Agenda

NHS Medway NHS Foundation Trust

Public Meeting of the Trust Board

Date: On 04 May 2017 at 1.30pm – 4pm

Location: Boardroom, Postgraduate Centre, Medway Maritime Hospital

Item	Subject	Presenter	Time	Action
1.	Patient Story	Director of Nursing	1.30pm	Note
Opening of the Meeting				
2.	Chair's Welcome	Chairman	2.00pm	Note
3.	Quorum	Chairman		Note
4.	Register of Interests	Chairman		Note
Meeting Administration				
5.	Minutes of the previous meeting held on 6 April 2017	Chairman	2.05pm	Approve
6.	Matters Arising Action Log	Chairman		Note
Main Business				
7.	Chair's Report	Chairman	2.10pm	Note
8.	Chief Executive's Report	Chief Executive	2.15pm	Note
9.	Strategy a) STP Update b) Trust Improvement Plan	Medical Director & Chief Executive Chief Executive	2.25pm	Note Discussion
10.	Quality a) IQPR	Executive	2.45pm	Discussion
11.	Performance a) Finance Report b) Communications Report	Director of Finance Director of Comms	3pm	Discussion Discussion
12.	Governance a) Corporate Governance Report b) EPRR Annual Report c) Board Assurance Framework	Director of Corporate Governance, Compliance, Legal	3.15pm	Assurance Assurance Assurance Note

Agenda

		& Risk		
13.	People a) Workforce Report	Director of HR & OD	3.25pm	Discussion
For Approval				
14.	Membership Strategy	Trust Secretary	3.45pm	Approve
15.	A&E Improvement Plan	Chief Executive		Approve
Reports from Board Committees				
16.	Quality Assurance Committee Report	QAC Chair	3.50pm	Note
17.	Finance Committee Report	Finance Chair		Note
AOB				
18.	Council of Governors' Update	Governor Representative	3.55pm	
19.	Any other business	Chairman		Note
20.	Questions from members of the public relating to the Agenda	Chairman		Discussion
Close of Meeting				
21.	Date and time of next meeting 1st June 2017 Boardroom, Post Graduate Centre, Medway Maritime Hospital			

Apologies: Diana Hamilton-Fairley, Medical Director

NHS Medway NHS Foundation Trust

MEDWAY NHS FOUNDATION TRUST

REGISTER OF INTERESTS FOR BOARD MEMBERS

1.	Jon Billings Non-Executive Director	• Director of Fenestra Consulting Limited • Associate of Healthskills Limited • Associate of FMLM Solutions
2.	Ewan Carmichael Non-Executive Director	• Timepathfinders Ltd • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
3.	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
4.	Stephen Clark Chair	• Pro-Chancellor and chair of Governors Canterbury Christ Church University • Deputy Chairman Marshalls Charity • Chairman 3H Fund Charity • Non-Executive Director Nutmeg Savings and Investments • Member Strategy Board Henley Business School • Business mentor Leadership Exchange Scheme with Metropolitan Police • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Access Bank UK Limited – Non Executive Director
5.	James Devine Director of HR & OD	• Member of the London Board for the Healthcare People Management Association
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.	Anthony Moore Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
9.	Joanne Palmer Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Lloyds Bank (Fountainbridge 1) Limited • Lloyds Bank (Fountainbridge 2) Limited • Halifax Premises Limited • Gresham Nominee1 Limited • Gresham Nominee 2 Limited

		• Lloyds Commercial Properties Limited • Lloyds Bank Properties Limited • Lloyds Commercial Property Investments Limited • Target Corporate Services Limited
10.	Karen Rule Director of Nursing	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
11.	Mark Spragg Non-Executive Director	• Trustee for the Marcela Trust • Trustee of the Sisi & Savita Chartiable Trust • Director of Mark Spragg Limited
12.	Jan Stephens Non Executive Director	• Trustee of Medway Youth Trust • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds. • Trustee of The Foord Almshouses
13.	David Rice Company Secretary	• Director and shareholder of Shooters Hill Management Co Limited

Meeting in Public

Medway NHS
NHS Foundation Trust

Board of Directors Meeting in Public on 06/04/2017 held Trust Boardroom, Postgraduate Centre, Medway Maritime Hospital

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Mrs L Dwyer	Chief Executive	LD
	Mr J Billings	Non-Executive Director	JB
	Mr E Carmichael	Non-Executive Director	EC
	Mr D Cattell	Interim Finance Director	DC
	Mr J Devine	Director of Workforce	JD
	Dr D Hamilton-Fairley	Medical Director	DHF
	Mrs J Palmer	Non-Executive Director	JP
	Mr M Spragg	Non-Executive Director	MS
Attendees:	Ms G Alexander	Director of Communications	GA
	Mrs S Hay	Deputy Director of Nursing, Co-ordinated Surgical Directorate (Representing the Director of Nursing)	SH
	Mr J Lowell	Director of Clinical Operations, Women and Children's Directorate	JL
	Mr D Rice	Trust Secretary	DR
Observers:	Mrs D King	Governor Board Representative	DK
Apologies:	Mr T Moore	Non-Executive Director	TM
	Mrs K Rule	Director of Nursing	KR
	Mrs J Stephens	Non-Executive Director	JS
	Mrs L Stuart	Director of Corporate Governance, Risk, Compliance & Legal	LS
	Members of the public/staff/Governors (7)		

PRESENTATION

The Chairman welcomed Caroline Selkirk, Medway CCG to the meeting.

CS gave a presentation entitled "Making Medway Better" which outlined the various initiatives being developed to provide integrated care across the Medway area.

1. Welcome and Apologies for Absence

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

2. Quorum

2.1 The Chairman confirmed that a quorum was present.

3. Register of Interests

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

4. Minutes of the Previous Meeting

4.1 The minutes of the meeting held on 2 March 2017 were **APPROVED** for signature as a true and accurate account of the meeting subject to minor amendments.

5. Matters Arising – Action Log

5.1 The Board of Directors **RECEIVED** the Action Log which was noted and updated accordingly.

6. Chairman's Report

6.1 The Chairman welcomed the two new non-executive directors, Jon Billings and Mark Spragg to their first board meeting. A third new non-executive Adrian Ward, would join the Board in July to coincide with the completion of the second and final term of Jan Stephen's directorship.

7. Chief Executive's Report

7.1 The Chief Executive presented her report which was taken as read and it was noted that:

- The Trust had held a successful Quality Summit on 17 March which had brought together all the Trust's system partners.
- The Trust's buddying agreement had ended on 31 March and this would be concluded at a closure event to be held on 25 April 2017.
- The redevelopment of ED was on track for delivery by the end of December 2018.
- A new substantive Director of Finance, Tracy Cotterill, had been appointed and would be joining the Trust at the beginning of May 2017 whilst Darren Cattell would remain as Interim Finance Director until the end of July 2017 enabling a period of transition.

- There had been recognition for staff service excellence at the NHS Kent, Surrey & Sussex's leadership and innovation awards with an award to Dr Sanjay Suman, Consultant Geriatrician for the Trust's Proactive Assessment Clinic for the Elderly and Dr Ghada Ramadan, Deputy Medical Director for the Women and Children's Directorate which had been a finalist for "Excellence in Quality and Safety".
- The Trust's School Nursing Contract with Swale had ended on 31 March 2017 as the service had changed to a contract to cover the whole of Kent.
- The "next steps" document had been published by NHSI and NHSE on 31 March 2017 and this set out the Five Year view and priorities for the next two years including delivering financial stability, improving A&E performance, strengthening access to GP & primary care and improving cancer and mental health services.
- An extra £2bn will be provided over three years for local authorities to fund social care, with £1bn available for 2017/18 and the Trust is developing its formal application for funding from the £100m capital budget for A&E departments.
- There had been an expansion of Financial Special Measures although NHSI had not published the criteria, the Trust was not expected to meet those currently in operation.

8. Strategy

8.1 STP Update

8.1.1 DHF explained that the final version of the "Case for Change" had been produced as progress is made on the Kent and Medway Sustainability and Transformation Plan (STP). The "Case for Change" set out the reasons for why the system needed to change and what was the best way of meeting the needs of the local population now and in the future. The plan outlined the fact that there was around £3.6bn available to be spent on health and social care each year and it was necessary to decide the best way of these being deployed.

8.2 Trust Improvement Plan

8.2.2 LD explained that the PMO had ceased with effect from 31 March 2017 and the Trust would be heading into Phase 3 of its improvement plan which had been scoped and would be presented to the Board in detail to explain the Trust's strategic objectives, key focus areas, and the CQC improvement plan.

8.2.3 SC noted that it was assuring that the improvement plan could now be continued by the Trust's own management.

8.2.4 Following a query from JB about staff engagement, LD explained that sustainment of the improvement plan would be driven by the staff and there would be a system of "upskilling" and providing support.

9. Quality

9.1 Summary of Quality Issues arising from the CQC Report

9.1.1 DHF explained that following the publication of the CQC report on 16 March 2017 there were 13 must dos and 20 should dos which were contained in an

improvement plan which would form a part of an action plan agreed by NHSI to be submitted to the CQC by 14 April 2017. It was noted that the "must and should dos" had been known by the Trust before the publication of the CQC report and had included hand-washing and compliance with infection control measures regarding patients in isolation, mixed-sex accommodation breaches and the pathway through ED.

9.1.2 Following a question from EC there was a discussion about whether the internal messaging had been too complex regarding the need for hand-washing. SH noted that there was a five-step approach but that its importance should be demonstrated by the visibility of staff hand-washing, however, the messaging would be reviewed.

9.2 IQPD

9.2.1 DHF gave an overview noting that the Trust had not achieved the four hour ED target for February 2017. Whilst performance in ED had improved, from 71.96% in January to 76.17% in February, there were problems caused by an increase in critical attendances and with bed occupancy at 95% it was difficult to achieve flow. There was increased safety with patients being directed to appropriate areas and this had been assisted by the Sunderland Ward being used only for day surgery.

9.2.2 There had been a doubling in the number of mixed sex accommodation breaches in February which had totalled 56. RTT performance had seen a small decrease in February from 77.02% to 76.45% however, this was above the revised trajectory following the elective pause.

9.2.3 The cancer targets had not all been achieved with the 2 week wait performance decreasing by 7% to 89.16%, however, the performance for the two week wait for Breast Symptomatic remained above the target for the fifth month running.

9.2.4 Complaints had decreased by 31% to 46 from 67 in January.

9.2.5 Progress had been made on Serious Incidents (SI's) following the Pressure Ulcer Swarm, with 13 being signed off leaving only 8 for March over the 60 day deadline. There was an improved level of reporting which could result in some SI's being downgraded in future.

9.2.6 There was a discussion around HMSR and the fact that there was a three month lag in the figure reported to Board and the current figure being reviewed related to November 2016. DHF explained that the HMSR fluctuated and it was expected that this would increase for December 2016 and January 2017, however, there were no significant shifts in the trend. It was noted that since July 2016, every death was reviewed by two clinicians to monitor any particular factors or trends.

9.3 Nasogastric Tube Safety Alert

9.3.1 DHF explained that despite previous alerts by the National Patient Safety Agency, NHSI had identified that risks remained in the interpretation of the nasogastric tube positioning and placement. NHSI had issued a National Patient Safety Alert Stage 2 to trust boards to assure them that systems and processes are in place to prevent misplacement of nasogastric tubes.

9.3.2 The Board noted that DHF was the named Executive Director responsible for the delivery of the actions required in the alert. Training was currently easier as only one type of tube was used. DHF noted that there had been no "never events" in the last 18 months relating to an nasogastric incident.

9.3.3 Following a query raised by JB regarding whether the Trust was confident that there was a mechanism for monitoring alerts, DHF confirmed that there was a good level of governance and that staff were trained on the correct escalation procedures.

10 Performance

10.1 Finance Report

10.1.1 DC explained that Months 1-9 had met the financial plan; Month 10 had not achieved the plan due to increase in ED attendances and the resulting fall in elective work. Month 11 performance had seen a partial improvement resulting in the plan being £100k worse than the planned deficit. Elective income had partly recovered following elective activity restarting and the use of Sunderland Ward solely for day cases.

10.1.2 A risk to income was the lack of a formal agreement for the payment of all activity performed by the Trust due to the lack of a contractual agreement with the North Kent Commissioners, however, this was expected to be settled shorlty.

10.1.3 DC noted that forecast capital spend had been revised in month 9 to £18m against an original plan of £28m. The forecast had been reviewed by the Executive and presented to the Finance Committee and the Board was assured that this was a realistic forecast.

10.1.4 DC noted that under the CIP programme delivery to Month 11 was for £10.8m compared to the plan of £12.6m.

10.2 Communications Report

10.2.1 GA noted that over the previous month there had been intensive communication and engagement activity further to the release of the CQC report. This had generated considerable media interest both locally and nationally and particularly in the health press.

10.2.2 Discussions were continuing with health and social care partners about how the Trust would engage with the local community on the Sustainability and Transformation Plan. There was an increasing focus on the future implications of the STP. An Engagement Officer had joined the Trust at the end of March and she will be supporting the delivery of the Trust's engagement strategy which would involve working with local people to ensure that they were involved in the discussions about service improvement.

10.2.3 EC commented that he was impressed by the work of the Communications team, particularly over the CQC report and exit from Special Measures.

10.2.4 JB queried if the Trust had links to other communications teams and it was confirmed that there was a network which met regularly to discuss current issues.

11 Governance

Corporate Governance Report

11.1 The paper was taken as read. LD explained that following the Internal Audit Report from KPMG of Risk Management arrangements, the Trust had received an Assurance Rating of "Significant Assurance with Minor Improvement Opportunities" which was in line with the Trust's own forecast rating.

11.2 The streamlining of all the Trust's policies and procedural documents continued and the status of the 17 corporate policies was noted.

11.3 The status of complaints was noted with only 34% of complaints received in December being responded to within 30 days, compared to 51% in November. The implementation of the Datix-Web system for complaints management from 1 April 2017 will help to provide detailed performance data on a real time basis.

11.4 LD explained that portals were being established to ensure compliance with the requirement to publish Freedom of Information requests on the Trust's website.

Senior Information Risk Owner Report (SIRO)

11.5 The Board noted SIRO Report which was provided for assurance.

12 People

Workforce Report

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

12.1.3 Nurse recruitment in the Philippines had been successful and 240 offers had been made which were subject to pre-employment checks including the International English Language Testing System. The full benefits of the recruitment, however, would not be noticed until the end of the year.

12.1.4 The recruitment initiatives were showing signs of success with recruitment of 35 qualified nurses and 29 clinical support workers in February and this was accompanied by lower numbers of leavers.

12.1.5 The pay-bill was reducing (£600k reduction from January 2017 to February 2017) with fewer agency staff as many had moved to the Trust's staff bank.

12.1.6 IR35 tax legislation, which was designed to combat tax avoidance by workers supplying their services via a limited company, did not represent a significant issue for the Trust.

12.2 Following a query from JP there was a discussion about the Apprenticeship Levy and JD confirmed that the levy was around £1m which would pay for around 15 new apprenticeships. JP suggested that the levy could be used for upskilling of staff in the area of digital technology.

12.3 JD commented that the Workforce Strategy provided to the Board had been reviewed by the Executive. The Board **APPROVED** the strategy noting that a more detailed plan for the next two years would follow in due course.

Staff Survey

12.2 JD gave a presentation which summarised the results of the 2016 Staff Survey as follows:

- 2,004 staff members had participated
- the response rate had increased from 37% to 49.5%
- levels of engagement had increased from 3.66 to 3.76 (where 5 is best)

12.2 During 2016 the Trust had addressed workplace bullying, embedded the Trusts' vision and values, developed leadership and management programmes and created a smoke-free site.

12.3 Staff experience had improved the most since 2015 in the area of reporting experiences of harassment which had increased from 29% to 43% in 2016. The score however had increased from 61% to 63% of instances where staff attended work whilst sick.

12.4 Further improvements were expected with the development of a Health & Wellbeing Programme, strengthening the anti-bullying campaign and promoting the Trusts' values and behaviours.

12.5 There had been agreement from the CQC that, with improvements noted in 44 areas, the results were good and had demonstrated a high level of staff engagement.

12.6 Following a comment from EC there was concern about there being cases of physical violence by members of staff against colleagues and that it was necessary to obtain a clearer picture of the nature of such incidents.

12.7 JP queried whether it was possible to determine whether specific groups of staff were outliers to the general trend of the survey. JD noted that there were no specific concerns arising from any particular areas of the Trust but the survey was more geared to monitoring overall trends.

13 Board delegation to Integrated Audit Committee

13.1 The Trust Secretary noted that due to timing constraints it was suggested that approval for the Annual Report and Accounts for the financial year 2016-17 be delegated to the Integrated Audit Committee which would be meeting on 22 May 2017.

13.2 Following a discussion, the Trust Board **RESOLVED** that the Integrated Audit Committee (the "Committee") be delegated the authority to approve the final version of

the Annual Report and Financial Statements 2016-17 at the meeting to be held on 22 May 2017.

14 Quality Assurance Committee Report

13.3 The Quality Assurance Committee had met on 16 March and EC noted the following:

- the Co-ordinated Surgical Care Directorate quarterly report was reviewed and demonstrated encouraging levels of reporting and scrutiny, however, complaints were building up;
- there was a review of the Deteriorating Patient and whilst there had been improvements with the "Do Not Resuscitate" documentation, communications of pre-planned decisions were needed;
- Adult and Child Safeguarding would be included in the same report for Q3;
- On allegations made against staff the dominant cause was "neglect and acts of omission";
- Quality account priorities were explained by Michelle Woodward; and
- the Committee was reviewing its terms of reference and the timing of the meetings and the relationship with the Quality Information Group.

14. Finance Committee

14.1 The Finance Committee had met on 30 March and TM summarised the following matters which had been discussed:

- the risks to the planned year end forecast were based around income recovery from the CCGs although the control total would be achieved;
- the Financial Recovery Plan would be presented to the Trust Board in May; and
- Business cases were reviewed including updates on the North Kent Pathology service project and the ED redevelopment.

15. Integrated Audit Committee

15.1 The Integrated Audit Committee had met on 1 March and SC gave a verbal update noting the following:

- KPMG, the Trust's internal auditors had carried out a review of the Trust's Gifts & Hospitality Policy and the recommendations were being followed up alongside the new requirements regarding Conflicts of Interest which were coming into effect from 1 June 2017.
- KPMG, had also reviewed the procedures for providing healthcare for "Overseas Visitors".
- The internal audit for 2016-17 was on track and the Internal Audit work plan had been agreed for 2017-18.

- The Serious Incidents procedure was under review and this should be concluded by the end of April 2017.

14 Questions from the members of the public

14.1 Mr Stephens noted that, given the traffic restrictions arising from the ED redevelopment, there were problems with cars blocking the roundabout when dropping off patients and sometimes ambulances were unable to get to ED and the buses were often prevented from getting into the bus-stop.

ACTION: To ensure that the roundabout was not becoming congested as a dropping point.

15 Any other business

15.1 DK asked that the Governors be kept informed about the developments concerning the STP. SC agreed that as ideas developed into proposals that there should be appropriate dissemination to governors, members and stakeholders. It was noted that David Brake, (Medway Council Health & Wellbeing Board) would be attending the next Council of Governor's meeting on 11 April to give a presentation on the STP. GA added that there was a Kent-wide STP website and newsletter and details of this would be circulated to all governors.

ACTION: To send the new Kent & Medway STP newsletter to Governors.

16 Date of next meeting

The next meeting of the Trust Board will be held on Thursday 4 May 2017 in the Boardroom, Postgraduate Centre, Medway Maritime Hospital.

The meeting closed at 2.35 pm.

Stephen Clark: Date:
Chair

PUBLIC BOARD ACTION LOG
ITEM 06

NHS Medway NHS Foundation Trust

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB - 0369	02/02/17	15.4	DC and GA agreed to investigate if drilled down information could be provided on the infographics in the IQPR.	Director of Finance & Director of Communications	02/03/17 – There will be development work to link reporting once the Trust website is set up.	Open (red)
PUB - 0371	02/03/17	9.10	It was agreed that the re-admission data should be split out to show the figures for elderly patients.	Director of Finance	06/04/17 – The analysis of re-admission data would be reflected in the information provided to the May meeting.	Closed (green)
PUB - 0374	06/04/17	15.1	To ensure the roundabout is not becoming congested as a dropping off point.	Director of Estates	04/05/17 – Director of Estates informed and confirmed that the security officials are monitoring the situation and it is a short –term problem.	Closed (green)
PUB - 0375	06/04/17	16.1	To send the Kent & Medway STP newsletter to Governors.	Trust Secretary	04/05/17 – STP newsletter sent to Governors on 10 April 2017.	Closed (green)

NHS Medway NHS Foundation Trust

Chief Executive's Report – March 2017

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

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

1. Opening Summary

As mentioned in my previous report, the Trust has submitted its improvement plan to the CQC detailing the further improvements it intends to make in order to achieve the 'Must do' and 'Should do' actions from the report. The CQC have made an initial response confirming that from a first look they do not have any concerns.

On the 9 May the Trust, along with the CCG, has been called to meet with NHS England and NHS Improvement to discuss the Trust's performance in A&E. Although demand for our services, particularly in the emergency department, remains high, we are starting to see a positive impact from the actions we are taking to better manage flow across the hospital, however, we are still in the bottom percentage of trusts. At the meeting we will share our improvement plan and discuss our strategies and new initiatives such as developing the 'Front Door Model'.

We were honoured to receive a visit on 19 April from Her Royal Highness, the Countess of Wessex. The Countess officially opened Abigail's Place, the Trust's Bereavement Suite. During the visit she spent time with our maternity teams and we had the opportunity to showcase the work carried out by staff in the Birth Place and Delivery Suite.

As you are aware we are currently in purdah in the lead up to the general election on 8 June. As an NHS Trust there are certain restrictions on the information we can discuss publicly so that we are not seen to be attempting to influence the election. It is important that we are aware of our obligations during purdah. We will remain in this period until the election has passed and a new government has formed.

2. At and Around Medway Foundation Trust

Trust Improvement programme

- The buddy agreement with Guys and St Thomas' NHS Foundation Trust (GSTT) was officially drawn to a close during the event on 25 April which recognised the impact of the support from GSTT.

- The Trust is now working through the next phase of the improvement plan and is working with 2020 to design how we move forward and develop through our strategy of Better, Best, Brilliant. Work has begun with the executive team to decide how the workstreams are mapped out and how they will be brought to life using an inclusive approach which is exciting for staff to be part of.

Front Door Model

- The Trust is working with the CCG to apply for funding to enable us to develop the 'Front door' model to support the Trust to improve performance in the emergency department. The model is based on an approach used by Luton and Dunstable Trust which joins up local health services to ensure patients are directed to the most appropriate care pathway within the health and social care system.

Emergency Department Construction

- The rebuild of the Emergency Department at Medway Maritime Hospital continues to progress on schedule and is expected to be completed by the end of 2017.

- The redevelopment is closely monitored by a project team which meets weekly to discuss progress and to ensure that delivery is within budget.

Workforce and Recruitment

European Nurse recruitment

- As you will read from the Board papers, the international recruitment drive plan is well underway and the Trust welcomed 12 European nurses who commenced their posts on 20 April with a further cohort arriving in July.

Targeted doctor recruitment

- The Trust has begun a targeted recruitment programme for doctors. Although this is in its early stages, we are hopeful that this will be a successful project for the Trust. The company that the Trust is working with has completed some initial diagnostic work that we will receive feedback on shortly.

Board recruitment update

- The recruitment process for a substantive Director of Finance is complete and the Trust welcomed Tracey Cotterill to the position on 2 May.

Recognition for service excellence

MFT Staff Excellence Awards

The Trust's staff excellence awards are taking place on 26 May. This is another great opportunity to showcase the great work our staff are doing in providing the best of care.

Baby Friendly Status

- Women and Children's were awarded their unicef "Baby Friendly Initiative" stage 2. This is the first time that Medway have achieved this prestigious award and we will be working towards stage 3 within the next twelve months. Success at stage 3 will mean that Medway would be the first trust in Kent to hold this higher award.

Nomination for the HSJ award

- The bereavement team have been announced as finalists in the obstetrics and gynaecology category for the HSJ awards. The winner will be announced at the end of May.

The GMC CEO coming to visit

- Charlie Massey, the CEO of the GMC will be visiting the Trust and in particular, our maternity services on 4 May where we will be showcasing *Abigail's Place* and he will be given an opportunity to view a "gentle" caesarean birth.

Service changes

Rheumatology

- The Trust had extended the rheumatology service at Darenth Valley Hospital (DVH) in Dartford for a further six months.

Dermatology

- The Trust continues to have ongoing discussions with the CCG about the West Kent dermatology service in relation to its role in providing this service to patients.

STP update

- The Trust continues to support the Kent and Medway STP across a number of work streams including finance, workforce and the hospital care programme. The establishment of a North Kent and Medway delivery board is now taking shape and the first meeting to determine how that will look going forward took place this week. As chair of this board I am working hard to provide an increased focus on the actions which need to be taken more locally to deliver on the system wide STP changes.

3. Away from MFT

National NHS priorities

Pre-election period

- During the pre-election period, the Trust is restricted in its external activities. In practice this has already applied in Medway as there are county council elections taking place in May, affecting the Swale area. However, in the run-up to the general election the NHS is expected to be a focus of attention.

Race equality standards

- A second annual report into race equality across the NHS was published this week. The Workforce Race Equality Standard (WRES) report publishes data from providers of NHS-funded care, including the voluntary and private sector, to demonstrate how they are addressing equality issues.

- This year's report includes for the first-time data covering nine WRES indicators including four relating to the workplace covering recruitment, promotion, career progression and staff development alongside BME board representation. The remaining four indicators are based on data from the NHS staff survey 2016, covering harassment, bullying or abuse from patients, relatives or the public.

Kent and Medway NHS and Social Care Partnership Trust

- The Care Quality Commission has noted improvements at Kent's mental health trust, KMPT. As a result of the latest inspection in January 2017, the trust has been rated as "Good" overall, and "Outstanding" for being caring. Safety is rated "Requires Improvement". KMPT is one of the largest mental health trusts in England, providing services to a population of 1.7 million people.

Royal College of Nursing

- The Royal College of Nursing, the largest nursing union, is canvassing member opinion on strike action or other forms of industrial action, such as working only their contracted hours or refusing to do work expected of more senior staff. The poll of members will close on Sunday 7 May and the results will be announced at the union's annual conference later in May. Following this, a decision will be made on whether to issue a formal ballot.

- The RCN claims a combination of pay freezes and caps on pay rises since 2010 have effectively led to a 14 per cent pay cut due to the rising cost of living. The Department of Health has responded, saying affordable pay is protecting jobs.

Care Quality Commission

- The chairman of the CQC Peter Wyman has said in future it will carry out more unannounced visits and focus more on specific services rather than whole organisations. Asked about inspections in STP footprints, Mr Wyman said the aim would be to inspect 'component parts'

of an area at around the same time. That could be a whole STP area, or a section of it.

NHS Providers

- NHS Providers has published a report entitled 'Impact of regulation in a shifting environment'. It says two thirds of trusts (68 per cent) reported an increase in demand from regulators including NHS Improvement and the Care Quality Commission (CQC). But there is encouraging evidence that regulators are getting better at coordinating their approaches, it says.

New ombudsman

- Rob Brehens has been appointed as the new health ombudsman following the resignation of Dame Julie Mellor. Mr Brehens previously worked as an ombudsman for higher education in England and Wales, as well as complaints commissioner at the Bar Standards Board. He has promised to listen to concerns about the way the watchdog works to drive improvements.

Medway NHS
NHS Foundation Trust

Board Report

Report date: 4th May 2017

Title of Report	Better, Best, Brilliant – Our Trust Improvement Programme
Presented by	Lesley Dwyer, CEO
Lead Director	Lesley Dwyer, CEO
Committees or Groups who have considered this report	Executive Group
Executive Summary	The Board will recall that the Trust PMO was discontinued on the 31st March 2017 as we had reached the end of phase 2 Recovery. It is widely recognised that further external support is required for the Trust to continue on its improvement journey at the required pace under Phase 3. This is deliberately of a different nature. The Executive Group has engaged with an improvement provider called 2020 Delivery following recommendations of input and performance from NHSI, GST and Addenbrookes in Cambridge amongst others. The attached presentation outlines where we are with our progress for the required improvement programme under Phase 3. The Board is asked to note progress, endorse the approach so far and consider how the Board is involved in the next phase of leadership improvement.
Resource Implications	As outlined in the private Board.
Risk and Assurance	It is essential that the Board show leadership qualities in the design and management of the improvement programme. This presentation outlines where we are so far. The Board is asked to confirm how it would like to be involved in the design and the management of the programme going forward.

Legal Implications/Regulatory Requirements	None at this point. There is the clear expectation that further improvement in services standards and ratings in made. This programme will enable us to do that. If we do not then further regulatory action will follow.
Recovery Plan Implication	As above.
Quality Impact Assessment	All actions continue to follow an appropriate QIA process
Recommendation	**The Board is asked to note the report and consider how to be involved in the design and the management of the programme going forward.**
Purpose & Actions required by the Board :	Approval [x] Assurance [ ] Discussion [ ] Noting [ ]

Better, Best, Brilliant

Our improvement programme

Board Update

Thursday 4th May 2017

Best of care
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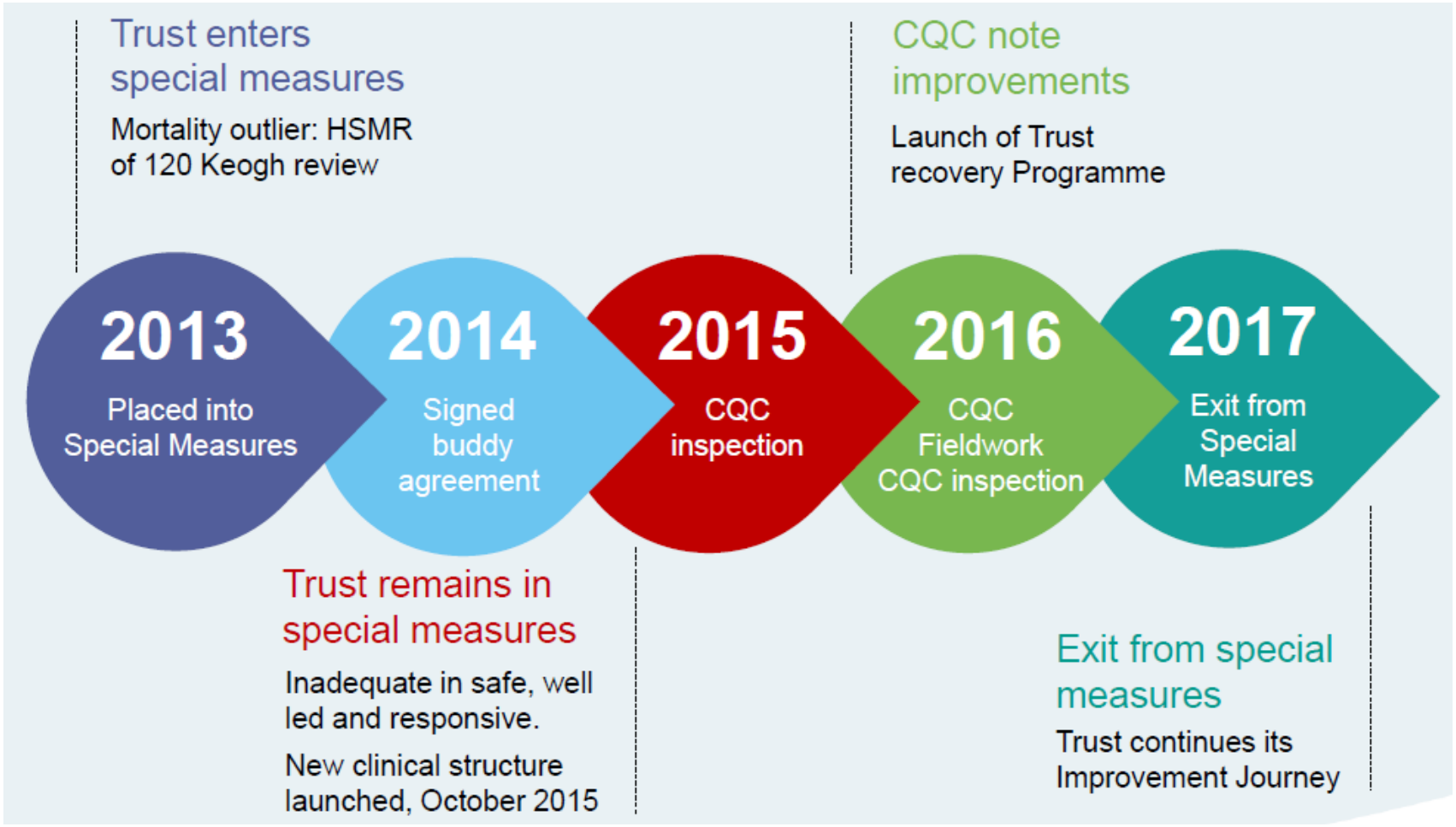
The Trust has made significant progress over the last few years…



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NHS Foundation Trust

…and we want to maintain momentum, continue to improve and become ‘Brilliant’

Medway Aiming For Best Journey – 3 stages of focus

EFFICIENCY AND SUSTAINABILITY

Bringing the hospital to the peak of value add and achieving financial sustainability.

Trust Improvement Programme Phase 3B

FLOW AND OPERATIONS

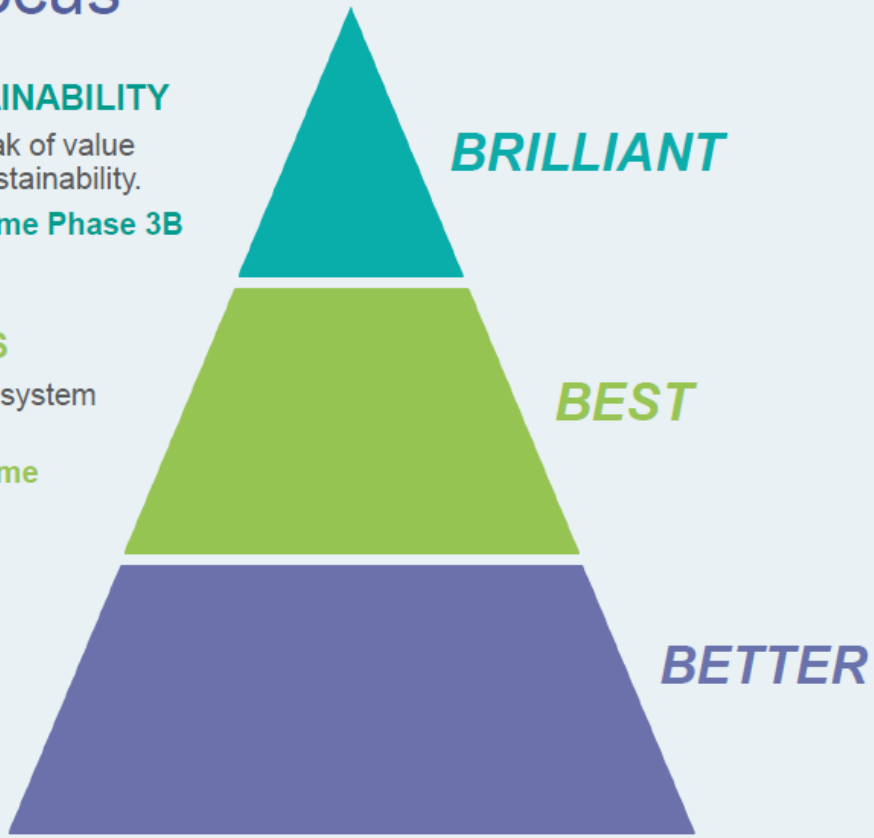
Getting the hospital and entire system to function consistently well.

Trust Improvement Programme Phase 3A

SPECIAL MEASURES

Planning and preparation to exit special measures.

Trust Recovery Programme Phases 1 & 2



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Our Better, Best, Brilliant programme is our way of doing this

Best of care
Best of people

Our values
Bold, Every person counts, Sharing & open, Together

Our strategy to be recognised as brilliant

Integrated health care	Innovation	People	Financial stability
We work with our partners across the community to deliver the **best** possible care for patients	We draw on the **best** ideas from inside and outside our organisation to drive improvement	We provide the **best** experience and outcomes for patients, carers and our staff	We are in the **best** possible financial position, with stability for the future

Our directorate and corporate strategies

We have bold ambitions and a focused programme of work for 2017/18

Integrated health care	Innovation	People	Financial stability
1. **Patient flow,** including: A&E, DTOCs	4. **Care redesign and networks**, including clinical and non-clinical functions and pathways, and Getting it right first time	8. **Building a sustainable workforce**, including recruitment, retention and 7-day working	11. **Financial recovery**
2. **STP** & working with our communities and out of hospital, especially planned care	5. **Digital**	9. **Culture & engagement**	12. **Commercial Efficiency** including: Pharmacy, procurement and tendering
3. **Quality**, including CQC improvement plan	6. **Development** programme & Continuous Improvement	10. **Governance and standards** including streamlined processes and assurance	13. **Estates**, including new ways of working
	7. **Informatics & analytics**		

Our directorate and corporate strategies

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We want a collaborative way of working, based on shared principles

Our better, best, brilliant way of working

1. **Inclusive & collaborative** - Staff and patients are involved in creating our improvement programme, and clinicians provide leadership in all of our Improvement Teams
2. **Exciting** – something people want to be part of and they can see how it will help them
3. **Consistent** approach to quality improvement supported by a shared, easy to understand language and through teaching and education
4. **Evidence-based** improvement – we will become brilliant by learning from the best
5. **Autonomy with accountability** – staff are trusted to make decisions, have time to work on improvements and are responsible for quality improvement
6. **Pace** – we make good decisions, quickly; we reduce numbers of meetings, and we get things done
7. **Learning** – we want to try things out, learn and improve, and feedback what's working

Our transformation plan will deliver this programme of work in a sustainable way, increasing the capability of our staff

	Q1: End Mar – End Jun 2017	Q2: Start Jul – End Sept 2017	Q3: Start Oct – End Dec 2017	Q4: Start Jan – End Mar 2018	Year 2 onwards
Phase	**Set-up, structure & start delivering results**	**Build foundations**	**Scale up the transformation**	**Learn & Embed**	**Sustained Improvement**

Activities	▪ Create vision and story that everyone can align around
	▪ Structure the work into bite-sized packages
	▪ Build teams of people determined to deliver opportunities
	▪ Establish agreed outcomes and milestones
	▪ Re-energise Patient Flow Workstream
	▪ Undertake Digital Review
		▪ Integrated governance
		▪ Deliver results through teams
		▪ Start development programmes:
		  ▪ Green Belt
		  ▪ Yellow Belt
		  ▪ White Belt
		▪ Engage wider organisation in cultural change
		▪ Engage STP, NHSI, CCG, & health economy partners
			▪ Leaders start new projects and drive change through performance management framework
			▪ Embed the development programme in organisation
			▪ Review learning so far and adjust programme
				▪ Integrate with 'business as usual'
				▪ Review learning so far and adjust programme
					▪ Review and adjust based on progress of transformation

	Period of external support				

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We will all work together throughout the programme to ensure our strategy is delivered

The Board	• Regular board updates • Leader's Better, Best, Brilliant training
Staff	• Senior managers' engagement events • Staff involvement in teams. For example, staff on Dickens have great ideas of how to improve • Junior doctor improvement project alignment • Green Belt and Yellow Belt Development Programme • White Belt training for more staff to help them understand the BBB programme
Patients	• User-engagement • Canteen Events
CCG, STP, NHSI, Partners	• Workshops and co-delivery of project

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Report to the Board of Directors

Board Date : 03th May 2017

Title of Report	Integrated Quality Performance Dashboard - Update
Presented by	N/A
Lead Reporting Director	Darren Cattell Director of Finance, however **Executive Team accountability**
Committees or Groups who have considered this report	Quality Assurance Committee Quality Improvement Committee
Executive Summary	To inform Board Members in the form of a flash report of March's performance across all functions and key performance indicators. A full report will be presented to the next Board. Key points are: • The Trust did not achieve the **four hour ED target** for February. Performance has increased from 76.17% in February to 77.51% in March. The main reasons for this as outlined by the Operational Teams are; o Flow issues caused by an increase in critical attendances and in outliers o The whole system of Medway and Swale indicated a high level of pressure o Bed occupancy was 94.7% • The Trust has reported a total of 3 **12 hour breaches** in March compared to 8 reported in February. • **HSMR** has decreased slightly to 102.0 when compared to the previous rolling 12 month period. We remain within benchmarked limits when compared with other Trust's nationally. • This month saw a 26.79% decrease in the number of **Mixed Sex Accommodation** breaches, these totalled 41 in March. • **RTT** performance has seen a small decrease in performance at 76.24% from 76.45%, however remains above the revised trajectory following the elective pause.

	• **Cancer targets** have not all been achieved. The 2 week wait performance increased 2% to 91.23%. The performance for the two week wait for Breast Symptomatic remains above target for the sixth month running. • There was an increased number of **falls** in March (64) when compared to February (59) • 56 complaints were reported in month, an increase of 22% from the 46 in February • 86.00% of our staff have now had an **appraisal**, slightly up on last month by 1.5%
Resource Implications	N/A
Risk and Assurance	See report
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	Supports the Recovery Plan in the following areas: Workforce, Data Quality, Nursing, Finance
Quality Impact Assessment	See report as appropriate
Recommendation	N/A
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

NHS Medway NHS Foundation Trust

Integrated Quality and Performance Report

April 2017

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

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Contents

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

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10452 Patients visited our ED , which is a **23.55% increase** on the previous month, with **77.51%** seen within 4 hours, compared to 76.17% . **2263** Patients were admitted, with a **increased** conversion rate of **21.65%** compared to 19.70% in February

There were **5472** total patient admissions March, and **5458** patients were discharged.

Bed Occupancy **decreased** by **1.40%** in March to **94.70%**.

3347 patients arrived at ED via ambulance which is over a **21.22% increase** on last month

33.9% Of ambulance patients were seen in under 15 minutes

March's Story....

423 Babies were delivered in the month of March (**59** more than February) with Emergency C-Section rate **increasing** by **3.69%** from the previous month to **21.28%**

HSMR has slightly **decreased** from the previous month to **102.04** when compared to last months value of **102.93**

86.0% of staff have had an appraisal which is a **1.45% increase** on the previous month

26650 Patients attended an outpatient appointment with **9.47%** DNA rate which is a increase of **0.67%** on last month

There were 64 total falls in March, compared to 59 in February

RTT Overall Incomplete Pathways for March was **76.24%** which decreased by **0.21%** on previous month. We remain on our improvement trajectory. The trust also reported 31 x 52 week waiters which decreased by 3 from February

31 day subsequent treatment surgery cancer target has increased by **12.24%** to **95.00%** in February (reported one month in arrears)

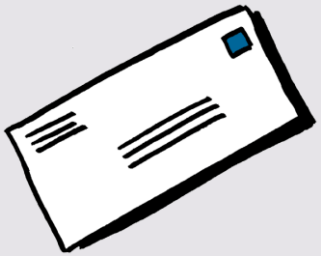
2 Week Wait symptomatic breast consistently remains above target of **93%** in January with performance of **97.37%** - up by 3.05%

2 Week Wait cancer performance for February was **91.23%** (reported one month in arrears) . This is a **2.07%** increase on January's performance

March's Performance....

96.03% of Patients waited under 6 weeks for diagnostic tests in the month of March, this has increased by **0.60%** since February's reported performance

Number of complaints received in March at **56** increased from those received in February by **17.4%**. In January **23%** of complaints previously received were responded to within 30 working days



There were 41 Mixed Sex Accommodation breaches in March which was a **26.79%** improvement on February's performance

Safe Page 10

Legend
- Compliant with target
- Breaching target

Infection Control

CDiff – no cases for March 2017

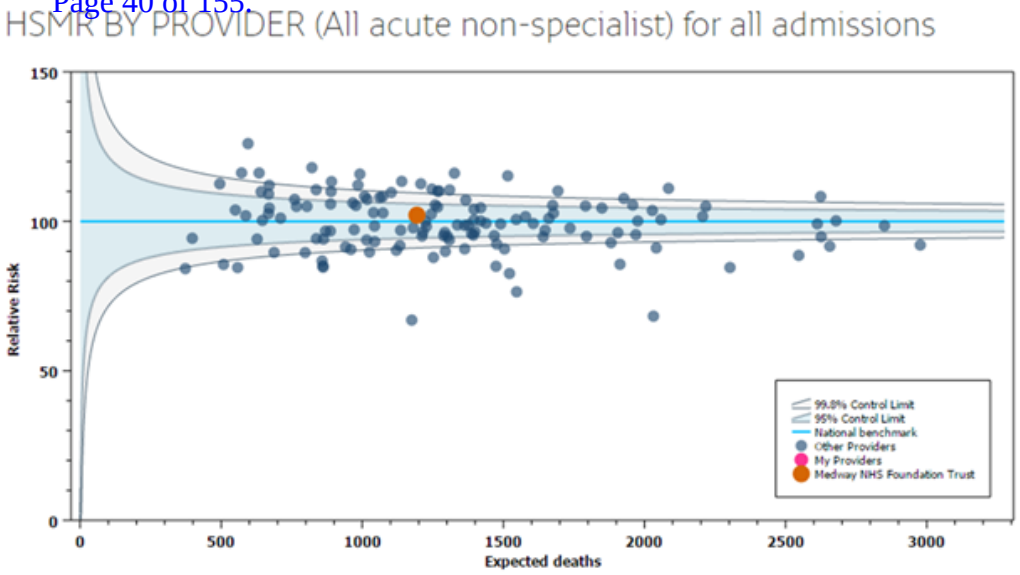
MRSA – the MRSA bacteraemia deemed unavoidable by the Trust has been returned to us following arbitration. NHS England have responded to the Trust with the decision that this is a Trust attributable MRSA bacteraemia as the Trust did not follow our own decolonisation protocol. The patient underwent a series of invasive procedures and improved infection control procedures could have prevented the MRSA translocation. The panel considered that there may have been missed opportunities to address the colonisation and prevent the infection from occurring.

Serious Incidents

Please see Serious Incidents slide on page 11

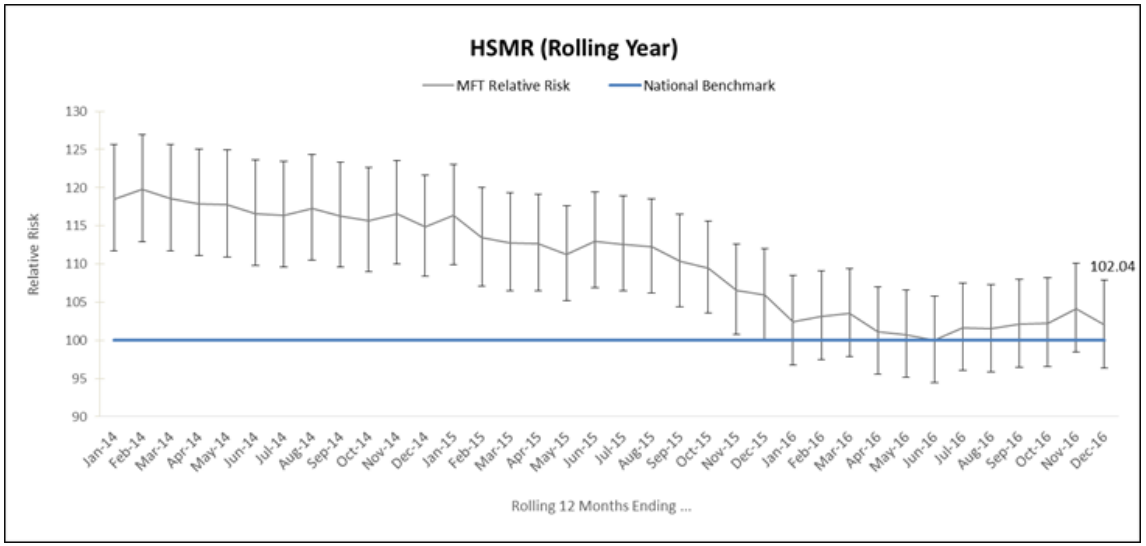
Mortality

The Hospital Standardised Mortality Ratio (HSMR) is currently 102.04 for data to December 2016 and remains within the expected range. The current position and rolling HSMR trend is demonstrated by the funnel plot and graph on the proceeding slide:



The most recently published SHMI value, for the period October 2015 – September 2016, is 1.09. This shows a further reduction on previous periods and is the lowest value for the Trust in this indicator for over two years. The Trust aimed to be within benchmarked limits by the end of 2016/17 and this has now been achieved. The Trust is optimistic that the SHMI will continue to demonstrate a reduction moving forward. The next SHMI value for the period January 2016 – December 2016 will be published on 22nd June 2017.

The SMR for Pneumonia has reduced further to 94.51, whilst the Acute & Unspecified Renal Failure SMR has now dropped below the benchmark to 90.60. Acute Cerebrovascular Disease has recently increased and is now statistically significantly high at 126.66. This will be discussed at the next Trust Mortality and Morbidity meeting on Friday 21st April 2016.



Effective Page 11

Please see CQUIN update under Effective

Caring Page 12

Friends and Family

Emergency department – 79.3%
Inpatient – 89.2%
Maternity – 99.2%

The Emergency department response rate continues to be challenging. A number of options to improve the response rate such as using a tablet to undertake survey are being considered including placing the FFT questions on a tablet and the use of a wall mounted option to enable patients and carer to participate in a more timely manner. There is the expectation that the improved response rate will increase the % likely to recommend the Trust to others. The Patient Experience Manager will help embed the benefits of FFT and staff will see the value of patient feedback.

ED – March saw 10450 total attenders, an increase of 3.4% on March 16 and 23.5% up on February's 8460. Ambulance attendances were 3347, slightly down on March 16 (4 attendances) and 21% up on February's 2761. MFT remains consistently one of the top performer's in the region and saw 33.9% of handovers within 15 minutes. Performance against the 4 hour standard was 77.5% for March, this is up on March 16's 74.71%.

The site continues to experience delays in progressing patients through the department once speciality referral takes place and a DTA is in place. The CDU functionality in ED ceased on October 4th with this area changed from 8 beds to 12 trolleys allowing the corridor use to cease. This function continues with zero use of the corridor despite pressures. Mental Health delays for beds remain a concern with delays of over 48 hours from arrival experienced. The majority of mental health presentations remain over 4 hours in the ED. Process mapping of all specialities continues with the majority taking more than 30 minutes to be seen after referral despite the majority being referred within an acceptable timeframe by the ED. Some 12 hour breaches experienced as flow became so restricted out of the ED and Lister and the Discharge lounge remained exclusively bedded, mainly with long term and frailty patients. The Lister (GPAU) patients are being managed by the Acute Physician team to maintain safety, continuity and to promote earlier discharges.
Emergency flow remains poor with a deficit between demand and capacity resulting in significant delays. Almost all alternate pathways have been dysfunctional with the exception of Ambulatory and Medocc. Ambulatory was available 7 days a week for almost all of December. The only shortfall was due to nursing availability.
A Rapid Assessment Process (RAP) was instigated, at the end of October, at the ED front door, providing a combined senior nurse and Associate Practitioner allowing much earlier interventions and streaming. This is being closely monitored with expectations it will improve the time to be seen by an ED clinician significantly as well as the number of patients streamed to alternate pathways.
The Clinical Coordination Centre commenced on 14th March. This is a clinically led operations centre managing all aspects of flow and escalation Monday to Friday. This has also had Saturday and Sunday cover for the first three weeks to support flow and is led by Senior Manager On Call and Matron at the weekends. The CCC has allowed the complete de-escalation of the discharge lounge which is now taking up to 30 patients per day allowing earlier bed availability. The thrombolysis and pacing rooms are no longer bedded and the surgical and gynae assessment rooms are now protected as is a 4 bedded bay on Lister ward. This ensures there is an assessment functionality for all pathways (Orthopaedics does not have an assessment pathway)

RTT

RTT performance is 76.24%, a decrease of 0.2% on the previous month. In total compared to February there are less patients waiting over 18 weeks, (5585 compared to 5654) however as the overall waiting list has dropped this has led to the drop in performance. The management of elective activity is being supported through further use of the independent sector.
There has been a small reduction in 52 week waiters from 34 to 31, and work is continuing to ensure patients are seen in a safe and timely fashion.

Cancer

- **2WW** - The Trust failed to meet the 2 week wait standard across two tumour sites. This was predominantly due to lack of clinic capacity, due to consultant vacancy for Skin. The single breach within Brain was as a result of patient choice.

- The Trust is compliant with the 2 week wait symptomatic breast standard

- **31D** - The Trust has failed to achieve the 31 day first definitive treatment standard. This is as a result of reduced elective surgery due to site pressures for one patient in Breast, surgical input required for one lung patient, cancelled surgery by the patient for one skin patient and treatment for an infection before the patient could commence treatment with Haematology. Of the 4 Urology breaches two patients originated from Maidstone; one patient being assessed unfit for treatment and further tests required before proceeding and a further patient with an agreed delay with the referring Trust consultant. Two Medway patients were delayed, one to due to an infection and one as a result of reduced elective surgery due to site pressures.

- The Trust is compliant with the 31 day subsequent surgery treatment standard and remains compliant with the 31 day subsequent drug treatment standard.

- **62D** - The Trust failed to meet the 62 day GP referral standard. Pathway breaches were varied due to delays to diagnostic tests and complex pathways within Haematology, Head & Neck, Lower GI, Lung and Skin.
  Of the Urology breaches 6 patients (3 shared breaches with Maidstone) were as a result of patient delay to diagnostic tests, patient delay due to decision making on treatment options, delay to diagnostic test and patient not fit for surgery. Three patients (1.5 breaches) were from Darent Valley Hospital with delays as a result of multiple diagnostic investigations for two patients and a delay to radiotherapy due to an existing disease for the remaining patient. Delays to 3 Medway patients were as a result of patient decision making on treatment options.

- The Trust is compliant with the 62 day screen services standard.

There is no performance standard for 62 day consultant upgrades. The 1 breach in Lung is as a result of cancelled appointments for diagnostic tests.

Well Led Page 14

Turnover remains largely stable compared to previous months (at 10%). Medical, Estates and Healthcare Scientists remain at under 5% turnover whilst all other staff groups remain over 10%.

This information will be cross-referenced to the new exit interview data to understand movements of staff from MFT. Updated sickness absence policy has been introduced which changes the trigger for action from Bradford score to number of episodes and we are currently managing 13 long term sickness cases in March.

Enablers Page 15

- The data quality team are continuing to work through the follow up review lists specialty by specialty.
- The validation of the Urology and ENT review lists is now complete. The Data Quality Team has delivered review list refresher training to the Urology admin team and a training session has been arranged for the ENT admin team later this month.
- The West Kent Dermatology review list and open pathway validation work is complete and handed back to Service Manager at the end of March.
- The data quality team have validated records affected by a PAS bug that allows appointments to be booked and not linked to a referral. Subsequently the patient is potentially not monitored against an RTT pathway.
- Since the last report period, the Data Quality Team have corrected 250 of 316 affected patient records, however, due to system limitations, 66 records remain affected. This system bug has been flagged with CST, which in turn was raised with Allscripts.

Serious Incident Current Position

Medway NHS
NHS Foundation Trust

As at 31 March 2017 there are a total of 39 open Serious Incidents (SIs). The key issues of note are as follows:

- Open SIs within allocated timeframe - **31**
- Open SIs breaching the allocated timeframe - **8**
- New SIs reported on STEIS in March – **20** two of which have been submitted to the CCG for closure which leaves 18 as open (included within the total of 39)
- **33** SIs have been submitted for closure at the April 2017 CCG SI Closure Panel including the pressure ulcer aggregate report (12 cases) from the Grand SWARM event, seven 12 hour trolley breaches and two Never Events
- SIs closed by the CCG SI panel during March 2017 – 21 (including two closed on STESI and 19 awaiting closure on STEIS pending submission of the Falls quality improvement plan)

Actions:

During the month of April we will be holding a number of SWARM events to facilitate prompt investigation and learning of serious incidents.

3. Safe

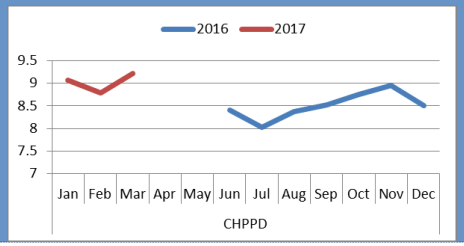
		Monthly Target	RAG Status	Trend Jan-17	Feb-17	Mar-17	Movement	YTD avg	Data Quality	Alignment Carter	SDF	Quality Account / CQUIN
1.1.3.2	Potential under-reporting of patient safety incidents (Quarterly)	Information on NRLS under review from DOH.										
1.1.4	Never events	0	G	0.00	0.00	0.00	⇔	0.2				✓
1.1.4.1	Never Events - Incidence Rate	0.00%	G	0.00%	0.00%	0.00%	⇔	0.0			✓	
1.1.5	Incidents resulting in death	0	R	7.00	7.00		↑	4.2				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days)	0.11	R	0.39	0.29		⇑	0.24				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days)	1.87	R	1.95	2.30		↑	1.7				✓
1.1.10	Incidents with moderate or severe harm with duty of candour response	100%	R	58.5%	71.7%		⇑	13.6				✓
1.1.14	Pressure ulcers (grade 2) attributable to trust	10	G	13.00	11.00	9.00	⇓	10.8				✓
1.1.15	Pressure ulcers (grade 3&4)	0	R	0.00	0.00	1.00	↑	1.2				✓
1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	0.2	G	0.13	0.07	0.06	⇓	0.1				
1.1.18	Falls per 1000 bed days	6.63	G	6.55	4.23	4.15	⇓	5.2				
1.1.19	Number of falls to fracture (per 1000 bed days)	0.2	G	0.25	0.07	0.00	⇓	0.1				
1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.00	0.00	0.00	⇔	0.0			✓	
1.1.21	% Duty of Candour with first letter	*Datix system being reconfigured to allow accurate data capture.*										
1.2.2	New VTEs - point prevalence in month	0.36%	R	0.6%	1.01%	1.21%	↑	0.7%			✓	
1.2.7	Emergency c-section rate	<15%	R	16.6%	18.1%	21.3%	↑	17.7%				
1.3.1	MRSA screening of admissions	95%	G	93.4%	92.9%	97.0%	⇑	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	G	0.00	1.00	0.00	↓	0			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	G	7.00	2.00	0.00	⇓	2			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	R		102.0		⇓	102.3			✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	R		106.8		⇔	105.6			✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	100	R		109		⇔	112			✓	✓

Commentary	Actions

Safe Staffing – Nursing Update - Highlights

Care Hours per Patient per Day

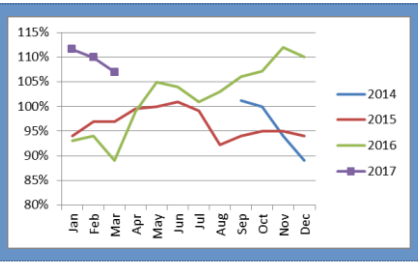
We have continued to see good performance with an increase to over 9 CHPPD for March.



Further work is being undertaken to ensure wards are adequately staffed for their activity, and patients remain safe.

Safe Staffing

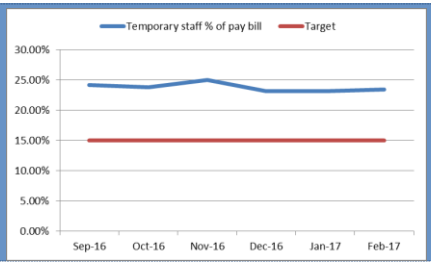
There has been a small decrease in the amount of actual hours worked vs plan, however we remain above 100%.



Staffing issues are being risk assessed daily, with staff being deployed from other areas where appropriate.

Temporary Staffing

The Trust remains below target for Temporary Staffing.



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

Staffing Levels – Nursing & Clinical Support Workers

			Day				Night				Day		Night		Quality Metrics / Actual Incidents					Associate Chief Nurse (Divisonal) review	
			Registered Staff		Care Staff		Registered Staff		Care Staff												
Directorate	WARD	Bed	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Number of escalations of nurse staffing	Number of hospital acquired Pressure Ulcers grade 2 and above	Number of Falls withmoderate to severe ha	Number of patient related medication errors - moderate to severe harm	Number of complaints relating to nursing care	ACND rag rating	Assurance statement
Acute & Continuing Care	Bronte Ward	18	1501	1309	1110	1097	1093	1114	717	764	87%	99%	102%	107%		1	0				2 RNs were on maternity leave and 1 RN was on short term sickness. The senior sister and matron worked on the ward clinically as required.
Acute & Continuing Care	Byron Ward	26	1430	1593	986	1809	1035	1530	1024	1470	111%	183%	148%	144%		1	0				ward safely staffed
Acute & Continuing Care	CCU	4	721	704	-11	35	702	713	0	58	98%	-329%	102%				0				ward safely staffed
Acute & Continuing Care	Gundulph	25	1955	1613	1578	1501	1342	1301	1364	1320	83%	95%	97%	97%			0				There are a number of long term vacancies and recuritment plan is implemented. The ward sister works clinically. A risk assessment completed and is reviewed weekly. This include temporary staffing looking ahead and prioritising at risk shifts. on a daily basis staffing is review and were appropriate staff redeployed from other areas.
Acute & Continuing Care	Harvey Ward	24	1190	1145	1638	1447	1046	1176	1046	1024	96%	88%	112%	98%			0				ward safely staffed
Acute & Continuing Care	Keats Ward	27	1532	1737	1253	1268	996	1407	990	1144	113%	101%	141%	116%			0				ward safely staffed
Acute & Continuing Care	Lawrence Ward	19	1089	1137	851	903	686	767	698	765	104%	106%	112%	110%			0				ward safely staffed
Acute & Continuing Care	Milton Ward	27	1487	1403	1205	2088	1013	1158	1024	1677	94%	173%	114%	164%			0				ward safely staffed
Acute & Continuing Care	Nelson Ward	24	1514	1257	1127	1831	1023	1012	671	1166	83%	163%	99%	174%			0				ward safely staffed
Acute & Continuing Care	Sapphire Ward	28	1722	1375	2353	2249	1001	1134	1350	1505	80%	96%	113%	111%			0				ward safely staffed
Acute & Continuing Care	Tennyson Ward	27	1618	1272	1235	1374	1046	1058	1046	1243	79%	111%	101%	119%		1	0				ward safely staffed
Acute & Continuing Care	Wakeley Ward	25	1974	1610	1594	1516	1384	1308	1384	1384	82%	95%	95%	100%			0				ward safely staffed
Acute & Continuing Care	Will Adams Ward	26	1573	1113	1154	1305	1012	1036	1012	1188	71%	113%	102%	117%		1	0				ward safely staffed
Co-ordinated Surgical	Arethusa Ward	27	1845	2160	1051	1734	1353	1694	1023	1591	117%	165%	125%	156%		1	0				Arethusa & Pembroke work as one unit to ensure safe staffing this includes the vulnerable patients that require 1:1
Co-ordinated Surgical	ICU	9	3763	3293	0	0	3458	3191	0	0	88%		92%			2	0				Adjusted staffing levels according to pt acuity and staff worked flexibly across all critical care areas
Co-ordinated Surgical	Kingfisher SAU	14	1865	1863	1550	1568	1364	1476	660	794	100%	101%	108%	120%			0				Increased care staff at nightime to provide 1:1 observation for vulnerable pts.
Co-ordinated Surgical	McCulloch Ward	24	1645	2031	1139	1772	1023	1388	1023	1565	123%	156%	136%	153%			0				Increased in both registered & unregistered staff to care for pts with specialist care needs & vulnerable pts who need
Co-ordinated Surgical	Medical HDU	6	1389	1326	317	356	1070	1071	357	356	95%	112%	100%	100%		1	0				Within critical care staff worked flexibly to ensure safe staffing.
Co-ordinated Surgical	Pembroke Ward	27	1489	1441	1145	1563	1023	1419	1023	1496	97%	136%	139%	146%			0				Arethusa & Pembroke work as one unit to ensure safe staffing, this includes the vulnerable patienst that require 1:1
Co-ordinated Surgical	Phoenix Ward	30	1833	2075	1594	1693	1364	1578	1331	1441	113%	106%	116%	108%		1	0				Increase in nursing hours to maintain safe staffing of vulnerable pts.
Co-ordinated Surgical	SDCC	26	2075	1596	1524	825	671	673	671	517	77%	54%	100%	77%			0				Reduction in nursing hours due to SDCC being returned to Day surgery unit.
Co-ordinated Surgical	Surgical HDU	10	2189	2263	394	307	1635	1787	0	0	103%	78%	109%				0				Within critical care staff worked flexibly to ensure safe staffing.
Co-ordinated Surgical	Victory Ward	18	1189	1293	634	1691	1012	1034	671	1573	109%	267%	102%	234%			0				Due to vulnerable pts on the ward a significant increase in care staff hours to provide safety.
Women & Childrens	Delivery Suite	15	2981	2915	564	549	2976	2960	534	511	98%	97%	99%	96%		1	0			green	unit safely staffed
Women & Childrens	Dolphin (Paeds)	34	3262	3149	872	998	2473	2657	357	380	97%	114%	107%	106%			0			green	ward safely staffed
Women & Childrens	Kent Ward	24	1117	1135	461	467	744	745	648	648	102%	101%	100%	100%			0			green	ward safely staffed
Women & Childrens	NICU	25	3684	3585	416	161	3554	3596	0	0	97%	39%	101%				0			green	unit safely staffed by moving staff across the unit
Women & Childrens	Ocelot Ward	12	852	862	545	915	744	730	372	748	101%	168%	98%	201%			0			green	ward safely staffed by incresaing the establishment to care for the acuity of the medical patients
Women & Childrens	Pearl Ward	23	1115	1247	709	714	1116	1100	372	349	112%	101%	99%	94%			0			green	ward safely staffed
Women & Childrens	The Birth Place	9	1115	1080	369	369	1116	1096	372	336	97%	100%	98%	90%			0			green	unit safely staffed
	Trust total	**633**	**52,713**	**50,579**	**29,351**	**34,102**	**40,074**	**42,906**	**21,738**	**27,010**	**96.0%**	**116.2%**	**107.1%**	**124.3%**	**0**	**10**	**0**	**0**	**0**		

Commentary

On-going daily assessments are in place to ensure safe staffing across acute and surgical care to ensure all areas are covered appropriately.

Actions

Recruitment plan in place to increase staffing.
Ward sisters are working clinically when staffing requires them to do so.
Work is ongoing to look at the role of the CSW for 1:1 when required.

Safe Staffing– Nursing Update KPIs

		Monthly Target	RAG Status	Trend Dec-16	Jan-17	Feb-17	Movement	YTD avg	Trend	Data Quality
1.5.2	Vacancy Rate (Overall)	8%	R	24.82%	23.67%	24.70%	↑	0.2		
1.5.3	Total Vacancies (WTE)	TBC		369.00	352.00	367.00	↑	362.7		
1.5.4	Vacancy Rate (Band 5)	TBC		50.18%	46.23%			0.5		
1.5.5	Vacancy Rate (Band 6)	TBC		47.24%	35.70%			0.41		
1.5.6	Vacancy Rate (CSW)	TBC		16.33%	16.33%			0.2		
1.5.7	Nursing Starters	TBC		21.00	10	23	↑	18.0		
1.5.8	Nursing Leavers	TBC		11.00	7	31	↑	16.3		
1.5.9	CWS Starters	TBC		38.00	23	39	↑	33.3		
1.5.10	CWS Leavers	TBC		9.00	3	31	↑	14.3		
1.5.11	Rolling annual turnover rate	8%	R	9.00%	9.67%	9.97%	↑	0.1		
1.5.12	Total WTE % Substantive	85.00%	R	77.94%	82.22%			0.8		
1.5.13	Total WTE % Bank	TBC		5.65%	6.65%			0.1		
1.5.15	Total WTE % Agency	15.00%		16.41%	11.14%			0.14		
1.5.16	Safe Staffing	94.00%	G	111.6%	110.0%	107.5%	↓	110.8%		
1.5.17	CHPPD	8.00	G	9.07	8.78	9.21	↑	893%		

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

Commentary	Actions
The trust has attended a job fair as well as nursing and CSW assessment days. Bank staffing has continued increase and recruitment is a priority.	We are still awaiting data from exit interviews and the focus remains on retention.

4. Effective

		Monthly Target	Status	Trend						Alignment		
			Status	Jan-17	Feb-17	Mar-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
2.5.4	Emergency Readmissions within 28 days	5%	R	17.0%	11.9%	13.3%	↑	11%			✓	
2.5.4.1	Emergency Readmissions within 28 days Under 65	5%	R		9.7%	11.9%	↑	11%				
2.5.4.2	Emergency Readmissions within 28 days 65 +	5%	R		14.3%	14.9%	↑	15%				
2.6	Discharges before noon	25%	R	13.7%	14.3%	16.7%	↑	14%			✓	✓

CQUIN Ref.	Q1	Q2	Q3	Q4	YTD(£)	Comments
NHS Staff and Wellbeing option B	£85,680	n/a	n/a		£85,680	Forecasting Q4 full achievement
NHS Staff and Wellbeing food	£0	n/a	n/a		£0	Did not achieve Q1. Expecting to achieve Q4
NHS Staff and Wellbeing flu	n/a	n/a	n/a		£0	Forecasting Q4 full achievement
Sepsis 2a - Emergency Department	£10,710	£0	£26,775		£37,485	Partial achievement
Sepsis 2b	£53,550	£0	£53,550		£107,100	
Antimicrobial Resistance 5a - reduction	£0	£0	£0		£0	In dispute with CCG regarding publishing of PHE data
Antimicrobial Resistance 5b - review	£0	£0	£0		£0	
National CQUIN Total Indicative Value	**£149,940**	**£0**	**£80,325**		**£230,265**	

CQUIN Ref.	Q1	Q2	Q3	Q4	YTD(£)	Comments
Joint Formulary	£0	£0	£0		£0	In dispute with CCG
Medicines Reconcilliation	£0	£0	£10,025		£10,025	
SIP Feed Review	£66,830	£66,830	£0		£133,661	
Pressure Ulcer Collaborative	£53,464	£53,464	£53,464		£160,393	
Discharge Before Midday	£53,464	£0	£0		£53,464	
Community Paediatric Paperless Referral	£53,464	n/a	n/a		£53,464	Forecasting Q4 full achievement
Improved EDN Information	£53,464	£80,196	£80,196		£213,857	
Children Asthma pathway	£53,464	n/a	n/a		£53,464	Forecasting Q4 full achievement
Local CQUIN Total Indicative Value	**£334,152**	**£200,491**	**£143,685**		**£678,329**	
Optimal Device						
Adult Critical Care Timely Discharge						
Increase take up of School Immunisation						

5. Caring

		Monthly Target	RAG Status	Trend Jan-17	Feb-17	Mar-17	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	*83%*	G	88.0%	87.2%	89.2%	↑	86%			✓	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	*65%*	G	78.6%	78.5%	79.3%	↑	76%			✓	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	*79%*	G	98.5%	98.5%	99.2%	↑	99%			✓	
3.1.3	Mixed Sex Accommodation breaches	*15*	R	37.00	56.00	41.00	↓	28.8			✓	
3.4.1	Number of Complaints	*45*	R	67.00	46.00	56.00	↑	48			✓	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	*85%*	R	23.0%			↓	43%			✓	
3.4.3	Number of complaint returners	↓	G	7.00	4.00		↓	6.8			✓	

Commentary	Actions
Please see commentary in Executive Summary	

6. Responsive

		Monthly Target	Status	Trend: Jan-17	Feb-17	Mar-17	Movement	YTD avg	Data Quality	Alignment: Carter	SCF	Quality Account / CSUM
4.1.1	RTT – Incomplete pathways (overall)	92%		77.02%	76.45%	76.24%	↓	76.87%			✓	
4.1.2	RTT - Treatment Over 52 Weeks	0		20	34	31	↓	19				
4.2.3	A&E 4 hour target	95%	R	71.96%	76.17%	77.51%	↑	78.31%			✓	
4.3.1	Cancer – 2 week wait (1 month in arrears)	93%	R	89.16%	91.23%		↑	84.99%				
4.3.2	Cancer - 2 Week Wait Breast (1 month in arrears)	93%	G	94.32%	97.37%		↑	91.54%				
4.3.3	Cancer - 31 day first treatment (1 month in arrears)	96%	R	95.92%	93.80%		↓	93.75%				
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	94%	G	82.76%	95.00%		↑	91.53%				
4.3.5	Cancer – 31 day subsequent treatments - drug (1 month in arrears)	98%	G	100.00%	100.00%		↔	99.62%				
4.3.6	Cancer - 62 day consultant upgrade (1 month in arrears)	N/A	R	71.43%	89.47%		↑	81.25%				
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	R	76.19%	82.95%		↑	79%			✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	90%	G	85.71%	100.00%		↑	88%			✓	
4.4.1	Diagnostic waits - under 6 weeks (1 month in arrears)	99%	R	90.84%	95.43%	96.03%	↑	92%			✓	
4.5.8	Patients seen by a stroke consultant within 24 hours (Sep to Nov figures reported)	95%	R	47.00%	54.00%	39.00%	↓	53%				✓
4.6.1	Average elective Length of Stay	<5	G	3.50	2.04	3.07	↑	2.6				✓
4.6.2	Average non-elective Length of Stay	<5	R	6.89	6.65	6.58	↓	6.4				✓
4.6.6	Average occupancy	90%	R	96.49%	94.64%	94.70%	↑	93%				✓

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

mmentary	Actions
Please see commentary in Executive Summary	Please see commentary in Executive Summary

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7. Well led

		Monthly Target	Status	Trend					Alignment		
			Status	Jan-17	Feb-17	Mar-17	Movement	YTD avg	Data Quality	Caring	SDF
5.2.1	Staff Friends and Family – Recommend as place to work (Quarterly)	*62%*	R		57.7%		↔	58.0%			✓
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	*79%*	R		73.1%		↔	73.0%			✓
5.3.7	Rolling annual turnover rate	*8%*	R	10.0%	10.0%	10.0%	↓	9%			✓
5.3.7.1	Executive Team Turnover Rate	*TBA*		0.0%	7.1%	0.0%	↓	3%			✓
5.3.8	Overall Sickness rate	*4.0%*	G	3.92%	3.93%	3.96%	↑	3.9%			
5.3.9	Sickness rate – Short term	*2.0%*	R	2.7%	2.8%	2.8%	↑	2.8%			✓
5.3.10	Sickness rate – Long term	*1.0%*	R	1.2%	1.2%	1.2%	↓	1.2%			✓
5.3.11	Temporary staff % of pay bill	*15%*	G	25.4%	25.4%			23.5%			✓
5.3.14	Starters	*N/A*		89	67	68	↑	76.7			
5.3.15	Leavers	*N/A*		46	32	54	↑	58.1			

Commentary	Actions
Please see commentary in Executive Summary	Please see commentary in Executive Summary

8. Enablers

		Monthly Target	Status	Trend						Alignment		
			Status	Jan-17	Feb-17	Mar-17	Movement	YTD avg	Data Quality	Caritas	SOF	Values Assess / Claim
7.2.1	APC – NHS number completeness (2 month in arrears)	*99%*	R	98.9%				98.9%				✓
7.2.8	A&E – Attendance disposal (2 month in arrears)	*99%*	R	96.0%				96.5%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	*11*	R	140	140		↔	72.2		✓		✓
7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	*0*	R	0	0		↔	0.0				
7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	*99.25*	R	201	195		⇩	357.3		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	*1%*	G	0.8%	0.8%		⇩	1.4%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	*103.50*	G	30	2		⇩	307.09				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	*0.00*	R	4.00	0.04		⇩	3.37				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	*949*	R	2561	2340		⇩	1596.1		✓		✓
7.3.13b	A&E % missing breach reason on breached attendances (1 month in arrears)	*50%*	R	100.0%	100.0%		↔	88.6%		✓		✓
7.3.17	Cancer 2ww invalid NHS Number (1 month in arrears)	*0.25*	R	3	15		↑	5.7		✓		✓
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	*13.25*	G	10	2		⇩	22.7		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	*0.01*	G	0	0		↔	1%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	*2*	G	0	0		↔	6.1		✓		✓
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	*1.25*	G	4	0		⇩	2.7		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	*1.25*	G	2	0		⇩	3.8		✓		✓
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	*1*	R	7	2		⇩	6.0		✓		✓

Commentary	Actions
Please see commentary in Executive Summary	Please see commentary in Executive Summary

Medway NHS
NHS Foundation Trust

Board Report

Report date: 4th May 2017

Title of Report	Report of the Director of Finance
Presented by	Darren Cattell, Director of Finance
Lead Director	Darren Cattell, Director of Finance
Committees or Groups who have considered this report	Executive Group Finance Committee 27-4-17
Executive Summary	This report summarises the M12 unaudited end of year financial performance against the plan. **The Finance Committee discussed this report on 27th April 2017.** A report from the Chair of the Finance Committee is elsewhere on this agenda and provides the Board with assurance over financial performance. Key headlines are: 1. We ended the year with a position of £42.9m deficit which was better than our "stretch" plan of £43.8m deficit and our control total of £46.6m deficit 2. We also ended the year delivering our £12.6m CIP target, delivering our revised Capital Plan (after ED re-phasing) and exceeded our cash in the bank requirement. **3. This is a significant achievement particularly in the same year as we exited Special Measures for Quality and I would recommend that the Board joins me in congratulating all our staff for this performance.** 4. There does of course remain much more to do and one word of caution, our trading performance was a deficit of £45.4m as forecast (we achieved our trading plan in M12) however we received two tranches of STF funding, one matched funding of £1.25m and a "bonus" of £1.25m for our performance. This performance was as expected and was within our control total however this is the place we start from for next year

	5. Expenditure – Pay costs and Agency costs in particular continue to be above plan but actions described are starting to impact on the run rate. Further actions are being proposed within Nursing (Price and Volume variances), as well as Doctors and Admin staff. As previously outlined, this focuses particularly on recruitment and retention initiatives to reduce the reliance on Agency staff. This is **the major area of focus** for us with procurement and getting paid for services we provide making up the majority of the CIP work plan. 6. Income – elective income has recovered in month following the elective activity restart and dedicated Sunderland day case beds. This needs to continue going in to April and beyond 7. Income – The Trust is still hopeful of agreeing a year end settlement position with the CCGs and NHSE 8. CIP – we achieved our CIP target of £12.6m 9. Cash – the Trust ended the financial year with £1.6m in the bank rather than the required £1.4m 10. Capital – We achieved our Capital plan within acceptable tolerance.
Resource Implications	As outlined
Risk and Assurance	• The Trust has closed its books for 2016-17 with a performance better than planned. The External Audit commences next week and there is a risk that the Auditors find a significant event that materially changes the reported position. This will be unlikely given we have prepared the draft Accounts in the same way as in previous years (which we have been commended on) but it remains a risk. **The Finance team have and will continue to liaise with the External Auditors to ensure openness and transparency in our joint work. The Audit Committee will be kept fully appraised of this.** • So far we have been unable to agree a year end settlement position with Commissioners. There is a risk that early in 2017-18 our numbers do not match. **We continue to pursue a settlement in the every short term and we rely on our provision to cover any financial risk in 2017-18. This will be discussed and agreed with our Auditors and the Audit Committee.** • The underlying position of the Trust is as forecast at £45.4m deficit and not the end of year reported deficit of £42.9m. Further work to reduce this run rate down to

	control total level is required in 2017-18 through CIP planning and delivery. **CIP planning has identified c2/3 of our target so far with further activity planned.** •
Legal Implications/Regulatory Requirements	None at this point within the unaudited accounts as we have bettered our control total. Inappropriate Estate and insufficient Facilities lead to higher than acceptable risk to Patients, visitors and staff and could lead to further regulatory action.
Recovery Plan Implication	Financial Recovery is one of the thirteen programmes of Phase 3, improvement.
Quality Impact Assessment	All actions continue to follow an appropriate QIA process
Recommendation	**The Board is asked to note the report and the reported position**
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Finance Report - APPENDICES

Month 12

2016/17

Best of care
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Medway NHS
NHS Foundation Trust

Finance Report for March 2016

1. Cash Flow

2. Loan Conditions

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

4. Capital

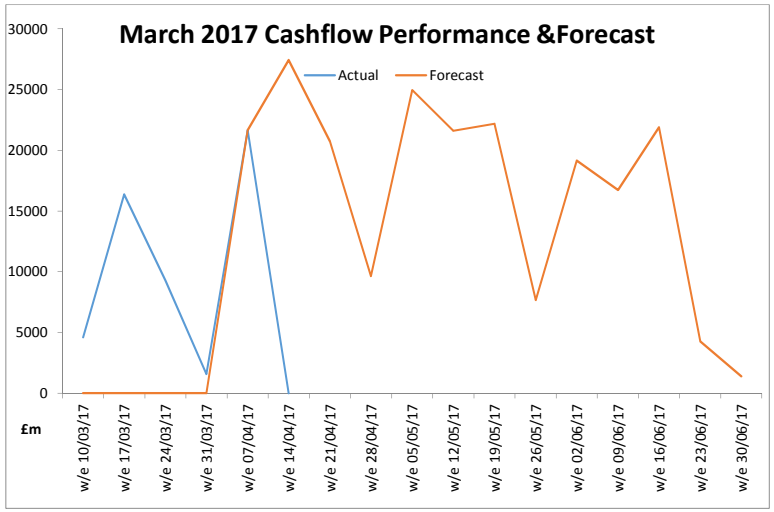
5. Cost Improvement Programme

1. Cash Flow

13 Week Forecast

	Actual				Forecast												
£m	w/e 10/03/17	w/e 17/03/17	w/e 24/03/17	w/e 31/03/17	w/e 07/04/17	w/e 14/04/17	w/e 21/04/17	w/e 28/04/17	w/e 05/05/17	w/e 12/05/17	w/e 19/05/17	w/e 26/05/17	w/e 02/06/17	w/e 09/06/17	w/e 16/06/17	w/e 23/06/17	w/e 30/06/17
BANK BALANCE B/FWD	**2.46**	**4.62**	**16.36**	**9.27**	**1.58**	**21.64**	**27.43**	**20.73**	**9.64**	**24.95**	**21.60**	**22.18**	**7.68**	**19.15**	**16.73**	**21.90**	**4.28**
Receipts																	
NHS Contract Income	1.86	4.03	2.58	0.62	21.00	8.39	1.67	0.00	14.77	0.00	3.14	0.00	14.27	0.00	3.51	0.00	0.00
Other	0.39	2.64	3.58	1.02	0.21	0.80	2.00	0.30	0.32	0.72	0.38	0.30	0.38	0.72	0.38	0.34	0.30
Total receipts	**2.25**	**6.67**	**6.17**	**1.63**	**21.20**	**9.19**	**3.67**	**0.30**	**15.09**	**0.72**	**3.52**	**0.30**	**14.65**	**0.72**	**3.89**	**0.34**	**0.30**
Payments																	
Pay Expenditure (excl. Agency)	0.00	(2.23)	(11.81)	(0.06)	0.00	0.00	(5.92)	(7.93)	0.00	0.00	(2.22)	(11.60)	(0.03)	0.00	0.00	(13.82)	(0.03)
Non Pay Expenditure	(2.35)	(2.13)	(2.94)	(7.75)	(1.14)	(3.41)	(2.35)	(3.46)	(2.88)	(4.07)	(2.95)	(3.21)	(3.15)	(3.15)	(4.37)	(3.14)	(3.14)
Capital Expenditure	0.00	0.00	0.00	(1.51)	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 payments	**(2.35)**	**(4.36)**	**(14.75)**	**(9.33)**	**(1.14)**	**(3.41)**	**(8.27)**	**(11.39)**	**(2.88)**	**(4.07)**	**(5.17)**	**(14.81)**	**(3.18)**	**(3.15)**	**(4.37)**	**(16.96)**	**(3.17)**
Net Receipts/ (Payments)	**(0.10)**	**2.32**	**(8.58)**	**(7.69)**	**20.07**	**5.78**	**(4.60)**	**(11.09)**	**12.21**	**(3.35)**	**(1.65)**	**(14.51)**	**11.48**	**(2.43)**	**(0.48)**	**(16.62)**	**(2.87)**
Funding Flows																	
FTFF/DOH - Revenue	0.00	6.14	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	4.06	(1.00)	0.00
FTFF/DOH - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	3.70	0.00	0.00
STF Funding	0.00	4.20	2.52	0.00	0.00	0.00	(2.10)	0.00	2.10	0.00	0.00	0.00	0.00	0.00	(2.10)	0.00	0.00
PDC Capital	2.27	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	2.23	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	(0.27)	(1.03)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	(0.65)	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
	2.27	**9.42**	**1.49**	**0.00**	**0.00**	**0.00**	**(2.10)**	**0.00**	**3.10**	**0.00**	**2.23**	**0.00**	**0.00**	**0.00**	**5.66**	**(1.00)**	**0.00**
BANK BALANCE C/FWD	**4.62**	**16.36**	**9.27**	**1.58**	**21.64**	**27.43**	**20.73**	**9.64**	**24.95**	**21.60**	**22.18**	**7.68**	**19.15**	**16.73**	**21.90**	**4.28**	**1.41**

Fig1. Cashflow Forecast



Commentary

The opening cash balance for March 2017 was £1.73m, with a closing balance of £1.58m. This is above the minimum liquidity level (£1.4m) required by DH by £0.15m.

The graph shows actual cashflow for March and projected weekly cashflow up to and including 30 June 2017.

Receipts in the month were £18.9m, plus £13.2m loans & funding, therefore the total cash inflow for March was £32.1m. Payments, including capital in the month were £32.2m.

The Trust received £46.6m of deficit loan funding during the year which included a £21.3m working capital facility converted to a lower interest rate loan and £25.3m in uncommitted loans. In addition to the deficit loan the Trust also received £10.4m STF funding during 2016/17.

PDC of £2.3m was drawn down during March in relation to the Emergency Department capital project.

Monthly payments for 16/17 have averaged at £27.3m, with 52% relating to payroll costs. This includes £8.4m per month for direct salary payments and £5.9m in relation to employer costs. Monthly receipts (excluding loans & STF) for 16/17 have averaged at £23m.

As we commence the start of the new financial year, contracts with the Trust's commissioners for 17/18 are agreed and in place. During April, the Trust normally receives an additional contract payment from each of the North Kent CCG's, recovered equally over the remainder of the year, however for 17/18 this will apply solely to Medway CCG. In light of this, non-pay expenditure will need to be monitored carefully during Q1 in order to avoid cash pressures so early in the year.

2. Loan agreement - status of compliance with additional terms

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

Loan Agreement Clause	Description	Implementation Timeframe	Progress	Compliance with Loan Status	Risk to Organisation	Comments
8 – 1	Notification to Monitor / DH if anticipating to miss reforecast and require additional cash support	Immediately if anticipating missing reforecast and not less than 2 months prior to requiring the cash support	Trust reported a V3 plan on 29 June in line with new control totals. NHSi/DH are aware of revenue and capital funding required in 16/17			Trust is reporting an operating deficit within the Control Total
8 – 2	Agency nursing procured through approved frameworks and within maximum cap	Immediately	Notice given to agencies breaching the cap. Action plan in place to substitute the non-framework agency nurses with bank and framework workers.			All non-framework usage to be eliminated by 1st April 2017.
8 – 3	Consultancy spend in excess of £50K pre-approved by Monitor	Immediately	Working through all business cases with Monitor team.			No new contracts introduced without prior approval.
8 – 4	Implementation of controls over VSMs and off-payroll workers	Immediately	In progress			Review completed
8 – 5	Review / benchmarking of Estates and Facilities costs	31st May 2016	In progress			We are benchmarking via the annual ERIC return as well as against live information on the Model Hospital portal.
8 – 6	Produce an Estates strategy	Summer 2016	In progress			Estates strategy is moving at pace but is an emerging and changing strategy and needs to be developed in conjunction with overall Trust strategy.
8 – 7	Use P21+ Procurement framework for publicly funded capital work	Immediately	Major capital works are being undertaken for the ED project. Specific dispensation was sought from Monitor for these works to be tendered outside of the P21+ contract.			ED redevelopment of Majors using P21+
8 – 8	Commission an assessment from SBS of benefit in outsourcing Finance, Accounting and Payroll services	9th May 2016	Payroll is being provided by SBS since February 2016. Outsourcing of other Finance and Accounting services to be further reviewed.			STP Finance Working Group assessing and producing business case
8 – 9	Assess benefit of outsourcing staff bank provider	9th May 2016	Completed - benefit is in moving in-house with a go-live date of 26th March 2016.			
8 – 10	Review savings opportunities in increased usage of NHS Supply Chain and provide copies of medical capital asset register and procurement plans	9th May 2016	Savings opportunities from using NHS Supply Chain are regularly reviewed by Procurement. Medical capital asset register is available.			
8 – 11	Test savings opportunities in use of CCS framework	9th May 2016	CCS framework used			
8 – 12	Become a member of the EEA portal and report relevant activity	Not specified	Member since 2010, activity is reported.			
8 – 13	Provide access to relevant authorised individuals to allow monitoring of progress on above conditions	Immediately	On-going			

3a. Consolidated Income & Expenditure

Consolidated I&E (March 2017)

	Current Month			Year to Date (YTD)		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*
	£'000	£'000	£'000	£'000	£'000	£'000
Revenue						
Clinical income	21,009	18,207	2,802	231,057	222,722	8,335
High Cost Drugs	1,561	1,840	-279	20,510	20,785	-276
STF Income	2,389	700	1,689	10,826	8,400	2,426
Other Operating Income	2,955	1,979	976	25,368	23,729	1,639
Total Revenue	**27,914**	**22,726**	**5,188**	**287,761**	**275,636**	**12,125**
Expenditure						
Substantive	-13,611	-15,744	2,133	-164,147	-187,710	23,562
Bank	-920	-168	-752	-8,439	-3,224	-5,216
Agency	-3,891	-1,399	-2,492	-40,530	-16,952	-23,578
Total Pay	**-18,422**	**-17,311**	**-1,111**	**-213,117**	**-207,885**	**-5,232**
Clinical supplies	-2,999	-2,773	-226	-37,181	-34,303	-2,878
Drugs	-2,361	-2,274	-87	-29,781	-29,898	117
Consultancy	-10	-2	-8	-484	-939	455
Other non pay	-5,374	-2,909	-2,465	-37,534	-33,430	-4,104
Total Non Pay	**-10,744**	**-7,958**	**-2,786**	**-104,979**	**-98,569**	**-6,410**
Total Expenditure	**-29,166**	**-25,269**	**-3,897**	**-318,096**	**-306,454**	**-11,642**
EBITDA	**-1,252**	**-2,543**	**1,291**	**-30,335**	**-30,818**	**483**
	-4%	*-11%*	*25%*	*-11%*	*-11%*	*4%*
Post EBITDA						
Depreciation	-763	-816	53	-9,593	-9,693	101
Interest	-186	-198	12	-1,900	-2,021	121
Dividend	0	-109	109	-1,289	-1,307	18
Profit/(loss) on sale of asset	-17	0	-17	261	0	261
	-967	**-1,123**	**156**	**-12,521**	**-13,021**	**501**
Net (Surplus) / Deficit	**-2,219**	**-3,666**	**1,447**	**-42,856**	**-43,839**	**983**
NHSi Control Total				***-46,637***		
Variance Against Control Total (Favourable/-Adverse)				***3,781***		

Commentary

Net (Surplus) / Deficit

The Trust reported a £2.2m deficit in month 12, favourable to plan by £1.5m mainly due to increased STF income. The year end position reported is a deficit of £42.9m, £1m favourable to plan and £3.8m favourable to the NHSi Control Total.

Clinical Income

A&E attendances continue with high volumes month on month, 4% higher in March 2017 compared to the corresponding period of 2015/16. The YTD comparison between 16/17 and 15/16 is a 10% increase. Elective and daycase activity during March has increased due to increased outsourcing, the return of a dedicated day case unit and reduced medical outliers in surgical areas. There has also been an acuity change within A&E from minor injuries to more complex presentations. Excess bed days have continued to under perform against plan due to the impact of the medical model and the reduction of length of stay within the emergency pathway. Meetings are ongoing with Commissioners to negotiate year-end settlements.

Other Operating Income

Other income YTD is favourable to plan mainly due to HMRC VAT income, pharmacy income and increased activity in the A&CC Directorate (pathology tests to other providers).

Pay

Pay expenditure is £1.1m adverse to plan in month mainly due to CIP non delivery, agency costs due to increased acuity of patients and pending recruitment. YTD is adverse to plan by £5.2m mainly due to CIP non delivery and premium agency costs related to increased emergency activity.

Non Pay

Clinical supplies in month are adverse to plan mainly due to increased activity offset by CIP delivery. YTD is adverse to plan mainly due to external outsourcing to improve RTT performance, additional expenditure on supplies due to increased activity offset by CIP delivery. Expenditure on drugs is adverse to plan in month due to increased high cost drugs activity and YTD favourable mainly due to CIP delivery and reduced planned activity.

CIP

The Trust has delivered £12.6m CIP YTD as per plan.

Directorate Reports

The income and expenditure position by Directorate is detailed later in the report.

Capital and Cash

Risks and Mitigations

Year-end settlements with the main Commissioners are pending agreement and a provision has been included.

3b. Run Rate Analysis - Financial

Anaylsis of 15 monthly performance - Financials

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue															
Clinical income	16.8	16.9	21.9	16.9	16.9	22.1	19.2	17.9	19.3	19.9	19.5	18.4	19.7	18.6	22.6
High Cost Drugs	1.7	1.7	1.7	1.8	1.6	1.8	1.7	1.6	2.0	1.8	1.7	1.5	1.8	1.6	1.6
STF Income				0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	0.7	1.0	2.4
Other Operating Income	1.9	2.4	2.0	1.9	2.1	2.3	2.1	1.9	2.2	2.0	1.7	2.0	2.3	2.1	3.0
Total Revenue	**20.4**	**20.9**	**25.6**	**21.3**	**21.3**	**26.9**	**23.7**	**22.2**	**24.2**	**24.4**	**23.6**	**22.6**	**24.6**	**23.4**	**29.5**
Expenditure															
Substantive	-13.1	-13.1	-12.9	-13.5	-13.5	-13.7	-13.6	-13.7	-13.7	-13.6	-14.0	-13.6	-13.9	-14.0	-13.6
Bank	-0.6	-0.6	-0.8	-0.6	-0.5	-0.6	-0.8	-0.7	-0.6	-0.6	-0.9	-0.8	-0.7	-0.8	-0.9
Agency	-2.7	-3.0	-2.8	-2.6	-2.8	-3.6	-2.8	-3.1	-3.6	-3.5	-3.8	-3.5	-3.7	-3.6	-3.9
Total Pay	**-16.4**	**-16.7**	**-16.5**	**-16.8**	**-16.8**	**-17.9**	**-17.2**	**-17.5**	**-17.8**	**-17.6**	**-18.6**	**-17.9**	**-18.3**	**-18.3**	**-18.4**
Clinical supplies	-2.7	-3.1	-3.6	-3.2	-3.4	-3.4	-3.4	-3.3	-3.2	-2.8	-2.7	-2.8	-2.9	-3.1	-3.0
Drugs	-2.4	-2.4	-2.6	-2.7	-2.9	-2.7	-2.5	-2.7	-2.8	-2.5	-2.1	-1.7	-2.4	-2.4	-2.4
Consultancy	-0.2	-0.2	-0.1	0.0	-0.1	0.0	-0.1	0.0	-0.1	0.0	0.1	0.0	-0.1	0.0	0.0
Other non pay	-2.9	-2.8	-2.7	-2.9	-2.4	-2.9	-2.6	-2.6	-2.4	-2.9	-3.0	-3.0	-3.0	-2.9	-7.0
Total Non Pay	**-8.1**	**-8.5**	**-9.0**	**-8.8**	**-8.8**	**-9.0**	**-8.6**	**-8.6**	**-8.5**	**-8.2**	**-7.8**	**-7.4**	**-8.5**	**-8.4**	**-12.4**
Total Expenditure	**-24.5**	**-25.2**	**-25.5**	**-25.6**	**-25.6**	**-26.9**	**-25.8**	**-26.1**	**-26.3**	**-25.8**	**-26.4**	**-25.3**	**-26.8**	**-26.7**	**-30.8**
EBITDA	**-4.1**	**-4.3**	**0.1**	**-4.3**	**-4.3**	**0.0**	**-2.1**	**-3.9**	**-2.1**	**-1.4**	**-2.8**	**-2.7**	**-2.2**	**-3.3**	**-1.3**
Post EBITDA															
Depreciation	-0.9	-0.9	-0.3	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.9	-0.8	-0.8	-0.8	-0.8
Interest	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
Dividend	-0.3	-0.3	0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	0.0
Fixed Asset Impairment	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Profit on sale of asset	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.2	0.0
	-1.3	**-1.3**	**0.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.1**	**-1.1**	**-1.0**	**-1.2**	**-1.1**	**-1.1**	**-0.9**	**-1.0**
Net Surplus / (Deficit)	**-5.4**	**-5.6**	**0.1**	**-5.3**	**-5.3**	**-1.0**	**-3.1**	**-5.0**	**-3.2**	**-2.4**	**-3.9**	**-3.8**	**-3.3**	**-4.2**	**-2.2**

3c. Clinical Activity

Clinical Activity by Point of Delivery (March 2017)

	Current Month			Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
PBR								
Elective Day Case	1,886	1,859	27	1,812	22,689	21,430	1,259	18,202
Elective Inpatient	533	624	-91	613	6,670	7,321	-651	6,412
Non Elective Inpatient	4,098	3,929	169	3,843	47,401	47,538	-137	42,788
Excess Bed Days	1,493	1,660	-167	1,656	19,862	24,023	-4,161	22,192
Outpatients	29,391	26,083	3,308	27,034	346,964	334,773	12,191	297,545
A&E (includes MEDOC)	10,348	9,926	422	9,953	115,056	105,514	9,542	104,222
Maternity Pathway	890	907	-17	898	10,825	10,852	-27	9,926
Direct Access Radiology	0	5,365	-5,365	1,953	0	54,203	-54,203	19,315
Adult Critical Care	876	916	-40	916	10,143	10,143	0	9,227
Chemotherapy	629	715	-86	716	9,543	9,499	44	8,784
Total PBR	**50,144**	**51,984**	**-1,841**	**49,394**	**589,153**	**625,296**	**-36,142**	**538,613**
Non PBR								
Direct Access	239,120	200,554	38,566	102,914	2,501,917	2,243,091	258,826	1,043,299
Paediatric & Neonatal Critical Care	945	1,062	-117	968	11,427	11,691	-264	10,320
Excluded Devices	102	67	35	77	1,163	882	281	917
Other cost per case	2,852	2,791	61	6,025	30,170	36,440	-6,270	66,708
Total Non PBR	**243,019**	**204,474**	**38,545**	**109,984**	**2,544,677**	**2,292,104**	**252,574**	**1,121,244**

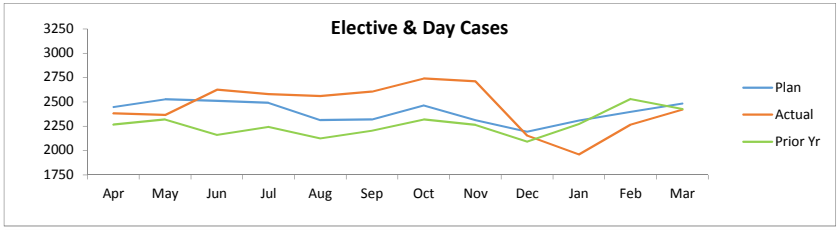
Commentary

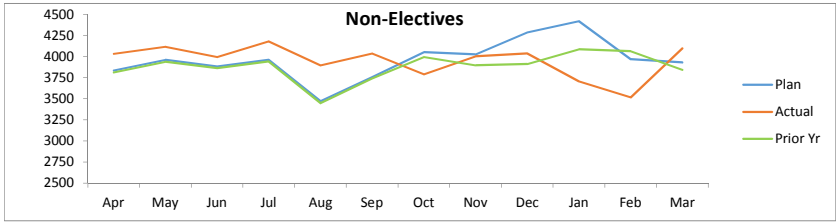
A&E attendances continue with high volumes month on month, 4% higher in March 2017 compared to the corresponding period of 2015/16. The YTD comparison between 16/17 and 15/16 is a 10% increase.

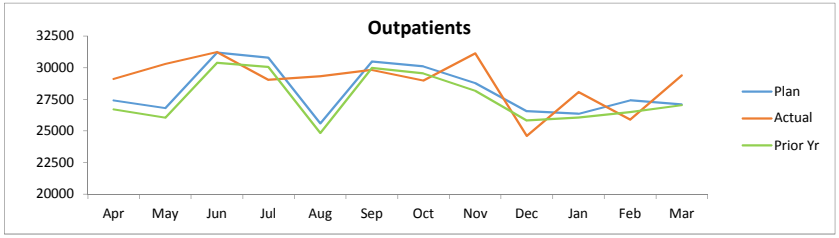
Day cases are over performing in month by 27 spells while Electives are under performing in month by 91 spells, however this is offset by YTD overperformance in outpatients of 3,308 attendances and increased emergency work. Critical care is underperforming by 40 beddays in the month.

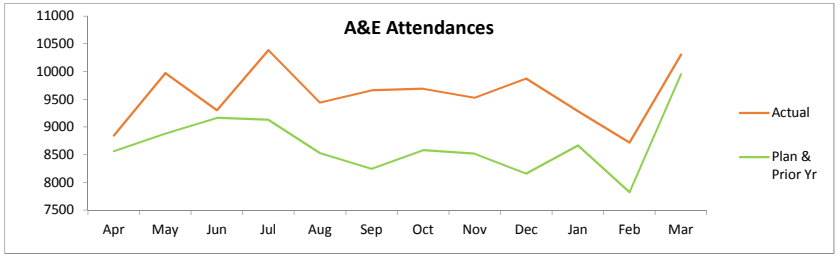
Excess bed days have continued to under perform against plan due to the impact of the medical model and the reduction of length of stay within the emergency Pathway.

Activity Performance against Plan







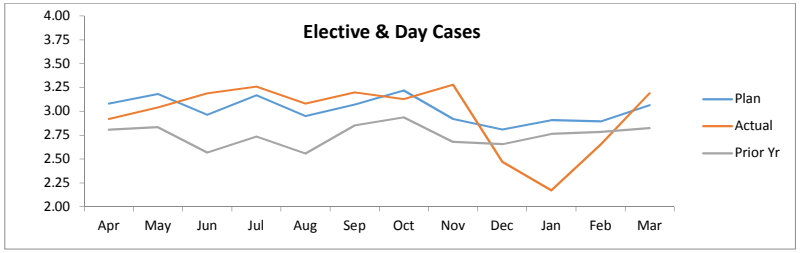


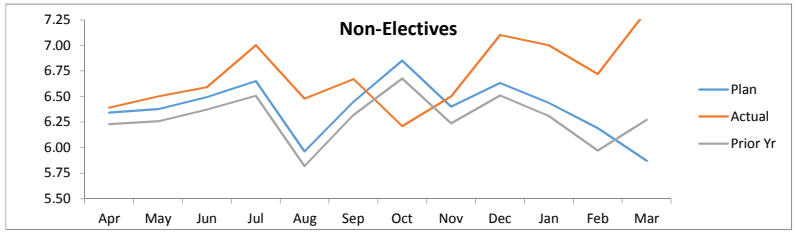
3d. Clinical Income

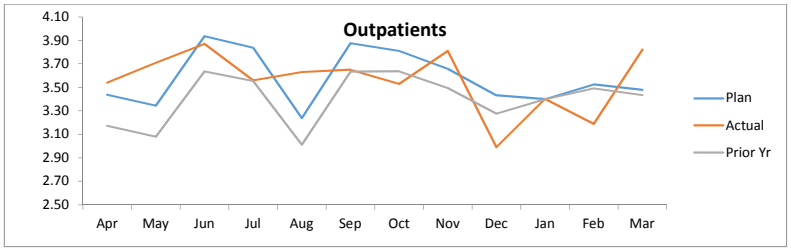
Clinical Income by Point of Delivery (March 2017)

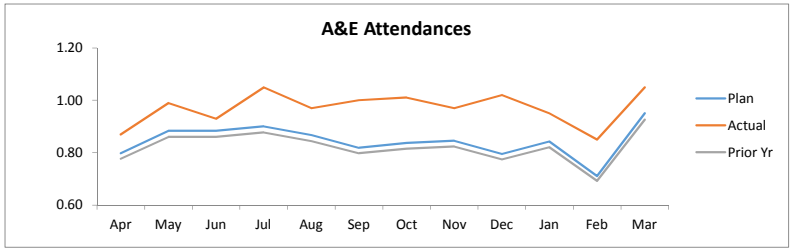
	Current Month			Prior Year In Month	Year to Date			Prior Year YTD
	Actual £m	*Plan* £m	*Variance* £m	*Actual* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Actual* £m
PBR								
Elective Day Case	1.79	1.38	0.41	1.29	17.98	16.39	1.59	14.86
Elective Inpatient	1.40	1.69	-0.29	1.53	17.68	19.85	-2.17	18.22
Non Elective Inpatient	7.34	5.87	1.47	6.27	80.12	76.66	3.46	75.59
Emergency Readmissions	-0.19	-0.19	0.00	0.00	-2.32	-2.32	0.00	-2.02
Emergency Marginal rate	-0.44	-0.27	-0.17	-0.17	-3.72	-3.18	-0.54	-3.11
Excess Bed Days	0.34	0.39	-0.05	0.39	4.60	5.75	-1.15	5.63
Outpatients	3.82	3.35	0.47	3.43	42.81	42.48	0.33	40.60
A&E	1.05	0.95	0.10	0.93	11.71	10.13	1.58	9.87
Maternity Pathway	0.94	0.92	0.02	0.83	11.19	10.88	0.31	10.93
Direct Access Radiology	0.00	0.22	-0.22	0.15	0.00	2.23	-2.23	1.55
Adult Critical Care	0.93	0.95	-0.02	0.94	10.96	10.38	0.58	10.27
Chemotherapy	0.08	0.10	-0.02	0.10	1.40	1.33	0.07	1.32
Total PBR	**17.06**	**15.36**	**1.70**	**15.69**	**192.41**	**190.58**	**1.83**	**183.71**
Non PBR								
High Cost Drugs	1.90	1.84	0.06	0.00	20.51	20.78	-0.27	0.00
Direct Access	0.75	0.53	0.22	0.53	8.82	5.98	2.84	6.40
Paediatric & Neonatal Critical Care	0.78	0.85	-0.07	0.72	9.25	9.49	-0.24	8.22
Excluded Devices	0.17	0.21	-0.04	0.21	2.18	2.30	-0.12	2.21
Other cost per case	0.31	0.27	0.04	0.27	3.23	3.47	-0.24	3.46
Block contracts	0.75	0.66	0.09	0.78	9.18	9.10	0.08	9.42
Outpatient efficiencies	-0.37	-0.23	-0.14	-0.21	-1.68	-2.73	1.05	-2.40
Total Non PBR	**4.29**	**4.13**	**0.16**	**2.30**	**51.49**	**48.39**	**3.10**	**27.31**
CQUIN	0.47	0.36	0.11	0.20	5.17	4.42	0.75	3.40
Contract Penalties	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-3.26
Sustainability & transformation Funding	2.39	0.70	1.69	0.00	10.82	8.40	2.42	0.00
Other Non-Contracted Income	0.53	0.09	0.44	0.00	1.15	1.06	0.09	0.00
Provision	0.00	-0.08	0.08	0.16	0.00	-1.25	1.25	-0.25
Prior Month Adjustments	0.00	0.03	-0.03	0.00	0.00	-0.21	0.21	0.00
Others (RTA & Overseas)	0.22	0.08	0.14	0.00	1.36	0.80	0.56	1.02
Total	**24.96**	**20.66**	**4.29**	**18.35**	**262.39**	**252.19**	**10.20**	**211.93**

Income Performance against Plan









Commentary

A&E income is over performing in month 12 by £93k and is over performing YTD by £1.5m. Non elective income is over performing £1.47m in month and (£3.47m YTD) . The main areas of overperformance are in General Medicine, Cardiology and Geriatrics . Whilst non elective activity has increased it attracts a lower tariff compared to planned care as a result of the marginal rate cap. Elective and day case income increased compared to the previous month mainly due to the return of a dedicated day case unit and reduced medical outliers in surgical areas.

Meetings are on-going with Commissioners to negotiate year-end settlements.

The Trust 's income position includes STF income of £10.8m which comprises of the original £8.4m, an additional £2.2m for improving the control total, £0.26m for gain of asset disposal £0.05 for change in discount rate but assumes a Q3 failure in the Cancer target with a financial impact of £0.1m.

3e. Workforce

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
		WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Substantive	Consultants	179	216	-37	2.19	2.50	-0.31	2.25	28.38	31.55	-3.17	26.93
	Junior Medical	330	371	-41	2.08	2.20	-0.12	1.81	23.39	25.62	-2.23	21.12
	Nurses & Midwives	1120	1486	-366	3.96	4.89	-0.93	3.71	47.37	59.87	-12.50	45.05
	Scientific, Therapeutic & Technical	446	507	-61	1.36	1.46	-0.10	1.32	16.63	18.11	-1.48	15.99
	Healthcare Assts, etc.	479	547	-68	0.93	1.09	-0.16	0.89	11.54	13.10	-1.56	10.71
	Executives	7	9	-2	0.14	0.14	0.00	1.89	1.41	1.63	-0.22	1.55
	Chair & NEDs	5	7	-2	0.04	0.01	0.03	0.01	0.16	0.16	0.00	0.14
	Admin & Clerical	817	956	-139	2.08	2.40	-0.32	0.06	24.40	28.76	-4.37	21.58
	Other Non Clinical	441	486	-45	0.91	0.86	0.05	0.82	10.97	10.29	0.68	10.03
	Pay Reserves	0	0	0	-0.08	0.18	-0.26	-0.03	-0.08	-1.37	1.29	0.00
	Substantive Total	**3,824**	**4,586**	**-762**	**13.61**	**15.74**	**-2.13**	**12.73**	**164.15**	**187.71**	**-23.56**	**153.11**
Agency	Consultants	28	0	28	0.42	0.08	0.34	0.29	4.16	0.95	3.2	2.51
	Junior Medical	56	0	56	0.52	0.48	0.04	0.60	7.18	5.43	1.7	8.21
	Nurses & Midwives	411	0	411	2.03	0.32	1.71	0.80	17.47	5.47	12.0	13.64
	Scientific, Therapeutic & Technical	35	0	35	0.18	0.23	-0.05	0.25	2.82	1.31	1.5	4.18
	Healthcare Assts, etc.	53	0	53	0.14	0.00	0.14	0.06	1.63	0.00	1.6	0.43
	Admin & Clerical	24	14	10	0.21	0.25	-0.04	0.55	5.55	3.43	2.1	3.97
	Other Non Clinical	47	0	47	0.11	0.03	0.08	0.20	1.44	0.35	1.1	1.74
	Agency Total	**654**	**14**	**640**	**3.61**	**1.40**	**2.21**	**2.76**	**40.25**	**16.95**	**23.30**	**34.68**
Bank	Nurses & Midwives	107	0	107	0.29	0.12	0.17	0.35	2.69	1.48	1.2	2.22
	Junior Medical	3	0	3	0.05	0.00	0.05	0.00	0.06	0.00	0.1	0.00
	Scientific, Therapeutic & Technical	11	0	11	0.04	0.01	0.03	0.04	0.57	0.10	0.5	0.46
	Healthcare Assts, etc.	209	0	209	0.58	0.05	0.53	0.20	3.52	0.64	2.9	2.79
	Admin & Clerical	52	1	51	0.15	-0.06	0.21	0.10	1.31	0.56	0.8	1.31
	Other Non Clinical	40	15	25	0.09	0.04	0.05	0.02	0.58	0.45	0.1	0.32
	Bank Total	**422**	**16**	**406**	**1.20**	**0.17**	**1.03**	**0.71**	**8.72**	**3.22**	**5.50**	**7.10**
	Workforce Total	**4,900**	**4,616**	**284**	**18.42**	**17.31**	**1.11**	**16.20**	**213.12**	**207.88**	**5.24**	**194.89**

	Current Month						Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
Staff Group:	WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Consultants	207	216	-9	2.61	2.58	0.03	2.54	32.54	32.50	0.04	29.44
Junior Medical	389	371	18	2.65	2.68	-0	2.41	30.63	31.05	-0.42	29.33
Nurses & Midwives	1,638	1,486	152	6.28	5.34	0.94	4.86	67.53	66.82	0.71	60.91
Scientific, Therapeutic & Technical	492	507	-15	1.58	1.70	-0.12	1.61	20.01	19.52	0.49	20.63
Healthcare Assts, etc.	741	547	194	1.65	1.14	0.51	1.15	16.69	13.73	2.96	13.93
Executives	7	9	-2	0.14	0.14	0.00	1.89	1.41	1.63	-0.22	1.55
Chair & NEDs	5	7	-2	0.04	0.01	0.03	0.01	0.16	0.16	0.00	0.14
Admin & Clerical	893	971	-78	2.44	2.59	-0.15	0.71	31.26	32.75	-1.49	26.86
Other Non Clinical	528	501	27	1.11	0.94	0.17	1.04	12.99	11.09	1.90	12.09
Pay Reserves	0	0	0	-0.08	0.18	-0.26	-0.03	-0.08	-1.37	1.29	0.00
Workforce Total	**4,900**	**4,616**	**284**	**18.42**	**17.31**	**1.11**	**16.20**	**213.12**	**207.88**	**5.24**	**194.89**

Commentary:

Pay expenditure is overspent compared to plan in month by £1.11m mainly due to CIP and premium agency costs due to emergency demand pressures. Increases on prior year in month expenditure are mainly due to increments, inflationary and national insurance increases of 3.3% and agency costs.

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

Wte for agency and bank staff for the majority of areas are included in the substantive wte as they are covering established posts whereas the financial premium cost is included in the agency/bank budget. The planned agency wte relates to the PMO as these are non recurrent posts.

		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	180	178	179	178	181	179	177	179	179	180	181	180	179	178	179
	Junior Medical	319	324	326	321	311	322	307	335	334	328	329	327	321	321	330
	Nurses & Midwives	1,066	1,077	1,102	1,110	1,107	1,105	1,089	1,084	1,097	1,105	1,106	1,098	1,118	1,134	1,120
	Scientific, Therapeutic & Technical	450	448	453	464	466	460	452	451	456	442	446	450	448	448	446
	Healthcare Assts, etc	465	466	477	471	465	457	461	450	457	458	459	463	455	472	479
	Executives	4	5	6	7	7	7	7	7	8	8	10	6	5	7	7
	Chair & NECs	7	7	7	7	7	7	7	7	7	6	6	6	6	6	5
	Admin & Clerical	750	768	779	794	800	801	802	801	809	808	809	809	812	821	817
	Other Non Clinical	417	422	420	443	435	451	467	464	458	464	458	434	433	438	441
	Substantive Total	**3,658**	**3,695**	**3,749**	**3,795**	**3,779**	**3,789**	**3,768**	**3,778**	**3,805**	**3,801**	**3,804**	**3,772**	**3,777**	**3,823**	**3,824**
Agency	Consultants	8	11	14	10	13	14	16	19	25	20	18	18	19	20	28
	Junior Medical	59	51	59	50	52	51	54	59	65	68	61	70	62	53	56
	Nurses & Midwives	200	245	159	168	224	330	201	254	340	324	364	290	366	339	411
	Scientific, Therapeutic & Technical	52	55	49	44	52	61	55	61	28	35	54	63	50	37	35
	Healthcare Assts, etc	10	8	42	- 9	31	46	26	44	63	49	57	45	82	63	53
	Admin & Clerical	32	39	52	40	41	61	58	30	22	22	57	57	51	47	24
	Other Non Clinical	48	53	73	57	45	36	35	35	35	44	45	45	45	51	47
	Agency Total	**409**	**462**	**448**	**360**	**458**	**598**	**444**	**502**	**578**	**562**	**656**	**588**	**675**	**611**	**654**
Bank	Nurses & Midwives	47	49	92	58	58	46	51	47	44	53	57	57	39	64	107
	Junior Medical	-	-	-	-	-	-	-	-	-	-	-	-	-	1	3
	Scientific, Therapeutic & Technical	10	10	10	4	4	28	27	18	17	18	20	21	6	3	11
	Healthcare Assts, etc	118	108	91	91	91	153	120	117	108	114	124	127	121	134	209
	Admin & Clerical	48	50	42	36	36	19	62	106	51	59	78	59	67	64	52
	Other Non Clinical	9	11	10	3	3	1	4	9	3	13	45	40	41	44	40
	Bank Total	**232**	**228**	**245**	**192**	**192**	**247**	**264**	**297**	**223**	**257**	**324**	**304**	**274**	**310**	**422**
	Workforce Total	**4,299**	**4,385**	**4,442**	**4,347**	**4,429**	**4,634**	**4,476**	**4,577**	**4,606**	**4,619**	**4,784**	**4,664**	**4,726**	**4,743**	**4,900**

Analysis of 15 monthly performance - £

		Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Feb-17
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.29	2.23	2.26	2.31	2.37	2.33	2.38	2.33	2.30	2.48	2.48	2.34	2.40	2.46	2.19
	Junior Medical	1.95	1.93	1.81	1.86	1.83	1.91	1.88	1.99	1.95	1.96	2.10	1.95	2.01	1.86	2.08
	Nurses & Midwives	3.74	3.77	3.73	3.97	3.95	4.00	3.89	3.91	3.92	3.92	3.91	3.89	3.91	4.14	3.96
	Scientific, Therapeutic & Technical	1.36	1.35	1.32	1.45	1.43	1.42	1.38	1.38	1.42	1.18	1.39	1.40	1.40	1.42	1.36
	Healthcare Assts, etc	0.95	0.95	0.94	0.99	0.95	0.97	0.96	0.94	0.97	0.94	0.96	0.94	1.02	0.97	0.93
	Executives	0.09	0.19	0.06	0.11	0.11	0.13	0.15	0.12	0.13	0.10	0.10	0.12	0.09	0.10	0.14
	Chair & NECs	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.02	-	0.01	0.01	0.04
	Admin & Clerical	1.82	1.83	1.91	1.98	2.01	2.00	2.01	2.01	2.02	2.03	2.04	2.08	2.06	2.07	2.08
	Other Non Clinical	0.83	0.84	0.82	0.91	0.87	0.91	0.93	0.96	0.94	0.93	0.96	0.85	0.89	0.92	0.91
	Substantive Total	**13.04**	**13.11**	**12.83**	**13.59**	**13.52**	**13.61**	**13.51**	**13.65**	**13.66**	**13.48**	**13.88**	**13.57**	**13.78**	**13.96**	**13.61**
Agency	Consultants	0.18	0.24	0.29	0.24	0.26	0.31	0.37	0.37	0.44	0.31	0.29	0.37	0.41	0.37	0.42
	Junior Medical	0.70	0.59	0.60	0.66	0.54	0.50	0.56	0.60	0.64	0.57	0.62	0.72	0.61	0.64	0.52
	Nurses & Midwives	0.94	1.34	0.80	0.72	0.96	1.68	1.01	1.18	1.58	1.56	1.81	1.43	1.82	1.69	2.03
	Scientific, Therapeutic & Technical	0.39	0.32	0.25	0.28	0.28	0.31	0.27	0.26	0.14	0.24	0.29	0.25	0.21	0.10	0.18
	Healthcare Assts, etc	0.02	0.02	0.06	0.04	0.08	0.12	0.06	0.11	0.16	0.12	0.15	0.13	0.31	0.19	0.14
	Admin & Clerical	0.31	0.34	0.55	0.53	0.50	0.50	0.40	0.52	0.42	0.56	0.52	0.50	0.49	0.41	0.21
	Other Non Clinical	0.14	0.14	0.20	0.15	0.14	0.13	0.14	0.09	0.17	0.10	0.08	0.09	0.08	0.16	0.11
	Agency Total	**2.68**	**3.01**	**2.76**	**2.63**	**2.76**	**3.55**	**2.81**	**3.13**	**3.55**	**3.47**	**3.76**	**3.49**	**3.94**	**3.55**	**3.61**
Bank	Nurses & Midwives	0.19	0.19	0.38	0.20	0.24	0.22	0.30	0.17	0.16	0.10	0.27	0.31	0.20	0.24	0.29
	Junior Medical	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	0.01	0.05
	Scientific, Therapeutic & Technical	0.03	0.04	0.04	0.00	0.01	0.10	0.08	0.06	0.06	0.06	0.06	0.07	0.02	0.01	0.04
	Healthcare Assts, etc	0.28	0.24	0.20	0.22	0.22	0.29	0.28	0.26	0.24	0.26	0.28	0.27	0.30	0.31	0.58
	Admin & Clerical	0.11	0.12	0.10	0.14	0.07	-0.05	0.13	0.21	0.09	0.05	0.14	0.11	0.12	0.15	0.15
	Other Non Clinical	0.02	0.03	0.02	0.03	0.01	0.00	0.00	0.02	0.01	0.09	0.10	0.09	0.07	0.08	0.09
	Bank Total	**0.63**	**0.62**	**0.75**	**0.59**	**0.54**	**0.56**	**0.79**	**0.72**	**0.57**	**0.55**	**0.85**	**0.85**	**0.71**	**0.80**	**1.20**
	Workforce Total	**16.35**	**16.74**	**16.34**	**16.81**	**16.82**	**17.72**	**17.11**	**17.50**	**17.78**	**17.50**	**18.50**	**17.91**	**18.43**	**18.30**	**18.42**

4.Capital

Capital Programme Summary

	2017-18 Final Position				
	Original Plan	Revised Plan	Actual Out-turn	Variance from Orig	Variance from Rev'd
	£m	£m	£m	£m	£m
Expenditure					
Recurrent Estates & Site Infrastructure	5.06	4.47	5.16	-0.10	-0.69
IM&T	5.90	2.38	2.69	3.21	-0.31
Medical & Surgical Equipment	1.52	1.83	1.61	-0.09	0.23
Specific Business Cases	3.88	1.75	1.64	2.24	0.11
Transform Projects (ED/AAU)	11.84	6.77	6.47	5.37	0.30
Total	**28.20**	**17.20**	**17.56**	**10.64**	**-0.36**

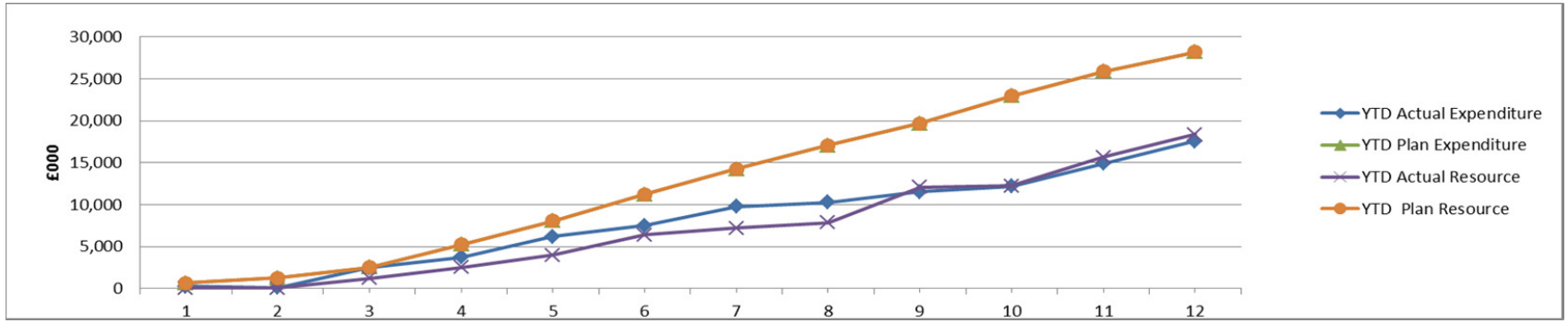
Commentary

As at Month 12 the Capital programme shows a net undershoot against the original control total amounting to £10.7m. This position has continued to be in line with the previous forecast position reported to the DH and consists principally of projects that were to have been funded by external loans and which will therefore be carried forward to 2017-18. During month 12 a number of relatively additional minor slippages arose simply as timing issues and these were subsequently mitigated by the further acceleration of recurrent capital expenditure projects from 2017-18. As a result it will be noted that overall capital expenditure in 2016-17 year has been kept within available resources The principal variances from the original plan are as follows

- ED Refurbishment £5.37m This project was subsequently commenced in October 2016 with a programme that revised the original phasing and that has been further impacted by more recent controlled programme slip.
- IT Projects £3.3m,This consists principally of Telephony project (£1m) and Electronic Data management (£630k) each of which have been re-phased operationally into 2017-18. Other variances relate to Bed management (£429k) and Electronic order Communications (£700k) which has been impacted by the timetable for the joint pathology project with Dartford and Gravesham NHST.
- Specific Business cases £2.2m variance Consisting principally of 2nd CT Scanner (£1m) Medical HDU design (£0.3m) GS1 Inventory (£0.25m). These projects have been re-phased into coming months as a result of operational constraints or efficiencies.

It is again re-iterated that whilst any change to the original phasing of a capital programme could have presented a risk it should be noted that in this instance all changes were discussed and agreed with the relevant clinical or operational teams and where necessary mitigating actions put in place. Slippages this year principally arose as a result of over optimistic planning or necessary constraints upon access to busy clinical areas.

Capital Monthly Profile



5. 2016/17 Cost Improvement Programme Summary

	Acute & Continuing Care £0	Surgery £'000	Womens & Childrens £'000	Corporate £'000	Estates £'000	Central £'000	TOTAL £'000
Divisional Schemes	2,111	2,002	1,186	877	263	260	**6,699**
Medicine Management						2,100	**2,100**
Procurement	2,112	509	163	1		1,061	**3,846**
TOTAL	**4,223**	**2,512**	**1,349**	**878**	**263**	**3,421**	**12,645**

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 4 May 2017

Title of Report	Communications report
Presented by	Glynis Alexander
Lead Director	Director of Communications
Committees or Groups who have considered this report	Not applicable
Executive Summary	The purpose of this report is to summarise the communications highlights of the last month. The focus now is to communicate our improvement plan – Better, Best, Brilliant – and ensue opportunities for input and engagement.
Resource Implications	None
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA
Recovery Plan Implication	The Communications Team's work is aligned with the improvement plan.
Quality Impact Assessment	NA
Recommendation	For noting by the Board
Purpose & Actions required by the Board :	Approval Assurance Discussion Noting

				x

NHS Medway NHS Foundation Trust

Communications report – May 2017

1. EXECUTIVE SUMMARY

1.1. Phase three of our improvement plan – Better, Best, Brilliant – is being launched at the beginning of May, and this will be supported by a range of communications and engagement channels.

1.2. We are keen to engage local stakeholders in initiatives to improve care for patients, as well as ensuring our staff are able to influence how plans are developed and rolled out.

1.3. Following the agreement of the House of Commons to hold an early election on June 8, the pre-election period began on 22 April. During this period, there are restrictions placed on the communications activity of public bodies. This prevents announcements which could influence or be seen to influence the election.

2. ENGAGING COLLEAGUES

2.1 We continue to keep staff informed through a range of communications – all-staff email updates, weekly messages from the Chief Executive, themes of the week, and News@Medway, as well as utilising other tools such as screensavers and posters. We also believe in the importance of face to face communications for those staff without PC access and encourage team meetings and huddles to ensure staff have a chance to discuss and raise questions.

2.2 We have continued to work on the communications strategy and visual identity for Better, Best, Brilliant and its associated programmes

2.3 We have refreshed the Trust Internal Communications Strategy and are exploring new channels for engaging with colleagues, including a closed Facebook group.

2.4 We provided support to the GSTT Buddying Event, a forthcoming Trust-wide infection control campaign and numerous internal communications projects.

NHS Medway NHS Foundation Trust

3. MEDIA

3.1 The Trust has featured extensively in local, regional and national media coverage this month.

3.2 We were delighted that the hard work of our staff was featured in national media coverage, with the award-winning STOMP initiative achieving significant exposure in the Mail on Sunday, Daily Mail Online. Daily Mirror, the Independent and the Sun. This has been very well received by the public and shared extensively via social media.

3.3 Other notable items in the local and regional media included the Countess of Wessex' visit to the Trust and the Trust's new Funky Frames initiative.

3.4 We have also been working with HSJ Intelligence to produce a comprehensive report on the achievements at the Trust and challenges moving forward. These best-practice case studies are an invaluable resource for acute trusts and commissioners.

3.5 On a less positive note, the Trust received negative coverage on the potential relocation of the League of Friends shop and the Alan Woods inquest.

3.6 Our media relations work will be restricted during the pre-election period.

4. SOCIAL MEDIA

4.1 Over the past 28 days we have engaged with 74,300 people on Twitter and 387,086 people on Facebook. We have gained 22 new followers on Twitter and 103 on our Facebook account, taking our total number of followers to 2,706 and 4,411 respectively. Key topics over the last month were autism awareness, Easter weekend and our funky frames initiative.

4.2 We continue to engage with local and national health organisations and stakeholders with our posts retweeted/shared by a number of followers, including Medway Council, Healthwatch Medway and Swale CCG.

5. STAKEHOLDER ENGAGEMENT

5.1 Our Council of Governors and members have been involved in discussions about quality priorities and metrics.

5.2 We held a members' event at the beginning of April when the Chief Executive discussed our latest Care Quality Commission report which raised our rating to 'requires improvement' and led to the removal of special measures.

5.3 Our governors and members receive regular updates from the Chairman providing news on the Trust's progress and developments.

5.4 The team worked with the Royal Household and Abigail's Footsteps to organize the Countess of Wessex' visit to the Trust

5.5 Our stakeholder engagement activity will be restricted during the pre-election period.

6. COMMUNITY ENGAGEMENT

6.1 The Trust's recently appointed Engagement Officer has made contact with numerous community and voluntary organisations, including seldom heard from communities.

6.2 We are identifying opportunities for interaction with various audiences, such as at a recent roadshow held by Kent Active Retirement Association. A calendar of events is being compiled, along with engagement methods in each case. For example, at the Kent County Show in July we will be able to gather feedback from a wide range of visitors, while meeting with local, special interest groups will create opportunities for more focused conversations.

6.3 We are working with other health and social care organisations to create opportunities for patients and public to hear about and have input into the emerging Sustainability and Transformation Partnership.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 4 May 2017

Title of Report	Corporate Governance Report
Presented by	Lynne Stuart
Lead Director	Lynne Stuart
Committees or Groups who have considered this report	
Executive Summary	The report outlines current activity and issues in corporate governance.
Resource Implications	N/A
Risk and Assurance	The report outlines the progress of a number of Trust wide initiatives designed to improve corporate governance arrangements.
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	Continuing the work to improve our corporate and clinical governance which will support both safe and high quality patient care and a productive working culture for staff.
Quality Impact Assessment	N/A
Recommendation	The Board are requested to note the report and the assurance and risks stated.
Purpose & Actions required by the Board :	Approval ☐ Assurance ☑ Discussion ☐ Noting ☐

NHS Medway NHS Foundation Trust

Corporate Governance Report – 4 May 2017

1. EXECUTIVE SUMMARY

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

2. CARE QUALITY COMMISSION

2.1. Following the inspection by the CQC in November and December 2016 and receipt of the Quality Report on 17 March 2017, the Improvement Plan developed in response to the findings has been sent the CQC.

2.2. The Medical Director and Director of Nursing are the responsible officers for ensuring full implementation of the Improvement Plan and that robust internal monitoring of this will be undertaken at the Quality Improvement Group.

3. RISK AND REGULATON QUALITY ASSURANCE

3.1. The report from the National Trauma Peer Review follow up visit which took place in February 2017 has been received; it notes good progress from the full review in 2016 and advises that the 2017 review will take the format of a self-assessment against the national criteria.

3.2. There will be a Quality Assurance Visit on 18 May 2017 by NHS Public Health - Fetal Anomaly Screening Programme of the Biochemistry Laboratory. The Screening Programme Quality Assures a number of Antenatal and newborn Screening Programmes and in June 2015 MFT were subject to review for those screening programmes to which MFT contributed. Subsequently the Biochemistry Department at MFT commenced the provision of biochemical testing contributing to the Down's Syndrome Screening (DSS) Programme and the departmental policies and procedures will be assessed during the visit in May 2017.

4. HEALTH AND SAFETY

4.1. The comprehensive audit of workplace health and safety standards was completed by 31 March 2017. The resulting report and gap analysis will be shared with the Executive Team and, subsequently, the Board.

5. DOCUMENTATION MANAGEMENT

5.1. Streamlining all of the Trust's policies and procedural documents continues and whilst this is demonstrating positive compliance in many areas, there are still a number of documents to be reviewed and updated. The table below shows the status of the 17 corporate policies which are identified as those requiring Board approval. The Board will note that there are four policies which still require review and approval:

Corporate Policy	Document Owner	Status
Complaints	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Duty of Candour	Medical Director	Approved; Available on intranet and website
Emergency Preparedness, Resilience and Response	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Estates, Facilities and Security	Director of Finance	Approved; Available on intranet and website
Finance	Director of Finance	Approved; Available on intranet and website
Fire Safety	Director of Finance	Approved; Available on intranet and website
Health and Safety	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
HR	Director of Workforce and OD	There are a number of SOPS and related documents however there is currently no overarching Corporate HR Policy. The Deputy Director of Workforce and OD is taking this forward.
Information Governance	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Medicines Management	Medical Director	First draft written. A framework of SOPs will be

Corporate Policy	Document Owner	Status
		reviewed against the 'Marsden Manual' once implemented.
Patient Care and Management	Director of Nursing	First draft written. Awaiting implementation of the 'Marsden Manual'; the draft policy will be reviewed against the 'Marsden Manual' once implemented.
Risk Management	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Safeguarding	Director of Nursing	The Trust follows Kent & Medway Adult Safeguarding policies and protocols however a corporate policy stating this, and identifying roles and responsibilities, is underway.
Serious Incidents	Medical Director	Approved; Available on intranet and website
Standards of Business Conduct	Company Secretary	Awaited
Violence, Aggression and Disruptive Behaviour	Security Director (currently Director of Finance)	Approved; Available on intranet and website

6. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

6.1. A comprehensive update on EPRR is provided separately in the Annual EPRR report to the Board.

7. GOVERNANCE

7.1. In response to some of the recommendations made within the Corporate Governance Report on a Review of the Governance and Effectiveness of the Trust's Clinical Governance Framework carried out in January 2017, Lynne Stuart, Katy White and Fiona Egan delivered the first in a series of three Governance training and

development sessions on 20 April. These sessions are targeted at all individuals who have some Governance remit within their role. This first session focused on an Introduction to Corporate Governance, Good Meetings Governance and Risk Management for Governance staff. There were fifteen staff in attendance from across the Trust (23 invited) and the evaluation was wholly positive.

7.2. Under NHSI's Risk Assessment Framework and in line with the Code of Governance for Foundation Trusts, FTs are expected to carry out an external review of their governance every three years. Foresight at GE Healthcare Finnamore have commenced their review and started the process of 1:1 interviews and board and committee meeting observations. The review outcomes will be fed back to the Board in a development session on 6 July.

7.3. A corporate governance dashboard has been developed and was recently disseminated to all clinical directorates and corporate functions. The dashboard gives an overview of performance across a range of corporate governance indicators including:

- Responsiveness to FOI Act requests, and the extent to which the statutory requirement to respond within 20 working days is fulfilled;
- Numbers of Information Governance incidents resulting in a notification to the Information Commissioner's Office;
- Mandatory training rates in key corporate governance areas: Information Governance, Fire Safety, Health and Safety, Manual Handling (unfortunately the data available is not specific and is only available on a Clinical Directorate level with everything else being attributable to "Corporate". This means that it is not possible to drill down into more specific functions);
- Whether policy and procedural documents are being maintained within their review cycles or whether they are out of date;
- The extent to which the time frames for responding to complaints set out in the Trust's Complaints Management Policy are being met;
- Compliance with the CQC fundamental standards and any regulatory actions arising;
- The degree to which the risk management framework is embedded through regular review of risks;
- The extent to which essential emergency preparedness, resilience and response training is fulfilled and whether business continuity documentation is being maintained within its review cycle;
- The extent to which health and safety requirements are being fulfilled;
- Legal claims and responsiveness in delivering required documentation within timescales;
- The application of the duty of candour;
- Responsiveness to Incidents logged on Datix by showing data for incidents awaiting review, overdue, or awaiting final approval;

- Responsiveness to alerts issued by the Central Alerts System;
- Trust wide adherence to the statutory requirement in responding to Subject Access Requests.

7.4. Where Trust targets or statutory requirements are not met, a narrative exceptions report is compiled and disseminated.

7.5. The resulting dashboards and exception reports will be reviewed at the Performance Review Meetings from May. Where possible the data is shown at each Clinical Directorate or corporate function level so that the accountable Executive has clarity about any areas of under-performance where remedial actions are needed.

NHS Medway NHS Foundation Trust

Report to the Trust Board

4 May 2017

Title of Report	Emergency Preparedness, Resilience and Response Annual Report
Presented by	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and
Lead Director	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Emergency Preparedness, Resilience and Response Group on 14 March 2017 Executive Group 5 April 2017
Executive Summary	The EPRR Annual Report provides assurance to the Board that the Trust is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response. In May 2016 the Trust Board agreed the presented Work Plan for Emergency Preparedness, Resilience and Response for 2016/17. The Trust is a Category One Responder subject to the Civil Contingencies Act 2004. The Annual Report is the conclusion of the Work Plan and associated annual NHS England Emergency Preparedness, Resilience and Response Core Standards Framework Audit 2016/17 that was commissioned by NHS Medway CCG. The Board are requested to endorse the 2017/18 Work Plan.
Resource Implications	N/A
Risk and Assurance	Trust compliance with the annual audit of NHS England Emergency Preparedness, Resilience and Response Core Standards (2015) was recorded at the Local Health Resilience Partnership in October 2016 by NHS Medway CCG as 'Fully Compliant'. The Board received a report on the self-assessment process and outcome on 27 October 2016. NHS South East Coast Ambulance Service undertook an audit in January 2017 on part of the Core Standards wholly related to Chemical, Biological, Radiological and Nuclear planning and response capabilities and found the Trust to be 'Fully Compliant'. The Trust target for EPRR Training is aligned to the Trust target percentage of 95% for Mandatory Training. There is no national or regulated compliance for EPRR Training. A shortfall of 15% was evidenced (80% achieved) mainly within Silver (tactical) and

	Bronze (operational) training where staff were subject to operational pressures and did not attend the planned sessions. Assurance has been given that these staff will be given priority in 2017/18, reoffered training and Directorates will be asked to assist with the release of this cohort of staff.
Legal Implications/Regulatory Requirements	The Civil Contingencies Act 2004
Recovery Plan Implication	N/A
Quality Impact Assessment	N/A
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) • Endorses the 2017/18 EPRR work plan.
Purpose & Actions required by the Board :	Approval ☑ Assurance ☑ Discussion ☐ Noting ☐

Emergency Preparedness, Resilience and Response – Annual Report to Board 2017 (Period May 2016 – May 2017)

1. 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 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 provides assurance to the Board that Medway NHS Foundation Trust is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response (EPRR) as defined within the duties above.

2016/17 Assessing and Documenting Compliance

2. NHS EPRR Core Standards (2015)

2.1. The Trust undertook a primary self-assessment on compliance against 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 Trust EPRR Group in August 2016. The Medway and Swale NHS Clinical Commissioning Groups audited the Trust in September 2016 via the NHS South East Coast Commissioning Support Unit and published their findings to the Trust and NHS England South in October 2016 at the NHS Local Health Resilience Partnership meeting. The submission stated that out of the 48 of the core standards which are applicable to the organisation it is fully compliant. Full compliance equates to a statement that 'Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve'.

2.3. In addition to the above NHS South East Coast Ambulance Service undertook an audit in January 2017 on part of the Core Standards wholly related to Chemical, Biological, Radiological and Nuclear planning and response capabilities and found the Trust to be fully compliant.

3. Business Continuity Aligned to ISO 22301

3.1. The Trust's business continuity arrangements were last audited within the 2013/14 financial year by NHS Kent and Medway Commissioning Support Unit (KMCS) on behalf of NHS Medway Clinical Commissioning Group. The Trust scored 95.8% compliance.

3.2. 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 has reflected this best practice by introducing an audit programme which will span a three year period.

3.3. The outcome for 2016/17 was that the following policy and standard operating procedures (SOP) for use by Directorates, were reviewed and published:

- Management of Business Continuity Policy
- Construction and review of Trust Strategic Business Impact Analysis (SOP)
- Template Service Business Continuity Plan (SOP)
- IT System Business Continuity Plans (SOP)
- Business Continuity for New IT Systems via Health Informatics Project Management Office (SOP)
- Business Impact Assessment for Estates Project Team and Operational Estates (SOP)

3.4. All of the Directorate required Services Business Continuity documents were mapped to a refreshed scope for agreement by Directors.

3.5. Publication of Directorate Service Business Continuity Plans has been tracked and non-compliance against annual review dates reported back to Directors for corrective action as well as reported to the EPRR Group and added to the EPRR Risk Register. The out-turn position for 2016/17 was that 70% of the plans had been reviewed by Directorates in 2016/17. Of the 31 remaining plans, 12 had not been reviewed within 12-36 months and the remaining had either been newly listed or lapsed in March 2017.

4. CQC Inspection Feedback for EPRR

4.1. In November 2016 the Care Quality Commission inspected the Trust. There were no immediate concerns raised in relation to EPRR. The inspection team requested a sample of Service Business Continuity Plans and training compliance which was provided. The Trust's final evidence submission did not include the baseline number to be trained identified on the EPRR Training Needs Analysis for 2016/17 and tracked by the EPRR Group. The report stated 'Some staff are required to complete Emergency Preparedness Resilience and Response (EPRR Training. As at November 2016 1,067 staff had completed this training, however the trust did not provide figures for how many staff required this training'.

5. Exercises/Incidents

5.1. Within the NHS England Core Standards for Emergency Preparedness Resilience and Response Framework (2015) there is a standard requirement that the Trust evidences a Live Exercise every three years, a table top exercise annually and communications exercises bi-annually. The last live exercise was Exercise Lapwing in June 2015 and

therefore the duty to perform the next live exercise falls in 2018/19. A table top exercise and two communications tests were mandated for 2016/17. These are referred to in and across sections 5.2 – 5.13 of this report.

5.2. Action by the British Medical Association in relation to the Junior Doctor Contract was planned and enacted in April 2016 and planned but cancelled in September 2016. The learning from each requirement to plan and respond, with its associated assurance process to the Clinical Commissioning Groups and Department of Health via NHS England has been used to strengthen the Trust Management of Strike Action Arrangements and associated Operational Order; which identifies the command and control and bespoke operational mitigations required.

5.3. In April 2016 the Trust took part in a multi-agency exercise to assess common understanding and perceptions in relation to the responsibilities of each agency for an industrial accident on the Isle of Grain. The Isle of Grain industries are identified on the Kent and Medway Community Risk Register and are subject to Control of Major Accident Hazards Regulations. There were no corrective actions identified for Medway Hospital on the exercise, the next exercise will be held in 2019.

5.4. In June 2016, at the request of NHS England, the Trust Emergency Planning and Business Continuity Manager took part in Exercise Fortuna (Trauma Network – Mass Casualties Exercise). This gave detailed insight into the new NHS South East Coast Kent and Medway Trauma Network Mass Casualties Framework and allowed for enhanced early planning in relation to the Trust Major Incident Plan to further align process and communications across the Network. The local Trauma Network Table Top Exercise, Watling Street, planned with NHS Public Health England for a mass casualty response in Kent and Medway took place on 08/03/2017. The learning from this exercise is subject to a whole network debrief and will be fed back early in the 2017/18 EPRR Work Plan period.

5.5. In August 2016 the network Radiology System (RIS) experienced a hardware failure in its hosted location at Pembury Hospital. The Incident was graded as a Moderate Significant Incident against the Trust Scale of Incident Matrix and managed accordingly by the responsible Directorate using the Trust Significant Incident Plan and supporting RIS IT System Business Continuity Plan. The main impact, as a result of the failure, was a delay in the reporting of CT Scans. The identification of additional Radiologists to support CT Reporting was immediately actioned and backlog loading of imaging downtime reports commenced once the system was tested and live. The resulting action was a review and uplift of the RIS IT System Business Continuity Plan to ensure the lessons identified were included.

5.6. October 2016 saw the launch of the Trust Winter Resilience Plan and an annual exercise (Vivaldi) to test winter resilience. The exercise aim was to prepare the Trust for Winter 2016/17 by fully testing and validating the Winter Resilience Plan and associated Policies and Procedures, strengthening communication and resilience between partners and maximising the understanding of the Single Health Resilience Early Warning Database (SHREWD) System and its capabilities. The immediate requirement to update the Trust Surge and Escalation Plan to include the Single Health Resilience Early Warning Database and the Trust escalation triggers and associated actions was immediately escalated to the author of the Trust Surge and Escalation Plan via the Director of Clinical Operations for Acute and Continuing Care. All other learning outcomes were minor revisions to the Winter Resilience Plan that were actioned to give the required assurance to the Executive and North Kent Clinical Commissioning Groups prior to the Trust plan's inclusion within the

North Kent Clinical Commissioning Groups overarching Winter Resilience Plan. The annual planning cycle will commence in May 2017 with a Winter 2016/17 Debrief on 16/05/2017.

5.7. The Trust were invited by NHS England to take part in a National Exercise (Cygnus) related to Pandemic Influenza. The requirement on the Trust was to offer support to NHS England South (South East) in the identification and validation of data which was required on the National Exercise live play. The data sets were in relation to excess deaths and impacts on the pathway from acute mortuary provision, outbreak within the prison population and impacts on the acute hospitals serving those populations. All learning from the National Exercise will be reviewed by NHS England and any corrective actions linked back into the Kent Resilience Forum (KRF) annual Work Plan via the KRF Plans and Capabilities Group.

5.8. The first Communications Exercise for 2016/17 took place, as planned, at 11:49 on 10/08/2016. The concern raised post exercise was that the cascade took two operators, in working hours, 30 minutes. Although the cascade is designed so the Emergency Department would be ready to respond earlier than, for example, the Tactical Control Room or Strategic Control, it is still appropriate to look at an technological solution for a multi-operator system to speed up the overall cascade. The EPRR Group agreed that the installation of the pre-purchased Open Scape Alarm Response System (OSCAR) be brought forward to give the availability of a fully auditable campaign system.

5.9. On 30/09/2016 NHS South East Coast Ambulance Service (SECAmb) put Medway NHS Foundation Trust on Standby for receipt of casualties from Medway City Estate. This was followed by the Trust being declared as a receiving hospital (Major Incident Declared) at 22:45. At 22:51 SECAmb stood the Major Incident down at the scene but did not confirm to the Hospital where the known casualties would be sent. As the closest Trauma Unit the Trust checked back before standing down from the Major Incident and receiving the casualties as priority trauma calls The learning from this out of hours Major Incident was a heightened awareness that the Switchboard did not have the immediate available resource to fulfil the speedy delivery of both the Standby and Major Incident Declared cascades in turn out of hours. The resourcing of Switchboard, out of hours, remains on the Trust Risk Register. The requirement to introduce OSCAR was re-escalated to Health Informatics for the go-live date to be brought forward to mitigate the risk of the availability of only one Switchboard operator out of hours.

5.10. On 05/09/2016 The Trust and a Key Supplier of non-mains water exercised the Trust Water Resilience Plan. The exercise validated the Trust Water Resilience Plan, which has been published and confirmed the planned infrastructure changes required to the outside of the Boiler House to give better access for water bowser delivery to the main Water Tanks. This work is planned within the Estates programme for 2017/18.

5.11. The National Police Disaster Victim Identification Team held Exercise Obas; a Mass Fatalities Exercise in Kent on 9 February. The Trust was invited to represent all the acute hospitals of Kent and Medway by NHS England. The lessons identified by the Trust's Human Tissue Act Designated Individual, Mortuary Manager and Emergency Planning and Business Continuity Manager have served to strengthen and re-affirm key working relationships with Kent Police and the Coroner in the management of Mass Mortuary arrangements. The planned review of the Kent Resilience Forum Mass Fatalities Plan is scheduled from March 2017 with Medway NHS Foundation Trust being fundamental in that process.

5.12. The second mandated Major Incident Communications Exercise was undertaken on 28/02/2017 using the existing process within Switchboard. The verbal report on this

exercise was received at the March EPRR Group with the formal paper to be received at the May EPRR Group.

6. Training

6.1. Within 2016/17 EPRR Training was aligned to the Trust target percentage of 95% for Mandatory Training although the subjects are deemed as Essential Training by the Trust. There is no national or regulated compliance for EPRR Training.

6.2. All new staff are required to have EPRR Awareness as part of the Trust Induction Programme.

2016/17			
Count in people	Required	Completed	%
Gold	13	12	92%
Silver	76	63	83%
Bronze	204	148	73%
Loggists	12	11	92%
Writing and Reviewing a Business Continuity Plan	100	92	92%
	405	**326**	**80%**

6.3. Of the 405 staff across the organisation identified on the bespoke Annual EPRR Training Needs Analysis for 2016/17 (80%) 326 staff received training. The shortfall in Silver and Bronze training will be addressed in the first quarter of 2017/18 by extending the training offering again to those staff as a matter of priority.

7. Risk Register

7.1. Three items are documented on the EPRR Risk Register and mitigating actions are scheduled into the 2017/18 Work Plan:

- Departmental Business Continuity Plans which have not been reviewed annually and updated within the 2016/17 Work Plan period.
- The deployment of OSCAR, a multi-operator telecommunications system to be deployed for Major Incident cascade; to reduce cascade time and increase resilience.
- The requirement for the Emergency Department Management Team, based on the Emergency Department's construction project work to review the department's internal risks and update the Emergency Department Business Continuity Plan at each phase of the project programme.

8. EPRR Work Plan Items uncompleted in 2016/17

8.1. The following items will move forward from 2016/17 to 2017/18

- Exercise Ragdoll (Infant Abduction), to match Kent Police Exercise resourcing.
- Electrical Incident Table Top Exercise, to align with the commissioning of the bunkered fuel tanks.

9. EPRR Corrective Actions unresolved in 2016/17

9.1. The following items remain as identified on the EPRR Corrective Action Database as unresolved and assurance will continue to be requested on their planned closure to the EPRR Group

- Upgrade of the end of life Trust Telecommunications System from DBX to VOIP to increase resilience (as evidenced in the Trust Health Informatics Directorate Risk Register)
- Deployment of OCSAR as defined at 7.1 above

10. Suggested EPRR Group Work Plan 2017/18

The EPRR Group Work Plan 2017/18 has been drafted for agreement at Appendix 1. It takes into the duties as set out by the Civil Contingencies Act 2004 and any requirement to complete new work that may arise in the course of completing the Work Plan:

- The NHS England EPRR Framework (Nov, 2015)
- The NHS England Business Continuity Management Toolkit (Feb, 2016)
- The Information Governance Toolkit Submission 2017/18
- Trust Strategy (content to be reviewed on publication to update Strategic Business Impact Assessment) including but not limited to:
  - Assessment of the impacts of planned capital programmes and the Estates Department planned maintenance programme for 2017/18
  - Assessment of the impacts of planned IT infrastructure and system changes planned by Health Informatics for 2017/18
- Trust EPRR Plans and Policies matched to the Trust contractual requirements for the 2017/18 NHS Contract.
- Planned EPRR Policy and Plan updates for 2017/18
- EPRR Group Work Plan Actions not closed in 2016/17
- EPRR Group Corrective Actions not closed in 2016/17

11. Recommendation to Board

It is requested that the Board 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.

The Board are requested to note the continued designation of an Executive Lead for EPRR for 2017/18 to attend the Local Health Resilience Partnership and Chair the Trust Emergency Preparedness Resilience and Response Group. This will continue to be the Director of Corporate Governance, Risk, Compliance and Legal.

The Board are requested to endorse the 2017/18 EPRR Work Plan at Appendix 1.

NHS Medway NHS Foundation Trust

Emergency Preparedness, Resilience and Response – Annual Work Plan 2017 – 18

Appendix 1.

Local Health Resilience Partnership – Assurance Programme				
ID	**Identification**	**Status**	**Requirement**	**Assurance Route**
EPRR Framework	Self-Assessment	Annual – July 2017	Civil Contingencies Act/NHS EPRR Assurance	Trust EPRR Group August 2017
EPRR Framework	External Audit	Annual – September 2017	Civil Contingencies Act/NHS EPRR Assurance	Clinical Commissioning Group
EPRR Framework	External Audit CBRN	Annual – January 2018	Civil Contingencies Act/NHS EPRR Assurance	South East Coast Ambulance Service
EPRR Framework	Annual Report	Annual - June 2017	Civil Contingencies Act/NHS EPRR Assurance	Trust Board

Plans and Policies				
Name	**Identification**	**Status**	**Requirement**	**Assurance – Trust EPRR Group**
Strategic Business Impact Assessment	SBIA and Scope	Annual Review	NHS EPRR Assurance	May 2017
Heatwave Plan	POLCOM011	Annual	NHS EPRR Assurance -re-alignment to NHS England Heatwave Plan	May 2017
Major Incident Plan	POLCS006	Annual - Exp Sept 2017	Civil Contingencies Act/NHS EPRR Assurance	August 2017
Significant Incident Plan	OTCOM006	Annual – Exp Sept 2017	Civil Contingencies Act/NHS EPRR Assurance	August 2017
Winter Resilience Plan	OTCOM033	Annual – July 2017	NHS EPRR Assurance	August 2017
Chemical/Biological/Radiological/Nuclear Plan	OTCOM088	Revision – ED Project April 2017	NHS EPRR Assurance	May 2017 and adhoc based on risk.
Fuel Crisis Plan	OTCOM0012	3 yearly review	NHS EPRR Assurance	August 2017
Water Resilience Plan and Significant Incident	OTCOM030	1st Review – Exp Sept 2017	NHS EPRR Assurance	August 2017

Addendum				
Infant Abduction Plan	POLDNM002	Post Exercise Review	Security Group	August 2017
Service Business Continuity Plans	Scope/Audit 2017/18	Annual	NHS EPRR Assurance	Each Group
IT System Business Continuity Plans	Scope/Audit 2017/18	Annual	NHS EPRR Assurance	Each Group

Exercises				
ID	**Identification**	**Status**	**Requirement**	**Assurance – EPRR Group**
Major Incident Live Exercise	Exercise Faith	Three yearly	NHS EPRR Assurance	February 2018
Electrical Resilience Exercise	Electrical Exercise Table Top	Best Practice	Best Practice	August 2017
CBRN Live Casualty Exercise	Exercise Hope	Best Practice	NHS EPRR Assurance	November 2017
Major Incident Communications Exercise	2017/18 Communications 1	Annual	NHS EPRR Assurance	August 2017
Major Incident Communications Exercise	2017/18 Communications 2	Annual	NHS EPRR Assurance	May 2018
Infant Abduction live/Table Top Exercise	Exercise Ragdoll	Best Practice	NHS EPRR Assurance	August 2017
Winter Resilience Assurance Exercise	Debrief 16/05/2017 Exercise Vivaldi #2	Annual	Best Practice	October 2017
External Exercises	TBC	Annual	Civil Contingencies Act/NHS EPRR Assurance	May 2018

Resource Capabilities - Equipment				
ID	**Identification**	**Status**	**Requirement**	**Assurance – EPRR Group**
Powered Respiratory Protective Suits	Planned Protective Maintenance	Annual - September 2017	NHS EPRR Assurance	November 2017
Powered Respiratory Protective Suits	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group
RAMGENE (Radiation Monitors)	Planned Protective Maintenance	Annual – March	NHS EPRR Assurance	May 2017
RAMGENE (Radiation Monitors)	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group

Decontamination Unit	Planned Protective Maintenance	Annual – September 2017	NHS EPRR Assurance	November 2017
Decontamination Unit	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group
Police Documentation Team Boxes	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group
CBRN Small Equipment	Assurance Checks	Monthly	NHS EPRR Assurance	Each EPRR Group

Resource Capabilities –Staff via Training Needs Analysis				
ID	**Identification**	**Status**	**Requirement**	**Assurance – EPRR Group**
New Trust Staff - Induction	Induction	Once	CQC/ Civil Contingencies Act/NHS EPRR Assurance	(Board from Learning and Development)
Strategic Major Incident	Gold – Major Incident/Exercise Admiral	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Tactical Major Incident	Silver – Major Incident/ Exercise Master	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Operational Major Incident	Bronze – Major Incident/Exercise Crew	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Strategic Significant Incident	Gold – Significant Incident	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Tactical Significant Incident	Tactical – Significant Incident	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group
Operational Significant Incident	Bronze – Significant Incident	Annual Awareness in Business Continuity Awareness Week	Civil Contingencies Act/NHS EPRR Assurance	August 2017
Writing and Reviewing a Service Business Continuity Plan	N/A	Designated Directorate Staff - Once plus refreshers	Best Practice	Each EPRR Group
Writing and Reviewing an IT System Business Continuity Plan	N/A	Designated Directorate Staff Once plus refreshers	Best Practice	Each EPRR Group
Resilience Radio Handsets	Radio Training	Once plus refreshers	Best Practice	Each EPRR Group
Trust Loggists	Loggist Training	Annual	Civil Contingencies Act/NHS EPRR Assurance	Each EPRR Group

Civil Contingences Act - Kent Resilience Forum/Partnership Work				
ID	**Identification**	**Status**	**Requirement**	**Assurance Route**
Local Health Resilience Partnership	LHRP Strategic Meeting	Trust Director	Civil Contingencies Act/NHS EPRR Assurance	NHS England
Local Health Resilience Partnership – Delivery Group (EPRR Leads)	EPRR Leads Group	Acute EPRR Lead	Civil Contingencies Act/NHS EPRR Assurance	Local Health Resilience Partnership
Mass Fatalities	KRF - Subgroup	Primary Acute EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group
Pandemic Influenza	KRF – Task and Finish group	Secondary EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group
Risk Assessment	KRF – Main Group	Primary Acute EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group
Trauma Network	Trauma Network EP Leads	Trauma Network	NHS EPRR Assurance	Trauma Board
Railcare Team	Acute Hospitals Lead	Trust nominated	NHS EPRR Assurance	Post meeting report to EPRR Leads Group
Medway Safety Advisory Group and COMAH Plan Review Group	KRF - Subgroups	Primary Acute EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group /Report to Commissioners via Commissioning Support Unit
Swale Safety Advisory Group and Resilience Groups	KRF - Subgroups	Primary Acute EP Lead - NHS England selected	Civil Contingencies Act/NHS EPRR Assurance	Post meeting report to EPRR Leads Group /Report to Commissioners via Commissioning Support Unit
Media and Communications Group	KRF Sub - Group	Trust Communications Team Representative	Civil Contingencies Act	Post meeting report to EPRR Leads Group

Please note the above is a share of the Civil Contingencies Act responsibilities for the NHS – The Groups not allocated for attendance by this Trust currently are:

KRF - Plans and Capabilities Group
KRF - Training and Exercising Group
KRF - East Kent Safety Advisory Groups
KRF - Business Continuity Group
KRF – Marine Aquatics Group
KRF – Pan Kent Flood Group
KRF – New Threats Group
KRF - Safety Advisory Chairs Group
KRF – West Kent Safety Advisory Groups
KRF – Local Authority Emergency Planning Group
KRF – Strategic Group
KRF – Executive Group
KRF – North Kent Safety Advisory Groups
KRF – Humanitarian Group

Medway NHS
NHS Foundation Trust

Report to the Trust Board

Date: 04 May 2017

Title of Report	**Corporate Risk Register and Board Assurance Framework**
Presented by	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Lead Director	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Executive Group 05.04.2017
Executive Summary	• A Summary Corporate Risk Register (CRR) report is given at appendix 1, with the full Corporate Risk Register Report at appendix 2. • The Board Assurance Framework is given at appendix 3 • The Trust Risk Management arrangements were subject to internal audit by KPMG February 2017. The Report gives an Assurance Rating of "Significant Assurance with Minor Improvement Opportunities" and was in line with forecast. • A programme of extensive reviews of the Directorate and Programme risk registers has commenced, with feedback to the management teams and risk owners.
Resource Implications	N/A
Risk and Assurance	Set out in report.
Legal Implications/Regulatory Requirements	The Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver its strategic and operational plans and comply with the registration requirements of the quality regulator. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks. For Foundation Trusts, this also includes risks to compliance with the terms of authorisation. The Trust Board is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives.
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Board are requested to:- • Receive and note the Corporate Risk Register (CRR) • Receive and note the Board Assurance Framework (BAF).
Purpose & Actions required by the Executive Group :	Approval ☐ Assurance ☑ Discussion ☑ Noting ☐

Corporate Risk Register and Board Assurance Framework – May 2017

1. EXECUTIVE SUMMARY

1.1. A Summary Corporate Risk Register (CRR) report is given at appendix 1, with the full Corporate Risk Register Report at appendix 2.

1.2. The CRR has been revised and reviewed at the Executive Group meeting on 05 April 2017, with updates detailed below.

1.3. The Board Assurance Framework is given at appendix 3.

1.4. The Trust Risk Management arrangements were subject to internal audit by KPMG February 2017. The Report gives an Assurance Rating of "*Significant Assurance with Minor Improvement Opportunities*" and was in line with forecast.

1.5. A program of extensive reviews of the Directorate and Programme risk registers has commenced, with feedback to the management teams and risk owners.

2. CORPORATE RISK REGISTER (CRR)

2.1. A Summary Corporate Risk Register (CRR) report is given at appendix 1, showing score trends.

2.2. The full Corporate Risk Register report from RiskAssure is given at appendix 2. The CRR has been reviewed and updated with information from the associated risk owners and by reference to the CQC report March 2017 and subsequent action plan.

2.3. Summary of updates to CRR:-

- **CRR-2017-001 - Innovation and digital technology**, new risk added 07.03.17, as discussed at Executive Group January 2017.
- **CRR-2016-004** - **Emergency Department** – score reduced from 15 (3x5) to 9 (3x3) due to effectiveness of control and assurance from CQC report 17.03.2017.
- **CRR-2016-006** – **Medicines Management** - score reduced from 9 (3x3) to 6 (3x2), due to effectiveness of control.
- **CRR-2016-007** - **Estates** – score reduced from 12 (4x3) to 8 (4x2), due to effectiveness of control and assurance from CQC report 17.03.2017.
- **CRR-2016-011 – Compliance** – score reduced from 9 (3x3) to 6 (3x2) following Trust CQC rating moving from Inadequate to Requires Improvement and MFT being taken out of Special Measures.
- **CRR-2016-013 – Training and Appraisal rates** – score reduced from 9 (3x3) to 6 (3x2) due to effectiveness of control and assurance from staff survey.

3. BOARD ASSURANCE FRAMEWORK (BAF)

3.1. The Board Assurance Framework (BAF) has been reviewed and updated to include target risk scores and information from the associated Executive Leads, from the updated Corporate Risk Register and by reference to the CQC Quality Report and action plan.

4. INTERNAL AUDIT

4.1. The Trust Risk Management arrangements were subject to internal audit by KPMG in February 2017. The Report with the Assurance Rating of "*Significant Assurance with Minor Improvement Opportunities*" was in line with the forecast rating of the Director of Corporate Governance, Risk, Compliance & Legal.

4.2. The report was presented at the Trust Audit Committee Meeting on 1 March 2017. The improvement opportunities identified were also identified within the Corporate Governance Directorate and form part of the Business Plan and Objectives for the Risk Management team going forward.

5. REGULAR REVIEW OF DIRECTORATE RISK REGISTERS

5.1. In line with the next phase of embedding risk management, the Head of Risk and Regulation Quality Assurance has started the "deep dive" reviews of the risk registers by Directorate and Programme, with feedback to the Directorates and Risk Owners on how the risk articulation scoring and reviews can be improved. This project also addresses the KPMG internal audit recommendations regarding the Directorate Risk Registers.

5.2. It is important that the feedback from the deep dive reviews is taken on board by the directorates and functions. A further review will be scheduled to review the extent of improvement and actions taken to address the feedback.

6. APPENDICES

1. Corporate Risk Register (CRR) and Appendix A - tabulated linked risks to CRR.
2. Summary Corporate Risk Register Report
3. Board Assurance Framework

Appendix 1 Summary Corporate Risk Register Report

All Risks Due for Review 01.06.2017

Risk Ref	Risk Title / Brief Description	Risk Domain	Risk Owner	Current Score			Target Score	Score Trend			Date Risk added
				C	L	R = C x L	TR = C x L	Last Month	Last 3 Months	Last 6 Months	
CRR-2016-001	**Safe Nurse Staffing –** Nursing staff shortages may lead to sub optimal care, impacting on patient safety processes and clinical outcomes	Patient Safety	Director of Nursing	4	4	16	4 (2x2)	⟺	⟺	⇓	26.09.16
CRR-2016-010	**Operational Performance –** Failure to meet national performance standards results in delayed diagnosis and harm to patients, financial penalties and reputation damage.	Quality / Audit	Chief Executive	4	4	16	4 (2x2)	⟺	⟺	⟺	26.09.16
CRR-2016-002	**Safe Medical Staffing –** Inability to recruit sufficient numbers of suitably qualified medical staff, may lead to sub optimal care, impacting on patient safety processes and clinical outcomes.	Patient Safety	Medical Director	4	3	12	4 (2x2)	⟺	⟺	⟺	26.09.16
CRR-2016-008	**Equipment Failure –** Significant high value equipment that is out of date and past its replacement date may not be reliable or fit for purpose impacting on service delivery and income.	Service / Business Interruption	Finance Director	4	3	12	4 (2x2)	⟺	⟺	⟺	26.09.16
CRR-2016-009	**Patient Flow - Patient Safety Risk –** Due to failure to meet operational performance standards and maintain effective patient flow there is a risk of delayed diagnosis, treatment and/or discharge of patients.	Patient Safety	Director of Nursing	4	3	12	4 (2x2)	⟺	⟺	N/A	17.11.16
CRR-2016-015	**Finance –** Failure to achieve planned financial control total through Cost Improvement Plans and Carter Review efficiencies across the Trust affects the financial sustainability and Going Concern assessment of the Trust.	Finance	Finance Director	4	3	12	6 (2x3)	⟺	⟺	⟺	26.09.16

Summary Corporate Risk Register Report

Risk Ref	Risk Title / Brief Description	Risk Domain	Risk Owner	Current Score			Target Score	Score Trend			Date Risk added
				C	L	R = C x L	TR = C x L	Last Month	Last 3 Months	Last 6 Months	
CRR-2017-001	**Innovation and digital technology –** Due to financial constraints, conflicting priorities and the current capacity for innovative change, there is a risk that the Trust may be in a position to embrace innovation and digital technology to support the best level of care for patients and facilitate improved working practices for staff.	Service / Business Interruption	Finance Director	4	3	12	9 (3x3)	New Risk			07.03.17
CRR-2016-003	**Reduced capacity and capability in non-nursing and medical staff groups –** Reduced capacity and capability across the organisation impacts on delivery of operational objectives and may compromise patient care	Staffing Competence	Director of HR & OD	3	3	9	4 (2x2)	⟺	↓	↓	26.09.16
CRR-2016-004	**Safeguarding –** Failure to protect vulnerable children and adults may cause harm and potential reputation damage due to inadequacies in meeting statutory responsibilities	Patient Safety	Director of Nursing	3	3	9	4 (2x2)	⟺	⟺	⟺	26.09.16
CRR-2016-005	**Emergency Department –** Physical restrictions in the layout of ED lead to overcrowding which impacts on patient care. Resus and Trolleys area of the ED are not suitable for the service provided, or big enough to accommodate the potential number of people using the service at any one time.	Service / Business Interruption	Director of Clinical Ops ACC	3	3	9	4 (2x2)	↓	⟺	↓	26.09.16
CRR-2016-007	**Estates –** The combination of under investment in a dilapidated estate and the absence of a coherent strategic approach to the management of estates mean that the infrastructure does not meet business needs and capital funding and resources may be insufficient to deliver what is required.	Service / Business Interruption	Director of Estates	4	2	8	4 (2x2)	↓	↓	↓	26.09.16

Summary Corporate Risk Register Report

Risk Ref	Risk Title / Brief Description	Risk Domain	Risk Owner	Current Score			Target Score	Score Trend			Date Risk added
				C	L	R = C x L	TR = C x L	Last Month	Last 3 Months	Last 6 Months	
CRR-2016-014	**Learning from incidents, complaints and claims and application of Duty of Candour-** Learning from incidents, complaints and claims is not structured and formalised across the Trust meaning that learning opportunities are not adequately disseminated and further patient harm may result from repeat incidents.	Quality / Audit	Medical Director	2	4	8	04 (2x2)	⟺	⟺	⟺	26.09.16
CRR-2016-006	**Medicines management –** Pharmacy support and resourcing does not meet Trust requirements impacting on patient care and outcomes. Inability to recruit sufficient suitably qualified pharmacists and other staff to adequately meet the needs of all Trust services results in a risk to prescribing management and storage of medicines across the Trust.	Staffing Competence	Director of Clinical Ops ACC	3	2	6	4 (2x2)	⇓	⟺	⇓	26.09.16
CRR-2016-011	**Compliance –** The Trust may not be compliant with key statutory and mandatory requirements. This may lead to patient harm, regulator interventions and reputation damage	Compliance Audit Governance	Director of Corporate Governance, risk, compliance & Legal	3	2	6	4 (2x2)	⇓	⟺	⇓	26.09.16
CRR-2016-012	**Deteriorating patient –** Tools and skills in recognising and escalating deterioration in patients is not embedded successfully in the Trust leading to poor outcomes for patients	Patient Safety	Medical Director	3	2	6	04 (2x2)	⟺	⇓	⇓	26.09.16
CRR-2016-013	**Training and appraisal rates –** Poor training and appraisal rates may result in an inability to retain a high quality, trained workforce, impacting detrimentally on quality and safety of care to patients	Organisational Development	Director of HR & OD	3	2	6	4 (2x2)	⇓	⟺	⇓	26.09.16

Summary Corporate Risk Register Report

Risk Matrix					
	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

Appendix 2.

Detailed Corporate Risk Register Report - Ordered by Highest Risk

Corporate Risk Register

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence
CRR-2016-001	Safe Nurse Staffing	Nursing staff shortages may lead to sub optimal care, impacting on patient safety processes and clinical outcomes	Corp_Patient Safety	5	4	20	16 (4x4)	04 (4x4)	Potential patient harm incidents. Potential complaints and claims. Increased agency use and associated increased cost. Potential regulatory action by CQC. Potential increased staff stress and potential increased staff sickness	Karen Rule	Director of Nursing	26/09/2016		Inability of Resourcing team to fulfil the level of vacancy requirements Inability to Provide Interventional Radiology On-Call Service Low number of exit interviews conducted and limited understanding of staff leaving reasons. Neurology, Rheumatology and Dermatology: Staffing levels: Nursing and medical. Neurology: Nurse recruitment Temporary staffing fill requirements. Inability of Temporary Staffing Team to fulfil the level of staffing requests.

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Reviewing staff on a daily basis, shift by shift relocating staff to ensure safety. Vacant posts being filled by agency staff where possible and ensuring robust induction for these staff – recruitment plan in place to recruit to roles on a permanent basis. Business Critical posts identified and extra recruitment resource and priority given. March 2017 Recruitment Drive in the Philippines for new nurses, more than 200 offers have been made.	The CQC report March 2017 noted that There had been an effective nurse recruitment Programme, and there had been a marked reduction in the use of agency nurses, they noted that Nursing staff levels continued to pose a challenge. However, the trust had introduced several recruitment strategies.	Streamlining recruitment process to make it easier/quicker for candidates to apply. Recruitment exhibition stands at both the BMJ, RCN and AGM Conferences in London October and Overseas recruitment for NICU nurses and EU nurses active as part of the recruitment plan. recruitment of 19.8 WTE band five nurses. When in post, the overall band five vacancy rate reduces to 3%.	Karen Rule	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence
CRR-2016-010	Operational Performance	Failure to meet national performance standards results in delayed diagnosis and harm to patients, financial penalties and reputation damage.	Corp_Quality / Audit	4	4	16	16 (4x4)	04 (2x2)	Potential moderate/serious harm events due to delayed diagnosis and subsequent treatment, poor patient experience with potential for complaints and claims. Financial penalties Reputational damage	Lesley Dwyer	Chief Executive	26/09/2016		Cancer targets and patients on the waiting lists Cancer Waiting Time Performance and Compliance Failure to to meet 18 Week Target Neurology: review list Stroke Unit does not meet 7 day SSNAP Standards due to Therapy provision and Consultant workforce The Trust is not meeting the 18week Referral to treatment time (RTT) target THERAPIES Patient equipment for discharge

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Clinical Coordination Centre implemented 14.03.2017. In relation to the 18 week target, the Surgical Directorate has initiated outsourcing. Capacity and Demand models have been implemented and there is a new Lead in post to review and challenge performance. Cancer waiting times and performance - Weekly monitoring of Patient tracking list (PTL), agreed trajectory and breach reports. RCA's to interrogate reasons for delays and to implement remedial actions. Cancer remedial action and improvement plan in place. Mortality reviews in place in all specialities within Directorates and taking place routinely. Trust Mortality Learning Coordinator in place and assisting with the quality of reviews and their outcomes. Mortality Data scrutinised at all levels of the Directorate Governance Structures.	PTL meetings and subsequent actions taken are impacting on the theatre lists. Trust Mortality performance is showing significant improvements, HSMR's are improving with the exception of 'acute and unspecified Renal Failure' which remains an outlier. AKI reporting app has been launched, Outreach team review and visit identified patients daily. March 2017 Controls in relation to performance have prevented exacerbation of risk impact, current risk score maintained.	For oversight Executive further sub groups are in development, Performance Review Meetings are taking place. Reporting structure and templates have been developed and disseminated to Executives on 14.06.2016.	Lesley Dwyer	01/06/2017

CRR-2016-002	**Safe Medical Staffing**	Inability to recruit sufficient numbers of suitably qualified medical staff, may lead to sub optimal care, impacting on patient safety processes and clinical outcomes.	Corp_Patient Safety	4	3	12	12 (4x3)	04 (2x2)	Potential patient harm incidents. Potential complaints and claims. Increased locum use and associated increased cost Potential regulatory action by CQC	Diana Hamilton-Fairley	Medical Director	26/09/2016	

Risk Mitigation/Controls	**Update on Control Effectiveness**	**Action Required & Gaps in Control**	**Control Owner**	**Review Date**
Medical model and patient surveillance e.g NEWS in place to prioritise patient safety. Use of regular agency staff to ensure consistency. Recruitment of locum consultants while substantive appointments are made.	Controls in place are maintaining current score, but due to difficulty in filling all medical shifts for April, the current level of risk remains the same.	Consultants: Targeted recruitment strategy. Out to advert for approved posts. Some staff awaiting GMC registration. Further Business Cases for Consultant posts being completed and submitted Junior Doctors: Negotiations with Deanery, recruitment of non training rotations doctors, MIT roles. Physician associates and other roles to support medical teams.	Diana Hamilton-Fairley	01/06/2017

Evidence

- Acute ONcology and Cancer: Insufficient Consultant provision
- Inability of Resourcing team to fulfil the level of vacancy requirements
- Medical Staffing
- Neurology, Rheumatology and Dermatology: Staffing levels: Nursing and medical.
- Safe Medical staffing levels
- Surgery - Inappropriate Transfer of Paediatric Patients

Risk Ref:	**Risk Title / Controls**	**Description of Risk / Update on Control**	**Risk Type**	**Consequence**	**Likelihood**	**Initial Risk**	**Current Risk Score**	**Target Risk Score**	**Impact of Risk:**	**Risk Owner**	**Ultimate Accountable Owner**	**Date Risk Raised**	**Date Risk Closed**
CRR-2016-008	**Equipment Failure**	High value equipment that is out of date and past its replacement date may not be reliable or fit for purpose impacting on service delivery and income	Corp_Service/Business Interruption	4	3	12	12 (4x3)	04 (2x2)	Potential for service disruption with adverse impact on patient care. Inability to meet the demands of the service with potential for delayed diagnosis and or treatment. Increased maintenance costs with associated financial impact.	Darren Cattell	Director of Finance	26/09/2016	

Evidence

- Age of ENT Outpatient Washer
- Fire Alarm System
- Fire doors
- Loss of Ability to Provide Fluoroscopy Service
- Mortuary Fridges Maintenance and Repair
- PHARMACY Isolators in aseptics-Malfunction
- Risk of malfunctioning robot

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Service led risk based Medical Devices replacement programme in place for up to 150k replacement of equipment under, annual replacement programme, 10% of overarching allocated budget retained as contingency for ongoing urgent replacement. Business case as required over 150k replacement.	Trust wide risk based prioritisation process.	Consideration of alternative funding arrangements, such as managed equipment services to provide advance budgeting of equipment within services. Periodic review of remaining capital programme budget considering reprioritisation to mitigate new and key risks.	Darren Cattell	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence
CRR-2016-009	**Patient Flow - Patient Safety Risk**	Due to failure to meet operational performance standards and maintain effective patient flow there is a risk of delayed diagnosis, treatment and/or discharge of patients.	Corp_Patient Safety	4	3	12	12 (4x3)	04 (2x2)	Potential avoidable moderate / serious harm to patients Potential regulatory intervention	Karen Rule	Director of Nursing	17/11/2016		Bed Occupancy averages 97-99% across the Trust (15/16) Management of the rehabilitation element of the trauma pathway. Patient Flow Through the Hospital

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Implementation of improvement programmes as part of the Trust Recovery Programme, including in relation to: a) Reducing delays to the diagnosis and treatment of patients (e.g. Medical model, Planned Care and Outpatients) b) Identifying risks to patients and preventing them from crystallising (deteriorating patients, transforming nursing care, governance and standards); and c) Ensuring we have appropriate numbers of sufficiently skilled staff (workforce) Introduction of Clinical Coordination Centre from 14/03/17 to oversee and challenge flow of patients.	Improved performance against key safety and operational performance indicators (KPIs). CQC report March 2017 noted that the Trust had made improvements to flow through the introduction of the Medical Model implemented in April 2016 and had made significant improvements to the way in which patients' care was managed.	All access points into the Trust identified and clinical pathways being reviewed and agreed as affecting flow from ED and into appropriate clinical areas, reviews to be completed by 15.05.17. Development of a "Clinical Discharge Hub" with all partners by end Sept 2017. Enhancement of Hospital @ Home by end Sept 2017.	Karen Rule	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence
CRR-2016-015	**Finance**	Failure to achieve planned financial control total through Cost Improvement Plans and Carter Review efficiencies across the Trust affects the financial sustainability and Going Concern assessment of the Trust.	Corp_Finance	4	3	12	12 (4x3)	06 (2x3)	Potential for further licence conditions and regulatory action Increased pressure on staff to meet efficiency targets whilst maintaining quality of patient care. Insufficient funding for on-going service commitments in staff and suppliers; investment in Estates, IT and equipment. Services provided are sub-optimal and open to criticism from Regulators under an inspection regime.	Darren Cattell	Director of Finance	26/09/2016		2016/17 Year End Commissioner contract position 2017/18 Contract Income Work Plan and long stop agreement with commissioners. Capital Funding Cost Improvement Programs (2017-18) (CIP's) Financial Performance 2017/18 Liquidity Patient Level Costing (PLICS) and Service Line Repoting (SLR) Unfunded Cost Pressures (2017-18)

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Directorates have been engaged in budget setting & all budgets formally signed off. Monthly reporting of actual vs. budget performance reviewed at Performance Review Meetings (PRMs) and presented to the Board. The Cost Improvement Programs(CIPs) process has been amended to include a gateway from Idea to CIP; to RAG rate the schemes with a monthly review process. The target for 2016/2017 is 4% (£12.6m) but with a contingency of £1.8m. Review of all income opportunities by specialist external resource working with the Trust team. Income analysis by speciality now reported in monthly Finance Reports. Liquidity: Operational plan clearly outlines revenue funding requirements. On-going discussion with DH to confirm requirements. Business cases for key capital investments prepared with NHSi and DH prior to approval of Board. Funding source secured prior to plans being finalised. Clarity of requirement for external funding signalled in Operational Plan. Development of financial recovery plan.	Plans to implement Patient Level Costing (PLICS) and Service Line Reporting (SLR) have been agreed, this is a Key enabler for Trust deficit reduction over medium term. Reforecast to 31.03.2017 - the Trust is expecting to deliver a year end position at (worst case) or better than the £46.6m Financial Control total. Year end forecast for CIP is delivery to plan.	Finalisation and agreement of Financial Recovery Plan by 31.05.17, subsequent implementation over next 3 years to achieve financial sustainability. Engagement with the Sustainability & Transformation Plan (STP) to identify longer term financial sustainability actions and impacts.	Darren Cattell	01/06/2017

CRR-2017-001	**Innovation and digital technology**	Due to financial constraints, conflicting priorities and the current capacity for innovative change, there is a risk that the Trust may be in a position to embrace innovation and digital technology to support the best level of care for patients and facilitate improved working practices for staff.	Corp_Service/Business Interruption	4	4	16	12 (4x3)	09 (3x3)	Potential sub optimal patient care, potential for increased costs maintaining outdated systems and multiple interfaces, suboptimal working practices for staff.	Darren Cattell	Director of Finance	07/03/2017	

Evidence
GE RIS disc failure
Storage solution running out of capacity

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Current mitigation in place in various areas to lessen the effects of potential impact. Some improvement plans in place, further plans being developed described in actions required and gaps in control.		1. External consultancy support to facilitate change in vision by 30.04.17 2. Development of Digital Strategy within Trust and across STP footprint by 30.09.17 3. Identification of investment money to implement change by 30.09.17.	Darren Cattell	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-003	**Reduced capacity and capability in non nursing and medical staff groups**	Reduced capacity and capability across the organisation impacts on delivery of operational objectives and may compromise patient care	Corp_Staffing/ Competence	4	3	12	09 (3x3)	04 (2x2)	Potential patient harm events, reputational impact, increased stress on existing staff and potential recruitment and retention issues. May impact on Trust ability to meet statutory requirements.	James Devine	Director of HR & OD	26/09/2016	

Evidence
Lack of Sufficient WTE Pharmacy Support to Critical Care
Patient Safety Team
PHARMACY Provision of home care services by the commercial sector
PHARMACY Staffing
Resources for QI programmes
SI Investigators
THERAPIES Therapy Staffing

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
In house bank introduced in March 2016. Fill rates increased. Regular Locum and agency staff where possible to improve consistency, with rolling recruitment adverts in many areas. Emphasis on local induction and training to enhance capability. Working with agencies to address agency capping arrangements, and directorates to recruit to roles where bank/agency is in place	March 2017 Controls in place maintaining current score.	Service reviews and staff recruitment where required underway in many areas. Review of model of rehab/therapy provision underway by Head of Therapies due 31.05.17.	James Devine	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence
CRR-2016-004	Safeguarding	Failure to protect vulnerable children and adults may cause harm and potential reputation damage due to inadequacies in meeting statutory responsibilities	Corp_Patient Safety	3	3	9	09 (3x3)	04 (2x2)	Potential failure to protect vulnerable adults & children leading to patient harm events. Failure to meet statutory requirements may lead to regulatory action. Financial impact due to potential penalties and claims. Adverse reputational impact.	Karen Rule	Director of Nursing	26/09/2016		Elderly Medicine: Falls risks Increasing safeguarding activity (e.g. referrals and training requirements) Safeguarding referral process Safeguarding vulnerable adults Staff understanding of MCA and DOLS

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Safeguarding team resource increased & Safeguarding team visible in clinical areas to support staff. Content of mandatory training reviewed. Additional training session in place. Resources to support staff understanding & management of safeguarding - policies, protocols, quick guide manuals on all wards, generic e-mail for safeguarding team, safeguarding page on intranet	CQC report March 2017 shows that compliance with mandatory training for safeguarding is lower than required, current score maintained and progress to be reviewed. However they noted the Trust Safeguarding improvement plan and the multi-agency approach to safeguarding.	Interim staff employed until substantive appointments made. Review of safeguarding activity & resource required. Plans in place to improve mandatory training compliance, monthly reports to be provided to directorates to ensure compliance is monitored locally and via PRM. Review of safeguarding paperwork underway to be completed by 30.08.17 to ensure it is easily identifiable in patient's records.	Karen Rule	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence
CRR-2016-005	Emergency Department	Physical restrictions in the layout of ED leads to overcrowding which impacts on patient care. Resus and Trolleys area of the ED are not suitable for the service provided, or big enough to accommodate the potential number of people using the service at any one time.	Corp_Service/Business Interruption	3	5	15	09 (3x3)	04 (2x2)	Potential patient harm events. Increased complaints and potential claims Inability to comply with statutory regulations and meet patient care targets, leading to adverse financial and reputational loss.	Alistair Lindsay	Director of Clinical Operations - ACC	26/09/2016		Cohorting practice Delay in assessment of patients referred to specialist team. Elderly: Patient capacity- number of patients Inappropriate referrals to the Gynaecology Assessment Unit (GAU) Length of stay of psychiatry patients in ED Management of Trauma patients Patient Records Manual/Electronic Section 31 notice Security

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Controls have been put in place as detailed in cohorting escalation policy. Patients in all ED are being frequently reviewed to ensure patient safety and prompt escalation were appropriate. Introduction of Clinical Coordination Centre from 14/03/17 to oversee and challenge flow of patients.	March 2017 Score reduced from 15 (3x5) to 9 (3x3) Cohorting no longer takes place but SOP is in place for managing in times of surge – patients waiting by ambulance, patients involved in Immediate Handover from SECAmb, and supervision of patients in the waiting area.	March 2017 - ED new build project underway in staged process to ensure patient safety. Due to finish Phase 2 which is Majors and Resus by January 2018, and Phase 3 (CDU) July 2018 Working with SECAmb on Immediate Handover policy to ensure safety of patient is paramount	Alistair Lindsay	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence
CRR-2016-007	Estates	The combination of under investment in a dilapidated estate and the absence of a coherent strategic approach to the management of estates means that the infrastructure does not meet business needs and capital funding and resources may be insufficient to deliver what is required	Corp_Service/Business Interruption	4	4	16	08 (4x2)	04 (2x2)	Service disruption due to estates issues may impact adversely on patient safety. Potential regulatory action due to non compliance with DH Guidance. Financial impact of remedial action leading to non compliance with financial restrictions placed on the Trust.	Claire Lowe	Director of Estates and Facilities	26/09/2016		End of life infrastructure: Theatre Exposure to bodily fluids Fire Alarm System Fire doors Inadequate drainage Inadequate storage and maintenance of Patient Records Inappropriate Recovery Environment Medical High Dependency Unit Non Compliance with HBN Regulations Roof of Deceased Records Library Void fire compartmentation Water infrastructure

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Effective senior management of the E&F function with focus on Trust priorities has been established, including restructuring the directorate, bringing external contracts in-house (e.g. fire safety and training and a local security management specialist), creating and recruiting a new internal facilities audit team to improve auditing systems, revision of the terms of reference for estates and facilities groups, reviewing policies and the housekeeping operating plan.	March 2017 Current risk reduced from 12 (4x3) to 8 (4x2) Estates Infrastructure Group Established and working to collate information on clinical strategies. Engagement commenced with External Stakeholders on site wide strategy and future STP being developed.	Business Impact Assessment for Estates Project Team and Operational Estates procedure in place since August 2016. Various business cases underway across the Trust in relation to Estate improvements required. 2017/18 Capital programme being developed and design briefs in hand to enhance compliance with DH and regulatory requirements.	Claire Lowe	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence

CRR-2016-014	**Learning from incidents, complaints and claims and application of Duty of Candour**	Learning from incidents, complaints and claims is not structured and formalised across the Trust meaning that learning opportunities are not adequately disseminated and further patient harm may result from repeat incidents.	Corp_Quality / Audit	2	4	8	08 (2x4)	04 (2x2)	Dissatisfaction of users and commissioners of the service, potential increased complaints and claims. Reputational damage Increased burden on staff time to investigate repeated events.	Diana Hamilton-Fairley	Medical Director	26/09/2016		Clinical negligence claims and inquest outcomes

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Learning events are being rolled out across the Trust. Learning from serious incidents is included in the F1/F2 doctors training sessions, grand rounds, Nursing and Quality Forum. Feedback from serious incident investigations facilitated by the Patient Safety Team relating to the teams and trends. Action plan monitoring undertaken in the SI monitoring group. Deep dives into the actions will be undertaken regularly to provide assurance. Newsletter is being published. 07/09/16 - first swarm event took place looking at SI's. Trajectory has been set to reduce the Serious Incident investigation breach rate and is being monitored monthly. Directorates are identifying investigators, investigation tracker is in place and an escalation framework . Developed closer working arrangements between Patient Safety Team and Legal Services. Weekly meetings held. Developing process for reporting and triangulation of claims and inquest data with other patient safety metrics.	Complaints process revised Sept 16 and improved methodology has been implemented. March 2017 Current score reduced from 08 (2x4) to 6 (2x3), complaints process revised, SI Committee re-established, trends identified, actopn plan maintained and learning achieved.	Deep dives into the actions will be undertaken regularly to provide assurance. Newsletter is being published.	Diana Hamilton-Fairley	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence
CRR-2016-006	Medicines management	Pharmacy support and resourcing does not meet Trust requirements impacting on patient care and outcomes. Inability to recruit sufficient suitably qualified pharmacists and other staff to adequately meet the needs of all Trust services results in a risk to prescribing management and storage of medicines across the Trust.	Corp_Staffing/ Competence	3	3	9	06 (3x2)	04 (2x2)	Potential for medication errors and omissions due to lack of pharmacy support, leading to potential patient harm events. Increased stress on existing staff with an adverse impact on recruitment and retention.	Alistair Lindsay	Director of Clinical Operations - ACC	26/09/2016		Lack of Sufficient WTE Pharmacy Support to Critical Care Medicine Management - precribing and administration Medicine Managment - stoarge PHARMACY - MEDICINES MANAGEMENT 1) Poor Prescribing 2) Mismanagement of Controlled drugs 3) Inappropriate administration of medicines / omitted doses 4) Medicines Management Committee attendance PHARMACY Storage/ temperature management of medicines on wards externally to pharmacy Research governance - pharmacy department compliance Undetected medication errors

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Drug charts are reviewed on ward round. Double checking of prescription charts by nurses. Use of locum staff were possible with emphasis on local induction. Drug charts sent to pharmacy to review and validate, wards can contact pharmacy with queries.	March 2017 Risk score reduced from 9 (3x3) to 6 (3x2) - Bank staff employed as needed but substantive numbers increased. Workforce strategy undertaken and to go to Execs end of March focused on 7/7 services, discharge and modernization of service Ambient temperature monitoring project completed and trust-wide room temperature monitoring system is in place	Workforce strategy completed and being presented to Execs for approval end of March 2017 Critical Care - Business Case being developed by Pharmacy with the input of the Clinical Director to request additional pharmacy support. Prescribing audit required to find where pharmacist is most needed, along with skill mix review. Critical Care - Business Case being developed by Pharmacy with the input of the Clinical Director to request additional pharmacy support. Ambient temperature monitoring project pharmacy are working with estates and equipment services to identify a trust-wide room temperature monitoring system.	Alistair Lindsay	01/06/2017

CRR-2016-011	**Compliance**	The Trust may not be compliant with key statutory and mandatory requirements. This may lead to patient harm, regulator interventions and reputation damage	Corp_ Compliance/Audit/Governance	3	3	9	06 (3x2)	04 (2x2)	Patient safety may be adversely affected. Potential for regulatory action and financial penalties. Potential restrictions on the Trust's healthcare licences, up to and including service closures. Increased regulatory oversight, diverting management resources from core activities Reputational damage with potential for adversely affecting staff recruitment and retention.	Lynne Stuart	Dir. of Corp. Governance, Risk, Compliance & Legal	26/09/2016	

- Breach of Construction (Design and Management) Regulations
- Breast unit accomodation inadequate for the volume of patients, resultiing in non-compliance with QA action plan and service safety.
- Clinical Effectiveness Team
- Equality Delivery System - Board requirements
- Equality Delivery System - non implementation
- Medical High Dependency Unit Non Compliance with HBN Regulations
- Medway NHS FT (MFT) and Darrenth Valley Hospital (DVH) Pathology Joint Venture
- Post mortem room flooring.
- Record retention periods applied inappropriately or not applied at all
- Resilient Major Incident Communications Cascade
- SI Breaches
- There is no secuity solution to restrict the use of USB memory sticks

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Implementation ofTrust Recovery Programme (work streams related to quality, operational performance and financial improvement) Patient safety controls in place as described in relation to Corporate Patient safety risks e.g. Nurse and Medical Staffing. Implementation of CQCAssure to provide automated process for self-assessment and collection and overview of results. NHS Provider Licence Standard Conditions:- Regular meetings and reporting and submissions to NHS Improvement; submission of self-assessment templates to NHS Improvement (NHSI) in accordance with the Risk Assessment Framework.	11.01.2017 Risk Domain changed to Compliance Audit Governance. March 2017 CQC report, Trust rating changed from Inadequate to Requires improvement and Trust has been taken out of Special Measures. Successful Quality Summit with engagement from key Trust stakeholders - risk score reduced from 9 (3x3) to 6 (3x2).	Further embedding of CQCAssure, to ensure systems in place within directorates for on-going monitoring and review of fundamental standards and the KLOE assessments.	Lynne Stuart	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence
CRR-2016-012	**Deteriorating patient**	Tools and skills in recognising and escalating deterioration in patients is not embedded successfully in the Trust leading to poor outcomes for patients	Corp_Patient Safety	4	3	12	06 (3x2)	04 (2x2)	Potential patient harm events, potential for increased complaints and claims with associated adverse financial impact and reputational damage.	Diana Hamilton-Fairley	Medical Director	26/09/2016		Imaging Recovery Room and inability to recover patients in an appropriate environment Patient Flow Through the Hospital Recognition and escalation of the deteriorating patient

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
National Early Warning Score (NEWS) training for substantive and agency staff. NEWS training for all nursing staff now mandatory and compliance is being monitored. Outreach Team and Site team supporting nurses. Matrons and Senior Sisters working clinical shifts on a regular basis to monitor and supervise care. Audit of NEWS and other aspects of care. Block booking of agency. Review of staffing levels on a day by day, shift by shift basis.	March 2017 Current score reduced from 8 (4x2) to 6 (3x2), tools and skills now embedded, NEWS established with regular audit, last results showed 95% in all areas. Acute response team recruited to, down to 2 vacancies.	Acute & Continuing Care Directorate Business case to be submitted for practice development nurses on wards.	Diana Hamilton-Fairley	01/06/2017

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed	Evidence

CRR-2016-013	**Training and appraisal rates**	Poor training and appraisal rates may result in an inability to retain a high quality, trained workforce, impacting detrimentally on quality and safety of care to patients	Corp_Organisational Development	3	3	9	06 (3x2)	04 (2x2)	Potential for patient harm events with increased complaints and claims, associated financial and reputational loss. Staff not able to perform effectively in their roles, adverse impact on staff recruitment and retention.	James Devine		26/09/2016	Employees failing to attend mandatory training sessions for IG. Failure to achieve 95% target for IG Toolkit Low levels of achievement review (appraisal) compliance. Low levels of recorded local induction. Non-compliance in mandatory training requirements.

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Mandatory Training:- Trust wide Development and implementation of action plan. Data provided weekly to Directorates & HR Business Partners (HRBPs). Information Governance (IG) All staff required to undertake annual (IG) training. New IG Manager appointed 01.06.16; programme of work and identification of specific problem areas is being developed Moving & Handling:-Review of training availability and accessibility has identified more workplace based training is required. A recovery trajectory plan is now in place. Mental Capacity Act & Deprivation of Liberty (MCA & Dols): Content of mandatory training reviewed. Additional training session in place. Safeguarding team resource increased. Safeguarding team visible in clinical areas to support staff. Appraisal:- Directorates agreeing trajectories of compliance with HR Business Partners (HRBP). New achievement review replaced appraisal Sept 16, simplifies process.	A regular compliance report generated via MOLLIE, reviewed and discussed at monthly Executive Performance review Meetings (PRMs). March 2017 Staff Survey indicates positive position in appraisal & Stat man training.	Further developments of MOLLIE on-going.	James Devine	01/06/2017

Strategic Objective One

Our People: We will enable our people to give their best and achieve their best

Strategic Blueprint

We will have effective and appreciative leadership throughout the organisation, creating a high performance environment where staff have clarity about what is expected of them, receive regular feedback and understand that poor performance will be addressed. Our employees will be engaged, committed to continuous improvement and embrace change. We will be an employer of choice.

Lead Directors
Director of Human Resources and Organisational Development (HR & OD), Medical Director, Director of Nursing.
Risk Register Reference
Corporate Risk Register: CRR-2016-001, CRR-2016-002, CRR-2016-003, CRR-2016-004, CRR-2016-011, CRR-2016-012, CRR-2016-013

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
The Trust may be unable to attract, recruit and retain high quality staff impacting on a continued dependency on temporary staff and safe staffing levels, affecting quality of care, and financial costs.	Vacancy rates. Temporary staff usage rates. Patient safety incidents	Nursing staff shortages may lead to sub optimal care, impacting on patient safety processes and clinical outcomes. Inability to recruit sufficient numbers of suitably qualified medical staff may lead to sub optimal care, impacting on patient safety processes and clinical outcomes. Reduced capacity and capability across the organisation impacts on delivery of operational objectives and may compromise patient care.	**15 (5x3)**	**12 (4x3)**	**4 (2x2)**	Consultant Vacancies in Dermatology, Gastroenterology and Vascular. Increased referral demand in Dermatology and Gastroenterology Diagnostic delays (MRI and CT), particularly affecting T&O. Difficulty fulfilling all medical shifts. System plans were not flexed / revised sufficiently quickly when reduced capacity (particularly Packages of social and health Care) and increased demand was noted both before Christmas 2016 and in the period between Christmas and New Year.

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
Workforce diversity is not achieved due to a lack of strategic focus and oversight on statutory and contractual equality and diversity obligations.	Workforce Race Equality Standards (WRES) Equality Delivery System (EDS2) outputs	The Trust may not be compliant with key statutory and mandatory requirements. This may lead to patient harm, regulator interventions and reputation damage.	**9 (3x3)**	**6 (3x2)**	**4 (2x2)**	EDS2 process has not commenced, but will be a priority for the newly appointed Head of Equality & Diversity. Lack of Board understanding/focus on the requirements due to absence of board development or induction in this area.
Trust may not have stable and effective leadership and well trained, competent staff at all levels.	Appraisal rates, Induction rates, Mandatory training rates, Leadership development programme, Management development programme.	Poor training and appraisal rates may result in an inability to retain a high quality, trained workforce, impacting detrimentally on quality and safety of care to patients. Learning from incidents, complaints and claims is not structured and formalised across the Trust meaning that learning opportunities are not adequately disseminated and further patient harm may result from repeat incidents. Tools and skills in recognising and escalating deterioration in patients is not embedded successfully in the Trust leading to poor outcomes for patients	**9 (3x3)**	**6 (3x2)**	**4 (2x2)**	Formal development plans for middle and frontline staff. Training needs analysis has not been undertaken/formalised in a way that gives organisational oversight and enables a planned approach to addressing training needs or areas of risk Mandatory training and appraisal rates are insufficient in some areas Organisational development planning being developed to map out a culture change programme; diagnostic around prevailing culture has not been undertaken Structured succession planning and talent management approach is not in place
Staff are unable to participate in learning and development opportunities due to staffing shortages.	Mandatory training rates, Learning and development programme and take-up, Appraisal rates, Induction rates.	Poor training and appraisal rates may result in an inability to retain a high quality, trained workforce, impacting detrimentally on quality and safety of care to patients. Learning from incidents, complaints and claims is not structured and formalised across the Trust meaning that learning opportunities are not adequately	**9 (3x3)**	**9 (3x3)**	**4 (2x2)**	Migrating data from Oracle Learning System (OLM) to Medway on Line Learning & Interactive Education System (MOLLIE). Jan 2017, WIRED (Workforce Information Reporting Engine Database) no longer updated to track training and appraisal rates, MOLLIE not fully functional as training history being migrated, resulting in

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
		disseminated and further patient harm may result from repeat incidents.				incomplete data and difficulty in assessing areas of poor training and appraisal rates.

Assurance Providers		
First Line (Business Management)	**Second Line (Corporate Oversight)**	**Third Line (Independent)**

The Director of Nursing provides a monthly report to the Board which details the previous month's Unify data, areas of risk, mitigations in place and plans going forward.
The HR Board paper from April will introduce other staff groups.
 	
Refreshed recruitment plan in place, now seeing benefits of the plan. This will improve the vacancy rate and also improve retention, particularly Nursing. HR has also commenced a similar piece of work for Consultants.
 	
International Nurse recruitment campaign including Philippines, successful expected to result in appointment of around 120 Nurses following checks.
 	
Dedicated nurse recruitment campaign commenced January 2017 and includes the review of incentives; and analysis of exit data to ascertain why individuals leave the Trust, showing improved position with reducing number of leavers.
	Performance against the Key Performance Indicators (KPIs) agreed within the Trust Recovery Plan which is reviewed and monitored at the fortnightly Executive Recovery Committee which reports direct to the Board, but with oversight by the Clinical Council on a monthly basis.
	
	The Head of Resourcing and Deputy Finance Director also hold weekly reviews of non-clinical temporary staffing usage.
	
	The Trust has partnered with award winning media company TMP Worldwide (TMPW) who work with many NHS Trusts across the country on providing expert resourcing campaigns.
	
	PID developed Performance Review meetings with Directorates / ToR and framework.
	Monitoring of quality and safety indicators via clinical governance framework:
	• Quality Assurance Committee;
	• Quality Improvement Group; with upward reporting from the following
	  ○ Patient Safety Group (with upward reporting from Resuscitation and Acute Deterioration Group, Hospital Transfusion and Thrombosis Group, and Nutrition group)
	  ○ Patient Experience Group (with upward reporting from End of Life Care Group and Food Quality Focus Group);
	  ○ Clinical Effectiveness and Research Group (with upward reporting from Clinical Audit & NICE Guidance Compliance Group, Mortality & Morbidity and Clinical Outcomes Group, Research & Development and Innovation Governance Group and Research Operational Group);
		The CQC report 17.03.2017 noted that There had been an effective nurse recruitment Programme, and there had been a marked reduction in the use of agency nurses.
		
		Monthly Quality Oversight Committee with NHSI, CQC, CCGs
		
		Weekly reporting on KPIs via email submission by Head of Staff Resourcing and Interim Deputy Director of Finance, to the CCG, NHSI and the CQC
		
		Published monthly Unify data
		
		Board/Executive visits to ward areas
		
		Trust Wide (CQC) and Service Specific regulatory bodies review service outputs as an assessment of staffing levels, these include evidence of staff meetings, mandatory training percentages, appraisal rates, responsiveness to incident reporting and follow up investigations and actions complete, audit performance and non-conformance management, training and competency records, equipment maintenance logs, staff feedback

Assurance Providers		
First Line (Business Management)	**Second Line (Corporate Oversight)**	**Third Line (Independent)**
Expenditure on agency reduced in Feb 17, compared to Jan 17, although a shorter month, also conversion of agency to bank. A Strategic Workforce Group has been established as a sub-group of the Executive Group.	○ Medicines Management Group (with upward reporting from Drugs & Therapeutics Group, Safe Sedation Group and Medical Gases Group); ○ Safeguarding Assurance Group (with upward reporting from Children and Adult Safeguarding Group); ○ Infection & Anti-Microbial Stewardship Group (with upward reporting from Water Safety Group and Decontamination Group)	mechanisms and the results of these.
The Equality and Diversity Group Terms of Reference with onward reporting to the Executive Group. HR has also now appointed a Head of Equality & Diversity in post from 01.04.17.	Board Equality and Diversity champion now identified Equality and Diversity Annual Report to Board	Reporting to Commissioners on WRES outputs
Monthly reporting to Directors of Clinical Operations and Executives provides data on recruitment, appraisal, induction, mandatory training rates Directorate Management Board and Programme Board structure and upward reporting to Quality Improvement Group and Performance Review meetings.	Workforce Report to the Board by Director of HR & OD. December 2016 87% of staff had appraisal and were compliant with Mandatory training requirements. Appointed an Associate Director of Workforce Development and OD, who is now leading this agenda.	Local Supervising Authority Audit Report (Supervision of Midwives)
Director of HR & OD reporting	Directorate Management Board and Programme Board structure and upward reporting to Quality Improvement Group and Performance Review meetings	

Actions to address gaps in control / assurance
April 2017:- Targeted doctor recruitment programme commenced to be completed April 2017, with marketing and advertising commencing May 2017. This will focus on both junior doctor and Consultant vacancies, particularly in areas with high vacancy rates, or difficult to fill roles. Work being undertaken on reviewing areas of continued reliance on temporary staffing, with dedicated support from HR Business Partners, to be reviewed at monthly Performance Review Meetings (PRMs).

Strategic Objective Two

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

Strategic Blueprint:

We will protect people from harm, giving them treatments that work and ensuring that they have a good experience of care. We will create an open and sharing environment where research and innovation can flourish achieving dual aims of enhancing the quality of patient care and contributing to the financial sustainability of the organisation. We will have a culture where staff are given the opportunity, training and resources to research and innovate. We will proactively develop partnerships with other organisations, underpinned by robust governance arrangements, to enable execution and exploitation of innovation projects to benefit the population that we serve.

We will do this by increasing the use of modern technology and the availability of quality information systems. We will take both a local and whole systems approach to implementing a digital strategy that will result in providing real time access to patient information across all providers of healthcare in Kent and Medway.

Lead Directors
Director of Finance
Risk Register Reference
Corporate Risk Register: CRR-2017-001

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
The Trust remains behind peers in the implementation of technology and is reliant on outmoded systems. The Trust does not have the ability to generate requisite financial resources to introduce all technical innovations that are needed. Although the Trust has made progress in implementing technology it is still reliant on multiple outmoded systems and multiple interfaces. Whilst capital funding may be allocated, financial resources	Business Case submissions to Executive Group for approval.	Due to financial constraints, conflicting priorities and the current capacity for innovative change, there is a risk that the Trust may be in a position to embrace innovation and digital technology to support the best level of care for patients and facilitate improved working practices for staff.	**16 (4x4)**	**12 (4x3)**	**9 (3x3))**	Corporate Informatics Group (CIG) Terms of Reference indicates onward reporting to the Executive Group, however reporting is not taking place. Project Change Advisory Board and intentional upward reporting to Corporate Informatics Group and Executive Group, however reporting to Executive Group is not taking place.

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
required to accelerate implementation may not be available unless clear and defined benefits are identified and ultimately delivered.						
Developing and aligning a digital strategy to meet Sustainability and Transformation Plan (STP) aspirations could mean that local improvements that have been developed or already approved do not then get implemented as the STP changes the direction of travel from the original concept. This may cause delays in implementing local improvements and cause developments designed to improve patient care to stagnate if STP partners are not aligned around the digital strategy.	Digital Strategy in place Health Informatics Project Management plans implementation reporting (% outstanding)		**16 (4x4)**	**12 (4x4)**	**9 (3x3))**	STP governance is not developed Resources are not aligned to STP requirements; staff are internally focussed dealing with Trust issues
A culture and environment for innovation where staff are encouraged to innovate or feel confident with modern technology requires development and time commitment and creating the conditions for innovation is difficult when staff are focussing on dealing with fundamental issues such as staff shortages and preparing for regulatory inspections. This may impede progress and support for innovation, impacting detrimentally on sustainability improvements designed to improve patient care.	Research income Successful project implementation outcomes		**16 (4x4)**	**16 (4x4)**	**9 (3x3))**	Research governance - lacks clarity or reporting to Executive / Board on research and innovation initiatives R&D team are unclear about routes for approval; Research governance is unclear and there is a lack of clarity about where initiatives can be approved Limited capacity and capability in Business Intelligence function: seeking sharing opportunities with other Kent acute trusts.

Assurance Providers		
First Line (Business Management)	**Second Line (Corporate Oversight)**	**Third Line (Independent)**
Health Informatics Risk Register maintenance and review process Health Informatics Programme Management Office.	Reporting from Trust wide PMO / Executive Recovery Group updates and oversight Data Quality Group Terms of Reference and onward reporting to CIG Implementation of improved site management processes to improve flow management (based on the Luton and Dunstable model) supported by improved utilisation of acute bed management software.	Internal Audit report on IT change management showed significant assurance with minor improvement opportunities. CQC report 17.03.2017 reported ED Information technology systems had been put in place to support safety, flow and data collection.
Chief Executive's and Medical Director's integration into STP process.	Chief Executive's reporting to Board on wider STP developments	External review of STPs and monitoring of health economy progress in development and implementation.
Speciality/Programme Board and upward reporting in the Directorate governance structure	Research Group reporting upwards to Clinical Effectiveness and Research Group Medical Devices & Equipment Group and upward reporting to Compliance and Risk Group / Escalation to Executive Group	CQC report 17.03.2017 Critical Care: - Services had successfully recruited to research studies that aimed to improve outcomes for critical care patients, including to studies of psychological impact of intensive care.

Actions to address gaps in control / assurance
External consultancy support to facilitate change in vision by 30.04.17 Development of Digital Strategy within Trust and across STP footprint by 30.09.17 Identification of investment money to implement change by 30.09.17.

Strategic Objective Three

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

Strategic Blueprint

Working strategically, as a trusted partner in the Sustainability and Transformation Plan we will work with partner organisations and the public to transform out-of-hospital care through the integration of primary, community and social care and re-orientate elements of traditional acute hospital care into the community. We will work collaboratively and progressively to develop an Accountable Care System (ACS), ensuring that protecting our local Trust interests does not stand in the way of achieving benefits for the wider health economy and public.

Lead Directors

Chief Executive, Director of Finance, Medical Director.

Risk Register Reference

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

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
Partners do not work strategically for the greater good and are not willing to sacrifice local interests. Delivery of transformation remains an aspiration rather than a reality; Other providers interests' may not be aligned and there may be resistance to change from within the organisation or the local authority	Representation and contribution to key strategic groups/ meetings Clinical engagement with wider health economy via Clinical Council and CRGs. Key access targets: • ED 4hr • RTT	Failure to meet national performance standards may result in delayed diagnosis and harm to patients, financial penalties and reputation damage. Physical restrictions in the layout of ED may lead to overcrowding within the department which may impact on patient care. Resus and Trolleys area of the ED are not suitable for the service provided, or big enough to accommodate the potential number of people using the service at any one time. Significant high cost equipment that is out of date and past its replacement date may not be reliable or fit for purpose impacting on	**16 (4x3)**	**12 (4x3)**	**6 (2x3)**	Controls being implemented re performance.

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
	• CWT • DM01	service delivery and income Poor patient flow throughout the hospital impacts on performance, results in sub-optimal care for patients and discharge delays Failure to meet national performance standards results in delayed diagnosis and harm to patients, financial penalties and reputation damage. Failure to protect vulnerable children and adults may cause harm and potential reputation damage due to inadequacies in meeting statutory responsibilities.				

Assurance Providers		
First Line (Business Management)	**Second Line (Corporate Oversight)**	**Third Line (Independent**
Medway & Swale A/E Delivery Board & Planned Care Board. Directorate Performance Review Meetings. The ACC directorate is implementing further changes to the urgent care flow model, based on national best practice examples.	Integrated Quality & Performance Report (IQPR). Chief Executive's monthly report to Board. CQUINS and monitoring of compliance. Board approved STP; governance arrangements for STP are that accountability / decision making rests with each component organisation EPRR Group and Local Health Resilience Partnership representation - onward reporting to the Board	Medway Council Overview and Scrutiny Committee Medway Health and Wellbeing Board Monthly Quality Oversight Committee with NHSI, CQC, CCGs Monthly Progress Review meeting with NHSI Quarterly Quality and Performance Committee with CCG. NHS England Assurance Process (EPRR) The structure of the STP is becoming more established and Governance Processes are being implemented. MFT are represented at all levels. External regulatory standards require accredited and regulated services to assess the quality of services they commission by the review of service

Assurance Providers		
First Line (Business Management)	**Second Line (Corporate Oversight)**	**Third Line (Independent**
		level agreements and quality outputs of the service, e.g. result turnaround times, participation in external quality assurance schemes etc. E.g. a Clinical Pathology Accreditation (CPA) accreditation requirement.

Actions to address gaps in control / assurance
Joint plans under development with commissioners to increase GP referrals to local alternative dermatology service providers, which include the establishment of MFT-consultant supported GP clinics and tele-dermatology services. Establishment of the Clinical Control Centre (CCC) and a CCG led front door model under development.

Strategic Objective Four

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

Strategic Blueprint

We will maximise in house efficiency in service delivery and operational management. We will regain and retain financial control. We will be outward looking, actively working in partnership with the wider health economy through the Kent and Medway Sustainability and Transformation Plan to maximise transformation opportunities in service delivery workforce, back-office functions, digital strategy and estates utilisation.

Lead Directors
Director of Finance
Risk Register Reference
Corporate Risk Register: CRR-2016-015, CRR-2016-007

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
The Trust's Going Concern assessment is challenged by failure to achieve its planned deficit reduction and budget for 2016/17 resulting in further licence conditions and potential regulatory action; failure to deliver financial recovery plans and Carter Review efficiencies, threatening long term sustainability; inability to operate without central funding (loans) which restricts the financial operation of the organisation and its autonomy which may impact on its ability to bring about required organisational changes; failure to work with local partners to develop a financially sustainable organisation/system and develop genuine changes in patient experience and health outcomes, for the longer term; failure to receive all the income for activity due to validation issues with the Commissioner or stretched commissioning budgets.	Cost Improvement Plans (CIPs) achievement Use of contingency / reserves Carter benchmark data and performance against targets Signed contracts with Commissioners. STP savings plans.	Failure to achieve planned deficit reduction through Cost Improvement Plans and Carter Review efficiencies across the Trust affects the financial sustainability and Going Concern assessment of the Trust. The combination of under investment in a dilapidated estate and the absence of a coherent strategic approach to the management of estates	**16 (4X4)**	**12 (4X3)**	**6 (2x3)**	Emergency pressures have put considerable strain on the Trust operationally and financially in December 2016. . Reprioritisation of identified capital priorities through reforecasting and engagement with service leads to mitigate in year critical risks.

Strategic Risks	Indicators	Corporate Risk Register	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Gaps in Controls / Assurance
		means that the infrastructure does not meet business needs and capital funding and resources may be insufficient to deliver what is required.				

Assurance Providers		
First Line (Business Management)	**Second Line (Corporate Oversight)**	**Third Line (Independent)**
Scheme of Delegation and authorisation levels Business planning process Financial Recovery Plan Interim Director of Finance appointed, substantive Director of Finance being recruited. Budgetary Control Framework in place from April 2016 ensuring that budget holders have clear responsibilities and accountability and they are supported by training alongside robust budgets. National agency caps; monitoring by procurement team of contracts for agency workers Control target of £43.8 deficit met Cost Improvement Plans year end forecast is for CIP delivery to plan.	Estates and Capital Group Integrated Audit Committee oversight of financial governance systems Monthly Finance Report to Board includes status report on compliance with Loan Terms from DH Finance Committee established and reviewing financial performance. Finance Report to Board. The Executive Team refine the forecast each month until the year end and report this to the Finance Committee and the Board and NHSI colleagues.	External audit of financial accounts and core financial systems Regular submissions to NHSI - NHS Improvement's monitoring of adherence to loan conditions Internal audit reports focused on areas of risk identified by Executive Directors, Non-Executive Directors and Peers.
Actions to address gaps in control / assurance		
Workforce WTE are below plan substantively due to vacancies across clinical and corporate areas. Continue to use a high number of temporary staff to cover vacancies. Recruitment and retention actions to increase substantive staff numbers continue. The Finance Director and HR Director developed a Programme supported by the revised PMO arrangements, that will encompass a number of current projects. The successful implementation of this programme has started to reduce the Trust's cost overruns and provide assurance internally and externally that this key area of staffing and spend is being properly controlled.		

NHS Medway NHS Foundation Trust

Report to the Board of Directors
Board Date : April 2017

Title of Report	Workforce Report
Presented by	James Devine, Executive Director HR & OD
Lead Director	James Devine, Executive Director HR & OD
Committees or Groups who have considered this report	Executive Team
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the hospital. The international recruitment plan for nursing continues with a total of 241 nurses being processed for posts at MFT. A further 12 nurses commenced in April from successful EU recruitment. Furthermore, the Trust is taking part in a collaborative regional procurement approach for international recruitment as part of the STP. Trust turnover remains static at just under 10%, sickness remains static under 4%, compliance with mandatory training has dropped in all directorates (Trust at 72%), achievement reviews marginally improved to 86%. Agency breaches (in line with NHS Improvement) continue to decrease week on week (decreased by two thirds compared to start of 2017) – the reporting shows a reduction of 70% when comparing the level of agency shift breaches in November, compared to April. Overall agency spend has increased, although this is largely due to late and disputed invoices rather than demand. Fill rates across staff groups have improved in medical, but slightly decreased in nursing in month. An update has been provided to highlight proposed schedule of works in relation to the Trust's Equality & Inclusion agenda.
Resource Implications	None
Risk and Assurance	• Nurse Recruitment • Temporary Staffing Spend The following activities are in place to mitigate this through: 1. Targeted campaign to attract local and national nurses

	2. Update on overseas campaign 3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway 5. Agency/Temporary Staffing Workstream as part of the 2017/18 cost improvement programme
Legal Implications/Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators.
Recovery Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan.
Quality Impact Assessment	n/a
Recommendation	Information
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☒ Noting ☒

Medway NHS Foundation Trust

WORKFORCE REPORT – APRIL 2017

TRUST BOARD MEETING

1. Introduction

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

2. Recruitment

2.1 The international campaigns in both Europe and the Philippines remain on track. 12 European nurses commenced in post on 20 April with a further cohort arriving in July. Harvey Nash, our international partner agency, is processing the 241 Filipino nurses that were offered posts in March, with the aim of these nurses arriving toward the end of the calendar year.

2.2 The Trust is partaking in a collaborative regional procurement approach for International Nurse Recruitment as part of the STP. It is anticipated that successful agency partners will be awarded contracts mid-June.

2.3 The recruitment plans highlighted in earlier Trust Board papers are continuing to show dividends with again a high number of qualified nurses and Clinical Support Workers being offered roles. The table below summarises the position on offers made, starters and leavers for March 2017. However, two successive months, registered nursing leavers exceed starters.

Role	Offers made in month	Actual Starters	Actual Leavers
Registered Nurses	33	10	15
Clinical Support Workers	10	29	4
Associate Practitioners	0	2	0

2.4 We have commenced work on a targeted doctor recruitment programme with award winning media company TMP Worldwide (TMPW). TMPW have completed some focused diagnostic work on junior doctor and Consultant vacancies and will feedback their findings to the Trust at the beginning of May. The findings will inform our medical marketing and advertising strategy. Further updates on progress will be provided to the Board in the coming months.

3. Directorate Metrics

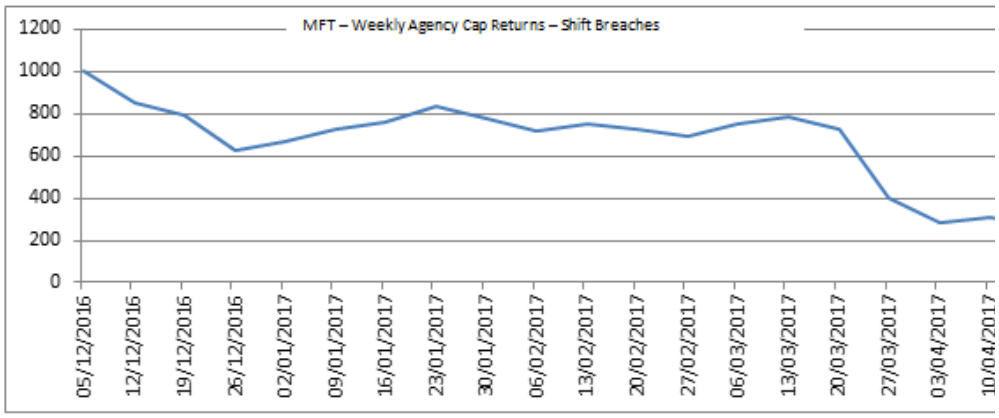
3.1 The table below shows performance across five core indicators by directorate. Turnover, at 9.97%, remains above the tolerance level of 8%. Sickness absence (at 3.96%) remains slightly below the tolerance level of 4%.

3.2 Trust achievement review rate stands at 86%, below the Trust target of 95%, Mandatory training remains below target (at 72%) – no directorates are currently meeting either target; HR Business Partners are working with directorates to devise robust plans which better support the achievement review approach as opposed to an annual appraisal system which was replaced in late 2016. Reporting mechanisms for achievement review are currently being examined to simplify reporting and support directorates to meet their target. Smarter, more transparent reports are currently being worked on based on MOLLIE data to help directorates make sense of their data and support departmental planning for training; these will be in place for end of May. In addition, directorates have been required to review their approach to mandatory training, and utilise the escalation and consequence process detailed within the policy where necessary.

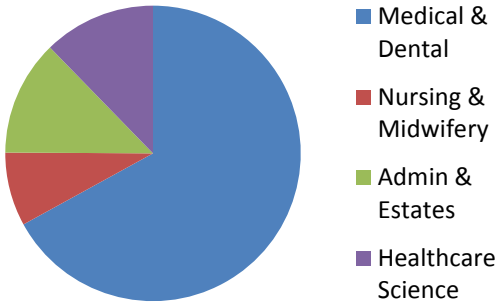
	Acute & Continuing Care (FTE)	Trend from previous month	Co-ordinated Surgical (FTE)	Trend from previous month	Women & Children (FTE)	Trend from previous month	Corporate (FTE)	Trend from previous month
Turnover rate (8%)	12%	⬆	9%	⬇	8%	⬇	15%	➡
Sickness rate (4%)	4%	➡	4%	➡	4%	➡	2%	➡
Vacancy rate	16%	➡	21%	➡	11%	➡	15%	➡
Achievement Review (95%)	89%	⬆	78%	➡	93%	⬆	82%	⬇
Mandatory Training (95%)	70%	⬇	73%	⬇	76%	⬇	63%	⬇

4. Temporary Staffing

4.1 Agency breaches continue to decrease week on week. The table below shows the weekly reporting between December 2016 and up to week three of April 2017. As can be seen from the table, in December 2016, the Trust was reporting around 1000 shift breaches per week. Since the end of March 2017, the Trust has reported a figure lower than 400 per week, with latest reporting data showing 285 breaches per week; this is a 70% reduction.



4.2 Areas of usage: The chart below shows the shift breaches by staff group from the latest weekly return (285 breaches). This level of usage in terms of proportion attributable to staff groups is in keeping with previous weekly returns. This showing that the highest level of shift breaches is within the medical and dental workforce (67%), followed by admin & estates (13%), healthcare science (12%) and the lowest being nursing and midwifery (8%).



4.3 Expenditure on agency increased by just over £100k in March 2017 compared to February 2017. However, over £700k of this spend this month can be attributed to late and disputed invoices. Work is currently being undertaken on reviewing areas of continued reliance on temporary staffing, with dedicated support from HR Business Partners to devise plans to recruit on a substantive basis. This has been reviewed at the monthly performance reviews.

4.4 Requests for temporary staffing to cover nursing and doctor vacancies increased by c.1000 shifts in March compared to February with 11,845 shifts requested; positively, there was a 5% increase in the medical locum fill rate; 90% medical locum requests were covered. However, there was a slight decrease (4%) in the nursing fill rate; 81% of nursing requests were covered.

4.5 A number of agency workers have reduced rates to now comply with the NHSI price cap, with 121 agency workers having either joined or are in the process of joining the Trusts in-house bank (resulting in the removal of agency premium); this includes 30 doctors, 26 CSWs and 44 nurses. Where negotiation has resulted in both parties not being able to agree rates that sit within the price cap, we have issued notice that their placements will end.

4.6 The Trust has reported 2 agencies to NHS Improvement, where these agencies have been non-negotiable on medical locum rates significantly above the price cap, and in excess of the value requiring NHSI approval.

5. Other Workforce Updates

5.1 Update on Equality and Inclusion:

Following the appointment of Alister McClure, Head of Equality & Inclusion in April 2017, the following high-level schedule of works are being developed:

- Equality Delivery System (EDS2);
- Gender Pay Audit;
- Workforce Race Equality Standard (WRES);
- Workforce Disability Equality Standard (WDES).

The main purpose of EDS2 is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty (PSED).

In effect, EDS2 operates as both an audit tool for Trusts' performance, policy and practice on equality, and as a planning tool for future objectives. It has nine stages of development. Whilst some of the stages can be run concurrently, most of them are dependent on the completion of other stages. The first stage (confirmation of the governance arrangements for EDS2) and the second stage (identification of stakeholders), are immediate priorities. There is a statutory duty to report equality information and performance data, and to review (and if necessary, change) equality objectives, on an annual basis. It is recommended that, in future, this should be before 31 March each year, to fit with performance and financial planning. This timeframe would also fit with the statutory duty to publish the Trust's Gender Pay analysis by 31 March each year.

Future reports schedule (proposal):

June 2017	Interim report on EDS2 and emerging priorities
July 2017	EDS2 Grades and MFT Equality Objectives 2017-2020
December 2017	Interim performance report on equality objectives
Jan/Feb 2018	Gender Pay Audit, outturn report
March 2018	EDS2 Grades (2018) with review/update of Objectives

Yet to be timetabled, there will be reports on NHS Workforce Equality Standards, i.e. an update on the WRES and preparation for the WDES, and any other relevant equality and diversity benchmarking tools. The aim of this programme of reporting is to ensure that the Board is provided with evidence-based equality data periodically, throughout the year, and to improve future planning.

5.2 Update on NHS Staff Survey:

The results of the NHS Staff Survey were made available to the Trust Board on 06 April 2017, with a presentation summarising our results. The Trust committed to conduct Action Planning Workshops with all services across the Trust, as well as set up an Improvement Support Group.

The Organisational & Professional Development (OPD) department has liaised with all services across the trust to arrange Action Planning Workshops. Workshops are being organised with HR & OD, Health Informatics, Women's & Children's and Estates and Facilities. OPD will continue to work with all the other services across the Trust to ensure they also have a workshop.

The role of OPD Service Manager is currently being recruited, who will be setting up the Improvement Support Group.

- End

Medway NHS
NHS Foundation Trust

Report to the Trust Board

Date: 04 May 2017

Title of Report	**Membership Strategy**
Presented by	David Rice, Trust Secretary
Lead Director	David Rice, Trust Secretary
Committees or Groups who have considered this report	Governors Membership Engagement Group Council of Governors
Executive Summary	• The Governors Membership Engagement Group reviews the membership strategy each year. • The strategy aims to ensure a breath of members which reflects the community in terms of age, gender, disability, sexuality and ethnicity. • The strategy includes initiatives to recruit new members and engage with existing members. • The budget for membership management which covers membership and governor communications, events, governor elections and training is £31,000 for 2017-18.
Resource Implications	N/A
Risk and Assurance	None.
Legal Implications/Regulatory Requirements	The Trust Board is responsible for reviewing and approving the Governors Membership Strategy each year.
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Board are requested to approve the Membership Strategy.
Purpose & Actions required by the Executive Group :	Approval ✓ Assurance ☐ Discussion ☐ Noting ☐

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Membership Strategy 2017/18

Reviewed by the Membership Engagement Group:	February 2017
Proposed and agreed by the Council of Governors:	**11 April 2017**
Approved by Trust Board:	
Review date:	March 2018

CONTENTS

MEDWAY NHS FOUNDATION TRUST

MEMBERSHIP STRATEGY

1. INTRODUCTION

This document describes Medway NHS Foundation Trust's strategy to attract, retain, engage and develop a representative and diverse membership. As a public benefit organisation we believe this type of membership will enable us to deliver better health care services that are more appropriate to a wide range of people.

Our aim is that Medway NHS Foundation Trust becomes an exemplar membership organisation and that our membership is truly reflective of our community in terms of gender, age, disability, sexuality, ethnic background and faith.

We acknowledge that the process of building an appropriate membership will take time, resource and commitment and that both the Trust and the Council of Governors have a responsibility to support, lead and develop this important area of work.

2. MEMBERSHIP

Membership of Medway NHS Foundation Trust comprises members of the Medway community and beyond, and Trust staff.

We believe that having a strong, active membership will mean that Medway NHS Foundation Trust will be better equipped to deliver services that are cognisant of the needs of people in Medway. This will be achieved by:

- Actively engaging with members and listening to what they have to say
- Consulting with members about important developments and changes
- Developing an effective Governing Council

Public membership is available for any individual member of the public aged 16 and over who lives in Medway, Swale or the rest of England and Wales. Members are invited to "opt in" by completing an written or electronic application form.

We are eager to involve our current and past patients and their carers and other members of our local community. We are also keen to involve those who live outside our community and who wish to become involved because they live within easy travelling distance, have some current or past connection with the Trust or may use health care services provided by the Trust.

Members are required to abide by the Trust's code of conduct and public service values. Members may be disqualified if:

- They have perpetrated a serious incident or violence in the past five years, towards any hospital or healthcare facilities or against any of the Trust's staff, Non Executive Directors, Council of Governors, in accordance with the relevant Trust's policy for withholding treatment from violent/aggressive behaviour
- They have been confirmed as a "persistant complainant" in accordance with the relevant Trust's policy
- Breached the Trust's code of conduct

Local Demographics
The demographics of the local population are set out below.

Medway and Swale have a younger population than average for England, but older people are now living longer and more independently. This means there will be an increasing demand for health and social care for older people and at the same time high demand for services for children and young people compared to other areas.

The population of Medway and Swale is predominantly white, being 89.64% and 96.55% respectively although ethnic minority communities are diverse and include several groups whose first language is not English.

The population of Medway is expected to reach 218,700[1] in 2017, with a growth forecast up to 237,800[1] expected by 2033. The population of Swale is expected to reach 113,100[1] in 2017 with a growth forecast up to 126,900[1] expected by 2033.

The Trust has calculated the population for Medway and Swale[1] to determine the percentage in each area. This percentage has then been set as the target percentage for the Trust's membership in Medway and Swale. The table also highlights the current membership total reached, converted to a percentage:

	Population	Percentage split of combined population	Membership as at 08/02/17	As %
Medway	218,700	68.7%	6902	78.73%
Swale	113,100	31.3%	1864	21.27%

Although the Trust's services are available to the whole of Swale, it is noted that not all Swale residents would automatically attend Medway Maritime Hospital or receive services that it provides in the community. There appears to be a natural geographical divide where residents were more likely to travel to Canterbury. It would be predominately people from Newington, Lower Halstow, Iwade, Sittingbourne and the Isle of Sheppey that would use Medway Hospital.

Staff Membership - Staff are eligible to become staff members if they have a permanent contract, a 12 month or longer fixed term contract, have an honorary contract or are employed by the Trust although they work with other NHS organisations locally. Staff will automatically become members unless they opt out.

Staff members may be disqualified on the same basis as public members. In addition a staff member may be asked to temporarily cease membership activities during any period of suspension under the Trust's code of conduct and associated staff policies and professional codes.

Corporate Membership
For other organisations such as local businesses who would like to be involved more closely with the Trust, it is likely that areas of fundraising, training and volunteering may provide appropriate opportunities to harness their interest. There is no opportunity within Foundation Trust status to offer corporate membership.

[1] Kent County Council Strategy Forecast (October 2014)

Membership Targets

The Trust set itself a target of recruiting 10,500 members within the first three years authorised as a Foundation Trust. This target was achieved in September 2011. The absolute minimum number of public members is defined in our constitution as 400.

	Membership Totals as at 10 March 2016	**Membership Totals as at 8 February 2017**
Medway	6779	6902
Swale	1841	1864
Rest of England & Wales	2272	2359
Public	10 892	11125
Staff		4411
Total		15,536

In order to ensure the public membership is representative of the population it serves, the information provided below detailed targets within each constituency based on gender, age and ethnicity, together with details of current membership percentages for those who disclosed the relevant information. The ethnicity targets are based on the 2011 Census data (27/3/2011) from the Office of National Statistics (ONS) © Crown Copyright. The gender and age targets are based on 2017 forecasted population data provided by Kent County Council Strategy Forecast (2014):

Medway Constituency

Gender	**Target**	**Current Membership As at 08/02/2017**
Male	49.38%	29.85%
Female	50.62%	67.90%
Unknown		2.25%
Age	**Target**	**Current Membership As at 08/02/2017**
16	1.56%	0.04%
17-21	7.89%	2.19%
22 – 30	90.51%	12.5%
31- 40		9.72%
41 - 50		10.56%
51 - 60		10.78%
61 - 70		11.45%
71 - 80		10.72%
81 – 90		5.45%
91+		0.78%
Unknown		25.81%
Ethnicity	**Target**	**Current Membership As at 08/02/2017**
White	89.64%	69.76%
Mixed	1.96%	0.99%
Asian or Asian British	5.16%	4.23%

Black or Black British	2.52%	3.33%
Other Ethnic Groups	0.72%	1.52%
Unknown		20.17%

Swale Constituency

Gender	**Target**	**Current Membership As at 08/02/2017**
Male	49.02%	33.48%
Female	50.98%	64.48%
Unknown		2.04%
Age	**Target**	**Current Membership As at 08/02/2017**
16	1.51%	0%
17-21	6.83%	1.07%
22 – 30	91.67%	6.44%
31- 40		9.44%
41 - 50		12.82%
51 - 60		11.75%
61 - 70		15.34%
71 - 80		15.02%
81 – 90		6.97%
91+		0.75%
Unknown		20.4%
Ethnicity	**Target**	**Current Membership As at 08/02/2017**
White	96.55%	70.07%
Mixed	1.16%	0.69%
Asian or Asian British	1.10%	1.13%
Black or Black British	1.03%	1.55%
Other Ethnic Groups	0.16%	13.9%
Unknown		12.66%

The details above highlight that further recruitment is required in various categories and the aim will be to improve the diversity of the public membrship over the next 12 months.

Whilst the Trust has not set a target for the Rest of England and Wales constituency, the membership figures are also analysed and recorded. The percentages listed below are based on the total public membership across all three public constituencies, where the relevant information has been disclosed:

Rest of England and Wales Constituency

Gender	**Current Membership As at 08/02/2017**
Male	29.2%
Female	61.09%
Unknown	9.71%
Age	**Current Membership As at 08/02/2017**
16	0%
17-21	2.88%
22 – 30	18.78%
31- 40	9.11%
41 - 50	9.11%
51 - 60	7.04%
61 - 70	6.49%
71 - 80	4.2%
81 – 90	1.44%
91+	0.2%
Unknown	40.75%
Ethnicity	**Current Membership As at 08/02/2017**
White	49.72%
Mixed	1.69%
Asian or Asian British	7.12%
Black or Black British	5.93%
Other Ethnic Groups	14.35%
Unknown	21.19%

The **Council of Governors** consists of 14 public (9 from Medway, 4 Swale, 1 rest of England and Wales), 5 staff and 6 partner governors. Staff representatives may be disqualified on the same basis as public members or have their membership temporarily suspended during any period of formal suspension under the Trust's code of conduct and associated staff policies and professional codes.

The 4 places on the Council of Governors for partner organisations comprise:

- Local Authority (represented by a member of the Medway Health and Wellbeing Board) x 1
- Local Authority (represented by a member of the Kent Health and Wellbeing Board) x 1
- Charities x 1 (seat currently represented by Medway Hospital League of Friends)
- Universities of Medway x 3

3. MEMBERSHIP RECRUITMENT

Our aim is to recruit a wide range of members, which represent the local community which the Trust serves. We do this by:

- Raising awareness of membership in all the qualifying communities within Medway and Swale
- Providing a simple, accessible and publicised process for becoming a member
- Ensuring that the composition of the membership reflects the diversity of the local communities
- Recognising and using members as a valuable resource
- Developing both external and internal publications to promote membership
- Targeting recruitment at specific groups or areas, for example, community groups, education institutions
- Displaying leaflets and application forms in areas of the hospital that have the greatest footfall
- High profile advertisement on site and on the Trust's internet
- Engaging staff and volunteers in recruiting public members
- Engaging health economy partner organisations
- Using local media to promote the campaign
- Developing the Trust's electronic interface with the public e.g. pop up reminders
- Holding membership recruitment drives by Governors in the Hospital foyer and across Swale.

The recruitment and engagement plan is attached as appendix A.

4. ENGAGING MEMBERS

We aim to focus on the quality and level of involvement of our members. We acknowledge that members will desire different levels of involvement, depending on their needs and reason they became members. It is important to ascertain at the outset what these levels of involvement are likely to be and to regularly check this is as members' circumstances change. Early information is collected via the membership application form.

The Trust also distributes a monthly newspaper called News@Medway which is available for people and members to pick up at from newsstands at various locations within Medway Hospital as well as at Medway Council Hubs. The newspaper is also available electronically on the Trust's website and members who have registerd to receive e-communications from the Trust receive notification of each News@Medway edition as well as a monthly e-bulletin from the Trust Chairman.

The Annual General Meeting provides an opportunity for members to meet governors (their representatives) and senior staff of the Trust. It provides a good opportunity for the Foundation Trust to market itself to increase membership.

Members' Meetings also take place at least eight times a year, the purpose of which is to inform, consult and engage with members.

The Trust issues a **membership card** on which key information about the Trust is provided. The intention here is to promote a sense of belonging. In addition, from time to time the Trust holds member **focus groups** on particular issues.

We have developed a members' section on the main website www.medway.nhs.uk via which members are able to make comments and ask questions.

5. MEMBERSHIP DEVELOPMENT

A detailed membership development strategy is outlined below:

- To increase the quality and level of participation in the Medway NHS Foundation Trust's democratic structures to enable the Trust to achieve its objectives and to ensure good governance.
- To increase the number of active, informed members who are representative of the local communities.
- To encourage more members to stand for election to the Medway NHS Foundation Trust Council of Governors.
- To adopt electoral processes which encourage the participation of all active members.
- To strive for the Medway NHS Foundation Trust Membership and Council of Governors to be diverse in their composition.
- To ensure the culture of membership is attractive to potential new generations of activists.
- To enable elected representatives to fulfil their designated roles and responsibilities and facilitate their participation in influencing decisions.
- To foster a partnership approach between members and management to encourage constructive working relationships and dialogue.
- To provide appropriate learning and development opportunities to members to facilitate their fulfilment of their roles and responsibilities.
- To provide appropriate learning and development opportunities to employees to further their understanding of the NHS Foundation Trust's values and principles as a public benefit corporation and membership organisation.

6. MANAGING THE MEMBERSHIP

The Trust has a responsibility to communicate with members. To this end the Trust and its Council of Governors will champion and promote membership as widely as possible. The Council of Governors will receive regular updates on the membership database from the Membership Engagement Group.

The work of the Membership Engagement Group is supported by the Trust'sCompany Secretary and Assistant to the Company Secretary, who acts as the membership secretary and their office is the main point of contact.

Resourcing the Membership Strategy

We need to adequately resource our membership function and to ensure that it is appropriately integrated with the organisation. This requires a commitment to providing membership services over the long term, developing them as required and supporting skills development. A budget of approximately £31,000 has been set for 2017/18 to cover the cost of membership management, member/governor communications and events, governor elections and governor training.

Evaluation

The Trust Secretary will provide a half yearly progress report on performance against this strategy to the Membership Engagement Group.

The Membership Engagement Group will provide an update on performance against this strategy to the Council of Governors on an annual basis.

Appendix A

Medway NHS Foundation Trust
Membership Recruitment and Engagement Plan

Aim	Action	Lead	Timescales

Increase membership, particularly in underrepresented categories	• Design and deliver at least 8 members' events per year in response to current issues, including the following topics:
	  ○ Quality Accounts; and
	  ○ Annual Plan
	• Explore venues which are consistent with underrepresented categories
	• Attend local college and university freshers' fairs
	• Invite staff leavers to become members
	• Invite membership via advert on the Trust's website
		Trust Secretary	Ongoing

Engage members in Medway NHS FT's annual plan and activities	• Produce and deliver monthly News@Medway via collection points and email • Produce and deliver regular e-bulletins • Provide information via the Trust's website • Engagement at the regular members' events • Promote participation in the annual Governor elections • Invite members to participate in in-house focus groups or committees, as appropriate.	Communications Team/Trust Secretary	Ongoing
Ensure that the Council of Governors' development needs are identified and addressed as part of an annual development plan	• Coordinate and facilitate an induction programme for new Governors •	Trust Secretary & Membership Engagement Group	Annual

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Quality Assurance Committee held on 20/04/2017

Report to:	**Trust Board**	**Date of meeting:**	**04/05/2017**	**1**
Presented by:	**Ewan Carmichael, Chair Quality Assurance Committee**	**Prepared by:**	**Ewan Carmichael Non-Executive Director**	

Matters for escalation	1. Medicines Management in respect of tracking gasses. 2. Acute & Continuing Care Directorate- medical staffing levels
Other matters considered by the group:	1. Review of the quarterly report from Acute & Continuing Care Directorate 2. Audit plans and action log 3. Quality Report & Quality Account Priorities 4. Medical Gasses report highlighting issues and further action plans. 5. CQUIN management 6. Corporate Quality risks of >12 7. Deteriorating patient- do not resuscitate documentation
Key decisions made/ actions identified:	1. Medicines Management to report update to Quality Improvement Group 2. Directorates will manage individual CQUINS which will be monitored and escalated to Quality Assurance Committee
Risks:	1. Medicines Management in respect of tracking gasses and drug temperature monitoring 2. Acute & Continuing Care Directorate - medical staffing levels 3. Complaints – starting to build up
Assurance:	Evidence was provided to assure high risk or priority areas continue to be monitored

Key Issues Report

Medway NHS
NHS Foundation Trust

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

Name and Job Title of Member	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Insert name and job title												
Ewan Carmichael, NED & Chair	✓											✓
Vivien Bouttell, Governor Representative	✓											✓
Lesley Dwyer, Chief Executive	x											x
Diana Hamilton-Fairley, Medical Director	✓											✓
Martin Nagler, Patient Representative	✓											✓
Karen Rule, Director of Nursing	✓											✓
Jan Stephens, NED	✓											✓

Best of care
Best of people

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Finance Committee held on 27/04/2017

Report to:	**Board of Directors**	**Date of meeting:**	**04/05/2017**
Presented by:	**Tony Moore Chair Finance Committee**	**Prepared by:**	**Tony Moore Chair Finance Committee**

1

Matters for escalation

1. The Finance Committee was pleased to receive a report which outlined a year-end financial performance which was
    a. better than our control total and our income and expenditure plan
    b. achieved our CIP target
    c. delivered our Capital plan and
    d. showed more cash in the bank than required.
2. The Finance Committee wish to congratulate Trust staff on this performance improvement especially during a year where the Trust also invested in improving the quality of our services to enable our exit from Special Measures
3. The Finance Committee also considered 2017-18 CIP planning and the requirement to reduce total pay costs as outlined by reducing our reliance on Agency staff
4. The Finance Committee also considered the contract work plan (this relates to those actions necessary to fully complete the 2017-19 contract) and any future implications for unfunded services

Other matters considered by the group:

1. Month 12 financial performance including Capital forecast
2. Year-end CIP performance
3. 2017-18 contract risks for CCG QIPPs and Trust Provider Intentions
4. Financial Recovery Plan development status and next step timescales
5. STP finance update
6. Business Cases
    a. ED – assurance received over ongoing project management

	7. 2017-19 Detailed budgets 8. Board Assurance Framework – all risks had been discussed during the meeting
Key decisions made/ actions identified:	1. Further simplified reporting for income and wte as part of the finance/workforce report from the new financial year. This particularly related to the price and volume variances in the wte chart in the finance report 2. A report would be presented to the June Finance Committee on our progress with Reference Costs/SLR/PLICs
Risks:	The Finance section of the Board Assurance Framework was considered. All risks apart were considered by the Committee under the agenda.
Assurance:	Assurance was provided on; 1. Financial reporting including CIPs, Capital and Cash management 2. 2017-19 Operational Plan refresh due diligence 3. Risk identification and risk management under the Board Assurance Framework 4. ED project governance

Key Issues Report

Medway NHS
NHS Foundation Trust

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