Agenda

NHS Medway NHS Foundation Trust

Trust Board Meeting in Public

Date: On Thursday 10 January 2019 at 12.30pm – 3.00pm

Location: Trust Boardroom, Postgraduate Centre, Medway NHS Foundation Trust

Item	Subject	Presenter	Page	Time	Action
1.	Patient Story	Director of Nursing	Verbal	1230	Note
2.	**Preliminary Matters**				
2.1	Chair's Welcome and Apologies	Chairman	Verbal	1250	Note
2.2	Quorum	Chairman	Verbal		Note
2.3	Register of Interests	Chairman	3		Note
3.	**Minutes of the previous meeting and matters arising**				
3.1	Minutes of the previous meeting held on 1 November 2018	Chairman	7	1255	Approve
3.2	Matters arising and actions from last meeting	Chairman	16		Discuss
4.	**Standing Reports and Updates**				
4.1	Chair's Report	Chairman	Verbal	1300	Note
4.2	Chief Executive's Report	Chief Executive	17		Note
4.3	Strategy a) Sustainability and Transformation Plan Update b) Transformation Programme Update	Director of Strategy Associate Director of Transformation/ Chief Operating Officers	Verbal 23		Discuss Discuss
5.	**Quality**				
5.1	Integrated Quality and Performance Report	Director of Nursing/ Medical Director/ Chief Operating Officers	59	1330	Discuss
6.	**Performance**				
6.1	Finance Report - Month 8	Director of Finance (Interim)	95	1355	Discuss
6.2	Board Assurance Framework	Company Secretary	99		Approval
6.3	Communications Report	Director of Communications	113		Discuss
7.	**People**				
7.1	Workforce Report	Director of HR/ OD	119	1425	Assurance

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8.	**Reports from Board Committees**				
8.1	Quality Assurance Committee Report	Quality Assurance Committee Chair	129	1435	Assurance
8.2	Finance Committee Report	Finance Committee Chair	133		Assurance
8.3	Integrated Audit Committee Report	Integrated Audit Committee Chair	135		Assurance
9.	**For Noting**				
9.1	Council of Governors Update	Governor Representative	Verbal	1445	Discuss
9.2	Any other business	Chairman	Verbal		Note
9.3	Questions from members of the public	Chairman	Verbal		Discuss
10.	**Date and time of next meeting: 7 March 2019, 12.30pm-3.30pm, Trust Boardroom**				

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MEDWAY NHS FOUNDATION TRUST

TRUST BOARD REGISTER OF INTERESTS

Name	Position	Organisation	Nature of Interest
Stephen Clark	**Chairman**	Marshalls Charity	Chairman
		3H Fund Charity	Chairman
		Nutmeg Savings and Investments	Non-Executive Director
		Henley Business School	Member Strategy Board
		Access Bank UK Limited	Non-Executive Director
		Brook Street Equity Partner LLP	Chairman Advisory Council
		Medway NHS Foundation Trust	Chairman
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Jon Billings	**Non-Executive Director**	Fenestra Consulting Limited	Director
		Healthskills Limited	Associate
		FMLM Solutions	Associate
		Medway NHS Foundation Trust	Chair Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Name	Position	Organisation	Nature of Interest
Ewan Carmichael	**Non-Executive Director**	Timepathfinders Ltd	
		Medway NHS Foundation Trust	Chair of Charitable Funds Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Anthony Moore	**Non-Executive Director**	Medway NHS Foundation Trust	Chair of Finance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Mark Spragg	**Non-Executive Director**	Marcela Trust	Trustee
		Sisi & Savita Charitable Trust	Trustee
		Mark Spragg Limited	Director
		Medway NHS Foundation Trust	Chair Integrated Audit Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Adrian Ward	**Non-Executive Director**	Bella Moss Foundation	Trustee
		Veterinary Sciences Limited	Director of Award
		National Midwifery Council	Chair Fitness to Practice Panel
		RCVS Preliminary Investigation Committee	Member
		BSAVA Scientific Committee	Member
		Medway NHS Foundation Trust	Member of the Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Name	Position	Organisation	Nature of Interest
Joanne Palmer	**Non-Executive Director**	Lloyds Gresham Nominee1 Limited	Director
		Lloyds Gresham Nominee2 Limited	Director
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
James Devine	**Chief Executive Officer**	London Board for the Healthcare People Management Association	Member
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Ian O'Connor	**Director of Finance (Interim)**	OCOBROWN Health Ltd.	Director
		Essex Partnership Trust	Spouse is a Senior Manager
Karen Rule	**Director of Nursing**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
David Sulch	**Medical Director**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Morfydd Williams	**Director of IT Transformation**	ZebraDot Logistics (Freight and Transport)	Director

Meeting in Public

NHS Medway NHS Foundation Trust

Board of Directors Meeting in Public on 01/11/2018 held at Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Ms L Dwyer	Chief Executive	LD
	Mr J Billings	Non-Executive Director	JB
	Mr R Boyce	Director of Finance and Business Services	RB
	Mr E Carmichael	Non-Executive Director	EC
	Mr J Devine	Deputy Chief Executive and Executive Director of HR & OD	JD
	Dr D Hamilton-Fairley	Director of Strategy	DHF
	Mr T Moore	Non-Executive Director	TM
	Mrs J Palmer	Non-Executive Director (from item 10)	JP
	Mrs K Rule	Director of Nursing	KR
	Mr M Spragg	Non-Executive Director	MS
	Dr D Sulch	Acting Medical Director	DS
	Mr A Ward	Non-Executive Director	AW
Attendees:	Ms G Alexander	Director of Communications	GA
	Mrs S Anderson	Interim Trust Secretary (Minute Taker)	SA
	Mr N Gerrard	Transition Lead	NG
	Mrs S Gorman	Clinical Co-Director (Item 1 only)	SG
	Mr A Harding	Lead Governor	AH
	Mr L Hinton	Director of Operational HR & OD	LH
	Mrs J Johnson	Patient Story (Item 1 only)	JJ
	Ms D King	Governor Board Representative	DK
	Mr J Lowell	Director of Planning and Partnerships	JL
	Mr G Lupton	Director of Estates & Facilities	GL
	Ms G Mahil	Director of Clinical Operations	GM
	Mr H McEnroe	Director of Clinical Operations	HM
	Mrs F Taylor	Patient Story (Item 1 only)	FT
Observers:	Seven members of the Governors, public or press		

1. Patient Story

1.1 SC and KR welcomed FT and JJ along with SG to the meeting. SC noted that the family has had an apology and do not want anyone else to have their experience. He thanked FT and JJ for being brave enough to come in and talk to the Board. SC stated that anything that goes wrong with care is the responsibility of management who need to ensure that every person is well-cared for and helped as every day is special. SC apologized on behalf of the Trust and noted that the Trust should be working for the people of Medway and Swale.

1.2 FT and JJ gave a detailed presentation on their mother's experience at the Trust, specifically highlighting that the family, who were the carers, had not been consulted with regard to her discharge.

1.3 JB asked what the Trust has done to consider the views of the family/carers when discussing discharge with patients. LD thanked the family for coming in and noted the pre-learning and changes that have been put in place following their experience and that these will be followed in the coming busy times. No one should have that experience and this should not happen to anyone else.

1.4 DS observed that not all doctors consult with or listen to the family, who are better placed to recognize subtle signs of change in a patient. Medicine has become very scientific and younger doctors should be encouraged to think and observe patients holistically. Regular patients should be admitted to specialist wards and not through A&E.

1.5 KR noted that it is key that the Trust learns from issues and identifies what it can do better. She reported an exercise that had occurred the previous day where the Trust was able to identify improvements and transformation work.

1.6 The Board passed on their thanks to FT and JJ for their detailed presentation.

2. Welcome and Apologies for Absence

2.1 The Chairman welcomed everyone to the meeting.

2.2 There were no apologies for absence to be noted.

3. Quorum

3.1 The meeting was declared quorate.

4. Register of Interests

4.1 The Register of Interests was noted.

5. Minutes of the Previous Meeting

5.1 The minutes of the previous public meeting were **APPROVED** as a true and accurate record of the matters discussed.

5.2 KR gave an update on dementia as per minute 1.7. Noted that there is a screening process in place to identify patients with dementia and provide specialized support required. Butterfly Representatives are on the wards and work with staff and patients to identify patients with dementia who need additional support. Also work with dementia buddies to identify which area needs most support. The Trust has implemented dementia training for all doctors when they rotate in ED. The Trust is regularly auditing the passport which should stay with patients and work with families when discussing care.

The Trust supports carers of dementia patients and is working in the community with these people.

6. Matters Arising and Action Log

6.1 The Board of Directors **RECEIVED** the Action Log and noted all actions on the action log had been closed.

7. Chair's Report

7.1 SC highlighted that the Board meetings like to start with a patient story and his concern when things do go wrong that the Trust needs to learn from this. However, he was concerned at the number of negative care stories coming to Board. KR noted that the learning is important and implemented from all bad experiences.

7.2 SC reported on the Annual Members Meeting (AMM) and the change in Lead Governor and gave his thanks to Stella Dick for her contribution as the Lead Governor.

7.3 SC referred to the Transformation Plans to improve the Hospital and reminded Board members and the public to have their flu jabs. He noted that the winter resilience plan has been developed and the Trust is as best prepared as it can be.

7.4 Many of the improvements at the Trust have come about under LD's leadership. SC thanked and wished her well. She is leaving the Trust in good hands and has built a strong executive team which should survive the test of time and continue as her legacy. LD was presented with some flowers.

8. Chief Executive's Report

8.1 LD noted the continuing to work to deliver transformation plans at pace. The Sapphire Acute Frailty Unit has been launched and the Trust is now able to place patients in the right place, which brings benefits for their health.

8.2 Noted the Lord Carter of Coles visit and his feedback. Reported on the 'You are the Difference' work, which is to be rolled out beyond the senior managers and Board. The Trust will get stronger and staff are adamant that the organisation will not slip backwards.

8.3 LD highlighted the Excellence in Teaching Awards from Kings College and the Diabetes Healthcare Professionals of the Year at the Quality in Care Diabetes Awards, which have been won by members of the Trust staff. She referred to the keenness of the organisation to learn. LD noted the change in job title to Chief Operating Officer for the two Directors of Clinical Operations and the new appointments.

8.4 LD noted that the Hospital is reducing smoking in pregnancy. She highlighted the Medilead programme with doctors visiting non-clinical areas and learning other roles.

8.5 LD noted that the North Kent Pathology Service (NKPS) has experienced some issues and concerns. She noted the change in practice and review that has been commissioned to ensure that health and safety of patients can remain the Trust's primary concern.

8.6 Saving the best to last, LD noted that the role of Chief Executive at Medway is a great job and that she would like to place this on record to the unitary board,

which has had to show commitment and determination. She is proud of where the Trust has come to and what it can be. No-one sits back and all learn and move forward.

8.7 As part of her transition LD handed over the position of Chief Executive at the Board meeting to JD.

8.8 The Board and public applauded LD and JD.

9. Strategy

9a) Sustainability and Transformation Partnership (STP) Update

9.1 LD updated the Board on the hyper acute stroke unit review and noted the disappointment that the Trust was not selected but that it is supportive of the proposal which will ensure the best care for patients. The Trust is working with MPs and other stakeholders to ensure joined up services for the people covered by the STP.

9.2 The Trust has been asked to nominate a NED to work with the STP and will keep Board informed. JB welcomes the move to involve NEDs across the system as this has been a gap in governance for the STP.

9b) Transformation Programme

9.3 JD noted that the report summarises two or three points that the transformation team is working on. Often the focus is on cost improvement but should also be improving the efficiency of how and where care is delivered. JD noted the links to the Strategy Unit led by DHF.

9.4 The Trust is ahead of plan but has much more to do on cost improvement and efficiency. He noted that flow and length of stay are key but that it is sometimes appropriate for patients to be here longer than average and that the Trust must do what best for patients.

9.5 JD noted that the variance between good and bad days in performance is lower and that the recovery is faster. The Trust is preparing for a better winter and has learnt lessons from last year as well as working with the A&E Delivery Board across the system. He is meeting with senior managers to refresh and remind them of processes.

9.6 The culture programme has had good numbers and created a positive vibe across the Trust. The metric slides in the report contain more detail to provide the Board with assurance and enable the Board to focus on projects

9.7 SC noted that the transformation programme is the most critical project that the Trust has undertaken in the last few years. It will refocus the Trust for the population, but this needs to be done in the context of the system too. The Trust is working with clinicians, not management consultants, as all believe in making Medway a better place for the community.

10. Quality

10a) IQPR

10.1 KR reflected that culture programme is absolutely critical to the success of the Trust and reiterated the commitment of the executives.

10.2 KR highlighted that mortality is being addressed separately along with workforce.

10.3 JP entered the meeting

10.4 KR noted that take up of the flu jab is going well and that the Trust has more to do to get to the 100% uptake target.

10.5 Safe staffing is still an area for concern but is performing better than last year and compares to the Model Hospital model as well as coming down to national benchmark levels. The temporary staffing metric is reporting significantly below the last two years and reflects the reviews undertaken and adjustments made. New assessment tools are enabling a more robust and focussed consideration.

10.6 From the directorate viewpoint, GM highlighted some performance data and HM noted that the transformation is the most robust plan he has seen with clear objectives.

10.7 JB raised a concern around the language and wondered how the Trust manages performance and links to quality and patient experience. He asked about staffing and who runs the daily huddles and how the outcome is recorded. KR explained the process, which occurs in directorates at handover each morning where they consider the staff and their need to flex, a site meeting and both directorates review the Trust-wide position and use a web based tool to inform decision making, review at end of day and have good handover for the site team.

10.8 SC noted the overwhelming amount of data and the need for the Board to trust the analysis when looking at front line assurance.

10b) Corporate Policy – Complaints Management

10.9 KR highlighted that this is one of the policies that comes to Board for review and approval. The Trust recently had an internal audit of complaints and has strengthened the policy and been more specific of the agencies it works with. The revision also included adding guidance on electronic communications and how the Trust manages complaints that are also recorded as serious incidents.

10.10 SC asked who owns the policy, and KR noted in was herself. There is a small central team that receipts and manages the complaints which are forwarded to the directorates – if both directorates are involved they will agree who will lead. The Chief Operating Officers have delegated authority to investigate and resolve complaints.

10.11 TM asked whether this policy makes it easy for a carer of a patient with a problem to find out information. KR noted that the policy aim is to resolve all concerns locally and where they are raised, so believes so.

10.12 RB asked whether the Trust knows that there is a serious incident before the complaint is raised. KR noted that the Head of Legal Services looks at all incidents and ensures the appropriate classification.

10.13 The Board **APPROVED** the Complaints Management Policy.

10c) Q1 Mortality and Morbidity Report

10.14 DS highlighted the action to consider changing the coding process which is making the Trust look like an outlier. He explained the annual audits on mortality and review of Dr Foster system. He noted that there will be an independent internal audit of the process by KPMG.

10.15 DS set out the Medical Examiner model of review for mortality which is to discuss issues with coroners at a meeting. The medical examiner should be independent of the organisation. This structure can be implemented relatively quickly and could be embedded by April 19.

10.16 IC queried why the learning from deaths dashboard and SELs on the table did not match up. DS suspected that this was due to a miscalculation.

10.17 JB queried the engagement with outside organisations on external reviews. DS said it appears to be a coding related issue and will review.

10.18 JD said that CQC noted our view on the imbalance on coding across areas. This is evidence that the Trust is getting to the detail. EC noted that patients who pass through the hospital to a hospice are counted against the hospital statistics due to the date of discharge. NHSI are working with the Trust on the coding of palliative care.

10.19 TM noted that one could consider the HSMR data and think that the Trust is an organisation in denial and justifying all OK. He requested that the index is reported along with the way that the coding works and relevance to patients. His second observation is that pneumonia is getting worse and asked if the relative risk of people dying at Medway is higher than other hospitals. DS responded that it seems to be and is considering the reasons and ensuring that the data is consistent. DS noted the general anxiety of the Board and is accelerating all he can do to give confidence.

10.20 Board requested an update at the next Board.

ACTION: Update on Mortality and Morbidity at the January Board meeting.

11. Performance

11a) Finance Report

11.1 RB noted that the Month 6 position is ahead of plan and the second half of the year is a big step with targets more difficult to achieve.

11.2 Noted that have plans in place and lot of cash as the Trust takes a long time to pay creditors. The deficit needs funding and the Trust needs to make sure that it is spending on the right things and deliver the control total. The Turnaround Team are not just looking at this year.

11.3 SC noted that there is no complacency on the scale of what needs to be done. The position has been scrutinised by Finance Committee.

11.4 JD noted the importance of managers managing their budgets and that turnaround and achieving financial targets is not the job of Finance. The Trust can support people who need development to manage budgets and enable them to be efficient through clinical strategy and transformation work.

11.5 SC noted the will to change is key to the success of the transformation team.

11b) Board Assurance Framework

11.6 SA presented the BAF and said that it needs a thorough review by the Board at the next Board Development Day. LD highlighted that the Execs do consider this on a regular basis.

11c) Corporate Policy – Information Governance

11.7 LH presented the policy and highlighted the changes and that it includes access to Data Security and Protection and assurance from NHS Digital.

11.8 SC noted that this is an update to an existing policy that has been place in for some time.

11.9 The Board **APPROVED** the Information Governance Policy.

11d) Communications Report

11.10 GA highlighted the current communications with staff and patients in the Frailty Unit as we approach winter. There have been some communications on flow and these have been discussed in detail with staff on the Exec walkabout – this will be shared with patients and the public.

11.11 There are a lot of posters and stories to highlight the importance of getting a flu jab.

11.12 GA noted the success of the 'You are the Difference' programme and that the Trust will make the pledges and commitments public to maintain positive commitment.

11.13 The Teddy Bear Hospital has been launched and is helping to reduce the fear of hospital for children

11.14 The Diabetes Team has been named Diabetes Healthcare Professionals of the Year at the Quality in Care Diabetes Awards.

11.15 The Trust responds to media on specific negative stories and the key ones at the moment are pathology and the dermatology service.

11.16 Governor engagement is ongoing with meetings for constituents in a few locations and a member event focused on quality improvements in nursing and midwifery.

11.17 The Trust is continuing with the programme to meet with harder to reach people in our area.

12. People

12a) Workforce Report

12.1 LH asked the members and attendees to take the report as read.

12.2 LH highlighted international and national recruitment for nursing, and new consultant starters and doctors on rotation from the Deanery.

12.3 Flu vaccinations are ahead of where need to be to achieve 100% target. NHSI best management self-assessment checklist has been reviewed and the Trust is confident it is performing well.

12.4 EAP issued last month and is an opportunity for employees to be supported.

12.5 JB asked about the NHSI checklist and LH confirmed this is only in relation to the flu campaign.

12.6 NHSI has been running a collaborative for the retention of nursing. The Trust has been accepted on this and will be able to better understand whether recruitment is replacing staff or achieving a higher staff base.

12b) Corporate Policy – HR and Organisational Development

12.7 LH highlighted that the policy has been updated for issues such as Modern Slavery.

12.8 The Board **APPROVED** the HR and Organisational Development Policy.

13. Quality Assurance Committee Report

13.1 JB referred to the fact that many items covered by the Committee have already been covered in the agenda of this meeting.

13.2 There were no questions.

14. Finance Committee Report

14.1 TM highlighted the challenge to generate real cash savings to the bottom line, which is a big ask. The cost recovery plan has been reviewed by the finance and transformation teams. There is a renewed ownership attitude with all feeling it is the right thing to do. The Board asked for more detail about cost improvement and TM noted that some is from an ongoing basis, not one offs. The Trust needs recurrent savings, not just in-year savings. The Trust needs to review and reaffirm its commitment to the financial plan by December. This may require virtual consultation with Board. The plan will reflect all activity and costs forward to next year.

14.2 SC highlighted the confidence level coming from the ground and difference between in-year and ongoing cost savings and the need to split out what can control and deliver compared with issues outwith the Trust's control. Cultural side is important for transformation. It is good that finances are over performing on the first six months of savings. Need to keep regulators informed and they seem to be more supportive than in other years. TM not spending too much time on revenue line as paid on basis of block contract therefore energy can focus on what the Trust is spending.

14.3 JL noted that the Trust has already started 2019/20 business planning and met with clinical directors to determine what objectives might look like. SC asked whether making progress in integrated care and DHF said that successful workshops had occurred and partners are engaged. DHF and JL working with contracts and seeking to maximise revenue and this work is feeding into contract talks. LD noted good position from the base that we have built and moving forward.

14.4 JB asked about skills to model predictions. JD said this is an area that is improving. The CCG often raise issues as the Trust is in a shadow contract because of the block contract. There is currently better understanding and the Trust is not just reporting data as there are links between the front line and contracting team. The modelling is considering how to understand data and how this is derived/validated.

14.5 JL commended the data assurance framework and data available to service this along with the better working to understand issues. Moved to one data warehouse. SC stated that the big thing has been to engage clinical directors to get things right.

15. Council of Governors' Update

15.1 DK thanked LD for the time that she has been here and taken the Trust into a position of trust from the public perspective. LD was wished well.

15.2 SC was reminded of the need to resume four weekly meetings with governors to keep them up to date.

16. Any Other Business

16.1 There was no other business.

17. Questions from members of the public

17.1 Question about what the Trust is doing about Brexit and the surrounding risk. LH responded on the Trust's Brexit planning, which includes workforce, reciprocal healthcare, medicines, research and innovation. The Trust is looking upwards for support from NHS Providers and also working with partners where it can.

17.2 There were no further questions from the public.

17.3 SC mentioned the Christmas Market and Lights on 7 December and that on 20 November the new ED will be opened.

17.4 SC provided his thanks to all those in attendance and closed the meeting.

The next Public Board will be held on Thursday 10th January 2019 at 12.30pm.
Venue: Boardroom, Post Graduate Centre, Medway NHS Foundation Trust.

The meeting closed at 3.11pm.

Stephen Clark: Date:
Chair

Meeting Actions Log

NHS Medway NHS Foundation Trust

Public Trust Board **Date: 10/01/2019**

Action Log Number	Agenda Item Description	Action Due Date	Outcome	Owner	Status
0402	Update on Mortality and Morbidity to be brought to the public Board meeting in January	10/01/2019	Update to be provided	Medical Director	

Agenda Item: 4.2

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Chief Executive's Report – January 2019

This report provides the Trust Board with an overview of matters 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.

In and around Medway

I am very proud to have taken over from Lesley Dwyer as Chief Executive in November 2018 and I look forward to working with our community, staff and stakeholders to continue to build on our recent achievements.

2018 was on the whole, a positive year for the hospital, and we saw teams and individuals recognised locally and nationally for achievements. Our operational performance is improving and we have stronger grip and control on our finances; that said, we recognise that we are still too inefficient in some areas and this again must be a focus over the next 12 months.

I have been clear with our staff across the hospital in saying that quality of care must remain our number one priority, and despite our operational and financial challenges, we will not compromise quality. There is more to do as we look to take the next step in our 'Better, Best, Brilliant' improvement journey but whilst there are many challenges ahead of us, there are many opportunities too.

We have worked well as a health and social care system this year to have good protocols and escalation processes in place, and as I write this note, I know that many of our staff are working incredibly hard over the Christmas and New Year period as we see an increased number of patients, and an increased acuity across the hospital.

As we start 2019, we must maintain momentum and take our hospital to the next level.

I believe the future is bright for Medway and I am delighted to lead this fantastic organisation on our continued pursuit of brilliance.

Transformation

Work to deliver the improvements we need to become efficient and effective continues at pace.

The programme on safe and appropriate discharge continues, with a focus on elderly care wards initially. We have seen a reduction in our overall length of stay, but sustaining this will be the critical success factor. The safe and appropriate discharge also includes flow through the front door (emergency department), which again we are seeing some improvement in both ambulance handover times, and rapid assessment. Whilst the new emergency

department will go some way to helping flow, it is phases 2 and 3 of the build that will really support us providing high quality care, in a high quality environment, and subsequently a sustained improvement in the 4 hour access standard.

Our cost improvement programme is progressing well this year. Over 130 schemes are being worked through as we strive to achieve the directed target of £21m for 2018/19. We have also commenced plans for 2019/20.

It is encouraging to see transformation in action around the Trust, with improvement projects underway to create a better experience for our patients and make us more efficient. Huddles are now taking place in a number of teams several times a week to involve staff in identifying where improvements are needed to enhance the quality of care while making our services more sustainable. We are also better utilising those staff who have undertaken white belt and yellow belt training in some of the key transformation programmes.

The Trust has also launched the '*We're Making Medway Brilliant'* campaign; this features our staff showcasing the work they have done to make improvements in their areas.

Culture programme

The '*You Are The Difference'* culture programme, in which the Trust is looking to address and redefine the culture at Medway, has continued with great success.

Since the launch in October 2018, senior manager sessions have taken place with more than 400 managers attending. The feedback has been extremely positive, with managers making their commitment to working to improve the culture within the Trust. In addition, more than 700 staff have attended sessions. You Are The Difference gets to the heart of staff being 'the best of people'. In delivering the best of care to our patients, they really are the difference.

All attendees are asked to sign a pledge to 'being the difference', and these are being placed around the hospital.

Developing our clinical strategy

I am pleased to say that we have commenced the work on our clinical strategy – setting out a clear direction for Medway. At the same time, we are bringing together other key strategies which really look to provide a clear vision for our staff; alongside the clinical strategy, these include the (1) system financial recovery plan, (2) the quality strategy and (3) the workforce strategy.

We have also set out the enablers which underpin the delivery. These are; (1) continuous improvement, (2) transformation programme, (3) You Are The Difference culture programme, (4) integrated partnerships, (5) digital transformation, and (6) estates plan.

It is hoped that this by bringing this together, we can set out a five year vision for Medway.

Within five years we want to:

- Be designated as a specialist emergency centre with associated designated specialties and one of the specialist women's and children's centres for Kent and Medway.
- Become a university hospital, delivering first class education and research.
- Routinely exceed national standards and access targets.

- Work with our partners to ensure that the hospital site is used optimally to provide services that meet the needs of the local people many of whom are among the most deprived in Kent.

Crucially, we will also be financially sustainable, going beyond financial balance so that we can reinvest to provide even better patient care.

The clinical strategy was presented to senior managers and staff for the first time in December and we are now seeking feedback.

Health Secretary praises improvements at the Trust

We were delighted to welcome Secretary of State for Health and Social Care, Matt Hancock MP to the Trust in November. He toured our new Emergency Department, Maternity Unit and Pre-habilitaion Unit, and met with staff.

It was a really positive acknowledgment of the hard work of our staff, and also of the way we are now working across the system in Medway and Swale – with the ambulance service, community services, social care, primary care and mental health provider, as well as local health commissioners

UNICEF awards baby-friendly status

Our maternity unit has been awarded the prestigious Baby Friendly Award, achieving international recognition from UNICEF. The Baby Friendly initiative was set up by UNICEF and the World Health Organisation to improve the care provided for all mothers and babies. By achieving this award, our maternity unit has demonstrated that we offer the highest level of care and support for mothers in forming strong and loving relationships with their babies and this is fantastic news for the mothers of Medway and Swale.

We are now an accredited Institute of Leadership and Management training centre

The Institute of Leadership and Management (ILM) is the UK's leading provider of leadership, coaching and management qualifications and training and I am delighted that we have been successful in our application to become an approved centre to deliver ILM-accredited courses and qualifications. Being an approved centre means that we can now provide training and leadership courses that lead to nationally recognised qualifications.

Strengthening ties with Canterbury Christ Church University

We were proud to sign a document that reaffirms our working relationship with the university. We already enjoy a close relationship, and the signing of this document establishes our partnership and commitment to working together to promote general and higher education.

We share a common interest in the development of research, scholarship, learning and teaching and we are excited where this special relationship is leading us, as we look forward to the medical school, and pursue our ambition to become a university teaching hospital.

Radiology ISAS Accreditation

Our radiology service was recently re-inspected by ISAS (Imaging Services Accreditation Scheme Accreditation) and passed with flying colours. They will now automatically transition

to the revised ISAS standards that are being implemented. This is no mean feat and identifies us as providing a high quality, efficient and effective service for patients.

Reinstatement of pharmacy training posts

Following a visit from Health Education England last year, our pre-registration pharmacists were reallocated to another training site with the posts being withdrawn with immediate effect. This was very disappointing news for the Trust.

I'm delighted to say that after a follow-up visit, Health Education England has reinstated our training posts, with an intake of new pre-registration trainees planned for August 2019.

The visiting panel witnessed numerous examples of how the Trust and the pharmacy leadership team had made a significant improvement to the culture, the educational infrastructure and governance within the department, providing confidence and assurance that future trainees could expect a great training experience in Medway. The team also heard from all of the current junior pharmacists who were able to describe the improvement journey.

Christmas celebrations

The Trust really got into the Christmas spirit with a number of festive activities. The inaugural Christmas Fair was a brilliant success – bringing the community together and raising £1,500 for the Trust's charity. We were delighted to welcome the Mayor to switch on our Christmas lights as well as carol singers from local schools.

Staff also took part in the Medway Christmas Decoration Challenge, bringing some colour and cheer to the site. Finally, we held a very special Christmas carol concert to thank our volunteers for their ongoing support.

Beyond Medway

Review into overprescribing

A national review into overprescribing has been announced, to be led by Chief Pharmaceutical Officer Dr Keith Ridge.

Estimated total NHS spending on medicines in England has grown from £13 billion in 2010 to 2011 to £18.2 billion in 2017 to 2018. This is an average growth of around five per cent a year – with 1.1 billion prescription items dispensed in primary care by GPs and pharmacists. Health Survey England 2016 found that nearly half of over 75-year-olds surveyed were taking five or more medicines, with this percentage rising the older people get.

English language tests

The Nursing and Midwifery Council (NMC) has accepted proposed changes to the requirements for overseas nurses and midwives taking the International English Language Test System (IELTS).

There will still be a requirement of an overall 7 for international registration, however from December 2018, the NMC began to accept level 6.5 in writing, alongside a level 7 in reading, listening and speaking.

Candidates with IELTS results less than two years old that meet the new requirements will be considered by the regulator.

The NMC has said that the change is in line with its commitment to better, safer care and will ensure that only nurses and midwives with the right skills, knowledge and command of English are able to register to work in the UK.

SECAmb chief executive

The chief executive of South East Coast Ambulance Service NHS Trust (SECAmb) Darren Mochrie has announced that he is to leave the organisation in the spring to take up a new role in the north west. A recruitment process is underway to appoint his successor.

Patient Safety Directors

All NHS trusts will be expected to appoint patient safety directors working at a senior level within a new national structure, it has been announced.

The new national patient safety director, Aidan Fowler, has set out his emerging vision for patient safety policy in the NHS, which will sit alongside the NHS long-term plan, but will not be finalised until March 2019, after a consultation with the NHS. Among his proposals is for NHS Improvement to become “more directive” over the 15 English patient safety collaboratives to deliver national programmes for improvement. Each of the new NHS regions will also have a safety structure under the national patient safety team.

CCG budget cuts

Clinical commissioning groups are to have their administration budgets cut by 20 per cent in the coming year.

A letter sent to all CCGs from NHS England said the CCGs must make the full recurrent savings by 2020-21. The letter added each CCG will have “administration limits” placed on it for the next financial year, with new ”resource allocations” for each one issued next month.

- End

Report to the Board of Directors

Board Date: Thursday, 10 January 2019 Agenda Item: 4.3(b)

Title of Report	**Transformation Programme update**
Prepared By:	Jack Tabner, Associate Director of Transformation
Lead Director	James Devine, Chief Executive
Committees or Groups who have considered this report	Transformation Assurance Group, 18 December 2018
Executive Summary	Transformation is gathering pace around the Trust. Many Better, Best, Brilliant projects underway and delivering improvements. New posters and other communication materials to be rolled out to raise awareness and celebrate achievements. This set of papers includes updates on the following 4 improvement programmes: **1. Cost Improvement Programme** • As at Month 8 (November), £12.1m has been delivered in Cost Improvement Plans Year to Date (YTD). This is £1.5m favourable to the phased plan of £10.6m at this point in the Financial Year. • Of this £12.1m, £6.6m is recurrent savings (54%) and £5.5m is non-recurrent (46%). • Further work is ongoing to identify non-recurrent savings which can be reflected in budgets for subsequent years. • The confirm and challenge rhythm of Programme-level assurance meetings continues, to be supplemented by Star Chambers in Months 9-12 to assure delivery right up to the end of the financial year. • As at Month 8, we are forecasting total 18/19 CIP delivery ranging from £18.2m (base case) to £20.8m (upside). This represents a decrease from the Month 7 forecast, ranging from £18.5m-£21.5m, due to slippage in a small number of schemes. • During the last month, significant progress has been made to scope the Cost Improvement Programme for FY2019/20. This includes the development of an efficiency strategy: Best in Class. **2. Clinical Strategy & Portfolio of Services Review** • A Trust clinical strategy has been developed and

communicated with all staff setting out our ambition to become a designated specialist emergency centre, as defined by the Keogh Review.

- Against this backdrop, the work of the Portfolio of Services Review working group continues, conducting deep dive data reviews of services in waves, identifying both services not compatible with the strategy as well as services we wish to grow and develop into tertiary services.
- This forms a rolling work programme as services are identified through the Spring and notice served collaboratively to commissioners.
- Contractual notice has been served to our commissioner on first tranche of services and demobilisation and/or re-design work is in train in collaboration with system partners.

3. Best Flow Programme, including Frailty

- The Best Flow Programme of work on flow enters its next phase, with a refreshed set of workstreams, leads, objectives/KPIs and under a new Oversight Group.
- As part of the Best Flow Programme, a new set of site processes have been introduced to better manage the aggregate bed balance of the hospital and improve the ways of working between the wards and the Site Operational Centre.
- This work aligns to the Full Capacity Protocol which has been approved and now provides staff with clear directions as to how to respond to the OPEL status of the site.
- A further MADE event was held on 18 and 20 December focusing on complex patients with the aim of discharging them safely home before Christmas – this was under the No Place like Home communications campaign.
- The Sapphire Acute Frailty Unit was formally opened by Dr Matt Thomas, Consultant Geriatrician from Poole Hospital, as part of the ongoing development of the frailty pathway at MFT. The frailty team have ambitious plans to create a centre of excellence for frailty at Medway within a “village” model whereby patients are cohorted based on complexity and acuity.

4. Culture Programme – You Are the Difference

- The Trust’s YATD culture programme continues, as the staff sessions and Manager follow up sessions are completed.
- This work moves into its next phase of work which will include the following:

Report to the Board of Directors

	○ Include YATD in Trust induction and medical induction ○ Develop and agree a culture strategy for the Trust ○ Create a culture programme board ○ Formally launch Ambassador
Resource Implications	N/A
Risk and Assurance	Detailed review of the Transformation Programme and the monitoring of risks/issues takes place within the Transformation Assurance Group which last met on 18 December.
Legal Implications/Regulatory Requirements	Non-delivery of the financial control total could result in the Trust being placed in a financial special measures regime.
Improvement Plan Implication	The Transformation programme is a critical enabler of the Trust's improvement and system recovery.
Quality Impact Assessment	Improvement projects are all subject to Quality and Impact Assessments.
Recommendation	To note the contents of this report
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

Agenda Item: 4.3(b)

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Transformation programme update 10th January, Trust Board

James Devine
Chief Executive

Jack Tabner
Associate Director of Transformation

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Best of people

Transformation in progress

NHS Medway NHS Foundation Trust

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Transformation programme
10th January, Trust Board report

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Month 8 CIP report and Model Hospital

Clinical strategy & Portfolio of Services Review

Best Flow Programme

Culture programme – You Are the Difference

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Cost Improvement Programme at Month 8

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Month 8 Position

Year to date position

£12.1m

£1.5m favourable to plan

Up from £10.4m in M7

18/19 CIP Forecast

Year end CIP forecast, based on YTD delivery and forecast delivery of existing schemes

Upside forecast

£20.8 m

£18.2m

Base Case Scenario

We are identifying more schemes in 18/19 to ensure we mitigate a) any slippage and b) cost pressures / budgetary overspend

1. ***DC rates***
2. ***Outpatient productivity***
3. ***KIMS Repatriation***
4. ***PPIB Savings***
5. ***Reducing Medicines waste***

18/19 Ideas

19/20 CIP plan

Based on the current plan the Full Year Effect of recurrent 18/19 schemes that will deliver in FY 19/20 is

£6.2m

We have an additional **21 schemes** forecasting a target of **£4m** in next year's plan – further validation and quantification required

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Year-to-date delivery is £1.5m favourable to plan – YTD the Trust has delivered £12.1m against a £10.6m target

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2018/19 CIP Forecast vs Target Month 8

Directorate Split	Unplanned Care (£'000)	Planned Care (£'000)	Corporate (£'000)	Estates (£'000)	Totals (£'000)
Target	**(10,100)**	**(8,174)**	**(2,021)**	**(726)**	**(21,021)**
CIP Budget as % of Expenditure Budget	7.0%	7.0%		3.1%	6.9%
Identified	**(6,954)**	**(7,685)**	**(4,709)**	**(1,439)**	**(20,787)**
Unidentified	(3,146)	(489)	2,688	713	**(234)**
% Identified to Target	**69%**	**94%**	**233%**	**198%**	**99%**
YTD Target	(5,235)	(4,236)	(682)	(413)	**(10,566)**
YTD Actual	(4,829)	(4,400)	(1,866)	(1,013)	**(12,108)**
YTD Variance	(406)	164	1,184	600	**1,542**
YTD % Delivery	**92%**	**104%**	**274%**	**245%**	**115%**

- YTD delivery at Month 8 of CIP is £1.5m favourable to plan – YTD the Trust has delivered £12.1m against a £10.6m target.
- The £12.1m delivered is made up of £5.5m in non-recurrent savings (46%), £6.6m in recurrent savings (54%). The £21m plan is split 71% recurrent and 29% non-recurrent.
- £2.9m of the £12.1m delivered YTD is in recording of YTD vacancies as non-recurrent savings. However, at Programme-level, many of these vacancies may be reflected in the budgets in subsequent years.

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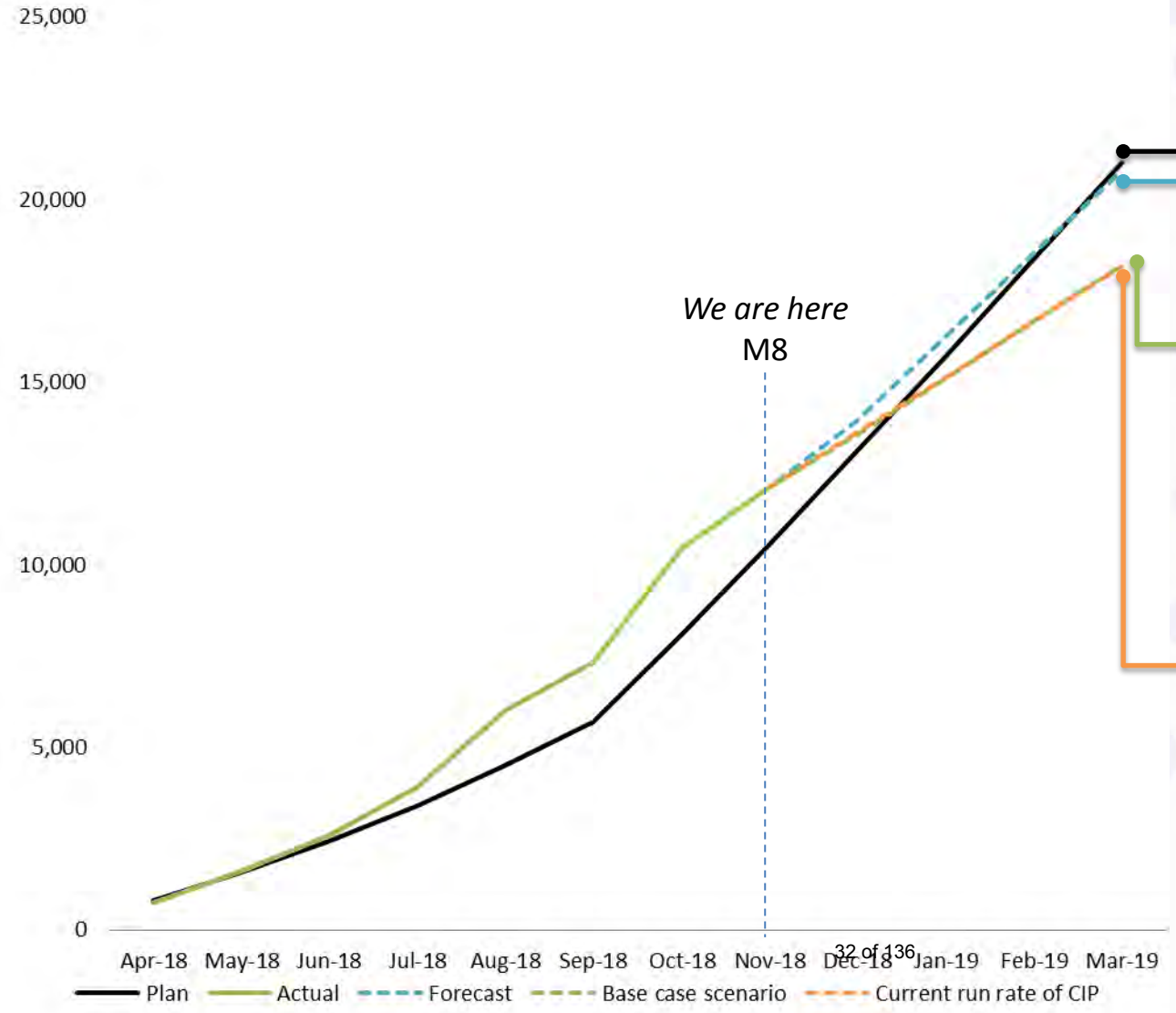
We are forecasting CIP delivery of £18.2m-£20.8m



Plan - £21m NHS I target, phased over 12 months

Upside Forecast - £20.8m. YTD actuals banked + future months forecast for all schemes including Amber and Red schemes

Base case scenario – £18.2m total, YTD actuals banked + future months forecast only for schemes that are Green in Planning

Average CIP delivery (Months 1-8) forecast through Months 9-12 – £18.1m total, based on current delivery profile

Years 2 and 3 of the transformation programme need to address the drivers of the deficit via quality and safety improvement

NHS Medway NHS Foundation Trust

Year 1

- Demonstrating **grip and control** of delivery
- **Raising the profile** of CIP and efficiency within the Trust
- **Pay spend controls** and temporary staffing daily reporting
- **Transactional** efficiencies e.g. holding vacancies
- Establishment of Transformation Team, new governance processes and **Confirm & Challenge cadence**

Years 2→

- A focus on **quality, safety and the patient experience** – from which the money falls out
- Fewer schemes, **more transformational** in nature e.g. re-design
- Genuinely **clinically-led** delivery, driven down to the lowest level possible
- Creating a culture that **incentivises and rewards efficiency**
- Transformation Team support **prioritised** by scale of opportunity

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‘Best in Class’

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1

Top 5 hurts

- Quality and safety → efficiency & Happy staff → productivity
- Quality priorities → system savings

2

Model Hospital

- *‘Move a metric’* projects delivered by MH champions
- Improved governance and link to GIRFT
- Exemplar Trust

3

BIC Partners

- Mutually beneficial partnerships with other organisations we can learn from
- E.g. TFL, Debenhams, BA, BAE, Arsenal

4

£10k challenge

- Behavioural nudges, awareness campaigns
- E.g. Save TED, “Did you know…?” programme, 10 small things

5

Headspace

- Week-long programme of development for Junior Docs and Registrars to K-O an improvement project/sprint

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Model Hospital data has been updated to include 2017-18 Reference Costs

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Model Hospital Productivity Cost per (WAU) for Medway Foundation Trust has decreased by 9% from £3852 to £3520.

2016-17 MFT Cost Per WAU

2017-18 MFT Cost Per WAU

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Transformation programme
10th January, Trust Board report

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Clinical strategy & Portfolio of Services Review

Best Flow Programme

Culture programme – You Are the Difference

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Clinical Strategy & Portfolio of Services update

Clinical Strategy

Our ambition is
to be designated as a specialist emergency centre with some tertiary specialist services

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Better Best Brilliant

We're making Medway *brilliant*

- A Trust **clinical strategy** has been developed and communicated with all staff setting out our ambition to become a designated specialist emergency centre, as defined by the Keogh Review.
- Against this backdrop, the work of the **Portfolio of Services Review working group** continues, conducting deep dive data reviews of services in waves, identifying both services not compatible with the strategy as well as services we wish to grow and develop into tertiary services.
- This forms a rolling work programme as services are identified through the Spring and notice served collaboratively to commissioners.
- **Contractual notice** has been served to our commissioner on first tranche of services and demobilisation and/or re-design work is in train in collaboration with system partners.

Briefing to Senior Managers and staff

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Transformation programme
10th January, Trust Board report

NHS Medway NHS Foundation Trust

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Best Flow programme update

NHS Medway NHS Foundation Trust

- The **Best Flow Programme** of work on flow enters its next phase, with a refreshed set of workstreams, leads, objectives/KPIs and under a new Oversight Group – some impacts from the flow improvement programme are shown on the slides on the next few pages
- As part of the Best Flow Programme, a new set of **site processes** have been introduced to better manage the aggregate bed balance of the hospital and improve the ways of working between the wards and the Site Operational Centre
- This work aligns to the **full capacity protocol** which has been approved and now provides staff with clear directions as to how to respond to the OPEL status of the site
- A further **MADE event** was held on 18 and 20 December focusing on complex patients with the aim of discharging them safely home before Christmas – this was under the No Place like Home communications campaign. At time of writing, impact not yet known
- The **Sapphire Acute Frailty Unit** was formally opened by Dr Matt Thomas, Consultant Geriatrician from Poole Hospital, as part of the ongoing development of the frailty pathway at MFT. The frailty team have ambitious plans to create a centre of excellence for frailty at Medway within a “village” model whereby patients are cohorted based on complexity and acuity

Best Flow Group	Objective	KPI(s)
UTC and Streaming Lead: Simon Collins & Cliff Evans	1. Instigate joint and regular review of MedOCC streaming rates 2. Establish and monitor a process to avoid patients being 'bounced back' to ED	1. No's streamed to MedOCC 2. Reduced in no. patients 'bounced back' to ED
ED clinical re-design Lead: Andrew Stradling	1. Complete the clinical redesign of ED	1. Ambulance Handover target (<15 minutes) achieved consistently 2. 0 Red chair breaches 3. Support achievement of Emergency Access Target trajectory (95% target by March 19) by maintaining non admitted performance at 98%
Medical Model Lead: Paul Kitchen	1. Complete redesign of Medical rota to optimise patient flow 2. Fully implement single clerking 3. Instigate medical triage within ED	1. No. of job plans reviewed 2. No. of PA's dedicated to supporting Flow 3. Reduced time to SDM
Pull Pathways Lead: Tzvetka Tencheva-Stoencheva & Gurjit Mahil	1. Establish and maintain 24-hour speciality assessments areas 2. Resilient assessment areas 3. Introduction of Frailty Assessment Area 4. Complete roll out off digital take lists 5. Establish Area 8 as co-located AEC and SAU units	1. Increased flow to in-patient beds 2. Reduced LOS in assessment areas
Effective Discharge Planning Lead: Simon Weeks & Tarina Phillips	1. Improve effectiveness of ward and board rounds 2. Implement CLD, R2G, EDN completion, TTOs 3. Running regular MADE events for complex discharges 4. Complete IDT Review	1. Increase no. patients discharged before 12pm) 2. Increase No. eDNs completed day before discharge 3. Increase No. of complex discharges facilitated by MADE events
Frailty village Lead: Sanjay Suman & Alison Streatfield	1. Complete re-design of Frailty bed base (SAFU & Ambulatory, Acute Frailty, Post-Acute long-stay ward, Medically Fit setting, EoL pathway)	1. Increase 0 LOS or same day discharges 2. Reduce average LOS (Days) 3. Increase % Discharges before noon 4. Reduction in Frailty Outliers
Site & Flow Lead: Korron Spence & Michelle Mackie	1. New processes embedded 2. Instigate and maintain behaviour change programme 3. Address staff ing and capacity issues	1. Reduction in No. of outliers 2. Reduction in average time for DTA admissions 3. No 12 hour breaches

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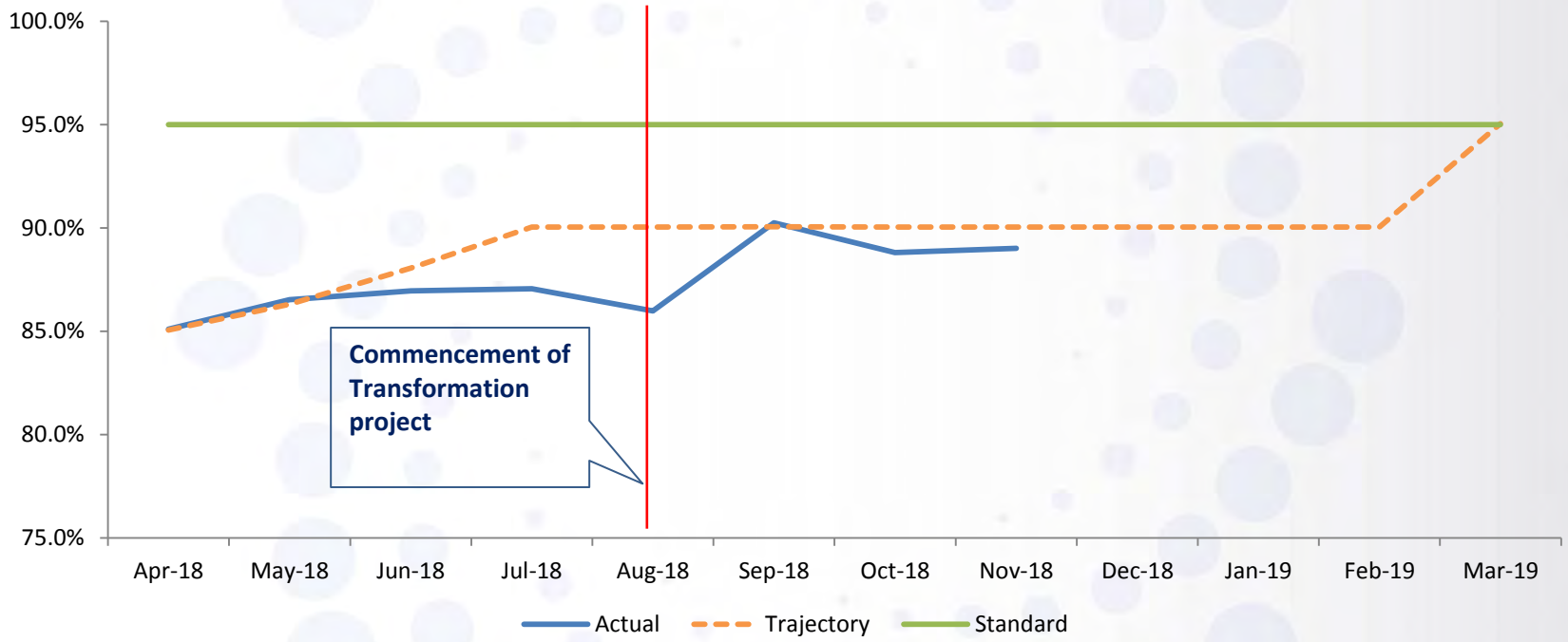
Progress towards 4 Hour Emergency Access Target



Our Emergency Access Pathway Improvement Plan is supporting a whole hospital approach to meeting the 4 Hour constitutional target.

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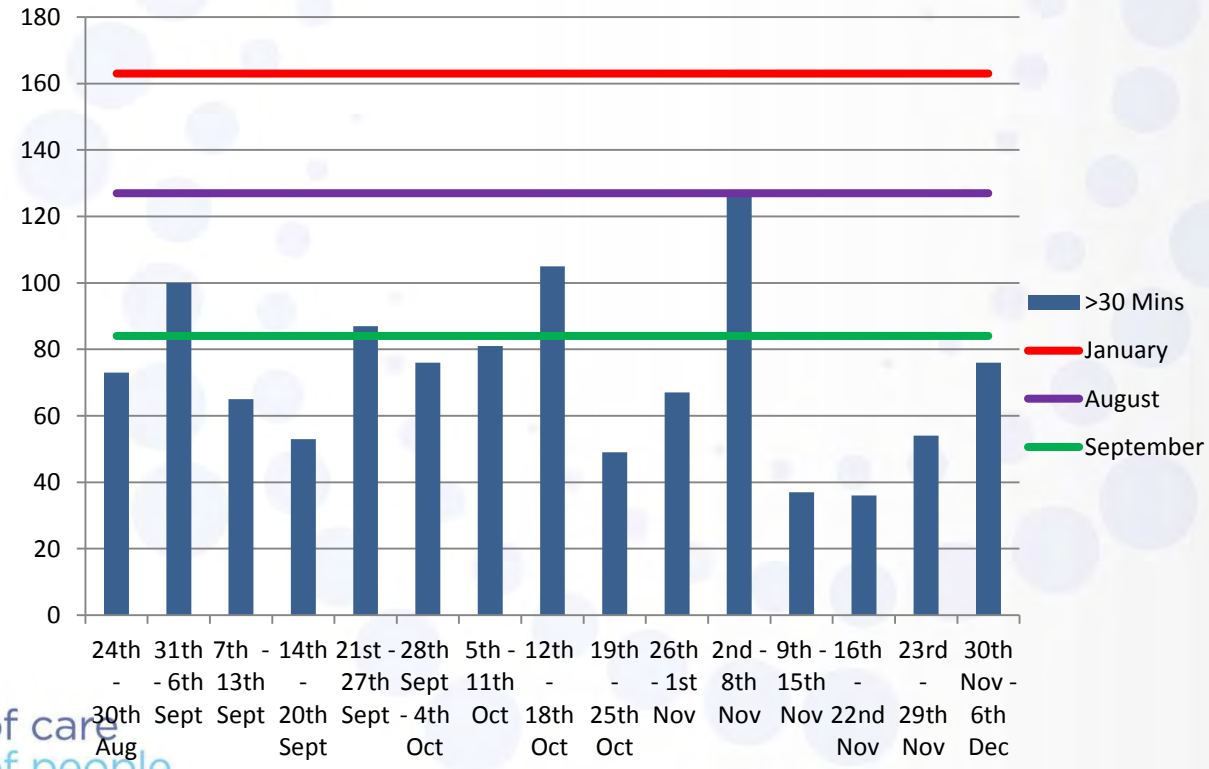
Improved SECAmb Performance 30 Minute Handover Performance

Medway currently has the highest percentage of **<15** minute ambulance handovers in the SECAmbs Region (over **63%** of handovers **<15** minutes).



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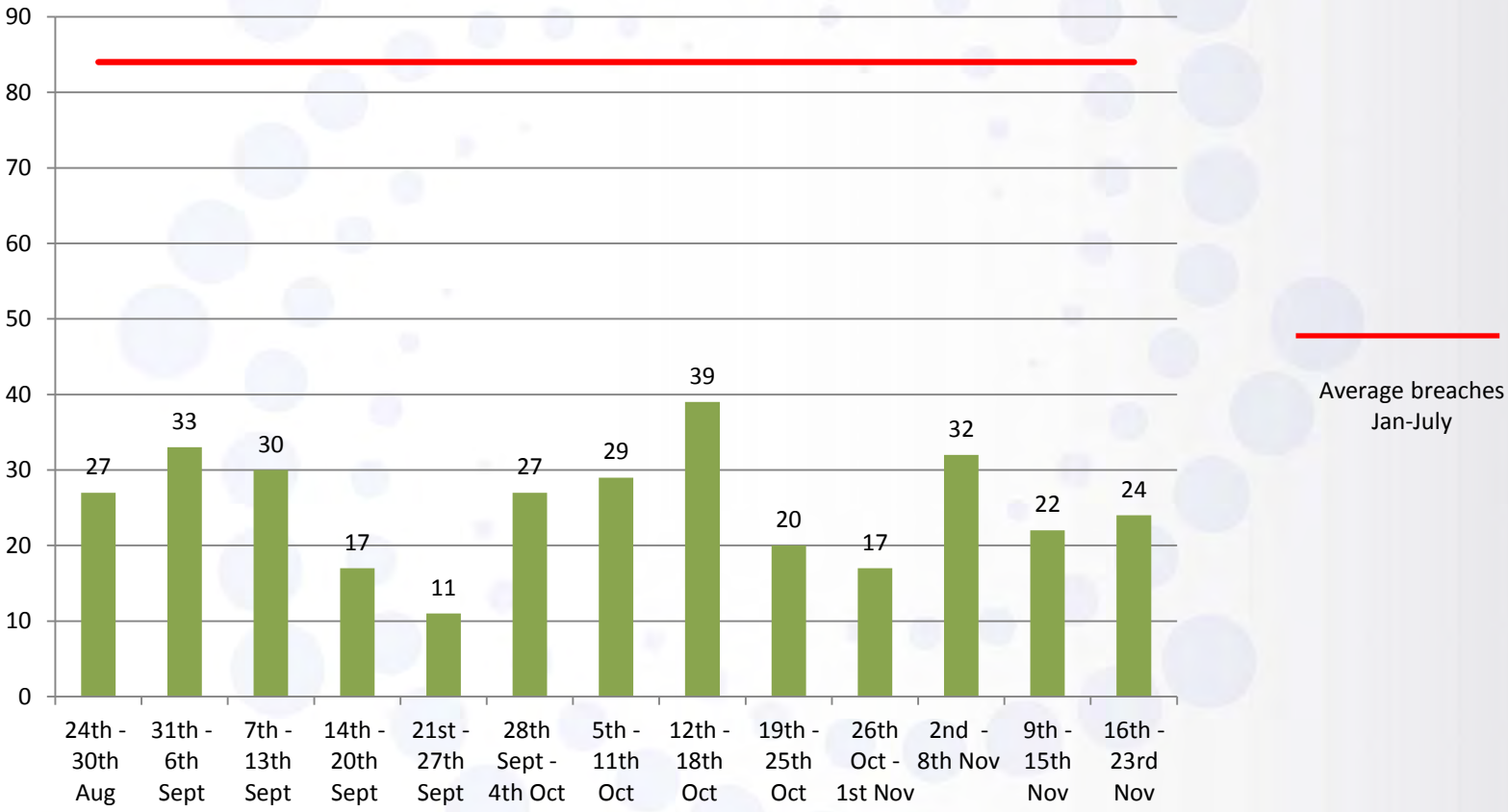
Reducing Ambulant Patient Breaches



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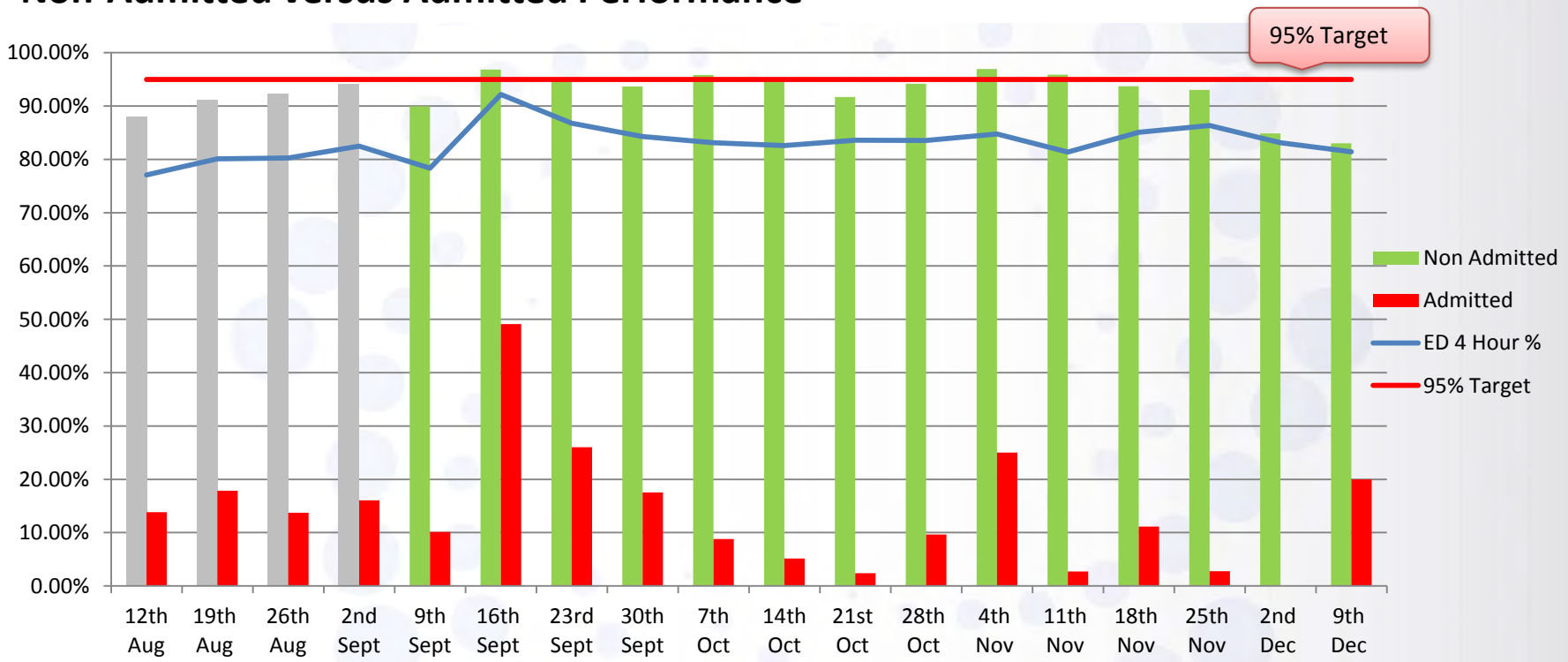
Our 'Majors Lite' area has been developed to stop ambulant patients not requiring further assessment breaching the 4 Hour target.

Non-Admitted versus Admitted Performance



Effective streaming and the management of ambulatory patients within ED which is delivering excellent Non-Admitted performance.

Admitted Performance is however 40% lower than last year (YTD). Sustained improvement in flow through the hospital is required to enable us to consistently meet our 4 hour Emergency Access target.

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Flow Improvement

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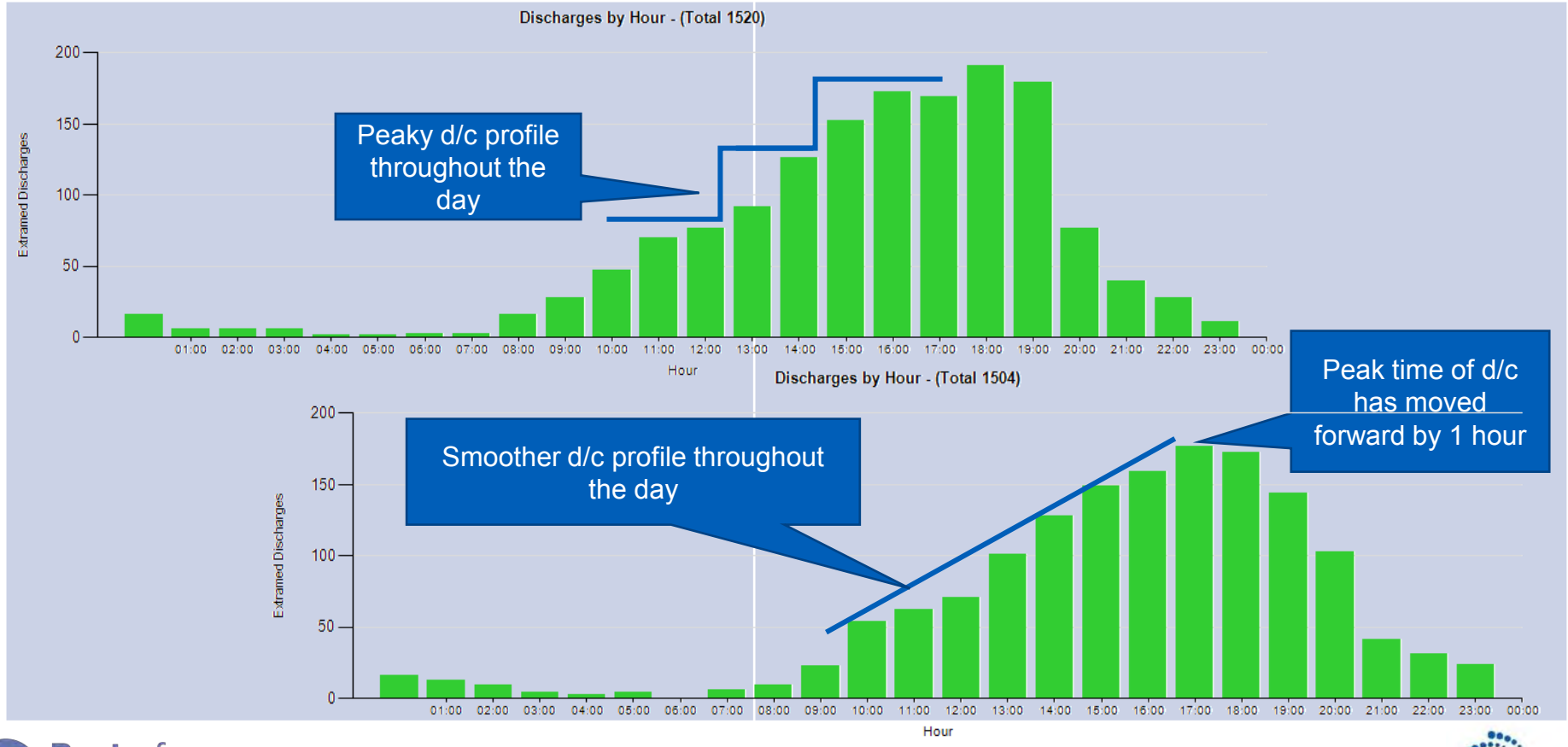
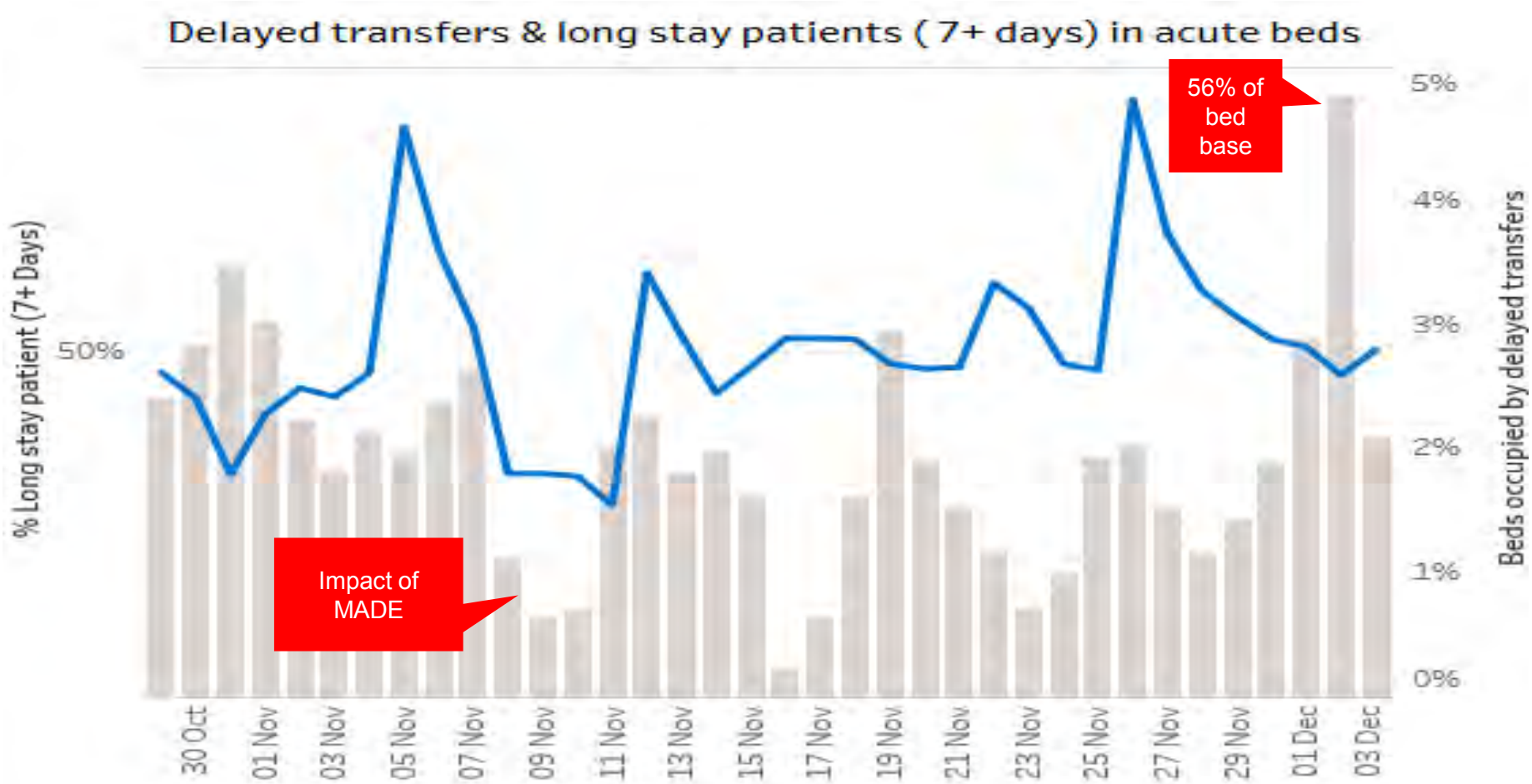
Impact

Before SITE huddles	Since SITE huddles



MADE impact


Delayed transfers & long stay patients (7+ days) in acute beds
56% of bed base
Impact of MADE
% Long stay patient (7+ Days)
50%
Beds occupied by delayed transfers
5%
4%
3%
2%
1%
0%
30 Oct
01 Nov
03 Nov
05 Nov
07 Nov
09 Nov
11 Nov
13 Nov
15 Nov
17 Nov
19 Nov
21 Nov
23 Nov
25 Nov
27 Nov
29 Nov
01 Dec
03 Dec

Matron & Lead Nurse actions (example)

NHS Medway NHS Foundation Trust

Actions apply for Unplanned and Planned Care unless otherwise specified

- Attending board rounds where appropriate with a focus on providing challenge to wards below their discharge target e.g. ward with high drop-offs or consistently below target
- Following up that key actions on wards or at the huddles have been completed and expedite definite discharges to the discharge lounge and act as a point of escalation for the conversion of queries
- Attendance at huddles, providing challenge for delays

- Attending all wards and providing challenge where appropriate at board rounds on wards which are consistently below their discharge target or have many drop-offs
- Following up on the wards that key actions have been completed
- Actively looking for patients to sit out and escalating discharge dependant diagnostics & procedure lists for today and tomorrow
- Act as a point of escalation in liaising with consultants to solve medical issues (if consultant is not scheduled to be on the ward)
- Lead nurse to meet with Medical/Surgical Matrons at 1130 in CCC room to discuss issues identified.
- Attend and provide challenge at all huddles (including 1500 for medicine)

- Reviewing transport need for discharges
- Working with DoN in walking MDT to unblock delays and expedite discharge

'Proposed' Schedule of meetings:

0800 Med huddle

0900 Walking MDT of Medical wards with Co DoN and DDoN & Therapies to expedite discharges

1015 Surg huddle

1130 Matron meeting in CCC to discuss & escalated issues on wards and confirm actions completed

1200 Med huddle

1500 Med huddle

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SAFU Official Opening
13th December, 2018

By
Dr Matt Thomas
(Consultant Geriatrician, Poole NHS Foundation Trust)

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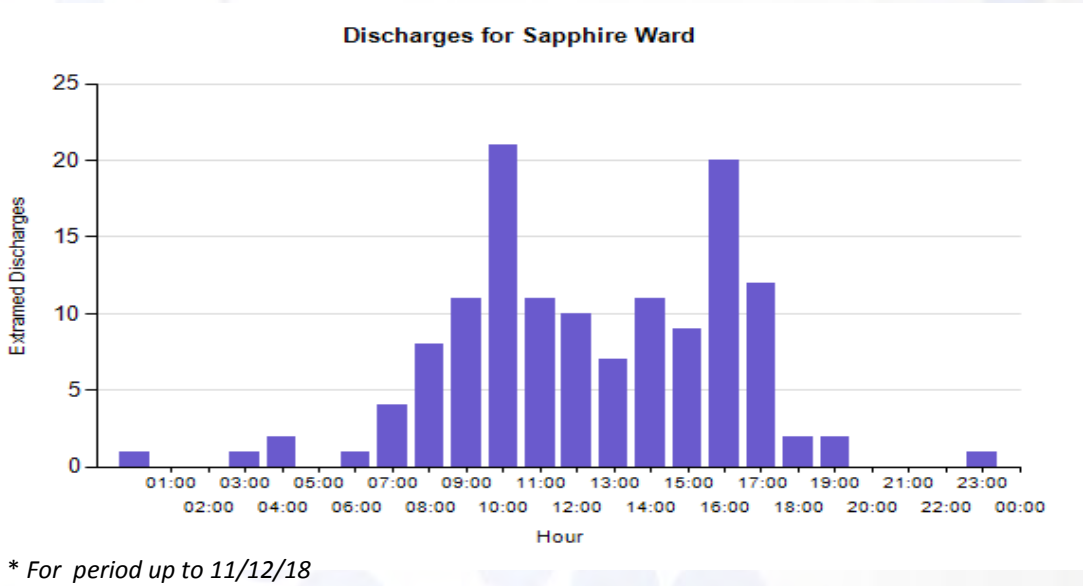
Sapphire Acute Frailty Unit: Impact Metrics

SAFU Pre-noon discharges = **38.7%*** (vs Trust 19.4%*)
Aim: Getting Frail patients home earlier in the day (especially in Winter)

SAFU Av LOS (Nov) : 6.2 days (vs. FBB avg LOS of 12.11 days)
Aim: Reducing unnecessarily long lengths of stay (ALOS) for Frail patients



* *For period up to 11/12/18*

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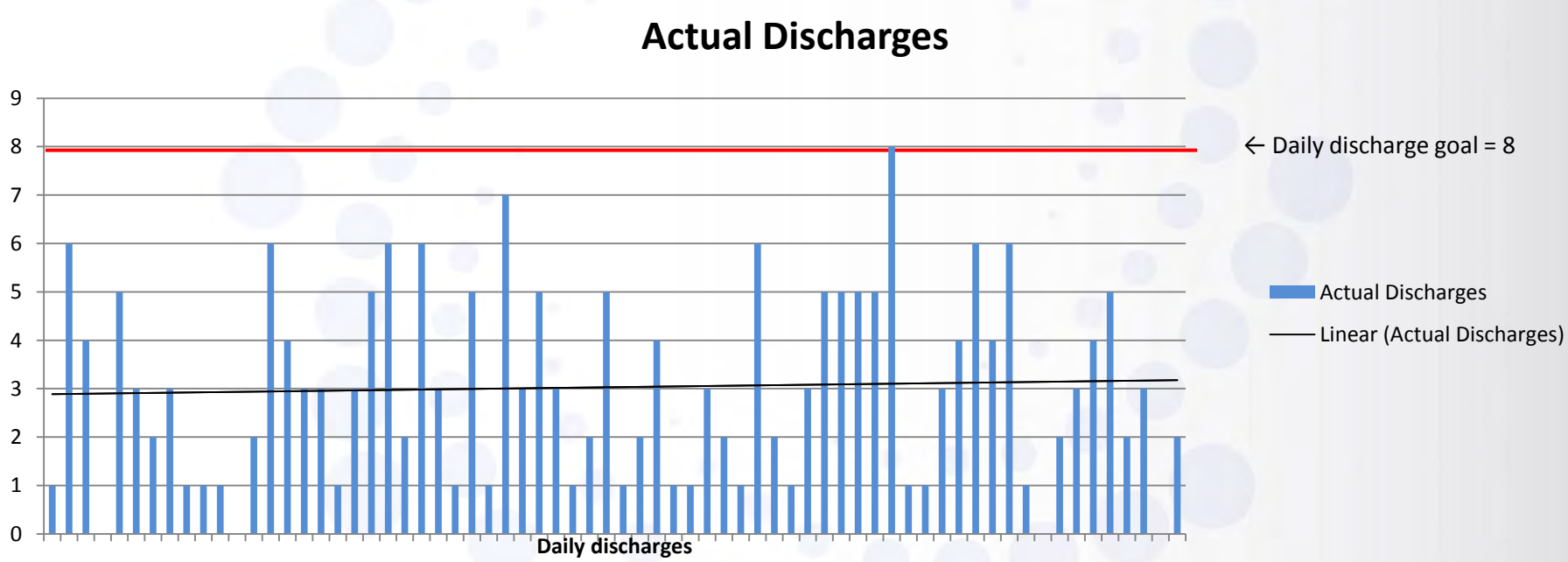
Sapphire Acute Frailty Unit: Impact Metrics

NHS Medway NHS Foundation Trust

223 patients discharged over 10 weeks (up to 11/12/18).
Aim: Reducing acute length of stay (ALOS) for Frail patients



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Acute Frailty Unit:
Developments since June 2018

NHS Medway NHS Foundation Trust

Frailty Bed Base
June 2018

- Established Milton, Byron, Tennyson as Frailty bed base
- Dedicated Multidisciplinary Team
- Consultant Led
- Focus areas:
  - ❑ Criteria Led Discharge
  - ❑ Effective Board Round
  - ❑ Prompt EDN completion
  - ❑ ↑Discharges before mid-day

ED / Medical Assessment Unit
September 2018

- MDT Embedded: Front Door Therapist, Frailty Specialist Nurses, Pharmacist)
- Identifying Frailty in ED (Clinical Frailty Scale applied)
- Consultant led pathway: 7 days, 12 hours
- Comprehensive Geriatric assessment commenced in ED
- Frail Patients streamed to Acute Frailty Unit or Frailty Bed Base depending on Expected Date of Discharge

Sapphire Acute Frailty Unit (SAFU)
October 2018

- Dedicated Multidisciplinary Team (Nursing, Medical, Therapies, Pharmacy, Discharge Team)
- Consultant-Led Unit
- Focus areas:
  - ❑ Rapid turnaround (<48 hours)
  - ❑ Improvements to the physical space befitting of a frailty unit i.e. Enablement Café, Dementia-friendly garden

Frailty Outpatient & Ambulatory Care
November 2018 >>

- Establishment of CCG commissioned Frailty Unit "hot clinics" for access to Specialist support from primary care
  - ❑ Same day MDT and diagnostic intervention
  - ❑ Proactive care approach to support admission avoidance
- SAFU post – mobilisation "stocktake" (Jan 2019) and culture programme commencement
- Implementation of formal Continuous Improvement approach

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Transformation programme
10th January, Trust Board report

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Culture programme – You Are the Difference

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Medway's context:

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17/18 Staff Survey

Staff survey 2017/18 and staff engagement

- 17/18 staff survey response rate of 40 per cent.
- Engagement index score of 3.66.
- Heat map revealed areas with low engagement
- Levels of engagement appear to have reduced across the Trust.

Culture is regularly cited as an inhibitor or an accelerator

- Change programmes historically have failed to address long-standing cultural challenges and behaviours. Experience from other organisations shows cultural change is a long-game and we now need to make this part of our strategic priorities.

Culture regularly

CQC Feedback

CQC highlighted some challenging cultural trends

- The culture throughout the organisation was a mixed picture.
- Some staff worked in silos and staff satisfaction was mixed.
- "That's not my patient…"
- Other teams worked well with staff in and out of the hospital.
- They did not feel empowered to raise concerns.

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Purpose Of The Programme

To Provide The Tools To Help Everyone
To Take A Proactive Approach In Developing
A New Culture, Which Is Positive, Inclusive,
And Delivers The Values Of The Trust

Evaluation – so far

Following the sessions:

65%

Of staff that attend YATD sessions **Very Strongly Agree** that they now recognise their own responsibility for improving the culture at MFT

41%

Of staff that attend YATD sessions **Very Strongly Agree** that they have the ability and tools to improve the culture at MFT (**compared to 18% before attendance**)

66%

Of staff that attend YATD sessions **Very Strongly Agree** with the belief that our values/behaviors directly affect our patients' results

69%

Of staff that attend YATD sessions **Very Strongly Agree** that positivity at work leads to better outcomes & I am committed to helping MFT create a positive culture

---

89% **Agreed** that the session was engaging, interesting and useful

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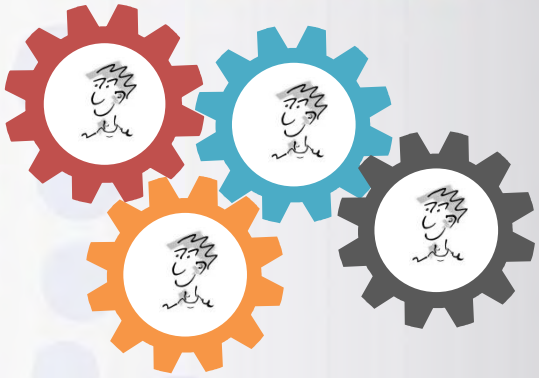
We need to now

We must keep YATD alive and **evolving**

Be clear that changing culture **cant happen overnight** – it takes time, support and reinforcement

Create a connected programme of work across the trust to

- **Keep** doing the great things
- **Stop** doing other "initiatives"
- **Start** our focussed cultural change programme of work



Create a **collective leadership** of YATD everywhere at all levels

Make YATD be the **core of everything** we do

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Proposed work plan for YATD

NHS Medway NHS Foundation Trust

November/ December 2018

- Complete staff sessions & Manager follow up sessions.
- Agree how we will roll out YATD to remaining staff.
- Agree plans for YATD 2019/20
  - Trust wide
  - Localised
  - Built into current work streams to join up / align YATD ethos/behavious
  - Agree how we will use Ambassadors

January – March 2019

- Include YATD in Trust induction and medical induction.
- Develop and agree culture strategy for the Trust.
- Create a culture programme board.
- Formally launch Ambassador support.
- Review staff survey results and create an ambitious work plan with culture change at the core.
- Create focus groups to define what brilliant culture looks like for us.
- Define leadership expectations to deliver YATD in their areas.
- Include YATD in staff recognition programmes.

March – September 2019

- Assess leadership capability/ competence.
- Create leadership development interventions to support YATD.
- Review performance review process to ensure behaviours are discussed/reviewed.
- Localise YATD programme to specific areas / teams / projects.
- Create series of supporting toolkits.
- Introduce quarterly pulse checks.
- Review recruitment process to include recruitment for behaviour/ attitude.

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Report to the Board of Directors

Board Date: Thursday, 10 January 2019 Agenda Item: 5.1

Title of Report	**Integrated Quality Performance Dashboard - Update**
Prepared By:	Associate Director of Business Intelligence
Lead Director	Director of Nursing
Committees or Groups who have considered this report	Draft to Quality Improvement Committee
Executive Summary	To inform Board Members in the form of a flash report of September'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** in the month but performance has improved from 88.82% in October to 89.01% in November. • There were no **12 hour breaches** in November. • **HSMR** data reported in this month's IQPR is for the period from October 2017 to September 2018. This is currently 116.56, which is higher than the expected range. • This month saw a 23.2% decrease in the number of **Mixed Sex Accommodation** breaches, which totalled 192 in November. An IT system has been launched to support the wards in accurately recording and reviewing MSA breaches. • **RTT** performance has increased to 82.59% from 81.77%. This is below the national standard of 92% but above the trajectory for the month. • 31-day **Cancer targets** for first and subsequent surgical cancer treatments did not meet the national standards at 94.77% and 92.59% respectively. The 2-week wait

Report to the Board of Directors

	and 62-day targets have not been met. The 2-week wait symptomatic breast performance has decreased by 14.98% to 75.76%. The 62-day GP performance was not achieved in October, with performance increasing by 2.94% to 68.13%. The 62-day screening standard was also not achieved in October, and performance has decreased by 5.8% to 83.33%. 54 complaints were reported in the month, a decrease from October's 65. There were 5 complaint returners in November.
Resource Implications	n/a
Risk and Assurance	See report
Legal Implications/Regulatory Requirements	n/a
Improvement Plan Implication	Supports the Improvement Programme in the following areas: Workforce, Data Quality, Nursing, Finance
Quality Impact Assessment	See report appropriate
Recommendation	n/a
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

Integrated Quality and Performance Report

December 2018

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NHS Medway NHS Foundation Trust

EXECUTIVE SUMMARY

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
ED - 4 Hours Type 1	Actual	71.19%	74.48%	74.43%	73.85%	71.91%	80.53%	77.34%	77.77%
	Planned	71.18%	74.49%	79.51%	83.37%	82.91%	83.22%	83.06%	83.20%
	Variance	0.01%	-0.01%	-5.08%	-9.52%	-11.00%	-2.69%	-5.72%	-5.43%
ED - 4 Hours All Types	Actual	85.11%	86.53%	86.95%	87.12%	85.98%	90.32%	88.82%	89.01%
	Planned	85.06%	86.30%	88.05%	90.04%	90.05%	90.05%	90.04%	90.05%
	Variance	0.05%	0.23%	-1.10%	-2.92%	-4.07%	0.27%	-1.22%	-1.04%

ED 4 Hour Trajectory Commentary:

We continue to move towards the national 4 hour target with a 0.25% increase against last years performance. We have seen an increase in walk-in patient attendance compared to last year an increase of 2500 YTD. ED Non-Admitted performance remains to be strong with a monthly average of 92.78% compared to the average Admitted performance which is struggling at 16.71%, a decrease from last year of 29.37% average. The Ambulance handover process changed in August where MFT were given the availability to input ambulance crew pins. November saw the opening of RAU and a new ambulance handover process was put into practice.

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
RTT - 18 Weeks	Actual	81.21%	82.38%	81.68%	82.52%	82.55%	81.77%	82.59%	82.62%
	Planned	81.21%	82.38%	82.12%	81.70%	82.43%	81.16%	81.48%	81.09%
	Variance	0.00%	0.00%	-0.44%	0.82%	0.12%	0.61%	1.11%	1.53%

RTT Trajectory Commentary:

The Trust remains on trajectory for RTT performance against the trajectory agreed with NHSI, however not meeting the National Standard. Dermatology remains an area of concerns from an RTT perspective. The team are currently working with DMC to ensure patients are being seen on time. Without Dermatology the performance for November would be 86.5%.

Constitutional Target Trajectories

NHS Medway NHS Foundation Trust

EXECUTIVE SUMMARY

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Cancer - 62 Days	Actual	86.42%	83.78%	90.64%	84.81%	79.17%	80.47%	83.85%
	Planned	86.40%	84.80%	84.00%	85.20%	85.10%	86.10%	86.10%
	Variance	0.02%	-1.02%	6.64%	-0.39%	-5.93%	-5.63%	-2.25%

Cancer Trajectory Commentary:

The Trust has improved the 62 day performance in October 2018 to 83.85%, however still not compliant against the national standard or trajectory.

38 day shadow reporting puts the Trust as compliant. Action plans are in place to address this performance.

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
DM01 - 6 Weeks	Actual	96.11%	92.90%	91.86%	92.30%	98.20%	99.24%	99.54%	98.76%
	Planned	96.10%	92.90%	91.60%	95.20%	95.80%	95.50%	97.40%	95.40%
	Variance	0.01%	0.00%	0.26%	-2.90%	2.40%	3.74%	2.14%	3.36%

DM01 Trajectory Commentary:

MFT continues to improve performance of the DM01 against both the agreed improvement trajectory (October – 2.14 above trajectory) and the national standard (October – 0.54% above standard).

The achievement of the national standard was achieved seven months ahead of plan, driven through robust, weekly meetings, close and responsive leadership and delivery expectation, combined with education and training for staff at all levels and professional group.

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SAFE

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Safe

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Harm Free Care	Falls (moderate or severe harms)	0.0	#	0	3	1	0	1	2	1	2	-	-	-	-	10	
	Falls Per 1000 Bed Days	0.0	#	3.97	5.03	4.75	5.25	4.27	3.87	4.22	4.24	-	-	-	-	35.59	
	Pressure Injuries (Low Harm)	0.0	#	20	7	13	18	16	16	16	15	-	-	-	-	121	
	Pressure Injuries (Moderate and High Harm)	0.0	#	0	2	0	2	1	1	0	0	-	-	-	-	6	
	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	-	#	0	0.04	0	0.07	0.07	0.07	0	0	-	-	-	-	0.24	
	Number of Medication Errors	0.0	#	1	2	1	0	1	0	0	0	-	-	-	-	5	
Incident Reporting	Never Events	0.0	#	0	0	0	0	0	0	0	1	-	-	-	-	1	
	Never Events - Incidence Rate	0.0	%	0	0	0	0	0	0	0	0.94	-	-	-	-	0.94	
	No of SIs on STEIS	0.0	#	10	12	12	13	15	4	10	6	-	-	-	-	82	
	% of SIs Responded To In 60 Days	-	%	50	100	100	100	100	100	100	93.33	-	-	-	-	93.26	
Infection Control	MRSA Bacteraemia (Trust Attributable)	0.0	#	1	0	2	1	3	0	1	0	-	-	-	-	8	
	C-Diff Acquisitions (Trust Attributable (Post 72 Hours)	19.0	#	1	2	3	0	2	4	4	1	-	-	-	-	17	
	C Diff Due to Lapses In Care	0.0	#	0	1	1	0	0	1	0	0	-	-	-	-	3	
	MSSA Surveillance (Trust Acquired)	0.0	#	2	4	1	3	1	1	3	3	-	-	-	-	18	
	E-coli (Trust Acquired) Infections	0.0	#	4	6	9	4	4	6	2	4	-	-	-	-	39	
Mortality	Crude Mortality Rate	2.5	%	1.78	1.63	1.49	1.46	1.31	1.44	1.41	1.24	-	-	-	-	1.44	
	HSMR (All)	100.0	%	112.9	114.15	114.06	113.3	112.87	113.62	115.95	116.59	-	-	-	-	114.18	
	HSMR (Weekday)	100.0	%	111.51	113.17	113.44	112.35	111.92	113.67	116.11	117.31	-	-	-	-	113.69	
	HSMR (Weekend)	100.0	%	117.06	117.11	115.99	115.92	115.39	113.04	115.56	114.39	-	-	-	-	115.55	
	SHMI	1.0	#	1.03	1.03	1.03	1.03	1.03	1.07	1.07	1.06	-	-	-	-		

Safe Commentary:

We reported 63 falls in November, two of these falls resulted in harm. An improvement action plan is in place. The key actions are to improve recording of lying and standing blood pressure and comply with the NICE guidance relating to neurological observations post fall.

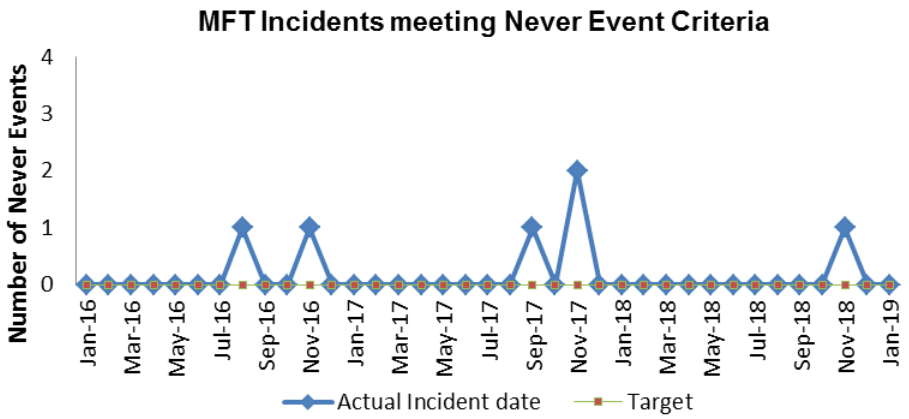
Of the four (check total once Kath & Louise have agreed the data)post 72 hour cases in October and November we have had finalised three out of four PIR's. Two cases were unavoidable. Year to date we have reported three level 3 lapses of care against our CDiff acquisitions.
The MRSA bacteraemia reported in October although trust attributable was unavoidable and likely to be a transient bacteraemia. There was no focus of infection.

E.coli: The IPCT carry out surveillance on all gram negative bacteraemia and analysis shows the majority of cases are secondary to gastrointestinal / hepatobiliary conditions, however there are cases where a urinary catheter is the source of the infection and evidence of good catheter management is insufficient. Both acute and CCG IPC teams are working collaboratively to make the required improvements in the reduction of GNBSIs across the Kent & Medway system and new Kent and Medway guidelines for the care of patients with urinary catheters are nearly finalised. A working group is being convened to lead the improvement actions, the first meeting is scheduled to take place in January 2019.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Safe – Never Events Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Incident Reporting	Never Events	0.0	#	0	0	0	0	0	0	0	1



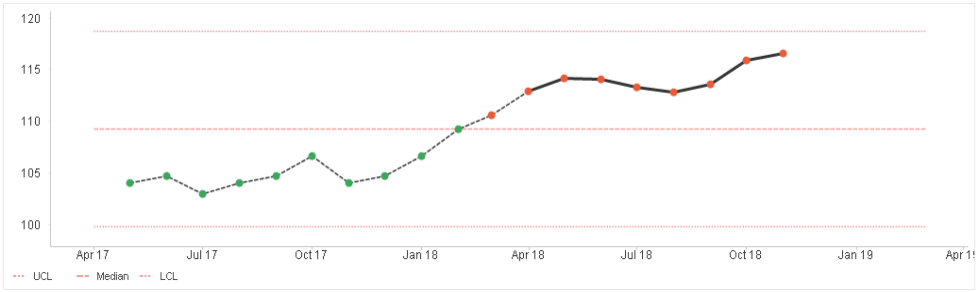
Never Event Definition:

Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations2 that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Commentary	Risks & Mitigating Actions
Incident date: 16/10/2018 Date identified: 05/11/2018 The nature of the incident was a retained swab post birth. As soon as incident identified the swab was removed, an ultrasound performed and a course of antibiotics prescribed. No lasting harm to the patient. The investigation found that the swab count was documented as being correct but there was no documentary evidence that the post repair swab count was checked with a colleague as per unit guidance. There were missed opportunities to identify and remove the swab when the patient was seen by her community midwife and GP. The Trust last reported a never event in November 2017.	This incident has been presented to the programme governance board. Actions taken in response are: • Update Operative Vaginal Delivery Guideline. This is to be linked with and acknowledged in the Standard Operating Procedure for swab, needle and instrument count • Update swab, needle and instrument count SOP to include obstetric delivery rooms • Update documentation to reflect NatSSIPS National Safety Standards • Highlight incident to all midwifery and nursing teams working in delivery suite by involving the NatSSIPS simulation team.

Safe – Total HSMR Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Mortality	HSMR (All)	100.0	%	112.9	114.15	114.06	113.3	112.87	113.62	115.95	116.59



Highest observed exceeding expected

Title	Rel. risk	Vol	Obs	Exp	O-E
Pneumonia	124.6	1711	278	223.1	54.9
Diagnostic imaging (except heart)	117.0	7680	359	306.8	52.2
Diagnostic imaging of heart	154.5	1560	106	68.6	37.4
Septicemia (except in labour)	109.3	1265	222	203.0	19.0
Aspiration pneumonitis, food/vomitus	130.2	166	67	51.5	15.5

HSMR Total Definition:

The HSMR is a subset of 56 diagnosis group relating to approximately 83% of in hospital deaths in England. A mortality risk for each patient is calculated based upon the admitting diagnosis combined with case mix adjustment factors such as age, admission history, deprivation and secondary diagnoses . The trust uses Dr Foster's methodology and it should be noted that prior period results are refreshed monthly.

Commentary

The Trust HSMR continues to climb, and has now risen to 116.6. Work carried out by the mortality committee during 2018 has identified key contributors to this, including:

- Reduction in expected mortality rates largely related to a reduction in palliative care coding
- Patients discharged from the Trust and dying at the Wisdom Hospice still counting as Trust deaths (whereas HSMR should only relate to deaths occurring in hospital)

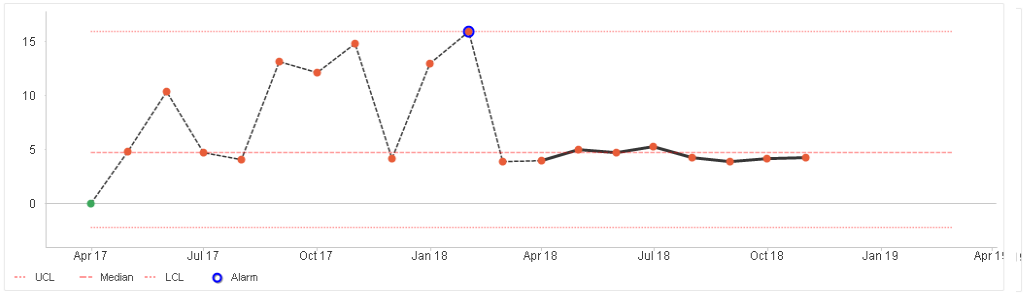
In contrast the SHMI has gradually reduced over the last 18 months (this measure covers deaths occurring up to 28 days after hospital discharge and specifically excludes palliative care patients).

Risks & Mitigating Actions

It has been agreed with the CCG and NHSI that the Z51.5 palliative care code will in future be applied to all patients who receive care from the Trust End of Life Care Team as well as those seen by the Palliative Care Team. Work is ongoing within coding to address the issue of the Wisdom Hospice patients. An estimate of HSMR if those changes are made is being prepared: previous work with NHSI and Dr Foster has suggested that the Trust HSMR would stand at around 102 after the changes to palliative care coding are made. However it must also be noted that the continued rise in HSMR is associated with a recent (six month) increase in both crude mortality and in observed deaths. Pneumonia has been flagged as an outlier diagnosis and the results of a deep dive into pneumonia mortality will be available for review at the Mortality Committee later in January. As a response to the continuing rise in HSMR the Medical Director is leading a focused task and finish group to review the underlying issues that may be contributing to HSMR, both from a data quality and a clinical and operational viewpoint. This review will report to the Executive Committee at the beginning of February.

Safe – Falls Per 1,000 Bed Days Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Harm Free Care	Falls Per 1000 Bed Days	0.0	#	3.97	5.03	4.75	5.25	4.27	3.87	4.22	4.24



Falls Definition:

The number of falls that occur in the Trust divided by the number of occupied bed days. Inpatient falls can be classified into three categories: accidental falls (derived from extrinsic factors, such as environmental considerations), anticipated physiologic falls (derived from intrinsic physiologic factors, such as confusion), and unanticipated physiologic falls (derived from unexpected intrinsic events, such as a new onset syncopal event or a major intrinsic event such as stroke).

Commentary	Risks & Mitigating Actions
We reported 63 falls in November, two of these falls resulted in harm: • Hip fracture (Severe harm) Harvey Ward • Ankle fracture (moderate harm) Arethusa Ward	An improvement action plan is in place. The key actions are to improve completion of falls risk assessment and post fall care, including use of the flat lift kit, and correct monitoring of neurological observation)

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CARING

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Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	274	144	230	192	259	226	250	192	-	-	-	-	1767	
	MSA %	0.0	%	5.92	3.67	5.02	3.37	4.33	6.04	4.87	4.51	-	-	-	-	4.66	
	% of EDNs Completed Within 24hrs	100.0	%	55.46	58.22	52.63	58.65	50.82	54.91	51.59	52.19	-	-	-	-	54.15	
	Inpatients Friends & Family % Recommended	83.0	%	88.23	87.03	87.33	87.09	83.9	84.45	86.47	86.21	-	-	-	-	86.35	
	Inpatients Friends & Family Response Rate	25.0	%	20.72	20.75	19.95	20.05	19.97	21.79	20.08	21.82	-	-	-	-	20.64	
ED Care	ED Friends & Family % Recommended	65.0	%	79.78	76.59	78.92	78.44	77.03	80.65	80.48	78.86	-	-	-	-	78.83	
	ED Friends & Family Response Rate	25.0	%	15.68	15.01	15.8	14.95	14.08	15.58	14.14	13.94	-	-	-	-	14.9	
Maternity Care	Maternity Friends & Family % Recommended	79.0	%	99.63	97.81	97.74	100	99.26	98.82	100	100	-	-	-	-	99.08	
	Maternity Friends & Family Response Rate	25.0	%	34.96	35.46	30.86	28.42	28.42	18.5	22.71	23.62	-	-	-	-	27.92	
Outpatients Care	Outpatients Friends & Family % Recommended	83.0	%	89.28	89.05	89.89	90.77	89.8	89.3	89.85	91.04	-	-	-	-	89.88	
	Outpatients Friends & Family Response Rate	25.0	%	15.37	15.62	14.43	14.39	14.63	14.23	13.51	13.88	-	-	-	-	14.48	

Caring Commentary:

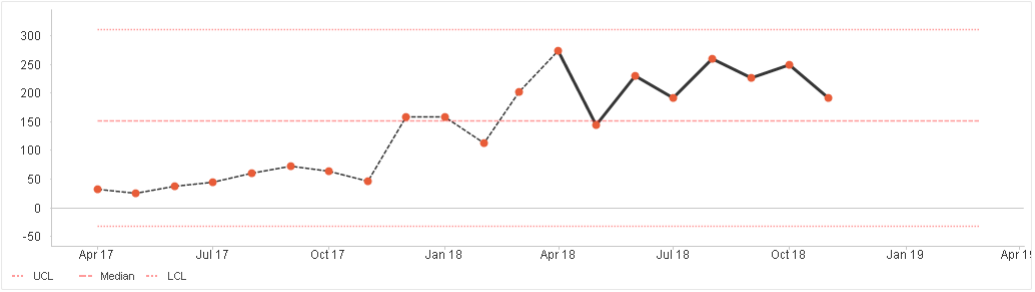
The current focus of our FFT work is working with the PMB leads to improve the response rate and would recommend rate for FFT for outpatients, inpatients and ED. Actions to date include:

- Establishing a working group to review and address the operational barriers to the FFT.
- We have a leaflet called ‘ways in which we seek your feedback’ which alerts patients to the FFT contact they will receive once discharged. All patients are given the leaflet on discharge with the aim that they are more likely to respond if they know why we request their feedback and how we use it to make positive changes for future patients.
- Representatives from BI and IT are working with the Trust Patient Experience manager to implement a process to collate the FFT feedback from patients before they are discharged for the calendar month of February to see if that impacts positively on the scores.
- There is currently a national review of the FFT underway and there will be anticipated actions from the outcome of this review
- The PE manager is supporting Senior Sisters to review their FFT data including ‘you said we did’ and negative feedback reports.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Caring – Mixed Sex Accommodation Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	274	144	230	192	259	226	250	192



KPI Name	Specialty		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Mixed Sex Accommodation Breaches	100 - GENERAL SURGERY	#	29	7	12	20	9	-	2	-
	110 - TRAUMA & ORTHOPAEDICS	#	-	-	-	-	4	-	-	-
	192 - CRITICAL CARE MEDICINE	#	56	58	44	88	156	82	136	85
	300 - GENERAL MEDICINE	#	95	44	47	29	43	64	25	41
	301 - GASTROENTEROLOGY	#	2	-	-	-	6	-	-	-
	303 - CLINICAL HAEMATOLOGY	#	-	3	2	-	-	-	-	-
	320 - CARDIOLOGY	#	31	8	3	11	11	33	10	10
	328 - STROKE MEDICINE	#	12	-	93	-	-	-	51	40
	340 - RESPIRATORY MEDICINE	#	49	20	29	32	15	42	26	16
	420 - PAEDIATRICS	#	-	-	-	7	1	-	-	-
	430 - GERIATRIC MEDICINE	#	-	4	-	5	14	5	-	-
	-	#	-	-	-	-	-	-	-	-

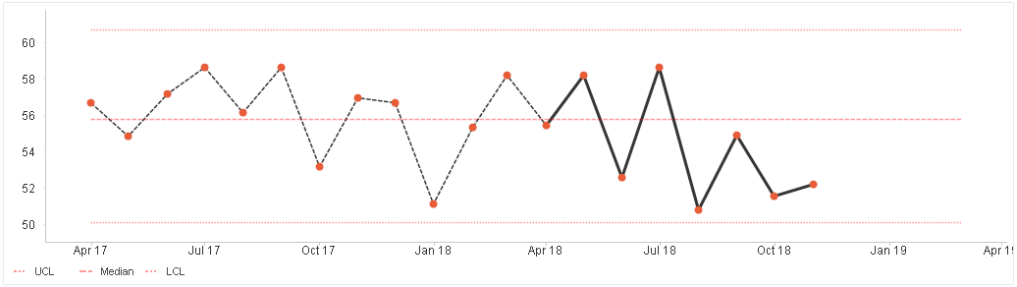
Mixed Sex Accommodation Definition:

The number of patient breaches by day of mixed-sex accommodation (MSA). This includes all sleeping accommodation where it is not deemed best for the patient's care, patient choice or the patient has not consented to share mixed sex accommodation. This measure excludes A&E.

Commentary	Risks & Mitigating Actions
November showed an improved position reporting 192 breaches a fall of 44 breaches from the 236 reported in October This improvement is largely due to increased diligence with validation of data We remain challenged in placing critical care patients fit for ward based care into ward beds and in placing patients requiring assessment, short stay or specialist care, contributing to the majority of the breaches. The critical factor to achieving our trajectory is successful delivery of the Emergency Pathway and LOS improvement plans.	• IT system developed for validation of MSA breaches • MSA breaches discussed at Trust Clinical Site meetings • Daily report MSA to management teams • Weekly validation meeting commence January 2019 • Met with CCG Dec 2018 to review position and request additional support for Harvey ward

Caring – Electronic Discharge Notification (EDN) Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Admitted Care	% of EDNs Completed Within 24hrs	100.0	%	55.46	58.22	52.63	58.65	50.82	54.91	51.59	52.2



KPI Name	Programme		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
% of EDNs Completed Within 24hrs	ACUTE MEDICINE	%	58.32	54	58.87	57.06	56.18	55.82	56.8	56.86
	CANCER, DIAGNOSTICS & CLINICAL SUPPORT SERVICES	%	3.26	4.02	2.61	4.59	1.75	2.62	2.61	4.87
	PERIOPERATIVE & CRITICAL CARE	%	98.51	97.59	96.97	100	98.82	98.99	93.59	100
	SPECIALIST MEDICINE	%	28.52	24.27	26.91	26.65	23.96	25.45	23.15	26.53
	SURGICAL SERVICES	%	66.79	68.3	70.65	66.63	64.08	64.68	67.51	68.14
	WOMEN'S & CHILDREN'S HEALTH	%	80.95	82.61	61.54	83.8	65.06	85.9	64.6	63.76

Electronic Discharge Notification Definition:

The Electronic Discharge Notification (EDN) is required to be completed and sent to a patient's GP within 24 hours of discharge. The discharge summary provides information to the GP of the reason for admission and any post-discharge plans.

Commentary	Risks & Mitigating Actions
EDN completion remains at a suboptimal level. A number of pieces of work were carried out in 2018, particularly a review of the completion of EDN's for deceased patients. However these actions have not made any noticeable difference to the EDN completion rate. The completion rate is Directorate and Programme dependent, with excellent completion rates in Perioperative and Critical Care and very poor rates in Specialist Medicine – consistently below 30%. Issues contributing to this include some problems with scarce junior doctor resource on some of the downstream medical wards – Keats and Will Adams being particularly affected by this.	The programmes have been tasked with reviewing their data to accurately understand the reasons for the low completion percentage and action plans to address these issues will be reviewed in the next programme PRM's and will be fed back to the Board with the next IQPR report.

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Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Best Practice	7 Day Readmission Rate	10.0	%	5.19	5.81	4.94	5.46	4.69	4.67	4.36	-	-	-	-	-	5.02	
	30 Day Readmission Rate	10.0	%	11	11.57	10.78	11.26	9.92	10	9.92	-	-	-	-	-	10.64	
	Discharges Before Noon	25.0	%	17.57	16.72	16.76	15.05	15.46	15.87	15.06	14.58	-	-	-	-	15.86	
	Fractured NOF Within 24 Hours	100.0	%	50	0	20	40	66.67	75	60	20	-	-	-	-	36.73	
	VTE Risk Assessment % Completed	95.0	%	91.56	90.79	86.3	78.3	66.98	59.98	54.91	57.71	-	-	-	-	73.18	
Maternity	Elective C-Section Rate	13.0	%	11.95	12.07	11.56	10.99	11.93	12.77	13.54	13.32	-	-	-	-	12.27	
	Emergency C-Section Rate	15.0	%	18.05	17.98	17.09	18.02	17.14	20.48	18.96	17.06	-	-	-	-	18.09	
	Total C-Section Rate	28.0	%	30	30.05	28.64	29.01	29.07	33.25	32.51	30.37	-	-	-	-	30.36	
	Number of Deliveries (Count of Mothers)	-	#	410	405	398	455	461	415	443	428	-	-	-	-	3415	
	12+6 Risk Assessment	90.0	%	83.67	83.91	79.35	84.04	81.4	-	-	-	-	-	-	-	82.51	
Stroke	Stroke SSNAP Rating *	B	-	E	E	E	-	-	-	-	-	-	-	-	-		
	% of Pts Seen by Stroke Cons in 24 Hours *	95.0	%	33.33	33.33	33.33	-	-	-	-	-	-	-	-	-	33.33	
	Stroke Pts Scanned Within 1 hour *	90.0	%	49.28	49.28	49.28	-	-	-	-	-	-	-	-	-	49.28	

* Stroke metrics available quarterly from 2018/19

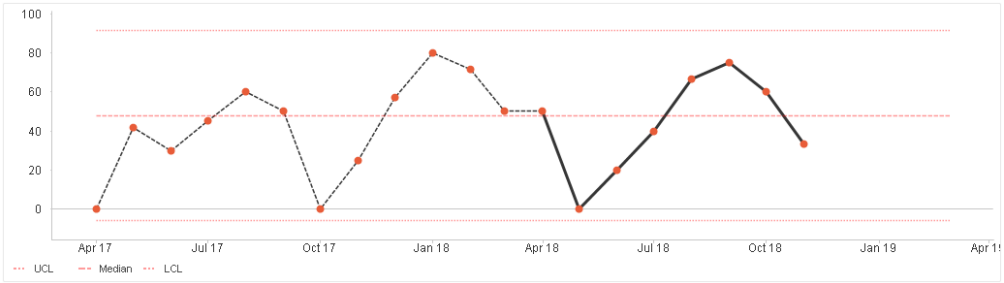
Effective Commentary:

The stroke SSNAP rating is E. This is related to three key issues, alongside delays in data entry which have affected the Trust's audit score.
Consultant input – in terms of early review and delivery of thrombolysis
Access for stroke patients to beds on Harvey Ward
Inadequate therapy staffing
The impact of the decision not to site a HASU at Medway will affect the potential to recruit additional therapists, although options for shared appointments with DGT and MTW are being reviewed. An internal review of consultant working patterns may enable some adjustments to be made which will improve the consultant aspect of the SSNAP scores, and bed management decisions are continually reviewed to try and ensure that appropriate patients are admitted to the correct ward area (not just in stroke).
The Trust continues to face the challenge of the maintenance of stroke services until spring 2020 as this is the timescale within which DGT and MTW will be in a position to deliver the HASU / ASU models.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Effective – Fracture Neck of Femur Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Best Practice	Fractured NOF Within 24 Hours	100.0	%	50	0	20	40	66.67	75	60	33.33



Specialty		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
100 - GENERAL SURGERY	%	-	-	-	-	-	-	-	100
103 - BREAST SURGERY	%	-	-	-	-	-	-	0	-
110 - TRAUMA & ORTHOPAEDICS	%	50	0	25	40	66.67	75	75	25
300 - GENERAL MEDICINE	%	-	-	0	-	-	-	-	-
430 - GERIATRIC MEDICINE	%	-	-	-	-	-	-	-	0

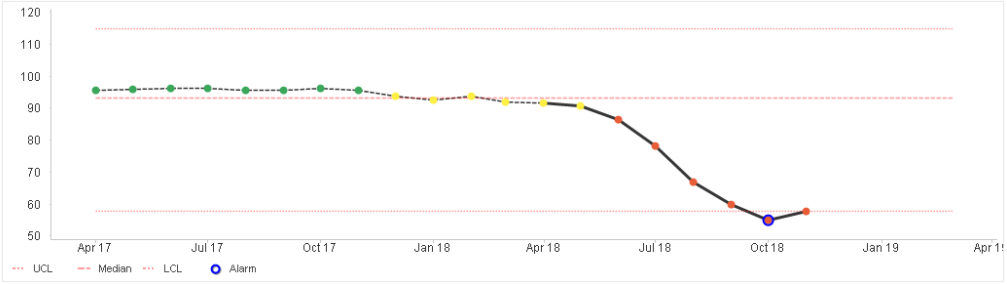
Fractured NOF in 24 Hours Definition:

The NICE guidance states that patients admitted with a fractured neck of femur (NOF) should have surgery within 24 hours of admission. This lowers overall mortality risk and aids in the patient's return to mobility. A Best Practice Tariff (BPT) is associated with this indicator to encourage prompt surgery.

Commentary	Risks & Mitigating Actions
T&O have struggled with # NOF activity within 24 hours. In part because of : • the flow/attendance profile • trauma theatre utilisation/management • complex patients who require significant working up prior to surgery • variation in anaesthetic support/confidence in managing frail patients requiring surgery • Vacancies in the Trauma Coordinator role	• Re-established the # NOF working group under the clinical leadership of Mr Paras Mohanlal • Agreement to profile # NOF as golden on the Trauma list • Explicit focus within team on the target led by the Trauma Coordinator • New Clinical Lead • Physician Associate focus 1st thing in the morning on prepping # NOF for theatre • Review of other trusts performance on management of # pathway. Plan to visit Swindon Hospital • Profile and improvement action plan will be discussed at Surgery Programme Board and in the Orthopaedic Team Meeting to ensure awareness of performance • Performance and targets fed back through the daily Trauma meeting.

Effective – VTE risk Assessment Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Best Practice	VTE Risk Assessment % Completed	95.0	%	91.56	90.79	86.3	78.3	66.98	59.98	54.91	57.71



VTE Risk Assessment Definition:

A **venous thromboembolism** (VTE) risk assessment should be carried out on all patients admitted to the Trust both electively and as an emergency. A VTE is a condition where a blood clot forms in a vein. This is most common in a leg vein but a blood clot can form in the lungs.

Commentary	Risks & Mitigating Actions
Small improvement noted from last month Trust process for data collection changed in April 2018 to Ward Clerk to input data. Trust wide training completed. Reduction in Data inputting and scrutiny following VTE specialist nurse vacancy. (August 2018) Round table/SWARM event held in November 2018with internal stakeholders transformation team and Professor Hughes to discuss immediate actions and risk review.	• VTE specialist nurse recruited commences 7th January 2018. • Task and finish group in place. • Updated training and education sessions planned for all ward clerks and senior sisters in January 2019. • Data to be included on Nursing and Midwifery report. • Daily BI reporting Ward by Ward for oversight. • Harm review- Dip test – random review of 20 sets of notes to be completed by end January 2019. • All admitted/ acquired VTE now reported on Datix.

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Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Bed Management	Bed Occupancy Rate	92.0	%	93.33	89.92	90.77	89.42	90.71	92.3	91.57	90.2	-	-	-	-	91.02	
	Average Elective Length of Stay	5.0	#	2	1.94	1.95	2.49	1.96	2.72	2.53	1.95	-	-	-	-	2.18	
	Average Non-Elective Length of Stay	5.0	#	8.19	8.16	8.02	7.68	8.25	8.43	8.5	8.73	-	-	-	-	8.23	
	Escalation Beds Open Point Prevalence in Month	0.0	#	0	76	61	123	331	327	354	226	-	-	-	-	1498	
	Delayed Transfer of Care Point Prevalence in Month	0.0	#	86	126	129	121	162	153	164	230	-	-	-	-	1171	
	% of Delayed Transfer of Care Point Prevalence in Month	3.5	%	0.58	0.85	0.89	0.82	1.06	1.02	1.05	1.54	-	-	-	-	0.98	
	Medically Fit For Discharge Point Prevalence in Month	0.0	#	2651	2942	3266	3375	3465	3285	3234	3060	-	-	-	-	25278	
	% Medically Fit For Discharge Point Prevalence in Month	7.0	%	1.11	1.16	1.32	1.42	1.34	1.29	1.15	1.14	-	-	-	-	1.24	
ED Access	ED 4 Hour Performance All Types	95.0	%	85.1	86.54	86.94	87.12	85.97	90.32	88.82	89.01	-	-	-	-	87.47	
	ED 4 Hour Performance Type 1	95.0	%	71.18	74.48	74.31	75.46	71.9	80.53	77.34	77.76	-	-	-	-	75.07	
	Median Time to ED Clinician (60mins)	60.0	#	46	52	44	42	35	33	36	36	-	-	-	-		
	Median Time to Ambulance Assessment (15mins)	15.0	#	4	3	3	4	4	3	4	3	-	-	-	-		
	30 Mins Ambulance Handover Delays	0.0	#	511	462	492	620	455	321	332	261	-	-	-	-	3454	
	60 Mins Ambulance Handover Delays	0.0	#	53	62	51	80	54	17	18	8	-	-	-	-	343	
	Number of ED arrivals by Ambulance	-	#	3129	3182	3098	3160	3018	2941	3124	3278	-	-	-	-	24930	
	ED Conversion Rate	20.0	%	26.45	24.27	25.86	26.74	25.36	25.48	25.71	23.05	-	-	-	-	25.36	

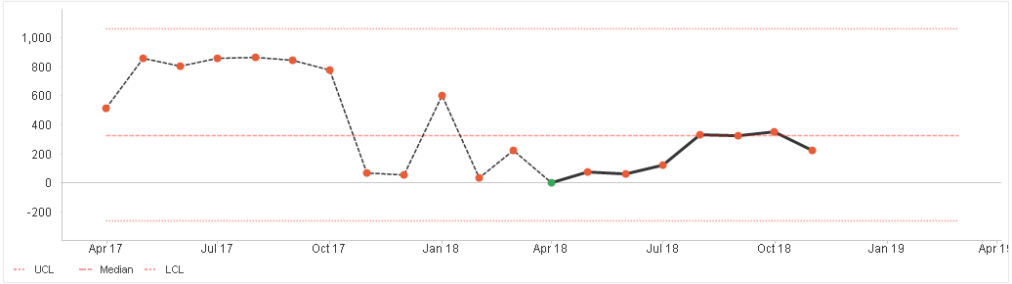
Responsive – Non-Elective Commentary:

Bed occupancy has continued to improve for 3 consecutive months with a reduction in LOS, areas identified as most improved are Byron and SAFU, both with a reduction of 5days. Areas for improvement are Milton and Tennyson with an average of 3 days increase.
Requirement for escalation beds increased in the month of November, usage was the highest YTD.
Ambulance handovers continues to improve. ED performance remains below trajectory

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Responsive – Escalation Beds Open Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Bed Management	Escalation Beds Open Point Prevalence in Month	0.0	#	0	76	61	123	331	327	354	226



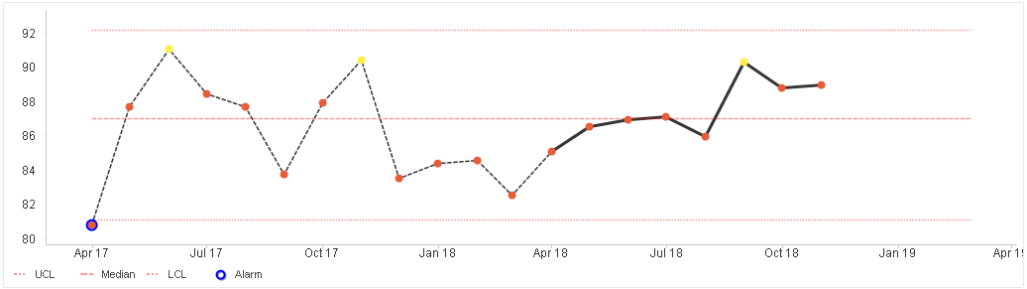
Commentary	Risks & Mitigating Actions
November has seen a significant decrease in the use of escalation beds	Financial Impact. Additional controls in place to manage staffing challenges vacancy gaps, absenteeism or the need for additional capacity

Escalation Beds Definition:

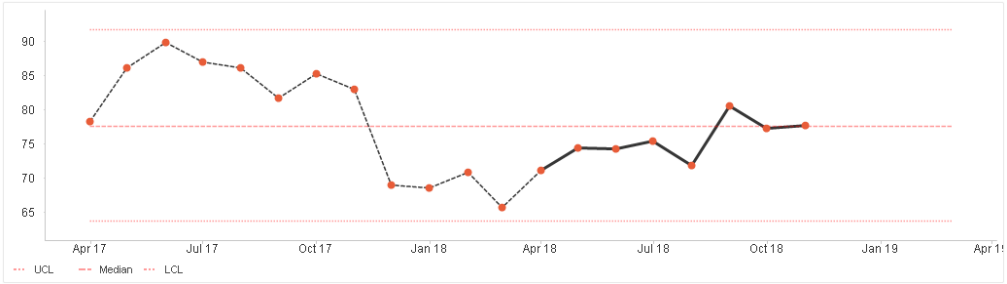
An escalation ward is defined by the NHS as a temporary ward or bed used by a Trust to support capacity in times of high demand to create additional capacity. It is acknowledged that patients "boarded" on an escalation ward are more likely to have poorer experience and high delays in discharge. These wards are not funded and staffed from a planned annual budget.

Responsive – ED 4 Hr Performance All Types and Type 1 Spotlight Report

All Types



Type 1



ED 4 Hr Performance Definition:

The four-hour A&E waiting time target is a pledge set out in the NHS Mandate. The operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. The All Types metric refers to all ED department attendances in Type 1 (on site ED) and Type 3 (MedOcc, and WICs) departments across the Trust's footprint area.

Commentary	Risks & Mitigating Actions
ED performance remains below trajectory largely due to flow. 89.71% improvement on previous month – Majors light down from 82% to 89% being treated within the 4hours standard. MEDOCC activity remains static. ED attendances were down 207 on the previous month. Increase in conveyances of 125 on the previous month.	Implementing an escalation process for ED and MEDOCC in order to manage the throughput in the department which includes MEDOCC, Secamb and Hospital capacity and demand

Responsive – Elective

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Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Diagnostic Access	DM01 Performance	99.0	%	96.11	92.9	91.86	92.3	98.2	99.24	99.54	-	-	-	-	-	95.43	
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	81.21	82.38	81.68	82.52	82.55	81.77	82.59	-	-	-	-	-	82.1	
	18 Weeks RTT Over 52 Week Breaches	0.0	#	1	1	0	2	12	11	12	-	-	-	-	-	39	
	18 Weeks RTT Total Backlog	2,000.0	#	4080	3773	3807	3645	3693	3915	3803	-	-	-	-	-	26716	
	18 Weeks RTT Completed Admitted Performance	90.0	%	51.96	50.87	54.18	55.94	56.49	55.41	55.12	-	-	-	-	-	54.3	
	18 Weeks RTT Completed Non-Admitted Performance	95.0	%	81.06	82.28	82.32	82.42	81.5	81.27	81.01	-	-	-	-	-	81.71	
	Daycase Rate	85.0	%	65.29	64.07	65.19	66.93	65.69	64.71	65.98	63.36	-	-	-	-	65.15	
	DNA Rate	10.0	%	8.41	8.6	8.45	8.53	8.52	8.86	8.73	8.54	-	-	-	-	8.58	
	First to Follow Up Ratio	-	#	1.18	1.15	1.16	1.12	1.13	1.16	1.16	1.18	-	-	-	-	1.16	
Theatres & Critical Care	Operations Cancelled By Hospital on Day	0.0	#	21	17	21	19	11	17	29	24	-	-	-	-	159	
	Cancelled Operations Not Rescheduled < 28 days	0.0	#	0	0	0	0	0	0	0	0	-	-	-	-	0	
	Urgent Operations Cancelled for the 2nd Time	0.0	#	0	0	0	0	0	0	0	0	-	-	-	-	0	
	Critical Care Occupancy Rate	92.0	%	96.55	94.33	91.61	92.66	94.44	90.69	96	94.02	-	-	-	-	93.8	

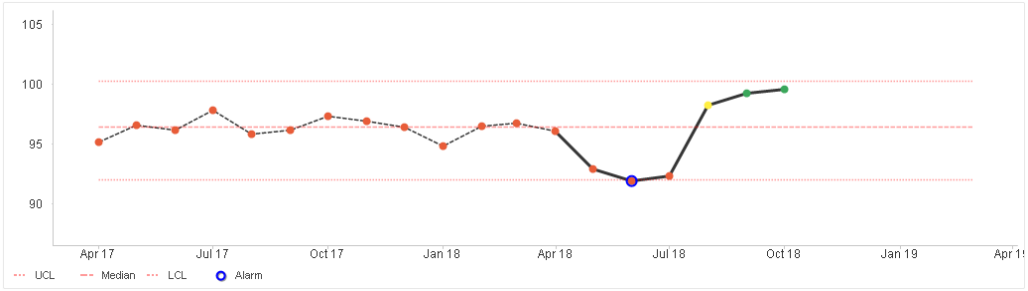
Responsive – Elective Commentary:

Diagnostic access standards remain on target.
Elective access targets – Although the Trust is not meeting the 18 weeks national standard of 92%, the Trust is compliant against the trajectory agreed. There has been an increase in 52 week breaches, and this has been driven by the long waits within Dermatology, this is being addressed through additional capacity.
Theatres – In November the Trust had 24 patients cancelled on the day of their operation, this was due to patient snot being well on the day of procedure and also due to site pressures around flow.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Safe – DM01 Performance Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
Diagnostic Access	DM01 Performance	99.0	%	96.11	92.9	91.86	92.3	98.2	99.24	99.54



KPI Name	Specialty		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
DM01 Performance	101 - UROLOGY	%	100	100	100	99.38	99.26	100	100
	104 - COLORECTAL SURGERY	%	95.48	96.71	97.36	98.44	98.08	97.12	98.81
	301 - GASTROENTEROLOGY	%	99	98.51	96.88	97.39	94.44	95.04	97.26
	320 - CARDIOLOGY	%	99.61	99.83	100	99.32	99.5	100	99.28
	341 - RESPIRATORY PHYSIOLOGY	%	100	99.4	100	100	100	97.06	100
	400 - NEUROLOGY	%	-	-	-	-	-	-	-
	812 - DIAGNOSTIC IMAGING	%	96.25	91.63	90.24	90.01	98.26	99.6	99.69
	840 - AUDIOLOGY	%	87.8	87.94	89.32	95.22	98.06	99.55	100

DM01 Performance Definition:

This measure looks at the percent of patients waiting for a diagnostics test in nationally specified modalities that have waited less than 6 weeks from referral to test.

Commentary

DM01 Performance has continued to improve against national standard and trajectory, out performing expectation.

Services meet weekly to review performance and discuss issues, risks and mitigations required, with agreed plan for improvement/delivery over next four weeks.

A TCI report is delivered weekly, enabling teams to review TCI dates vs current wait and mitigate breeches and unexpected long waits, enabling frequent and regular validation also.

The majority of services are delivering the expected standard, with the exception of Colorectal Surgery and Gastro.

Issues across all services remain and are driven by:
- Capacity (routine)
- Consultant Led clinics
- GA capacity

The DM01 & RTT meetings have now joined to ensure pathways are appropriately supported

Risks & Mitigating Actions

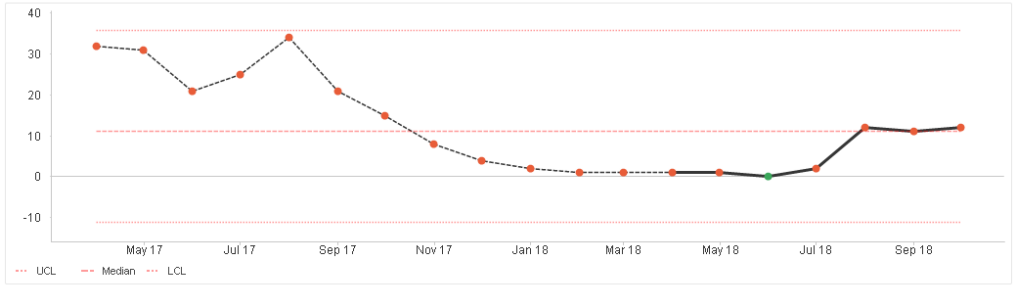
Risks:
- Capacity (Routine)
  - MRI
  - Respiratory
  - Gastro
- GA capacity
- Consultant Led Clinic capacity

Mitigations:
- Additional MRI capacity purchased (4 weeks), with plan for monitoring breeches
- Capacity and Demand review to be completed – plan for capital group submission re MRI capacity on medium to long term basis
- Additional lists running in Cardiophys for sleep studies on regular basis
- Review of sleep studies location due to ward closure (Dickens)
- Care UK contract signed for Gastro
- Additional GA & Paed lists running for MRI
- Additional GA lists running for Gastro

Safe – RTT > 52 Weeks Breaches Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	YTD
Elective Access	18 Weeks RTT Over 52 Week Breaches	0.0	#	1	1	0	2	12	11	12	39

Trend



Drill Down By: Directorate Programme **Specialty**

KPI Name	Specialty		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
18 Weeks RTT Over 52 Week Breaches	100 - GENERAL SURGERY	#	0	0	0	0	0	0	1
	104 - COLORECTAL SURGERY	#	1	0	0	1	0	0	0
	107 - VASCULAR SURGERY	#	0	0	0	0	0	1	0
	110 - TRAUMA & ORTHOPAEDICS	#	0	1	0	0	1	1	0
	300 - GENERAL MEDICINE	#	0	0	0	0	0	1	1
	330 - DERMATOLOGY	#	0	0	0	0	11	6	9
	341 - RESPIRATORY PHYSIOLOGY	#	0	0	0	0	0	1	0
	400 - NEUROLOGY	#	0	0	0	1	0	0	0
	811 - INTERVENTIONAL RADIOLOGY	#	0	0	0	0	0	1	1

>52 Weeks Breaches Definition:

A 52 week breach occurs at the point a patient has been waiting 365 days from the when a Trust receives a referral for a new condition to when the patient commences their first treatment or a pathway clock is stopped.

Commentary	Risks & Mitigating Actions
The number of 52 week breaches as a Trust has increased. This has been driven in the main by the long waiting time within the Dermatology service. Additional capacity has been sought by the Trust.	Weekly meetings are in place to review the RTT patient tracking list. The lists are reviewed and patients are tracked through their pathways to ensure safety and quality. All patients that breach the 52 week standard have a clinical harm review completed by the clinical team. This is then reviewed at Directorate level.

Responsive – Cancer & Complaints

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Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Cancer Access	Cancer 2ww Performance	93.0	%	92.99	92.47	92.76	90.44	72.61	65.19	68.13	-	-	-	-	-	82.25	
	Cancer 2ww Performance - Breast Symptomatic	93.0	%	77.61	83.33	80	98.46	88.89	90.74	75.76	-	-	-	-	-	83.76	
	Cancer 31 Day First Treatment Performance	96.0	%	100	98.78	97.84	98.66	96.6	100	94.77	-	-	-	-	-	98.06	
	Cancer 31 Day Subsequent Treatments (Surgery)	94.0	%	100	78.95	95	96.15	100	95	92.59	-	-	-	-	-	94.08	
	Cancer 31 Day Subsequent Treatments (Drugs)	98.0	%	100	100	100	100	100	100	100	-	-	-	-	-	100	
	Cancer 62 Day Treatment - GP Refs	85.0	%	86.42	83.78	90.64	85.19	79.17	80.47	83.85	-	-	-	-	-	84.46	
	Cancer 62 Day Treatment - Screening Refs	90.0	%	88.24	76.92	94.44	86.21	81.13	89.13	83.33	-	-	-	-	-	85.38	
	Cancer 62 Day Treatment - Cons Upgrades	-	%	81.82	75	91.89	76.67	78.38	79.31	74.19	-	-	-	-	-	79.91	
	Cancer 62 Day Backlog Performance	0.0	#	27	26	40	49	64	82	304	-	-	-	-	-	592	
	104 Day Cancer Waits	0.0	#	4	7	5	8	14	12	18	74	-	-	-	-	142	
Complaints Management	Number of Complaints	45.0	#	79	81	75	62	64	51	65	54	-	-	-	-	531	
	Number of Complaints Returners	-	#	2	2	2	5	3	-	6	5	-	-	-	-	25	
	% Complaints Responded to Within 30 Days	85.0	%	41.79	47.22	51.61	64.18	50.88	75.51	87.18	68.89	-	-	-	-	58.52	

Responsive – Cancer & Complaints Commentary:

Cancer – Unfortunately the Trust did not meet the 2 week wait standard. This has been mainly driven by an increase wait for Dermatology. Plans are in place and we are now seeing an increase in compliance. The 62 day performance is on an upward trajectory and shadow reporting places the Trust as compliant.

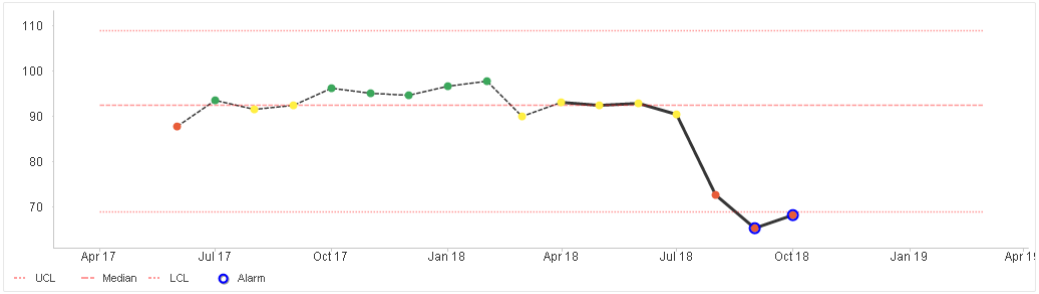
The Planned Care directorate achieved their trajectory of 100% compliance with complaint response rates in October. This was maintained in November and the directorate had zero complaints re-opened (returners). The directorate complaint process is being carefully managed within the Governance team to ensure deadlines are met, and as such, a marked improvement in performance has been seen over the past few months, and is expected to continue. An escalation process has been established to include an email from the Clinical Governance Lead, which is proving effective in ensuring comments are returned in a timely manner.

It has been more challenging to deliver improvement in complaints performance in the Unplanned and Integrated Care directorate. This is largely due to the higher number of 'backlog' of complaints.
In November Unplanned and Integrated Care received 25 new complaints with 4 complaints re-opened in November. Overall the Directorate closed 53 complaints and are progressing to clear the historic backlog of breach complaints (currently 24 outstanding breach complaints across the Directorate) by the end of January in addition to ensuring ongoing complaints are completed within the trust deadline. Trajectories have been set to monitor each Programme ensuring compliance against upcoming complaint response timeframes occurs in addition to identifying a cohort of historic breached complaint responses are closed. Methods of escalation have been established by the Deputy Director of Nursing and Deputy Medical Director.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Responsive – 2 Week Wait Performance Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
Cancer Access	Cancer 2ww Performance	93.0	%	92.99	92.47	92.76	90.44	72.61	65.19	68.13



KPI Name	Specialty		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
Cancer 2ww Performance	101 - UROLOGY	%	98.59	95	98.06	100	96.24	97.67	99.13
	103 - BREAST SURGERY	%	93.98	92.83	93.69	91.96	91.97	88.78	96.96
	104 - COLORECTAL SURGERY	%	91.43	88.79	91.11	87.25	88.14	68.6	52
	120 - ENT	%	98.31	96.13	95.42	92.82	93.4	96.91	97.59
	301 - GASTROENTEROLOGY	%	84.75	90.63	90.48	96.77	92.59	93.02	92.22
	303 - CLINICAL HAEMATOLOGY	%	100	100	100	83.33	100	66.67	100
	330 - DERMATOLOGY	%	92.86	91.32	90.62	84.85	29.73	18.64	19.94
	340 - RESPIRATORY MEDICINE	%	93.33	100	90	100	100	100	100
	400 - NEUROLOGY	%	92.31	100	100	-	100	90	85.71
	502 - GYNAECOLOGY	%	89.9	90.59	93.85	92.31	93.2	89.22	93.55
	OTHER/CORPORATE	%	81.25	96.3	92.59	90.91	100	58.33	28.57

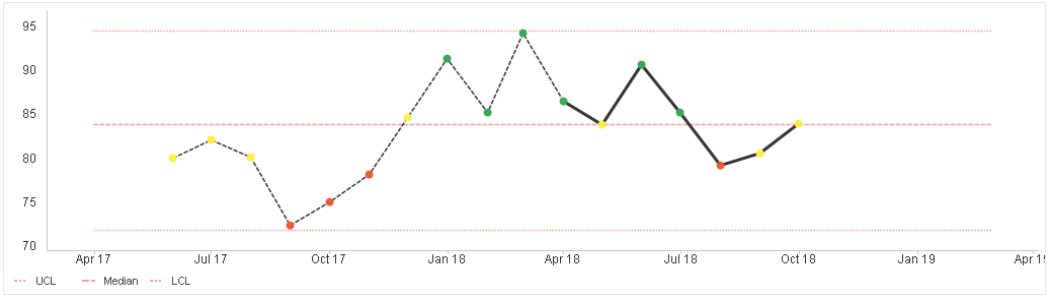
2 Week Wait Definition:

The percent of patients seen by a specialist within 14 days of an urgent GP referral for suspected cancer.

Commentary	Risks & Mitigating Actions
2 WW performance has declined particularly in the Dermatology service. The service had an increased waiting time, and is now booking at 13 days.	Demand and capacity has been carried out for Dermatology and additional clinics were allocated for 2 WW patients. Patients are being tracked carefully through the pathway to ensure all data is validated in a timely fashion. All tumour groups that are non compliant will be having deep dive pathway process mapping completed with the clinical team to ensure that the pathways are streamlined and clear.

Responsive – 62 Day Wait GP Performance Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
Cancer Access	Cancer 62 Day Treatment - GP Refs	85.0	%	86.42	83.78	90.64	85.19	79.17	80.47	83.85



KPI Name	Specialty		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
Cancer 62 Day Treatment - GP Refs	101 - UROLOGY	%	91.04	90.14	96.72	79.71	86.27	84.09	85.71
	103 - BREAST SURGERY	%	100	94.12	93.33	100	100	85.71	88.89
	104 - COLORECTAL SURGERY	%	70.59	80	66.67	50	36.36	25	33.33
	120 - ENT	%	20	16.67	66.67	100	33.33	66.67	60
	301 - GASTROENTEROLOGY	%	33.33	87.5	33.33	80	83.33	16.67	20
	303 - CLINICAL HAEMATOLOGY	%	100	0	80	87.5	33.33	100	0
	330 - DERMATOLOGY	%	96.67	91.89	100	92.86	91.67	97.37	97.3
	340 - RESPIRATORY MEDICINE	%	66.67	40	77.78	100	0	25	100
	502 - GYNAECOLOGY	%	80	50	66.67	0	87.5	100	100

62 Day Wait GP Definition:

The percent of patients treated by a specialist within 62 days of an urgent GP referral for first definitive cancer treatment.

Commentary	Risks & Mitigating Actions
62 day performance continues to improve in October 2018, however does not meet the national standard of 85%. 38 day shadow reporting does place the Trust as complaint against the standard. Specific work is being carried out in the tumour groups that are non compliant to reduce the time patients are waiting.	All tumour groups that are non compliant will be having deep dive pathway process mapping completed with the clinical team to ensure that the pathways are streamlined and clear.

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ENABLERS

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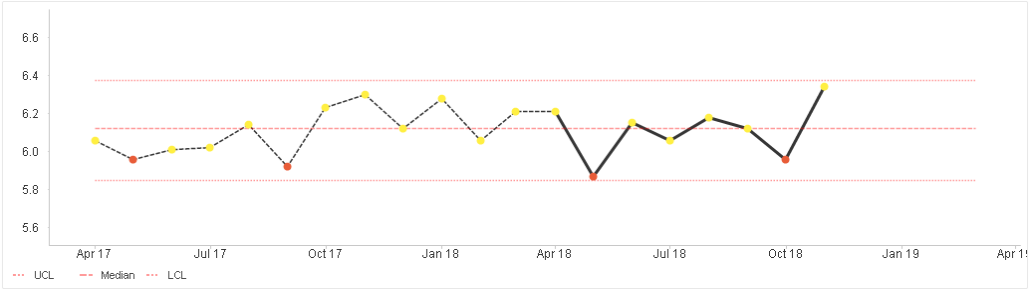
Enablers – Depth of Coding Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Data Quality & Coding	Clinical Coding - Depth of Coding	6.5	#	6.21	5.87	6.15	6.06	6.18	6.12	5.96	6.34



KPI Name	Programme		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18
Clinical Coding - Depth of Coding	ACUTE MEDICINE	#	9.06	8.62	9.06	8.81	9.14	8.84	8.79	9.18
	CANCER, DIAGNOSTICS & CLINICAL SUPPORT SERVICES	#	4.87	4.79	4.99	5.22	5.24	4.99	5.04	5.46
	PERIOPERATIVE & CRITICAL CARE	#	3.13	3.31	3.83	3.87	3.41	3.81	4.35	4.09
	SPECIALIST MEDICINE	#	6.4	6.33	6.55	6.27	6.11	6.48	5.7	6.47
	SURGICAL SERVICES	#	5.12	4.99	4.96	5.03	4.97	5.38	5.22	5.52
	WOMEN'S & CHILDREN'S HEALTH	#	3.38	3.1	3.22	3.14	3.35	3.31	3.36	3.21

Depth of Coding Definition:

'Depth of coding' is defined as the number of secondary diagnosis codes for each record (inpatient admission) in the data. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities, but may also be due to differences in coding practices between trusts.

Commentary

Following the annual nationally mandated clinical coding audit in 2017/18 it was identified that the Trust met all international standards of coding (over 90% accuracy for diagnosis and procedure codes compared to the target of 80% for both). However, multiple audits carried out in 2017/18 with internal consultants and the clinical coding team have identified challenges with patient record documentation. The team will expand the current coding training session so it is tailored to each specialty with support from national subject matter experts. Recruitment and retention challenges across Kent and Medway continue to put pressure on the incumbent clinical coding workforce at MFT.

Risks & Mitigating Actions

Risks:

- HSMR negative impact through reduced expected deaths following no diagnosis recording of some spells
- Challenges in 2019/20 contract planning as baseline data affected.
- Commissioner data Quality challenges
- Potential £1.8m FYE loss of income due to specialised commissioning activity not coded.
- Non-compliance with a number of Information Governance toolkit standards

Mitigating Actions:

- ✓ Workforce plan submitted via formal route. Decision expected October 2018.
- ✓ Clinical documentation review to be undertaken by national experts subject to receipt of an acceptable proposal.
- ✓ Enhanced training programme implementation following workforce redesign project

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WELL-LED

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WELL-LED

Contractual Staff in Post (FTE) (Current Reporting month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Fe
Contractual Staff in Post (FTE) (Current Reporting month							3818.37				
StatMan compliance (current reporting month)	86.69%	86.63%	87.17%	86.65%	85.74%	75.68%	74.50%	74.30%			
Agency Spend as % Paybill (current reporting month)	5.59%	8.43%	5.91%	5.00%	4.66%	5.74%	5.11%	4.04%			
Agency Spend as % Paybill (financial YTD)	8.00%	9.11%	7.03%	5.92%	5.89%	6.23%	6.01%	5.77%			
Bank Spend as % Paybill (Current Reporting month)	12.06%	11.24%	11.42%	16.26%	8.40%	13.22%	12.44%	12.40%			
Bank Spend as % Paybill (financial YTD)	12.10%	11.77%	11.89%	14.57%	9.02%	12.75%	12.12%	12.15%			
Temp Staffing Fill Rate - Nurse & Midwifery	72%	76%	74%	76%	73%	73%	76%	79%			

Well Led Commentary:

StatMan has dropped over the last 3 months due to migration from Mollie to OLM platform.
Agency spend as a percentage of the paybill has dropped in November compared to October and is reflective of ongoing work to increase bank.
Bank spend as a percentage of the paybill has dropped in November compared to October.
Temporary Staffing fill rate for nursing and midwifery increased in November compared to October.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Well Led – Total Sickness Rate Spotlight Report

For Slide 32

For Slide 32

For Slide 34

For slide 34

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Sickness Rate (Current Reporting month, FTE%)	3.83%	3.85%	3.94%	3.99%	3.98%	4.02%	4.11%	4.22%
Short Term sickness Rate (Current reporting month, FTE%)	1.84%	1.84%	1.92%	1.95%	1.95%	1.97%	2.04%	2.06%
Long Term sickness Rate (Current reporting month, FTE%)	1.99%	2.01%	2.02%	2.04%	2.03%	2.05%	2.07%	2.16%

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Acute Medicine	4.64%	4.57%	4.75%	5.14%	5.10%	5.06%	4.64%	4.61%
Cancer, Diagnostic & Clinical Support Services	3.27%	3.24%	3.28%	3.24%	3.16%	3.16%	3.22%	3.32%
Other/Corporate	2.20%	2.41%	2.23%	2.32%	2.28%	2.38%	2.56%	2.66%
Perioperative & Critical Care	4.01%	4.20%	4.30%	4.35%	4.48%	4.57%	4.84%	4.95%
Specialist Medicine	3.28%	3.23%	3.31%	3.37%	3.31%	3.28%	3.99%	4.06%
Surgical Services	4.22%	4.16%	4.07%	3.52%	3.54%	3.34%	3.46%	3.66%
Womens & Childrens Health	3.52%	3.67%	4.00%	4.11%	4.17%	4.29%	4.11%	4.21%

Acute Medicine
Cancer, Diagnostic & Clinical Support Services
Other/Corporate
Perioperative & Critical Care
Specialist Medicine
Surgical Services
Womens & Childrens Health

Commentary

Sickness absence has gone up in November compared to October by +0.11

Risks & Mitigating Actions

Sickness Rate Definition:

The *absence rate* is the *ratio* of workers with absences to total full-time wage and salary employment.

Safe Staffing

NHS Medway NHS Foundation Trust

		Day				Night				Day		Night	
		Registered Staff		Care Staff		Registered Staff		Care Staff					
WARD	Beds	Total monthly planned staff	Total monthly actual staff	Total monthly planned staff	Total monthly actual staff	Total monthly planned staff	Total monthly actual staff	Total monthly planned staff	Total monthly actual staff	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Average fill rate - registered staff (%)	Average fill rate - care staff (%)
Arethusa Ward	27	1507	1188	1598	1565	968	1034	987	1051	79%	98%	107%	106%
Bronte Ward	18	1095	1077	716	716	1058	1117	705	705	98%	100%	106%	100%
Byron Ward	26	1522	1092	1092	1174	1013	1000	1011	1062	72%	108%	99%	105%
CCU	4	976	687	0	221	690	690	0	46	70%		100%	
Delivery Suite	16	2835	2832	594	589	2772	2782	360	360	100%	99%	100%	100%
Dickens Ward	25	1762	138	1324	234	990	360	660	231	8%	18%	36%	35%
Dolphin (Paeds)	30	3126	2914	1688	1372	2415	2336	345	359	93%	81%	97%	104%
Harvey Ward	25	1577	1123	1560	1501	1013	1015	1013	1013	71%	96%	100%	100%
ICU	9	3728	2977	0	0	3362	2784	0	0	80%		83%	
Keats Ward	26	1519	1009	1067	1952	990	924	990	1717	66%	183%	93%	174%
Kent Ward	24	1076	1049	588	546	720	720	672	624	97%	93%	100%	93%
Kingfisher SAU	18	1841	1684	1091	1072	1650	1640	660	693	91%	98%	99%	105%
Lawrence Ward	19	1089	1027	1108	1195	1013	1015	675	765	94%	108%	100%	113%
Lister Assessment Unit	19	2637	1990	1787	1828	1350	1360	675	751	75%	102%	101%	111%
McCulloch Ward	29	1902	1490	1251	1198	1650	1705	671	674	78%	96%	103%	100%
Medical HDU	6	1409	1206	340	346	1369	1248	0	12	86%	102%	91%	
Milton Ward	26	1544	986	1459	1835	1013	1021	1013	1021	64%	126%	101%	101%
Nelson Ward	24	1576	1009	1165	1214	993	981	660	770	64%	104%	99%	117%
NICU	32	4110	3688	419	116	4129	3529	46	0	90%	28%	85%	0%
Ocelot Ward	12	885	888	518	531	720	731	348	348	100%	103%	102%	100%
Pearl Ward	23	1005	1006	565	565	1043	1046	360	360	100%	100%	100%	100%
Pembroke Ward	27	1860	1550	1068	1544	1650	1650	660	1210	83%	145%	100%	183%
Phoenix Ward	30	1957	1358	1241	1160	1320	1320	990	924	69%	93%	100%	93%
Sapphire Ward	23	1559	1082	1122	1238	990	990	990	1016	69%	110%	100%	103%
SDCC	26	2468	1418	1287	923	484	626	242	374	57%	72%	129%	154%
Surgical HDU	10	2216	2050	361	360	1980	1892	0	0	93%	100%	96%	
Tennyson Ward	27	1576	1035	1211	1404	990	976	990	1023	66%	116%	99%	103%
The Birth Place	9	1064	1064	360	360	1044	1048	240	240	100%	100%	100%	100%
Victory Ward	18	1075	737	764	726	990	836	660	649	69%	95%	84%	98%
Wakeley Ward	25	1579	1068	1134	1134	1013	1069	1012	1000	68%	100%	106%	99%
Will Adams Ward	26	1581	1104	1134	1189	1001	1014	1001	1067	70%	105%	101%	107%
Trust total	**659**	**55,653**	**43,523**	**29,606**	**29,835**	**42,378**	**40,457**	**18,635**	**20,063**	**78.2%**	**100.8%**	**95.5%**	**107.7%**

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: Thursday, 10 January 2019 Agenda Item: 6.1

Title of Report	**Finance Report**
Prepared By:	Ian O'Connor, Director of Finance (Interim)
Lead Director	Ian O'Connor, Director of Finance (Interim)
Committees or Groups who have considered this report	Executive Group Finance Committee
Executive Summary	Summary report attached.
Resource Implications	None
Risk and Assurance	BAF compliance and Risk assessments undertaken.
Legal Implications/Regulatory Requirements	At Q3 it is likely there will be a need to reforecast the net year end deficit. Regulators have been informed and are working closely with the Trust on plans to limit any deficit and deliver the best possible position.
Improvement Plan Implication	Additional cost improvements will be required and a continuation of the grip and control processes already in place.
Quality Impact Assessment	Resources are not being starved to front line provision. Confirm and challenge sessions and additional cost improvement opportunities continue to be developed and managed through the established Quality Impact Assessment Framework.
Recommendation	The Board is asked to note this report and consider any further delegated action it might want to delegate through the finance committee.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 This report is intended to represent a summary of the more detailed report provided to the Finance Committee. It is intended to provide the Board with assurance, knowledge and insight into the Trusts financial standing.

1.2 Appendix 1 of this report sets out a series of individual metrics designed to show progress over time and assess the risks associated with operational performance and the impact on the Trust's financial position.

2 INCOME AND EXPENDITURE

2.1 To the end of November the Trust is reporting a year to date deficit of £33.0m (excluding income from the Provider Sustainability Fund). This is favourable to the planned deficit by £8k. November's in month performance is a deficit of £3.0m although this is supported by £0.7m of non-recurrent adjustment.

2.2 PSF income in November is £0.9m adverse to plan by £0.4m due to the Trust not meeting the A&E performance target. PSF income is predicated on hitting the planned financial position at the end of every quarter. It is anticipated the Trust will achieve the control total at the end of December yet will start to move away from this plan in the final quarter. This will require a review of our forecast once the Quarter 3 position is known.

2.3 The forecast year end position at Month 8 reported to NHSI excluding PSF is a deficit of £46.9m and including PSF is £38.1m adverse to plan by £3.8m due the A&E performance target not being met. These are best case forecasts and it is likely there will be a need to vary the forecast at the end of Quarter 3 in line with the most likely outturn scenario.

	Month 8			Year to Date			Annual		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Clinical Income	20,700	22,265	1,565	166,057	168,731	2,674	246,617	250,943	4,325
Other Income	1,984	2,026	42	15,507	18,008	2,501	23,243	26,802	3,559
Pay	(15,473)	(16,664)	(1,192)	(134,692)	(137,562)	(2,871)	(197,966)	(206,139)	(8,173)
Non –pay	(9,017)	(9,240)	(223)	(70,761)	(72,795)	(2,034)	(104,801)	(104,177)	624
EBITDA	**(1,806)**	**(1,613)**	**193**	**(23,889)**	**(23,619)**	**271**	**(32,907)**	**(32,571)**	**336**
Non Operating Expenses	(1,193)	(1,389)	(196)	(9,126)	(9,389)	(262)	(14,036)	(14,370)	(334)
Surplus/(Deficit) before STF	**(2,999)**	**(3,002)**	**(3)**	**(33,016)**	**(33,007)**	**8**	**(46,943)**	**(46,941)**	**2**
PSF	1,266	885	(381)	6,964	4,874	(2,090)	12,663	8,865	(3,798)
Total Surplus/(Deficit)	**(1,733)**	**(2,117)**	**(384)**	**(26,052)**	**(28,133)**	**(2,082)**	**(34,280)**	**(38,076)**	**(3,796)**

Report to the Board of Directors

3 COST IMPROVEMENT PROGRAMME

3.1 The targeted cost improvement programme overall is reported ahead of plan at the end of November by £1.4 million. This has been offset by number of pressures across divisions, although of most significance in unplanned care.

3.2 Cumulatively to the end of November these offset the over-performance on the cost improvement programme with a net £8,000 favourable variance before the Provider Sustainability Fund is applied.

4 CAPITAL

4.1 The capital plan for 2018/19 was ambition with expenditure of £31.2 million anticipated. Current forecasts are that around £18.3million will be spent however there is some concern that this is also ambition with £6 million being spent in the first 8 months of 2018/19, according to the table below.

	Month 8			Year To Date			Annual		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Backlog Maintenance	400	120	(280)	4,210	1,490	2,720	5,700	5,700	0
Plant/Equip/Trans/Fits/Other	120	70	(50)	700	1,160	(460)	2,400	2,100	300
Fire Safety	1,327	362	(965)	7,100	1,585	5,515	14,200	8,000	6,200
IT	200	390	190	1,190	1,530	(340)	2,200	2,500	(300)
Emergency Department	370	0	(370)	5,020	0	5,020	6,600	0	6,600
Original Plan Total	**2,417**	**942**	**(1,475)**	**18,220**	**5,765**	**12,455**	**31,100**	**18,300**	**12,800**
FUNDED - Wifi Enhancements	130	100	(30)	130	100	30	130	130	0
Total	**2,547**	**1,042**	**(1,505)**	**18,350**	**5,865**	**12,485**	**31,230**	**18,430**	**12,800**

5 WORKING CAPITAL

5.1 The Trust relies on deficit cash loans each month. The cash held is managed by ensuring these funds are drawn in line with the planned deficit and that loans are not requested (hence incurring interest charges) ahead of when the cash is needed. This follows a standard monthly cycle and is actively managed by the financial control team.

Report to the Board of Directors

6 FINANCE AND USE OF RESOURCES METRICS

6.1 The rating at Month 8 is a 3. With the changing forecast, the Trust will move away from a score of 2, to a score of 4 for distance from financial plan. However, at the end of the financial year, the overall Use of Resources Rating will remain at 3 due to the excellent agency rating of 1.

Summary Metrics: Finance and Use of Resources

Key Metrics	Current Month	Trend
Capital service cover rating	4	
Liquidity rating	4	
I&E margin rating	4	
Distance from financial plan	2	
Agency rating	1	
Overall Use of Resources Rating	3	

7 CONCLUSION

7.1 The Board is asked to note the position in this report in particular the likelihood for a need to reforecast the financial position once the Q3 position is known.

Ian O'Connor
Interim Director of Finance
December 2018

Report to the Board of Directors

Board Date: Thursday, 10 January 2019 Agenda item: 6.2

Title of Report	**Board Assurance Framework**
Prepared By:	Brenda Thomas, Company Secretary
Lead Director	James Devine, Chief Executive
Committees or Groups who have considered this report	Board Development Session Executive Group
Executive Summary	The Board Assurance Framework (BAF) was discussed at the Board development Session on 6 December 2018 and subsequently reviewed by the Executive Directors at the Executive Group meeting on 19 December 2018. This report summarises the above discussion and review, which resulted in the presentation of a new BAF, revised risk scoring and new risks raised. There are 11 risks on the BAF with risk threshold of 12 or higher.
Resource Implications	None at this time.
Risk and Assurance	As per Risk Management Strategy and Policy.
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.
Improvement Plan Implication	Not applicable.
Quality Impact Assessment	Not required at this stage.

Board Assurance Framework

Recommendation	The Trust Board is asked to: i. Review the BAF, provide necessary scrutiny and provide feedback on the risks; ii. Note that the BAF is still work in progress; and iii. Approve the new BAF format.			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☒	☒	☒	☒

Board Assurance Framework

1 EXECUTIVE SUMMARY

1.1 At the Trust Board Development session on 6 December 2018, members of the Board reviewed the Board Assurance Framework (BAF). Subsequently, Executive Directors, at the Executive Group meeting on 19 December 2018, reviewed their individual strategic risks and a new BAF format. The new BAF format, which brings reporting of strategic risks in line with other Foundation Trusts, was agreed by the Executive Group on 19 December 2018.

1.2 Risks have been revised and new strategic risks raised. Risk description now includes a title, cause and effect and impact of the risk on the Trust. In addition, what the key controls are and assurances on these controls.

1.3 Summary of the review is presented under heading two and the full BAF, which is still work in progress, presented as Appendix 1.

2 BOARD ASSURANCE FRAMEWORK REVIEW

2.1 The agreed revisions to the strategic risks and their scorings are summarised below:

2.1.1 **Finance risks: (Link to Strategic Objective Three - Financial Stability)**

Previous BAF

There were three strategic risks on the previous BAF:

Going Concern	initial risk = 16 (4x4); current risk = 16 (4x4); target risk = 6 (2x3)
Unable to deliver our financial control total	initial risk = 16 (4x4); current risk = 16 (4x4); target risk = 6 (2x3)
Risk that central funding is not made available as required to support the deficit, capital investment, and loan repayments that fall due	initial risk = 16 (4x4); current risk = 8 (4x2); target risk = 6 (2x3)

New BAF

There are now four strategic risks on the BAF (refer to the full BAF in Appendix 1):

Delivery of financial control total	initial risk = 16 (4x4); current risk = 20 (4x5); target risk = 12 (4x3)
Investment	initial risk = 16 (4x4); current risk = 12 (4x3); target risk = 12 (4x3)
Failure to achieve longer term financial sustainability	initial risk = 16 (4x4); current risk = 25 (5x5); target risk = 12 (4x3)
Going Concern	initial risk = 16 (4x4); current risk = 8 (4x2); target risk = 8 (4x2)

2.1.2 **Workforce risks: (Link to Strategic Objective Four: Our People)**

Previous BAF

There was a single strategic risk on the previous BAF:

Recruit/ Retain sufficient qualified staff	initial risk = 16 (4x4); current risk = 12 (4x3); target risk = 4 (2x2)

New BAF

There are now three strategic risks on the BAF (refer to the full BAF in Appendix 1):

Staffing levels including recruitment and retention	initial risk = 16 (4x4); current risk = 8 (4x2); target risk = 8 (4x2)
Staff Engagement	initial risk = 12 (3x4); current risk = 12 (3x4); target risk = 6 (3x2)
Best staff to deliver the best of care	initial risk = 12 (3x4); current risk = 12 (3x4); target risk = 6 (3x2)

2.1.3 **System Integration risks: (Link to Strategic Objective One - Integrated Health Care**)

Previous BAF

There were three strategic risks on the previous BAF:

Failure of partnership and integration	initial risk = 16 (4x3); current risk = 9 (3x3); target risk = 6 (2x3)
Brand failure	initial risk = 12 (4x3); current risk = 9 (3x3); target risk = 6 (2x3)
Collaborating with partners	initial risk = 16 (4x4); current risk = 9 (3x3); target risk = 6 (2x3)

New BAF

There is now a single strategic risk on the BAF, which incorporates the three previous risks (refer to the full BAF in Appendix 1):

Failure of partnership working to deliver systems integration, stability and better patient services via the formation of an Integrated Care Partnership (ICP).	initial risk = 16 (4x4); current risk = 12 (4x3); target risk = 6 (3x2)

2.1.4 **Innovation risks: (Link to Strategic Objective Two: Innovation)**

Previous BAF

There were three strategic risks on the previous BAF:

Innovation Strategy	initial risk = 16 (4x4); current risk = 12 (4x3); target risk = 9 (3x3)
Capability	initial risk = 9 (3x3); current risk = 9 (3x3); target risk = 4 (2x2)
Funding	initial risk = 9 (3x3); current risk = 9 (3x3); target risk = 4 (2x2)

New BAF

Risk titles largely remained the same, with the exception of risk 1 - 'Strategy' being removed from 'Innovation Strategy'.

Innovation	initial risk = 16 (4x4); current risk = 16 (4x4); target risk = 12 (4x3)
Capability	initial risk = 9 (3x3); current risk = 12 (4x3); target risk = 9 (3x3)
Funding	initial risk = 9 (3x3); current risk = 9 (3x3); target risk = 9 (3x3)

2.2 The above proposed changes have been reflected in the BAF attached as Appendix 1.

3 NEXT STEPS

3.1 Should the Board approve the new BAF, subsequent reporting will include highlight report showing movement on the risk scoring (if any) for the past three meetings.

4 APPENDICES

4.1 Appendix 1- Board Assurance Framework (new format)

4.2 Appendix 2 - Risk Matrix

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

COMPOSITE RISK: Finance							
EXECUTIVE LEAD: Director of Finance							
LINKS TO STRATEGIC OBJECTIVE: Objective Three - We will deliver financial sustainability and create value in all we do							
Risk Description	**Initial Risk Rating**	**KEY Controls**	**KEY Assurances on Controls**	**Gaps in Controls and Actions to address**	**Current Risk Rating**	**Target Risk Rating**	**Target Date**
TITLE: Delivery of financial control total **CAUSE AND EFFECT:** There is a risk that the Trust may be unable to establish financial sustainability within the required timeframe due to inability to realise efficiencies. **IMPACT:** This may lead to inability to return to balance position and deliver the financial control total leading to a reputational impact.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Monthly reporting of financial position to finance committee and Board, demonstrating: • agency usage has reduced and bank usage increased – continuing to focus on this, and to address bank rate differentials • improving run rate during the year. 2. Establishment of Programme Management Office and appointment of Financial Improvement Director to track operational delivery and financial consequences of those actions. 3. Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board. Weekly performance overview meetings. Internal accountability framework at programme level. 4. Monitoring controls: Monthly reporting of actual v budget performance for review at PRMs and presented to the Board. Weekly performance overview meetings. Internal accountability framework at programme level. 5. Fortnightly system transformation meetings to look at strategy for efficiency across care pathways. 6. Monthly Integrated Assurance Meetings with regulators.	1. Heightened Grip and Control processes (Q4 2018/19) 2. Setting of revised forecast (Q3 2018/19)	1. Establishment and prosecution of system wide recovery plan 2. Understanding of shifts in reference costs and model hospital between years 3. Assessing impact of quarterly spend and activity on reference costs	**4 (major) X 5 (almost certain) = 20 [Extreme]**	**4 (major) X 3 (possible) = 12 [High]**	Establishment of system wide Recovery Plan: **31/03/2019** Prosecution of system wide Recovery Plan: **Dependent on the Plan** Assessing impact of quarterly spend: **2019/20**
TITLE: Investment **CAUSE AND EFFECT:** If there is insufficient cash to invest in new technologies, there is a risk to the transformation plan. **IMPACT:** Non-delivery of transformation plan.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Governed entirely by the availability of cash, obtaining loans for significant investment in new technologies will require business cases to be signed off by regulators unless affordable within the existing capital programme or through a revenue stream. (Note: Risk not fully mitigated from the Trusts perspective until it starts to generate a cash surplus).	1. Development of standard business case process and 6 month review point by Finance Committee (Q4 2018/19).		**4 (major) X 3 (possible) = 12 [High]**	**4 (major) X 3 (possible) = 12 [High]**	**31/03/2019**

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

COMPOSITE RISK: Finance							
EXECUTIVE LEAD: Director of Finance							
LINKS TO STRATEGIC OBJECTIVE: Objective Three - We will deliver financial sustainability and create value in all we do							
Risk Description	**Initial Strategic Risk Rating**	**KEY Controls**	**KEY Assurances on Controls**	**Gaps in Controls and Actions to address**	**Current Strategic Risk Rating**	**Target Strategic Risk Rating**	**Target Date**
TITLE: Failure to achieve longer term financial sustainability. **CAUSE AND EFFECT:** Achieving financial sustainability is a statutory responsibility. Improving the position will lead to enhanced reputation leading to an improved capability for recruitment into key roles. **IMPACT:** This may lead to further regulatory action.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Transformation reports on delivery of in-year efficiency programmes 2. Benchmarking material available from model hospital and other sources	1. Development of longer term financial model based on impact of 2018/19 delivery (M12 18/19). 2. Programme for the development of service line information and its migration to service line management processes to be established (Q4 2018/19) (IOC). 3. Reporting of identified pressures alongside CIP and budgetary delivery to Finance Committee on a regular basis (M8 2018/19 and ongoing) (IOC) 4. Developing planning tools to better triangulate resources with activity. (Linked Capacity, Activity, Financial and Workforce plans) (JL) 5. Development of system wide financial narrative and joint plans with commissioners and other key stakeholders. (IOC)	1. Better understanding of run rate and impact of changes. 2. Development of service line and Patient Level Information and Costing System (PLICs). 3. Closer scrutiny at PRMs	**5 (catastrophic) X 5 (almost certain) = 25 [Extreme]**	**4 (major) X 3 (possible) = 12 [High]**	**2019/20** **December 2019** **Q4 2018/19**
TITLE: Going Concern **CAUSE AND EFFECT:** There is a risk that the Trust's Going Concern assessment is at risk given the proportionality of the continued and sustained deficit. **IMPACT:** This could lead to further licence conditions and potential regulatory action.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Interaction with regulators for loans to support deficit and capital requirements has mitigated this risk. (**Note:** Risk may increase with a national context with working capital needing to be managed effectively to maintain the supply chain).			**4 (major) X 2 (unlikely) = 8 [High]**	**4 (major) X 2 (unlikely) = 8 [High]**	

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

COMPOSITE RISK: Workforce							
EXECUTIVE LEAD: Director of Human Resources and Organisational Development							
LINKS TO STRATEGIC OBJECTIVE: Objective Four - We will enable our people to give their best and achieve their best							
Risk Description	**Initial Risk Rating**	**KEY Controls**	**KEY Assurances on Controls**	**Gaps in Controls and Actions to address**	**Current Risk Rating**	**Target Risk Rating**	**Target Date**
TITLE: Staffing levels including recruitment and retention **CAUSE AND EFFECT:** There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function **IMPACT:** This may lead to an impact on patient experience, quality, staff morale and safety	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Strategy: Workforce Strategy in place to address current workforce pressures, link to strategic objectives and national directives.	Workforce strategy in place from April 2018 to 31 March 2019	Talent management to support the Trust's successional planning process due to form part of revised Workforce Strategy alongside culture programme. [April 19] Launch of retention programmes across Trust from [January 2019].	**4 (major) X 2 (unlikely) = 8 [High]**	**4 (major) X 2 (unlikely) = 8 [High]**	**March 2020**
		2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating: • Current contractual vacancy levels (workforce report) • Sickness, turnover, starters leavers (IQPR) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners.	1. Trust vacancy rate at 17.5%. 2. Sickness rate 4.1% 3. Substantive workforce 82.4%				
		3. Monitoring controls: • Monthly reporting of vacancies and temporary staffing usage at PRMs; • Daily temporary staffing reports to services and departments against establishment; Daily pressure report during winter periods for transparency of gaps.	1. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing. 2. Temporary staffing and daily pressure/gap report in operation.				
		Attraction: Resourcing plans based on local, national and international recruitment. Progress on recruitment reported to Board. Employment benefits expanded.	1. Number of substantive nurses currently at highest point since 2015. C.450 international nursing offers in place.				
		4. Temporary staffing delivery: • NHSI agency ceiling reporting to Board; • Weekly breach report to NHSI; • Reporting to Board of substantive to temporary staffing paybill.	1. £3.4m favourable to ceiling; 2. Averaging 14 breaches per week compared to c1000 in 2016 3. Agency workforce 5% 4. Bank workforce 12%				
		5. Workforce redesign: • PRM review of hard to recruit posts and introduction of new roles; • Reporting to Board apprenticeship levy and apprenticeships.	84 apprentices of 101 target				
		6. Operational: • Operational KPIs for HR processes and teams reported monthly.	85% of operational HR KPIs met				

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

COMPOSITE RISK: Workforce							
EXECUTIVE LEAD: Director of Human Resources and Organisational Development							
LINKS TO STRATEGIC OBJECTIVE: Objective Four - We will enable our people to give their best and achieve their best							
Risk Description	**Initial Risk Rating**	**KEY Controls**	**KEY Assurances on Controls**	**Gaps in Controls and Actions to address**	**Current Risk Rating**	**Target Risk Rating**	**Target Date**
TITLE: Staff Engagement **CAUSE AND EFFECT:** Should there be a deterioration of staff engagement with the Trust due to lack of confidence, this may lead to worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice	**3 (moderate) X 4 (likely) = 12 [High]**	1. Strategy: Workforce Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the 'Best Culture'.	1. Workforce strategy in place from April 2018 to 31 March 2019.	Local survey action plans to be developed and discussed through PRM processes. Pulse surveys to be implemented to enable continuous feedback. Values-based recruitment to be reviewed in March 2019. Lower than average staff engagement score (staff survey 2017) of 3.66.	**3 (moderate) X 4 (likely) = 12 [High]**	**3 (moderate) X 2 (unlikely) = 6 [Moderate]**	**March 2021**
		2. Culture Intervention: The Trust has engaged with specialist to deliver 'You are the difference' culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change.	1. You are the difference (YATD) commenced in Q2 18/19, baseline and progress to be assessed [Feb. 2019]; 2. YATD Ambassador programme implemented to further embed ethos locally and sustain the programme.				
		3.Staff Communications: • Weekly Chief Executive communications email; • Monthly Chief Executive all staff session (December 2018 onwards); • Senior Team briefing pack monthly.	Communications routes well-established in Trust.				
		4. Staff Survey results: Annual report to Board demonstrating: • Trust scores across key domains; • Comparative results from previous years and other organisations; • Heat maps for targeted interventions. • Local survey action plans to address key concerns.	Survey 2017 staff engagement score, 3.66 – lower than average (3.79)				
		5. Leadership development programmes: • Implemented to ensure leadership skills and techniques in place.	1.Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3.Henley Business School MA leadership programme launched in Q4 18/19.				
		6. Policies, processes and staff committees in place: • Freedom to speak up guardian route to Chief Executive; • Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; • Respect – countering bullying in the workplace policy; • Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.	1. Freedom to speak up guardians in place; 2. Promoting professional pyramid in place, training for peer messengers continuing; 3. Respect policy in place; 4. JSC and JLNC in place.				
		7. Well-being interventions in place: • Employee assistance programme and counselling; • Advice and health education programmes; • Connect 5 training front line staff to help people improve mental wellbeing and signpost to specialist support.	1. Employee assistance programme launched and live; 2. Advice, education and Connect 5 programmes live.				
		7. Values embedded into the Trust and culture: • Values-based recruitment (VBR) in place for medical and non-medical positions; • Values-based appraisal in conjunction with performance.	1. VBR in place since June 2018; 2. Qualitative and quantitative values-based appraisal in place since April 2018.				

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

COMPOSITE RISK: Our People							
EXECUTIVE LEAD: Director of Human Resources and Organisational Development							
LINKS TO STRATEGIC Objective Four - We will enable our people to give their best and achieve their best							
Risk Description	**Initial Risk Rating**	**KEY Controls**	**KEY Assurances on Controls**	**Gaps in Controls and Actions to address**	**Current Risk Rating**	**Target Risk Rating**	**Target Date**
TITLE: Best staff to deliver the best of care **CAUSE AND EFFECT:** Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover. **IMPACT:** This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.	**3 (moderate) X 4 (likely) = 12 [High]**	1. Strategy: Workforce Strategy in place to address the underlying cultural issues within the Trust to deliver the 'Best Culture' with the best of people.	Workforce strategy in place from April 2018 to 31 March 2019	Competency compliance to be linked to incremental pay progression [April 2019]	**3 (moderate) X 4 (likely) = 12 [High]**	**3 (moderate) X 2 (unlikely) = 6 [Moderate]**	**March 2021**
		2. Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency. Overall StatMan (statutory and mandatory training) compliance report to Board (bi-monthly) and internally weekly.	Competency profile in place for all positions.				
		3. Right attitude and values: • Values-based recruitment (VBR) in place for medical and non-medical positions; • Values-based appraisal in conjunction with performance; • Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; • Respect – countering bullying in the workplace policy.	1. VBR in place since June 2018; 2. Qualitative and quantitative values-based appraisal in place since April 2018; 3. Promoting professional pyramid in place, training for peer messengers continuing; 4. Respect policy in place.				
		4. Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity: • Current contractual vacancy levels (workforce report) • Monthly reporting of vacancies and temporary staffing usage at PRMs; • Reporting to Board of substantive to temporary staffing paybill.	1. Trust vacancy rate at 17.5%; 2. Substantive workforce 82.4%; 3. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing.				
		5. Leadership development programmes implemented to ensure leadership skills and techniques in place.	1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 3. Henley Business School MA leadership programme launched in Q4 18/19.				
COMPOSITE RISK: System Integration to deliver sustainable future system model of care							
EXECUTIVE LEAD: Director of Planning and Partnerships							
LINKS TO STRATEGIC OBJECTIVE: One - Integrated Health Care: We will work collaboratively with our local partners to provide the best of care and the best patient experience							
Risk Description	**Initial Risk Rating**	**KEY Controls**	**KEY Assurances on Controls**	**Gaps in Controls and Actions to address**	**Current Risk Rating**	**Target Risk Rating**	**Target Date**
TITLE: Failure of partnership working to deliver systems integration, stability and better patient services via the formation of an Integrated Care Partnership (ICP). **CAUSE AND EFFECT:** There is a risk that the Trust may not be seen as an organisation to partner with and therefore not be able to transform clinical services to the degree required. **IMPACT:** The trust is unable to achieve its strategic objective of working within an Integrated Care System (ICS) via the formation of a local Integrated Care Partnership (ICP) to achieve system sustainability and improve the quality of care provided to serve.	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Establishment of fortnightly Medway & Swale Transformation Board. > Chair alternates between the CCG AO and MFT CEO. >Membership is made up of executive from all provider and commissioning organisation > System recovery is a standing agenda item. >CIP & QIPP plans as well as commissioners key transformational programmes monitored via the Board.	1. Progress against system recovery and integration plans monitored independently via NHS England and NHS Improvement bi-monthly Assurance meetings. 2. Regular updates against milestones submitted to Executive and Board of Directors meetings. 3. Collaborative agreements drafted with corporate governance best practice utilised. 4. Legal advice procured regarding agreements. NHS England and NHS Improvement new models of care teams utilised for advice and guidance on process.	1. Unsure planning guidance form NSHE/I as to future models. 2. No formal legal vehicle in existence to facilitate alternative forms. 3. Patient and staff side engagement strategy needs to be further developed.	**4 (major) X 3 (possible) = 12 [High]**	**3 (moderate) X 2 (unlikely) = 6 [Moderate]**	**March 2020** to form a functioning ICP
		2. Systems wide strategic vision written in partnership with all sector partners.					
		3. Agreed Intergraded Care Partnership model in place with systems partners actively working to mobilise key collaborative elements.					
		4. A formal Strategy & Planning Function has been established up within the Acute Trust.					

APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

COMPOSITE RISK: Innovation							
EXECUTIVE LEAD: Director of Finance							
LINKS TO STRATEGIC OBJECTIVE: Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care							
Risk Description	**Initial Risk Rating**	**KEY Controls**	**KEY Assurances on Controls**	**Gaps in Controls and Actions to address**	**Current Risk Rating**	**Target Risk Rating**	**Target Date**
TITLE: Innovation There may be difficulty in making appropriate decisions with imperfect information on the future clinical and IT strategy of the STP and the organisation's role therein. **CAUSE AND EFFECT:** **IMPACT:**	**4 (major) X 4 (likely) = 16 [Extreme]**	1. Organisational structure devised to ensure services aligned and encourage innovation. Further work in progress on colocation of services to assist best working practices. 2. Working with Getting it Right First Time (GIRFT) to improve efficiency and effectiveness of surgical pathways.		Development of longer term Innovation Strategy	**4 (major) X 4 (likely) = 16 [Extreme]**	**4 (major) X 3 (possible) = 12 [High]**	
TITLE: Capability There is a risk that the Trust does not have sufficient capacity and capability to implement the required technology. **CAUSE AND EFFECT:** **IMPACT:**	**3 (major) X 3 (possible) = 9 [High]**	1. Innovative front door model streaming to Primary Care (MEDOCC), ambulatory emergency centre and assessment areas. £1m capital Investment received for Urgent Care Front Door.		IT Capability ▪ development of tender	**4 (major) X 3 (possible) = 12 [High]**	**3 (major) X 3 (possible) = 9 [High]**	31/03/2019
TITLE: Funding There is a risk that the Trust will be unable to secure sufficient funding for investment in clinical research. There is a risk that the Trust will be unable to secure sufficient capital to invest in the desired new technologies. **CAUSE AND EFFECT:** **IMPACT:**	**3 (major) X 3 (possible) = 9 [High]**	1. Trust investment in the R&D department which has shown success attracting NHS and private funding for trials. Ensuring communication and engagement with patients eligible for trials so they are aware of opportunities to join trials. 2. Partnering arrangements being secured for managed services in a number of areas to enable cost of innovation to be spread over the life, as well as ensuring there is sufficient expertise for optimum implementation and adoption. 3.IT project office has a programme for delivering a number of digital solutions in the year. 4. Working across the STP on digital plan for interoperability between partners.		Develop reporting mechanism to appropriate committees.	**3 (major) X 3 (possible) = 9 [High]**	**3 (major) X 3 (possible) = 9 [High]**	31/03/2019

Appendix 2 - Risk Matrix

This chart shows the level of risk a risk represents and sets out the priority which should be given to each risk:

	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

Report to the Board

Board Date: Thursday, 10 January 2019 Agenda item 6.3

Title of Report	**Communications and Engagement report**
Prepared By:	Glynis Alexander
Lead Director	Glynis Alexander, Director of Communications and Engagement
Committees or Groups who have considered this report	NA
Executive Summary	In the past two months we have stepped up communications and engagement around our transformation and culture programmes. We have developed communications to raise awareness of our clinical strategy, beginning with a staff briefing. Externally we continue to engage with community groups to create opportunities to discuss improvements at the hospital, and to hear what's important to patients and public. Our Governors have played an important role in engaging with local residents by holding events in Medway and Swale.
Resource Implications	NA
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA
Improvement Plan Implication	Communications and engagement activity is aligned with the Better, Best, Brilliant transformation plan.
Quality Impact Assessment	NA
Recommendation	The Board is asked to note the report.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 In the past two months we have stepped up communications and engagement around our transformation and culture programmes.

1.2 We have developed communications to raise awareness of our clinical strategy, beginning with a staff briefing.

1.3 Externally we continue to engage with community groups to create opportunities to discuss improvements at the hospital, and to hear what's important to patients and public.

1.4 Our Governors have played an important role in engaging with local residents by holding events in Medway and Swale.

2 ENGAGING COLLEAGUES

2.1 We have continued to engage staff in transformation projects under our Better, Best, Brilliant improvement programme, including reducing the length of stay for patients, and improving flow.

2.2 We have launched the 'Making Medway Brilliant' campaign to showcase some of the fantastic work taking place across the Trust to transform the care provided by the Trust.

2.3 We have continued to raise awareness of the Trust's financial position and to communicate the work taking place to improve patient care and achieve financial sustainability as part of Better, Best, Brilliant.

2.4 In December, we launched a new monthly staff briefing and James Devine's first briefing session was attended by more than 300 staff. The new briefings will also feature the presentation of the employee and team of the month awards. To support this, the Communications Team has relaunched the awards to encourage staff members to nominate colleagues.

2.5 The Trust clinical strategy was introduced at a senior manager and all staff session; staff have been encouraged to provide feedback.

2.6 Communications to promote awareness of the 'You are the Difference' culture led to significant number of bookings to the sessions from both managers and staff.

2.7 The Communications and Organisational Development teams have worked together to promote the NHS staff survey.

2.8 We have continued to implement the flu vaccination campaign and we are pleased to see that uptake for the vaccination has been good.

2.9 The team provided communications support for a number of festive activities, including the Christmas fair, staff song and Christmas card.

Report to the Board of Directors

3 MEDIA

3.1 Since the beginning of November this year the communications team has dealt with ` 22 interactions with local, regional and national media.

3.2 There was significant coverage of the opening of our new Emergency Department, with the event being the running theme for the entirety of BBC Radio Kent's breakfast programme on the day through a live broadcast. BBC South East, ITV Meridian, the Medway Messenger and KMTV also covered the opening.

3.3 The visit by the Secretary of State for Health and Social Care generated a real buzz around the hospital, with staff in the Emergency Department, maternity and the prehabilitation unit showcasing their improvements. This led to significant media coverage.

3.3 Other positive stories have included a number of donations and Christmas visits to our children's wards; the formal 'ribbon-cutting' of the Emergency Department; and three interviews with Trust staff by the Medway Messenger after their nomination for the local 'Pride in Medway' awards.

4 SOCIAL MEDIA

4.1 Since the last update Medway has retained its position as Kent's most-followed acute Trust on both Twitter and Instagram, owing to an increased following across all social media channels.

4.2 Several key announcements were shared across our social media accounts in this period, resulting in more than 100,000 people viewing our posts throughout November and December (33,101 on Facebook and 86,900 on Twitter).

4.3 Medway's social media account followers now total 4,435 on Twitter (up from 4,339 at the last update), 6,220 on Facebook (up from 6,038) and 1,151 on Instagram (up from 1,053).

4.4 Our social media channels notably raised awareness of a visit to the Trust by Health and Social Care Secretary Matt Hancock; the departure of former Chief Executive Lesley Dwyer; the opening of our new £11.5 million Emergency Department building; a special musical Christmas video message from our staff to the local community (which reached 20,000 people alone on Facebook); the success of the Christmas Fair which helped to raise money for the Medway Hospital Charity; our regular members' and Governor events; and alternative treatment options for those considering visiting our Emergency Department during periods of increased pressure and throughout the winter period.

Report to the Board of Directors

5 COMMUNITY ENGAGEMENT

5.1 Governors

5.1.1 We continue to actively engage with our local community. The majority of the people we are talking to are very complimentary of hospital services and the care our staff provide.

5.1.2 Since our last report the Trust's Community Engagement Officer and governors held engagement stands at Sittingbourne Memorial Hospital and Sheppey Community Hospital.

5.1.3 Constituents welcomed the opportunity to speak with governors, asking questions about how services are commissioned and the Emergency Department and Walk in Centre.

5.1.4 They expressed concerns about hospital wastage and the training of overseas staff.

5.1.5 Our Governors and Chief Executive met members, patients and the public at Rainham Healthy Living Centre.

5.1.6 Here our community wanted reassurance that staff were receiving regular customer care training and are wearing their yellow name badges so that they can be easily identified.

5.1.7 Concerns were also raised over hospital access for emergency patient particularly at peak times.

5.1.8 Our governors were able to be part of Oasis Academy Dementia Café. The school runs regular café for local nursing home residents with Dementia.

5.1.9 The recent café was filmed by Songs of Praise and will be aired on Sunday 13 January 2019.

5.2 Members

5.2.1 We are regularly communicating with members. Our messages include the Chair's update, Membership and Governor Engagement events and information about Trust fundraising activities.

5.2.2 We continue to hold membership recruitment events within the hospital.

5.2.3 Going forward we intend to increase our use of healthy living centres and community hospitals to engage with our local community and recruit members, as well as talking to people within the hospital.

5.3 Reaching out to less engaged audiences

5.3.1 In collaboration with the voluntary sector we have started to engage with victims of domestic violence.

5.3.2 Following the success of our Teddy Bear Hospital, we will be inviting children from local primary schools to the four planned Teddy Bear Hospital Sessions.

5.3.3 We have developed a good relationship with the NHS retirement fellowship and have been invited to give a presentation to their members in 2019.

5.4 Other engagement

5.4.1 We continue to support the organ donation committee to raise the awareness of organ donation among the BAME community.

5.4.2 In 2019 we will focus on how we can support BAME communities to promote this in their communities.

Report to the Board of Directors

Board Date: Thursday, 10 January 2019 Agenda item: 7.1

Title of Report	**Workforce Report**
Prepared By:	Elizabeth Nyawade, Deputy Director of HR & OD
Lead Director	Leon Hinton, Executive Director of HR & OD
Committees or Groups who have considered this report	Senior HR 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 Trust. The Trust's recruitment campaigns, including national, local and international have delivered 475 candidates to date – 50 candidates supplied to us by Cpl Healthcare and 165 candidates provided by HCL. The original Philippines recruitment plan for nursing continues with a total of 74 candidates being processed for posts at MFT. Trust turnover has increased at 12.60% (+0.30%) from 12.30%, sickness absence at 4.20% (+0.10% from 4.10%) is above the Trust's tolerance level of 4%, and appraisal compliance has increased to 81.30% has remained the same compared to October and is below Trust target of 85%. Statutory and Mandatory training is at 74.39% (-0.32% from 74.71%) and is below Trust target of 85%. The percentage of pay bill spent on substantive staff in November at (82%) remained the same compared to the month of October. The percentage of agency usage at 6% (+1% from 5%) is up compared to the month of October. The percentage of pay bill spent on bank staff at 12% in November is the same compared to October.
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 Work stream as part of the 2018/19 cost improvement programme

Report to the Board of Directors

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.			
Improvement 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. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).			
Quality Impact Assessment	Not applicable			
Recommendation	Not applicable			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☐	☒	☐	☒

Report to the Board of Directors

1 INTRODUCTION

1.1 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 Trust.

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During November 2018, 15 FTE registered nurses and midwives joined the Trust on a substantive basis, alongside 1 FTE substantive clinical support worker.

2.2 The initial international campaign in the Philippines continues. Harvey Nash, our international recruitment partner agency working on Filipino nurse recruitment campaign is continuing to process 74 of the Filipino nurses that remain engaged in the process. Six Filipino nurses have commenced in post via Harvey Nash. A further 15 Harvey Nash candidates have recently passed their International English language Test (IELTS); Seven of the candidates are expected to commence in post in the early part of 2019.

2.3 A total of 67 international nurses have undertaken the OSCE exam since April 2018 and 66 have passed. Five international nurses successfully undertook the OSCE exam in November 2018 and are now working in their allocated ward areas.

2.4 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Four Cpl international nurses have commenced in post, with 50 in the pipeline. Twenty four HCL nurses have also commenced in post, with a further 165 candidates with offers being processed.

2.5 The Trust is also working with 7 additional permanent recruitment agency providers: We Solutions, Ascend, Cromwell Medical Recruitment, Medline, HealthPerm, Xander Hendrix and IELTS Medical. The agency partners are working with the Trust on developing a pipeline of nurses.

2.6 To support the Trust in achieving its targets new campaigns are being launched with a select number of agencies: Medline, We Solutions, Ascend and Cromwell Medical Recruitment.

Report to the Board of Directors

Table 1 below summarises the Trust's recruitment pipeline via all our partner agency providers.

Agency Provider	Commenced	Pipeline	Agency total	Anticipated new starters over the next 12 months from pipeline
Harvey Nash	6	74	80	(10%) 7
Cpl Healthcare	4	50	54	(20%) 10
HCL	24	165	189	(26%) 43
Person Anderson	24	0	24	(100%) 0
Cromwell Medical Recruitment	17	72	89	(28%) 20
MSI Group	3	5	8	(20%) 1
Xander Hendrix	3	13	16	(54%) 7
We Solutions	4	43	47	(46%) 20
Blue Thistle	0	8	8	(0%) 0
Medline	0	37	37	(40%) 15
HealthPerm	0	7	7	(86%) 6
IELTS Medical	0	1	1	(100%) 1
EPSN	1	0	1	(100%) 0
Total	86	475	561	130

(Table 1: Nurse recruitment pipeline as of November 2018)

2.7 To increase reach the Trust commissioned the services of Medical Careers Global, a careers advertising platform for 12 months on a fixed fee. All clinical posts are advertised on this platform with a view to attracting more applicants. To date 75,435 individuals have viewed MFT vacancies and 46 applications have been received. The applications received through this platform from candidates who are yet to undertake the required IELTS/OET examinations will be stored to create a local talent pool.

Table 2 below summarises offers made, starters and leavers for October 2018.

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses & midwives	66 (33 NHS Jobs/open days & 8international nurses via skype)	15	2
Clinical support workers	5	1	7

(Table 2: Nursing starters and leavers November 2018)

2.8 During November 7 non-training medical staff joined the Trust including 1 ED SAS, 1 MTI and 5 Trust Grade doctors' backfilling vacant trainee posts.

Report to the Board of Directors

3 DIRECTORATE METRICS

3.1 The table below (table 3) shows performance across five core indicators by the directorate. Turnover, at 12.60% (+0.30% from 12.30%), remains above the tolerance level of 8%. HR Business Partners will work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let's work together commissioned by Health Education England) and staff survey results to implement service specific retention plans. Sickness absence at 4.20% (+0.10% from October) is above the tolerance level of 4%. Employee Relations are proactively carrying out analysis to support managers to manage sickness and reviewing trends for interventional support.

3.2 The Trust appraisal rate stands at 81.3% same as October and is below the Trust target of 85%, two directorates (Corporate and Estates and Facilities) are meeting the appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings have been included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics. Statutory and Mandatory training stands at 74.39% (-0.32% from 74.71%) and is below Trust target of 85%.

		Trust			Corporate			Estates & Facilities			Planned Care			Unplanned & Integrated Care		
	Trust Target	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend
Turnover rate (Voluntary, 12-month rolling)	8.0%	12.6%	▲		16.0%	▲		5.8%	▲		11.8%	▼		14.5%	▲	
Vacancy rate	12.0%	17.4%	▼		15.6%	▲		17.7%	▲		16.9%	▲		18.5%	▼	
Sickness rate (12-month rolling)	4.0%	4.2%	▲		2.7%	▲		6.1%	▲		4.3%	▲		4.0%	▲	
Statutory & Mandatory Training	85.0%	74.4%	▼		86.0%	▲		58.6%	▼		75.7%	▼		75.3%	▼	
Medway Appraisal	85.0%	81.3%	▲		87.0%	▼		86.8%	▼		81.4%	▲		77.8%	▼	
Agency costs (as % of total paybill)		4.0%	▼		4.2%	▲		-0.2%	▼		3.4%	▼		5.3%	▲	
Bank costs (as % of total paybill)		12.4%	▼		2.8%	▲		8.9%	▲		9.8%	▼		17.8%	▲	
Substantive costs (as % of total paybill)		83.6%	▲		93.0%	▼		91.2%	▲		86.8%	▲		76.9%	▼	

(Table 3: Key workforce metrics)

Report to the Board of Directors

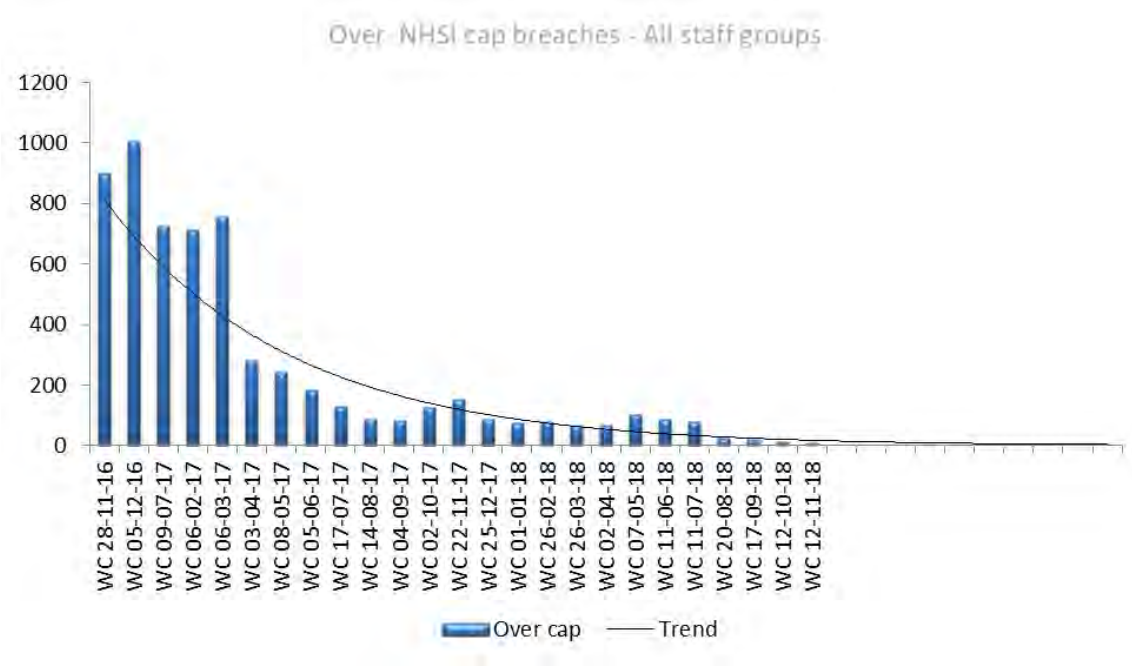
4 TEMPORARY STAFFING

Table 4 below demonstrates that temporary staffing expenditure increased in November compared to October 2018.

		Mar-17	Apr 18	May 18	June 18	July 18	Aug 18	Sept 18	**Oct 18**	**Nov-18**
Spend	Agency	3,890,198	943,419	1,502,866	1,003,597	895,452	799,288	968,606	881,163	988,934
	Bank	920,473	2,307,191	2,003,992	1,939,086	2,914,663	1,441,538	2,231,622	2,145,475	2,068,000
	Substantive	13,611,458	13,904,703	14,328,856	14,032,556	14,112,477	14,916,485	13,681,072	14,213,731	14,283,166
% Pay bill	Agency	21%	5.5%	8%	6%	5%	5%	6%	5%	6%
	Bank	5%	13.5%	11%	11%	16%	8%	13%	12%	12%
	Substantive	74%	81%	81%	83%	79%	87%	81%	82%	82%

(Table 4: Workforce profile based on contractual arrangement)

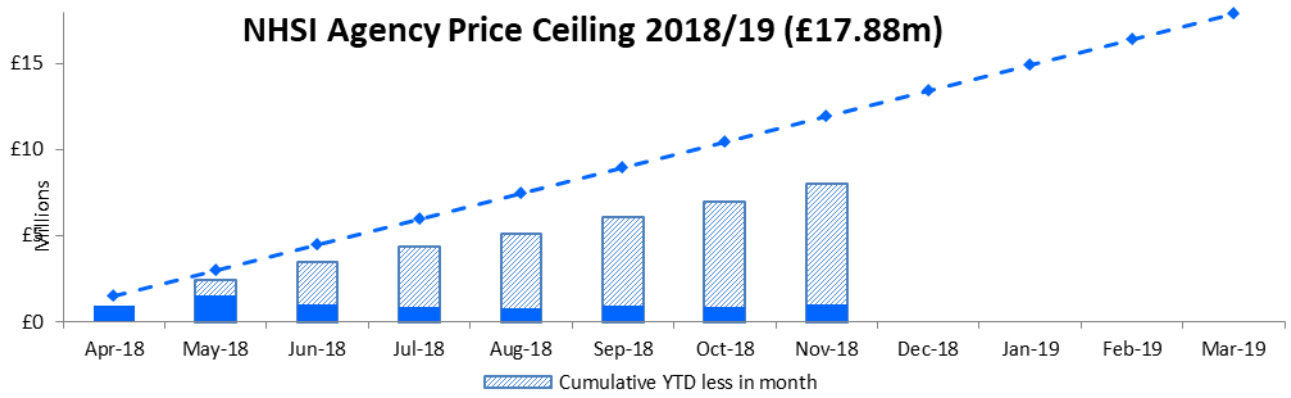
4.1 The agency cap breaches across all staff groups continues to decrease as illustrated in chart 1 below. During the month of November 2018 the Trust reported an average of 12 breaches per week.



(Chart 1: NHSI cap breaches)

4.2 The Trust's NHSi annual agency spend celing has decreased from £21.6m in 2017/18 to £17.88m (corrected ceiling based on Model hospital figures) in 2018/19. Based on cumulative agency spend YTD, the Trust is £3.94m below the NHSi agency ceiling cap target as illustrated in the chart and table below.

Report to the Board of Directors



(Chart 2: NHSI agency ceiling)

Table 5 below shows NHSI agency ceiling performance

Column1	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18
Cumulative NHSI ceiling target	£2,980,000	£4,470,000	£5,960,000	£7,450,000	£8,940,000	£10,430,000	£11,920,000
Agency in month actual spend	£1,502,866	£1,003,597	£895,452	£799,288	£986,606	£881,163	£988,934
Cumulative below ceiling	£539,882	£1,020,285	£1,620,833	£2,311,544	£2,832,938	£3,441,775	£3,942,842

(Table 5: NHSI agency ceiling performance)

4.3 Temporary nursing demand in November 2018 decreased compared to October 2018 (8,675 shift requests in October 2018 compared to 7,937 shift requests in November 2018). The fill rate increased to 79% (+5%). Medical locum demand increased in November 2018 compared October 2018 (1,137 shift requests in October 2018 compared to 1,704 shift requests in November). The fill rate increased to 93%.

5 RETENTION PROGRAMME

5.1 Retention of the workforce at MFT remains a focus given a turnover rate of 12.60% as at end of November 2018. It is vital to understand what matters to staff, if we are to retain them. To demonstrate added focus, the Trust recently signed up for the retention direct support programme cohort 4 by NHS Improvement in October 2018; whilst this support for retention is directed at nursing staff the initiatives suggested can be applied to all staff groups.

5.2 Appendix I lists out the delivery plan for the forthcoming year with regards to understanding and improving turnover and includes actions for each stage of the employee journey:

- Attraction to Medway;
- Post offer to hire;
- Induction to Medway;
- Staying at Medway;
- Leaving Medway.

5.3 Retention direct support programme by NHSI cohort 4: The aim of the direct support programme is for Trusts to develop a retention plan over a 120 day period. This programme should be clinically led and it is targeted at improving nursing retention. The support offered includes:

- Identified lead for the Trust to help develop the action plan during the 120 days;
- Access to NHSI retention resources portal with details of initiatives used by other NHS organisations;
- A detailed pack for MFT, source ESR, for trends in our Turnover rates, reasons for leaving and age profile.

5.4 NHSI recommends focussing on 3 main actions, listed below, that have had demonstrable success and caution that it will take at least 12 months' for organisations to see impact:

- Early years' careers support;
- Internal rotation programme;
- Pastoral care support for new starters and qualified nurses joining the Trust at the start of their careers.

5.5 The measures of success of this programme of work will be measured by improved stability rate; lower turnover rate for specific staff groups; a reduction in the cost of temporary staffing; improved metrics for quarterly friends and family test and staff survey; qualitative stories collated from staff about their experiences of working at MFT and shared with existing and applicants.

6 NMC LANGUAGE TEST REQUIREMENTS

6.1 Changes to language test requirements for nurses and midwives:

With effect from 5 December 2018, the NMC will accept level 6.5 score in writing for overseas nurses taking the International English Language Test System (ILETS) test instead of a level 7 score. However, a level 7 score will still be required for the reading, listening and speaking tests. The change is in line with the nursing regulators' commitment to 'better, safer care and will ensure that only nurses and

midwives with the right skills, knowledge and command of the English are able to register to work in the UK'. NHS Employers welcomed the change stating that it will increases access for much needed nursing talent. This change means that candidates who took the test and attained a level 6.5 score can submit their results to the regulator, if these are less than two years old. It is the expectation that MFT will benefit by seeing an increase in the number of candidates coming through the international recruitment pipeline.

7 ILM ACCREDITATION

7.1 Institute of Leadership and Management accreditation:

In November 2018, the Trust achieved accreditation from the Institute of Leadership and Management (ILM) for the in-house delivered level 5 Certificate in Leadership and Management course. Staff undertaking level 5 Certificate in Leadership and Management course, aimed at colleagues in bands 5-7, will now be awarded with a certificate from the ILM. In addition, the Trust will be able to generate income by offering this leadership programme to neighbouring organisations. Future plans following receipt of the accreditation include the Trust applying to City and Guilds to convert the level 5 Certificate in Leadership and Management course into an apprenticeship to enable drawing down funds from the levy. This will result in increased income generation that can be used to invest in developing further leadership courses for our staff. The accreditation is testament to the quality of the in-house developed and delivered leadership course.

End

8 APPENDIX I: RETENTION PROGRAMME DELIVERY PLAN

NHS Medway NHS Foundation Trust

Intervention	Description	Stage	In progress	Q4 18/19	Q1 19/20	Q2 19/20	Q3 19/20	Q4 19/20	Measures
NHSI focus	NHSI recommends focussing on 3 main actions, listed below, that have had demonstrable success and caution that it will take at least 12 months' for organisations to see impact: Early years' careers support; Internal rotation programme; Pastoral care support for new starters and qualified nurses joining the Trust at the start of their careers	throughout employee journey	Develop	Delivery	Delivery	Delivery	Delivery	Review	Stability Index & Staff Survey
Career Stories	A story for posts advertised – these will help applicants to understand what a day in the life of an employee looks like	Attraction			Develop	Delivery	Delivery	Review	Stability Index
Values-based recruitment (VBR)	Values-based recruitment (VBR) – this can help to contribute to a reduction in staff turnover by ensuring from the outset that staff recruited fit within the organisation's values. The Trust implemented VBR in Q2, an assessment of the impact will be carried out at the end of Q4	Recruitment selection	Delivery	Review					Turnover
Flexible working advertising	Advertising posts stating that flexible working is welcome in the form of part-time, job shares and annualised hours	Attraction	Develop	Delivery	Delivery	Delivery	Delivery	Review	Turnover & Staff Survey
Onboarding portal	Online portal detailing all staff benefits available, values and other orientation material	Onboarding	Delivery		Delivery	Delivery	Delivery	Review	Turnover
Keeping in touch comms	Regular communications throughout the onboarding period (from unconditional offer to hire) detailing one or two specifics about the organisation, about the team, about the future	Onboarding		Develop	Delivery	Delivery	Delivery	Review	Turnover
Social media forum	Create a closed social media group for new starters to engage with HR colleagues	Onboarding			Develop	Delivery	Delivery	Review	Turnover
Meet the Director of Nursing	Inviting newly qualified and new starter nurses to tea with the executive director of nursing; this will demonstrate support for nurses in their new roles	Induction		Delivery	Review				Stability Index
Preceptorship development	Develop a robust preceptorship programme full of clinical skills to empower the new nurses at the start of their career journey with the Trust	Induction	Delivery	Delivery	Delivery	Review			Stability Index
Preceptor visibility	Provide pin badges for preceptors to wear which highlights to others that the practitioner is in their transitional phase to supporting learning	Induction	Delivery	Delivery	Delivery	Delivery	Review		Stability Index
Stay conversation	What made you join MFT? What would make you stay at MFT?; What would make you leave MFT? A quarterly conversation with all new starters in the first 12 months; A six-monthly conversation with staff under 2 years of service but over 12 months; An annual discussion with existing staff – probably incorporating this in the annual appraisal process	Throughout employee journey		Develop	Delivery			Review	Turnover, Stability Index and Staff survey
Itchy feet discussion	These include having conversations with employees considering leaving but have not made up their mind. Nominate a career development lead for each staff group that can be contacted by staff to discuss professional and personal career development; Introduce career clinics, run on a monthly basis; Implement internal transfer scheme to allow staff to move wards or departments rather than leave the organisation; Invest in a helpline for staff considering to leave to talk to HR staff or other who may be able to advise and address any issues	Throughout employee journey		Develop	Delivery	Delivery	Delivery	Review	Turnover
Exit intelligence	Review exit processes across teams to promote exit questionnaires, interviews to improve response rate and intelligence gathered for analysis and feedback to areas.	Exit		Develop	Delivery	Delivery	Delivery	Review	Turnover

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Quality Assurance Committee held on 23/11/2018

Report to:	**Trust Board**	**Date of meeting: 10 January 2019**	**8.1**
Presented by:	**Jon Billings** **Chair, Quality Assurance Committee**	**Prepared by:**	**Jon Billings** **Chair, Quality Assurance Committee**
	The papers and full minutes will be available for Board members to review on BoardPad		

Matters for escalation or highlighting

- The Quality Assurance Committee (QAC) received an update on progress with the Care Quality Commission (CQC) improvement plan. The QAC expressed some concern at the pace of implementation with six out of 12 must-do recommendations still with evidence of compliance outstanding. Significant progress is expected to be reported at the January meeting of QAC.

- The QAC received a detailed presentation from the Medical Director on HSMR and the work to understand what is driving the current upward trend. Discussions continue with NHS Improvement, the CCG and Dr Foster to agree the most appropriate handling and reporting of this issue. However, since the QAC meeting, the Chief Executive has asked the Medical Director to intensify the focus on this work through a four-week review of the data.

- The QAC received a draft Safeguarding Adults and Children's Annual Report 2017 - 2018 and requested additional detail to be included regarding where safeguarding concerns have been raised against the trust. In addition, the Committee also requested that an introduction be added to the report and for the report to be consistent in presentation before submission to board. The report will come for information to a subsequent Board meeting.

Other matters considered by the committee:

- Progress with the new quality dashboard
- Oral update on the process for Quality Impact Assessment (QIA) of service change
- Directorate assurance report – focus on winter preparation
- CQUIN programme 2018/19

Key decisions made/ actions identified:	• Additional details to be included to the draft Safeguarding Adults and Children's Annual Report 2017 - 2018.
Risks:	• Key area discussed was the DIPC report and follow up steps agreed.
Assurance:	• A regular focus on QIA of service change will provide assurance as the Transformation Programme progresses.

Key Issues Report

NHS Medway 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			✓		✓			✓				
Diana Hamilton-Fairley, Director of Strategy			✓									
Karen Rule, Director of Nursing			✓		✓			✓				
Jon Billings, NED & Chair			✓		✓			✓				
Adrian Ward, NED			x		x			✓				
David Sulch, Medical Director					✓			✓				

Best of care Best of people

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of the Finance Committee held on 22/11/2018

Report to:	**Trust Board**	**Date of meeting:**	**10/01/2019**
Presented by:	**Tony Moore, Finance Committee Chair**	**Prepared by:**	**Ian O'Connor, Director of Finance (Interim)**

8.2

Matters for escalation

1. Actual deficit figure to be produced in the event the A&E financial target or any of the financial numbers are not achieved
2. Clarity to be provided on the range of possible deficits that is likely to be acceptable going into the next financial year, for the Committee to assess the Trust's position within that range.
3. Cost Improvement Programme: Report to be provided on the additional pressures to the required £21m to achieve the control total.
4. Report on the number of plans that make up the integrated Plan.

Other matters considered by the group:

1. Financial position at Month 7 £12k favourable to plan.
2. The forecast year end position has been maintained at £46.9million pre-PSF (Provider Sustainability Funding). Achieving this deficit is considered the best case scenario with the range of possible deficits ranging from £46.9million to £54.8million.
3. At Month 7, £10.48m has been delivered in Cost Improvement Programmes (CIPs) YTD, which is £2.4m favourable to the phased plan of £8.1m. There are additional pressures to the required £21m to achieve the control total.
4. Cash position better than last year's; with 40% of invoices being paid within 30 days of invoice date and ongoing work to ensure robust processes are in place.
5. A number of facilitated sessions held to discuss the Business Plan. A top-down, bottom-up approach will be taken to identify gaps.
6. Pathology Assurance Group introduced. This will see NEDs in attendance from Dartford and Gravesham and Medway Foundation Trusts, with CEO input.

Key decisions made/ actions identified:	Additional to actions included under matters for escalation. 1. Plans to be shown against the benchmark in the Hospital Model tool. A tool could be chosen during the course of the year for discussion. 2. Report on the CIP and the pressures over the course of the next few months.
Risks:	1. No new risks identified
Assurance:	1. Ongoing discussions at the Executive Group about meeting the trajectory and steps being taken to achieve this. 2. Progress on the deficit is also discussed at the Transformation Assurance Group (TAG). 3. The Quality Impact Assessment (QIA) process to be presented to the Quality Assurance Committee to provide assurance that none of the Trust's QIPP schemes compromise safety and quality.

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of the Integrated Audit Committee held on 22/11/2018

Report to:	**Trust Board**	**Date of meeting:**	**10/01/2019**	**8.3**
Presented by:	**Mark Spragg, Integrated Audit Committee Chair**	**Prepared by:**	**Ian O'Connor, Director of Finance (Interim)**	

Matters for escalation	1. Conflicts of Interest Policy to be reviewed, setting out expectation; reissue to staff and review yearly. 2. Non-responses for the five overdue recommendations relating to the Homecare Services to be followed up. 3. Internal auditors to produce a list of the high priority recommendations that had been accepted by the Trust in the last 18 months, with their status. 4. Trust Board to have sight of the Integrated Annual Report and Accounts timetable. 5. More narrative to be provided on the losses and special payments report going forward. 6. Declaration of interest to be a standing item on the agenda going forward.
Other matters considered by the group:	1. On internal audit, 16 outstanding recommendations were reported, with eight new recommendations raised since August 2018, and five overdue recommendations. Of the eight new recommendations (which relate to the audits of Adult and Child Safeguarding) four have been accepted and three have been partially accepted. Recommendations which are not yet due for implementation relate to Data Quality, Homecare Services and Nurse Revalidation reviews. The five overdue recommendations relates to the Homecare Services review. 2. Internal Audit reports were presented on Adult Safeguarding and Child Safeguarding. Both received an overall assessment of significant assurance with minor improvement opportunities (amber-green rating). The areas flagged for improvement include mandatory training compliance rates and getting timely updates from the Local Authority since the introduction of the general Data Protection Regulation. 3. On Local Counter Fraud Specialist (LCFS) service, fieldwork has been completed on the invoice fraud review, which led to criminal conviction. The LCFS will work with the communications team to include this information in the LCFS newsletter. 4. On external audit, the Audit Plan is to be presented to the Committee at its meeting in February 2019. The Committee was informed of some accounting standards changes which would pose concern for

	implementation across the NHS, particularly around IFRS 9 (Financial Instruments) and IFRS 15 (Revenue from contract with customers), which became relevant from 1 April 2018. 5. The Committee noted the key dates in relation to the production of the 2018/19 Annual Accounts. 6. The Committee queried the losses and special payments numbers, which appeared to be low compared to the previous year. 7. The Committee received the single tender waiver report and queried the management apprenticeship figure. 8. The Committee was advised that the Board Assurance Framework (BAF) will be reviewed in detail by the Board at its development session. 9. The Committee discussed the self-assessment form. The Non-Executive Directors were satisfied that steady progress has been made on improving processes. However, further improvement is required.
Key decisions made/ actions identified:	The Committee approved the recommendation to continue to work with the Trust's current Valuer, District Valuer Services, for 2018/19, to resolve the issues raised by the external auditors for the last two annual audits and therefore defer a change in Valuer until 2019/20, when a full revaluation will be required.
Risks:	No new risks identified. The BAF was reviewed by the Board at its development session in December 2018.
Assurance:	Assurance was provided on: 1. Progress with the recommendations from audit reports. 2. Reviews of Adult Safeguarding and Child Safeguarding both received an overall assessment of significant assurance with minor improvement opportunities (amber-green rating). 3. Testing the weakness revealed by the invoice fraud and segregation of duties in place for raising invoices through to making payments. 4. Having an online training system commissioned in August 2018 with NHS Elect to assist with mandatory online training. 5. Developing a system to have a summary of the outstanding internal audit actions reviewed by the Executive team on a monthly basis. 6. Committee self-assessment: The Non-Executive Directors were satisfied that the Committee has complied with its obligations and expectations as noted in its terms of reference, with steady progress being made on improving processes. However, further improvement is required.