	7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	R	3		*0*	1309	1051			1577.0		✓	✓		✓
	7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	R	1		*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%		0.0%		✓	✓		✓
	7.3.13a	A&E No. missing breach reason on breached attendances	R	2		*0*	494	553	488		292.6		✓	✓		✓
	7.3.13b	A&E % missing breach reason on breached attendances	R	3		*0*	76.9%	78.4%	74.9%		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	1		5.8		✓	✓		✓
	7.3.18	Cancer 2ww missing referral received date	G	0		*0*	0	0	0		0.0		✓	✓		✓
	7.3.19	Cancer 2ww missing urgent referral type	R	1		*0*	0	0	1		2.1		✓	✓		✓
	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*	16	28	6		12.3		✓	✓		✓
	7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex	R	2		*0*	3.60%	2.97%	0.59%		4%		✓	✓		✓
	7.3.23	Cancer 31 day missing NHS number	G	0		*0*	0	0	0		0.0		✓	✓		✓
	7.3.24	Cancer 31 day invalid NHS number	G	1		*0*	1	0	0		0.3		✓	✓		✓
	7.3.25	Cancer 31 day missing primary diagnosis	R	3		*0*	12	10	7		7.0		✓	✓		✓

Theme	Ref	Indicator	Status	Number of m YTD at red	Escalation month	Monthly target	Feb-16	Mar-16	Apr-16	12m Trend	YTD avg	Data Quality	18m plan	Monitor		Quality Account
	7.3.26	Cancer 31 day missing tumour laterality	R	3		0	10	9	7		6.7		✓	✓		✓
	7.3.27	Cancer 31 day missing decision to treat date	G	1		0	1	0	0		0.2		✓	✓		✓
	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	12	7	6		5.1		✓	✓		✓
	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	1	0	0		0.3		✓	✓		✓
	7.3.32	Cancer 62 day missing primary diagnosis	R	3		0	4	6	4		4.6		✓	✓		✓
	7.3.33	Cancer 62 day missing tumour laterality	R	3		0	4	4	4		4.3		✓	✓		✓
	7.3.34	Cancer 62 day missing decision to treat date	G	1		0	1	0	0		0.2		✓	✓		✓
	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	14	4	7		5.6		✓	✓		✓
	7.3.37	Cancer 62 day missing consultant upgrade	R	3		0	45	57	44		45.4		✓	✓		✓

Enablers
Estates 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 improve 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 VTE and Cancer 62 day target data quality audit has been completed, the results of which will be fed back through the DQ groups and recommendations carried out in due course. The lilac outcome form has been agreed in the data quality user group and will have been approved by the data quality management group by the time this report is being seen. This vastly improves the lilac form to include outcomes which were missing or unclear. This will lead to better data quality in the inputting of the data on to PAS. This feeds in to the work that is happening in Gynaecology where the pathway co-coordinators are out coming on to PAS, which will see the outcomes of clinics for Gynaecology be done in a much improved time. The monitoring of this is happening currently, results from this will be shown in later board papers. The Data Quality Improvement Plan (DQIP) within the contract with Commissioners (CCG's and NHS England) is still being agreed. 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 reports continue to go out to the services on a daily basis and work is on-going to prioritise 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. Another project being by the Head of Clinical Coding (HoCC) and going through the data quality groups is looking at the procedure forms used by clinics to code the procedures taking place. The HoCC is reviewing each of the forms and seeing how they can be improved to capture the relevant procedures that take place in each specialty. This work is being carried out in conjunction with service managers, general managers and clinicians.

Apr-16 — Performance Review Scorecard - Executive Directorate Summary

Ref	Indicator	Units	Target	R/G	All areas — Trust	Acute & Continuing Care — Current Reporting Period	Previous Reporting Period	Trend	Co-ordinated Surgical — Current Reporting Period	Previous Reporting Period	Trend	Womens and Children — Current Reporting Period	Previous Reporting Period	Trend
Safe														
1.1.3	Total Serious Incidents	Number	5	Green	3	2	4		0	1		1	0	
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%	Red	94.95%	95.01%	94.98%		93.90%	97.00%		100.00%	100.00%	
1.2.3	Pressure ulcers (grade 3&4)	Number	0	Green	0	0	0		0	0		0	0	
1.2.5	Patient falls with moderate or severe harm	Cases	0		0	0	2		0	1		0	0	
1.3.1	MSRA screening of admissions	Monthly %	95%	Red	94%	97%	98%		93.57%	97.17%		90.00%	100.00%	
1.3.3	C-Diff acquisitions (Trust-attributable)	Number	0		0	0	0		0	0		0	0	
1.4.1	Hospital Standardised Mortality Ratio (HSMR) - Weekend **	Number	100	Red	104.4	101.87	117.28		109.17	101.21		215.13	216.32	
1.4.4	Deaths in Hospital	Number	N/A		116	93	121		23	20		0	1	
1.5.1	Safe staffing – ratio of actual to planned nursing hours	Ratio	0		0									
Effective														
2.2.1	Non elective Length of Stay	Cum ALOS	N/A		4.24	5.97	6.98		5.06	4.55		1.31	1.27	
2.2.4	Complaints	Number	N/A		45		26			17			7	
2.5.2	Number of day cases (Quality Account)	Number	N/A		1750	790	794		843	867		117	151	
2.5.3	Emergency readmissions within 7 days	Monthly %	N/A		4.51%	5.39%	5.89%		3.27%	4.36%		4.75%	5.15%	
2.5.4	Emergency readmissions within 28 days	Monthly %	10%	Red	10.11%	12.10%	12.54%		7.31%	7.94%		10.67%	10.21%	
Caring														
3.1.3	Mixed sex accommodation breaches	Cases	0	Green	0		13					0	0	
3.1.4	No. Patients cancelled on day of Surgery	Number	0		24	4	4		18	47		2	3	
3.1.5	Patients cancelled and not admitted within 28 days	Number	0		0	0	0		0	5		0	0	
3.1.6	Friends and Family Test response rate (Admitted)	Monthly %	40%	Red	25%	22.70%	22.20%		28.20%	27.10%		22.50%	23.98%	
3.1.7	Friends and Family Test % recommend (Admitted)	Monthly %	83%	Green	84%	78.40%	74.90%		84.70%	77.00%		89.20%	82.47%	

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

Ref	Indicator	Units	Target	R/G	All areas — Trust	Acute & Continuing Care — Current Reporting Period	Previous Reporting Period	Trend	Co-ordinated Surgical — Current Reporting Period	Previous Reporting Period	Trend	Womens and Children — Current Reporting Period	Previous Reporting Period	Trend
Responsive														
4.1.1	RTT – Incomplete pathways (overall)	Monthly %	92%	Red	67.90%	63.65%	63.26%		65.83%	66.19%		91.40%	90.87%	
4.1.2	RTT – Treatments over 52 weeks	Number	0		19	7	6		3	3		0	1	
4.1.3	RTT – Total complete pathways (non admitted)	Monthly %	95%	Red	71.10%	57.38%	57.85%		72.12%	70.30%		94.80%	95.17%	
4.1.4	RTT –Total complete pathways (admitted)	Monthly %	90%	Red	56.30%	56.67%	70.97%		43.40%	43.23%		89.00%	88.69%	
4.3.1	Cancer – 2 week wait (1 month in arrears)	Monthly %	93%	Green	94.06%	94.66%	95.72%		92.93%	96.75%		96.77%	100.00%	
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	Monthly %	94%	Red	82.86%	69.23%	90.00%		90.91%	78.95%		No pts	100.00%	
4.3.5	Cancer – secondary chemotherapy <31 days (1 month in arrears)	Monthly %	98%	Green	100.00%	100.00%	100.00%		100.00%	100.00%		No pts	No pts	
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	Monthly %	85%	Red	83.02%	85.71%	89.47%		80.00%	59.68%		85.71%	100.00%	
4.3.9	Cancer – 62 day screening (1 month in arrears)	Monthly %	98%	Red	72.73%	No pts	No pts		72.73%	96.15%		No pts	No pts	
4.6.1	Average elective length of stay	Cum ALOS	<5	Green	1.1	0.63	0.62		1.51	1.83		1.2	1.46	
4.6.3	Discharges before noon	Monthly %	25%		14.00%	13.88%	14.90%		14.57%	12.88%			18.16%	
4.7.2	Follow-up to new ratio	Ratio			2.09	2.9	2.73		1.91	1.89		1.33	1.53	
4.7.3	Did not attend rate	Monthly %	10%	Green	8.70%	8.00%	8.90%		9.10%	8.50%		9.20%	9.70%	
Well-Led														
5.3.4	Appraisals completed (% all staff)	Monthly %	95%	Red	72%	70.57%	73.97%		67.78%	73.46%		63.70%	70.22%	
5.3.6	Mandatory training compliance	Monthly %	85%	Green	85%	79.91%	80.28%		86.71%	85.91%		87.42%	88.57%	
5.3.7	Rolling annual turnover rate	Monthly %	8%	Red	10%	12.59%	13.01%		10.87%	9.96%		7.10%	7.86%	
5.3.8	Overall Sickness rate	Monthly %	3%	Green										
5.3.10	Temporary staff % of pay bill	Monthly %	15%	Green										
Enablers														
6.2.2	CIP variance to plan	Monthly %	95%											
6.4.1	NHS number completeness (Inpatients and Outpatients) *****	Monthly %	TBC		99.13%		99.13%							
6.4.2	Primary Diagnosis (Inpatients) *****	Monthly %	TBC		99.95%		99.95%							
6.4.5	Primary Procedure (Inpatients and Outpatients) **Under Review**		TBC											
560	Elective activity vs profiled plan - cumulative variance	Cum var %	0%											
606T	New patients seen vs plan (all categories, in arrears)	Mthly var	0											
Income	Income against plan - var ytd (in arrears)	Cum £k	£0											
102	Overall budgetary variance	Mthly % var	£0					Under Review with Finance to agree Financial KPIs						
Pay	Pay expenditure in month (neg=bad)	Mthly % var	0%											
Non-pay	Non-pay expenditure in month (neg=bad)	Mthly % var	0%											
POC	Total Number Invoices with PO's	Mthly %	90%											

Report to the Board of Directors

Board Date : 26th May 2016

Title of Report	Month 1 Finance Report
Reporting Officer	Steve Smith, Financial Controller
Lead Director	Darren Cattell, Director of Finance
Responsible Sub-Committee	Executive Committee
Executive Summary	This paper provides a summary of Trust and Directorate financial performance for Month 1 of 2016-17 financial year.
Risk and Assurance	This is a month 1 financial performance report. The financial plan and base budgets have been based on V2 Operating plan, the Board is asked to note that V3 Operating Plan is still in development. Budgets are not expected to change because of the way we have set them but there is always a risk they might need to. Clearly there is risk in CIP planning and delivery, this is reported in the report.
Legal Implications/Regulatory Requirements	Terms of Licence and breach of Licence
Recovery Plan Implication	Completely integrated under Financial Recovery Plan and financial performance
Quality Impact Assessment	Will be built in to any financial change expectations eg CIPs
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Noting
Recommendation	The Board is asked to note this update and the further action required from Directorates to recover any areas of unexpected negative financial performance.

Finance Report

Month 1

2016/17

Finance Report for April 2016

1. Executive Summary

1a. Executive Summary (April 2016)

Key Messages	Report Reference
Activity and Finance	
Patient Activity Summary	Page 17
A&E Activity is significantly (12%) above plan in April and questions have been raised with Commissioners to assist in understanding the drivers.	
Adult critical care c.20% lower than plan a combination of a high in month plan and lower level of discharges. The Surgical Directorate has been requested to review this.	
Income summary from Patient Activity	Page 18
Clinical income is favourable to plan by £0.18m in April - split £0.48m favourable over performance on high cost drugs (with consequent increase in clinical supplies expense) and £0.30m adverse on activity (adult critical care £170k (as above) and maternity £140k represented by a low level of antenatal bookings). The Womens and Childrens Directorate has been requested to review this.	
Workforce Summary	Page 19
Workforce is significantly below plan (the plan has been rebased on run rate including vacancies) due to vacancies across most areas. The use of temporary staff continues however not all shifts are covered, that said from a safety perspective, number of breaches on the 1:8 ratio continues to reduce.	
Expenditure Summary	Page 10
Pay:	
Pay was £0.5m favourable to plan due to the (uncovered) vacancies in Directorates.	
Non Pay:	
Drugs (net of HCD recharges) have underspent by £0.2m in April. Clinical supplies in April is £0.5m adverse mainly due to outsourcing activity to improve RTT performance, with income also reflected in income from patient activity.	

1b. Critical Actions

This table highlights critical actions proposed by the Executive team for Board approval and support.

	Action	Current Status	Executive Lead	Action Completed?	Timescale
Medium Term	Refresh scheme of delegation and authorisation levels	Setting up task and finish group to review limits and relaunch scheme of delegation	DC/LS	In progress	Jun-16
	Baseline review	EY Final report due by 20 May	DC	In progress	May-16
	Focus on loan conditions and cash generation	On-going process	DC	In progress - V3 of plan next key milestone	On-going
Long Term	Recruitment plan	Draft approach to be considered by Executive at 18 May meeting	RB	In progress	Jun-16
	Business planning to set more accurate budgets	On-going process	DC	In progress - V3 of plan next key milestone	On-going

2. Liquidity

2a. Cash Flow

13 Week Forecast

£m	Actual w/e 01/04/16	w/e 08/04/16	w/e 15/04/16	w/e 22/04/16	w/e 29/04/16	Forecast w/e 06/05/16	w/e 13/05/16	w/e 20/05/16	w/e 27/05/16	w/e 03/06/16	w/e 10/06/16	w/e 17/06/16	w/e 24/06/16	w/e 01/07/16	w/e 08/07/16	w/e 15/07/16	w/e 22/07/16	w/e 29/07/16	w/e 05/08/16
BANK BALANCE BFWD	10.46	35.55	34.65	31.31	15.69	13.65	26.05	30.46	20.84	10.35	19.95	17.22	17.21	3.58	14.61	11.86	19.19	5.84	3.58
Receipts																			
NHS Contract Income	29.45	0.42	3.36	0.03	0.21	14.73	3.32	1.16	0.00	11.95	0.00	3.56	0.26	13.28	0.00	3.56	0.00	0.00	13.28
Other	0.98	0.30	0.85	0.12	0.34	0.16	1.23	2.14	0.25	0.80	0.26	0.30	0.25	0.80	0.25	0.30	0.25	0.80	1.97
Total receipts	30.43	0.72	4.21	0.15	0.55	14.89	4.55	3.29	0.25	12.75	0.26	3.86	0.51	14.08	0.25	3.86	0.25	0.80	15.24
Payments																			
Pay Expenditure (excl. Agency)	(0.02)	0.00	0.00	(12.84)	(0.01)	0.00	0.00	(5.13)	(7.60)	(0.05)	0.00	(2.13)	(10.60)	(0.05)	0.00	(2.13)	(10.60)	(0.05)	0.00
Non Pay Expenditure	(5.09)	(1.61)	(2.82)	(2.58)	(2.49)	(2.29)	(0.13)	(7.37)	(2.81)	(2.79)	(2.67)	(3.47)	(3.22)	(2.67)	(2.67)	(2.67)	(2.67)	(2.67)	(2.67)
Capital Expenditure	(0.23)	0.00	0.00	(0.23)	(0.08)	(0.21)	0.00	(0.34)	(0.33)	(0.31)	(0.31)	(0.31)	(0.31)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)
Total payments	(5.34)	(1.61)	(2.82)	(15.65)	(2.58)	(2.50)	(0.13)	(12.84)	(10.74)	(3.15)	(2.98)	(5.90)	(14.14)	(3.05)	(3.00)	(5.13)	(13.60)	(3.05)	(3.00)
Net Receipts/ (Payments)	35.55	34.65	36.04	15.80	13.65	26.05	30.46	20.92	10.35	19.95	17.22	15.18	3.58	14.61	11.86	10.59	5.84	3.58	15.83
Funding Flows																			
FTFF/DOH	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.04	0.00	0.00	0.00	8.60	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	(4.73)	(0.12)	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding Flows	0.00	0.00	(4.73)	(0.12)	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	2.04	0.00	0.00	0.00	8.60	0.00	0.00	0.00
BANK BALANCE CFWD	35.55	34.65	31.31	15.69	13.65	26.05	30.46	20.84	10.35	19.95	17.22	17.21	3.58	14.61	11.86	19.19	5.84	3.58	15.83

April 2016 Cashflow Performance & 14 week Cashflow Forecast
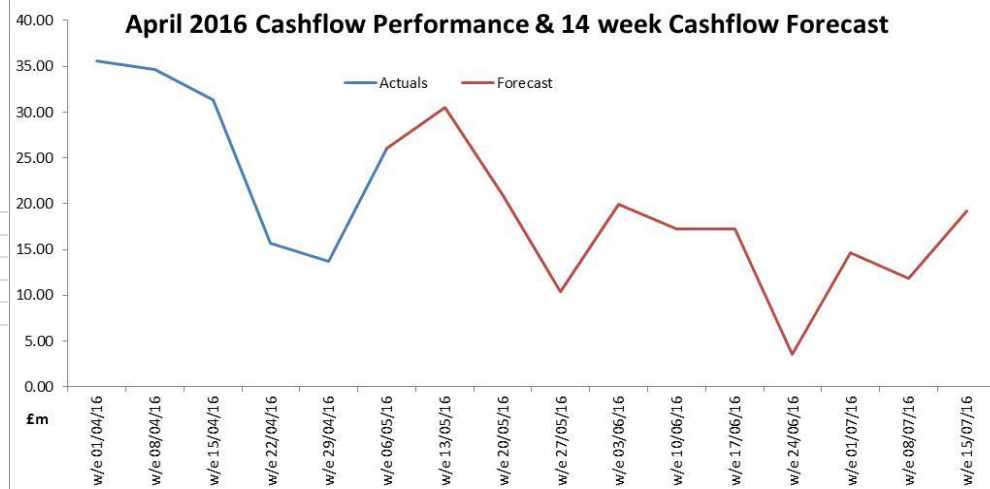
Commentary

This graph shows the Actual cash profile for the Trust for April 2016; and it also illustrates the forecasted profile up to the 5th August 2016.

The Trust ended April with £13.65m of cash, which is greater than the minimum required by DoH (£1.6m). To Date (FY 2016/17) the Trust has not drawn down any funding from the DoH, neither has it used any of the DoH Working Capital Facility.

The trust's current cash position is due to the "Double" monthly instalment of Clinical Income freceived from the North Kent CCG's received in early April.

During the month (April 16) the trust repaid the £4.7m Working Capital facility that was drawn from the DoH prior to the year end.

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

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

Loan Agreement Clause	Description	Implementation Timeframe	Progress	Compliance with Loan Status	Risk to Organisation	Comments
8 – 1	Notification to Monitor / DH if anticipating to miss reforecast and require additional cash support	Immediately if anticipating missing reforecast and not less than 2 months prior to requiring the cash support	V2 Operating Plan submitted in April	🟢	🟡	Trust has reported a loss in M1 in line with V2 Plan
8 – 2	Agency nursing procured through approved frameworks and within maximum cap	Immediately	All agencies routinely used are compliant with frameworks. Compliance with price caps is on a downward, improving trajectory.	🔴	🔴	The 1st April price cap has resulted in an increase in the trajectory which needs to be managed
8 – 3	Consultancy spend in excess of £50K pre-approved by Monitor	Immediately	Working through all business cases with Monitor team.	🟢	🟢	No new contracts introduced without pre-approval.
8 – 4	Implementation of controls over VSMs and off-payroll workers	Immediately	In progress	🟡	🟡	Market Forces and compliance through Remuneration Committee
8 – 5	Review / benchmarking of Estates and Facilities costs	31st May 2016	In progress	🟡	🔴	Timing of benchmarking exercise TBC
8 – 6	Produce an Estates strategy	Summer 2106	In progress	🟡	🔴	Estates strategy needs to be developed in conjunction with overall Trust strategy.
8 – 7	Use P21+ Procurement framework for publicly funded capital work	Immediately	Major capital works are being undertaken for the ED project. Specific dispensation was sought from Monitor for these works to be tendered outside of the P21+ contract.	🟢	🟢	ED redevelopment of Majors using P21+
8 – 8	Commission an assessment from SBS of benefit in outsourcing Finance, Accounting and Payroll services	9th May 2016	Payroll is being provided by SBS since February 2016. Outsourcing of other Finance and Accounting services to be further reviewed.	🟡	🟡	Confirmed baseline with SBS who will now submit their proposal
8 – 9	Assess benefit of outsourcing staff bank provider	9th May 2016	Completed - benefit is in moving in-house with a go-live date of 26th March 2016.	🟢	🟡	Sustainability risk
8 – 10	Review savings opportunities in increased usage of NHS Supply Chain and provide copies of medical capital asset register and procurement plans	9th May 2016	Savings opportunities from using NHS Supply Chain are regularly reviewed by Procurement. Medical capital asset register is available.	🟢	🟢	
8 – 11	Test savings opportunities in use of CCS framework	9th May 2016	CCS framework used	🟢	🟢	
8 – 12	Become a member of the EEA portal and report relevant activity	Not specified	Member since 2010, activity is reported.	🟢	🟢	
8 – 13	Provide access to relevant authorised individuals to allow monitoring of progress on above conditions	Immediately	Ongoing	🟢	🟢	

3. Financial Performance

3a. Consolidated Income & Expenditure

Consolidated I&E (April 2016)

	Actual £m	Plan £m	Variance £m	Prior Year In Month Actual £m
Revenue				
Clinical income	17.61	17.92	-0.30	17.47
High Cost Drugs	1.80	1.32	0.48	1.73
Other Operating Income	1.94	1.98	-0.04	1.98
Total Revenue	**21.35**	**21.21**	**0.14**	**21.18**
Expenditure				
Substantive	-13.34	-15.00	1.67	-12.76
Bank	-0.59	-0.26	-0.33	-0.62
Locum	-0.25	-0.26	0.01	-0.27
Agency	-2.63	-1.84	-0.79	-2.74
Total Pay	**-16.81**	**-17.36**	**0.55**	**-16.39**
Clinical supplies	-3.18	-2.66	-0.52	-2.41
Drugs	-2.70	-2.39	-0.30	-2.24
Consultancy	-0.04	-0.07	0.04	-0.09
Other non pay	-2.93	-3.03	0.10	-2.69
Total Non Pay	**-8.84**	**-8.15**	**-0.69**	**-7.43**
Total Expenditure	**-25.65**	**-25.51**	**-0.14**	**-23.82**
EBITDA	**-4.30**	**-4.30**	**0.00**	**-2.64**
	0%	*-6%*	*0%*	*-12%*
Post EBITDA				
Depreciation	-0.80	-0.77	-0.04	-0.88
Interest	-0.12	-0.17	0.05	-0.05
Dividend	-0.11	-0.11	0.00	-0.34
Fixed Asset Impairment	0.00	0.00	0.00	0.00
	-1.03	**-1.04**	**0.01**	**-1.28**
Net (Surplus) / Deficit	**-5.33**	**-5.35**	**0.02**	**-3.92**

Commentary

Net Surplus / (Deficit)
The Trust reported a £5.33m deficit in month 1, on plan. The Trust's planned deficit for the year is £59.4m (as outlined in V2 of the Operating Plan. Work continues on V3 which will be submitted to on the 10th June 2016 following Board approval.

Clinical Income
Clinical income was adverse to plan in month 1 by £0.3m mainly due to reduced critical care and maternity activity. Directorates have been requested to review this and report to the Performance Review Meetings. High cost drugs income is favourable to plan by £0.48m mainly due to increases in Health care at home drugs and Hepatitis C drugs reclaimed.
Contract negotiations are yet to be finalised with CCGs, any adjustments that are required following completion of negotiations will be retrospectively applied.

Other Income
Other income is largely on plan.

Pay
Pay was favourable to plan in month 1 due to vacancies in the Directorates.

Non Pay
The drugs overspend in month is offset by pass through high cost drugs income. Clinical supplies in month is adverse mainly due to external outsourcing to improve RTT performance. Compensatory income is included above. However Directorates have been asked to review internal efficiency to ensure the greatest value return for fixed pay costs

Directorate Reports
The expenditure position by Directorate is detailed later in the report. Clinical Income reporting by Directorate will be reported from month 2 as contract negotiations are pending and it has not been possible to provide the Directorate level detail.

Appendix 3b. Divisional Analysis - Acute & Continuing Care

	Current Month		
	Actual	*Plan*	*Variance*
	£m	£m	£m
Revenue			
Other Operating Income	-0.12	-0.13	0.02
Total Revenue	**-0.12**	**-0.13**	**0.02**
Expenditure			
Substantive	3.94	4.53	-0.60
Bank	0.05	0.22	-0.18
Locum	0.09	0.11	-0.01
Agency	1.24	1.02	0.22
Total Pay	**5.31**	**5.88**	**-0.57**
Clinical supplies	0.94	0.82	0.13
Drugs	2.33	2.04	0.28
Consultancy	0.02	0.00	0.02
Other non pay	0.47	0.50	-0.03
Total Non Pay	**3.76**	**3.36**	**0.40**
	9.07	9.25	-0.17
EBITDA	**8.96**	**9.11**	**-0.16**

CIP Delivery Month 1	**0.09**	**0.09**	**-**
CIP Annual Plan	**4.60**		
CIP Unidentified	**2.80**		

Commentary

1. Overview

The Directorate is £0.16m underspent in month 1 compared to plan.

2. Revenue

Clinical income reporting has not been possible within this Board level report due to contract negotiations pending. Reporting should commence from month 2 onwards. Other operating income is largely on plan.

3. Pay

Pay expenditure is £0.57m underspent due to substantive vacancies (£0.18m Acute Specialist Medicine, £0.28m Emergency Medicine). Bank availability as a result of the move to the in-house bank system has generally led to a reduction in the use of bank (£0.16m), offset by increased agency usage (£0.14m). Fewer red escalation shifts being used in A+E and the impact of the medical model to reduce bed numbers has contributed to the reduced temporary staff expenditure.

4. Non Pay

Non pay expenditure is £0.40m overspent. £0.28m of this relates to High Costs drugs expenditure with favourable variances in clinical income funding these pass-through costs. The remaining non pay overspend is largely as a result of £0.07m blood sciences external tests and £0.04m outsourcing to Will Adams for Gastroenterology waiting lists coverd by increased clinical income.

5. CIP

The Directorate delivered the £0.09m CIP plan for month 1 relating to the closure of Dickens Ward. £2.8m of the £4.6m CIP target remains to be identified, and it is expected that the Division will bring plans to close this gap by the end of June 2016. Unidentified CIP assumes delivery from month 7.

6. Risks and Mitigations

The Directorate is in the process of developing its CIP programme for unidentified CIP. Business cases are pending for the impact of the new medical model implemented.

Appendix 3b. Divisional Analysis - Co-Ordinated Surgery

	Current Month		
	Actual	*Plan*	*Variance*
	£m	£m	£m
Revenue			
Other Operating Income	-0.34	-0.35	0.01
Total Revenue	**-0.34**	**-0.35**	**0.01**
Expenditure			
Substantive	4.40	5.09	-0.69
Bank	0.23	0.00	0.23
Locum	0.15	0.15	0.00
Agency	0.70	0.33	0.36
Total Pay	**5.48**	**5.58**	**-0.10**
Clinical supplies	2.00	1.59	0.41
Drugs	0.27	0.26	0.02
Consultancy	0.00	0.00	0.00
Other non pay	0.35	0.39	-0.04
Total Non Pay	**2.62**	**2.24**	**0.38**
	8.10	7.82	0.28
EBITDA	**7.76**	**7.47**	**0.29**

CIP Delivery Month 1	**0.00**	**0.00**	**0.00**
CIP Annual Plan	**3.48**		
CIP Unidentified	**3.48**		

Commentary

1. Overview
The Directorate is overspent compared to plan by £0.29m mainly due to overspends in non pay.

2. Revenue
Clinical income reporting has not been possible within this Board level report due to contract negotiations pending. Reporting should commence from month 2 onwards. Other operating income is largely on plan.

3. Pay
Pay is favourable to plan by £0.1m. Whilst substantive pay is £0.69m favourable to plan this is funding the overspend on bank and agency whilst recruitment takes place. Agency spend is due to vacancies and maternity leave in Medical staffing with T&O 5 wte vacancies and general surgery covering the HOT clinic. Agency usage is also being incurred in the Ultrasound Dept due to vacancies. Due to data quality issues in temporary staffing this position is subject to change in month 2.

4. Non Pay
Non pay is overspent mainly due to £0.3m for outsourcing activity to external providers to address waiting list performance. The budget for this will be addressed in V3 of the plan in addition to the clinical income planned. In addition there is a £0.045m overspend due to the extension of a lease for an ultrasound and MRI scanner previously classified as a finance lease (and therefore capitalised). This was not reflected in budget setting and the Directorate has been asked to clarify.

5. CIP
The annual CIP plan assumes delivery from month 7 with CIP plans in the process of being developed.

6. Risks and Mitigations
The Directorate is in the process of developing its CIP programme.
A business case is being developed to close demand and capacity gaps in order for the Directorate to achieve the 18 week RTT performance standards. In addition a business case is being developed to request funding for the extended leases cost pressure.
Review of workforce and schemes to retain existing staff are ongoing.

Appendix 3b. Divisional Analysis - Women & Children

	Current Month		
	Actual	*Plan*	*Variance*
	£m	£m	£m
Revenue			
Other Operating Income	-0.09	-0.09	0.00
Total Revenue	**-0.09**	**-0.09**	**0.00**
Expenditure			
Substantive	2.59	2.78	-0.19
Bank	0.06	0.00	0.06
Locum	0.01	0.00	0.01
Agency	0.12	0.02	0.10
Total Pay	**2.78**	**2.80**	**-0.02**
Clinical supplies	0.19	0.21	-0.03
Drugs	0.09	0.09	0.00
Consultancy	0.00	0.00	0.00
Other non pay	0.06	0.06	0.00
Total Non Pay	**0.33**	**0.36**	**-0.02**
	3.11	3.16	-0.04
EBITDA	**3.03**	**3.07**	**-0.04**
CIP Delivery Month 1	**0.14**	**0.14**	**0.00**
CIP Annual Plan	**1.35**		
CIP Unidentified	**0.00**		

Commentary

1. Overview
The Directorate is underspent by £0.04m in April compared to plan partially due to vacancies and partially due to low expenditure in clinical supplies. The Directorate forecasts to remain on budget for the remainder of the year.

2. Revenue
Clinical income reporting has not been possible within this Board level report due to contract negotiations pending. Reporting should commence from month 2 onwards. Other Operating Income is as per budget.

3. Pay
Substantive pay costs are underspent due to vacancies in NICU (20+ WTE), General Paeds (15+ WTE), Midwifery (6+ WTE). Non recurrent CIPs are in place recognising some of the slippage on these vacancies but this underspend is in excess of the CIP. Recruitment has picked up and vacancy numbers are expected to significantly decrease in all of these areas throughout 2016/17.

Bank usage is £0.06m and agency usage is £0.12m.

In line with the highlighted vacancies agency spend is particularly high in NICU, which has used £0.03m of Thornberry agency nurses in month 1 plus £0.01m sourced from other agencies. The Directorate has been requested to provide an exit plan for this non-framework agency. In addition £0.02m agency expenditure has been incurred in Midwifery. Recruitment in NICU and the Community continues to be a challenge with workforce plans currently being developed.

4. Non Pay
Expenditure in clinical supplies for Womens Health is lower than budget this month and £0.02m relates to Newborn Screening to be validated by the Directorate in month 2.

5.CIP
The Directorate CIP target has been fully achieved in April. A number of non recurrent schemes relating to vacancy slippage were achieved in April.

6. Risks and Mitigations
CIPs phased later in the financial year have yet to be fully developed and therefore an element of risk exists around these schemes. The Directorate is in the process of reviewing its CIP programme to mitigate the risk and also to identify recurrent schemes to replace the non recurrent schemes for 17/18.
In 2015/16 a serious incident in relation to reduced fetal movement was raised and as a direct result the Directorate intends to implement a weekend scanning service following a successful business case process on quality and safety grounds.

Appendix 3b. Divisional Analysis - Corporate

	Current Month		
	Actual	*Plan*	*Variance*
	£m	£m	£m
Revenue			
Other Operating Income	-0.21	-0.22	0.01
Total Revenue	**-0.21**	**-0.22**	**0.01**
Expenditure			
Substantive	1.41	1.69	-0.28
Bank	0.02	0.00	0.02
Locum & Agency	0.00	0.00	0.00
Agency	0.42	0.27	0.16
Total Pay	**1.86**	**1.96**	**-0.11**
Clinical supplies	0.03	0.02	0.02
Drugs	0.00	0.00	0.00
Consultancy	0.01	0.07	-0.05
Other non pay	0.39	0.38	0.01
Total Non Pay	**0.43**	**0.46**	**-0.03**
	2.29	2.43	-0.14
EBITDA	**2.08**	**2.21**	**-0.13**

CIP Delivery Month 1	**0.08**	**0.08**	**0.00**
CIP Annual Plan	**0.90**		
CIP Unidentified	**0.00**		

Commentary

1. Overview
The Corporate areas are £0.13m underspent in month 1 mainly due to a level of vacancies throughout the Directorate not being covered by bank or agency.

2. Revenue
Other operating income is largely on plan.

3. Pay
Corporate Pay in April is £0.11m underspent, this mainly relates to the following areas:

Health Informatics - In 2016/17 the Trust brought in house IT services previously provided as part of the local HIS contract. In the short term this has created a significant number of vacancies which are in the process of being recruited to. There are currently 31.6 wte vacancies currently in health Informatics, 15 wte are validators covered by bank and agency staff, much of the rest remains uncovered causing an underspend of £0.07m in this service.
Finance 6.42 wte Vacancies, mainly in Procurement, Operational Finance and Finance Management, £0.02m underspend relates entirely to Finance Management.
Nursing 6.98 wte Vacancies, underspend of £0.02m, across all services Safeguarding, Infections Control, Specialist and Nursing & Quality.
Workforce 6.90 wte Vacancies, underspend of £0.02m, 4 wte vacancies in Employee Relations £0.01m underspend, 2 wte Vacancies in the Senior HR team £0.01m.

4. Non Pay
There is a £0.05m underspend in consultancy, this relates entirely to an unexpected credit for expenditure incurred in 15/16.

5.CIP
Fully achieved in April. £0.01m relates to non recurrent schemes that will be replaced by recurring schemes for 17/18. Efficiency schemes will continue to be generated throughout the year.

6. Risks and Mitigations
Workforce Consultancy and recruitment fee budgets have been set significantly lower than 15/16 outturn, this is an objective of the current Workforce Director so is expected to be achievable. The service has controls in place to prevent this and a monitoring process is due to be set up.
Temporary Staffing was brought in house at the end of 15/16, a budget is in place for the service and will be developed further with costs for the service being monitored closely.
PMO is currently funded to the level in the original Monitor business case approved by the board in 15/16. Continuation of the PMO is planned, the costs of which would be expected to offset by additional savings achieved with a business case pending approval.

Appendix 3b. Divisional Analysis - Facilities & Estates

	Current Month		
	Actual	*Plan*	*Variance*
	£m	£m	£m
Revenue			
Other Operating Income	-0.46	-0.45	0.00
Total Revenue	**-0.46**	**-0.45**	**0.00**
Expenditure			
Substantive	0.88	0.85	0.03
Bank	0.03	0.03	0.00
Locum	0.00	0.00	0.00
Agency	0.15	0.19	-0.05
Total Pay	**1.06**	**1.07**	**-0.02**
Clinical supplies	0.02	0.02	0.00
Drugs	0.00	0.00	0.00
Consultancy	0.00	0.01	-0.01
Other non pay	0.90	0.92	-0.02
Total Non Pay	**0.93**	**0.95**	**-0.02**
	1.99	2.03	-0.04
EBITDA	**1.53**	**1.57**	**-0.04**

CIP Delivery Month 1	**0.00**	**0.00**	**0.00**
CIP Annual Plan	**1.07**		
CIP Unidentified	**1.07**		

Commentary

1. Overview
The Directorate is underspent compared to plan by £0.04m in April mainly due to a reduction in agency use and a favourable variance in other non pay. The Directorate forecasts to remain on budget for the remainder of the year.

2. Revenue
Other Income is as per budget.

3. Pay
Substantive pay is overspent due to recruitment of 1 wte mini bus driver in Car Parking and 1 wte in Estates, currently budgeted for within the agency plan. The budget is due to be transferred in month 2 following approval of a virement. Agency is underspent due to the recruitment of substantive posts and reduced expenditure in the management team.

4. Non Pay
Expenditure in other non pay for Facilities and Estates is underspent mainly due to cleaning materials in Housekeeping, provisions and utility bills.

5.CIP
The annual CIP plan assumes delivery from month 7 with CIP plans in the process of being developed.

6. Risks and Mitigations
The Directorate is in the process of developing its CIP programme.

3c. I&E Run Rate Analysis

Anaylsis of 12 monthly performance - Financials

	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue												
Clinical income	18.0	15.8	18.1	18.0	17.1	17.1	17.3	16.7	16.8	16.9	21.9	17.6
High Cost Drugs	1.4	1.4	1.8	1.5	1.6	1.7	1.6	1.7	1.7	1.7	1.7	1.8
Other Operating Income	2.1	2.1	2.2	1.9	1.9	2.0	2.0	1.9	1.9	2.4	2.0	1.9
Total Revenue	**21.5**	**19.4**	**22.1**	**21.4**	**20.5**	**20.8**	**20.8**	**20.3**	**20.4**	**20.9**	**25.6**	**21.4**
Expenditure												
Substantive	-12.7	-12.7	-12.4	-12.5	-12.7	-12.5	-12.6	-12.5	-12.8	-12.9	-12.6	-13.3
Bank	-0.7	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.8	-0.6
Locum	-0.3	-0.2	-0.3	-0.3	-0.2	-0.3	-0.3	-0.3	-0.3	-0.2	-0.3	-0.2
Agency	-2.6	-2.5	-3.2	-3.3	-2.9	-3.0	-2.4	-3.6	-2.7	-3.0	-2.8	-2.6
Total Pay	**-16.2**	**-16.0**	**-16.4**	**-16.6**	**-16.4**	**-16.4**	**-15.8**	**-17.0**	**-16.3**	**-16.7**	**-16.3**	**-16.8**
Clinical supplies	-2.6	-2.3	-2.7	-2.8	-2.8	-2.8	-2.9	-3.0	-2.7	-3.1	-3.6	-3.2
Drugs	-2.1	-2.0	-2.5	-2.2	-2.3	-2.5	-2.4	-2.4	-2.4	-2.4	-2.6	-2.7
Consultancy	-0.1	-0.1	-0.2	-0.2	-0.3	-0.1	-0.1	-0.1	-0.2	-0.2	-0.1	0.0
Other non pay	-2.7	-2.7	-2.8	-2.9	-2.8	-2.9	-2.5	-2.7	-2.9	-2.8	-2.7	-2.9
Total Non Pay	**-7.6**	**-7.1**	**-8.1**	**-8.2**	**-8.1**	**-8.4**	**-7.9**	**-8.3**	**-8.1**	**-8.5**	**-9.1**	**-8.8**
Total Expenditure	**-23.8**	**-23.1**	**-24.5**	**-24.7**	**-24.5**	**-24.8**	**-23.7**	**-25.3**	**-24.5**	**-25.2**	**-25.5**	**-25.6**
EBITDA	**-2.3**	**-3.7**	**-2.4**	**-3.3**	**-4.0**	**-4.0**	**-2.9**	**-5.0**	**-4.0**	**-4.3**	**0.1**	**-4.3**
Post EBITDA												
Depreciation	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.3	-0.8
Interest	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.1	-0.1	-0.1	-0.1	-0.1
Dividend	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	0.2	-0.1
Fixed Asset Impairment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
	-1.3	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**0.0**	**-1.0**
Net Surplus / (Deficit)	**-3.6**	**-5.0**	**-3.7**	**-4.6**	**-5.3**	**-5.3**	**-4.2**	**-6.3**	**-5.3**	**-5.6**	**0.1**	**-5.3**
Revaluation Gain	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Net Surplus / (Deficit)	**-3.6**	**-5.0**	**-3.7**	**-4.6**	**-5.3**	**-5.3**	**-4.2**	**-6.3**	**-5.3**	**-5.6**	**0.4**	**-5.3**

3d. Clinical Activity

Clinical Activity by Point of Delivery (April 2016)

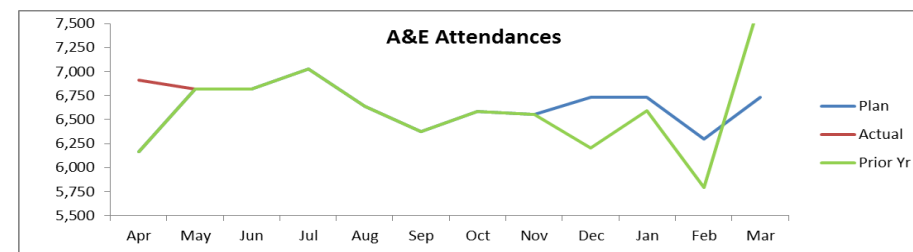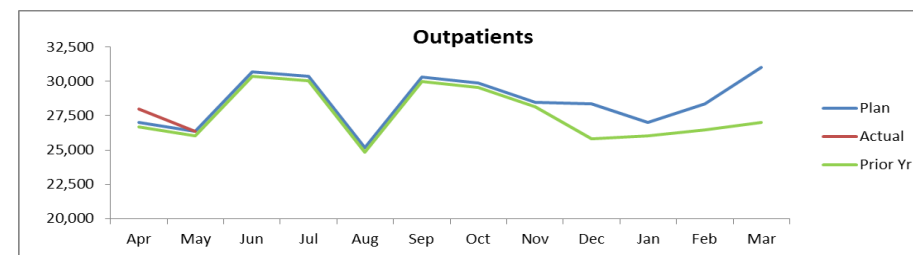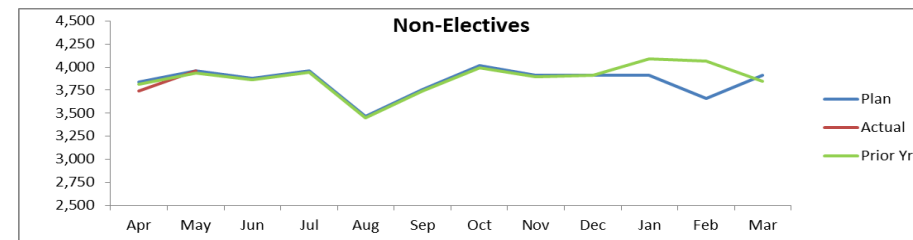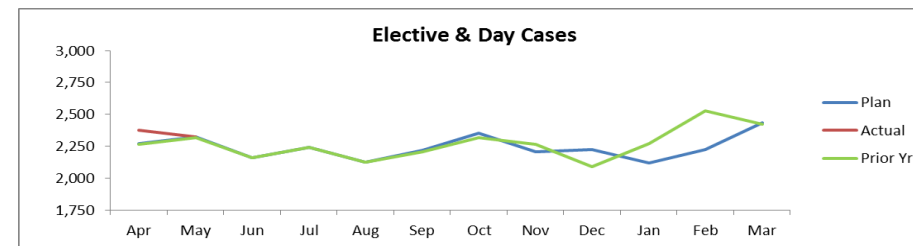|	Current Month			Prior Year In Month	Year to Date			Prior Year YTD
	Actual	Plan	Variance	Actual	Actual	Plan	Variance	Actual
PBR								
Elective Day Case	1,750	1,659	91	1,659	1,750	1,659	91	1,659
Elective Inpatient	628	609	19	607	628	609	19	607
Non Elective Inpatient	3,744	3,811	- 67	3,775	3,744	3,811	- 67	3,775
Excess Bed Days	2,143	2,310	- 167	2,247	2,143	2,310	- 167	2,247
Outpatients	27,963	27,021	942	25,674	27,963	27,021	942	25,674
A&E	6,914	6,164	750	6,164	6,914	6,164	750	6,164
Maternity Pathway	855	903	- 48	903	855	903	- 48	903
Direct Access Radiology	6,244	4,954	1,290	1,721	6,244	4,954	1,290	1,721
Adult Critical Care	677	859	- 182	859	677	859	- 182	859
Chemotherapy	881	818	63	818	881	818	63	818
Total PBR	**51,799**	**49,108**	**2,691**	**44,427**	**51,799**	**49,108**	**2,691**	**44,427**
Non PBR								
Direct Access	197,950	85,006	112,944	88,239	197,950	85,006	112,944	88,239
Paediatric & Neonatal Critical Care	1,115	936	179	863	1,115	936	179	863
Excluded Devices	77	79	- 2	79	77	79	- 2	79
Other cost per case	4,909	3,176	1,733	5,486	4,909	3,176	1,733	5,486
Total Non PBR	**204,051**	**89,197**	**114,854**	**94,667**	**204,051**	**89,197**	**114,854**	**94,667**

Commentary

A&E attendances are significantly above plan in April, this is driven by the recent surge in attendances where average daily attendances has risen from circa 200 per day to 230 per day, with some days having seen over 300 attendances per day for a sustained period. Questions have been raised with Commissioners to assist in understanding the increase.

Non-Elective Activity is close to planned volumes however following introduction of the medical model, there has been a marginal shift of long-stay activity and short-stay activity to same day emergency care, which reflects the new pathways and intention to discharge patients same day to avoid the overnight stay and relieve pressure on bed capacity.

Adult critical care days were below plan in Month 1, this was driven by a combination of higher discharges in April 15 which the plan was based on and a lower level of discharges in April where critical care days were present. The Directorate view is that there a number of patients currently still in the hospital who have been stepped down from the critical care unit but have not been discharged from hospital to date. It is expected that this income will be recovered in future periods.

Following identification of an error in reporting as part of contract negotiations for 2016/17, the activity plan for Pathology direct access needs to be restated to reflect tests and not profiled tests. This will be corrected for Month 2 reporting following resubmission of v3 of the Trust financial plan to NHS Improvment.

Elective & Day Cases

Non-Electives

Outpatients

A&E Attendances

3e. Clinical Income

Clinical Income by Point of Delivery (Plan 2016)

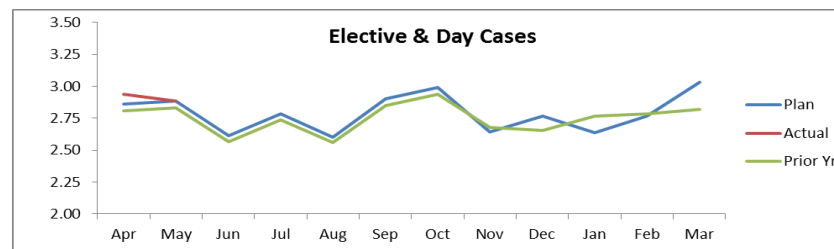|	Current Month			Prior Year In Month
	Actual	Plan	Variance	Actual
	£m	£m	£m	£m
PBR				
Elective Day Case	1.32	1.23	0.10	1.31
Elective Inpatient	1.61	1.63	-0.02	1.75
Non Elective Inpatient	6.31	6.38	-0.08	5.62
Emergency Readmissions	-0.19	-0.19	0.00	-0.19
Emergency Marginal rate	-0.27	-0.21	-0.07	-0.10
Excess Bed Days	0.49	0.56	-0.07	0.46
Outpatients	3.29	3.31	-0.02	3.47
A&E	0.88	0.79	0.09	0.75
Maternity Pathway	0.81	0.95	-0.14	0.81
Direct Access Radiology	0.18	0.12	0.07	0.11
Adult Critical Care	0.67	0.84	-0.17	0.72
Chemotherapy	0.12	0.11	0.01	0.10
Total PBR	**15.22**	**15.52**	**-0.30**	**14.82**
Non PBR				
High Cost Drugs	1.80	1.32	0.48	1.73
Direct Access	0.56	0.55	0.01	0.50
Paediatric & Neonatal Critical Care	0.79	0.70	0.09	0.60
Excluded Devices	0.14	0.20	-0.06	0.18
Other cost per case	0.27	0.27	0.01	0.22
Block contracts	0.85	0.85	-0.01	0.78
Outpatient efficiencies	-0.24	-0.19	-0.04	-0.16
Total Non PBR	4.18	3.70	0.48	3.84
CQUIN	0.34	0.35	- 0.01	0.33
Contract Penalties	-0.39	-0.38	0.00	0.00
Other Income Adjustments:	0.00	0.00	0.00	0.19
Other Non-Contracted Income	0.07	0.05	0.02	0.03
Prior Month Adjustments	0.00	0.00	0.00	0.00
Total	19.41	19.23	0.18	19.20

Commentary

Clinical income is above plan by £0.18m in April, relating to under-performance of £0.3m for reduced activity and £0.48m over-performance on high cost rechargeable drugs.

The key variances to plan relate to Adult critical care activity and the Maternity Pathway. Adult critical care is expected to be recovered in future months as patients are discharged from the hospital. The Maternity Pathway variance is driven by a lower than planned level of antenatal bookings in April. Directorates have been asked to review these positions.

Contract negotiations are yet to be finalised with CCGs, any adjustments that are required following completion of negotiations will be retrospectively applied in Month 2.

Elective & Day Cases

Non-Electives

Outpatients

A&E Attendances
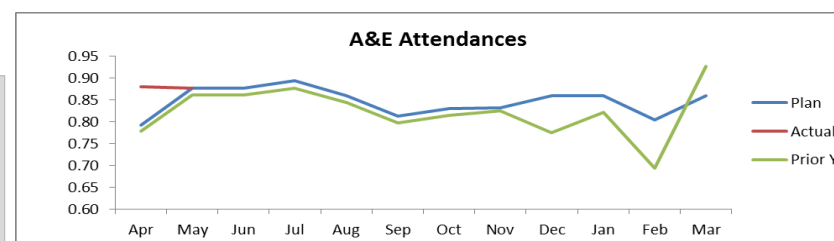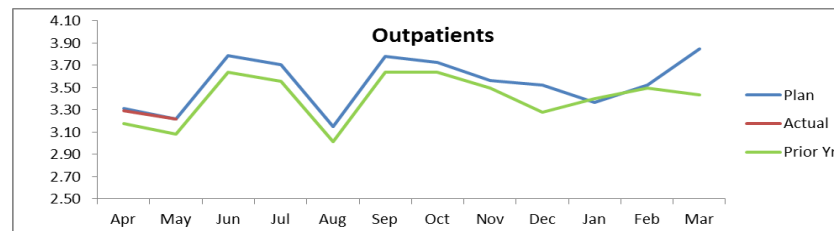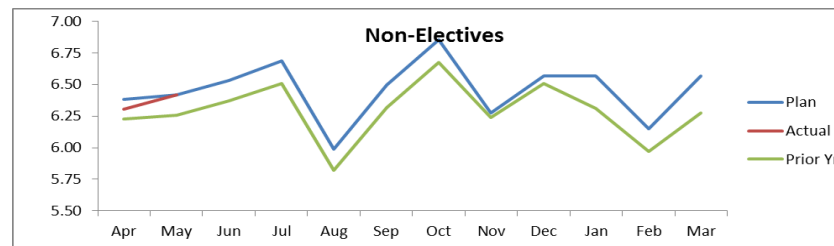
3f. Workforce

		Current Month			Prior Year In Month
		Actual	*Forecast*	*Variance*	*Actual*
		£m	£m	£m	£m
Substantive	Consultants	2.07	2.27	-0.20	2.10
	Junior Medical	1.85	2.04	-0.20	1.67
	Nurses & Midwives	3.97	4.87	-0.89	3.93
	Scientific, Therapeutic & Technical	1.45	1.49	-0.04	1.37
	Healthcare Assts, etc	0.99	1.07	-0.08	0.95
	Executives	1.99	2.31	-0.32	0.01
	Chair & NEDs	0.01	0.01	0.00	0.13
	Admin & Clerical	0.10	0.14	-0.04	1.83
	Other Non Clinical	0.91	0.81	0.10	0.77
	Pay Reserves	0.00	0.00	0.00	0.00
	Substantive Total	**13.34**	**15.00**	**-1.67**	**12.76**
Agency	Consultants	0.24	0.11	0.14	0.27
	Junior Medical	0.66	0.46	0.21	0.70
	Nurses & Midwives	0.72	0.66	0.06	0.98
	Scientific, Therapeutic & Technical	0.28	0.12	0.16	0.30
	Healthcare Assts, etc	0.04	0.00	0.04	0.04
	Admin & Clerical	0.53	0.35	0.19	0.33
	Other Non Clinical	0.15	0.15	0.00	0.12
	Agency Total	**2.63**	**1.84**	**0.79**	**2.74**
Bank	Nurses & Midwives	0.20	0.14	0.06	0.23
	Scientific, Therapeutic & Technical	0.00	0.01	-0.01	0.04
	Healthcare Assts, etc	0.22	0.06	0.16	0.21
	Admin & Clerical	0.16	0.02	0.14	0.10
	Other Non Clinical	0.01	0.03	-0.01	0.03
	Bank Total	**0.59**	**0.26**	**0.33**	**0.61**
Locum	Consultants	0.24	0.25	-0.01	0.26
	Junior Medical	0.01	0.01	0.00	0.01
	Locum Total	**0.25**	**0.26**	**-0.01**	**0.27**
	Workforce Total	**16.81**	**17.36**	**-0.55**	**16.38**

Commentary:

Pay expenditure is underspent compared to plan by £0.55m mainly due to vacancies. Increases on prior year in month expenditure are mainly due to the inflationary and national insurance increase of 2.8%.

Establishments have been set based on a run rate basis including vacancies and agreed opening budgets with Directorates.

4. Balance Sheet

4a. Balance Sheet

	Last Month	Current Month		
	Actual	Actual	Plan	Variance
	£m	£m	£m	£m
Non current Assets	**166.4**	**165.7**	**178.1**	**-12.4**
Current Assets				
Inventories	6.4	6.4	6.7	-0.4
Trade receivables	15.1	26.3	18.2	8.1
Other receivables	2.4	2.7	0.0	2.7
Other current assets	3.0	5.8	2.2	3.6
Cash at bank	5.6	14.4	8.0	6.4
Current Assets Sub Total	**32.5**	**55.6**	**35.2**	**20.4**
Current Liabilities				
Trade payables	-16.2	-21.2	-17.7	-3.5
Other payables	-16.4	-29.6	-14.8	-14.9
Borrowings	-1.2	-1.1	-1.1	0.0
Provisions	-0.1	-0.1	-0.1	0.0
Other liabilities	-1.8	-16.1	-18.4	2.3
Sub Total Current Liabilities	**-35.7**	**-68.2**	**-52.1**	**-16.1**
Net Current Assets	**-3.2**	**-12.6**	**-16.9**	**4.3**
Non Current Liabilities				
Borrowings	-90.4	-85.7	-88.1	2.4
Provisions	-0.8	-0.8	-1.0	0.2
Other liabilities	0.5	0.4	0.5	-0.1
Sub Total Non Current Liabilities	**-90.8**	**-86.1**	**-88.5**	**2.4**
Net Assets Employed	**72.4**	**67.0**	**72.7**	**-5.7**
Taxpayers' and Others' Equity				
Public Dividend Capital	129.5	129.5	131.0	-1.5
Retained Earnings	-89.4	-94.7	-104.1	9.4
Revaluation Reserve	32.3	32.3	45.9	-13.6
	72.4	**67.0**	**72.7**	**-5.6**

Commentary

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

The capital program has seen a slow start to the year with April spend at £150K.

4b. Debtors

Aged Debtors

	Total	Current	30 - 60	61 - 90	90 - 120	121 days - 6 months	6 months - 1 year	1 - 2 years	2 - 3 years	3+ years
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS										
Medway CCG	0.75	0.43	0.10	(1.29)	0.38	0.80	0.19	0.02	0.13	0.00
Swale CCG	0.67	(0.14)	0.56	0.08	0.13	0.01	0.01	0.03	0.00	0.00
Dartford & Gravesham CCG	0.51	0.39	(0.31)	(0.03)	0.03	0.11	0.21	0.08	0.03	0.00
Other CCGs	1.83	0.57	0.18	0.12	0.22	0.05	0.47	0.16	0.06	0.00
NHS England	0.42	0.23	0.00	0.14	0.00	0.00	0.01	0.02	0.02	0.00
Other	3.21	0.57	0.30	0.59	0.12	0.70	0.42	0.32	0.11	0.09
Partially Completed Spells and Overperformance	4.25	4.25	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total NHS	**11.64**	**6.30**	**0.83**	**(0.40)**	**0.87**	**1.66**	**1.30**	**0.63**	**0.36**	**0.09**
Non NHS										
Nursery	0.07	0.02	0.01	0.00	0.00	0.01	0.01	0.01	0.01	0.00
Payroll	0.15	(0.00)	0.00	(0.00)	0.01	0.01	0.04	0.03	0.01	0.06
Overseas patients	0.29	0.01	0.02	0.01	0.01	0.02	0.09	0.06	0.05	0.02
Medway Comm Healthcare	0.38	0.05	0.08	0.04	0.00	0.09	0.07	0.02	0.02	0.02
Other	0.76	0.37	(0.02)	0.09	0.06	0.08	0.09	0.07	0.02	0.00
Total Non NHS	**1.65**	**0.44**	**0.08**	**0.14**	**0.09**	**0.20**	**0.30**	**0.19**	**0.11**	**0.11**
Bad debt provision	**(0.90)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.23)**	**(0.47)**	**(0.20)**
Total Debtors	**12.39**	**6.74**	**0.91**	**(0.26)**	**0.96**	**1.86**	**1.60**	**0.58**	**0.00**	**0.00**

Commentary

The Trade Receivables Debt outstanding to the trust has continued its downward trend and is £2.7m lower than March 16; this broken down as an £0.9m improvement in Aged Debt and a £1.8m decrease in Current Debt.

NHS Debtors have fallen by £2.07m month on month, the largest NHS debtors remain the North Kent CCGs.

Non NHS debtors have shown a £650k decrease when compared to prior months.

To increase transparency, the bad debt provision (which is in accordance with Trust policy) has been shown separately.

The Trust has now recruited a substantive Credit Controller to post (starting late April 16) and will continue to allocate resource and work to improving the Trust's invoicing and the collection of aged debts.

Aged Debtor Monthly profile

22
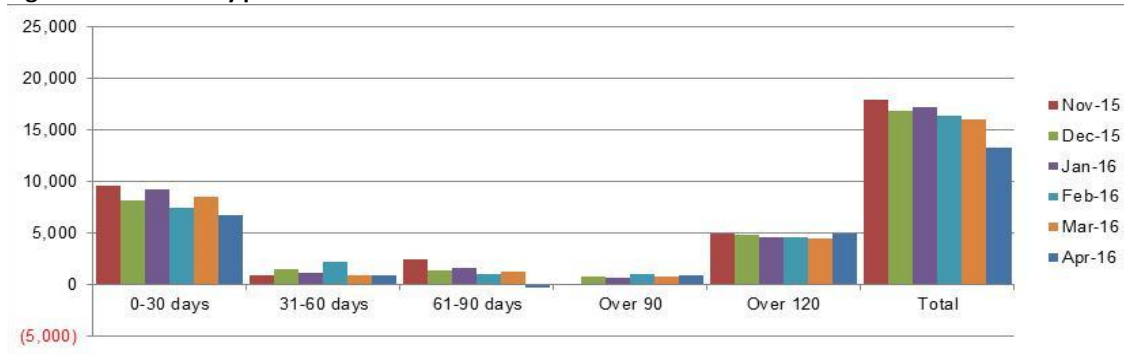
4c. Creditors

Aged Creditors

	Total £m	Current £m	30 to 60 £m	61 to 90 £m	Over 90 £m	Over 120 £m
NHS						
NHS Business Services Authority	0.60	0.36	0.12	0.12	0.00	0.00
Dartford and Gravesham	1.21	0.18	0.29	0.15	0.18	0.40
National Blood	0.14	0.12	0.02	0.00	0.00	0.00
Other	2.65	0.32	1.13	0.24	0.05	0.91
NHS Pension Scheme	2.18	2.18	0.00	0.00	0.00	0.00
Total NHS	6.78	3.15	1.56	0.52	0.23	1.31
Non NHS						
NHS Professionals	0.32	0.20	0.00	0.00	0.00	0.12
NHS Supply Chain	0.66	0.57	0.09	0.00	0.00	0.00
Johnson and Johnson	0.27	0.08	0.18	0.01	0.00	0.00
Other	13.19	6.30	4.97	0.81	0.31	0.80
Total Non NHS	14.42	7.14	5.24	0.82	0.31	0.92
Total Creditors	**21.21**	**10.30**	**6.80**	**1.34**	**0.54**	**2.23**

Commentary

The key NHS and Non NHS trade creditors are shown in the table to the left. Trade Creditors are now at £21.21m which is a £5m increase when compared to March 16.

However, taken when in context March included an additional payment run for the Year End position and Creditors were therefore lower than anticipated - When compared to February this is a £3m increase.

The reasons behind this increase are
- Creation of the In-House bank
- An general Increase in the time taken to authorise invoices

The Trust has continued to maintain payments between 45 and 60 days from the invoice date for Approved Invoices.

Finance & Procuremnent are currently working together to embed the Purchase Order system within the Culture of the trust.
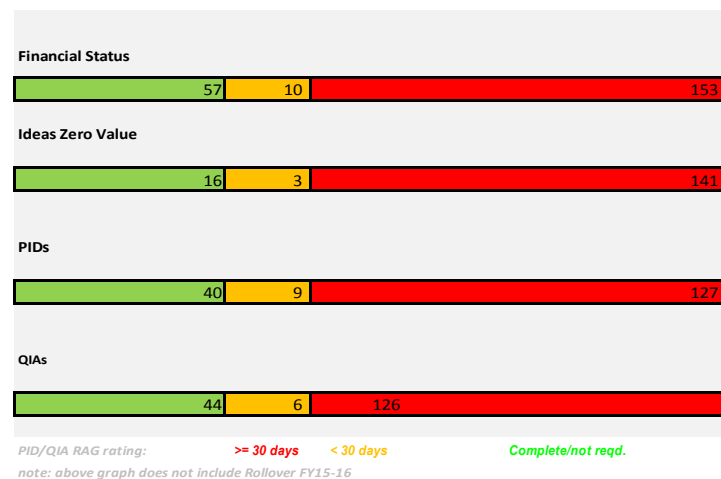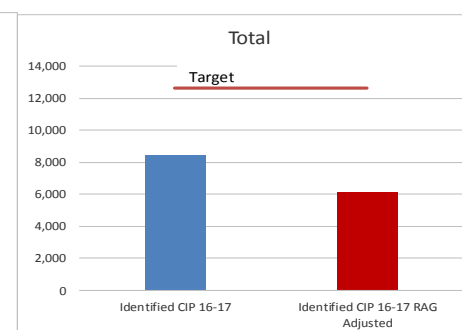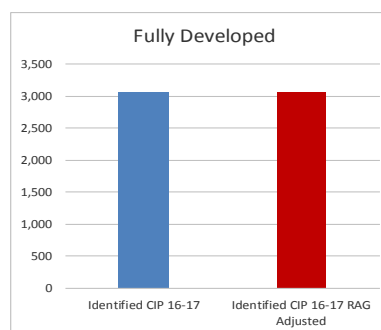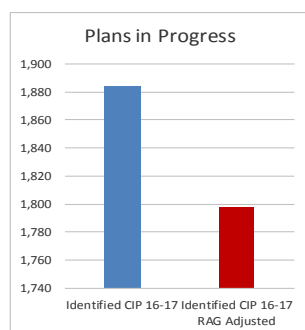
Aged Creditor Monthly Profile
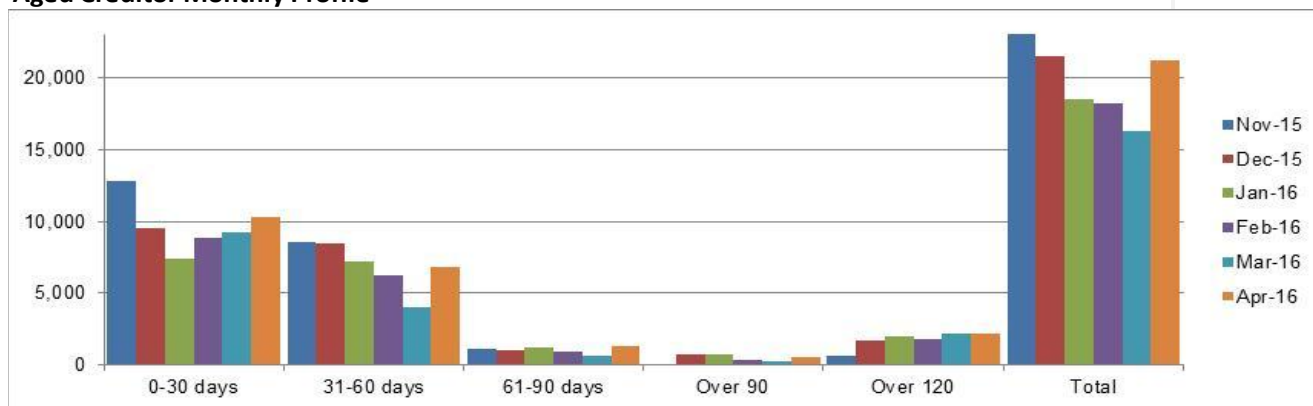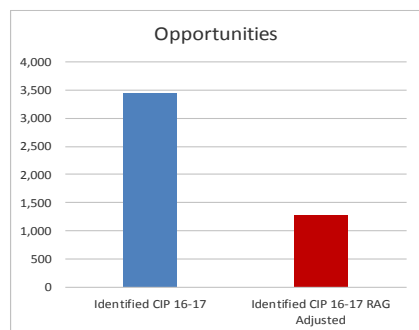
5. CIP's

Pipeline Ideas April 2016

Workstream Programme Theme	Draft Targets FY16-17 £'000	FY 16-17 Gross £'000	FY 16-17 RAG Adj £'000
Deteriorating Patient		345	259
Emergency Pathway		-	-
Bed Base/LOS		-	-
Medical Model		-	-
Agency		-	-
Workforce		64	16
Procurement	-	2,239	1,169
Medicine Optimisation		150	38
Technical Adjustments	1,304	1,304	1,304
Division Schemes			
Acute	4,598	1,282	1,167
Womens & Childre	1,307	756	725
Surgery	3,483	397	345
Corporate	879	856	856
Estates	1,074	1,051	263
Pathology & Imaging		-	-
Rollover FY15-17		-	-
Sub-total	12,645	8,445	6,141
Income Completeness		400	400
Grand Total	12,645	8,845	6,541

Financial Status

57	10	153

Ideas Zero Value

16	3	141

PIDs

40	9	127

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QIAs

44	6	126

PID/QIA RAG rating: **>= 30 days**   **< 30 days**   *Complete/not reqd.*

note: above graph does not include Rollover FY15-16

note: above graph does not include Rollover FY15-16

Opportunities
(bar chart: Identified CIP 16-17 ≈ 3,450; Identified CIP 16-17 RAG Adjusted ≈ 1,300)

Plans in Progress
(bar chart: Identified CIP 16-17 ≈ 1,885; Identified CIP 16-17 RAG Adjusted ≈ 1,800)

Fully Developed
(bar chart: Identified CIP 16-17 ≈ 3,050; Identified CIP 16-17 RAG Adjusted ≈ 3,050)

Total
(bar chart with Target line: Identified CIP 16-17 ≈ 8,450; Identified CIP 16-17 RAG Adjusted ≈ 6,100)

6. FRP

6a. Milestones

Phase 1 Governance & Control
- Review and Update all areas of control and process that impact on financial delivery COMPLETION 17th JUNE

Phase 2 Diagnostics, What is Going Wrong and Why
- Carter Metrics
- Income Completeness
- Clinical Mix
- Productivity & Efficiency
- COMPLETION 24th JUNE

Phase 3 Strategies
- Output of Diagnostics feed in
- Alignment to Trust Strategy
- Aggregation into financial recovery
- Risks and Mitigation
- COMPLETION 8th JULY

Phase 4 The Plan
- Drafting of the Plan
- Review and Feedback
- Edit
- Board Sign Off
- Submission
- COMPLETION 26th AUGUST

Report to the Board of Directors

Board Date : May 26th 2016

Title of Report	Strategy Development Update
Reporting Officer	Pippa Bagnall Director of Strategy and Partnerships
Lead Director	Pippa Bagnall
Responsible Sub-Committee	In development
Executive Summary	In addition to the Operational Plan 2016-2017 MFT is in the process of developing a longer term Strategy 2016-2020. A high level Strategic Intent to provide high quality care for the local population has been shared with managerial and clinical staff. The next stage will be a process of stakeholder engagement with all key partners internally and externally. It is expected the strategy development work will be complete by the end of July/early August. Having clarity about the MFT Strategy will ensure key priorities and objectives are reflected in the Kent and Medway Sustainability and Transformation Plan. The Steering Committee is Chaired by Glenn Douglas (CEO of Maidstone and Tunbridge Wells NHS Trust) and attended by Lesley Dwyer and Caroline Selkirk (AO CCG) from Medway.
Risk and Assurance	There will be a meeting in early June for Board members to review the STP before submission to NHS England by the end of June 2016.
Legal Implications/Regulatory Requirements	Nil at present.
Recovery Plan Implication	To be determined.
Quality Impact Assessment	Will be required where there are recommendations to change service configuration.
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision**	For information

• **Information**	
Recommendation	The Board to note the progress and requirement for approval of the STP by June 2016.

Strategic Planning and Delivery across Kent and Medway

Medway Annual Operational Plan 2016/17

MFT Priorities

Local Planning Groups

Kent & Medway Emerging Shared Vision

- Provide the best of care by embracing new and innovative models supported by technology and learning.
- Improve system integration and leadership
- Enable staff to be their best & give their best
- Create financial sustainability & value in all we do

To improve the health and Well being outcomes of the population and individuals we serve, through delivering efficient and effective care, which ensures a good experience for the individual, and those close to them, when they use services; whilst allowing the NHS and local authorities to manage within available resources.

MFT Strategic Alignment and Planning Processes

- Development of the Strategic Plan 2016-2020

- Underpinned by Operational Plan for 2016/2017 and then integrated with the STP

- Influenced by the MF Trust Clinical Strategy

- Detailed through the clinical directorates programmes and business cases

- Underpinned by the enabling plans to support delivery

Report to the Board of Directors

Board Date : 26 May 2016

Title of Report	Annual Report - Emergency Preparedness, Resilience and Response (EPRR)
Reporting Officer	Jess Scott, Emergency Planning and Business Continuity Manager.
Lead Director	Lynne Stuart, Director of Governance, Risk, Compliance and Legal
Responsible Sub-Committee	
Executive Summary	The Annual Report seeks to provide assurance to the Board that Medway NHS Foundation Trust is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response.
	The report details compliance with NHS England guidance (2015).
	The report details outputs from the 2015/16 Work Plan and reflects on the Trust response to incidents within the year.
	The report suggested inputs to the 2016/17 Work Plan for ratification.
Risk and Assurance	Detailed within the Annual Report attached.
Legal Implications/Regulatory Requirements	
Recovery Plan Implication	No
Quality Impact Assessment	No. A Quality Impact Assessment is not required as the Trust was audited by NHS Medway Clinical Commissioning Group against the full range of content of this report
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Assurance
Recommendation	It is requested that the Board: • Re-affirms its understanding of the Trust's statutory obligations as a Category 1 responding organisation (Civil Contingencies Act (2004)

	• Notes the designation of the Executive Lead for EPRR for 2016/17 to attend the Local Health Resilience Partnership and Chair the Trust Emergency Preparedness Resilience and Response Group. • Agrees the 2016/17 EPRR Work Plan at Appendix 1

EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE GROUP ANNUAL REPORT 2016

1. ANNUAL REPORT EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE OVERVIEW

THE CIVIL CONTINGENCIES ACT (2004)

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

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

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

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

- Risk Assessment

- Develop Emergency Plans

- Develop Business Continuity Plans

- Warning and Informing

- Sharing Information

- Co-operation with other local responders.

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

1.6. In this year the Trust has had three changes of Executive Lead for Emergency Preparedness Resilience and Response and has still ensured that the Trust is represented within the Local Resilience Forum sub-groups (Civil Contingencies Act, 2004), The Local Health Resilience Partnership (LHRP); co-chaired by NHS England and Public Health England and Safety Advisory Groups of both Swale and Medway Councils.

2. 2015/16 ASSESSING AND DOCUMENTING COMPLIANCE

Nhs Core Standards 2015

2.1.   The Trust undertook a primary self-assessment on compliance with the NHS England Core Standards for Emergency Preparedness Resilience and Response Framework 2015. The self–assessment translated into a Statement of Compliance ratified by the Executive lead for EPRR in August 2015. The Clinical Commissioning Group audited the Trust in September 2015 and published their findings to the Trust and NHS England South (South-East) in October 2015 at the Local Health Resilience Partnership.

2.2.   The submission stated that out of the 82 of the core standards which are applicable to the organisation it is fully compliant with 81 of these core standards; and will become fully compliant with the remaining 1 detailed within a Work Plan led by the Local Health Resilience Partnership.

2.3.   Having reviewed submissions by other acute Trusts in England (who are all aligned to the same assurance process) the Medway NHS Foundation Trust is not out of kilter with the published results of peers with a mature EPRR Programme.

Business Continuity Aligned to ISO 22301

2.4.   The Trust was last audited on the subject of Business Continuity within the 2013/14 financial year by Kent and Medway Commissioning Support Unit (KMCS); on behalf of NHS Medway Clinical Commissioning Group. The Trust scored 95.8% compliance.

2.5.   On 18 February 2016 NHS England revised the published Business Continuity Management Toolkit (Gateway Ref 04416). Within the document it recommends that an internal audit cycle be of three years in duration to complete the entire Business Continuity Programme of an organisation. The Trust going forward will reflect this best practice guidance.

CQC Self- Assessment

2.6.   In August 2015 the Trust completed a self-assessment on EPRR against the CQC Standards for each of the Clinical Divisions. Two elements were identified as requiring improvement (Benchmarking of Outcomes and Mechanisms to encourage and act on Patient Feedback). The two elements were immediately addressed within the annual review of the Trust Major Incident Plan and training uplifted to reflect the

change.

2.7. The Trust Governance Team reviewed a compliance statement and no further action was required. The EPRR assurance programme will continue to include a CQC Self-Assessment on an annual basis.

Chemical, Biological, Radioactive and Nuclear (CBRN) Capability Assessment.

2.8. Assurance for Chemical, Biological, Radioactive and Nuclear (CBRN) Powered Respirator Protective Suits (PRPS) and Decontamination Unit Equipment was undertaken in year by the contracted specialist provider. The Trust's stock of PRPS Suits, based on a directive from the Office of the Deputy Prime Minster, has an extended shelf life up to ten years from manufacture. This being the case the Trust has followed the explicate direction and criteria to ensure this is taken forward and compliance is fully documented.

2.9. The Trust in 2015 aligned its CBRN Process to that of all initial responders by adopting the 'Initial Operational Response' (IOR) methodology of dry decontamination prior to wet decontamination – IOR can be undertaken with public under the instruction of the Triage Nurse/Decontamination Zone Manager without a full deployment.

2.10. The number of staff trained to use the Trust CRBN Equipment currently stands at 26. A minimum of seven staff are required to operationalise the Decontamination Unit and therefore the Emergency Department continues to monitor the rota and 'call in' arrangements to ensure it is able to deploy this specialist resource in a timely fashion.

Exercise Lapwing (CBRN – Chemical Self Presenting Casualties Exercise)

2.11. Staff were subjected to a Live Exercise in June 2015. This Bi-Agency Exercise (Kent Fire and Rescue Service and Trust) was part of a suite of Exercises with direct reference to the regulated industrial activity on the Isle of Grain. Lessons identified from the joint deployment of resources have been reviewed by the Emergency Department CBRN Trainers and additionally have proved valuable in the initial planning proposals for the Emergency Department re-development.

Communication Tests

2.12. Two Mandatory Communication Tests using the Major Incident cascade were undertaken during the financial year. Preliminary enquiries were made in 2013/14 and repeated again in 2015/16 into a virtual multi-operator system which can launch a pre-set campaign and provide an auditable record. This modernisation will be explored more fully in 2016/17 by Health Informatics and remains a known limitation to the organisation in that it currently relies on Switchboard Operator/s to complete

the cascade list.

Exercises

2.13.   During 2015/16 the Trust took part in one Kent Resilience Forum Exercise. Exercise Tungsten (Multi-Agency Table-Top Exercise) Marauding Terrorist Firearms attack (MTFA). The main objectives were to raise awareness of the current MTFA threat and the specialist capability, validate the current Kent MTFA plan and model response and validate individual agencies plans. The Trust benefited from attendance at this exercise from the knowledge gained and the formation of the Trauma Network Emergency Planning Group; that now reports directly to the Trauma Board via Kings College Hospital.

2.14.   The Trust planned for and undertook a Black Start Generator Exercise on Sunday 9 August 2015. During the planning the Trust was able to further develop a detailed understanding of Electrical Resilience/Impact of disruption and publish an Addendum to the Significant Incident Plan (Electrical Resilience and Incident Plan Addendum OTCGR143). This will now occur bi-annually and the Plan reviewed as part of that process.

2.15.   The Trust undertook a primary exercise to consider the current level of knowledge and resource requirements in relation to a Medical Gas (Piped Oxygen Disruption). The findings from this exercise, which was played by staff within their own clinical environments, were submitted to the Trust Medical Gas Committee who has taken the lessons identified to enhance process, planning and training. The forward view is that this exercise will be undertaken again in 2016/17 to assess continuing improvement.

2.16.   In November 2015 the Trust took part in a multi-agency workshop to assess common understanding and perceptions in relation to the responsibilities of each agency if a whole site evacuation was ordered for an acute hospital. The outcomes for this led to a collective agreement that two types of plan are required, one for a planned (slow-time) evacuation and the other for a rapid evacuation. All acute Trusts can currently give assurance in relation to horizontal evacuation plans and therefore have been graded as compliant by NHS England via the CCG Audit. This being the case the findings from the workshop have gone back to NHS England South (South – East) to review the risk with the Local Resilience Forum – Risk Sub-group and the requirements for multi-agency planning.

2.17.   The Trust Major Incident Table Top Exercise was delayed from quarter four to May 2016 as a result of the requirement to prepare for and respond to the series of Industrial Action by British Medical Association in relation to the Junior Doctor Contract. This being the case there will be two exercises played within 2016/17 so as to still meet the requirement.

3. Training

3.1. The subject Training Needs Analysis (TNA) is reviewed and confirmed each December for delivery within the next financial year.

3.2. All staff receive an introduction to EPRR upon appointment via the corporate welcome although this offering has been significantly limited to information within a welcome pack. Therefore further to this key staff are invited via their management teams to attend bespoke EPRR training and refresher sessions as agreed within the TNA.

- During 2015/16 the targeted training offerings were role based with a total of 323 staff applying for and completing a bespoke course:
  - Senior Manager on Call Training (Major Incident and Significant Incident)
  - Executive on Call Training (Major Incident and Significant Incident)
  - Switchboard Operators (Major Incident and Radio Training)
  - Emergency Department Trainers (Major Incident and CBRN)
  - Emergency Department Medical Staff (Major Incident and Significant Incident)
  - Emergency Department Reception Staff (Major Incident and CBRN awareness)
  - Outpatient Staff (Customer Care Team) (Major Incident and Radio Training)
  - Service Managers (Writing and reviewing Service Business Continuity Plans, Significant Incident and Major Incident)
  - IT System Managers ((Writing and reviewing System Business Continuity Plans)
  - Security Staff (Major Incident, Significant Incident and Radio Training)
  - Imaging Accreditation Scheme (Major Incident and Significant Incident)

3.3. Training objectives are aligned to the requirements designated by Skills for Justice for Operational, Tactical and Strategic responses to incidents.

3.4. Induction Training is recorded on OLM by the Trust Learning and Development Team and reported via that Department.

3.5. Bespoke training is recorded via OLM by the EPRR Department.

3.6. During 2015 the Care Quality Commission inspected the Emergency Department and was critical in relation to the evidence held in the Department of the number of Medical staff who had received training. As stated at 3.4 and 3.5 all records of mandatory and bespoke training are held on OLM. An action was taken to resolve this on two levels and assurance reported back to the Corporate Team.

- Publish a copy of the Medical Staff Training within the Emergency Department

- Force book Medical Staff due to their clinical commitments; who otherwise may pass 31 March 2016 without undertaking refresher training.

3.7. In 2016/17 the programme will move to a competency self-assessment model. The offerings will be streamed against command and control methodology. The target being that staff self-assess prior to and following training, within their own EPRR Workbook and any staff not meeting the standard of 'Competent' or above after training (self-assessed as 'Novice' or 'Advanced Beginner') will receive a supplementary individual intervention within the following 6 months.

- Operational – Bronze Training (Major Incident, Significant Incident and CBRN awareness)

- Tactical – Silver Training (Major Incident, Significant Incident, CBRN awareness and running a Tactical Control Room)

- Strategic – Gold Training (Major Incident, Significant Incident, Media and running a Strategic Control Room)

In addition where detailed on TNA:

- Radio Training

- Emergency Department CBRN Deployment Training

- Service Managers (Writing and reviewing Service Business Continuity Plans, Significant Incident and Major Incident)

- IT System Managers (Writing and reviewing System Business Continuity Plans)

4. Risk Registers

4.1. The National Risk Register is unchanged for 2015/16.

4.2. The National Threat Level has been reviewed in the Kent and Medway Resilience Forum Risk Assessment; that underpins the Trust EPRR and Security planning assumptions.

4.3. The Kent and Medway Resilience Forum Risk Register has not been republished within 2015/16.

4.4. The Trust EPRR Risk Register currently has one reported risk. This is in relation to the resilience of the Trust Telecommunication System where it is not fully aligned to VoIP technology. (Voice over Internet Protocol is a category of hardware and software that enables people to use the Internet as the transmission medium for telephone calls by sending voice data in packets using Internet Protocol rather than by traditional circuit transmissions of the Public Switched Telephone Network)

5. Incidents

5.1. During 2015/16 the Trust had no requests from the Ambulance Service to be a declared receiving Hospital for casualties from a Major Incident.

5.2. Significant Incidents were graded on the basis of their disruption using the Significant Incident Plan Incident Matrix. There were five incidents reported as Moderate each requiring Directorate led intervention with monitoring by a member of the Executive in case of a requirement to escalate to Serious and thereby invoke a requirement to communicate with the Clinical Commissioning Group about a loss of contracted activity.

5.3. Following each incident a debrief was undertaken and corrective actions agreed and monitored via the Trust EPRR Group. In the case of the resilience of the underground water pipework the Estates and Facilities Directorate additionally made an entry on their Directorate Risk Register due to the age of the Trust infrastructure and the requirement for capital funding.

- Underground Water Leak Perimeter Road by Residence 8

- Underground Water Leak Social Club Car Park

- Intermittent failure of 64 Slice CT Scanner

- Boiler House Water Valve Leak

- Plant Room A Block Water Tank Valve Leak

5.4. The following incidents were graded externally by the Department of Health and a requirement to follow the prescribed EPRR Critical Command and Control methodology applied by NHS England.

- British Medical Association Industrial Action (December 2015, January, February, March and April 2016)

5.5. Following each incident a hot debrief was undertaken and corrective actions ratified by the principal Clinical Executive Director for any changes to forward planning for the next in the series and finally to cold debrief Report.

6. Incomplete Outputs from 2015/16 EPRR Work Plan and Corrective Action Database

6.1. Incomplete outputs from the 2015/16 EPRR Work Plan will be forwarded to the 2016/17 Work Plan. These are:

- Exercise Ragdoll – Infant Abduction Exercise with Kent Police.

- External ratification by contingency provider and finalisation of the Water

Resilience Plan and Significant Incident Addendum

- Maturity report and exercise of the Trust Health Informatics (post Health Informatics Service re-intergration)

- Trust Major Incident Table Top Exercise that has been postponed to May 2016 due to the time constraints of the BMA Junior Doctors Industrial Action.

6.2. Incomplete outputs from the 2015/16 Corrective Action Database will be forwarded to the 2016/17 Work Plan. These are:

- Service Business Continuity Plan for the Emergency Department aligned to re-development project.

7. EPRR Group Work Plan 2016/17

7.1. The Group Work Plan 2016/17 has been drafted for agreement at Appendix 1. It takes into account the following, in addition to the duties prescribed by the Civil Contingencies Act 2004:

- The NHS England EPRR Framework (Nov, 2015)

- The NHS England Business Continuity Management Toolkit (Feb, 2016)

- The Information Governance Toolkit Submission 2016/17

- Trust Strategy (content to be reviewed on publication) including but not limited to:
  - o Re -embedding of the EPRR programme and governance arrangements following the Trust structural changes 2015/16
  - o Assessment of the impacts of planned capital programs and the Estates Department planned maintenance programme for 2016/17
  - o Assessment of the impacts of planned IT infrastructure and system changes planned by Health Informatics for 2016/17

- Trust EPRR Plans and Policies matched to the Trust contractual requirements for the 2016/17 NHS Contract.

- Planned EPRR Policy and Plan updates for 2016/17

- EPRR Group Work Plan Actions not closed in 2015/16

- EPRR Group Corrective Actions not closed in 2015/16

- The ability to task and finish work required on any new or emerging EPRR risk in year that do not fall within the current planned capabilities of the Trust.

8. Recommendation to the Board

It is requested that the Board:

8.1. Re-affirm their understanding of the Trust's statutory obligations as a Category 1 responding organisation (Civil Contingencies Act (2004):

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

8.2. Note the designation of an Executive Lead for EPRR for 2016/17 to attend the Local Health Resilience Partnership and Chair the Trust Emergency Preparedness Resilience and Response Group.

8.3. Agree the 2016/17 EPRR Work Plan at Appendix 1.

Medway NHS Foundation Trust						APPENDIX 1
Emergency Preparedness, Resilience and Response Group Work Plan						The Medway NHS NHS Trust
2016/17						

Work Plan Objective - To demonstrate compliance with the requirements in Emergency Preparedness, Resilience and Response for the out-turn submission of 2016/17.

Work Plan Target		Activity	Lead	To Be Completed By	Milestone(s)	Action Taken/ Progress
1. **Plans and Policy updates**	1a	Annual prescribed review of the Trust Major Incident Plan POLCS006 and Paediatric Major Incident Arrangements POLCOM015 and PIL00001275-1	EPRR Department	September 2016	Final to August Group	
	1b	Annual review of Service/ IT System Business Continuity Plans	All Directorates	March 2017	Statement to December Group	
	1c	Three year review Management of Business Continuity Policy POLCOM031	EPRR Department	September 2016	Final to August Group	
	1d	Three year review Fuel Crisis Plan OTCOM0012	EPRR Department	September 2016	Final to August Group	
	1e	External ratification by contingency provider and Finalisation of the Water Resilience Plan and Significant Incident Addendum	EPRR Department/ Estates Department	August 2016	Final to August Group	
	1f	First anniversary review Adverse Weather Plan OTCOM022	EPRR Department	November 2016	Final to August Group	
2. **Corrective Actions from Incidents and reports/Governance**	2a	Close outstanding corrective actions from 2015/16	EPRR Department		Each Group	
	2b	Agree new corrective actions on exercises and incidents and maintain Database Reports	EPRR Department		Each Group	

	2c	CQC EPRR review of evidence for Standards with Governance Manager	EPRR Department	June 2016	Report to August Group	
	2d	Annual NHS England EPRR Assurance Programme	EPRR Department	August 2016	Report to December Group	
*3. **Training Programme/TNA***	3a	Annual Review	EPRR Department	November 2016	December Group	
*4 **Partnership Working***	4a	Medway Safety Advisory Group	EPRR Department		Monthly Meetings	
	4b	Swale Safety Advisory Group	EPRR Department		Bi- Monthly Meetings	
	4c	Isle of Grain Industry COMAH Exercises	EPRR Department	Exercise Combine April 2016 Linked CBRN Exercise June/July 2016	Report to August Group	
	4d	Kent Police (via Trust Security Group Lockdown, Infant Abduction, Missing Persons) KRF Mass Fatalities, Risk Assessment Group	EPRR Department	Continuous Policy Development/Joint Exercises and Training	KRF Minutes on File	
	4e	Kent Fire and Rescue Service KRF, Risk Assessment Group, North Group, Training Team.	EPRR Department	Continuous Policy Development/Joint Exercises and Training	KRF Minutes on File	
	4f	South East Coast Ambulance Service (NHS Emergency Planning Leads Meetings)	EPRR Department	Continuous Policy Development/Joint Exercises and Training	EP Leads Minutes on File	

Medway NHS Foundation Trust				APPENDIX 1
Emergency Preparedness, Resilience and Response Group Work Plan				The Medway **NHS**
2016/17				NHS Trust
Exercise/Testing Plan Objective - To demonstrate compliance with the requirements in Emergency Preparedness, Resilience and Response for the out-turn submission of 2016/17				
		Activity/Type/Aim	**Lead**	**Milestones**
5 **Testing Plan CBRN**	5a	Monthly Radiation RAMGENE Monitor testing	Emergency Department CBRN Lead	Report to each Group
	5b	Monthly ED Major Incident Cupboard Small Equipment Audit/Police Documentation Box checks	Emergency Department	Report to each Group
	5c	Monthly Personal Respiratory Protection Suit Audit	Emergency Department CBRN Lead	Report to each Group
	5d	Quarterly Decontamination Unit testing via deployment	Emergency Department CBRN Lead	Report to each Group
	5e	Annual Decontamination Unit maintenance (under contract)	EPRR Department	Annual Report to December Group
	5f	Annual Quality Assurance Programme for PRPS Suits	EPRR Department	Annual Report to December Group
	5g	Annual calibration of radiation RAMGENE Monitor	Emergency Department CBRN Lead	Annual Report to December Group

The table also has an **Action Taken/Progress** column on the far right, which is empty for all rows.

		Activity/Type/Aim	Lead	Attended By	Action Taken/Progress
6 **Exercise Plan - Major Incident Plan**	6a	Annual Trust Major Incident 1.Table Top Exercise 2. Live Exercise** (Switchboard METHANE to ED, ED Triage deployment, ED Triage Comms to Tactical Control and Tactical Control SITREP)	EPRR Department/ ED Trainers	Representatives of all Directorates and SECAmb	Exercise 1: May 2016 Exercise 2: October 2016
	6b	Attend one other external exercise in 2016/17	NHS England		Exercise1:
7 **Exercise Plan – Linked to Significant Incident Plan**	7a	Medway Exercise Ragdoll	EPRR Department with Women and Children Division	Kent Police	Exercise1:
8 **Exercise Service Business Continuity Plans**	6a	Key Service Business Continuity Plans Mini Table Top Exercises 1. Water 2. Electricity 3 IT Infrastructure 4 Medical Gases	EPRR Department	Senior Managers on call/Water Direct/Estates Staff/IT Staff/ Site Team Staff in own areas	Exercise 1: Exercise 2: Exercise 3: Exercise 4
9. **Testing Plan Communication**	7a	Annual Communications Test 1	Telecommunications Manager	Observer:	Test 1: June 2016
	7b	Annual Communication Test 2	Telecommunications Manager	Observer:	Test 2: February 2017
	7c	Out of Hours Communication Test	Telecommunications Manager	Observer:	Test 3: September 2016
	7d	Command Post Exercise	NHS England (Kent and Medway)		Exercise:

Live Exercise** to meet criteria of a Live Exercise (NHS England South)

Report to the Board of Directors

Board Date : 26 May 2016

Title of Report	Research & Development 2015 – 2016 Board Report
Reporting Officer	Dr Diana Hamilton-Fairley
Lead Director	Dr Diana Hamilton-Fairley
Responsible Sub-Committee	Quality Assurance Committee
Executive Summary	Medway Foundation Trust continues to support Research & Development with a broad range of clinical trials, over achievement in terms of patient recruitment and a broad range of studies across the clinical spectrum. This report outlines the progress and achievements over the last 12 months.
Risk and Assurance	Not Applicable
Legal Implications/Regulatory Requirements	Not Applicable
Recovery Plan Implication	Not Applicable
Quality Impact Assessment	Not applicable
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	**Information**
Recommendation	

Research & Development Annual Report for the period 1st April 2015 to 31st March 2016

1   Introduction

Medway Foundation Trust continues to support Research & Development with a broad range of clinical trials, over achievement in terms of patient recruitment and a broad range of studies across the clinical spectrum. This report outlines the progress and achievements over the last 12 months.

2   Commitment to research as a driver for improving the quality of care and patient experience

- There were 8958 patients recruited during the year to participate in research approved by the research ethics committee.
- The Medway NHS Foundation Trust was the highest at recruiting patients into clinical Trials in Kent, Surrey and Sussex (Out of 20 member organisations).
- All of the studies approved by the Trust went through full governance review and the median approval time was 11 days which is within the national timeline of 15 days.
- The Trust claimed £915k from the Clinical Research Network Kent Surrey & Sussex (CRN KSS). In addition £180k was received as direct income from trials.
- The good reputation of MFT in conducting research allowed expansion of our commercial portfolio with 7 commercial studies open last year and more in the pipeline.

3   Recruitment to NIHR studies

MFT is actively involved in research supported by the National Institute for Health Research (NIHR).

Figure 1 presents the annual recruitment target and the actual number of patients at MFT recruited into the NIHR adopted studies over six years with significant increase in recruitment over the last 2 years;

- 1st April 2010/31st March 2011,
- 1st April 2011/31st March 2012,
- 1st April 2012/31st March 2013,
- 1st April 2013/31st March 2014,
- 1st April 2014/31st March 2015
- 1st April 2015/31st March 2016.

Patient recruitment to National Institute of Health Research (NIHR) suppported research at Medway NHS Foundation Trust
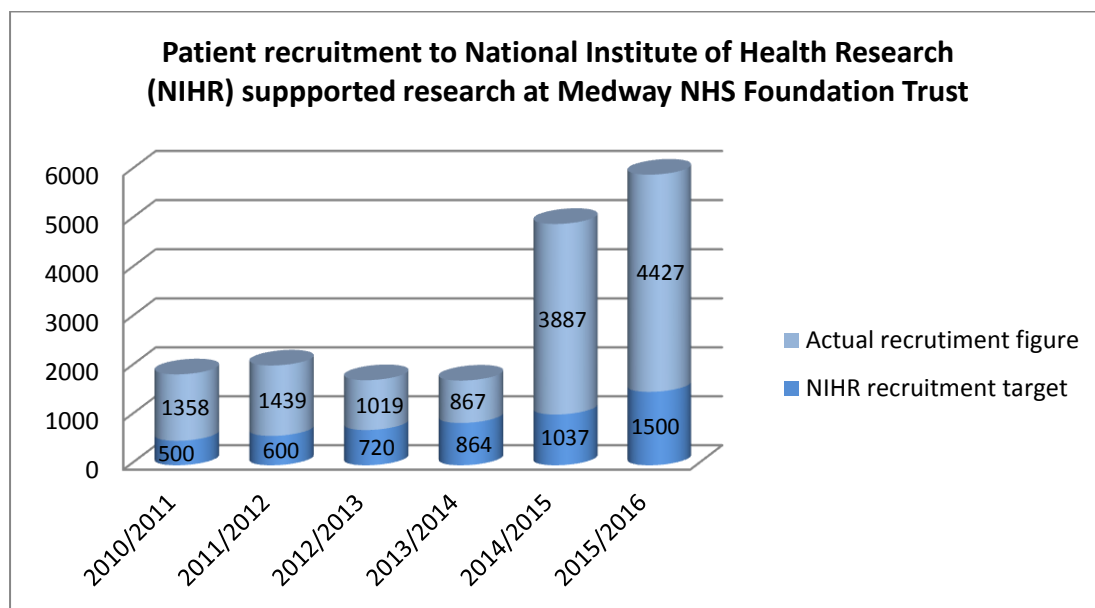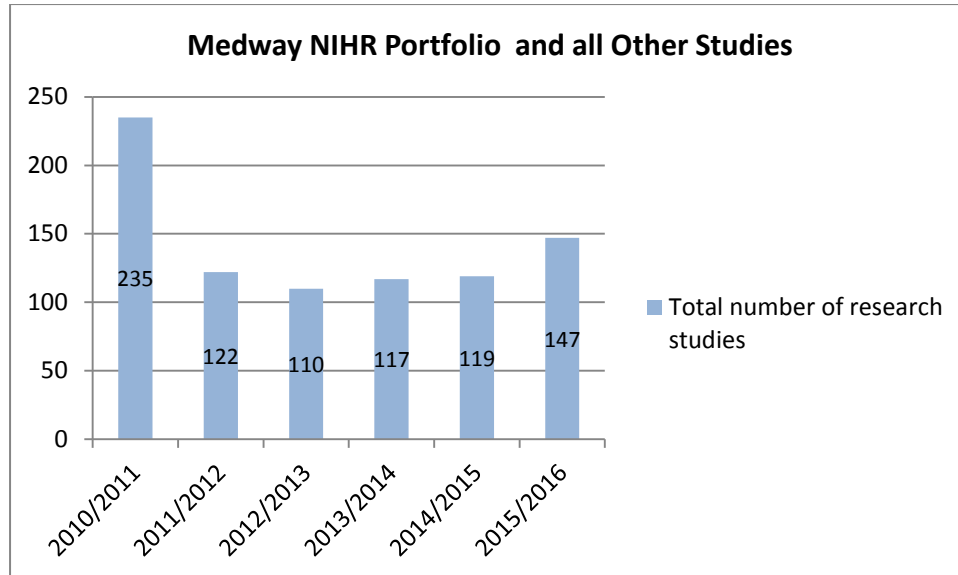
Figure 1.

Participation in clinical research demonstrates MFT's commitment to improving the quality of care we offer to patients and to making a contribution to improving healthcare services. Our clinical staff stay abreast of the latest treatment possibilities through active participation in many different types of research that lead to successful patient outcomes.

For the period 1st April 2015 to 31st March 2016 there were a total of 147 research studies across 21 specialties conducted at MFT, including staff undertaking MSc final year dissertations. For the same period MFT took part in 128 NIHR supported studies, including 62 cancer specialty studies.

Figure 2 presents the number of studies that MFT participated in over six years, from 1st April 2010 to 31st March 2016.

Medway NIHR Portfolio and all Other Studies

A bar chart showing the total number of research studies per year:
- 2010/2011: 235
- 2011/2012: 122
- 2012/2013: 110
- 2013/2014: 117
- 2014/2015: 119
- 2015/2016: 147

The majority of cancer studies are designed with the intent to increase life expectancy. The Investigators for a number of other studies stated that their research <u>definitely</u> contributed to the reduction in overall mortality.

4   Examples of the breadth of Research Studies undertaken at Medway Foundation Trust

Medway Foundation NS Trust is involved in a wide range of research studies and some examples and rationale are provided below;

Table 2 examples of the intent/rationale for eight studies undertaken between 1st April 2015 and 31st March 2016.

Study Name / Acronym	Rationale
RESPITE	Childbirth can be extremely painful and the majority of women who deliver in modern obstetric units choose a pharmacological method of pain relief. Aim of the study is to compare two types of pain relief medication (remifentanil intravenous PCA to intramuscular pethidine). In addition to effectiveness of pain relief, the effects on the baby and mother at delivery are also considered.

LeoPARDS	Current treatment for septic shock includes giving patients adrenaline-like drugs via drips into a large vein. However, adrenaline-like drugs can have side-effects. The trial investigates another drug called levosimendan to test whether it improves blood flow to prevent organs failing and if it reduces the side-effects of adrenaline type drugs.
EPOCH	Out of 150,000 patients undergoing emergency surgery, 90,000 patients develop complications resulting in over 20,000 deaths. The aim of the study is to evaluate the effect of a quality improvement intervention to promote the implementation of an integrated peri-operative care pathway on survival at 90 days following emergency laparotomy.
AQUA	Assessing children who are showing some of the signs and symptoms associated with attention can be a difficult task. A new computerised assessment has been designed to try and improve the measurement of these symptoms. The aim of the project is to find out if a computerised assessment (the QbTest) can help clinicians confirm or exclude a diagnosis of ADHD and improve medication management.
HIPvac	Genital warts present as lumps in the skin of the anogenital area. While usually painless with occasional irritation or bleeding, they are emotionally distressing, require prolonged, time consuming and uncomfortable treatment, and frequently relapse after apparently successful treatment. Surgery may be required in recurrent or persistent cases. The best and most cost-effective treatment for patients with anogenital warts is unknown. The study aims to compare the effectiveness of a course of HPV vaccine started at the same time as topical wart treatment.
POSNOC	Women with early breast cancer that has spread to the first 1 or 2 lymph glands (sentinel nodes) receive chemotherapy or endocrine therapy (hormone therapy), or both. Radiotherapy is given to the breast in all women who undergo lumpectomy, and to the chest wall in some who undergo mastectomy. These treatments are called

	adjuvant therapy. Currently, these women also have treatment to their **armpit (axilla)**. This treatment is either a second operation to remove all the lymph glands in the armpit, or radiotherapy to the armpit. The aim of the study is to compare (i) adjuvant therapy alone with (ii) adjuvant therapy plus armpit treatment.
MaPLe	The purpose of the project is to create dataset which links molecular testing of lymphomas to routine clinical data about patient demographics, treatments and other clinical outcomes. The aim is use the information in targeted treatment of lymphomas and to test whether molecular characterisation of lymphoma can be carried out as a standardised, routine practice in NHS.
MDS Bio	The myelodysplasmic syndromes (MDS) are a group of neoplasmic blood disorders where patients have low red cells (anaemia), white cells (neutropenia) and platelets (thrombocytopenia). They require support with red cell and platelet transfusions and commonly suffer infections, develop leukemia, rheumatoid arthritis and other medical conditions. The aim of this study is to examine the genetic programs in normal and abnormal bone marrow cells in order to deduce how blood cells are made and to find out what happens when things go wrong.

5   Links to Patient Health Outcomes

Medway NHS Foundation Trust is committed to improving patient outcomes and an active research programme plays a key part in supporting that outcome.

In the period between 1st April 2015 and 31st March 2016 the Investigators at MFT published 15 articles listed in Appendix 1. Continual growth in research activity indicates our commitment to work in successful partnership to provide flexible, first class health care to local people and our desire to improve patient outcomes and experience across the NHS.

6   Innovation

Our engagement with clinical research also demonstrates MFT's commitment to testing and offering the latest medical treatments and techniques. As an example, The Trust supports innovative new technology 'Cupris Health App'. Ear, nose and throat infections are an everyday occurrence. Unfortunately as much as 90% of sufferers are children who are likely to develop an ear infection by the age of six. 50% of these children are prone to reoccurring ear infections thereafter. This chronic condition not only requires parents to repeatedly take time off work but also keeps children off school in order to see their doctor.

The Cupris communication app and website platform has been developed to simplify remote diagnosis and management of such infections from the comfort of the patient's home.

The app achieves this by providing the patient who suffers from reoccurring infections with a medical device that mimics an Otoscope and is attachable to a smart phone. Through the device an image of the ear, nose or throat area can be captured, the image is then uploaded on the app, together with the patient's medical history. After answering some simple customised questions the data is swiftly sent onto the GP or ENT Consultant. The information enables a decision whether a referral or consultation is required.

7   Staff Participating in Research

There are 75 clinical staff participating in research approved by the research ethics committee covering 21 medical specialties

Number of Studies by Medical Speciality	2015 - 2016
Cancer	62
Cardiovascular	4
Critical Care	9
Dermatology	1
Diabetes	2
Ear Nose and Throat	1
Fetal Medicine	5
Gastroenterology	1
Genitourinary Medicine	2
Gynaecology	4
Neonatology	6
Neurosciences	7
Obstetrics	2
Older People	2
Orthopaedic	3
Other*	13
Paediatrics	3
Respiratory and Thoracic	3
Rheumatology	6
Stroke	4
Surgery	5
Urology	2

8   Notable Achievements 2015 – 2016

The collaboration with the local academia continues to grow. Examples include:

- Grand Round in June 2015 where three local Universities (the University of Greenwich, Kent and Canterbury) showcased their interests and achievements in research.
- R&D Officer for non-portfolio studies recruited in September 2015. The post is jointly funded with the University of Greenwich (UoG). The position has been extremely successful and prompted submission of 2 funding applications by the end of March 2016 (total around £700K) and further 7 are in a working progress.
- Facilitated student placements (in a form of attachments) at the Cardiology Department for students from the Institute of Medical Sciences at Christ Church University.
- A PhD student from the UoG is working at the Trust supporting Estates and Facilities Manager in developing Energy saving project. Another business case for a PhD post with the University of Kent to work on a similar project relating to water saving is currently being developed. The projects have potential of saving millions of pounds to the Trust and the recommendations are most likely to be transferred across NHS.
- The Trust participates in a number of student vacation schemes.

Other events:

- In November 2015, local MP Kelly Tolhurst visited to specifically learn about Trust research activities.
- Clinical Trials Day in May 2015 for patients. The feedback was extremely positive and another event is being organised in June 2016 (Kelly Tolhurst will be attending).
- One of the research investigators featured his project in local news.
- Other governance related achievements:
- From 1st April 2016, a single centralised Healthcare Research Authority (HRA) application and approval process has been implemented (replacing the previous Ethics). The R&D Department had to re-align its processes accordingly and continues to monitor the changes in requirements.
- A new Local Permission Management System (LPMS) called EDGE is being introduced by the National Institute for Health Research (NIHR). The R&D Department started to prepare for the transition of the data from the current system ReDA.

Diana Hamilton-Fairley, Medical Director
Edyta McCallum, Research & Development Manager
May 2016

Appendix 1

<u>List of publications</u>

I. Akolekar R, Syngelaki A, Gallo DM, Poon LC, Nicolaides KH. Umbilical and fetal middle cerebral artery Doppler at 35-37 weeks' gestation in the prediction of adverse perinatal outcome. Ultrasound Obstet Gynecol. 2015; 46:82-92.

II. Akolekar R, Sarno L, Wright A, Wright D, Nicolaides KH. Fetal middle cerebral artery and umbilical artery pulsatility index: effects of maternal characteristics and medical history. Ultrasound Obstet Gynecol. 2015; 45:402-408.

III. Balachandran AA, Duckett JR. The risk and severity of developing symptomatic palpitations when prescribed Mirabegron for overactive bladder. Euro J Obstet Gynecol Reprod Biol 2015; 187; 60-3.

IV. Carbajal R, Eriksson M, Courtois E, et al, on behalf of the EUROPAIN Survey Working Group. Sedation and analgesia practices in neonatal intensive care units (EUROPAIN): results from a prospective cohort study. *Lancet Respir Med* 2015; published online Sept 24. http://dx.doi.org/10.1016/S2213-2600(15)00331-8.

V. Earl HM, Hiller L, Dunn JA, Blenkinsop C, Grybowicz L, Vallier AL, Abraham J, Thomas A, Provenzano H, Hughes-Davies L, Gounaris I, McAdam K, Chan S, Ahmad R, Hickish T, Houston S, Rea D, Bartlett J, Caldas C, Cameron DA, Hayward L. Efficacy of neoadjuvant bevacizumab added to docetaxel followed by fluorouracil, epirubicin, and cyclophosphamide, for women with HER2-negative early breast cancer (ARTemis): an open-label, randomised, phase 3 trial. Lancet Oncol 2015; 16: 656-66.

VI. Gil MM, Revello R, Poon LC, Akolekar R, Nicolaides KH. Clinical implementation of routine screening for fetal trisomies in the UK NHS: cell-free DNA test contingent on results from first-trimester combined test. Ultrasound Obstet Gynecol. 2016;47:45-52.

VII. Lally PJ, Pauliah S, Montaldo P, Chaban B, Oliveira V, Bainbridge A, Soe A, Pattnayak S, Clarke P, Satodia P, Harigopal S, Abernethy LJ , Turner MA, Huertas-Ceballos A, Shankaran A, Thayyil A. Magnetic Resonance Biomarkers in Neonatal Encephalopathy (MARBLE): a prospective multicountry study. BMJ Open 2015;5:e008912.doi:10.1136/bmjopen-2015-008912.

VIII. Maaskant JM, Vermeulen H, Apampa B, Fernando B, Ghaleb MA, Neubert A, Thayyil S, Soe A. Interventions for reducing medication errors in children inhospital (Review). *The Cochrane Library* 2015, Issue 3.

IX. O'Gorman N, Wright D, Syngelaki A, Akolekar R, Wright A, Poon LC, Nicolaides KH. Competing risks model in screening for preeclampsia by maternal factors and biomarkers at 11-13 weeks gestation. Am J Obstet Gynecol. 2016;214:103.e1-103.e12.

X. Peasgood T, Bhardwaj A, Biggs K, Brazier JE, Coghill D, Cooper CL, Daley D, De Silva C, et al. The impact of ADHD on the health and well-being of ADHD children and their siblings. Eur Child Adolesc Psychiatry DOI 10.1007/s00787-016-0841-6.

XI. Revello R, Sarno L, Ispas A, Akolekar R, Nicolaides KH. Screening for trisomies by cell-free DNA testing of maternal blood: consequences of failed result. Ultrasound Obstet Gynecol. 2016 Jan 7. doi: 10.1002/uog.15851.

XII. Ridgeon E, Bellomo R, Myburgh J, Saxena M, Weatherall M, Jahan R, Arawwawala D, Bell S, Butt W, Camsooksai J, Carle C, Cheng A, Cirstea E, Cohen J, Cranshaw J, Delaney A, Eastwood G, Eliott S, Franke U, Gantner D, Green C, Howard-Griffin R, Inskip D, Litton E, MacIsaac C, McCairn A, Mahambrey T, Moondi P, Newby L, O'Connor S, Pegg C, Pope A, Reschreiter H, Richards B, Robertson M, Rodgers H, Shehabi Y, Smith I, Smith J, Smith N, Tilsley S, Whitehead C, Willett E, Wong K, Woodford C, Wright S, Young P. Validation of a classification system for causes of death in critical care: an assessment of inter-rater reliability. Critical Care and Resuscitation. Volume 18 Number 1. March 2016.

XIII. Syngelaki A, Nicolaides KH, Balani J, Hyer S, Akolekar R, Kotecha R, Pastides A, Shehata H. Metformin versus Placebo in Obese Pregnant Women without Diabetes Mellitus. N Engl J Med. 2016;374:434-443.

XIV. Valiño N, Giunta G, Gallo DM, Akolekar R, Nicolaides KH. Biophysical and biochemical markers at 35-37 weeks' gestation in the prediction of adverse perinatal outcome. Ultrasound Obstet Gynecol. 2016;47:203-209.

XV. Valiño N, Giunta G, Gallo DM, Akolekar R, Nicolaides KH. Biophysical and biochemical markers at 30-34 weeks' gestation in the prediction of adverse perinatal outcome. Ultrasound Obstet Gynecol. 2016;47:194-202.

Report to the Board of Directors

Board Date : 26 May 2016

Title of Report	Communications Report
Reporting Officer	Paul Lehmann, Director of Communications
Lead Director	Paul Lehmann
Responsible Sub-Committee	
Executive Summary	This paper outlines our communications activity over the last month, including around the CQC's letter on progress with our recovery.
Risk and Assurance	N/A
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	• 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
Quality Impact Assessment	N/A
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Information
Recommendation	Board is requested to note the paper

Communications Report : May 2016

Introduction

The last few weeks have been good in terms of improving our external profile, and we have also made steady progress in continuing to build staff engagement.

PUBLICATION OF SIR MIKE RICHARDS' LETTER TO JEREMY HUNT

We carried out an intensive burst of activity to ensure that our staff and stakeholders knew about the letter, which was published on the day of the last Board meeting. We held a meeting for senior managers the day before publication, which was attended by about 70 people – a great turnout, given it was only possible to give about 24 hours' notice of the meeting. We sent out communications to all staff as well as governors straight after midnight, the planned publication time of Sir Mike's letter. Later that morning, we sent notes to key local politicians and to all members.

In the media, Lesley did a live interview with BBC Radio Kent on the morning of publication and with BBC South East and ITV Meridian straight after the Board meeting, in the afternoon. Both channels gave the letter extensive coverage in their evening reports. There was also significant coverage in the Medway Messenger and a positive piece in Health Service Journal.

EMERGENCY DEPARTMENT ENABLING WORKS

The start of the roadworks earlier this month was a major milestone in the continuing refurbishment of the ED. In the not too distant past, my sense is that it would have been left to staff and local people to find out about this on a reactive basis, but we made sure we were proactive in our communications. We told staff the week before that the work was happening, and that this would pave the way for the start of works on majors and resus. We also spoke to the local ward councillors to let them know, in case local residents contacted them about any disruption. We also tipped off the Messenger so that they could publicise the works and ensure that people knew that there could be minor disruption. In addition, we posted information about the works via our Twitter account, including a link to the press release. BBC South East's Mark Norman also commented on the works via his Twitter account.

OTHER MEDIA ISSUES

Other issues covered in the media over the past couple of weeks have been as follows:

- The turnaround of the maternity department – we promoted this in the Kent and Medway print and online media, following earlier coverage in the BBC

- A press release about the new Medical Model was sent out to local and regional media contacts
- Michelle Ashby inquest. Despite the Coroner concluding that Mrs Ashby died of natural causes, we still attracted negative attention from national titles, including the Mail and Mirror. In response to this, we issued a short statement acknowledging the coroner's verdict and passing on our best wishes to Mrs Ashby's family.
- The latest junior doctors' strike created the usual interest from local and regional media. In keeping with the previous strikes, we issued a statement on behalf of Director of Clinical Operations Margaret Dalziel, advising of our contingency plans.
- The Trust featured in documentary 'Crash: An anatomy of an accident' which aired on ITV nationally and demonstrated the great skill and teamwork of our doctors and nurses during the 2013 Isle of Sheppey road collision. The Kent Messenger online, print and broadcast also covered the story with interviews from Consultant, Abhijit Dey.
- The Medway Council Labour Group issued a press release to the Kent Messenger saying that 32% of people in Medway are unable to make a timely appointment with their family doctor. Labour Health Spokesperson Teresa Murray cited this as a key reason for the Trust receiving such 'high demand' from the public.

OTHER PUBLIC-FACING COMMUNICATIONS

This has been another good month on social media. Over the past 30 days we have engaged with 51,400 people on Twitter and 121,226 people on Facebook. We have gained 72 new followers on Twitter, taking our total number of followers to over 2,000 for the first time. We have also gained 329 new followers on our Facebook account, taking our total number of followers to 3,737 respectively.

Key topics over the last month included our Governor coffee mornings – the social media activity, together with the mailings to members, publicity by Medway Council and coverage in the Medway Messenger helped to ensure a good turnout for these events.

Our top post was around International Nurses day on 12 May which reached an audience of 138,374. We continue to build relations with local and national health organisations with our posts retweeted/shared by the Nursing Times, Healthwatch Medway, Medway Community Healthcare, NHS Medway CCG and A Better Medway. A number of stakeholders and journalists also commented positively on social media about Sir Mike Richards' letter.

News @ Medway this month was designed to tell the story of changes taking place in the Trust, with features on the medical model, Home First and our deteriorating patient programmes, among others.

We have also been working with the governors to plan forthcoming events for members. Publicity for the members' event on innovation on 18 May has generated a fair degree of interest (this will have taken place by the time of the Board). We have invited members and governors to participate in our Clinical Trials Day on 6 June, which will see our consultants

speak about the ground-breaking work they are doing in various different research areas, such the use of iPhone technology to detect hearing problems. We are also planning a members / public event on smoking in late June / early July.

WHAT'S COMING UP?

The next key milestone in terms of staff engagement is the publication of a magazine called Our Medway, which profiles a number of different individuals and teams in the Trust, telling the story of what they are doing to provide the best of care for patients and improve the hospital. This is due for publication around the time of the Board meeting.

Report to the Board of Directors

Board Date : 26 May 2016

Title of Report	Quality Assurance Committee
Reporting Officer	Ewan Carmichael
Lead Director	Ewan Carmichael
Responsible Sub-Committee	
Executive Summary	Priority was given to attending the 'Sign Up for Safety' day, which provided a comprehensive overview on quality matters within the Trust (the QAC itself was cancelled). The day was a credit to the Trust and those who organised with evidence of considerable improvement in many areas, but also of topics where the Trust must concentrate (those areas are listed in the main body of the report). In future, every effort must be put into gaining maximum effect within the Trust from such a valuable event.
Risk and Assurance	
Legal Implications/Regulatory Requirements	
Recovery Plan Implication	Yes
Quality Impact Assessment	No. I consider that the Trust having identified and highlighted areas for improvement, has already started the development process.
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Assurance Information
Recommendation	● The Trust embraces the potential opportunity presented to learn and act on those areas known within its workforce yet requiring further effort. ● Focusing on the areas drawn out as causes for concern (in the attached report) will produce genuine improvement in patient safety and quality improvement.

Quality Assurance Committee Chair's report to the Trust Board On 'Sign Up for Safety'

May 2016

The Trust organised the annual 'Sign Up for Safety' day on the proposed date of the May QAC. However, given the broad remit of the day, the direct relevance of the subject matter to the efforts of the QAC, and the opportunity to get a sense of the interest in safety and quality improvement among the workforce, I decided to cancel May's QAC so that my fellow NED member and I could devote our attention to attending the day. I am glad we did, and we have both agreed the content of this report.

The day was very well organised, with a strong programme, which was well-structured, imaginative and relevant. It's content was consistent with the Trust's aims, strategy and priorities and I think it worth drawing to the Board's attention that the Kent, Surrey and Sussex Patient Safety Collaborative (KSS PSC) Co-Director, who attended, stated in his own presentation that he was "blown away" by the change he had seen. This was echoed by the Regional Medical Director.

Uptake from staff was perhaps fair, given that so many would be at the clinical coalface. The greatest number in the lecture theatre at any time was about 50, reflecting a broad range of disciplines (and special mention is due to a notably good turnout from Physiotherapy and Women's and Children's) and seniority, and there was a rolling turnover of attendees listening through the day. That said, it would be even better if the opportunity had been taken by directorates and departments to pack the theatre, because there was much of importance and value.

We got the impression that many of the attenders were familiar faces and, whilst admirable, makes one wonder whether the Trust has records showing those who seldom, or never, attend anything other than the mandated minimum. This would be worth investigating, if it is not already known.

If the demands of the workload are cited as the reason not to attend, efforts must be sought to support 'buy-in', by both individuals and line-management, enabling and empowering staff to attend such a valuable day in terms of safety and quality improvement.

Importantly, everything on the programme is known to someone in the Trust, so our reflections and recommendations are not novel, intended instead to reinforce concentration on a few key topics. Audit demonstrates that there has been simultaneously considerable improvement but also areas where we still have a way to go.

Good points, which should be maintained or even reinforced, would include (NB. those marked with (*) have an accompanying remark on areas to focus on in the subsequent section):

- The Trust was an early contributor to KSS PSC, demonstrating leadership within the region and active commitment to patient safety.

- The Trust has clear safety priorities.

- Serious Incident investigation is improving and has sped up (*).

- There have been no deaths associated with emergency laparotomy in the first half of the year, making the Trust better than the national average.

- Particular effort has been made to prevent Falls to Fracture.

- Sepsis bundle compliance is improving (*).

- Effort has gone into Pressure Ulcer monitoring (*).

- Expert frailty cover has been extended to 7 days per week.

- There is now a dedicated sedation bay in ED, making it clearer where, and to whom, sedation is being given.

Areas where there is continuing cause for concern, requiring attention, include:

- The Trust has not exploited the opportunities presented by technology, such as…

  - We should seek more intelligent linking of patient safety data.

- Important staff concerns include:

  - Staffing levels.

  - A feeling that they are given insufficient time to complete tasks properly.

  - A plea for training in incident investigation (NB. This is being rolled out).

- Despite NEWS score compliance improving, our capacity to respond to unwell patients requires improvement (although I note efforts to recruit appropriate staff).

- Sepsis bundle compliance is not consistent.

- On Acute Kidney Injury, we are not good enough at recording fundamental information, such as fluid balance.

- Despite overall awareness of pressure ulcers, some wards must focus on assessment, skin and nutritional factors. Also, everyone should be mindful of poor conditioning created by hospital stays as patients are transferred onwards.

- For patients recorded as Do Not Attempt Cardio-Pulmonary Resuscitation, 50% have inadequate records of Ceiling of Care, which creates avoidable uncertainty on what to do.

In summary, the efforts put into the Sign Up for Safety day, and many of the activities provided as evidence, are particularly encouraging but, at all levels, the Trust must continue to ensure that this is more than a paper exercise, embraced by all, and which supports improvement.

Recommendations:

- My top recommendation is that, at all levels, the Trust embraces the potential opportunity presented to learn and act on those areas known within its workforce yet requiring further effort.

- Focusing on the areas drawn out as causes for concern (above) will produce genuine improvement in patient safety and quality improvement.

E B Carmichael
Non-Executive Director; Chair, Quality Assurance Committee
20 May 2016