Medway NHS Foundation Trust

Papers for the Trust Board Meeting in Public

Thursday, 07 November 2019 at 12.30pm

In the Trust Boardroom, Postgraduate Centre, Medway NHS Foundation Trust

Windmill Road, Gillingham, Kent, ME7 5NY

NHS Medway NHS Foundation Trust

Agenda

Trust Board Meeting in Public

Date: Thursday, 07 November 2019 at 12.30pm – 3pm

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

Subject		Presenter	Page	Time	Action
Patient Story		Director of Nursing	Verbal	12:30	Note
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chairman	Verbal	12:55	Note
1.2	Quorum	Chairman	Verbal		Note
1.3	Conflicts of Interest: i. Register of Interest ii. Declaration of Interest	Chairman	5 Verbal		Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting held on 5 September 2019	Chairman	9	12:57	Approve
2.2	Matters arising and actions from last meeting	Chairman	17		Discuss
3.	**Standing Reports**				
3.1	Chair's Report	Chairman	Verbal	13:00	Note
3.2	Chief Executive's Report	Chief Executive	19		Note
4.	**High Quality Care**				
4.1	Integrated Quality and Performance Report	Divisional Director of Nursing/ Medical Director/ Chief Operating Officer	23	13:15	Discuss
4.2	Quality Assurance Committee Assurance Report	Quality Assurance Committee Chair	53		Note
4.3	Quality Assurance Committee Terms of Reference	Quality Assurance Committee Chair	57		Approve
4.4	Responding to Deaths	Medical Director	63		Discuss
5.	**Innovation**				
5.1	Transformation Programme Update	Director of Transformation	75	14:00	Discuss
6.	**Integrated Health Care**				
6.1	Sustainability and Transformation Plan Update	Chief Executive	Verbal	14:10	Note
6.2	Communications and Engagement Report	Director of Communications and Engagement	87		Note

NHS Medway NHS Foundation Trust

Agenda

7.	**Financial Stability**				
7.1	Finance Report - Month 6	Director of Finance	93	14:20	Discuss
7.2	Finance Committee Assurance Report	Chair of Finance Committee	99		Note
7.3	Finance Committee Terms of Reference	Chair of Finance Committee	103		Approve
8.	**Our People**				
8.1	Workforce Report	Director of HR and OD	107	14:30	Note
9.	**Policies for approval**				
9.1	Corporate Policy - Serious Incident Investigation and Management	Divisional Director of Nursing, Planned Care	119	14:40	Approve
9.2	Corporate Policy - Duty of Candour	Divisional Director of Nursing, Planned Care	143		Approve
9.3	Corporate Policy - Information Governance Framework	Director of IT Transformation	165		Approve
9.4	Corporate Policy - Human Resources and Organisational Development	Director of HR and OD	179		Approve
10.	**Other Business**				
10.1	Council of Governors' Update	Lead Governor	Verbal	14:50	Note
10.2	Any other business	Chairman	Verbal		Note
10.3	Questions from members of the public	Chairman	Verbal		Discuss
11.	**Date and time of next meeting: Wednesday 8 January 2020, 12.30pm-3pm, Trust Boardroom**				

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MEDWAY NHS FOUNDATION TRUST

TRUST BOARD REGISTER OF INTERESTS

NOVEMBER 2019

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 Applied	Associate
		University of Kent	Wife is Professor of Applied Health Research, Centre for Health Service Studies
		Medway NHS Foundation Trust	Chair Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Ewan Carmichael	**Non-Executive Director**	Medway NHS Foundation Trust	Chair of Charitable Funds Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Name	Position	Organisation	Nature of Interest
Mark Spragg	**Non-Executive Director**	Marcela Trust	Trustee
		Sisi and 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
Joanne Palmer	**Non-Executive Director/ Senior Independent 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**	London Board for the Healthcare People Management Association	Member
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Ian O'Connor	**Executive Director of Finance**	Essex Partnership Trust	Spouse is a Senior Manager
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Name	Position	Organisation	Nature of Interest
Karen Rule	**Executive Director of Nursing**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Dr David Sulch	**Executive Medical Director**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Leon Hinton	**Executive Director of HR and OD**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

NHS Medway NHS Foundation Trust

Minutes of the Trust Board of Directors Meeting in Public

Thursday 5 September 2019 at 12.30pm, in the Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members	Name	Job Title
Voting:	Mr Stephen Clark	Chairman
	Ms Joanne Palmer	Non-Executive Director and Senior Independent Director
	Mr Adrian Ward	Non-Executive Director
	Mr Ewan Carmichael	Non-Executive Director
	Mr Jon Billings	Non-Executive Director
	Mr Mark Spragg	Non-Executive Director
	Mr Ian O'Connor	Executive Director of Finance
	Ms Karen Rule	Executive Director of Nursing
	Dr David Sulch	Executive Medical Director
	Mr Leon Hinton	Executive Director of HR and OD
Non-Voting:	Ms Gurjit Mahil	Deputy Chief Executive
	Ms Morfydd Williams	Executive Director of IT Transformation
	Ms Glynis Alexander	Executive Director of Communications and Engagement
	Mr Harvey McEnroe	Chief Operating Officer
	Mr Jack Tabner	Executive Director of Transformation
Attendees:	Dr Kirtida Mukherjee	Deputy Medical Director *(item 9.2 only)*
	Ms Brenda Thomas	Company Secretary (minutes)
	Ms Doreen King	Governor Board Representative
	Mr Glyn Allen	Lead Governor
	Ms Jameel	Patient Story *(item 1 only)*
	Ms Sue Gillham	Matron, Paediatrics *(item 1 only)*
	Ms Lyndsay Barrow	Patient Experience Manager *(item 1 only)*
	Ms Gail Locock	Kent and Medway Director of Infection Prevention and Control *(item 9.1 only)*
Apologies:	Mr James Devine	Chief Executive
	Mr Gary Lupton	Executive Director of Estates and Facilities
Observers:	Professor Simon Mackenzie	Medical Director System Improvement and Professional Standards, South East Region - NHS England and NHS Improvement
	Mr Alastair Harding	Governor Advisor
	Ms Vivienne Boutell	Governor
	1 member of the public	

The minutes have been recorded following sequence on the agenda and not sequence of discussion at the meeting.

01/19 Patient Story

1.1 Karen Rule, Executive Director of Nursing introduced Mrs Jameel who attended the meeting to give account of her son Armaan's ordeal with Medway NHS Foundation Trust (Trust). Armaan, now 11 was diagnosed at birth with beta thalassaemia major (body does not make red blood cells) - the only patient with the condition at the Trust at the time. The family went through a very traumatic eight year period, with a number of mistakes made by junior rotational doctors on regular occasions having a detrimental effect on the family. It was very difficult for Mrs Jameel to manage his anxiety and the logistics of attending the ward again and managing other siblings. The problem was eventually remedied when a chart was placed in Armaan's file about the procedure and the Children's Outreach and Specialist Team (COaST) became involved. Nursing staff would ensure that the blood transfusion was ordered and prescribed correctly by a doctor and then administered by the nurses on the ward. Mrs Jameel commended and thanked the nursing team; in particular Matron, Sue Gillham and Dr Ramadan whose care and support she highly praised. Armaan is now happier, has got a place in Grammar school and even wrote an article for the UK Thalassaemia Society. Despite being in a low privileged area, Mrs Jameel's expectation is that the standard of treatment for all patients should not be dissimilar.

1.2 The Chairman, on behalf of the Board, thanked Mrs Jameel and apologised for the family's ordeal, querying the length of time it took to resolve the matter. David Sulch, Executive Medical Director, commented that junior doctors are now more inclined to seek help when required, which is a step forward and the Trust would continue to tackle negative behaviours. Karen Rule noted the importance of senior clinicians and leadership teams within the services having a good understanding of the kind of care being provided within their services.

1.3 David Sulch, in response to the query on the need for a more systemised way of working - better codified way of responding to patients with rare conditions, noted that there is a UK Strategy for Rare Diseases, which is a basis to utilise and build on. **Action: TB/2019/030.** Mrs Jameel gave consent for the slides to be shared at the Clinical Council and utilised for junior doctors training. **Action: TB/2019/031.** Doreen King advised that most major train companies offer heavily discounted train travel to children/ young adults with chronic diseases. Gurjit Mahil agreed to take this forward. **Action: TB/2019/032.** The Chairman once again thanked Mrs Jameel noting it was a time well spent.

02/19 Preliminary Matters

2.1 Welcome and Apologies for absence

2.1.1 The Chairman welcomed everyone to the meeting, particularly Professor Simon Mackenzie, Medical Director System Improvement and Professional Standards -South East Region, NHS England (NHSE) and NHS Improvement (NHSI). He noted this was Doreen King's last meeting as Board Governor Representative. Glyn Allen, Lead Governor will take on the role as part of his Lead Governor role from November.

2.1.2 Apologies for absence were noted as recorded above.

2.2 Quorum

2.2.1 The Chairman confirmed the meeting was quorate.

2.3 Register of Interests

2.3.1 There were no declarations of interest in relation to items on the agenda.

2.3.2 The Chairman reminded members to review their interests and contact the Company Secretary should there be any change in their interests.

2.3.3 The Register of Interests was noted.

03/19 Minutes of the previous meeting and Matters Arising

3.1 Minutes of the previous meeting

3.1.1 The minutes of the previous meeting held on 3 July 2019 were **APPROVED** as an accurate record of the meeting.

3.2 Matters Arising and Action Log

3.2.1 Matters Arising: The Board at its last meeting delegated authority to the Chairman to sign off the Project Initiation Document (PID) for the Integrated Care Partnership (ICP) on the

Board's behalf. This document has been reviewed by Gurjit Mahil, Deputy Chief Executive and ready to be signed off by the Chairman.

3.2.2 Action Log: The following actions were agreed to be closed: **TB/2019/002**, **TB/2019/011, TB/2019/019, TB/2019/023, TB/2019/024, TB/2019/026, TB/2019/027, TB/2019/029.**

3.2.3 Updates were provided for the following actions:

i. TB/2019/025 (b) - of the 39 must and should do actions, there are no red actions and six amber actions, which are progressing. Work around best flow transformation is starting to deliver support to progress some of the actions. The Care Quality Commission (CQC) receives monthly update on the Improvement Plan and an engagement meeting was recently held with them. No concerns were raised on the actions following discussion with the Hospital Inspector. **Agreed to close.**

ii. TB/2019/028 - This now forms part of the best access programme and is also part of the Outpatient Improvement Group. Boards have been ordered for specific areas and formal update would be provided at next meeting via the best access programme.

04/19 Standing Reports and Updates

4.1 Chair's Report

4.1.1 The Chairman welcomed members of the public, press and governors and expressed thanks for taking a keen interest in the Trust's progress. He noted as follows:

a) Unprecedented levels of attendances at the Emergency Department (ED) were seen during summer. The Chairman, on behalf of the Board, conveyed thanks to all staff who have worked incredibly hard to maintain the Type One performance despite the increased pressure

b) Engaging with the community and stakeholders remains a priority for the Trust and delivering of an extensive community engagement programme continues

c) The Chairman and Chief Executive recently met with local political stakeholders, MPs Kelly Tolhurst and Tracey Crouch who are very supportive of the Trust, to update them on developments at the Trust

d) An update has recently been received on the two pending judicial claims against the decision to establish three hyper acute stroke units in Kent and Medway. Dates for the hearing have now been set at 3, 4 and 5 December 2019

e) Brexit - this is on the radar, with the Trust working closely with the NHS network as a whole to ensure apt preparation in the event of a no-deal Brexit

f) The Trust will be hosting its Annual Members' Meeting at 6pm on Thursday 19 September in the Trust restaurant. The Chairman extended an invitation to all, to reflect on achievements of the previous year and look to the future.

4.2 Chief Executive's Report

4.2.1 Gurjit Mahil, Deputy Chief Executive, presented the report which was taken as read and highlighted the following key issues:

a) An increase in ED attendances with improved performance during summer was noted. The Trust is working closely with system partners to improve Type Three activity

b) Improvement in breast cancer two-week wait standard continues to be seen. Unvalidated figures for August show an improvement on other cancer areas

c) Delivery on transformation work continues. A detailed report has been provided under the transformation programme update

d) The Trust has launched a zero tolerance campaign, as part of the wider campaign to improve staff safety

e) A new Lead Freedom to Speak Up Guardian, Natasha Pritchard, has been appointed.

4.2.2 The Chairman reminded the Board that freedom to speak up is a consequence of a failure in line management, as this means that staff do not have the confidence to speak up to their line managers.

4.3 Strategy

4.3(i) Sustainability and Transformation Partnership (STP) Update

4.3.1 Gurjit Mahil gave a verbal update on the STP, reiterating that the ICP PID has been reviewed and is ready to be signed off. There are clear workstreams for the Medway and Swale ICP,

with all system partners working closely together. The Board would receive an update once workstreams, with their leads are finalised.

4.3(ii) Transformation Programme Update

4.3.2 Jack Tabner, Executive Director of Transformation, presented the report, with input from Harvey McEnroe, Chief Operating Officer. The report was taken as read and the key areas highlighted. The four transformation programmes, (BEST Flow, Service Transformation and Access Review (STAR), Theatres Productivity and Quality Improvement) which have continued to gather pace, are all led by a member of the executive team with oversight by the Transformation Operation Board (TOB). The initial diagnostic phase for the Best Flow Programme has concluded and the Trust has progressed a number of operational improvements which have demonstrably improved Type One ED performance as well as increased number of safe discharges per day. The programme will now accelerate operational work on the Integrated Discharge Team, and address reporting and productivity issues that have surfaced relating to the MedOCC (Medway On Call Care). The plan to deploy a new acute medical model; a new continuity of care model and a new integrated discharge plan model was noted. Improvement has been seen on Type Three activity, although the national target is still to be met. Thanks was conveyed to the MedOCC team for this improvement. The expectation for the STAR programme is that patients who need to be seen by a specialist in hospital will be seen quicker, exploring the role of technology, for instance virtual consultations and tele-health for managing long-term conditions.

4.3.3 Cost Improvement Programme (CIP) - as at Month four, £4.5million has been delivered in CIPs, adverse to plan by £121,000, largely driven by theatres and outpatients performance. Clear plans are in place to rectify under-delivery. The Board was assured that the Trust is on track to achieve the £18million CIP target, albeit focused work is required in planned care. The Trust's infrastructure was reviewed by NHSI and NHSE and all recommendations for improvement have been implemented. Continuous improvement methodology continues to be embedded within the Trust through the improvement huddles and monthly Yellow Belt training. A transformation newsletter and transformation blog have been launched with the help of the communications team. The transformation portfolio has formed a working partnership with the Digital Health London programme to support digital transformation. In addition, a general inspiring speakers programme is to be launched in October and members were encouraged to input into the schedule building of names.

4.3.4 The following comments were made during discussion:

f) To emulate working on logistical smoothness (citing Amazon as an example) and leadership/ teamwork to work in greater efficiencies, with enthusiasm running throughout the Trust, starting from the top
g) To give thought to how the transformation programme could be used to drive forward the Trust's core strategies
h) To ensure a joined up approach in the governance around transformation and other parts; not having parallel governance/ parallel effort.

The Board conveyed thanks to the transformation team for an excellent job.

4.3.5 **The Board received assurance on the progress made and was supportive of direction of travel on the transformation work.**

05/19 Quality

5.1 Integrated Quality and Performance Report (IQPR)

5.1.1 Karen Rule presented the report, with input from the David Sulch, highlighting operational and quality performance across key performance indicators for July 2019.

One MRSA bacteraemia was reported in July, bringing the total to three, against a trajectory for the year of no more than four. The Trust is no longer a national outlier for mortality, with improvements seen in mortality for frail patients during week days. The suspected link between mortality and long patient waits in ED has not been substantiated. Significant improvement has been seen, with actual number of deaths at its lowest for a number of years. Improvement was also seen in the rate of falls. Pressure ulcer acquisition is within the mean rate; however, more work is to be done to reduce rates. Reducing same sex accommodation breaches remains challenging; however, the work around best flow transformation is starting to deliver some improvements.

The Trust has made contact with Lesley Goodburn, Senior Improvement Manager, NHSI (she has supported other Trusts to elevate their patient experience work) to support the work in improving patient experience and achieve improved Friends and Family Test (FFT) scores. Lesley will facilitate a workshop provisionally scheduled for 13 November.
Electronic Discharge Notification (EDN) performance remains unsatisfactory and a refreshed workstream has been set up to accelerate the required pace of change for improved performance. The Fractured Neck of Femur (#NOF) performance has been impacted by another period of increased demand for trauma services and orthopaedic services. Venous thromboembolism (VTE) delivered sustained change, however the summer period and the number of ward clerk vacancies has identified a need to train additional staff in VTE assessment documentation. Escalation beds remained open to support timely admission and treatment on non-elective patients and there has been a reduction in medical outliers.
For the constitutional standards that have not been reported on during the meeting, the Trust did not meet the 4 hour performance standard. 18 weeks referral to treatment (RTT) performance remained steady at 82 per cent but below trajectory. Diagnostics saw improved performance in July achieving 95 per cent; however endoscopy capacity remained a concern. Compliance was maintained with the Trust target for appraisal and statutory and mandatory training.

5.1.2 The Board:

a) Queried the redesign workflow in relation to EDNs. It was noted that the EDN process is being simplified, with a plan to frontload and care being taken to avoid process delays into the discharge process
b) Noted, in relation to the query on junior doctors, that they go through induction, are mentored, provided with relevant information about how their particular services work and there are clear expectations. The key is whether the link is drawn between EDNs, for example, and quality and safety, which is not the case. The hard work of junior doctors was recognised, noting that having new junior doctors drive a variation in performance; therefore, constant support is a key to maintaining performance.
c) Noted that for consistency in terminology same sex accommodation should be used.

5.1.3 **The Board noted the Integrated Performance and Quality Report**.

5.2 Quality Assurance Committee Assurance Report

5.2.1 Ewan Carmichael, Non-Executive Director (who chaired the last committee meeting), highlighted a number of areas from the report. He clarified that the Trust is reporting fewer than average outliers and there were actions in relation to further work in pneumonia and complaints/ incidents/ coroners case triangulation.

5.2.2 **The Board noted the Quality Assurance Committee Assurance Report.**

5.3 Maternity Clinical Negligence Scheme for Trusts

5.3.1 Karen Rule presented the report noting that the Board at its development session on 1 August 2019 received a paper which set out the Trust's position in relation to the 10 safety actions to support the national ambition for the reduction of still birth. This was presented at that meeting due to a submission deadline of 15 August. The Board delegated authority to the Chief Executive to sign the self-declaration, subject to the Executive Director of Nursing reviewing the evidence in relation to safety action nine: staff training; and additional evidence required for safety action one: compliance with standard to reporting still birth. The outstanding issues had been resolved and the Trust had declared compliance with all 10 safety actions, with the self-declaration submitted by the deadline. The outcome is expected by 30 September 2019.

5.3.2 **The Board noted the contents of the report.**

06/19 Finance and Performance

6.1 Finance Month Four Report

6.1.1 Ian O'Connor, Executive Director of Finance, presented the month four finance report which showed a year to date (YTD) deficit of £16.9 million (excluding Provider Sustainability Funds (PSF), Marginal Rate Emergency Tariff (MRET) and financial recovery funds. Operationally this is adverse to the current operational plan by £985,000. Against the declared plan with NHSI the Trust is £611,000 favourable to plan. The position deteriorated from month four as

a result of the rephrasing of the plan and the slippage in the CIP. A lot of work is to be done in order to achieve the CIP target and in turn meet the control total. There is closer working with the operational teams to ensure that they not only stay within budget, but also promote delivery of their improvement plans and generate new ideas. Within the reported figure, there is a £1.2million optimism bias reserve which if removed will present a better position.
The month four flash report showed a reduction in the number of greens (six out of nine), a deterioration from the month three position (eight out of nine).

6.1.2 **The Board noted the Finance Month Four Report.**

6.2 Finance Committee Assurance Report

6.2.1 Jo Palmer, Senior Independent Director talked through the contents of the report, which covered Reference Cost submission, Finance risk register, CIP, Capital Plan 2019/20, Emergency Department Water Mist System, Project Updates on the STAR programme and Electronic Documents Records Systems (EDRMS).

6.2.2 **The Board noted the Finance Committee Report.**

6.3 **Communications and Engagement Report**

6.3.1 Glynis Alexander, Executive Director of Communications and Engagement, presented the report highlighting specific areas. An overarching communications plan has been developed, with supporting materials for the next phase of the transformation programme. There has been continued communication of the Trust's core strategies, in addition to the vision, values and strategic objectives. The monthly staff briefings with the Chief Executive have continued with very good attendance and engagement from staff. There has been communication support with the car parking scheme and the Organ Donation Week, for which a number of activities have been lined up. Two recent campaigns were held: zero tolerance and infection prevention. The Trust has continued to grow its following across all social media channels, where key messages have been shared and passed the 5,000 follower mark on Twitter. Governors have been receiving positive feedbacks in relation to community engagements. All feedback received are collated and logged on to the Datix system. There was engagement with the Commissioner around outpatient services and work ongoing with STP colleagues to gain feedback on the Kent and Medway Long Term Plan. Work is currently ongoing with NHSE on an engagement event around vascular services. The behind the scenes event with an 'open day' organised for Members had proved popular.

6.3.2 **The Board noted the Communications and Engagement Report**.

07/19 People

7.1 Workforce Report

7.1.1 Leon Hinton, Executive Director of HR and OD presented the July workforce report, with a slightly different format to include update on medical and dental; allied health professional; and scientific, technical and therapeutic professional recruitment. There was a net increase of nine registered nurses and midwives. There were 280 nurses in the pipeline via the international recruitment campaign, with 156 expected new starters over the next 12 months. Consultant recruitment is taking place across a range of specialties. The Trust continues to experience difficulty recruiting band six physiotherapy staff. Turnover and sickness rate remained stable. The Trust has exceeded its 85 per cent statutory mandatory target, with all but one programme compliant. The Trust is below the NHSI agency ceiling cap by £3.6 million. A pre and post anonymous survey has been done for the 'You are the Difference' (YatD) programme. Across all measures, there was a swing of +5.4per cent following the session. The Trust's culture and engagement action plan has been modelled on the NHSI culture and leadership toolkit. The current status of the staff survey action plan was noted.

7.1.2 **The Board noted the Workforce Report.**

08/19 Assurance Reports

8.1 Integrated Audit Committee Annual Report

8.1.1 Mark Spragg, Non-Executive Director, presented the report which was taken as read. In relation to all internal audit recommendations, it was noted that a running log is maintained for each of these and these are reviewed and monitored to ensure execution.

8.1.2 **The Board received the Integrated Audit Committee Annual Report.**

8.2 Integrated Audit Committee Assurance Report

8.2.1 Mark Spragg, Non-Executive Director, presented the report which was taken as read.

8.2.2 **The Board noted the Integrated Audit Committee Assurance Report.**

09/19 Annual Reports

9.1(i) Infection Prevention and Control Annual Report

9.1.1 David Sulch, with input from Gail Locock, Kent and Medway Director of Infection Prevention and Control (IPC) presented the report which showed the Trust's position for 2018-19, detailing the performance and the current compliance against the Health and Social Care Act. He thanked Dr Rella Workman, former Director of IPC for her years of service and hard work. The report reflects a difficult year for the Trust in relation to IPC. There were eight MRSA bacteraemia; 25 cases of c-difficile, against a trajectory of 19. The main issues that led to the poor performance include the use of personal protective equipment, hand hygiene, isolation, adherence to uniform policy, anti-microbial stewardship lacking, poor compliance to statutory mandatory training, lack of robustness on IPC internal governance. The IPC team have faced increased pressures due to the move of the IPC anti-microbiology lab to North Kent Pathology Service (NKPS).

9.1.2 The Board was assured on a number of initiatives taken to address the issues highlighted. The Executive Medical Director has now taken the role of Director of IPC to ensure executive oversight; a Lead Nurse and a new named doctor for IPC are in place. The governance structure has been revamped and there is a strong focus on mandatory training, with compliance now over 95 per cent. IPC is part of Junior doctors induction. The summary of the in depth review of the Trust's compliance against the Health and Social Care Act was highlighted. Updates were provided against some of the criteria - Criteria 1: overall governance of programme - significantly improved; Criteria 3: anti-microbial stewardship, improving but remains an issue; Criteria 7: isolation facilities - work in progress; Criteria 9: policies - all group of policies relating to IPC are being reviewed. A robust process is now in place for post infection reviews. Foundations are now in place for improved performance. So far this year, 17 cases of c-difficile and three bacteraemia have been reported.

9.1.3 The Board discussed the challenge posed on the robustness of the oversight of IPC at Board level and queried the length of time it took to bring the issues to light and address them; and the seeming absence of the Quality Assurance Committee (QAC) focus. Jon Billings, as Chair of QAC noted that the committee has had regular focus on IPC, but there could be further discussions to make this more vigorous. It was agreed that IPC should be a standing item on the Quality Assurance Committee agenda and assurance provided to the Board. **Action: TB/2019/033.** It was suggested that thought be given to taking forward consistency in leadership role modelling, which has been a proven tool to address IPC issues and making data visible on wards to compel staff to action. **Action: TB/2019/034.**

9.1.4 **The Board received Infection Prevention and Control Annual Report.**

9.1(ii) Self-assessment against the Health and Social Care Act 2008

9.1.5 This report was discussed as part of 9.1(i) above.

9.2 Medical Appraisal and Revalidation Annual Report

9.2.1 David Sulch introduced Kirti Mukherjee, Deputy Medical Director and Responsible Officer who presented the Medical Appraisal and Revalidation for approval. The report provided assurance regarding the discharge of Responsible Officer's Regulations particularly in relation to effective appraisal and safe revalidation recommendations and sought approval of the statement of compliance confirming the Trust is in compliance with the Responsible Officer regulations. The main highlight was that for the appraisal year 2018/19, 353 out of 361 connected doctors (97.7 per cent) had a completed appraisal, which compared favourably with national comparator data - 89.3 per cent for the same sector designated bodies and 91.5 per cent for all sectors designated bodies.

9.2.2 Kirti noted that there has been increased workload due to the increased number of doctors. NHSE had five years ago recommended two senior appraisers for the Trust; there is currently only one. The Board formally thanked Dr Mukherjee for her hard work as Responsible Officer, as she will be stepping down effective 30 September.

9.2.3 **The Board received the Medical Appraisal and Revalidation Annual Report; approved Dr David Sulch as Responsible Officer effective 30 September 2019 and approved the statement of compliance.** The Chairman/CEO would sign off the Statement of Compliance confirming that the Trust, as a Designated Body, is in compliance with the regulation.

9.3 Organ Donation Committee Annual Report

9.3.1 Dr Gill Fargher, Chair of the Organ Donation Committee and Dr Paul Hayden gave a presentation on organ donation, highlighting the key metrics for 2018/19: 96 per cent referral rate (44/46 patients), (39/40 patients for 2017/18); eight organ donors, no change from previous year; 15 organs were transplanted, (16 for 2017/18); 22 tissue donors (14 for 2017/18). The Trust is a level two unit for organ donation (six to 12 organ donations/ year) and is one of the best for the numbers of people being approached. There is every confidence staff are doing their best to maximise potential organ donors. The work of the organ donation team focuses on their four strategic objectives. Law change on organ donation will come into force from next Spring and an event about the impending law and its impact has been organised. In addition, an event to increase awareness on organ donation among the Black, Asian, Minority Ethnic (BAME) community is scheduled for 28 September. Education and communications work continue.

9.3.2 Dr Fargher thanked all organ donation committee members for their hard work, noting that the support of the Board is valued. The Chairman, on behalf of the Board voiced appreciation for the enthusiasm and commitment of Dr Fargher and the team to organ donation.

9.3.3 **The Board received the Organ Donation Committee Annual Report.**

10/19 Policies and Strategies

10.1 Corporate Policy: Modern Slavery

10.1.1 Leon Hinton presented for approval the Modern Slavery Policy, which has been reviewed by the Executive Team. No substantive changes have been made. No reports were received in the last financial year to indicate that modern slavery practices have been identified.

10.1.2 **The Board approved the Modern Slavery Policy.**

11/19 Other Business

11.1 Council of Governors' Update

11.1.1 Doreen King, Board Governor Representative gave her final report, noting that it has been an interesting journey with a lot of lessons learnt. She further noted that a number of the issues she had raised at Board meetings have been actioned, including reinstating the Anti-smoking Group to enforce no smoking onsite and pet dogs. In relation to the issue flagged about a number of contaminated blood samples, it was noted that this matter has not been flagged by NKPS, but would be looked into. **Action: TB/2019/035.**

11.1.2 The Chairman reiterated thanks to Doreen and wished her well for the future.

11.2 Any Other Business

11.2.1 There were no matters of other business.

11.3 Questions from members of the public

11.3.1 There were no questions from the member of the public.

12/19 Date and time of next meeting

12.1 The next Board Meeting in Public will be held on Thursday, 7 November 2019 at 12.30pm in the Trust Boardroom, Post Graduate Centre, Medway NHS Foundation Trust.

12.2 The meeting closed at 3.20pm.

These minutes are agreed to be a correct record of the Trust Board Meeting in Public of Medway NHS Foundation Trust held on Thursday, 5 September 2019

Signed …….. Date ……
Chair

Board of Directors in Public
Action Log

Agenda Item: 3.2
Date: Thursday,07 November 2019

Actions are RAG Rated as follows:

Off trajectory - The action is behind schedule	Due date passed and action not complete	Action complete/ propose for closure	Action not yet due

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
03-Jul-19	TB/2019/028	Council of Governors' Update Publish waiting times in clinics to aid patients' planning.	05-Sep-19	Harvey McEnroe Chief Operating Officer	This now forms part of the best access programme and is also part of the Outpatient Improvement Group. Formal update to be provided via the best access programme.	Green
05-Sep-19	TB/2019/030	**Patient Story** Put in place a better codified way of responding to patients with rare conditions, building on the UK Strategy for Rare Diseases.	08-Jan-20	David Sulch Medical Director	Action due in January 2020.	
05-Sep-19	TB/2019/031	**Patient Story** Share the patient story slides at the Clinical Council and utilise for junior doctors training	07-Nov-19	David Sulch Medical Director	The slides will be shared at the November Clinical Council.	Green
05-Sep-19	TB/2019/032	**Patient Story** Follow up the information about major train companies offering heavily discounted train travel to children/ young adults with chronic diseases.	07-Nov-19	Gurjit Mahil Deputy Chief Executive	Southeastern was contacted and their response was that they have no specific policy on this issue and would look at all such applications on a case by case basis. Should the Trust have patients who might be in need of subsidised travel, details should be sent to Southeastern who would look into the matter. Patients however may be able to claim a refund of travel costs under the Healthcare Travel Costs Scheme.	Green
05-Sep-19	TB/2019/033	**Infection Prevention and Control (IPC) Annual Report** IPC to be a standing item on the Quality Assurance Committee agenda and assurance provided to the Board	07-Nov-19	Brenda Thomas Company Secretary	Included in the Quality Assurance Committee work plan.	Green
05-Sep-19	TB/2019/034	**Infection Prevention and Control (IPC) Annual Report** Give consideration to taking forward consistency in leadership role modelling and making data visible on wards to compel staff to action.	07-Nov-19	David Sulch Medical Director	'Waking Up Medway' will give a range of senior leaders the opportunity to role model good IPC behaviour and to challenge poor practice, and the Chief Executive and Chief Operating Officer have messaged this again with front door gel initiative. As far as local data goes, the Head of IPC is working out how most easily to transmit this information to the wards (currently working on an automated report from North Kent Pathology Service to assist).	Green

Board of Directors in Public
Action Log

Agenda Item: 3.2
Date: Thursday,07 November 2019

Actions are RAG Rated as follows:

Off trajectory - The action is behind schedule	Due date passed and action not complete	Action complete/ propose for closure	Action not yet due

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
05-Sep-19	TB/2019/035	**Council of Governors' Update** Look into the issue flagged about a number of contaminated blood samples.	07-Nov-19	Harvey McEnroe Chief Operating Officer		

Agenda Item 3.2

NHS Medway NHS Foundation Trust

Chief Executive's Report – November 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

As we near the winter period we hope to see the fruits of the hard work by staff across the Trust all year to ensure we are fully prepared for surges in capacity.

We are confident that the improvements we have made to our patients' journey through the hospital and the enhanced processes we are putting into place to escalate and react to increased pressures will stand us in good stead.

Our patients can also play a role in helping us by ensuring that they choose the best place for their care (it's not always our Emergency Department), having a flu vaccination, and recognising the importance of hand hygiene when visiting the hospital.

Thank you to all our staff for their hard work to help get Medway ready for the colder weather.

Transformation

Our goal continues to be to transform care for our patients, and there have been some key developments on this front.

Our Best Flow programme continues and is aimed not just at improving the experience of patients in our Emergency Department, but throughout the hospital to discharge. We were delighted to be recognised externally for this programme by winning the Patient Flow Programme of the Year Award at the Executive Patient Flow Summit.

Our new Best Access programme aims to improve Outpatient, Cancer, Diagnostic and Theatre/Day case pathways, as well as create a central access function. The programme will be the focus of the Trust's new Delivery Unit.

As well as looking to improve our patients' experience, we are also looking at ways we can adapt, evolve and improve our own processes. Our Delivery Unit comprises a small team of project management professionals with support from a range of operational subject matter experts. The unit sets precise workplans and its outputs are deadline driven.

Waking up Medway

In October, we were delighted to launch 'Waking up Medway'. This encourages staff to cancel or rearrange meetings between 8am and 10am and get 'back to the floor' to support clinical staff in delivering high quality patient care.

We have already seen some of our staff play a really important role in encouraging members of the public to support us in protecting our patients from infection, by encouraging them to wash their hands as they enter the site.

Protecting our patients from flu

We have launched our annual campaign to vaccinate our staff against the flu. So far we have had a very positive uptake from staff members who have taken advantage of the numerous options available to them (including ward visits and drop-in sessions) to have their jab.

Stop! Gel! Go!

Getting the basics right for our patients keeps them safe, and in some cases keeps them alive; it's something we take very seriously, and that's why we have launched our new Stop! Gel! Go! awareness campaign.

The campaign messages are highly visible in the hospital main entrance, sending a clear message to our staff and our community that they should not enter our premises without supporting us in protecting our patients.

Being ready for the unexpected

The saying goes 'fail to prepare, prepare to fail' and it's vital that as a Trust we ensure that we are prepared for all eventualities.

That's why in October we undertook a large-scale decontamination event with actors portraying victims who had been exposed to a substance. I would like to thank everyone involved in the exercise which generated lots of valuable learning.

Thank you to rapid relief

A massive thank you to the Rapid Relief Team, a community based charity that supports the emergency services, for providing a feast to our staff in October.

Not only did they cook enough food for 3,200 hungry Medway staff, but their team of 75 volunteers also delivered 1,380 pre-orders to our staff who were unable to get away from their work area. It was very much appreciated by us all, thank you!

Thanks to the kind donations made by staff we also raised more than £1,300 for the Medway Hospital Charity.

A successful Annual Members' Meeting

In September we held our Annual Members' Meeting, our yearly gathering of our Trust members and stakeholders where we have the opportunity to present our Quality Report and Annual Accounts to our community.

It was fantastic to reflect on the progress we have made over the last 12 months and to hear presentations on our Prehabilitation Programme and from the Acute Medicine Team. Both of these teams were the recipients of last year's Chief Executive Scholarship for Brilliance Award.

Most importantly it was a great opportunity to hear from our community about the issues that matter to them.

Chief Executive's Scholarship for Brilliance

A special part of the Annual Members' meeting was the announcement of the winners of the Chief Executive's Scholarship for Brilliance Award. I was delighted to receive many excellent applications for this year's award. The entries were judged against our strategic objectives – high quality health care, integrated healthcare, innovation, financial stability and people.

The Medway Hospital Charity has agreed to contribute £10,000 towards the scholarship and I would like to thank the committee for their ongoing support.

Two bids, from the Smoking Cessation Team and from Dr Samantha Black, stood out.

The Smoking Cessation Team

Dr Nandita Divekar, Dr Rahul Sarkar and pharmacist Sandra Sowah applied to visit the University of Ottawa in Canada to experience first-hand its evidence-based smoking cessation model.

The team plans to modify the model to meet local needs and will set up a training programme for staff so that Medway can truly become a smoke free hospital.

Dr Samantha Black

Dr Black applied to visit experts in Adelaide, Australia to develop Hypnosis in Paediatric Preparation for Surgery (HIPPS) at the hospital. This programme aims to reduce fear in young patients by putting the child at the very heart of their hospital journey.

I am delighted to announce that both projects will be funded to allow collaboration with experts across the world, bringing excellence and innovation to the Trust.

CPR'athon

The Trust staged a CPR'athon in October to help highlight the importance of life-saving cardiopulmonary resuscitation (CPR).

The Trust's inaugural 'CPR'athon' included staff competing in teams over 10 minute rounds of continuous chest compressions using the latest hi-tech manikins. The teams were assessed by the technology built into the manikins, which measured the depth, rate and recoil of their CPR against the current Resuscitation Council (UK) guidelines, giving a final percentage of overall effectiveness.

The final of the competition saw staff from the Trust's Acute Response Team crowned the overall winners with a score of 98.64 per cent.

Hospital Radio Medway

I was delighted to take part in a live Hospital Radio Medway show in the main entrance of the hospital. It was fantastic to be involved and see first-hand the passion that the volunteers have for the work that they do. We are incredibly grateful for the support we receive from our Trust volunteers, League of Friends and Hospital Radio Medway. They are a critical part of what makes Medway so special.

Further afield

New structure for CCGs

All eight Kent and Medway clinical commissioning groups (CCGs) have now agreed to form a single CCG as part of system changes.

The merger application was approved by NHS England and NHS Improvement in October. The single CCG will go live on 1 April 2020.

This is a first step towards Kent and Medway becoming an integrated care system, with a single CCG, integrated care partnerships and primary care networks.

Reducing single-use plastic in our restaurant

A drive to reduce the amount of single-use plastics in hospitals has been announced by the NHS chief executive, Simon Stevens. Retailers operating in hospitals have committed to cut the use of avoidable plastics starting with straws and stirrers, followed by cutlery, plates and cups phased out over the following 12 months. The NHS bought at least 163 million plastic cups, 16 million pieces of plastic cutlery, 15 million straws and 2 million plastic stirrers last year.

At Medway we have already taken steps to reduce the use of single-use plastics in our restaurant, for example introducing bottled sauces to replace sachets, and replacing plastic cutlery with wooden versions.

CQC – annual assessment published

The Care Quality Commission has published its State of Health Care and Adult Social Care in England 2018/19. The report is the CQC's annual assessment of health and social care in England and looks at trends in quality, shares examples of good and outstanding care, and highlights where care needs to improve.

CQC has found that the overall quality of care that people receive in England has improved very slightly from last year. When people are receiving care, it is mostly of good quality.

Access and staffing are presenting challenges across all care settings, with geographic disparities in provision presenting particular barriers in some parts of the country.

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Integrated Quality and Performance Report	**Agenda Item**	**4.1**
Lead Director	Karen Rule, Executive Director of Nursing		
Report Author	Executive Team		
Executive Summary	This report informs Board Members in the form of a dashboard report of September 2019 quality and operational performance across key performance indicators. **Safe** Our Infection Prevention and Control (IPC) performance for September shows that the Trust has had 0 MRSA bacteraemia cases since July 2019 therefore we remain within trajectory of no more than four for the whole year. The Trust is on trajectory for *C. difficile* infections (19 versus trajectory of 21 for end September) and the antimicrobial stewardship group activity will assist in ensuring controls against this are effective The IPC action plan is being monitored closely with actions being closed as appropriate. The updated May Hospital Standardised Mortality Ratio (HSMR) figure now sits at 103, which is not a national outlier. Reviews are currently taking place with specific teams; these reports will be taken to the Mortality and Morbidity Committee in November. A further independent review will take place in November by NHS Improvement (NHSI). **Caring** Reducing our same sex accommodation breaches remains challenging. The main area of focus is Critical Care which is being addressed through the Best Flow Programme. Electronic Discharge Notification (EDN) performance remains below trajectory, recent deep dive analysis with the teams has been completed and refreshed trajectories and resources have been clarified to ensure completion within 24 hours. **Effective** Venous Thromboembolism (VTE) performance fell in the first half of 2018/19, but a continued improvement in performance and VTE compliance is evident, climbing consistently since October 2018 and stabilising in the first quarter of 2019/20, due to better engagement, stronger leadership and constant monitoring, review and flexing of process to amend issues as they arise, but remaining below the target of 95%. The Fractured Neck of Femur (#NOF) performance has been impacted by another period of increased demand for trauma services and orthopaedic services. Plans are being implemented to create additional trauma lists and evening orthopaedic lists to meet demand.		

	Responsive The Trust did not meet the 4 hour performance standard; however an improvement to 86.14% was seen in September. 18 weeks referral to treatment (RTT) performance remains steady at 81%, with 0 52 week breaches but below trajectory. An improved performance for Diagnostics was seen in September achieving 98%. Cancer performance has significantly improved in August to 94% (2week wait) and 83.7% (62 day). **Well Led** We have maintained compliance with Trust target for appraisal and statutory and mandatory training however we have seen a decrease from previous months. The need to sustain and further improve performance against these targets has been discussed at Executive and Divisional meetings and weekly reporting is in place to support timely monitoring and intervention.	
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒
	Finance: We will deliver financial sustainability and create value in all we do	☒
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Committees or Groups at which the paper has been submitted	Executive team (content discussed, not entire report) Division and Programme leadership teams (content discussed, not entire report).	
Resource Implications	Nil	
Legal Implications/ Regulatory Requirements	Nil	
Quality Impact Assessment	Not Applicable	
Recommendation/ Actions required	The Board is asked to discuss and note the report.	

Approval	Assurance	Discussion	Noting
☐	☐	☒	☒

Appendices	None

Integrated Quality and Performance Report

September 2019

Contents

NHS Medway NHS Foundation Trust

Best of care Best of people

NHS
Medway
NHS Foundation Trust

SAFE

Best of care
Best of people

Safe

NHS Medway NHS Foundation Trust

SAFE

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	12M
Harm Free Care	Falls Per 1000 Bed Days	6.6	#	3.95	4.01	4.46	5.19	6.99	4.54	4.72	4.73	4.99	4.2	4.1	4.86	4.72
	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	1.0	#	0	0	0.12	0.24	0	0	0.2	0.06	0	0	0	0.13	0.06
Incident Reporting	Never Events	0.0	#	0	1	0	0	0	0	0	0	0	0	1	0	2
	No of SIs on STEIS	90.0	#	10	6	6	7	6	4	5	20	8	11	10	12	105
	% of SIs Responded To In 60 Days	-	%	100	93.33	100	100	100	100	100	100	100	100	100	100	99.07
Infection Control	MRSA Bacteraemia (Trust Attributable)	4.0	#	-	-	-	-	-	-	0	1	1	1	0	0	3
	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	43.0	#	-	-	-	-	-	-	3	2	7	5	1	1	19
	C-Diff: Hospital Onset Hospital Acquired (HOHA)	-	#	-	-	-	-	-	-	3	2	1	1	1	1	9
	E-coli (Trust Acquired) Infections	30.0	#	1	4	4	4	7	3	5	4	6	6	9	5	58
Mortality	Crude Mortality Rate	2.5	%	1.41	1.35	1.14	1.29	1.51	1.92	1.5	1.9	1.78	1.42	1.53	1.29	1.48
	HSMR (All)	100.0	%	113.3	111.38	109.91	107.35	103.88	104.15	103.54	102.9	-	-	-	-	107.09
	HSMR (Weekday)	100.0	%	112.54	111.23	109.28	105.46	100.66	100	100.27	99.14	-	-	-	-	104.85
	HSMR (Weekend)	100.0	%	114.8	111.13	110.79	111.79	112.74	115.81	112.27	112.74	-	-	-	-	112.75
	SHMI	1.0	#	1.06	1.1	1.1	1.1	1.09	1.09	1.07	1.09	-	-	-	-	

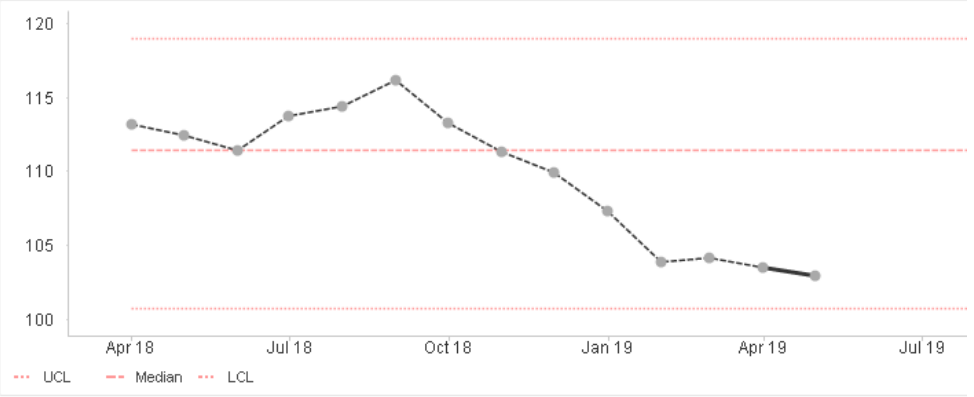
Safe Commentary:

Clostridium difficile infections - Trust attributable cases remain within annual trajectory with a year to date total of 19 cases.
MRSA blood stream infections is above the zero tolerance at 3 cases year to date but an improvement plan is in place to ensure controls and implement prevention. The blood culture contamination rate within the Emergency Department has improved significantly and sustained, falling to within national benchmark.
Work in being undertaken to understand the sources of E.coli HAI and investigate these cases.
The Trust continues to work through the agreed Infection Prevention Control and Health & Social Care Act action plans.

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

Safe – Total HSMR Spotlight Report

Domain	KPI Name	Target		Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19
Mortality	HSMR (All)	100.0	%	116.17	113.3	111.38	109.91	107.35	103.88	104.15	103.54	102.9



HSMR Total Definition:

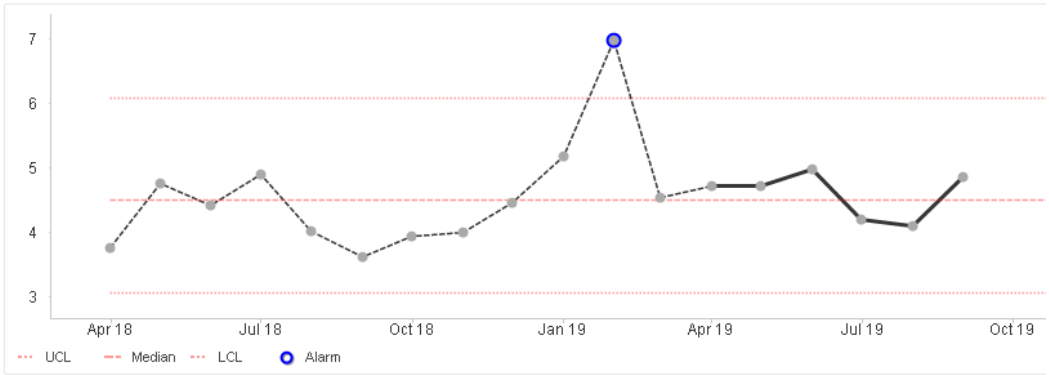
The HSMR is a subset of 56 diagnosis group relating to approximately 83% of in hospital deaths in England. A mortality risk for each patient is calculated based upon the admitting diagnosis combined with case mix adjustment factors such as age, admission history, deprivation and secondary diagnoses .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

Commentary, Risks & Mitigating Actions

Please note June 2019 data is not available at the time of completing this report.

Safe – Falls Per 1,000 Bed Days Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Harm Free Care	Falls Per 1000 Bed Days	6.6	#	3.95	4.01	4.46	5.19	6.99	4.54	4.72	4.73	4.99	4.2	4.1	4.86



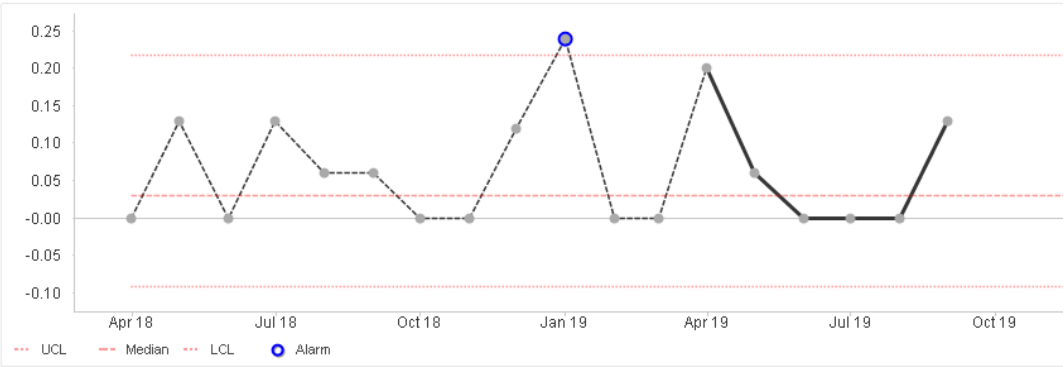
Falls Definition:

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
In September there were 78 in patient falls • 14 falls (18%) related to patients with a diagnosis of Dementia • 3 falls (4%) related to patients with a history of alcohol excess • 6 falls (8%) was related to one patient withdrawing from illicit drug use. • 3 incidences of harm were sustained from falls categorised as moderate/severe harm or death Falls with harm per occupied bed days remained below the national target this month	The Falls CQUIN audit is demonstrating a lack of documentation to evidence that • A walking aid has been given • Medication has been reviewed and rationale documented Ward stock of walking frames is insufficient to provide a separate walking frame for every patient that needs one. Ward stock is often given to expedite a patient discharge and the Ward Environment is not always conducive to having a walking aid at the bedside. In response, a Mobility Aid project will be undertaken with pilot wards identified for the Quality Strategy and then rolled out Trust wide The Falls Team will work with a new Frailty Pharmacist (due in post 04/11/19) to support in driving evidence based medication practice. Medical colleagues advised to document medication review even if no changes made.

Safe – Pressure Ulcers Per 1,000 Bed Days Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Harm Free Care	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	1.0	#	0	0	0.12	0.24	0	0	0.2	0.06	0	0	0	0.13



Pressure Ulcer Definition:

The number of pressure ulcers acquired in the hospital and resulting in moderate or high harm divided by the number of occupied bed days. Pressure ulcers are injuries to the skin and underlying tissue primarily caused by prolonged pressure on the skin.

Commentary,	Risks & Mitigating Actions
In September the total number of pressure ulcers hospital acquired were 25. The total number of pressure ulcers per occupied bed days was above our mean rate and we are currently above our trajectory target by 10. Across both directorates there were a total of • 15 category 2, 3 DTI • 6 Unstageable pressure ulcers • 1 unstageable which was the cause of a medical device. In September our highest incident wards were Harvey, Keats and Wakeley, the highest anatomical location being the buttocks ASSKINg audit results were 69% against a Trust target of 95%.	Tissue Viability continue to carry out a point prevalence and ASSKINg audit every month to highlight which wards require support and highlight areas of good practice. Enhanced support is being provided to the wards with the highest incidents and lowest audit scores. Training for pressure ulcer prevention and management continues to be provided on a monthly basis and ad hoc. The pressure ulcer panel meeting takes place monthly basis, all pressure ulcers that have been acquired are reviewed with the overarching trust pressure ulcer improvement plan attached to this. MFT continue to participate in a national collaboration with NHS England/Improvement for the reduction of pressure ulcers.

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Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	12M
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	252	192	248	234	252	147	85	107	97	139	100	138	**1991**
	MSA %	0.0	%	1.61	1.32	1.63	1.47	1.74	0.93	0.59	0.7	0.66	0.9	0.64	0.91	**1.09**
	% of EDNs Completed Within 24hrs	100.0	%	50.62	51.1	51	48.06	48.64	48.82	50.55	50.62	50.74	49.42	47.99	50.75	**49.87**
	Inpatients Friends & Family % Recommended	85.0	%	86.47	86.21	81.98	85.05	76.33	85.59	85.6	84.41	83.66	88.01	85.26	86.55	**84.9**
	Inpatients Friends & Family Response Rate	22.0	%	21.54	22.7	19.45	19.69	12.1	20.64	15.83	18.51	20.65	20.72	22.67	22.04	**19.85**
ED Care	ED Friends & Family % Recommended	85.0	%	80.48	78.86	71.97	72.05	72.18	75.56	73.34	73.14	72.58	72.9	77.85	84.55	**76.11**
	ED Friends & Family Response Rate	22.0	%	14.14	13.94	14.01	13.99	13.23	13.42	10.64	12.35	13.45	12.96	15.3	14.38	**13.56**
Maternity Care	Maternity Friends & Family % Recommended	85.0	%	100	100	95.19	97.64	99.6	99.66	100	100	99.6	99.29	98.77	99.64	**99.24**
	Maternity Friends & Family Response Rate	22.0	%	22.71	23.62	28.15	32.81	38.67	31.78	29.77	28.88	11.01	23.56	18.51	19.86	**24.39**
Outpatients Care	Outpatients Friends & Family % Recommended	85.0	%	89.93	90.93	91.63	90.28	89.48	91.14	89.23	89.77	89.42	89.9	91.51	91.2	**90.41**
	Outpatients Friends & Family Response Rate	22.0	%	13.56	13.94	13.06	14.78	14.83	14.15	10.32	12.87	12.75	12.91	15.04	15.09	**13.63**

Caring Commentary:

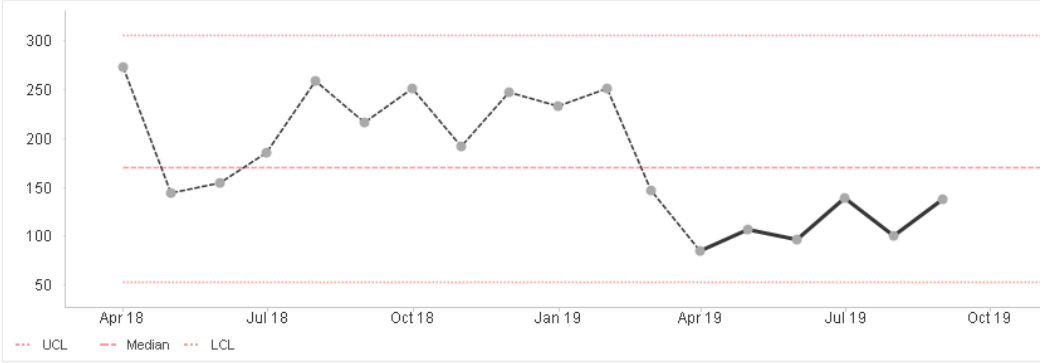
MSA breaches remains high and above the national and Trust ambition of zero tolerance. These breaches are within Critical Care and this is being addressed through the Best Flow Programme with support from NHS I/E. New national guidance has been published. The Trust is currently reviewing current management against these guidelines and will amend Trust policy accordingly. At this time it is difficult to say if the new guidelines will support an improvement in Trust performance.

The increased FFT response rate for inpatients has continued into September. There are also more consistent scores for 'would recommend' rates for inpatients Outpatients have also seen a higher score for the last 2 months for both response rates and 'would recommend' rates. Although ED scores are rated red, the latest available national scores for August 19 show a response rate of 13.2% and a 'would recommend' rate of 86%. The response rates achieved by ED often exceed the national scores. Going forward additional focus is on improving 'would recommend rates' across the Trust.

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

Caring – Mixed Sex Accommodation Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	252	192	248	234	252	147	85	107	97	139	100	138



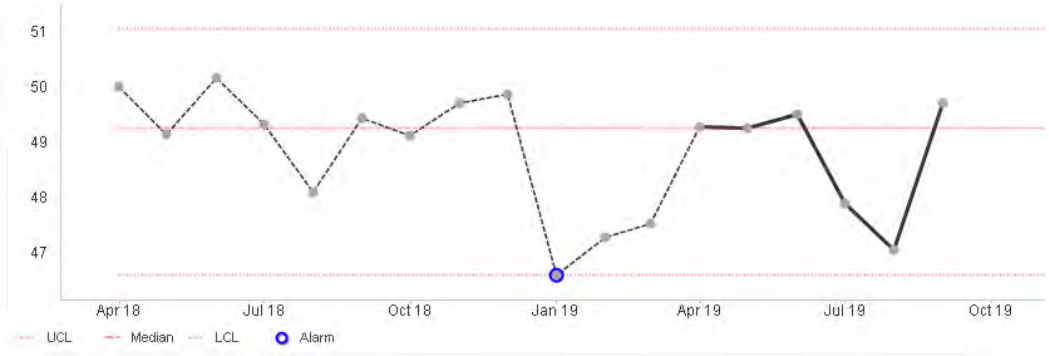
Mixed Sex Accommodation Definition:

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
September saw a rise in Same Sex Accommodation breaches. Of the 138 breaches 134 occurred in critical care areas. This impacted on 55 patients who had delayed discharge from the units due to lack of appropriate level one beds. • ITU 12 patients = 41 breaches • MHDU 22 patients = 40breaches • SHDU 21 patients = 53 breaches There were some issues with system recording that are being addressed in multi-disciplinary meeting to resolve (nursing, BI, IT)	Critical care undertake a review of the breaches that occurred and provide teaching to staff around safe movement of critical care patients to avoid breaches. The Best Flow programme includes a focus on reducing delayed discharge from critical care units. DH updated guidance for managing Same Sex Accommodation. • Clearer guidance around not moving patients between 2200 – 0700hr with guidance for critical care that the clock stops and is restarted at 0700hr. • SDEC, Galton day Unit, Neuroscience Infusion Suite to be excluded as treatment areas • Assessment units included, however guidance on excluding chairs and waiting rooms.

Caring – Electronic Discharge Notification (EDN) Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Admitted Care	% of EDNs Completed Within 24hrs	100.0	%	49.12	49.7	49.86	46.58	47.28	47.51	49.27	49.24	49.5	47.88	47.05	49.71



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

The EDN completion continues to be at a suboptimal level and overall no improvement achieved for September 2019 at 49.71%. Furthermore it has been identified there are some IT issues with the EDN connection with GP systems and are awaiting feedback from IT. In addition workforce improvements will take effect as of August 2019 at junior doctor level, with 4 based on each medical ward thus further improvements in performance are expected.

A number of pieces of work have been carried out and actions implemented, particularly a review of the completion of EDN's for deceased patients. However the actions have not made any noticeable difference to the EDN completion rate. The completion rates are programme dependent, with excellent completion rates in Peri-operative and Critical Care and poor rates in Specialty Medicine consistently below 30%. Issues contributing to this include problems with junior doctor resource on some of the downstream medical wards, Keats and Will Adams being particularly affected.

We have set up a Working Group in the Effective Discharge Workstream within the Best Flow Programme in order to accelerate the pace of change on EDN completion rates in particular improvements in Board Round Processes by utilising whiteboards and improving team performance.

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Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	12M
Best Practice	7 Day Readmission Rate	10.0	%	4.38	4.14	4.56	4.31	4.49	4.21	4.64	4.39	4.6	4.57	5.64	-	4.54
	30 Day Readmission Rate	10.0	%	9.84	10.53	10.46	9.25	9.97	9.37	10.46	9.41	9.71	10.15	10.91	-	10
	Discharges Before Noon	25.0	%	13.85	15.4	17.25	15.4	16.16	15.94	13.98	14.71	14.73	14.9	15.27	14.56	15.18
	Fractured NOF Within 36 Hours	100.0	%	67.7	45.2	46.9	45.5	71.4	85.7	75	61.7	60	58.1	52.2	-	60.85
	VTE Risk Assessment % Completed	95.0	%	55.6	58.19	50.57	74.46	88.65	90.46	95.3	92.67	90.32	92.85	91.86	90.78	83.35
Maternity	Elective C-Section Rate	13.0	%	13.54	13.26	9.69	13.2	12.97	11.63	13.26	13.59	13.04	14.56	13.32	15.91	13.2
	Average occupancy	15.0	%	18.96	16.74	20.42	20.05	21.45	21.45	17	15.53	16.91	18.14	18.34	18.76	18.63
	Total C-Section Rate	28.0	%	32.51	30	30.1	33.25	34.41	33.07	30.26	29.13	29.95	32.7	31.66	34.68	31.83
	Number of Deliveries (Count of Mothers)	-	#	443	430	382	409	401	387	347	412	414	419	398	421	4863
	12+6 Risk Assessment	90.0	%	83.33	83.84	85.19	82.52	82.47	87.21	83.15	81.82	81.58	-	-	-	83.44
Stroke	Stroke SSNAP Rating *	B	-	E	E	E	D	D	D	D	D	D	-	-	-	
	% of Pts Seen by Stroke Cons in 24 Hours *	95.0	%	41.25	41.25	41.25	31.13	31.13	31.13	30.51	30.51	30.51	-	-	-	33.55
	Stroke Pts Scanned Within 1 hour *	90.0	%	48.75	48.75	48.75	42.45	42.45	42.45	50	50	50	-	-	-	47.04

Effective Commentary:

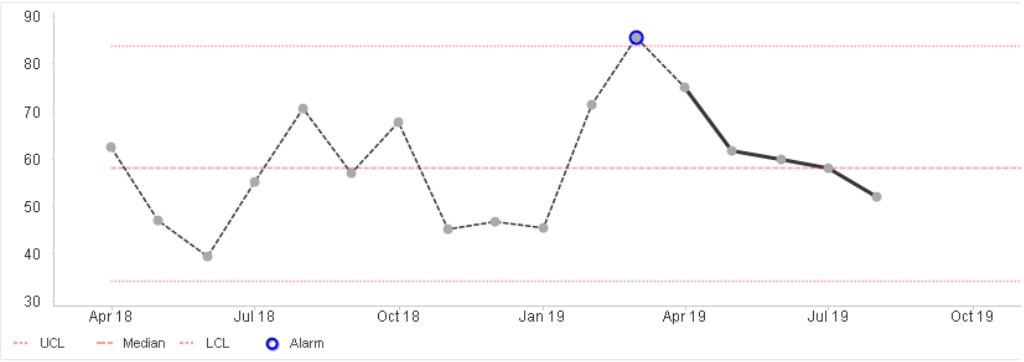
The total c-section rate in September is above the target set, however is within local benchmarking parameters.

Fractured NOF compliance has decreased due to priority trauma cases, patients being on anti-coagulants and patients being medically unwell requiring optimisation for surgery. The Team have identified clear actions to address – see spotlight report.

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		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19
Best Practice	Fractured NOF Within 36 Hours	100.0	%	67.7	45.2	46.9	45.5	71.4	85.7	75	61.7	60	58.1	52.2



Commentary
Risks & Mitigating Actions

	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19
Surgery within 36 hours %	59.3	72.72	75.7	81.81	53.65%	80%	48.27	60
Pre-op AMTS	93.93	100%	100%	100%	100%	100%	100%	85%
Ortho Geriatric review	100%	100%	100%	100%	95.12	100%	96%	100%
Physio assessment within 24 hours	100%	100%	96%	96%	100%	100%	100%	100%
4AT assessment	100%	100%	100%	100%	100%	100%	100%	100%
MUST score (nutrition)	96%	100%	100%	100%	97.56	100%	100%	95%
Falls assessment	100%	100%	100%	100%	100%	100%	100%	100%
Bone protection	100%	100%	100%	100%	100%	100%	100%	100%

Our BPT compliance is again on a downward trend over the last couple of months. Priority trauma appears to the main cause, apart from patients on anti-coagulants and patients being medically unwell requiring optimisation for surgery.

Actions

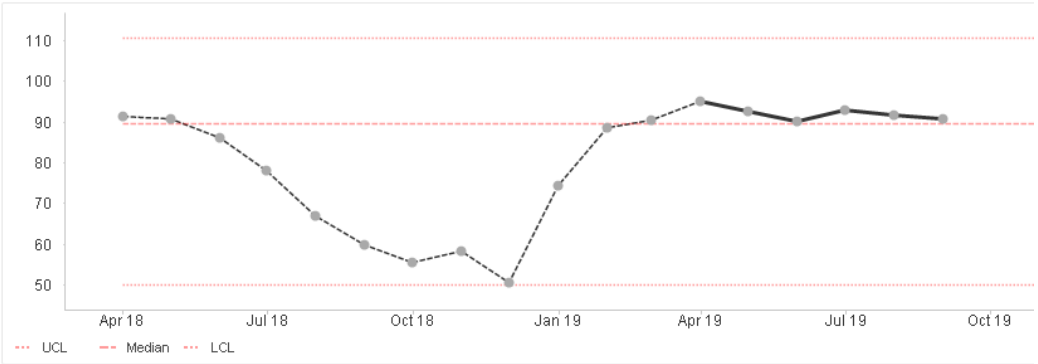
1. Development of a flowchart to help improve BPT performance. The flowchart will guide all clinicians, theatre staff and managerial team when we are unable to operate on patients with hip fractures within 36 hours
2. Discussion with theatre team and trauma co-ordinators to escalate when a hip fracture is being cancelled for lack of time
3. Pro-active monitoring of our BPT performance

Fractured NOF in 36 Hours Definition:

The NICE guidance states that patients admitted with a fractured neck of femur (NOF) should have surgery within 36 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.

Effective – VTE risk Assessment Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Best Practice	VTE Risk Assessment % Completed	95.0	%	55.6	58.19	50.57	74.46	88.65	90.46	95.3	92.67	90.32	92.85	91.86	90.78



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
VTE performance fell in the first half of the 18/19 year, but a continued improvement in performance & VTE compliance is evident, climbing consistently since October 2018 and stabilising in the first quarter of 19/20, due to better engagement, stronger leadership and constant monitor, review and flexing of process to amend issues as they arise, but remaining below the target of 95%. Performance, following Summer flow, is expected to rise and deliver a consistent 95%+, with better availability & coverage of ward duties and further training being undertaken. **Examples of Improving Practices:** • Lister ward has improved compliance • Engagement of the consultants and junior medical team increased through Trust Induction and Ward visibility of VTE nurse	**Risks:** • VTE delivery and performance recording relies on a single point of failure – the Ward Clerk • Availability of Ward Clerks has continued to be a challenge, due to a high number of vacancies and lack of bank availability for additional shifts • Staff sickness in Paediatric Wards resulting in lack of capacity to enter VTE compliance **Mitigations/actions taken:** • Training sessions have been delivered for all Ward Managers and Ward Clerks for the completion & entry of VTE risk assessments • Specific training sessions have been completed on both Lister and on the Paediatric wards • VTE nurse is working hard on maintaining performance in areas where staffing is limited • Dr Bijral has been appointed as the lead for Hospital Transfusion and Thrombosis

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Responsive – Non-Elective

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	12M
Bed Management	Bed Occupancy Rate	92.0	%	90.22	87.21	88.76	90.61	91.38	88.66	83.87	84.93	87.17	88.08	84.27	85.86	**87.56**
	Average Elective Length of Stay	5.0	#	2.72	2.02	2.48	2.02	2.25	2.15	2.24	2.79	2.1	2.09	2.46	2.46	**2.31**
	Average Non-Elective Length of Stay	5.0	#	8.5	8.33	8	9.23	8.79	8.61	8.72	8.56	8.43	8.39	8.24	10.41	**8.67**
	Escalation Beds Open Point Prevalence in Month	0.0	#	775	750	340	775	700	775	750	775	182	162	451	849	**7284**
	Delayed Transfer of Care Point Prevalence in Month	-	#	164	385	302	228	243	321	373	347	281	341	344	212	**3541**
	% of Delayed Transfer of Care Point Prevalence in Month	3.5	%	0.98	2.45	1.87	1.36	1.59	1.94	2.44	2.16	1.82	2.11	2.11	1.33	**1.84**
	Medically Fit For Discharge Point Prevalence in Month	-	#	3234	3060	2991	3211	3345	3663	3379	3060	2829	3114	3104	3222	**38212**
	% Medically Fit For Discharge Point Prevalence in Month	7.0	%	19.34	19.48	18.54	19.17	21.85	22.18	22.14	19.03	18.35	19.25	19.01	20.06	**19.85**
ED Access	ED 4 Hour Performance All Types	95.0	%	88.77	88.95	87.34	83.03	77.07	77.8	79.6	80.61	81.84	80.8	82.41	86.14	**82.85**
	ED 4 Hour Performance Type 1	95.0	%	77.24	77.63	74.42	65.94	64.75	66.1	68.09	68.85	70.53	74.08	74.33	74.44	**71.39**
	ED 12 hour DTA Breaches	0.0	#	13	0	1	5	16	1	7	48	11	4	1	2	**109**
	Median Time to ED Clinician (60mins)	60.0	#	36	36	40	48	53	48	37	38	36	36	27	29	
	Median Time to Ambulance Assessment (15mins)	15.0	#	4	3	3	3	4	4	4	4	4	4	4	4	
	30 Mins Ambulance Handover Delays	0.0	#	332	261	315	364	449	423	346	408	450	378	439	432	**4597**
	60 Mins Ambulance Handover Delays	0.0	#	18	8	72	192	212	133	105	98	108	66	90	78	**1180**
	Number of ED arrivals by Ambulance	-	#	3124	3278	3500	3475	3088	3346	3391	3379	3302	3577	3174	3144	**39778**
	ED Conversion Rate	20.0	%	25.71	23.06	24.74	22.15	20.3	21.78	24.74	24.78	25.19	21.36	20.96	22.2	**23.05**

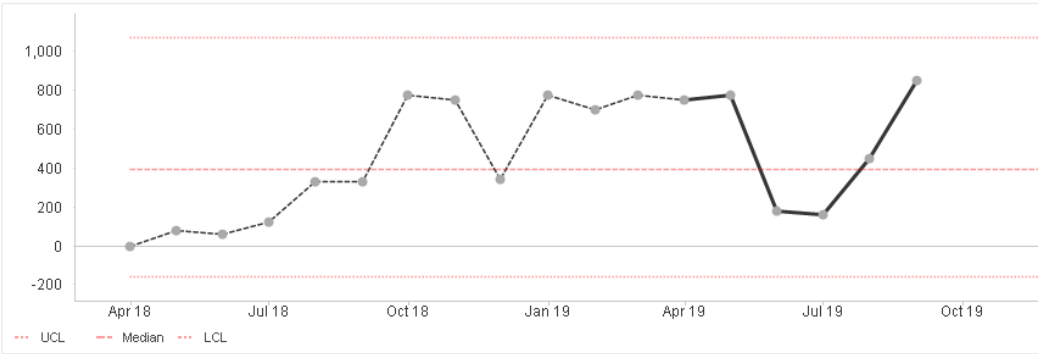
Responsive – Non-Elective Commentary:

A persistent bed occupancy rate of >99% has meant our weekly admitted 4hr performance has been <20% and as a result our type 1 performance is around 15% below trajectory. We are significantly off-plan with our ambulance handover trajectory for >60 minute breaches (target = 5). Stranded patient metric for both 7+ and 21+ has been at peak levels (>75% of bedbase) for 9 consecutive weeks with MFFD caseload regularly >100 patients. Internal standards for emergency care remain intact with initial assessment times for ambulance patients < 5 minutes. TTT within 60 minutes remains a regional leader with >80% of patients seen within 60 minutes of arrival. Type 3 MEDDOC performance has been maintained >90% (IQR 86 – 100) with continuation of recovery plan. Satellite type 3 continues to hit 99-100%. DTA profile at 0800 and 2000hrs has been reduced with cyclical peaks noted on Mon and Tue. Aggregate delay for admitted patients remains exceptional at 272 minutes for medicine.

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

Responsive – Escalation Beds Open Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Bed Management	Escalation Beds Open Point Prevalence in Month	0.0	#	775	750	340	775	700	775	750	775	182	162	451	849



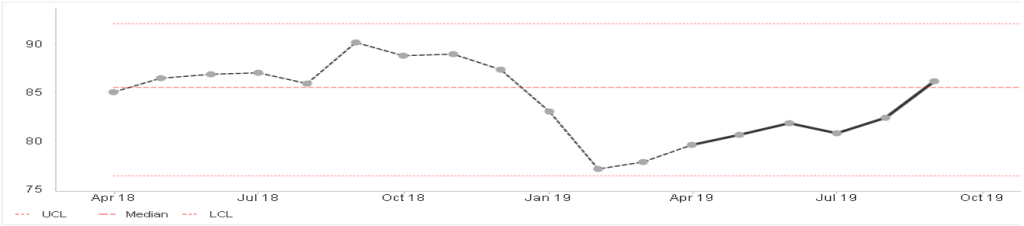
Escalation Beds Definition:

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.

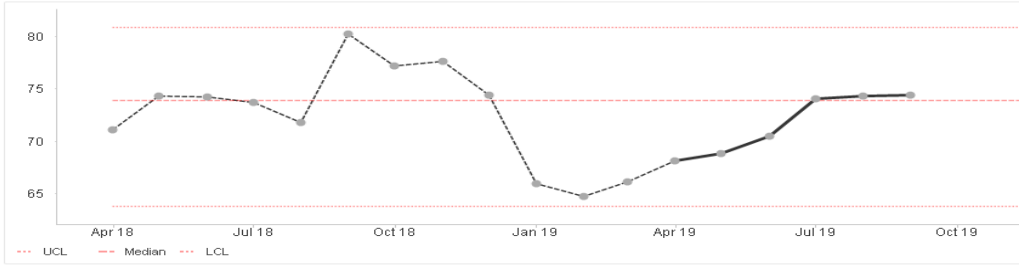
Commentary	Risks & Mitigating Actions
Flex (escalation) capacity has been operated through M6 due to bed occupancy levels of >99% and high MFFD levels.	Management of Dickens ward transferred to Site Operations Patient flow policy being revised by Head of Site Management. UIC Divisional Director of Nursing overseeing Head of Site Management in working with TOP and SpecMed care groups to determine operational, staffing and quality capability until M12. Integrated Discharge Team (MFT) overseeing patient selection and discharge from flex capacity. Discharge Market Place with system partners, CCG and NHSI support scheduled with Transformation Nous partners. IDS / IDT specification review between MCH and MFT ongoing. SDCC and all assessment areas removed as flex capacity from patient flow policy

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

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
ED Access	ED 4 Hour Performance All Types	95.0	%	88.77	88.95	87.34	83.03	77.07	77.8	79.6	80.61	81.84	80.8	82.41	86.14



Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
ED Access	ED 4 Hour Performance Type 1	95.0	%	77.24	77.63	74.42	65.94	64.75	66.1	68.09	68.85	70.53	74.08	74.33	74.44



ED 4 Hour Local Trajectory

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
ED - 4 Hours Type 1	Actual	68.10%	68.87%	68.85%	74.09%	76.96%	74.37%
	Planned	68.13%	77.21%	82.28%	83.22%	82.35%	88.98%
	Variance	-0.03%	-8.34%	-13.43%	-9.13%	-5.39%	-14.61%
ED - 4 Hours All Types	Actual	79.66%	80.77%	80.60%	86.66%	82.38%	86.10%
	Planned	79.66%	83.05%	87.76%	90.00%	90.00%	90.00%
	Variance	0.00%	-2.28%	-7.16%	-3.34%	-7.62%	-3.90%

Commentary	Risks & Mitigating Actions
All types performance improved by 4% between M5 and M6. Gains through non-admitted pathway and MEDDOC type 3 performance. Remain off plan for type 1 (14%) and all types (3.9%) Admitted pathway remains <20% due to high bed occupancy and high aggregate patient delay for referred patients	**Type 1 recovery** AAU / SDEC pathways launched in mid-October via Acute Medicine working group and supported by TN. **Type 1 recovery** Quicker allocation of vacant capacity via revised site model with pathway bed managers **Type 1 recovery** SAU working group launched with actions TBC **Type 1 recovery** Site working group launched with revised Hospital at Night and Hospital at Weekend projects **Type 1 recovery** IDT remodelling in-utero with Executive oversight **Type 3 recovery** CPN remains active with MEDDOC but recovery plan deployed with oversight of dedicated on-site management team

Responsive – Elective

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Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	12M
Diagnostic Access	DM01 Performance	99.0	%	99.54	98.76	97.4	96.85	98.92	98.7	95.41	93.72	92.03	95.87	98.84	98.49	**96.92**
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	82.59	82.62	80.97	80.84	80.25	80.75	83.08	83.27	82.5	82.35	81.36	81.46	**81.81**
	18 Weeks RTT Over 52 Week Breaches	0.0	#	12	9	13	20	27	37	8	5	3	3	1	0	**138**
	Daycase Rate	85.0	%	65.99	62.81	63.11	67.28	68.15	65.17	65.31	65.75	66.06	65.24	62.82	63.83	**65.14**
	DNA Rate	10.0	%	8.7	8.5	8.74	8.48	8.03	7.76	7.81	7.77	8.08	7.88	7.85	8.18	**8.17**
	First to Follow Up Ratio	-	#	1.16	1.18	1.2	1.16	1.2	1.18	1.19	1.15	1.14	1.14	1.18	1.14	**1.17**
Theatres & Critical Care	Operations Cancelled By Hospital on Day	0.0	#	29	24	52	46	51	14	41	15	29	26	11	21	**359**
	Cancelled Operations Not Rescheduled < 28 days	0.0	#	2	6	17	23	22	17	8	7	2	5	3	0	**112**
	Urgent Operations Cancelled for the 2nd Time	0.0	#	1	1	0	0	0	0	0	0	0	0	0	0	**2**
	Critical Care Occupancy Rate	92.0	%	96	94.02	94.55	98.78	94.95	95.88	84.83	89.21	89.54	86.21	84.09	87.93	**91.33**

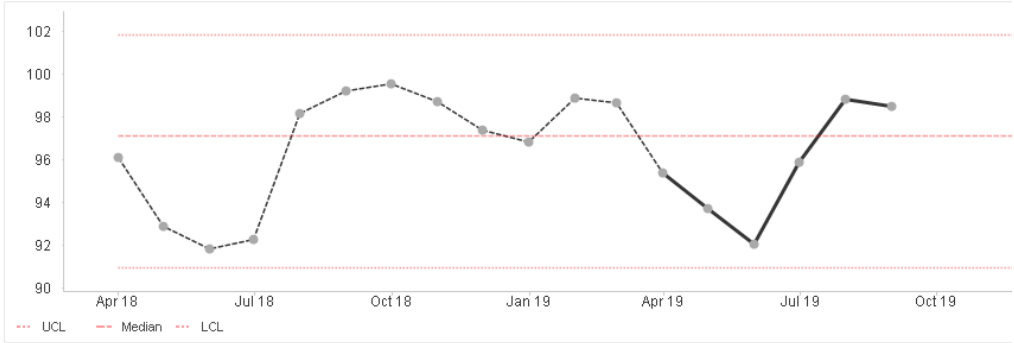
Responsive – Elective Commentary:

The Trust failed to hit the required constitutional standard for RTT 18 weeks and the DM01 standard. The DM01 has been improving over the last two months failing just short of the standard by less than 1%. The main concerns remains in Endoscopy. RTT 18 weeks remains a concern hitting 81.46% of the 92% standard, the main arears of concern are Neurology, ENT and General Medicine.

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

Responsive – DM01 Performance Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Diagnostic Access	DM01 Performance	99.0	%	99.54	98.76	97.4	96.85	98.92	98.7	95.41	93.72	92.03	95.87	98.84	98.49



DM01 Local Trajectory:

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
DM01- 6 Weeks	Actual	95.41%	93.72%	92.03%	95.87%	98.84%	98.39%
	Planned	99.20%	99.60%	99.80%	99.40%	99.80%	99.80%
	Variance	-3.79%	-5.88%	-7.77%	-3.53%	-0.96%	-1.41%

Commentary

DM01 performance has risen steadily over the last few months with August reporting 96.84% - the highest position for five months. However performance continues to remain challenged and failing to achieve the national target of 99%/constitutional standard, driven by:

- Increased MRI demand (clinically indicated)
- Continued compliance in all modalities outside of Imaging and Lower/Upper GI

Unfortunately due to significant capacity issues in Endoscopy, the Trust will remain challenged to deliver the expected KPI of 99% until a long term solution to the capacity issues in this service are realised.

The Enhanced processes have been introduced for the management f DM01 performance e.g.

- Weekly & monthly DM01 report for validation for undated/ forecastable breaches + joint PTL meeting + weekly Exec Review Meeting
- Monthly action report for breeches < 2 weeks notice of end of month
- Weekly & monthly forecasted performance against KPI

Risks & Mitigating Actions

Risks:

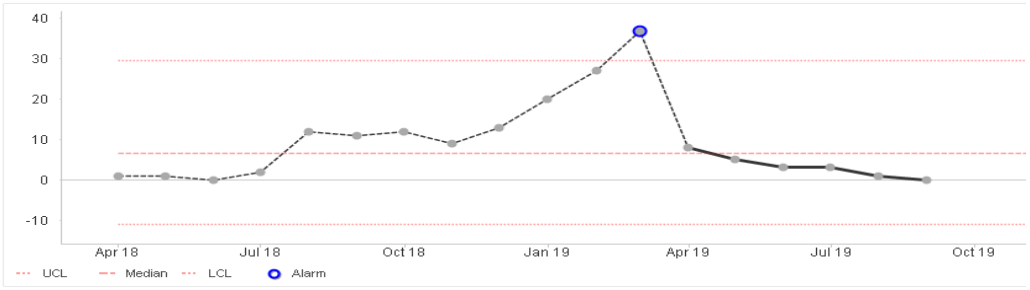
- Capacity (Routine)
  - MRI
  - Gastro (Upper and Lower GI)
  - Urodynamics
- Consultant vacancy – Endo / Colo
- Pensions Tax Issue affecting willingness to undertake adhoc sessions (Endo/Imaging)
- Reporting capacity within Radiology
- Increasing demand in Imaging without sufficient capacity

Mitigations:

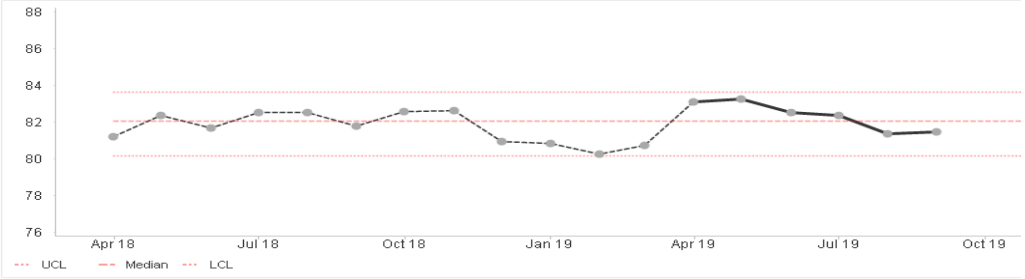
- A Review and refresh of interventions in all specialties for 19/20, in line with clinical strategy and RTT for each DM01 area **(complete)**
- 10 weeks of additional MRI van capacity purchased **(complete)**
- Ongoing long term increase of mobile from 7 to 14 days pcm **(contract to commence Sept 19)**
- Enhanced Capital expansion plan for 20/21 for MRI, CT and Endoscopy services **(ongoing)**
- USS MSK Injector Sonographer in place 2 PA **(complete)**
- Successful recruitment of 4 wte Sonographers **(complete)**
- All modalities undertaking a demand & capacity exercise **(complete)**
- Urodynamics machine delivered to site **(complete)**
- Source NHS Locum Gastroenterologist to undertake lists OOH / undertake clinics to release substantive Consultants to complete lists
- Advertise and recruit Consultant Radiologists (Locum & Perm) **(ongoing)**

Responsive – RTT Performance Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Elective Access	18 Weeks RTT Over 52 Week Breaches	0.0	#	12	9	13	20	27	37	8	5	3	3	1	0



Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	82.59	82.62	80.97	80.84	80.25	80.75	83.08	83.27	82.5	82.35	81.36	81.46



RTT Local Trajectory :

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19
RTT - 18 Weeks	Actual	83.08%	83.27%	82.50%	82.35%	81.36%	81.46%
	Planned	82.85%	84.98%	85.73%	86.76%	87.66%	87.76%
	Variance	0.23%	-1.71%	-3.23%	-4.41%	-6.30%	-6.30%
RTT - 52 Week Breaches	Actual	8	5	2	3	1	0
	Planned	27	6	4	2	0	0
	Variance	-19	-1	-2	1	1	0

Commentary	Risks & Mitigating Actions
The Trust reported zero 52 week breaches for the first time in a number of years, however the overall RTT position remains below the standard and below trajectory.	Best Access is now underway with the clear mandate of improving the Trusts constitutional standards and improving care across outpatients, Cancer, DM01, Theatres and engagement. The main areas of concern for RTT are Neurology 56%, Gastroenterology 70% and Urology 73%. A NHSI demand v capacity model is in place for all services and action plans are also in place for all services that are not on trajectory. Weekly live meetings are also in place which will change in line with Best Access with a clear aim to breach avoid and reduce wait times for our patients.

Responsive – Cancer & Complaints

NHS Medway NHS Foundation Trust

RESPONSIVE

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	12M
Cancer Access	Cancer 2ww Performance	93.0	%	68.13	73.11	88.35	72.87	73.01	61.66	83.39	88.69	90.12	91.61	94.09	-	**79.84**
	Cancer 2ww Performance - Breast Symptomatic	93.0	%	75.76	72	44.3	7.61	6.33	41.51	70.67	89.19	84.93	59.46	88.71	-	**56.66**
	Cancer 31 Day First Treatment Performance	96.0	%	94.77	96.62	95.51	89.31	87.5	95.45	94.62	94.59	92.59	97.5	95.9	-	**93.98**
	Cancer 31 Day Subsequent Treatments (Surgery)	94.0	%	92.59	89.66	89.47	75.76	75	73.91	82.61	73.91	100	93.33	100	-	**84.75**
	Cancer 31 Day Subsequent Treatments (Drugs)	98.0	%	100	93.94	100	100	100	100	100	100	96.08	94.74	91.67	-	**97.58**
	Cancer 62 Day Treatment - GP Refs	85.0	%	83.85	81.7	83.64	79.75	67.42	75	76.69	71.67	82.14	75.21	83.7	-	**78.34**
	Cancer 62 Day Treatment - Screening Refs	90.0	%	83.33	63.41	71.79	51.52	42.86	92.31	94.59	100	90.48	100	57.14	-	**77.07**
	Cancer 62 Day Treatment - Cons Upgrades	-	%	74.19	90.63	81.82	67.65	84.38	80.77	73.33	86.96	68.42	85	88	-	**80.29**
	104 Day Cancer Waits	0.0	#	4	3	6	5	6	9	5	7	6	4	3	-	**58**
Complaints Management	Number of Complaints	41.0	#	65	57	64	67	69	71	57	81	62	74	62	67	**796**
	% Complaints Responded to Within 30 Days	85.0	%	87.18	68.89	84.48	94.83	98.08	65.52	56.86	71.19	66.67	73.97	56.25	78.72	**74.7**

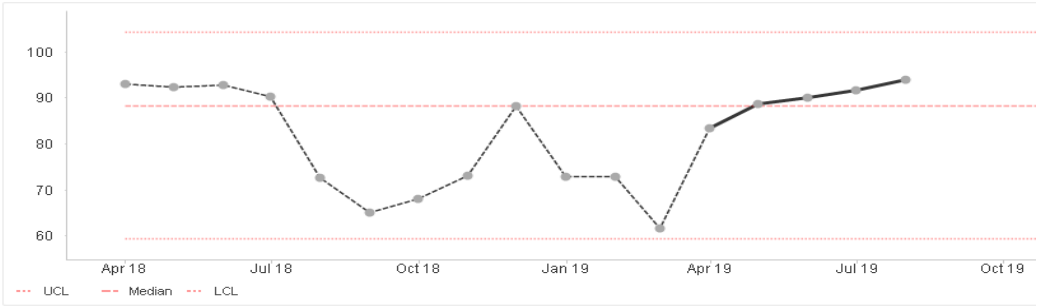
Responsive – Cancer & Complaints Commentary:

The Trust reported an overall improved cancer performance for the month of August hitting the 2ww target for the first time this year.

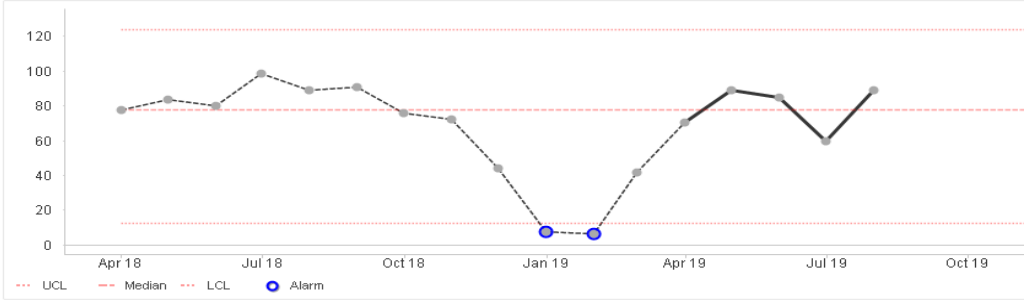
RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Responsive – 2 Week Wait Performance Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19
Cancer Access	Cancer 2ww Performance	93.0	%	68.13	73.11	88.35	72.87	73.01	61.66	83.39	88.69	90.12	91.61	94.09



Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19
Cancer Access	Cancer 2ww Performance - Breast Symptomatic	93.0	%	75.76	72	44.3	7.61	6.33	41.51	70.67	89.19	84.93	59.46	88.71



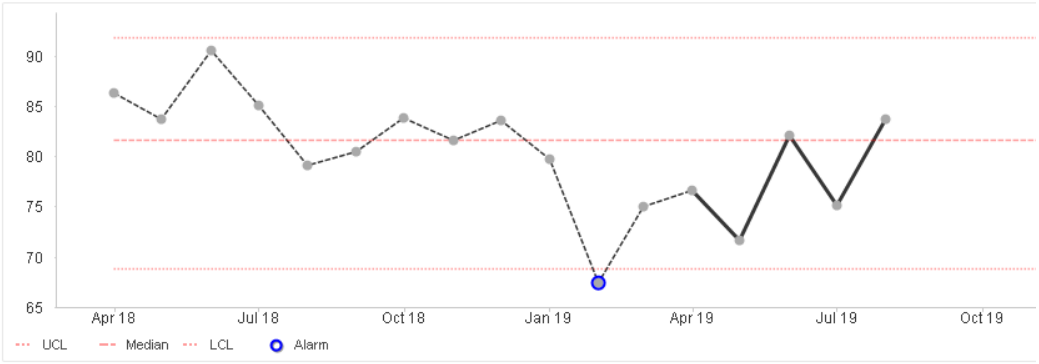
2 Week Wait Definition:

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

Commentary	Risks & Mitigating Actions
The Trust reported compliance in the 2 week wait standard for the month of August. This is the first time this year that the standard has been hit.	The performance is expected to be maintained for the next reporting period. **Risk:** There is significant challenge in Endoscopy due to availability of operators and equipment.

Responsive – 62 Day Wait GP Performance Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19
Cancer Access	Cancer 62 Day Treatment - GP Refs	85.0	%	83.85	81.7	83.64	79.75	67.42	75	76.69	71.67	82.14	75.21	83.7



Cancer Local Trajectory :

		Apr-19	May-19	Jun-19	Jul-19	Aug-19
Cancer - 62 Days	Actual	76.69%	71.67%	82.14%	75.21%	83.70%
	Planned	77.10%	77.80%	86.50%	81.40%	78.60%
	Variance	-0.41%	-6.13%	-4.36%	-6.19%	5.10%
Cancer - 2 Week Waits	Actual	83.39%	88.69%	90.12%	91.61%	94.09%
	Planned	87.10%	89.10%	93.90%	93.80%	93.00%
	Variance	-3.71%	-0.41%	-3.78%	-2.19%	1.09%

Commentary	Risks & Mitigating Actions
The Trust inaccurately reported non-compliance with the 62 day standard reporting a over performance of 83.7% In fact the Trust hit the 85% standard which will be amended at the end of the quarter (December)	Best Access is now underway with the clear mandate of improving the Trusts constitutional standards and improving care across outpatients, Cancer, DM01, Theatres and engagement. The main area of concern remains in upper and lower GI due to Endoscopy availability. Lung and ENT also have some concerns and remain a risk. The new GM for Cancer is supporting the above services and review patient by patient

NHS
Medway
NHS Foundation Trust

WELL-LED

Best of care
Best of people

Well Led

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	12M
Staff Experience	Staff Friends & Family - Recommend Place to Work	62.0	%	-	-	-	47.33	47.33	47.33	53.07	53.07	53.07	-	-		**48.98**
	Staff Friends & Family - Recommend Care of Treatment	79.0	%	-	-	-	64.15	64.15	64.15	66.62	66.62	66.62	-	-		**65.31**
Workforce	Appraisal % (Current Reporting Month)	85.0	%	81.01	81.3	81.3	82.8	83.2	84.43	88.66	90.59	91.41	91.43	91.43	88.22	**86.35**
	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	4.15	4.26	4.25	4.24	4.24	4.25	4.3	4.32	4.31	4.28	4.25	4.27	**4.26**
	Short Term Sickness Rate (Current Reporting Month, FTE%)	1.5	%	2	2	1.97	1.96	1.98	1.93	1.93	1.93	1.92	1.93	1.9	1.91	**1.95**
	Long Term Sickness Rate(Current Reporting Month, FTE%)	2.5	%	2.15	2.74	2.28	2.28	2.26	2.32	2.37	2.4	2.39	2.35	2.36	2.36	**2.35**
	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0	%	12.05	12.35	12.02	12.34	12.21	12.52	11.73	12.36	12.57	12.44	12.04	11.97	**12.22**
	Contractual Staff in Post (FTE) (Current Reporting Month)	-	#	3595	3779	3768	3765	3798	3786	3681	3701	3764	3896	3874	3893	
	StatMan Compliance (Current Reporting Month)	85.0	%	-	74.3	76.88	77.75	81.32	82.55	83.96	85.81	88.86	89.7	90.12	90.53	**84.24**
	Agency Spend as % Paybill (Current Reporting Month)	4.0	%	5.11	5.01	5.61	3.69	3.69	4.06	4	2.82	3.09	3.77	2.14	2.88	3.82
	Agency Spend as % Paybill (Financial Year YTD)	4.0	%	4.52	4.04	4.63	5.68	5.5	5.37	5.29	5.11	3.3	3.42	3.17	4.3	**4.53**
	Bank Spend as % Paybill (Current Reporting Month)	9.0	%	12.44	12.4	11.86	12.77	12.77	10.93	13.26	12.13	10.93	11.71	14.37	12.27	**12.32**
	Bank Spend as % Paybill (Financial Year YTD)	9.0	%	12.57	12.4	12.34	11.95	12.03	12.15	12.88	12.54	12.11	12	12.48	12.2	**12.3**
	Temp Staffing Fill Rate – Nurse & Midw ifery (Current Reporting Month)	75.0	%	76	79	79	74	78	79	79	76	71	74	74	76	**76.25**
Financial Position	Variance from Plan	0.0	%	-7	-7.8	-8.6	-18.4	-16.4	13	17.8	-4.5	-1.9	-5	-5.3	-16.3	
	Liquidity Ratio	2.0	#	0.49	0.52	0.47	0.42	0.42	0.32	0.36	0.4	0.41	0.37	0.34	0.31	
	Cash Actual (in $m)	1.4	#	4.4	8.6	13.7	7.5	8.2	10.8	17	29.2	26.4	26.2	24.6	20.6	
	Overall Underlying Financial Surplus / Deficit (in £m)	0.0	#	-29.9	-32.9	-36	-42	-43.6	-46.8	-4.6	-8.3	-12.2	-16.8	-22.8	-27.7	
	Capital Spend Vs Plan	0.0	%	64.5	67.8	70.9	72.1	72.8	63.3	0	-15.3	7.1	0.1	-26.5	-72.5	
	Cost Improvement Plans (CIPS) - Var to Plan YTD (in £'000)	0.0	#	2357	1544	1020	894	423	0	-68	74	69	-121	-325	-787	

Well-led:

Appraisal completion rate, at 88.82% has dropped from August but remains above the Trust's target (85%).

Overall Sickness absence rate at 4.27% has increased slightly and remains above the tolerance level of 4%. Short term sickness absence at 1.91% and Long term sickness absence, at 2.36%, remain relatively static. The ratios of long-term sickness to short-term sickness remain broadly even.

Voluntary Turnover at 11.97% has decreased (0.0.07%) compared to August and remains above the tolerance level of 8%.

StatMan compliance at 90.53% shows an increase and remains above the Trust's target of 85%

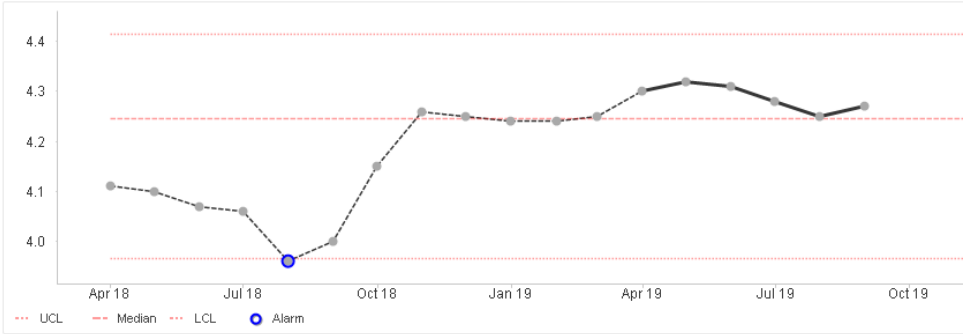
YTD Agency spend (as a percentage of pay bill) is 4.53%. The Trust continues to meet its agency ceiling cap. Ongoing work to reduce use of agency workforce remains in place and focus on converting agency staff into substantive and or bank assignments continues.

YTD Bank spend (as a percentage of pay bill) is 12.30%. Total YTD temporary spend sits at 16.83% which is above the Trust's target of 11.00%

Temporary staffing fill rate for Nurse and Midwifery at 76% saw an increase of 2% and is in line with the YTD average.

Well Led – Total Sickness Rate Spotlight Report

Domain	KPI Name	Target		Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19
Workforce	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	4.15	4.26	4.25	4.24	4.24	4.25	4.3	4.32	4.31	4.28	4.25	4.27



Commentary	Risks & Mitigating Actions
Overall Sickness absence rate at 4.27% has increased and remains above the Trust's tolerance level of 4%. Short term sickness absence has increased to 1.91% whilst long term absence has remained at 2.36% The ratios of long-term sickness to short-term sickness remain broadly even.	**Risks:** Possibility of increased use of temporary staffing to backfill Possibility of impact on patient experience and care due to lack of continuity in care **Mitigations:** The Employee Relations team continue to focus on supporting the timely management of sickness absence cases across the organisation. Use of the reports from Healthroster platform that identify colleagues who have hit the trigger. Encouraging staff to take up flu vaccine especially at this time

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		CHPDD	VACANCY %	
WARD	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Overall	RN	CSW
Arethusa Ward	90%	82%	88%	118%	6.93	17.46%	25.86%
Bronte Ward	100%	88%	99%	98%	7.69	20.99%	40.05%
Byron Ward	77%	122%	101%	126%	6.27	17.46%	12.65%
CCU	100%	87%	100%		14.46	22.86%	-16.28%
Delivery Suite	99%	100%	100%	91%	27.68	2.62%	0.00
Dickens Ward	31%	27%	49%	67%	2.07	N/A	N/A
Dolphin (Paeds)	88%	81%	90%	91%	14.82	12.45%	6.98%
Harvey Ward	88%	98%	120%	142%	7.78	25.11%	25.32%
ICU	84%		83%		26.72	10.45%	0.00%
Keats Ward	71%	117%	96%	133%	6.29	24.29%	15.39%
Kent Ward	96%	95%	93%	98%	10.00	2.62%	0.00
Kingfisher / SAU	99%	94%	94%	98%	19.01	34.16%	16.46%
Lawrence Ward	101%	113%	98%	117%	9.01	18.48%	24.99%
Lister Assessment Unit	79%	74%	95%	101%	7.08	44.87%	24.72%
McCulloch Ward	87%	89%	96%	112%	6.24	27.34%	8.13%
Medical HDU	94%	86%	92%		17.60	9.53%	40.25%
Milton Ward	81%	80%	97%	122%	6.25	33.44%	34.02%
Nelson Ward	81%	89%	98%	112%	5.75	12.89%	15.00%
NICU	87%	72%	80%	0%	13.09	7.72%	13.64%
Ocelot Ward	91%	69%	100%	99%	8.27	7.44%	26.54%
Pearl Ward	100%	100%	100%	100%	9.18	2.62%	0.00
Pembroke Ward	92%	130%	93%	160%	8.69	25.77%	20.89%
Phoenix Ward	91%	94%	93%	103%	6.06	2.74%	7.95%
SAFU						25.52%	27.29%
Sapphire Ward	92%	88%	100%	102%	7.16	100.00%	0.00
SDCC	63%	65%	84%	78%	20.09	31.06%	18.36%
Surgical HDU	92%	90%	96%		16.43	12.22%	-13.64%
Tennyson Ward	86%	117%	104%	155%	6.53	26.27%	11.25%
The Birth Place	100%	100%	100%	100%	17.90	2.62%	0.00
Victory Ward	67%	89%	72%	78%	9.66	32.78%	0.03%
Wakeley Ward	81%	102%	99%	107%	6.10	12.34%	20.03%
Will Adams Ward	83%	116%	112%	142%	7.02	15.00%	16.15%
Trust total	**85.42%**	**91.69%**	**92.69%**	**114.69%**	8.54		

Meeting of the Board of Directors in Public

Thursday, 07 November 2019

Assurance Report from Committees

Title of Committee:	**Quality Assurance Committee**	**Agenda Item**	**4.2**
Committee Chair:	Jon Billings, Non-Executive Director		
Date of Meeting:	Friday, 27 September 2019		
Lead Director:	Karen Rule, Executive Director of Nursing		
Report Author:	Karen Rule, Executive Director of Nursing		

The key headlines and levels of assurance are set out below, and are graded as follows:	
Assurance Level	**Colour to use in 'assurance level' column below**
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. Quality Dashboard Report The Committee discussed the progress report and data from July and August 2019, there was a couple of areas highlighted: *Mixed sex accommodation breaches*; the Committee asked that a report on the details of the breaches should come back; as it is an outlier a targeted control process is needed. Harvey McEnroe was asked to take a report to the Executive Team meeting and then bring it to the Quality Assurance Committee (QAC) at the November 2019 meeting. *Report format*; The Committee discussed the format of the report and the logistics/timeframes of producing it. The Committee suggested that although validated data is important, the most important thing for the Committee to understand is trends, what is happening, any concerns the teams have, what is being done to deal with the issues and when the actions are expected to have an impact. The Chair Jon Billings will meet with Karen Rule and Gurjit Mahil to agree a way forward.	**White**

2. Corporate Quality Risks The Committee discussed the risk profile for the Board Assurance Framework (BAF) Quality risks and asked whether: a) the risks identified reflect the current quality risks facing the Trust along with the risk ratings given to each risk. b) the identified controls and assurances provide the necessary assurance that these risks are being managed effectively. c) the assurances give the QAC members and Board members the necessary confidence that the controls put in place to manage these risks are working effectively The Committee asked for the BAF to go back to the Executive group for them to consider the following: a) If the risk rating has not changed/improved in three months, are the controls in place working? b) Are the controls in place adequate? c) Are we capturing the right risks? d) When will the target risk rating be achieved and when will they come off the register? e) BAF risk mitigations need to specifically address the issue of 'consistency' in delivering high quality, both over time and between departments/wards.	**Amber/Green**
3. Mortality and Morbidity Report The Committee was informed that overall the HSMR is decreasing. The correct coding has given the true reflection on what is happening in the hospital. Both Divisions are keeping close eye on the outliers conditions, they will be closely monitored. It was noted that the attendance at the Mortality and Morbidity meetings needs to improve and the administration could be better. Paul Kitchen and David Sulch will investigate why attendance at the Mortality and Morbidity meetings has declined. All committee members are to be written to remind them of the importance of attending committee meetings.	**Amber/Green**
4. Infection Prevention and Control The Committee was informed that there is an improving picture of compliance for IPC, and no outbreaks of infection to report within the six month period. The validated data is up to August 2019, the September 2019 data is currently unvalidated. The governance is now working better with meetings on a quarterly basis, which is a step forward for the Trust. The QAC Development session on the 25 October was an outreach session focusing on IPC in the hospital and led by Kris Khambhaita.	**Green**
5. Annual Complaints Report The Committee was informed that in accordance with NHS Complaints Regulations 2009, the report set out a detailed analysis of the nature and number of complaints received by Medway NHS Foundation Trust (MFT) during 1 April 2018 to 31 March 2019. In line with the Trust's Complaints Management Policy POLCGR005, the report gave an overview of	**Green**

compliance rates as agreed in section 11 ‘who may complain and timescales for complaints. The Committee approved the report but asked that more detail on Parliamentary and Health Service Ombudsman referrals and investigations should be included in future.	

Decisions made

- The amended Terms of Reference were **APPROVED** by the Committee

- The Committee discussed its self-assessment and review of effectiveness. This would be discussed further with the Chair, the Director of Nursing and Medical Director.

Further Risks Identified

All risks are captured within the risk register and the Board Assurance Framework.

Escalations to the Board or other Committee

None

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Quality Assurance Committee Terms of Reference	**Agenda Item**	4.3
Report Author	Brenda Thomas, Company Secretary		
Lead Director	Jon Billings, Chair of Quality Assurance Committee		
Executive Summary	The terms of reference for the Quality Assurance Committee (the Committee) were reviewed by the Committee at its meeting on 27 September 2019. The review took account of the following: 1) Changes made to the executive structure: a. deputies of the co-clinical directors to deputise for them in their absence in exceptional circumstances (4.1); b. job title changes (5.2); c. divisional directors of operations to be in attendance (5.2). 2) No distinction made between governors in attendance and observing (5.5). The Committee approved the above changes subject to including the following to be in attendance: a. Deputy Chief Executive; b. Divisional Medical Directors for Planned Care and Unplanned and integrated Care. These further changes have been incorporated (5.2).		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Committees or Groups at which the paper has been submitted	Quality Assurance Committee on 27 September 2019		
Resource Implications	None		
Legal Implications/ Regulatory Requirements	The terms of reference clarify the Committee's responsibilities to ensure legal and regulatory compliance.		

Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	The Board is asked to approve the Quality Assurance Committee Terms of Reference.			
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☐
Appendices	Appendix 1 - Quality Assurance Committee Terms of Reference.			

Terms of Reference

Quality Assurance Committee

1. Establishment

1.1. Board of Directors of Medway NHS Foundation Trust (the Trust) hereby resolves to establish a committee to be known as the Quality Assurance Committee (the Committee).

2. Purpose

2.1. The purpose of the Committee is to provide assurance to the Board of Directors that there is an effective system of governance, risk management and internal control across the clinical activities of the trust that support delivery of its strategic objectives and statutory or constitutional requirements for quality, in keeping with its ambition to deliver the Best of Care delivered by the Best of People.

3. Authority

3.1. The Committee is accountable to the Board of Directors and the Chair will report to the Board bi-monthly or as required by the Board

3.2. Any matters requiring Trust Board approval under the Trust's Scheme of Delegation and Reservation will be submitted to the Trust Board by the Chair of the Committee.

3.3. The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The Committee is specifically authorised to:

3.3.1. investigate any activity within its terms of reference and seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee;

3.3.2. obtain independent professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Trust Secretary; and

3.3.3. carry out any activities which are in line with the terms of reference, as part of the Committee work programme.

3.4. The Chair of the Committee will provide briefings to the Council of Governors on request from the lead governor on issues relevant to the remit of the Committee.

4. Membership

4.1. The members of the Committee shall comprise:

i. Three Non-executive directors (NEDs) one of which will be the Chair of the Committee
ii. Executive Medical Director (Co-director of Quality) or deputy (in exceptional circumstances)
iii. Executive Director of Nursing (Co-director of Quality)or deputy (in exceptional circumstances).

4.2 The Chair of the Committee will be appointed by the Trust Board from among the NEDs. In the absence of the Chair for any given meeting, one of the NEDs present will be selected as Chair for that meeting.

4.3. The Trust Secretary (or deputy) will attend all meetings as minute taker and work with the Chair to ensure effective and appropriate conduct of the Committee's business.

5. Attendees

5.1. The chief executive may attend the Committee meeting at their discretion or as invited by the Chair.

5.2. The following will be in attendance:
Deputy Chief Executive;
Chief Operating Officer;
Divisional Medical Directors for Planned Care and Unplanned and Integrated Care;
Divisional Directors of Operations for Planned Care and Unplanned and Integrated Care;
Divisional Directors of Nursing for Planned Care and Unplanned and Integrated Care.

5.3. Other Executive Directors, along with any other appropriate attendees, will be invited to attend by the Chair when areas of risk or operation that fall under their responsibility are being considered by the Committee.

5.4. Divisional leadership teams (triumvirates) will be invited to attend periodically in order to present 'deep dive' assurance reports about their area.

5.5. Up to three public governors may attend each meeting (governors assigned to the committee may appoint deputies to attend committee meetings in their absence). The lead governor may attend periodically at their discretion.

5.6. Other internal or external people may be invited to attend as deemed necessary and appropriate by the Chair for the effective delivery of the Committee's terms of reference.

6. Quorum

6.1. The meeting will be quorate provided that the Chair of the Committee (or deputy) and two other members are present, one of which must be an Executive Director or their deputy (in exceptional circumstances).

7. Frequency

7.1. Meetings will be held at least six times in each financial year. Meetings will be held on alternate months to Board to ensure there is a formal assurance meeting each month at which quality risks or issues can be considered.

7.2. The Chair of the Committee may request an extraordinary meeting if they consider one to be necessary.

7.3. Development meetings may be held each intervening month for the purposes of developing knowledge of members or allowing more discursive sessions. This may include 'site visits' to meet teams or service users in situ.

8. Objectives and programme of activities

8.1. The overarching objective of the Committee is to obtain assurance that the risks linked with the Trust's provision of excellent care are identified, managed and mitigated appropriately. The Committee will deliver this objective through a work programme which includes, but may not be not limited to:

8.1.1. Overseeing development and maintenance of a corporate quality strategy for approval by the Board;

8.1.2 Ensuring that strategic priorities for quality assurance best support delivery of the Trust's quality ambitions in relation to patient experience, safety and effective outcomes for patients and service users;

8.1.3. Evaluating the effectiveness of corporate and operational governance, leadership and management in delivering quality priorities, and reporting on these to the board and making recommendations for improvements where needed. This will include reviewing and monitoring activities of the various quality governance groups – receiving specific reports and/or minutes from these as needed;

8.1.4. Overseeing in-depth reviews as necessary in areas identified as risks to quality by the Board, the Committee or others;

8.1.5. Ensuring robust arrangements are in place for assessing the impact on quality and safety of planned changes to service delivery, for example resulting from cost improvement measures;

8.1.6. Reviewing the annual Clinical Audit Programme, to ensure it provides a suitable level of coverage for assurance purposes, and receiving reports as appropriate;

8.1.7. Reviewing compliance with regulatory standards and statutory requirements, such as: Duty of Candour, the CQC registration, NHSLA and the NHS Performance Framework;

8.1.8 Reviewing non-financial risks on the Risk Register or Board Assurance Framework which have been assigned to the Committee and satisfying itself as to the adequacy of assurances on the operation of the key controls and the adequacy of action plans to address weaknesses in controls and assurances; and

8.1.9. Reviewing statutory reports ahead of submission to the Board of Directors for approval, for example: Annual Infection Prevention and Control Report, Annual Safeguarding Report and Quality Account.

9. Reporting

9.1 Formal minutes of Committee meetings will be recorded and circulated to members within one month. These will normally be confirmed as accurate at the next meeting of the Committee.

9.2. The full minutes of the Committee will be made available to the Board of Directors via BoardPad or any future system in use. The Chair of the Committee will draw to the attention of the Board to any serious issues that require disclosure to the full Board. A summary of key issues will be presented by the Chair in the public session of the Board Meeting.

10. Review

10.1 These Terms of Reference should be reviewed annually as part of the Committee's review of its performance. Any significant changes to the terms of reference must be subject to approval by the Trust Board.

Terms of Reference

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Compliance against terms of reference	Annual review	Company Secretary	Chair of the Quality Assurance Committee	

Terms of Reference approved by the: Quality Assurance Committee on: 27 September 2019

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Responding to Deaths	**Agenda Item**	**4.4**
Lead Director	Dr David Sulch, Medical Director		
Report Authors	Hayley Usmar and Denise Thompson, Clinical Effectiveness Team		
Executive Summary	This report provides assurance that Medway NHS Foundation Trust has a robust process in place for reporting, reviewing and learning from deaths. The Trust's Standardised Hospital-level Mortality Indicator (SHMI) for the period June 2018 – May 2019 is 1.11. The Hospital Standardised Mortality Ratio (HSMR) for the period July 2018 to June 2019 is 106.2; this is higher than expected. Preliminary investigation suggests that this elevation may be due to variability in mortality of patients admitted on a weekday compared to the weekend, linked to patients assessed as frail using the HSMR methodology. An analysis of the Structured Judgement Reviews (SJRs) is being undertaken for patients admitted at the weekend to determine if this is the case. The HSMR Pneumonia diagnosis group is no longer an outlier; it has been within the as expected range for three consecutive months, having been falling since December 2018. The return to the 'as expected' range may be due to changes in Palliative Care Coding from February 2019, though there is no empirical evidence to support this. The SHMI for this diagnosis group has remained in the expected range throughout.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Committees or Groups at which the paper has been submitted			
Resource Implications	N/A		

Legal Implications/Regulatory Requirements	Failure to comply with national reporting requirements could result in regulatory action or a prosecution under the Care Quality Commission (Registration) Regulations 2009.			
Quality Impact Assessment	N/A			
Recommendation/ Actions required	The Board is asked to review and note the Trust's progress regarding mortality and morbidity review and monitoring.			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	N/A			

Executive Overview

This report represents a summary of mortality metrics and mortality review activity between 01 April 2019 and 30 September 2019.

During this period 706 patients died, including four early neonatal deaths and six child deaths. Three of the deceased patients had learning disabilities. To date, 58 percent of the patients who died during this period have been subjected to an initial mortality review; 17 percent of cases have had an in-depth review to provide narrative around their care and identify any safety and quality issues.

In quarter 2, six cases were referred to the Stage 2 Group for consideration of further investigation under the Patient Safety Framework; three cases have been declared as Serious Incidents and one will be subject to a High Level Internal Investigation.

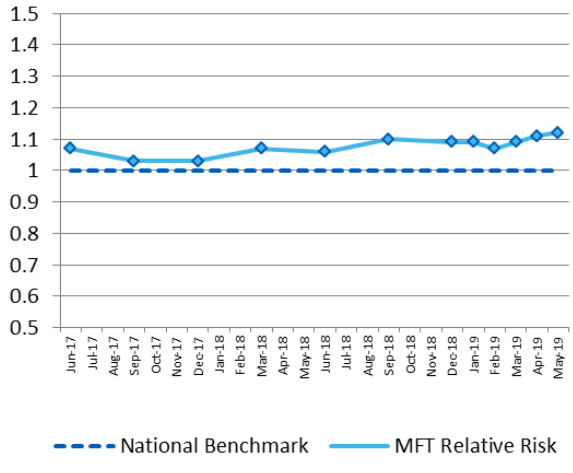
The Summary Hospital-level Mortality Indicator (SHMI) for the period June 2018 to May 2019 was published on 10 October 2019. The Trust's SHMI for this period was 1.11, which is within the expected range. This metric includes deaths in hospital and those which occurred within 30 days of discharge from hospital.

The Hospital Standardised Mortality Ratio (HSMR) for the period July 2018 to June 2019 was published on 24 October 2019. The Trust's HSMR for this period was 106.2, which is higher than expected. This metric includes deaths in a group of 56 diagnosis groups accounting for 80% of all hospital admissions. The elevation in HSMR is currently under investigation; analysis of the data suggests that it may be the result of a high relative risk for frail patients admitted at the weekend. The Medical Director is overseeing this work and the outcome of the investigation will be reported to the Trust Mortality & Morbidity committee in November 2019.

Standardised Hospital-level Mortality Indicator (SHMI)

The Trust's SHMI for the period June 2018 – May 2019 is 1.11, and is within the 'as expected' band. The last 12 data points are detailed in the table below.

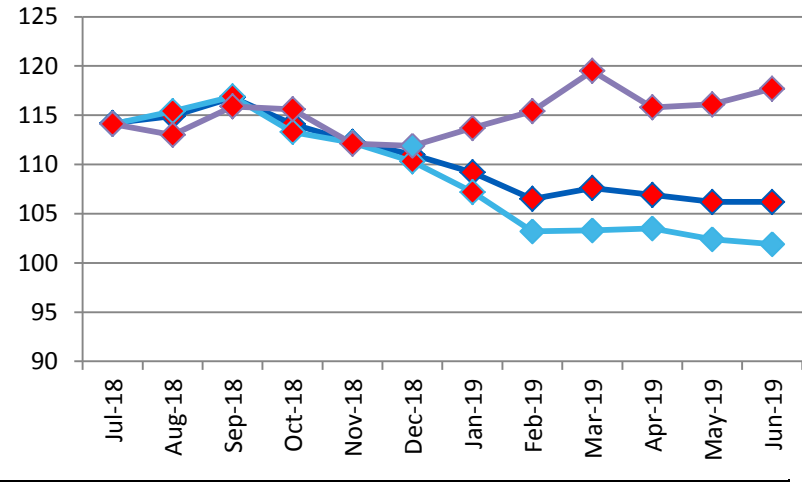
12 months to:	SHMI	Observed		Expected	Trend
		in hospital	post discharge		
Jun-17	1.07	1369	532	1775	
Sep-17	1.03	1354	513	1806	
Dec-17	1.03	1359	1897	1847	
Mar-18	1.07	1445	583	1900	
Jun-18	1.06	1429	606	1916	
Sep-18	1.10	1445	636	1888	
Dec-18	1.09	1350	625	1815	
Jan-19	1.09	1290	620	1755	
Feb-19	1.07	1275	610	1760	
Mar-19	1.09	1295	610	1740	
Apr-19	1.11	1315	620	1745	
May-19	1.11	1310	610	1730	



HSMR

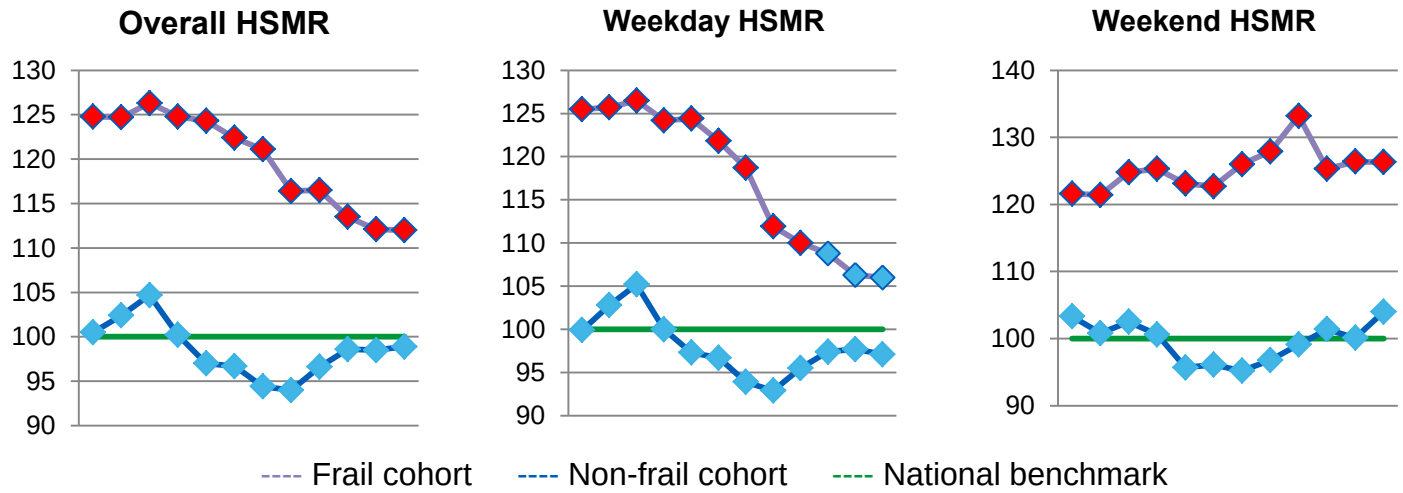
HSMR is published monthly, three months in arrears, the Trust's HSMR for the period July 2018 to June 2019 is 106.2. Whilst the overall HSMR for the Trust is higher than expected, there is a significant difference between the relative risk for weekday and weekend admissions. This data is presented in the table overleaf.

12 months to:	Overall HSMR ----	Weekday HSMR ----	Weekend HSMR ----	Trend
Jul 18	114.2	114.1	114.1	
Aug 18	114.9	115.4	113.0	
Sep 18	116.8	116.9	115.9	
Oct 18	114.1	113.3	115.6	
Nov 18	112.3	112.2	112.1	
Dec 18	111.0	110.3	111.9	
Jan 19	109.2	107.2	113.7	
Feb 19	106.5	103.2	115.4	
Mar 19	107.6	103.3	119.5	
Apr 19	106.9	103.5	115.8	
May 19	106.2	102.4	116.1	
Jun 19	106.2	101.9	117.7	



A review of the data provided by Dr Foster suggests that the reason for this discrepancy is linked to patients assessed as frail using the HSMR methodology. Any patient over the age of 75 who has a diagnosis or condition within the following groups will be classed as frail: dementia and delirium, mobility problems, falls and fractures, pressure ulcers and weight loss, incontinence, dependence and care, anxiety and depression.

The table below presents the HSMR data split between patients classed as frail and those who are not. The HSMR for the group who do not meet the Dr Foster frailty criteria has remained within the expected limits for the last 12 data points, whilst the frail group has been consistently high for the same period. Looking at the weekday HSMR, which includes patients who were admitted Monday – Friday, it is clear that there has been a downward trend over the last twelve data points, with the HSMR for quarter 1 of 2019/20 within expected limits. The same trend is not seen in the weekend HSMR figure, which includes patients admitted on a Saturday or Sunday.

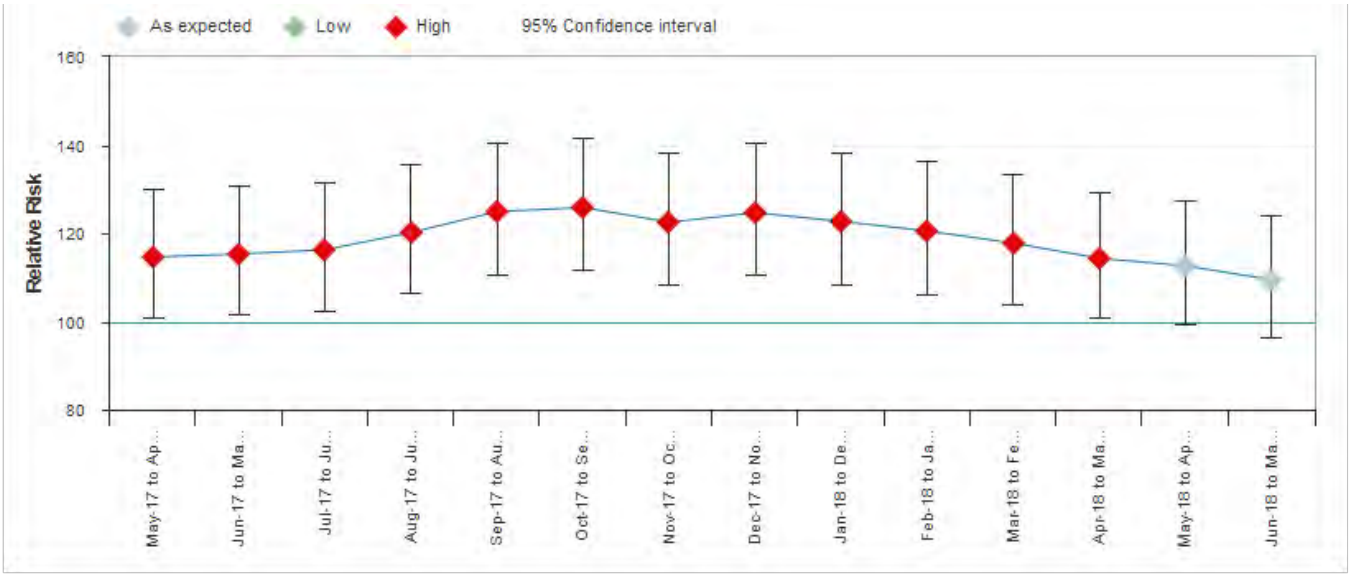


The deaths in this cohort between May 2018 and April 2019 are being reviewed with a view to establishing the underlying cause of this variance.

Outlier diagnosis groups

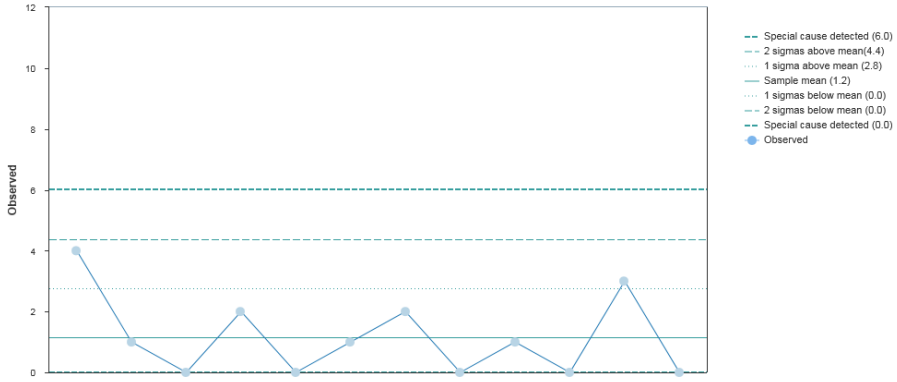
Pneumonia

The Pneumonia diagnosis group was consistently an HSMR outlier for the Trust between April 2018 and March 2019 (based on rolling 12 month data). Since February 2019, the HSMR for this diagnosis group has returned to 'as expected', with an HSMR for the period June 2018 – May 2019 of 103.5 (95 percent confidence interval 98.1 – 109.2). The graph below shows that the HSMR for this diagnosis group has been consistently falling since December 2018. There is no empirical evidence to explain this decrease in HSMR; however, the increase in palliative care coding which has impacted on the Trust's overall HSMR will also have affected this diagnosis group, as HSMR is risk-adjusted.



Other perinatal conditions

The Trust has been an HSMR outlier for other perinatal conditions since August 2018. In July 2018 four deaths were recorded in this diagnosis group, causing the HSMR to move into the high range, compared to an average of zero to two deaths per month. The spike in deaths was an isolated anomaly, as illustrated in the graph below, and therefore Dr Foster have advised that the outlier status should not be a cause for concern. It is anticipated that this diagnosis group will return to 'as expected' when the data for July 2019 is published.



Learning from Death

Between 01 April and 30 September 2019, the Trust has recorded 705 inpatient deaths; this figure includes four early neonatal and six child deaths. Three patients with learning disabilities died in hospital during this period.

An overview of the Trust's current position with regard to the Mortality Review Process is presented below. It should be noted that initial reviews are sometimes delayed, for example if a patient is referred to the coroner or an inquest is required. For this reason, the table also presents the percentage of requested reviews completed – this means that the casenotes have been delivered to the relevant team for the review to be undertaken.

	2019									2020			YTD
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Total no of deaths	146	115	124	116	101	103							705
Learning Disabilities	0	0	0	1	0	2							3
Child Deaths	2	0	1	0	3	0							6
Early neonatal deaths	0	3	1	0	0	0							4
Initial reviews completed %	68	69	61	55	52	39							58
Requested reviews completed (%)	70	79	86	82	70	59							76
In-depth reviews required	24	14	7	8	1	2							56
Required in-depth reviews completed %	100	93	86	100	100	100							96
Additional in-depth reviews completed	17	19	13	8	5	3							65
Total deaths subject to in-depth review %	28	29	16	14	6	5							17

All patients requiring an in-depth review are discussed at the monthly Specialty Mortality and Morbidity meetings, 72 meetings have been held since 01 April 2019 and minutes have been received for 62 of these. Following discussion at these meetings, further investigation is required then cases may be referred to other specialties for a second opinion, or to the Stage 2 Group.

Since April 2019, eight cases have been referred to the Stage 2 Group. Six cases have been progressed via the Patient Safety framework; five cases have been declared serious incidents (SIs) and one case is subject to a high level internal investigation (HLII). Following discussion, it was agreed that no further investigation is required for the final two cases.

In Quarter 2, two SI investigations were concluded with the Clinical Commissioning Group signing off on the investigations and agreeing action plans. Details of the closed cases are outlined below.

Date referred	Date of meeting	Month of death	STEIS Category	Issues Identified	Actions arising
22/05/2019	31/05/2019	Feb 2019	Sub-optimal care of the deterioratin g patient	• Failure of junior doctor to recognise seriousness of situation leading to failure to escalate to senior for review • Lack of full handover from ED to ward • Delay in escalating deteriorating patient to on-call doctor • Limited documentation	• Highlight need for full handover from ED to ward nursing staff on admission • Include case study at junior doctor induction training to highlight importance of discussing patients who have high NEWS score with senior colleagues • Medical registrars to be reminded of importance of maintaining oversight of acute take overnight, especially in the case of patients with high NEWS scores • Use the Big 4 communication tool to remind nursing staff that increased oxygen requirement to achieve target oxygen saturations is a sign of deterioration, even if target saturations are achieved and that all concerns should be escalated.

Date referred	Date of meeting	Month of death	STEIS Category	Issues Identified	Actions arising
12/06/2019	21/06/2019	Jan 2019	Sub-optimal care of the deterioratin g patient	• Lack of clear diagnosis leading to differential diagnoses being explored with some inconsistencies in communication and management plan • Multiple ward moves • Multiple staff involvement leading to lack of consistent care • Lack of clear communication, including acknowledging concerns raised by family • Failure to obtain cannulation leading to omission of IV antibiotics	• Develop a flow chart for escalation of difficult intravenous access and options available • Share investigation and findings with Site Team to ensure patient moves are appropriate and avoided when clinically indicated • Review availability and sign-posting of bereavement services within the Trust, in particular for children of bereaved relatives

The remaining three SIs and HLII are still currently under active investigation. The table below shows details of cases under active investigation following Stage 2 Group referral.

Date referred	Date of meeting	Month of death	Outcome	Additional information
26/06/2019	12/07/2019	Apr 2019	Serious Incident	STEIS category: Sub-optimal care of the deteriorating patient
07/08/2019	14/08/2019	Jul 2019	Serious Incident	STEIS category: Sub-optimal care of the deteriorating patient
13/08/2019	14/08/2019	Aug 2018	Serious Incident	STEIS category: Sub-optimal care of the deteriorating patient *Case picked up via Complaints process*
27/08/2019	25/09/2019	May 2019	High Level Internal Investigation	

Early neonatal and child deaths

Since 2004, any child who dies before their 18th birthday has been subject to the Child Death Review Process, which involves a multi-agency review of the child's care. Locally, these reviews are coordinated by the Kent and Medway Child Death Review (CDR) Team. It is also a statutory requirement for all deaths of children and young people under 18 to be referred to the local Coroner. In addition, the Trust's Neonatology and Acute Paediatric teams hold specialty mortality and morbidity meetings and discuss the care of these patients in those forums.

Trust Mortality and Morbidity Group

The Trust Mortality and Morbidity Group meets monthly. It is chaired by the Medical Director, who is also the Trust's Mortality Lead, and attended by representatives from both Divisions as well as key stakeholders including Medway and Swale CCGs and Medway Public Health.

In July 2019, the group heard from Dr Ashraf Syed, the Trust's Acute Kidney Injury (AKI) lead, who outlined measures that the Trust takes to ensure that patients safety in this area. The Trust's AKI team have been heavily involved in the Kent, Surrey and Sussex Patient Safety Collaborative and have contributed to overall AKI screening and monitoring in the region. Significant work has been undertaken within the Trust including provision of an AKI bundle, regular training for junior doctors and development of an AKI medication toolkit. In addition, performance has been audited annually; whilst it is not at optimal levels, there has been improvement year on year.

The Learning Disabilities (LD) team also spoke to the Group in July 2019 and outlined the work that they have undertaken to minimise the number of patients with learning disabilities dying in hospital when their preferred place of care is their usual residence. The discrepancy between life expectancy for those with learning disabilities and the general population was highlighted. On average, men with learning disabilities will died 23 years earlier and women 29 years earlier. The LD team have attended specialty meetings across the Trust over the past year to highlight the importance of meeting with these patients on their level – for example, by providing diagrams to explain procedures. It was also highlighted that a lack of ability to understand complex information does not equate to a lack of mental capacity, and for this reason adapting to an individual's needs is vital.

Anyone over the age of 4 who dies and has an LD diagnosis must be referred to the Learning Disabilities Mortality Review Programme (LeDeR). These cases are then subject to an independent multiagency review of care. The LD team have been working closely with the End of Life Care Team to focus on palliative care, enabling those with learning disabilities to go home with an appropriate support package at the end of their lives. As a result, there were no referrals from the Trust to LeDeR in Quarter 1 of 2019/20.

In September 2019, the Group was advised that mortality following Emergency Laparotomy has been highlighted as a potential concern through the National Emergency Laparotomy Audit. This has been added to the Group's agenda as a standing item so that actions to address this can be monitored.

Specialties are invited to present their mortality data and reviews at the Trust's Mortality & Morbidity Group on a regular basis. Key points raised by the specialties in Quarter 2 are outlined below:

- Elderly Care highlighted the continuing difficulty of balancing escalation and de-escalation of frail elderly patients; discussion with families and carers facilitates these decisions and this is emphasised to junior members of the team.
- Elderly Care also noted that there are continuing issues around bed moves for frail elderly patients; bed moves are disorientating for these patients and can put them at increased risk of falls as well as disrupting continuity of care. It was acknowledged that maintaining flow can lead to bed moves and that there is no easy solution to this problem.
- The importance of a good differential diagnosis for patients who are frail and elderly as they will often present with non-specific symptoms but can have serious and significant underlying pathology.
- ED have highlighted that patients are presenting to the department when they are clearly at the end of life; advanced care planning is vital to prevent unnecessary admissions. Details of the My Wishes register, which collates documentation around patient's wishes for end of life care, are to be circulated throughout the Trust to help address this.
- Critical Care have noted that documentation of Treatment Escalation Plans is not always optimal, which can result in inappropriate transfer to ICU. This has been addressed locally by the consultant on-call vetting all critical care referrals, and there is also Trust-wide work around Treatment Escalation Plan completion.

Medway NHS Foundation Trust: Learning from Deaths Dashboard: Apr – Sep 2019

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

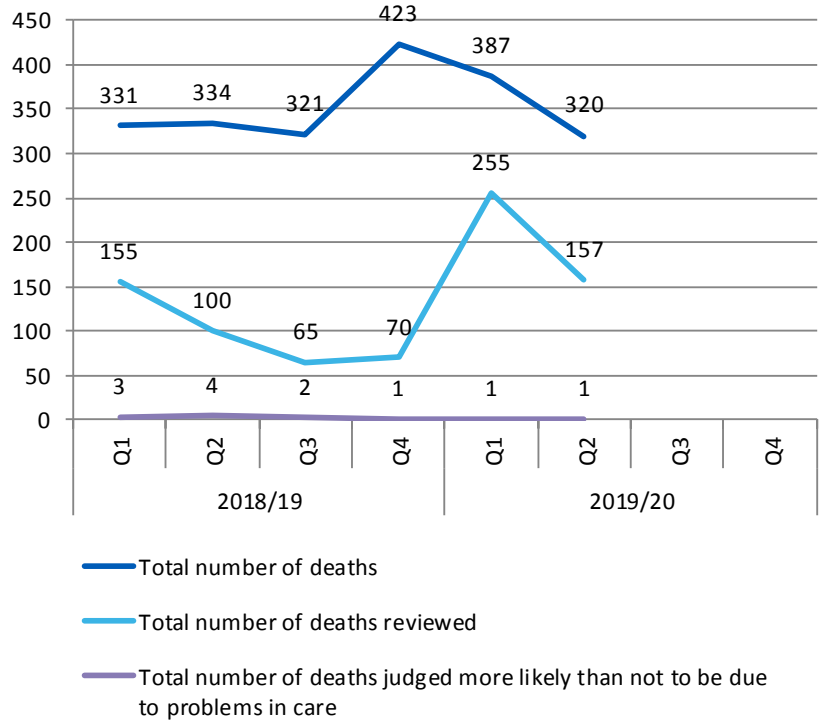
Total number of deaths, deaths reviewed and deaths deemed more likely than not due to problems in care

(does not include patients with identified learning disabilities)

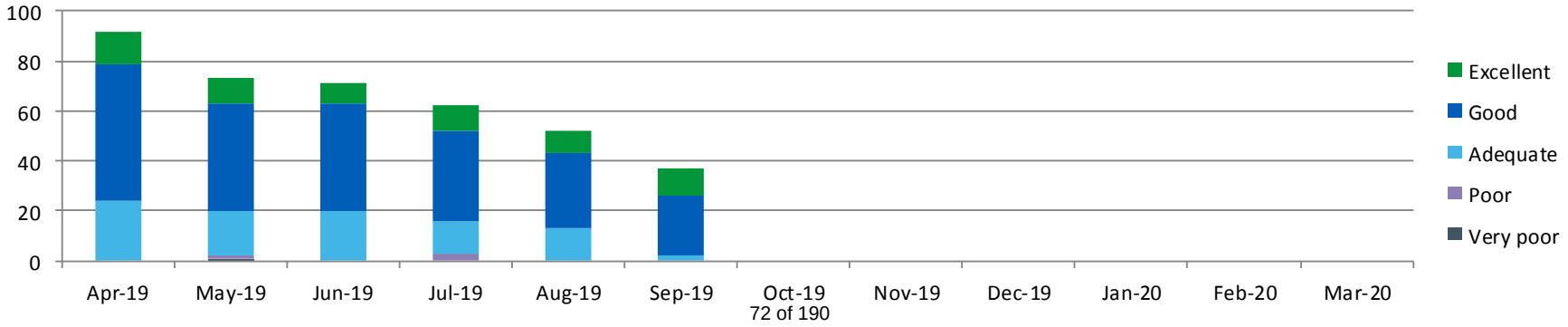
2019/20	Total number of adult deaths	Total number of deaths reviewed	Total number of deaths judged more likely than not to be due to problems in care
01/04/2019	144	100	0
01/05/2019	119	79	1
01/06/2019	124	76	0
Total Q1	387	255	1
01/07/2019	117	64	1
01/08/2019	99	53	0
01/09/2019	104	40	0
Total Q2	320	157	1
01/10/2019			
01/11/2019			
01/12/2019			
Total Q3			
01/01/2020			
01/02/2020			
01/03/2020			
Total Q4			
Year to Date	707	412	2

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care

(Note: Changes in recording or review practice may make comparison over time invalid)



Total deaths reviewed, categorised by Overall Care Score



Medway NHS Foundation Trust: Learning from Deaths Dashboard: Apr – Sep 2019

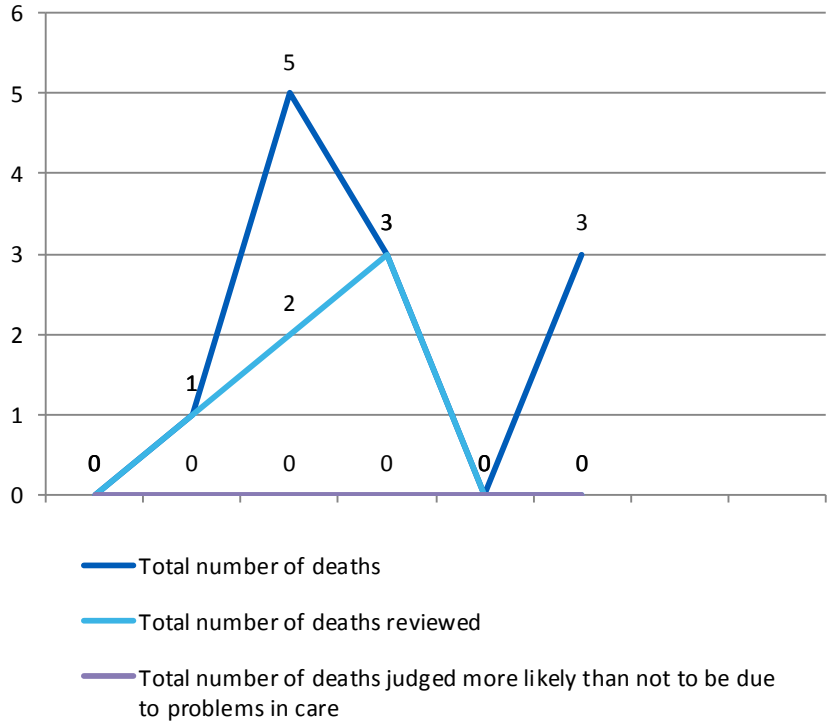
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

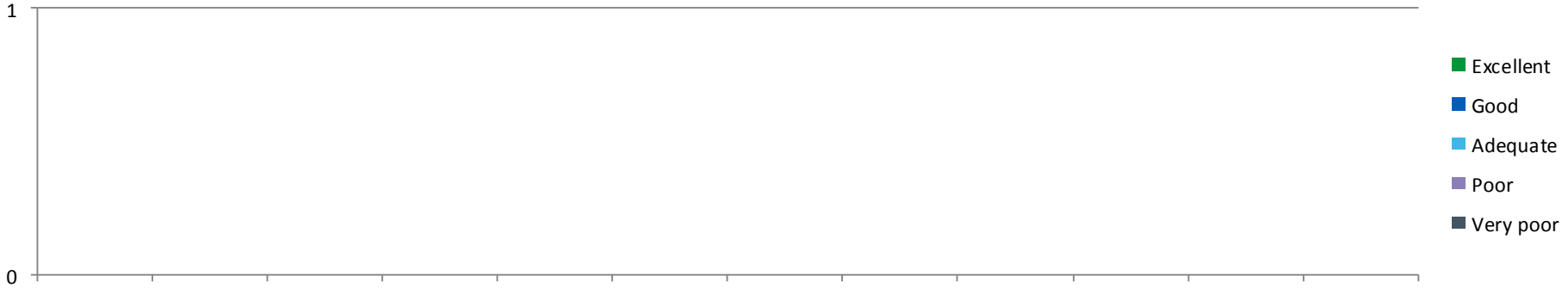
2019/20	Total number of deaths	Total number of deaths reviewed via local methodology	Total deaths reviewed through the LeDeR Methodology	Total number of deaths judged more likely than not to be due to problems in
01/04/2019	0	0	0	0
01/05/2019	0	0	0	0
01/06/2019	0	0	0	0
Total Q1	0	0	0	0
01/07/2019	1	0	0	0
01/08/2019	0	0	0	0
01/09/2019	2	0	0	0
Total Q2	3	0	0	0
01/10/2019				
01/11/2019				
01/12/2019				
Total Q3				
01/01/2020				
01/02/2020				
01/03/2020				
Total Q4				
Year to Date	3	0		0

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care

(Note: Changes in recording or review practice may make comparison over time invalid)



Total deaths reviewed, categorised by Overall Care Score



Conclusion

The Trust's mortality data for Quarter 1 2019/20 was within the 'as expected' band as reported in the published SHMI mortality metric; however, the HSMR for the same period was high. Preliminary investigation has suggested that the elevation in HSMR relates to patients classified as frail under the HSMR methodology who were admitted on a Saturday and Sunday. Further investigation is underway.

Of the 320 patients that died in Quarter 2 of 2019/20, 50 percent have been subject to a Structured Judgement Mortality Review. One reviewer felt that a patient's death was a result of failings in care during their final admission. Following review by the Stage 2 Group, this case is now subject to a Serious Incident investigation, which is ongoing. Overall the majority of patients experienced good or excellent care in their final admission.

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Transformation update	**Agenda Item**	**5.1**
Lead Director	Jack Tabner, Executive Director of Transformation		
Report Author	Jack Tabner, Executive Director of Transformation		

Executive Summary	The report provides an update on the Trust's 'Better, Best, Brilliant' transformation portfolio, including:
	
	• **Large, cross-hospital transformation programmes.** Activity within the Trust's core transformation programmes continues to gather pace:
	
	  ○ **BEST Flow:** the work continues to gather pace as we move into winter, and the Trust was delighted to take receipt of the Patient Flow Programme of the Year Award 2019 at the Executive Patient Flow Summit. Recent key achievements are included herein.
	
	  ○ **BEST Access:** adopting the same approach as our Best Flow Programme, we have now mobilised the Best Access programme, which coordinates improvement work across four areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/Referral to Treatment (RTT) management. The scope of the programme, its objectives, outcome measures and workplans are included herein.
	
	• **The Cost Improvement Programme (CIP).** As at Month 6, the Trust has delivered £7.2m in CIP. Year to date, this is adverse to the operational plan monitored internally by £786k. We are forecasting an outturn position of £15.8m with work ongoing to identify further opportunities to close the gap to our £18.0m target. As we begin planning for the Cost Improvement Programme schemes into next year (2020/21), we are working towards a challenging target of 4.3% of expenditure, circa £12m.
	
	• **Quality and Continuous Improvement.** We have now trained over 100 staff in Lean-based improvement science and have implemented huddle boards in over 30 clinical and non-clinical areas. Improvement projects are being delivered by frontline staff in 90-day cycles, which all align directly to the Trust's strategic objectives. Training pauses during the winter to allow staff to focus on core operations but coaching is always on offer from the Transformation Team.		

	• **The development of an Innovation Institute.** As the Kent and Medway Medical School becomes an increasingly real prospect, the Trust will launch in Q4 of this financial year, an Institute for Innovation and Improvement [working title]. Led by x3 newly appointed Clinical Directors of Innovation and Improvement, this will create a 'one stop shop' for our clinicians looking to conduct research studies and improvement projects. It will combine the best of our currently disparate teams under one new sub-brand. It will serve to provide a single point of entry for the many external agencies that exist to help scale and spread innovation, for instance Academic Health Science Networks and the local Universities.	
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒
	Finance: We will deliver financial sustainability and create value in all we do	☒
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Committees or Groups at which the paper has been submitted	Transformation Assurance Group (fortnightly) Finance Committee (latest CIP report – 23 October 2019)	
Resource Implications	Not Applicable	
Legal Implications/Regulatory Requirements	Failure to deliver the Cost Improvement Programme target and the Trust's agreed financial control total could result in the Trust being placed in a Financial Special Measures regime.	
Quality Impact Assessment	Quality Impact Assessments (QIAs) must be completed for all change projects including individual Cost Improvement Programme schemes. The Medial Director and Director of Nursing are required to sign-off all QIAs. For significant projects, QIAs are subject to more detailed discussion and potentially review by the wider Executive Team.	
Recommendation/ Actions required	The Board is asked to note the contents of this report.	

Approval ☐	**Assurance** ☒	**Discussion** ☒	**Noting** ☒

Appendices	Not Applicable

1 Executive Overview

1.1.1 The report provides an update on the Trust's 'Better, Best, Brilliant' transformation portfolio, including:

1.1.2 **Large, cross-hospital transformation programmes.** Activity within the Trust's core transformation programmes continues to gather pace:

- **BEST Flow:** the work continues to gather pace as we move into winter, and the Trust was delighted to take receipt of the Patient Flow Programme of the Year Award 2019 at the Executive Patient Flow Summit. Recent key achievements and a forward plan are included herein.
- **BEST Access:** adopting the same approach as our Best Flow Programme, we have now mobilised the Best Access programme, which coordinates improvement work across four areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/ Referral to Treatment (RTT) management. The scope of the programme, its objectives, outcome measures and workplans are included herein.

1.1.3 **The Cost Improvement Programme (CIP).** As at Month 6, the Trust has delivered £7.2m in CIP. Year to date, this is adverse to the operational plan monitored internally by £786k. We are forecasting an outturn position of £15.8m with work ongoing to identify further opportunities to close the gap to our £18.0m target. As we begin planning for the Cost Improvement Programme schemes into next year (2020/21), we are working towards a challenging target of 4.3% of expenditure, circa £12m.

1.1.4 **Quality and Continuous Improvement.** We have now trained over 100 staff in Lean-based improvement science and have implemented huddle boards in over 30 clinical and non-clinical areas. Improvement projects are being delivered by frontline staff in 90-day cycles, which all align directly to the Trust's strategic objectives. Training pauses during the winter to allow staff to focus on core operations but coaching is always on offer from the Transformation Team.

1.1.5 **The development of an Innovation Institute.** As the Kent & Medway Medical School becomes an increasingly real prospect, the Trust will launch in quarter four of this financial year, an Institute for Innovation and Improvement [working title]. Led by x3 newly appointed Clinical Directors of Innovation and Improvement, this will create a 'one stop shop' for our clinicians looking to conduct research studies and improvement projects. It will combine the best of our currently disparate teams under one new sub-brand. It will serve to provide a single point of entry for the many external agencies that exist to help scale and spread innovation, for instance Academic Health Science Networks and the local Universities.

2 Transformation Programmes

2.1 The Transformation Operational Board continues to oversee the delivery of the priority cross-hospital transformation programmes agreed by the Executive Team: 1) BEST Flow and 2) BEST Access.

2.2 **BEST Flow:**

2.2.1 The Best Flow programme is a large-scale transformation programme to improve patient flow through each step of the emergency access and inpatient pathways.

2.2.2 This represents the Trust's flagship transformation programme in 2019/20, as well as a key system priority as outlined in the local economy's System Recovery Plan. We have therefore partnered with expert operational improvement consultancy, Transformation Nous, to support this work.

2.2.3 Best Flow's objective is to enable the Trust to deliver improved 4hour emergency department (ED) waits performance. We recognise that this metric is a proxy for safe, effective, high-quality, efficient care in an orderly hospital within which our staff have time to care. This is not however an ED turnaround plan; it is much more than that. We have set out to reduce bed occupancy and achieve an earlier time of day of discharge with a more consistent and predictable discharge profile across the week and during the weekend.

2.2.4 The programme, run jointly with system partners Medway Clinical Commissioning Group (CCG) and Medway Community Healthcare, comprises 4 parts: 1) a 'one version of the truth' analytical suite; 2) changes to our medical model i.e. the configuration and location of both medical beds and staff; 3) improved operational discipline; and 4) engagement, leadership and capabilities.

2.2.5 Now five months in and having completed the initial diagnostic phase, the Programme is in the Delivery phase.

2.2.6 Key achievements include:

- Increase in discharges across divisions with the ambition to deliver a clear emergency pathway, reduce outliers (thereby allowing for an increase in elective activity) and improve the number of patients who are treated on the right specialty ward
- Improvement in site operations, utilising daily site meetings that serve to bring together clinical and operational teams across the Trust to instil operational grip, live problem-solving both delays to discharge and safety and quality concerns
- A redesigned medical model that will facilitate the right patient in the right bed to receive appropriate and timely specialist input and optimise flow through the hospital. For example, a new acute medical rota and ways of working, Frailty at the front door, a Medically Optimised (MO) ward
- Trust-wide effort to revamp/ introduce board rounds across every ward, guided by a detailed Standard Operating Procedure (SOP) and supported by engagement of senior clinical and operational teams
- Weekly working groups and programme board to engage and develop ownership within frontline staff to co-create solutions that address current issues around processes, pathways and ways of working
- Focus on implementing the agreed medical and surgical pathways to reduce ward moves and improve timely treatment

- 2x weekly stranded patient reviews to ensure that all patients with length of stay (LoS) greater than seven days are reviewed by a multi-agency team to decide the most appropriate care for patients after their acute treatment, where home is the default destination and the type of care that optimises independence
- Reduction in the use of escalation space means less moves for patients and more patients are admitted and discharged from the right bed. Staffing can also be redeployed to support base wards
- Reduction of medical outliers in surgery and improvement in processes to review remaining outlier patients

2.2.7 The Programme has so far impacted overall hospital performance as follows:

- Type 1 performance increased six percentage points from January to August 2019 and overall performance (All Types) has increased seven percentage points over the same period (against a national average deterioration of three percentage points during the same period). In some weeks, Medway NHS Foundation Trust (MFT) Type 1 performance is in the top quartile of Trust's nationally, up from the bottom quartile in previous years.
- In September, Type 3 performance has recovered to 99%, up from 90% in Jan to April 19 and up from a low of 80% in July after the programme surfaced both reporting and productivity issues – now addressed with improvement sustained
- In August and September, decision to admit (DTA) at 8am declined to single figures down from an average of 19 Jan to May 2019
- The DTA to checkout time decreased by on average a hundred minutes in August and September compared to January to July
- Financially, the programme's overhaul of the medical model, reduction in outliers and increased grip on the opening escalation capacity is on track to deliver a CIP of £1m in-year.

2.2.8 We are delighted to report that the Programme was awarded the Patient Flow Programme of the Year 2019, out of 70 hospitals nationally. Chief Operating Officer, Harvey and McEnroe and Director of Transformation, Jack Tabner collected the Award at the Executive Patient Flow Summit, where more than 200 NHS managers discussed new strategies, models and solutions that can be put in place to avoid unnecessary delays in hospital for patients. The Award win is validation in our approach and the work to date, though we acknowledge there is much more to do to sustain the positive impact and prepare for winter.

2.3 BEST Access:

2.3.1 This overall aim of this programme is to build and sustain operational resilience to deliver safe services, improve quality and patient experience in Cancer Care, Outpatient Services, Diagnostics and Elective Surgery (Inpatient and True Day Case), ensuring economy and efficiency.

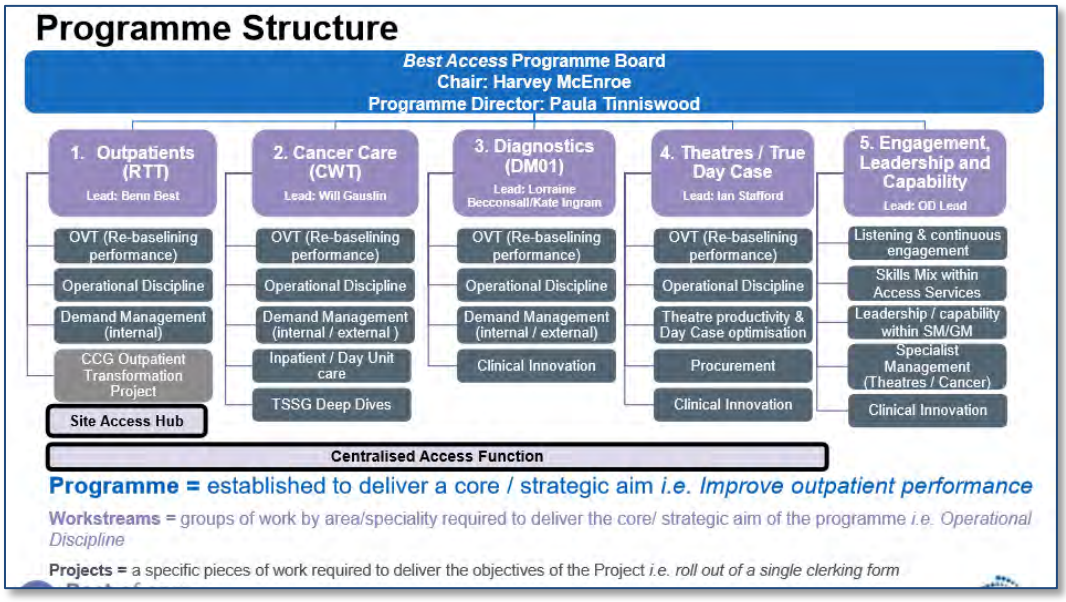
2.3.2 The programme launched formally in October, holding its first programme board supported by an internally established Delivery Unit. This is a co-sourced, high-performing internal consultancy, established to support the Trust's most pressing and complex problems.

2.3.3 The outcome or success measures of the programme are as follows:

	Key Success measures	Safety	Quality	Value for money
a	Compliance with all Cancer, RTT and DM01 Constitutional Standards, including incoming 28day FDS for Cancer	✓	✓	✓
b	Imaging and Pathology turnaround times across all modalities. Less than 7 days in from request to report in Imaging (RC Radiology), 7-10 days for Pathology (RC Path)	✓	✓	
c	Development and implementation of NG12 pathways in Urology (PSA), Lung (ACE) and Gynae (Pelvic USS); Direct Access pathway in Lower GI (FIT test) and STT pathway in Upper GI to manage demand appropriately to secondary care	✓	✓	✓
d	Effective PTLs with 100% representation of Senior Management within Cancer, RTT and Diagnostics which will be monitored against the agreed Breach Avoidance targets via the Access Site Office Hub with co-located booking/scheduling resources	✓	✓	✓
e	Implementation of, and adherence to, 6-4-2 session management process with 100% representation of Service Manager, Scheduling team and Theatre Operational Team	✓	✓	✓
f	Achieve 50% of theatre efficiency opportunity against 18/19 performance – measurement by Average Case Per Session, percentage utilisation, reduction in DNA rates and "on the day" cancellation	✓	✓	✓

2.3.4 The Best Access Programme will identify cost improvement opportunities in each Workstream. These are Theatre Productivity, Outpatients and RTT, Cancer, DMO1 and Diagnostics, Engagement, Capabilities and Leadership.

2.3.5 The Programme is made up of 5 workstreams:



2.3.6 The Theatre Productivity Programme Manager will support the delivery of improved theatre productivity. This programme includes both theatre session management (ensuring the Trust uses as many available operating sessions as possible) and in-session productivity (improving the average cases per list delivered).

2.3.7 The Outpatients/RTT Programme will review the scheduling of all appointments, evaluating DNA rates, Demand and Capacity and Patient Notification System. The joint working with the CCG on referral management will also be governed by this Programme.

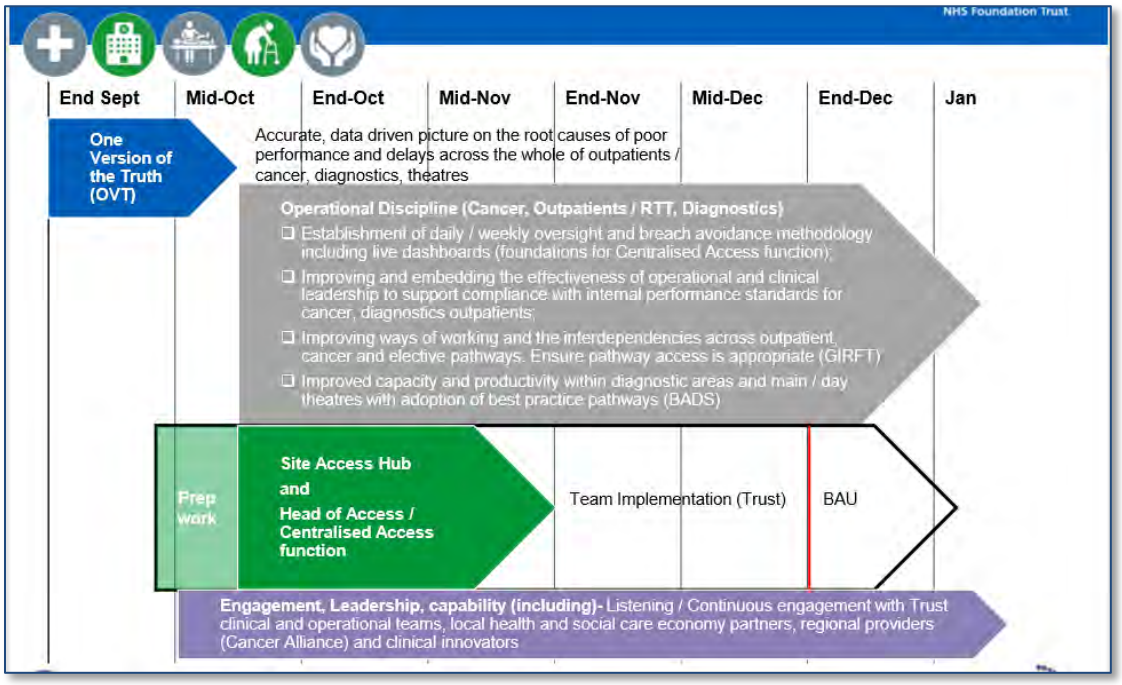
2.3.8 The Cancer Workstream will identify savings and additional income through a review of chemotherapy drug wastage, reduction in the number 4th and 5th line regimens, through clinical review, Multi-Disciplinary Team (MDT) discussion tariffs and contract reviews.

2.3.9 The Programme has commenced evaluation of Endoscopy, within the DMO1/Diagnostic Workstream. This shows lack of in-session productivity through significant downtime, existing outsourcing to a local provider and high volumes of on the day cancellations and DNAs.

2.3.10 Through focussed working with the Operational Leads, the Programme will implement grip and control, particularly through re-invigorated Patient Treatment List (PTL) meetings.

2.3.11 The Programme is working methodically with statistical process control (SPC) tools and is able to identify two core areas currently (theatre productivity and endoscopy) where significant gains could be delivered. This approach will be applied to all other Workstreams.

2.3.12 A summary overview workplan is provided below:



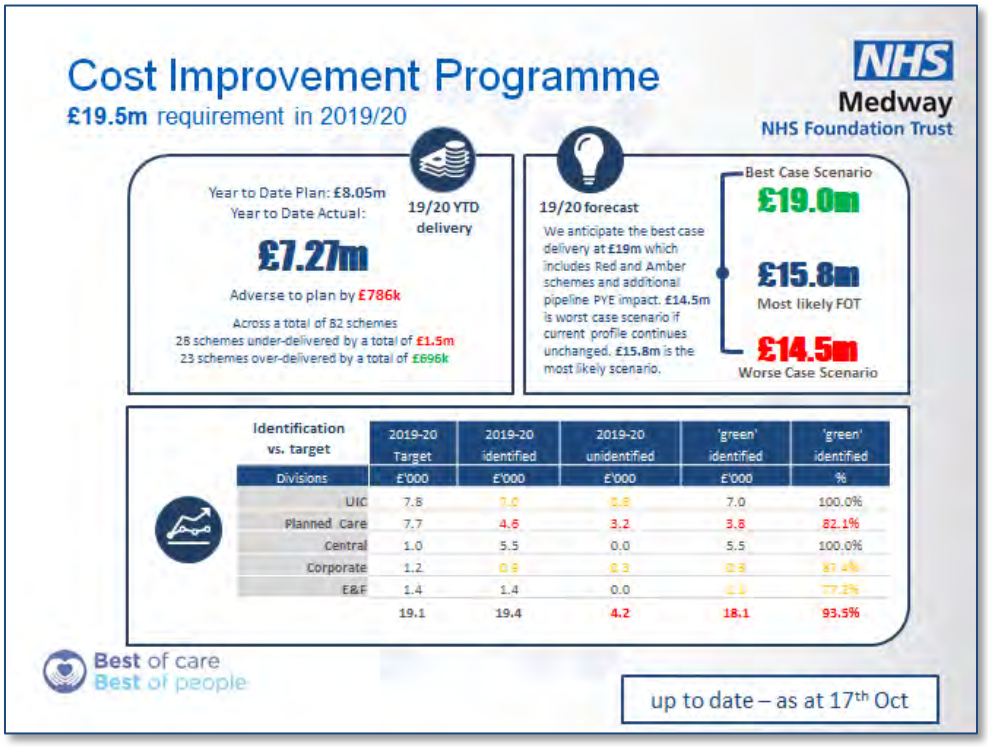
3 Cost Improvement Programme

3.1 We continue to work towards our challenging £18m Cost Improvement Programme target. Our plan comprises 82 schemes currently, all looking to make MFT more efficient by: improving expenditure control and budget management; reducing waste; optimising our processes and clinical pathways;

improving the quality and efficacy of care provided; and reducing our dependency on temporary workers through the investment in recruiting substantive staff.

3.2 As at Month 6, £7.2m has been delivered in cost improvements. While this is an enormous achievement by Divisional staff, this is adverse to our operational plan by £786k. A total of 28 schemes have under-delivered year-to-date by a total of £1.5m. In contrast 23 schemes have cumulatively over-delivered by £696k.

3.3 Two significant schemes have been the main drivers of under-performance: Theatres closure (£1.4m Full Year Effect) and Outpatients utilisation (£1.2m Full Year Effect). These schemes have now been removed from the plan and represent an 'unidentified' gap within the CIP programme.



3.4 Therefore, now half-way through the financial year, there are emerging concerns that the monthly deltas required for delivery of the targeted level of improvement across the remainder of the year (£19.5m requirement: £18.0m target + Best Flow investment of £1m in safe staffing investment of £0.5m) are becoming increasingly challenging i.e. the continued monthly average delivery of £1.21m as at Month 6 will not be enough to meet our target. We are therefore working closely with our finance team to consider potential use of our contingency fund to ensure we deliver our control total set for 2019/20.

3.5 At Month 6, we anticipate the best case delivery at £19m which includes 'Red' and 'Amber' schemes and additional pipeline part year effect (PYE) impact. £14.5m is worst case scenario if current profile continues unchanged. £15.8m is the most likely scenario and includes the phased impacts of 'Green' schemes delivering in Quarters 3 and 4. At the end of Month 9, Regulators will expect an update on expected outturn position.

3.6 The Programme Management Office (PMO) continues to work with finance and operations to find additional schemes for the 2019/20 CIP programme. Over the coming weeks, we are further reviewing data from the Model Hospital to identify any additional CIP opportunities. Work within the Best Access programme may also yield additional efficiencies yet to be calculated at time of writing.

3.7 Divisional control processes have improved during the last period with a weekly divisional meeting now held in both Planned Care and Unplanned and Integrated Care to review off-plan schemes, chaired by the Chief Operating Officer and Director of Transformation.

3.8 The PMO continues to support colleagues with finalising the Quality Impact Assessments for a pipeline of new schemes. We have calculated a part year effect value of c.£500k still to add in to the current projections, subject to review and approval by the Medical Director and Director of Nursing.

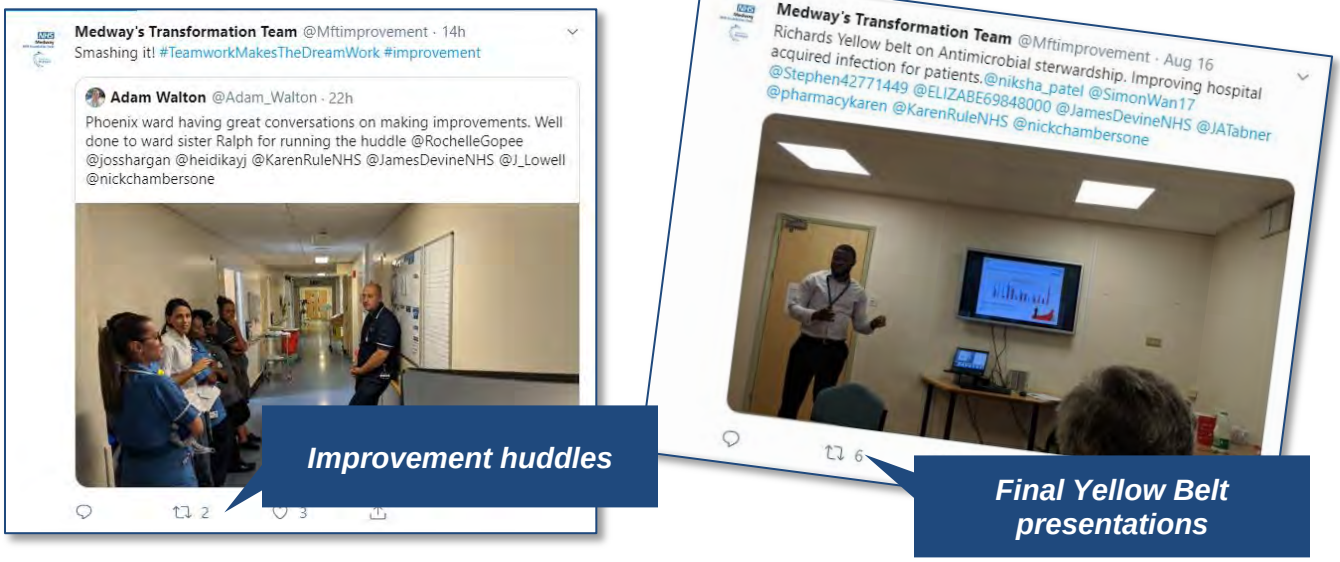
3.9 During the next period, in conjunction with business planning, we will begin planning for next year's Cost Improvement Programme. We are planning for a target of £12m (4.3%) based on current calculations of our control total deficit in 2020/21.

4 Quality and Continuous Improvement

4.1 Continuous improvement methodology and improvement science continues to be embedded within the Trust through the improvement huddles and monthly Yellow Belt training.

4.2 We have now trained over 100 staff in Lean-based improvement science and have implemented huddle boards in over 30 clinical and non-clinical areas. Over 100 small improvement projects have been delivered by frontline staff, which align directly to the Trust's strategic objectives.

4.3 Throughout the pressured winter months, some training is paused to allow staff to prioritise operational care delivery. Coaching is still always available from the Transformation Team for staff undertaking 90-day projects.



5 Innovation Institute

5.1 As the Kent and Medway Medical School becomes an increasingly real prospect, the Trust will launch in Q4 of this financial year, an Institute for Innovation and Improvement [working title].

5.2 Led by x3 newly appointed Clinical Directors of Innovation and Improvement, this will create a 'one stop shop' for our clinicians looking to conduct research studies and improvement projects. It will

combine the best of our currently disparate teams under one new sub-brand. It will serve to provide a single point of entry for the many external agencies that exist to help scale and spread innovation, for instance Academic Health Science Networks (AHSN) and the local Universities.

5.3 We are working collaboratively with the Medway Innovation Hub and the Kent, Surrey, Sussex AHSN to ensure this is an Institute that benefits the whole region and not just the Acute Trust.

5.4 The mission of the Institute is as follows:

5.5 The Institute will have 5 primary focus areas:

5.6 The Trust will be working over the next Quarter to develop the sub-brand and launch formally in the New Year. There will be co-design workshops throughout November and December to allow teams to contribute to what will be an exciting development for Medway.

6 Communications

6.1 The October/November issue of the Making Medway Brilliant transformation newsletter has now been published. This is the second issue of a new, regular publication to ensure staff are kept up to date on the various change programmes happening around the hospital.


Making Medway brilliant

NHS Medway NHS Foundation Trust

Transforming care for our patients

Issue 2 - Oct-Nov 2019

Let's wake up Medway

I'm so pleased that staff across the hospital are getting out and about each morning to help wake up Medway.

We all have a shared goal to improve our performance and the experience for our patients; it's what we get out of bed and come to work for. We know that a bad start to the day can lead to poor performance throughout the day, longer waits for patients, frustrations for staff, and pressures on our services.

A good start to the day ensures waits are kept to a minimum, patients go home without delays, beds are freed up for those who need them, and staff feel less stressed. It's really important that we get the absolute maximum out of that crucial start to the day; that's why I have asked our managers to release time from their diaries between 8am and 10am each day.

This time should be spent getting back to the floor and supporting staff to deliver high quality patient care. Critically this is also about your manager helping to free up your time, giving you permission to go out and help 'Wake up Medway', whether you are in a clinical or non-clinical function – everyone has a role to play.

Perhaps you can go out and offer a cup of tea and a friendly ear to one of our patients, support our ward admin staff, attend a board round or get out into the main reception or a ward entrance and encourage staff and visitors to get their hands.

Speak to your manager about how you can help to 'Wake up Medway.'

James Devine
Chief Executive

We asked our staff for their experiences of helping to 'Wake up Medway'

Kevin Cairney, Director of Operations
"I've taken the opportunity to walk through the hospital and speak to people who look lost or a bit upset. Recently I met a gentleman in a wheelchair who was exhausted and I pushed him the rest of the way to the Physio Gym".

Karen McIntyre, Divisional Director of Nursing
"I really think that 'Waking up Medway' focuses our purpose. We are here because patients are here and if you are spending time doing something that doesn't impact our patients we need to rethink – that two hours gives us the time to really make a difference"

Dan Small, Associate Director of Procurement
"Procurement Team members are going out with the Materials Management Team and asking if there is anything that will be needed throughout the day that they may have had to come down to stores for later."

6.2 The Trust induction for new joiners now features a 30-minute welcome from the Executive Director of Transformation.

6.3 To ensure all staff have a voice and can put forward ideas to improve the hospital – however big or small – we are exploring a potential solution to digitally crowdsource improvement ideas. This will make use of a virtual communications platform we hope to launch in the New Year as part of the Innovation Institute's communications strategy.

7 A forward look

7.1 In the next period, we will:

7.1.1 Focus intensively on launching the Best Access programme at pace, and assessing the extent to which additional income and CIP can be leveraged in theatres efficiency and additional outpatients and diagnostic activity.

7.1.2 Work with Medway Community Healthcare to develop system-wide plans for a Transfer of Care Collaborative; a development of our current Integrated Discharge Team.

7.1.3 Progress the design phase of the Innovation Institute.

7.1.4 Host a third visit from Lord Carter of Coles. On 27 November, Lord Carter will visit MFT to learn about the latest improvements and discuss our most pressing challenges.

7.1.5 Work alongside CCG partners to develop our Joint PMO, to support the development and submission of our five-year efficiency and transformation plan to NHS England and NHS Improvement.

8 Conclusion and Next Steps

8.1 The transformation portfolio continues to gather pace across the Trust. There is an enormous amount of work happening within clinical and corporate teams to support the pace and scale of change required.

8.2 The Board is asked to note the contents of this report.

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Communications and Engagement	**Agenda Item**	**6.2**
Lead Director	Glynis Alexander, Executive Director of Communications and Engagement		
Report Author	Glynis Alexander, Executive Director of Communications and Engagement		
Executive Summary	This report details some of the communications and activity since the last Board meeting, including initiatives to ensure staff, patients and stakeholders are aware of and involved in our transformation programme.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	None		
Resource Implications	None		
Legal Implications/Regulatory Requirements	None		
Quality Impact Assessment	Not applicable		
Recommendation/ Actions required	The board is asked to note the report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	None		

1 Executive Overview

1.1 This report details some of the communications and activity since the last Board meeting, including initiatives to ensure staff, patients and stakeholders are aware of and involved in our transformation programme.

1.2 It also includes feedback from recent engagement with our community.

2 Engaging Colleagues

2.1 The work of our Communications Team is aligned with the Trust's transformation priorities, making sure staff are kept updated and are engaged with the extensive improvement programme in place. To ensure staff (and public) engagement is designed into transformation projects, one member of the Communications team is part of the new Delivery Unit.

2.2 A key channel for keep staff informed about progress is the recently launched Making Medway Brilliant newsletter. The second edition is now published and distributed around the Trust, as well as shared electronically.

2.3 The team is implementing a communications plan to ensure that staff are fully prepared for the forthcoming CQC inspection; this includes guidance for staff on what to expect, and a showcase publication drawing together many examples of improvements and achievements of which staff should be very proud.

2.4 A Waking up Medway initiative has been launched with visuals and messaging produced, encouraging staff to spend the first two hours of their working day directly supporting patient care.

2.5 In October we launched a Stop! Gel! Go! campaign to encourage good hand hygiene practices among staff and visitors. It includes a large multimedia information screen in the main entrance of the hospital, as well as more traditional tools such as posters and screensavers.

2.6 Executive Directors continue to visit wards and other areas of the hospital as part of regular walkabout visits, observing, talking to staff and listening to what makes them proud and what causes frustration. These visits help the Executive Team to gain valuable insight into the issues that matter to staff.

2.7 The monthly staff briefings with James Devine have continued with very good attendance and engagement from staff. The information presented at the meeting has been adapted to ensure staff have a more complete picture of Trust performance.

2.8 The team continues to support the NHS Staff Survey and flu vaccination programme with widespread and regular communications, and uptake for both has shown an increase from last year.

2.9 Following the appointment of a new Freedom to Speak Up Lead Guardian, the team has worked closely with her to raise the profile of the programme throughout the organisation.

3 Media

3.1 It has been a particularly busy media period, with more than 30 interactions with local regional and national media. We have achieved a relatively balanced representation with both proactive good news stories about the Trust generated by the team, as well as reactive responses to media queries on sometimes less negative stories.

3.2 We have provided statements following recent inquests into two patients' deaths, long waits at times in the Emergency Department, a request from Unison abolish parking charges for NHS staff, and a staff complaint about parking.

3.3 Positive news has included articles on the fantastic work that is being carried out in our neonatal unit and innovations by our Falls team, as well as coverage on an event organised to raise awareness of the organ donation in the black, Asian and minority ethnic (BAME) communities.

3.4 A parody music video created by our Diabetes team to bring a light-hearted look at Hypoglycaemic awareness was featured widely on local and regional television. We also welcomed a TV crew on site to film our inaugural CPR'athon which was featured on ITV Meridian News, and KMTV who interviewed our Arrhythmia nursing team to highlight their use of technology to improve patient care.

3.5 The very popular free staff BBQ hosted by the Rapid Relief Team also generated a lot of media interest.

4 Social Media

4.1 We have seen good progress with our social media accounts since the last update, with a continued growth in followers across our three main channels – Twitter, Facebook and Instagram. On Twitter and Instagram, we remain as Kent's most-followed acute Trust, and are second only to Dartford and Gravesham NHS Trust on Facebook.

4.2 We used social media to share key messages on a range of initiatives, including the launch of the Stop! Gel! Go! campaign to promote better hand hygiene; the national award presented from the Ministry of Defence for our work in supporting the armed forces community; the release of the autumn edition of News@Medway; our 2019 Annual Members' Meeting; regular events hosted by our Charity and Fundraising Team; and other treatment options for those considering visiting our Emergency Department.

4.3 Videos produced in-house by the Communications Team proved popular and were seen by approximately 17,000 users. These covered the staging of our 'CPR'athon' which helped highlight the importance of Cardiopulmonary resuscitation (CPR) training

for of 'World Restart a Heart Day' and a clip to raise awareness during Organ Donation Week. Elsewhere, we also helped film and publicise a special parody music video created by our diabetes nurses to mark Hypo Awareness Week.

4.4 Our messages on social media received an increased number of views since the last update – approximately 475,000 on Facebook and 244,800 on Twitter. This compared to 122,000 on Facebook and 210,000 on Twitter last time.

4.5 Medway's social media account followers now total 5,320 on Twitter (up from 5,163 at the last update), 7,277 on Facebook (up from 7,086) and 1,768 on Instagram (up from 1,632).

5 Community Engagement

5.1 Governors

5.1.1 In October governors met constituents in the hospital foyer, when they heard a mixture of positive feedback and a few concerns about appointment letters and other examples of confusing patient communications.

5.1.2 Several patients spoke highly of our respiratory service, while there was praise from the friends of a patient on Lawrence Ward, whose final weeks were eased by the warmth and individual care shown by staff.

5.1.3 Governors, along with the Trust's Community Engagement Officer, have been involved in the PLACE assessment. Assessors visited 10 wards and 10 service areas, highlighting areas where improvements are needed and noting areas of excellence.

5.2 Community and patient engagement

5.2.1 In September an engagement event was held in Rochester to update patients on proposals for vascular services. Most attendees agreed that changes would be welcome, although all spoke highly of the care they have received at the Trust.

5.2.2 We have started attending Gypsy Traveller Action Group (GTAG) meetings which are organised through Kent police. Through this engagement we hope to work more closely with Gypsy Traveller communities, to understand their health needs and barriers to access.

5.2.3 The Trust Frailty team presented to the local NHS Retirement Fellowship on their vision for their service. They also received feedback from members who recently used Trust services, which has been shared with senior management within the care group.

5.2.4 The Trust engaged with families and members of the public at Kent Fire and Rescue Service's open day in Strood. More than 2,000 local residents and families attended, many of whom were pleased to be able to share their views of hospital services.

5.2.5 We welcomed Wayfield and Horsted Primary School to our Teddy Bear Hospital. This has been an excellent opportunity for children between the ages of four and seven to learn about what happens in a hospital to reduce the fear and mystery if they or their relatives need care.

5.2.6 On 28 September 32 people attended a first awareness event to promote organ donation and transplantation among BAME communities in Medway. The event was organised by the Trust in collaboration with local BAME leaders.

5.2.7 Attendees heard presentations from Professor Gurch Randawa from NHS Blood and Transplant, and a BAME donor family.

5.2.8 The Trust was represented at Medway Police's Community Liaison Hate Crime Awareness Event. This was a great opportunity to engage to develop relationship with new community groups and share information about the Trust and how people can get involved.

5.2.9 The Trust's Community Engagement Officer engaged with local schools and community groups to get involved in Allied Health Professionals (AHP) day. Twenty school students visited the hospital and spoke to AHPs about their roles. It is hoped this inspired some of the students to consider careers in these disciplines.

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	**Finance report September 2019**	**Agenda Item**	**7.1**
Lead Director	Ian O'Connor, Executive Director of Finance		
Report Author	Paul Kimber, Deputy Director of Finance		
Executive Summary	This paper reports the September 2019 financial position for the Trust and delivery against financial targets.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Finance Committee, 23 October 2019		
Resource Implications	Not applicable		
Legal Implications/Regulatory Requirements	Month 6 year to date favourable to NHS Improvement control total by £10,000.		
Quality Impact Assessment	Confirm and challenge sessions and additional cost improvement opportunities continue to be developed and managed through established Quality Impact Assessment Framework.		
Recommendation/ Actions required	The Board is asked to note the financial performance to 30 September 2019, being £10,000 favourable against the financial plan, adjusting to £2,105,000 adverse when compared to the improvements expected against the current cost improvement plan.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Appendix 1: Finance dashboard		

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 The finance dashboard report setting out key performance indicators is attached at Appendix 1. It reports a series of individual metrics designed to show progress over time, assessing the risks associated with operational performance and impact on the Trust's financial performance and position.

2 Income and expenditure

2.1 To the end of September 2019 the Trust is reporting a year to date deficit of £27.2 million, excluding Provider Sustainability Funds (PSF), Marginal Rate Emergency Tariff (MRET) and Financial Recovery Funds (FRF). This is adverse to the current operational plan by £2.1 million as shown in the table below. Against the declared plan with NHSI the Trust is £10,000 favourable; these plan positions will merge over the course of the year.

2.2 September's in month performance is a deficit of £4.3 million excluding PSF, MRET and FRF, being £0.9 million adverse to plan. This performance arises as a result of an increase in the pay run-rate, a downturn in the activity run-rate and underachievement of the cost improvement programme.

2.3 The Trust continues to forecast a year end deficit of £22.0 million including PSF, MRET and FRF.

2.4 PSF, MRET and FRF income to 30 September 2019 is £12.7 million and is £0.6 million favourable to plan. This variance relates to additional income received for achieving the 2018/19 control total; it is cash-backed but will not provide a benefit in measuring financial performance against 2019/20 control totals, hence is removed in the table below.

	Month 6			Year to Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Clinical income	22,164	21,492	(672)	131,241	128,729	(2,512)
Other income	2,013	2,305	292	11,762	12,226	464
Pay	(17,148)	(17,602)	(454)	(104,404)	(104,026)	378
Non pay	(9,180)	(9,357)	(177)	(55,948)	(57,007)	(1,059)
EBITDA	**(2,151)**	**(3,163)**	**(1,011)**	**(17,349)**	**(20,079)**	**(2,730)**
No- operating expenses	(1,283)	(1,175)	108	(7,696)	(7,070)	626
Surplus/(deficit) before PSF/MRET/FRF	**(3,434)**	**(4,337)**	**(903)**	**(25,045)**	**(27,150)**	**(2,105)**
PSF/MRET/FRP	2,194	2,194	0	12,102	12,682	580
Operational surplus/(deficit)	**(1,240)**	**(2,143)**	**(903)**	**(12,943)**	**(14,468)**	**(1,525)**
CIP rephasing	(384)		384	(2,115)	0	2,115
Surplus/(deficit)	**(1,624)**	**(2,143)**	**(519)**	**(15,058)**	**(14,468)**	**590**
18/19 PSF adjustment	0	0	0	0	(580)	(580)
NHSI control total surplus/(deficit)	**(1,624)**	**(2,143)**	**(519)**	**(15,058)**	**(15,048)**	**10**

3 Cost Improvement Programme

3.1 The cost improvement programme has delivered financial benefit of £7.3 million in the year to date, being adverse to the targeted value of £8.1 million. This is in large due to delays and slippage against the outpatient transformation and workforce redesign.

3.2 The PMO has implemented a series of check and challenge sessions, led by the Chief Operating Officer, to maximise delivery of existing schemes and/or identify mitigating schemes and actions where applicable.

4 Capital

4.1 Capital expenditure year to date is £8.3 million, which is ahead of plan. As detailed schemes are finalized it is likely that the plan will need to be re-profiled at scheme level but will remain within the overall annual plan of £23.7 million as agreed and submitted to NHS Improvement.

	Current Month			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Backlog Maintenance	250	446	(196)	2,550	1,810	740
Routine Maintenance	0	0	0	0	39	(39)
Plant/Equip/Trans/Fits/Other	280	209	71	1,020	561	459
Fire Safety	0	631	(631)	243	2,251	(2,008)
IT	200	977	(777)	1,000	1,934	(934)
ED	0	848	(848)	0	1,706	(1,706)
Capital Programme Totals	**730**	**3,111**	**(2,381)**	**4,813**	**8,301**	**(3,488)**

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. The strategy of obtaining earlier payment of contracted values from the Clinical Commissioning Group (CCG) is yielding benefit.

6 Conclusion and Next Steps

6.1 The Board is asked to note the financial performance and position to/as at 30 September 2019, being £10,000 favourable against the financial plan, adjusting to £2,105,000 adverse when compared to the improvements expected against the current cost improvement plan.

Appendix 1 – Finance dashboard

I&E Deficit EXCLUDING PSF YTD (£m)

	Jun	Jul	Aug	Sep	RATING
Plan	(2.3)	(1.8)	(3.7)	(1.6)	
Actual	(2.0)	(1.9)	(3.8)	(2.1)	
Variance	0.3	(0.0)	(0.1)	(0.5)	

The Trust has incurred a deficit of £2.1 million for Month 6, £0.5 million adverse to plan mainly due to non-delivery of the CIP target in month £0.5m and increase in pay costs £0.2m. The year to date provision for optimism bias is £1.4 million as part of the contingency reserve is used to cover the shortfall in CIP. Income estimates (activity driven) are coming under pressure.

Capital Expenditure YTD (£m)

	Jun	Jul	Aug	Sep	RATING
Plan	(2.2)	(3.0)	(4.1)	(4.8)	
Actual	(2.1)	(2.9)	(5.2)	(8.3)	
Variance	0.2	0.0	(1.1)	(3.4)	

19/20 Capital Expenditure is currently ahead of plan. This is not an indication of overspending simply work being ahead of schedule.
Accelerated spend on EDRMS, ED, Fire cladding and Theatres refurbishments accounts for 81% of the expenditure in month 6.

CIP Delivery YTD (£m)

	Jun	Jul	Aug	Sep	RATING
Plan	0.9	1.6	1.6	1.8	
Actual	0.9	1.4	1.4	1.3	
Variance	0.0	(0.2)	(0.2)	(0.5)	

CIP Delivery is £1.3 million in month, £0.1 million lower than August and now adverse to the cumulative plan by £0.8 million. As predicted the larger programmes not achieving their planned levels are Outpatients, Orthodontics and Unplanned Care Workforce changes.

Cash Actual £m

	Jun	Jul	Aug	Sep	RATING
Plan	5.0	5.0	5.0	5.0	
Actual	26.4	26.2	24.6	20.6	
Variance	21.4	21.2	19.6	15.6	

Month 6 Cash balance has reduced in line with recent expectations yet remains higher than plan, it will increase further in October as a result of cash timing receipts built into the contract.

Normalised Monthly Pay

	Jun	Jul	Aug	Sep	RATING
Plan	(17.5)	(17.3)	(17.1)	(17.1)	
Actual	(17.1)	(17.2)	(17.4)	(17.6)	
Variance	0.4	0.1	(0.3)	(0.5)	

Normalised pay expenditure in month is £17.6 million and £0.5 million adverse to plan. This has been an increase in cost due more substantive staff across clinical areas; the main variance to plan is caused by Workforce CIP schemes not delivering.

Normalised Monthly Agency Expenditure (£m)

	Jun	Jul	Aug	Sep	RATING
Plan	(0.7)	(0.6)	(0.6)	(0.6)	
Actual	(0.5)	(0.6)	(0.4)	(0.5)	
Variance	0.2	(0.0)	0.2	0.1	

Agency Spend is £0.5 million and favourable to plan by £0.1m. Although agency spend has increased by £0.1m there is a decrease in Bank Staff expenditure by £0.3m.

Better Payment Practice Code (BPPC by Volume (%)

	Jun	Jul	Aug	Sep	RATING
Plan	95.0	95.0	95.0	95.0	
Actual	53.34	44.63	46.07	47.55	
Variance	(41.7)	(50.4)	(48.9)	(47.5)	

BPPC is gradually improving after a brief period of deteriation associated with the implementation of the new system. Finance are currently working with operational departments to resolve invoicing delays in certain areas with a view to hitting the BPPC target in the next financial year.

All Aged Creditors 60+ Days (£m)

	Jun	Jul	Aug	Sep	RATING
Actual	7.0	5.8	4.7	5.8	

Creditors balances in excess of 60 days has increased due to a volumns of invoices from directorates being received into Finance after their due date.
Finance have met with Estates & Facilities and Pharmacy in month to provide clarification on invoicing, receipting and supplier liaison procedures to rectify the problem.

All Aged Debtors 60+ Days (£m)

	Jun	Jul	Aug	Sep	RATING
Actual	13.2	14.0	13.8	14.3	

Debtors over 60 days has increased slightly due to the conintued non-settlement of HCD invoices. The CCGs have advised the Trust on their position for these debts requesting minor credits before payments will be made. Payment is expected to be agreed and made by month 8.

Key:

	Adverse to Plan
	Favourable to Plan

Going in the right direction

Going in the wrong direction

Glossary of Terms:

I&E	Income and Expenditure
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
CIP	Quality Cost Improvement Programme
YTD	Year-to-Date

Meeting of the Board of Directors in Public

Thursday, 07 November 2019

Assurance Report from Committees

Title of Committee:	Finance Committee	**Agenda Item**	**7.2**
Committee Chair:	Joanne Palmer, Non-Executive Director		
Date of Meeting:	Thursday, 23 October 2019		
Lead Director:	Ian O'Connor, Executive Director of Finance		
Report Author:	Ian O'Connor, Executive Director of Finance		

The key headlines and levels of assurance are set out below, and are graded as follows:	
Assurance Level	**Colour to use in 'assurance level' column below**
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. Finance Month 6 Report The Committee discussed the Month 6 figures for the Trust and for both Unplanned and Integrated Care and Planned Care. The Executive Director of Finance to take the Response to the Five Year Plan – Control Total numbers to the Private Trust Board on 7 November 2019, for information.	**Green**
2. Finance Risk Register The Committee reviewed the Finance Risk Register and noted the risks and mitigations, together with current scores.	**Amber**

3. Cost Improvement Programme (CIP) The Committee received a report on the month 6 CIP position, which year to date (YTD) has delivered £7.2 million against our plan of £8.0million at Month 6. There are emerging concerns that the monthly deltas required for delivery of the targeted level of improvement across the remainder of the year (£19.5m requirement) are becoming increasingly challenging i.e. the continued monthly average delivery of £1.21million as at Month 6 will not be enough to meet our target. This represents a significant risk to the Trust and our ability to meet our £22.3million control total deficit position – failure to deliver this precludes the Trust from circa £10million in additional Provider Sustainability Funds (PSF) and Financial Recovery Funds (FRF). The Best Access change programme may serve to recover some of the adverse position in part; however this represents significant change effort as part of a circa two year programme of work akin to Best Flow. At the end of Month 9, Regulators will expect an update on expected outturn position. The Business Planning Round begins now to plan for next year's efficiency programme. The Programme Management Office (PMO) continues to actively monitor and support this work as well as working with scheme owners of other materially off plan schemes. The team will continue to report externally against the plan submitted in April 2019.	**Amber**
4. Capital Plan 2019/20 The Committee was given an update on the Capital programme for 2019/20. This included the following: - Current status of Capital - Progress against key projects - Next Steps The Committee noted the progress and additional capital funds which have been made available. Capital Plan pressures will be added to the Risk Register and approved projects will be tracked in the monthly Finance Report. The Director of Estates and Facilities was asked to give a verbal update to the Board 2019 in regard to the risk analysis at quarter three of the Capital Plans. The Board needs to understand the risk of achieving the capital plan spend and any risks to finance, reputational, health and safety issues in relation to capital spend.	**Green**
5. Project Updates <u>Electronic Documents Records Systems (EDRMS) programme</u> The Committee was informed that there has been a number of difficulties arise, on developing the investment case, therefore further work and time is needed to resolve these issues. One of the issues is obtaining the legal information on the lease of Sterling Park and also from a Health and Safety perspective, there is also consideration being given to off sit storage, scanning and medical records. The Committee granted the extra time needed and asked for a detailed update and report at the November 2019 meeting.	**Green**

Urology Robot The Committee was informed that NHS Improvement / NHS England had commissioned to undertake the activity. There would be certain rules to adhere such as how many procedures are completed in a year, but this is an extremely positive outcome and a good news story. Outpatients Redesign The Committee was informed that the Best Access Programme will focus on improvements across Cancer, Referral to Treatment and the whole Diagnostic Suite. Through baselining, detailed analysis of Statistical Process Control charts (SPC), the Programme aims to identify opportunities in respect of performance, quality indicators and cost improvements. Robust governance and assurance of the agreed deliverables will be applied via the Programme Board. The Committee asked that a deep dive report is presented at the November 2019 meeting. Laundry Project Update The Committee was informed that the Sustainability and Transformation Plan (STP) have offered their support on giving project management support on three of the schemes to move them forward. Due to the slow working pace and the turnover of project managers to date, the Director of Estates and Facilities will be working closely on the project to ensure it progresses.	
Decisions made 1) Amended Terms of Reference were APPROVED subject to the Company Secretary making some changes due to clarification around Governor deputies. 2) Added 'Model Hospital' to the Committee work plan, as a monthly agenda item.	
Further Risks Identified All risks are captured within the risk register and the Board Assurance Framework.	
Escalations to the Board or other Committee None	

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Finance Committee Terms of Reference	**Agenda Item**	**7.3**
Report Author	Brenda Thomas, Company Secretary		
Lead Director	Joanne Palmer, Chair of Finance Committee		
Executive Summary	The terms of reference for the Finance Committee (the Committee) were reviewed by the Committee at its meeting on 23 October 2019. The review took account of the following: a. the Chair of the Committee selecting another non-executive director to act as Chair in their absence (5.1); b. changes made to the executive structure (6.2); c. minor admin changes; d. making no distinction between governors in attendance and observing (6.2f). The Committee approved the above changes subject to clarifying that governors can send deputies in their absence, with deputies briefed prior to the meeting. This clarification has been made.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Finance Committee on 23 October 2019.		
Resource Implications	None		
Legal Implications/ Regulatory Requirements	The terms of reference clarify the Committee's responsibilities to ensure legal and regulatory compliance.		
Quality Impact Assessment	Not applicable		
Recommendation/ Actions required	The Board is asked to approve the Finance Committee Terms of Reference.		

Approval	**Assurance**	**Discussion**	**Noting**
☒	☐	☐	☐

Appendices	Appendix 1 - Finance Committee Terms of Reference.

Terms of Reference

Medway NHS Foundation Trust

Finance Committee

1. Purpose

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

2. Constitution

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

3. Authority

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

3.2. The Finance Committee is also authorised to implement any activities which are in line with its terms of reference.

4. Accountability

4.1. The Committee will report to the Trust Board bi-monthly.

4.2. The Committee will provide a report to the Council of Governors as required.

5. Chairperson

5.1 The Chair of the Committee will be chosen and appointed by the Trust Board from among the Non-Executives Directors (NEDs); in the absence of the Chair at any given meeting, the Chair will ahead of the meeting, select one of the NEDs to act as Chair.

6. Membership

6.1
a) Two NEDs one of which will be the Chair of the Committee
b) Executive Director of Finance
c) Executive Director of HR and OD
d) Executive Director of Communications and Engagement
e) Executive Director of Nursing.

In Attendance:

6.2
a) Company Secretary (or member of the secretariat) as minute taker
b) Chief Executive
c) Deputy Chief Executive
d) Chief Operating Officer
e) Executive Director of Transformation
f) Up to three public governors may attend each meeting (governors assigned to the committee may appoint deputies to attend committee meetings in their absence)
g) Attendees may contribute at the invitation of the Chair.

6.3 There is a requirement for members to attend at least 75% of all meetings in one calendar year.

6.4 Other staff may be requested to attend at the invitation of the Chair and participate in the financial review.

7. Quorum

7.1. Meetings will be quorate when at least three members, one non-executive and two executives are present.

8. Frequency

8.1. The meetings will normally be held monthly.

9. Key responsibilities

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

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

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

9.1.3. There is review of areas of financial risk through the Board Assurance process, and that all appropriate and available mitigations are in place.

9.1.4. There is scrutiny of major business cases, service developments and proposed investment decisions in excess of £0.5m on behalf of the Trust Board.

9.1.5. Post project evaluation and benefits realisation of major investments.

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

9.3. Finance Committee meetings will include the following standing items:

9.3.1. Review of the monthly Finance Report.

9.3.2. Review of Financial Recovery Plan.

9.3.3. Review of Capital Programme.

9.3.4. Review of cost improvement plans (CIP) and delivery.

9.3.5. Review of business cases for service developments/changes/contracts in excess of £0.5m.

9.4. Committee papers will be published at least five working days before the date of the Committee.

9.5 Committee minutes will be produced within five working days.

Terms of Reference

10. Terms of Reference

10.1 The Committee's terms of reference will be reviewed and approved by the Trust Board annually.

10.2 The Committee will monitor its performance against its terms of reference six monthly.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Compliance against terms of reference	Annual review	Company Secretary	Chair of Finance Committee	

Terms of Reference approved by the: Finance Committee on 23 October 2019.

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	**Workforce Report**	**Agenda Item**	**8.1**
Lead Director	Leon Hinton, Executive Director of HR and OD		
Report Author	Elizabeth Nyawade, Deputy Director of HR and OD		
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 640 candidates to date; 193 of these candidates have commenced in post over the last 12 months. Trust turnover has increased at 12.21% (+0.04%) from 12.17%, sickness absence at 4.23% (+0.13) compared to the month of August is above the Trust's tolerance level of 4%, and appraisal compliance has decreased to 88.22% (-2.65% from 90.87%) and is above Trust target of 85%. Statutory and Mandatory training is at 90.53% (+0.61% from 89.92%) and is meeting the Trust target of 85%. The percentage of pay bill spent on substantive staff in September at (85%) increased (+1%) compared to the month of August. The percentage of agency usage at 3% increased (+1% from 2%) compared to the month of August. The percentage of pay bill spent on bank staff at 12% (-2% from 14%) has decreased compared to August.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Executive Group Human Resources and Organisational Development Senior Team.		
Resource Implications	Not applicable		
Legal	Staffing levels and use of temporary/agency workers have been identified as		

<table>
<tr><td>Implications/Regulatory Requirements</td><td colspan="4">areas that need improvement by the Trust and our regulators.

• 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. Update on medical and dental; allied health professional; and, scientific, technical and therapeutic professional recruitment.
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 2019/20 cost improvement programme.</td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="4">Not applicable</td></tr>
<tr><td rowspan="2">Recommendation/ Actions required</td><td colspan="4">The Board is asked to note the content of this report.</td></tr>
<tr><td>Approval
☐</td><td>Assurance
☒</td><td>Discussion
☐</td><td>Noting
☒</td></tr>
<tr><td>Appendices</td><td colspan="4">None</td></tr>
</table>

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. The report to Board is aligned to the objectives and deliveries associated with the Trust's People Strategy.

Best of People

We aim to transform ourselves through innovative staff-led improvements that meet the needs of our patients now and in the future

2 Recruitment

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During September 2019, 29 FTE registered nurses and midwives joined the Trust (net increase +10 FTE) on a substantive basis, alongside 13 FTE substantive clinical support workers/maternity care assistants (net increase +1 FTE, table 2).

2.2 In September 2019, 13 international nurses undertook the Objective Structured Clinical Examination (OSCE); 10 nurses passed at the first sitting and 3 had partial fails and will retake the exam in October 2019. To date a total of 167 international nurses have taken the OSCE exam. The Trust has a first attempt pass rate of 82% and an overall success rate of 99%.

2.3 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Seven Cpl international nurses have commenced in post, with an additional two nurses expected before end of December 2019. 53 HCL nurses have also commenced in post. 36 candidates remain in the pipeline with offers being processed.

2.4 The Trust is also working with eight additional permanent recruitment agency providers: We Solutions, Ascend, Cromwell Medical Recruitment, Medline, Kate Cowhig, HealthPerm, Santuary Healthcare and Xander Hendrix. The agency partners are working with the Trust on developing a pipeline of nurses for the financial years 2019/2020 and 2020/2021.

2.5 To support the Trust in achieving its recruitment targets, new international campaigns are being launched with a select number of agencies: Medline, We Solutions, Ascend, Kate Cowhig, Sanctuary Personnel, MSI and Cromwell Medical Recruitment.

Table 1 below summarises the Trust's nursing recruitment pipeline as at end of September 2019:

Commenced	Pipeline	Agency total	Anticipated new starters over the next 12-months from pipeline
193	191	640	176

(Table 1: Nurse recruitment pipeline as of September 2019)

Table 2 below summarises offers made, starters and leavers for the month of September 2019:

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses and midwives	55 (38 NHS Jobs/open days and 17 international nurses via skype)	29	19
Clinical support workers/ Maternity Care Assistants	16 (Clinical Support Workers)	13	12

(Table 2: Nursing starters and leavers September 2019)

2.6 During September a total of 25 medical staff, including 14 junior doctors in training and two MTIs, joined the Trust. Focussed discussions on recruitment of medical staff takes place regularly within divisions during the vacancy control panel (VCP) meetings that are chaired by the divisional directors. Out of the 16 medical staff leavers in September, 11 were junior doctors in training taking up placement posts in other NHS Trusts. At present consultant recruitment is taking place for the following specialities Microbiology, Rheumatology, Gastroenterology, Anaesthetics and Haematology. As at end of September 2019 the Trust had 41 FTE vacant consultant posts and 53 FTE vacant non-consultant posts.

Table 3 below summarises offers made, starters and leavers for the month of September 2019:

Role	Offers made in month	Actual starters	Actual leavers
Medical Consultants	8	2	3
Junior doctors (including doctors in training)	7	23	13

(Table 3: Medical staff starters and leavers September 2019)

2.7 During September two Allied Healthcare Professionals (AHP) (Physiotherapists, Occupational Therapists, Radiographers and Dieticians) joined the Trust. Prior to filling vacancies with like for like replacement, discussions take place regarding use of alternative roles including apprentices and or new roles including assistant physiotherapy/occupational therapy especially when filling difficult to recruit to posts.

Table 4 below summarises offers made, starters and leavers for the month of September 2019

Role	Offers made in month	Actual starters	Actual leavers
Physiotherapists	1	1	2
Therapy Assistant Practitioner	0	0	0
Occupational Therapists	0	1	0
Dieticians	0	0	1
Radiographers	2	0	0
Sonographer	1	0	0

(Table 4: AHP starters and leavers September 2019)

2.8 During September two Scientific, Technical and Therapeutic (ST&T) staff (including, but not limited to, Pharmacy staff, Operating Department Practitioners) joined the Trust. Prior to filling vacancies with like for like replacement, discussions take place regarding use of alternative roles including apprentices and or new roles including assistant practitioners especially when filling difficult to recruit to posts. Pharmacy department is currently in discussions with local Community providers to develop joint rotational posts that will help fill some of the vacancies and providing learning in the different settings.

Table 5 below summarises offers made, starters and leavers for the month of September 2019:

Role	Offers made in month	Actual starters	Actual leavers
Pharmacy Technicians	0	0	0
Pharmacy Assistant	1(pre-registration trainee)	0	0
Pharmacists	7	1	1
Operating Theatre Practitioners / Theatre Nurses	0	1	0

(Table 5: ST&T starters and leavers September 2019)

3 Trust and Divisional Metrics

3.1 The table below (table 6) shows performance across five core indicators by the divisions. Turnover, at 12.21% (+0.04% from 12.17%), remains above the tolerance level of 8%. HR Business Partners 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 implementing service specific retention plans. Sickness absence at 4.23% (+0.13 from 4.10%) 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 88.22% (-2.56% from 90.87%) and is above the Trust target of 85%, all divisions 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.

3.3 Statutory and Mandatory training stands at 90.53% (+0.61% from 89.92%) and is meeting the Trust target of 85%. All divisions across the Trust are meeting the Statutory and Mandatory training target. Approximately 15,000 learning interventions need to occur during 2019/20 for the Trust to be compliant. These interventions occur across e-learning, classroom-based learning and also blended learning opportunities. SMEs provide sufficient capacity to provide face-to-face opportunities to meet the demand.

		MFT			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%	12.2%	▲		14.2%	▼		6.6%	▼		12.1%	▲		13.4%	▲	
Vacancy rate	12.0%	13.0%	▼		9.1%	▲		12.2%	▼		12.2%	▼		15.2%	▲	
Sickness rate (12-month rolling)	4.0%	4.2%	▲		2.5%	▲		6.3%	▲		4.4%	▲		3.9%	▲	
Statutory & Mandatory Training	85.0%	90.5%	▲		96.2%	▼		89.7%	▼		90.9%	▲		89.1%	▲	
Medway Appraisal	85.0%	88.2%	▼		89.0%	▼		89.3%	▼		89.8%	▼		85.7%	▼	
Agency costs (as % of total paybill)	11.0%	2.9%	▲		2.0%	▲		0.5%	▼		1.7%	▲		4.1%	▲	
Bank costs (as % of total paybill)		12.3%	▼		2.8%	▼		12.6%	▼		12.5%	▲		17.0%	▼	
Substantive costs (as % of total paybill)	89.0%	84.8%	▲		95.2%	▲		87.0%	▲		85.9%	▼		78.9%	▲	
Stability Index (12-month rolling, >12M)	85.0%	83.2%	▼													
Leavers citing "Work/Life Balance" 12m rolling	n/a	82.8	▲													

(Table 6: Key Workforce Metrics)

3.4 The table below (table 7) shows the compliance with StatMan on a divisional and care group basis:

Division >> Care Group	Compliance %
Corporate	96.20%
>> Communications	98.77%
>> Finance	96.75%
>> Human Resources & Organisational Development	98.25%
>> IT	98.14%
>> Medical Directorate	95.50%
>> Nursing Directorate	92.61%
>> Strategy, Governance & Performance	99.81%
>> Transformation	93.65%
Estates & Facilities	86.96%
>> Estates & Facilities Management	89.73%
>> Hard Facilities Management	99.15%
>> Soft Facilities Management	96.61%
Planned Care	88.52%
>> Cancer Services	90.93%
>> Perioperative & Critical Care	92.94%
>> Planned Care Infrastructure	91.72%
>> Surgical Services	91.21%
>> Women's & Children's Health	87.26%
Unplanned & Integrated Care	92.16%
>> Diagnostics & Clinical Support Services	89.11%
>> Specialist Medicine	92.16%
>> Therapies & Older Persons	86.40%
>> Unplanned & Integrated Care Management	91.40%
>> Urgent and Emergency Care	91.13%

(Table 7: StatMan compliance profile)

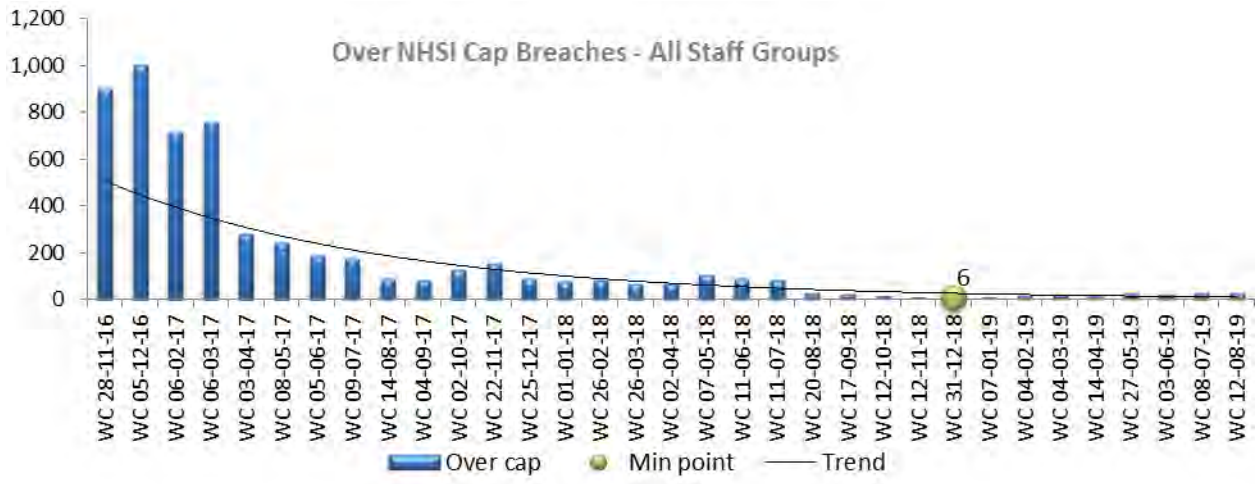
4 Temporary Staffing

4.1 Table 8 below demonstrates that temporary staffing expenditure decreased in September 2019 compared to August 2019.

		Mar 17	Mar 18	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sept 19
Spend	Agency	£3,890,198	£2,597,697	£783,127	£684,291	£497,825	£527,624	£648,395	£373,481	£506,702
	Bank	£920,473	£2,329,768	£2,105,055	£2,267,819	£2,136,062	£1,865,800	£2,011,274	£2,507,089	£2,160,649
	Substantive	£13,611,458	£13,542,990	£16,377,676	£14,152,087	£17,624,270	£19,446,639	£14,520,349	£14,561,728	£14,934,938
% of pay bill	Agency	21%	14%	4%	4%	3%	3%	4%	2%	3%
	Bank	5%	12%	11%	13%	12%	11%	12%	14%	12%
	Substantive	74%	74%	85%	84%	85%	86%	84%	84%	85%

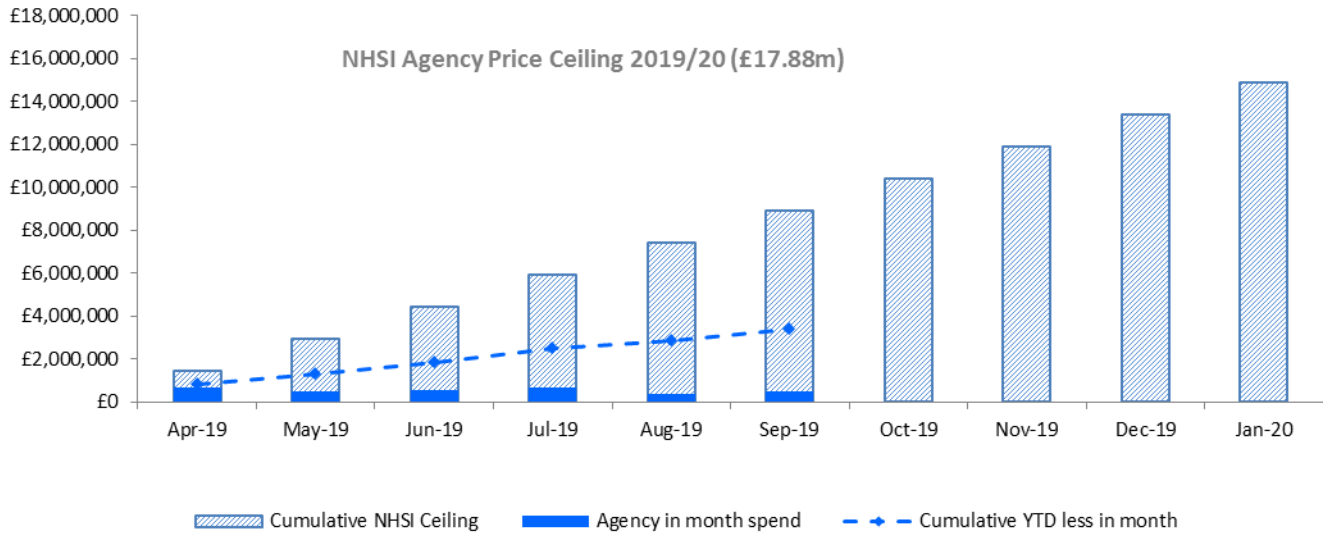
(Table 8: Contractual profile)

4.2 The agency cap breaches across all staff groups have remained stable as illustrated in chart 1 below. During the month of September 2019 the Trust reported an average of 30 breaches per week across the month.



(Chart 1: NHSI cap breaches)

4.3 The Trust's NHSI annual agency spend celling remains the same for 2019/2010 at £17.88m. Based on month 6 agency spend, the Trust is just over £5m below the NHSI agency ceiling cap target as illustrated in the chart and table below.



(Chart 2: NHSI agency ceiling)

4.4 Table 9 below shows NHSI agency ceiling performance:

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sept-19
Cumulative NHSI ceiling target	£1,490,000	£2,980,000	£4,470,000	£5,960,000	£7,450,000	£8,940,000
Agency in month actual spend	£684,291	£497,825	£527,624	£648,359	£373,481	£506,702
Cumulative below ceiling	£805,709	£1,182,116	£2,638,842	£3,601,865	£4,596,966	£5,073,562

(Table 9: NHSI agency ceiling performance)

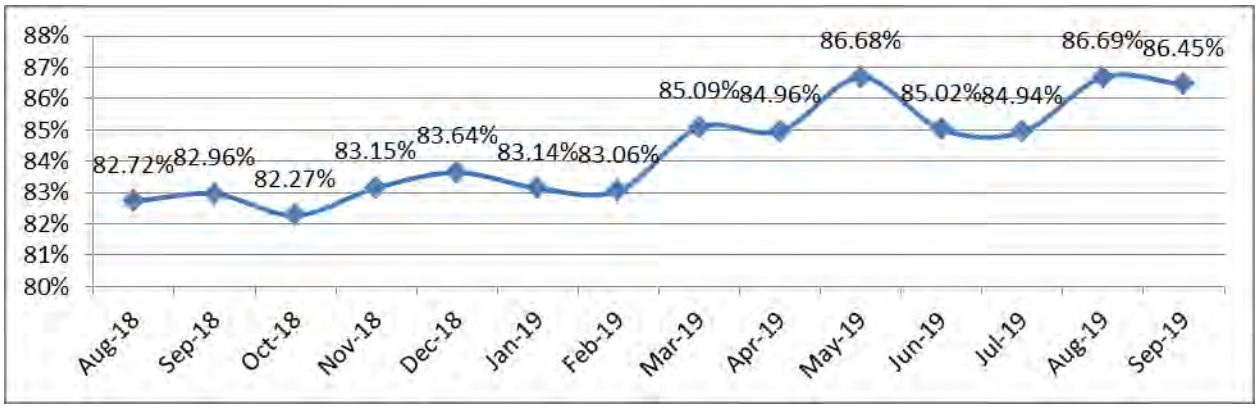
4.5 Temporary nursing demand increased in September 2019 compared to August 2019 (8,537 shift requests in August 2019 compared to 8,147 shift requests in August 2019). The fill rate increased by 2% to 72%. Medical locum demand also increased in September 2019 compared August 2019 (1,278 shift requests in September 2019 compared to 1,371 shift requests in August 2019). The fill rate for medical locum remains stable at 85%.

5 NHSI Nursing Retention

5.1 The following retention initiatives have been implemented this financial year for nursing staff; it is acknowledged that some of these retention initiatives will also be beneficial to other staff groups within the organisation.

1. Practice Development Nurse Support on all ward areas;
2. Staff Support, Recognition and Health and Wellbeing support;
3. Flexible Retirement Options for nursing staff.

5.2 Table 10 below shows nursing and midwifery stability index rate over the last 12 months. Overall, there is a significant and largely sustained and positive direction of registered nursing workforce stability. This will continue to be monitored and reported as part of the programme.



(Table 10: Nursing stability index)

Best Culture

We aim to have a culture of openness and transparency, values that staff live by, and quality-led actions across our entire workforce

6 You are the Difference

6.1 Focus remains on 'You are the Difference' (YatD) cultural change programme following completion of phase 2 which took place from January to May 2019. The cultural engagement team and 'You are the Difference' ambassadors are embedding 'making a difference' into everyday working practices across the Trust. This is being done through the facilitation of further sessions in ward areas and also as part of the corporate induction programme. The total number of ambassadors to date stands at 42.

Table 11 below provides a summary of the number of sessions and attendees of the 'You are the Difference' cultural change programme. Phase 1 which was from September 2018 to December 2018 had a total of 1116 attendees. Phase 2 which commenced in January 2019 and ended in May 2019 saw 288 attendees participate. Sessions continue and to date a total of 1749 members of staff have attended the sessions.

	Phase 1	Phase 2	Ongoing	Total
Number of staff sessions	31	27	17	75
Number of staff attended	831	271	267	1369
Number of Manager sessions	30	9	3	42
Number of Managers attended	285	17	27	329

(Table 11: YatD attendance)

7 Best Place to Work

7.1 On 25 June we launched our Best Place to Work online workshop in conjunction with Health Education England (HEE) and Clever Together. Best Place to Work aims to build on the YATD culture programme by looking in more detail about the experiences of staff at Medway. It attracted just over 700 participants from across the organisation, this equates to approximately 19% of the workforce (profiled as below). In September, the Trust received the key findings that included identification of the issues that mattered most to staff as shown in the diagram below. Findings and actions will be tied into staff survey action plans.

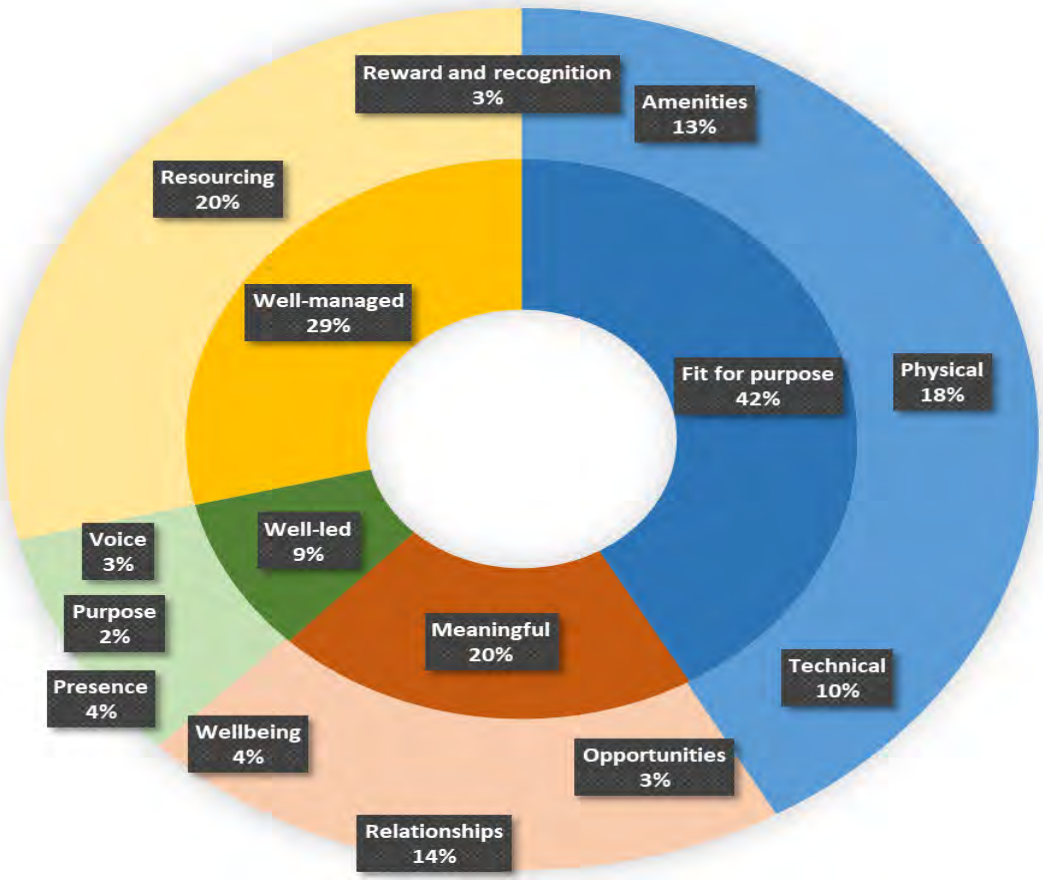
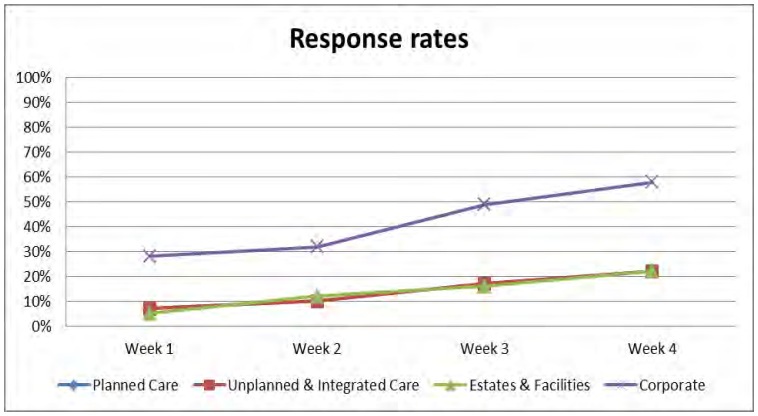


Chart 3 – Key findings from online workshop on issues that matter to staff

8 Staff Survey 2019

8.1 The 2019 national NHS staff survey is now live and the response rate as at end of week 4 (18 October 2019) was at 25%. This is higher than the average response rate for acute trusts that stands at 21% for trusts using Quality Health survey provider. The staff survey window for completion ends on 1 December 2019. Table 12 below shows a breakdown of response rates by Divisions across the Trust. A number of activities to encourage completion are in place including incentives such as iPads being awarded as a prize to the departments with highest completion rates. Senior leaders and line managers across the Trust will provide staff with protected time to complete the survey during the working day. Ongoing reminders including messages on screen savers, weekly bulletins and during key forums including the Chief Executive monthly briefing continue.



9 Apprenticeships update

9.1 The Trust's annual apprenticeship levy is £799,999 with a total of 117 monthly learners (against a target of 101).

9.2 The distribution of apprenticeships across the organisation is 90 clinical apprenticeships and 27 non-clinical. The Trust is currently using the levy to train staff in the following professional categories:

- 9.2.1 Corporate (Chartered Management Degree, Human Resources, Information technology, business administration, accounting) - 27
- 9.2.2 Pharmacy - 5
- 9.2.3 Healthcare Assistant – 36
- 9.2.4 Nursing associate – 10
- 9.2.5 Master's leadership and business administration - 31

9.3 Drop-out rate from the apprenticeship scheme is monitored and managers, providing support to apprentices to meet competing demands. To-date, six apprenticeships have dropped out due to personal reasons/work-life balance.

End.

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Corporate Policy - Serious Incident Investigation and Management	**Agenda Item**	**9.1**
Lead Director	Karen Rule, Executive Director of Nursing		
Report Author	Karen Rule, Executive Director of Nursing		
Executive Summary	The Corporate Serious Incident (SI) Policy is reviewed regularly to ensure it reflects current legal and regulatory requirements. The current policy is due for review October 2019. The corporate SI policy currently meets the requirements of the NHS England (NHSE) SI Framework published in 2015. Over the past 18 months NHSE have undertaken a consultation exercise on a new SI Framework. It was anticipated that a new national SI framework would be published prior to the date of this policy review. Publication of the new framework has been delayed and NHSE have not confirmed a publication date. In the absence of the new framework the corporate policy has been reviewed to ensure it reflects our current organisational structures and provides sufficient clarity in regards to our SI management. Minor changes were required in this review. This report therefore summarises the review and refresh of the corporate SI policy. The Board is requested to approve the policy with a review date of October 2020 in anticipation of publication of the new national SI framework within the next 12 months.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒

Committees or Groups at which the paper has been submitted	Executive Group 16 October 2019			
Resource Implications	None			
Legal Implications/ Regulatory Requirements	No change to existing legal or regulatory requirements.			
Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	The Board is asked to approve the corporate Serious Incident Investigation and Management Policy (SI Policy).			
	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Corporate Policy: Serious Incident Investigation and Management.			

1 Executive Overview

1.1 The Serious Incident Investigation and Management (SI) Policy is one of twelve corporate policies.

1.2 The main purpose of the policy is to facilitate staff understanding of what constitutes a serious incident and assists staff in applying a consistent approach to the management of serious incidents in a timely and open manner.

1.3 The corporate SI policy currently meets the requirements of the NHS England (NHSE) SI Framework published in 2015. It was anticipated that a new national SI framework would be published prior to the date of the Trust policy review. However, publication of the new framework has been delayed. NHSE have not confirmed a publication date.

1.4 This report therefore summarises the review and refresh of the Trust's SI policy.

2 Policy review and changes

2.1 The Trust last published a corporate SI Policy in October 2016. The policy is due for review October 2019.

2.2 In the absence of the new framework the Trust policy has been reviewed to ensure it reflects our current organisational structures and provides sufficient clarity in regards to our SI management. Minor changes were required in this review.

2.2.1 Front cover: Change of Author and Document owner

2.2.2 Throughout document: Change of Directorates to Divisions

2.2.3 Section 4.6: Expansion of definitions section including narrative to support incidents that meet the SI criteria as defined in the national SI framework

2.2.4 Section 7.0: Addition of organisational risk huddle

2.2.5 Section 8.0: Update of staff roles and responsibilities

2.2.6 Section 8.0: Addition of investigation process and timescales

2.2.7 Section 9.1: Update of committee and oversight responsibilities as previous groups no longer exist

2.2.8 Section 14.0: Update and removal of expired documents and links within the references section

3 Next Steps

3.1 The Board is requested to approve the policy with a review date of October 2020. This is in anticipation of publication of the new national SI framework within the next 12 months which will require a further review of the corporate policy.

CORPORATE POLICY - Serious Incident (SI) Investigation and Management Policy

Author:	Quality and Patient Safety Team
Document Owner:	Head of Quality and Patient Safety
Revision No:	6.0
Document ID Number	POLCGR071
Approved By:	
Implementation Date:	October 2019
Date of Next Review:	October 2020

Serious Incident Policy

Document Control / History	
Revision No	**Reason for change**
3.	To incorporate the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation produced by the National Patient Safety Agency 2010
3.1	To incorporate the Human Tissue Authority guidance on reporting and investigating Serious Incidents and Serious Adverse Reactions 2011
4.	Review and update to include Duty of Candour
4.1	Update job titles and SHA & PCT references
5.	Serious Incident Management Process – split into policy and see separate SI procedures and reviewed the NHS Serious Incident framework 2015 and related document published in 2016 as well as the Mazar recommendations.
6.	Policy revised in line with new internal MFT SI process and to strengthen in line with national SI Framework

Consultation
Director of Nursing
Chief Executive Officer
Medical Director
Chair of Quality Improvement Committee
Chair of Patient Safety Committee
Executive Group – 16 October 2019

Serious Incident Policy

Table of Contents

Serious Incident Policy

To be read in conjunction with any policies listed in Trust Associated Documents and Standard Operating Plans (SOP) associated with this policy.

1 Introduction

1.1 Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

1.2 The Trust intends to recognise the potential for harm and undertake timely interventions to minimise the impact of the harm or to reduce the possibility of an incident from the same source occurring in the future, where this is possible. Serious incidents are, therefore, subject to thorough investigation in an attempt to identify what factors contributed to the incident. Serious incidents can be isolated incidents or multiple linked, or unlinked, events.

1.3 Responding appropriately when things go wrong in the care and treatment of patients is a key part of the way that the Trust will continually improve the safety of the services that it provides.

1.4 Patient safety is the responsibility of all staff in Medway Foundation Trust. The Executive Team, Division leaders and ward/ department managers will model the behaviours expected by a fair and just culture and will set clear expectations around multi-disciplinary involvement with the Serious Incident pathway.

1.5 Responding appropriately to incidents or circumstances that have caused or may cause harm to staff, including contracted staff, or visitors is key to the Trust maintaining the safety and wellbeing of staff and visitors.

1.6 An incident reporting, management and investigation process is a prerequisite to the serious incidents process. This process facilitates the recognition, management and investigation of incidents and enables learning and the minimisation of future harm or loss.

1.7 When an incident has caused significant harm or loss to patients and/or staff, the Trust will respond to and investigate these following this policy which is aligned with the national Serious Incident Framework (March 2015).

1.8 This policy identifies the principles of being open and the legal Duty of Candour (see the Trust's Being Open and Duty of Candour Policy and Procedure). The needs of those affected by the incident will be the primary concern of those I involved in the response to the investigation of an incident.

1.9 When things go wrong, it is the responsibility of the organisation to ensure that there is significant learning from each one to prevent recurrences. The Trust will provide resources to ensure that lessons are learned from each incident. Learning programmes are designed in a variety of formats that are best suited to the information to be shared and the audiences involved.

2 Purpose , Aims and Objectives

2.1 This policy is in place to facilitate staff understanding of what constitutes a serious incident, e.g. Information Governance, Mental Health Act or Pressure Ulcer serious incident. This policy will assist staff in applying a consistent approach to the management of serious incidents in a timely and open manner so that immediate action can be taken to protect patients and staff, where necessary.

2.2 This document will focus on the identification and management of these incidents, using root cause analysis methodology and facilitating organisational learning from such incidents. This approach aims to reduce the likelihood of the same incidents occurring again or reduce their impact should they occur. This policy will identify the commitment to learning from each incident in a non-judgemental way, so that their recurrence is minimised and to ensure any changes to systems and processes recommended during the root cause analysis are implemented, mechanisms in place to monitor/implement and any necessary changes are made.

2.3 It will set out mechanisms and processes to ensure effective communication with patients, relatives, staff, media and other agencies is maintained at all times and appropriate information is conveyed. This document will set out the reporting arrangements for a Serious Incident to the Trust Board, lead clinical commissioning group (CCG), NHS England, Monitor, the and Care Quality Commission and other external agencies, where necessary, to meet the requirements of external stakeholders.

2.4 The Trust will ensure the process of investigation is open, fair and just, with the primary focus of any Root Cause Analysis based on the investigation of systems and processes, rather than focussing on an individual who may happen to be at the end of a series of faulty processes.

2.5 The identification of lessons to be learned is of the utmost importance to prevent recurrence of similar incidents. The Trust will support learning activities through the use of Grand Rounds, Schwartz rounds, Division monthly learning activities, quarterly corporate learning events, pop up events and swarm events that are tailored to the learning needs of the audience.

3 Scope

3.1 This policy applies to all permanent, locum, agency, bank and voluntary staff of Medway NHS Foundation Trust.

4 Definitions

4.1 **Incident –** any unexpected or unintended event or circumstance that leads to, or could have led to, harm, loss or damage to people, property or reputation. They may be clinical or non-clinical; e.g. suspected suicide, missing person, fire, theft, violence.

4.2 **Investigation-** A process by which an incident is examined to allow the organisation to consider if actions can be put in place to stop the incident occurring, or reduce the impact, should the incident recur.

4.3 **Patient safety incidents –** any unexpected or unintended event or circumstance that results in, or could result in, harm to a patient.

4.4 **Non-patient safety incidents -** any unexpected or unintended event or circumstance that results in, or could result in, harm to a member of staff (including contractors) or a visitor or loss/damage to the Trust, including financial, asset or reputational loss/damage.

4.5 **Notifiable safety incident** for health service bodies – any *unintended or unexpected incident* that occurred in respect of a patient's care that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in:

- the patient's unexpected death
- **severe harm**:

  a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb, or organ or brain damage, which is directly related to the incident and not to the natural course of the patient's illness or underlying condition.

- **moderate harm**:

  temporary, significant harm which is defined as the lessening of bodily, sensory, motor, physiologic or intellectual functions that is directly related to the incident and not to the natural course of the patient's illness or underlying condition and moderate increase in treatment, such as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in

hospital or as an outpatient, cancelling of treatment or transfer to another treatment area (such as intensive care, HDU).

- **prolonged psychological harm** for a continuous period of least 28 days

Identifying an issue as a notifiable safety incident does not automatically imply error, negligence or poor quality care. It indicates that an unexpected and undesirable clinical outcome that resulted from some aspect of the patient's care, rather than their underlying condition and that Medway Foundation Trust has a responsibility to investigate to identify why the incident occurred and to take active steps to correct any

All notifiable safety incidents trigger the statutory Duty of Candour (please refer to the Being Open and Duty of Candour Policy and Procedure).

4.6 **Serious Incidents requiring immediate reporting upon identification:** Incidents that must be declared as SIs include **(this list is not exhaustive and the SI Framework should inform decision making):**

- Never Events (whether or not there was patient harm)
- Falls to moderate harm, severe harm or death
- Serious Incidents identified through the Stage 2 mortality review committee
- Maternal death within a year of the birth of an infant
- Hospital-acquired pressure ulcers meeting the SI criteria (as defined in the pressure ulcer framework)
- Hospital-acquired MRSA bacteraemia
- Incidents involving patients being held under the Mental Capacity Act/ DOLS or Mental Health Act
- 12 hour trolley breaches where harm has come to a patient

4.7 **Apology -** a sincere expression of regret that forms the foundation of the Duty of Candour and is expected to be applied in every Serious Incident (please see p.15 section 8 of this policy and the Trust Duty of Candour Policy and SOP).

4.8 **Datix -** the electronic incident reporting system used by the Trust. Every incident that is considered to be a potential Serious Incident must have a Datix report.

4.9 **Unexpected death -** The death of a patient following a harm-related incident that is not related to the natural course of their disease**.** Unexpected deaths must be verified and certified by a medical practitioner and reported to the Coroner and would be put on the Trust Datix system.

4.10 **External agencies in which certain types of SI Incidents are reportable (this list is not exhaustive):**

- NHS England
- Medway CCG/ other relevant CCGs
- Care Quality Commission
- Medicines and Healthcare Regulatory Agency (MHRA)
- HM Coroner
- Police
- Serious Hazards of Transfusion (SHOT)
- Human Tissue Authority
- Adult and Children Safeguarding Boards
- Information Commissioners Office
- Healthcare Safety Investigation Branch

4.11 **Near miss/prevented incident –** any incident that had the potential to cause harm but was prevented, resulting in no harm. Not every near miss needs to be reported as a Serious Incident but the potential for severity of harm should be a prime consideration.

4.12 **Never Event -** a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented (see Appendix 6 Never Events). These are automatically declared as Serious Incidents. There does not necessarily have to be patient harm in order for an incident to considered a Never Event. These are considered to be automatically declared Serious Incidents.

4.13 **Open, fair and just culture –** Incident reporting, investigation and learning will not be effective in an organisation that does not respond to incidents using the principles and practices of a Just Culture. Traditionally healthcare's culture has held individuals accountable and culpable for all errors or mishaps that befall patients under their care (often referred to as the 'blame & shame' culture). This 'person centered' approach resulted in investigations that failed to identify effective organisational learning. The outcome of these investigations was to unjustly punish the staff involved but ignore the situation in which the incident occurred. Therefore, incidents were repeated.

4.14 **Root Cause Analysis –** a **systems** approach to investigating an incident to understand how and why it happened and to identify effective actions to prevent the incident from occurring again

4.15 **StEIS (Strategic Executive Information System)** – a Department of Health management information system used to collect information about NHS organisations, including Serious Incidents**.**

4.16 **SWARM:** a multi-disciplinary investigation methodology where involved parties do an intensive review of all available information. To identify contributory factors and to gather evidence to support completion of a draft report.

5 Management of Serious Incidents

5.1 A Serious incident (SI) is an accident or incident when a patient, member of staff or a member of the public suffers serious injury, unexpected or avoidable serious harm or death in hospital or other premises where NHS care is provided. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm which is either permanent (severe) or temporary (moderate) - including those incidents where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

The Trust should not wait for the outcome of a full investigation before reporting potential Serious Incidents to the CCG. As per national framework incidents should be declared to the commissioners within 48 hours of identification. If it subsequently emerges that an incident does not meet the criteria for a Serious Incident, the commissioner should be approached to downgrade the incident and remove it from STEIS.

5.2 Serious incidents may be identified through various routes, including, but not limited to:

- Incidents identified during the provision of healthcare
- complaints
- claims
- whistle blowing
- Serious Case Reviews
- safeguarding children and adults reviews/ enquiries
- prevention of Future Deaths Reports issued by the Coroner

5.3 This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or

other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.

5.4 Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. A full list of incidents meeting the Never Event criteria can be located at Never Events list 2018 (NHS Improvement)

- major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.
- an incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
    - failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
    - property damage;
    - security breach / concern;
    - incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
    - inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS); The Department of Health have updated their guidance on investigations and the application of Article 2 of the European Convention on Human Rights. This should be read in conjunction with the NHS England Serious Incident Framework;
    - the placement of children or young people, under the age of 18 years, on an adult psychiatric ward;
    - unauthorised absences of a person detained, or liable to be detained, under the Mental Health Act 1983 in relation to low, medium or high security levels (applicable to Bowman Ward).
    - significant healthcare associated infections i.e. an outbreak of infection that closes a ward/unit, failure in decontamination or infected healthcare worker.
    - maternity, infant and child incidents as described in the NPSA National Framework for Reporting and Learning from Serious Incidents Requiring Investigation.
    - death of a patient, or a person using the service, who is detained, or liable to be detained, under the Mental Health Act 1983.

- Ionising Radiation incidents
- systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
- activation of Major Incident Plan (by provider, commissioner or relevant agency)

5.5 If staff have concerns about unsafe practice, poor staffing, issues of professional misconduct or institutional neglect, they can report these in the first instance through a line manager, by following the Freedom to Speak Up: Raising Concerns at Work (Whistleblowing) Policy or by seeking advice from the Trust's Safeguarding Team.

5.6 Incidents are graded according to the level of harm or whether they have been identified as a Never Event. Incidents that may be classed as Serious Incidents are those where there has been moderate or severe harm, unexpected death or a Never Event. Definitions of each of these categories are found below and this list is not exhaustive.

6.0 Stage 1 – identification of a Serious Incident

6.1 Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
- Unexpected or avoidable death8 of one or more people.

- This includes suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past

- Unexpected or avoidable injury to one or more people that has resulted in serious harm;

- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:—
- the death of the service user; or
- serious harm;

- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:

- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring10; or where abuse occurred during the provision of NHS-funded care.

- This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information

6.2 Where it is not clear whether or not an incident fulfils the definition of a serious incident, providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response.

6.3 A review of all newly reported Datix incidents should take place daily within the Divisions to identify incidents meeting the SI criteria. Where a possible Serious Incident is identified a rapid review should be completed immediately.

7.0 Organisational response – Safety Risk Huddle

When an incident occurs in a Health Service a series of immediate actions must follow and decisions taken within the first 24 to 48 hours will set the tone and sense of urgency for appropriately responding, investigating and learning from these very serious incidents. This responsiveness will assist and support the organisational safety and learning culture that ensures we are focused on learning and improvement.

Incidents identified of a significant nature and Never Events should prompt a critical review meeting to take place.

The Safety Risk Huddle aims to complete an organisational risk assessment which as a minimum covers the following aspects;

- Immediate organisational risk assessment and actions taken to mitigate risk of reoccurrence
- Care for the patient / family
- Quarantine and isolation of equipment and/or environment as required

- Review care for the care giver – agree debrief arrangements for all staff involved also consideration of staff that may be impacted on as a second victim – consideration of time out form clinical duties in a non-punitive and supportive way
- Consideration of any clinical practice concerns that may trigger additional actions
- Consideration of legal implications and associated actions
- Agree serious incident investigation methodology and approach agreeing and appointing lead investigator using consideration of independence and objectivity
- Agree investigation time lines
- Consideration of any external investigators to participate in the investigation – often dependant on the case
- Notify Communications to prepare a media holding statement
- Identify and coordinate external reporting
- Agree progress reporting to CEO & Executive Team on any matters that arise from the organisational safety risk assessment huddle

7.1 Rapid Review – Section 1: a report containing all known facts of the incident that should be completed by the Division within 24 hours of incident identification. The completed rapid review must be submitted to the Divisional Deputy Director of Nursing, Deputy Medical Director or Division Consultant Clinical Governance Lead for review and sign off. The rationale section must be completed with adequate rationale to justify the decision for further investigation or downgrade of the incident.

Within 48 hours of the incident being reported on Datix the signed rapid review must be submitted to the Central Quality and Patient Safety Team. Where a Serious Incident is declared the rapid review will be submitted to the CCG within 72 hours of the incident being declared on StEIS.

7.2 Stage 2 - Investigation

The lead investigator may be nominated by the Divisional leadership team or by an Executive Lead. The lead investigator must be objective and suitably trained in root cause analysis and the investigation of Serious Incidents.

The investigation must use recognised tools and techniques to identify care/service delivery problems, lapses in care/acts/omissions, identifying contributory factors,

taking into account environmental, system and human factors to enable identification of the fundamental issues/root cause that needs to be addressed.

Serious Incident investigations must endorse the application of the seven key principles:

- Open and Transparent
- Preventative
- Objective
- Timely and responsive
- Systems based
- Proportionate
- Collaborative

It is important to recognise that Serious Incidents can impact on staff members involved and should be supported throughout the investigation process, given opportunity to access support and occupational health services. Staff should be fully briefed on the investigation process.

7.3 Investigation types:

- **High Level Investigation report – Section 2:** an internal investigation of an Incident using the RCA technique for incidents where there are failings in care or significant oppurtunities for learning where the SI criteria has not been met. The timeframe for completion of high level investigations is set by the Executive Tem at 28 calendar days.
- **Serious Incident Concise Investigation report – Section 2**: a comprehensive report on a declared Serious Incident that is presented to the CCG or any other external partner. This report is expected to be completed by the lead investigator within 28 calendar days but the timeframe may be increased at the executive's discretion. The completed investigation report requires Division and executive sign off prior to submission to the CCG/ other external partners; the national timeframe for submission is within 60 working days.
- **Independent Investigations** - may be required where the findings are likely to be challenged or where it will be difficult for the organisation to conduct an objective and independent investigation. Maternity incidents meeting the Healthcare Safety Investigation Branch criteria must be referred for external investigation. Independent investigations must be completed within six months of the incident being declared.

7.4 Investigation approval and closure

Completed investigation reports will be submitted to the Central Quality and Patient Once approved by the Internal SI Panel the Central Quality and Patient Safety Team will submit the investigation report to the Clinical Commissioning Group for review at the external Serious Incident panel. Once the investigation report has been agreed for closure it may be shared with the patient and/or family.

8 (Duties) Roles and Responsibilities

8.1 **The Trust Board will:-**

- Be made aware of Serious Incidents via relevant reports.
- Receive assurance regarding effective incident management and implementation of incident management policies and procedures from relevant Committees
- Be made aware of any particular concerns and issues in relation to trends or peaks in incidents and of the actions the Trust is taking to address these

8.2 **The Chief Executive**

- The Chief Executive has overall responsibility for the system of internal control and for protecting the health, safety and welfare of all who come into contact with the organisation and is ultimately accountable for the implementation of an organisational wide process associated with the investigation, analysis, learning and subsequent implementation of actions arising from incidents, complaints, contacts and claims. The Chief Executive will ensure that robust processes exist in order to implement the requirements of this policy.

8.3 **Executive Leads**

- The Chief Executive, Medical Director, Director of Nursing and other Executive Directors have a collective responsibility to ensure that this policy and procedure is effectively implemented. This includes ensuring that:
  - the required resources are available to facilitate the implementation of this policy,
  - the principles of open, fair and just culture are supported and maintained throughout the life of an incident (from reporting

through to completion of the report and implementation of the action plan)

- Authorise the declaration of Serious Incidents for reporting to the CCG or other appropriate external bodies
- In the event of a serious non-clinical incident or serious Information Governance Incident, the Director for Corporate Governance, Risk, Compliance and Legal will be the lead executive to oversee the investigation

- Ensure there is a robust process in place and followed for monitoring the implementation of action plans arising from incidents causing significant harm and
- The lead executive retains overall responsibility and accountability for the investigation.
- Upon receipt of the final report, the executive is responsible for signing off the report and for ensuring an associated action plan is developed and implemented based on the recommendations contained within the report and mitigate any risks.

8.4 **Division Responsibilities**

- Each Division will ensure that all permanent and temporary staff (including bank, agency and locum staff) receives information during induction on incident reporting and the use of the DATIX web and their responsibilities under the legal Duty of Candour process.
- Each Division will ensure timely reporting and escalation of potential Serious Incidents / Never Events
- The Division Governance and Senior Clinical leaders are required to notify the Executive Director of Nursing, Medical Director, Associate Director for Quality and Patient Safety of any potential Serious Incidents within 24 hours of identification
- The Division Governance Team and Senior Clinical leaders are responsible for ensuring the Investigation of incidents within the required agreed internal timeframe of 28 calendar days.
- Division leads will support the investigation process by ensuring that there is sufficient time and resources to conduct the investigation. Staff involved within a Serious Incident / Never Event are required to attend both MDT meetings and any organised SWARM events and participate in the gathering of crucial information as part of the investigation process as per professional codes of conduct.
- Action plans arising from investigations are the responsibility of the Division Management and each department within each Division is

responsible for implementing changes where appropriate. The Division management team are responsible for ensuring that all actions are implemented and assurance given.

- Division Leads are responsible for ensuring that there is a clear plan for sharing lessons learned from each Serious Incident, in collaboration with the Patient Safety Team.
-

8.5 **Patient Safety Team**

- Coordinate Organisational Safety Risk huddles in the event of a critical Trust incident to be held within 24 hours of identification.
- Patient Safety Team will provide expert advice, support and facilitation throughout the Serious Incident process to provide assurance that the investigations are conducted in line with the principles within the national SI Framework.
- Undertake quality assurance of investigation reports against the national SI Framework and to ensure learning is identified and recommendations are robust to mitigate recurrence.

8.6 **Lead Investigator will:-**

- Conduct a thorough and objective investigation, using the Root Cause Analysis (RCA) methodology. They may call upon any additional resources or personnel e.g. the health and safety advisor, clinical experts, Human Resources, managerial or technical staff may be required to provide specialist advice.
- Hold panel meetings or SWARM events as required and will assist in the taking of statements as necessary.
- Produce a robust report that meets the required standard in line with national framework as directed by the Executive Teams

8.7 **All staff**

- All staff have a responsibility to read and understand this policy.
- All staff have a duty to report any incident, including serious incidents and to take immediate steps to protect individuals, information or the environment.
- All members of Medway NHS Foundation Trust – whether permanent , locum, agency or contractors- whatever occupation or seniority- are required to co-operate with all investigations as requested.

- Staff are entitled to be accompanied by a member of a Trade Union or other staff side representative when giving statements or when being interviewed in the course of an incident investigation.
- Arrangements for staff support following a Serious Incident will be provided by the Division Management Team who may also make a referral to the Occupational Health Team as required.

9 Committee and Oversight Responsibilities

9.1 **Quality Monitoring Group –** a joint meeting between MFT and the CCG to discuss and review Quality and Patient Safety.

9.2 **Internal SI Panel –** quality assures and approves completed investigation reports prior to submission to the External CCG SI Panel, to ensure the reports meet the required standard aligned to the National Framework and Principles for Serious Incident & Investigation Management, ensuring recommendations are robust to mitigate risk of reoccurrence, with Executive oversight and leadership aligned to the overarching Quality Strategy.

9.3 **Patient Safety Group –** meet bi-monthly to discuss themes, trends and learning from Serious Incidents.

10 Duty of Candour

10.1 The Trust recognises the importance of full, open and honest communication in feeding back to patients or their nominated representative. There is a duty to give a genuine apology and an explanation of the facts as they are known at the time of the first discussion.

10.2 The most responsible senior clinician will lead this discussion and invite the patient or their representative to identify any questions that they may have to be answered by the investigation committee. They will be informed of investigation timelines and will be invited to meet to discuss the outcome of the investigations.

10.3 The Duty of Candour Policy and Procedure provide full details.

11 Learning Lessons

11.1 Serious incident investigation reports should identify specific recommendations for improvement. These recommendations are supported by actions for completion by an identified lead within a defined timescale. The Division Management Team is

responsible for following up and reporting on compliance with agreed actions and confirming that embedded learning has been achieved.

11.2 The Trust is committed to ensuring robust investigations are conducted which result in the organisation learning from SIs to minimise the risk of the incident occurring in the future, or to reduce the potential harm, and, as such, expects any actions to result in "embedded learning".

11.3 Embedded learning is defined as a change of behaviour at individual, team or organisational level. If appropriate, the serious incident investigation executive summary, or report, can be shared. The executive summary includes a précis of the incident and investigation and is fully anonymised to preserve confidentiality of the people involved. This will enable the executive summary to be widely shared. Learning can be shared from individual investigations or as an aggregate of similarly themed incidents. Learning programmes can take a variety of forms and the information can be tailored to suit the audience.

12 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	First review in one year and then every three years	Head of Patient Safety	Patient Safety Group, Quality Improvement Group	This policy will be reviewed in conjunction with any legislation changes and Trust objectives A revised Policy will be published via the Trust Intranet System for global access.
Numbers of Serious Incidents by Division by category	SIs will be reported monthly	Head of Patient Safety	Trust Board (monthly), Patient Safety Group and Quality Assurance Group (monthly) and the Quality Improvement Group (bimonthly)	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Trends and Themes reviews	Quarterly thematic reports quarterly	Head of Patient Safety	Trust Board, Patient Safety Group and Quality Assurance Group (monthly) and the Quality Improvement Group	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these
Audit	Yearly	Head of Patient Safety	Patient Safety Group	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these

13 Training and Implementation

13.1 The Trust shall provide training and support to managers and their delegated representatives to enable them to fulfil their responsibilities in the local investigation of incidents.

13.2 The Trust will train Lead Investigators in Root Cause Analysis investigation techniques. Those who have been trained will undertake the investigation of Serious Incidents.

13.3 Over time, a pool of individuals nominated to lead on investigations will be developed. The scope of this training will be :

- Incident reporting procedure and reasons for reporting and investigation
- Principles of investigation and Root Cause Analysis. (National Patient Safety Agency (NPSA) Model and internal model)
- Record keeping
- Identification and implementation or remedial action to prevent recurrence.

- Risk evaluation/Risk grading

14 References

Document	Ref No
References	
NHS England Serious Incidents Framework (March 2015)_ found via website on 08 August 2016: https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2016/03/serious-incdnt-framwrk-faqs-mar16.pdf	Guidance
NHS England Serious Incidents Framework (2016) https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf	Guidance
Cornwall Partnership NHS Foundation Trust Serious Incident Policy 2015	Policy
[3]Marks David, Patient Safety & the 'Just Culture': A Primer for Health Care Executives, 2001	
Reason James Managing the Risks of Organisational Accidents in 1997 (and subsequent work)	
Trust Associated Documents	
Slips, Trips and Falls	POLCGR057
Duty of Candour	POLCGR064
Medicine Management Policy	POLCPCM033
Child Protection Policy and Procedure	POLCPCM027
Significant Incident Plan	OTCOM006
Pressure Ulcer Prevention and Management Policy	POLCNM001
Resuscitation Policy	POLCPCM032
Serious Incident SI - Procedure	SOP0039

END OF DOCUMENT

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Corporate Policy – Duty of Candour	**Agenda Item**	**9.2**
Lead Director	Karen Rule, Executive Director of Nursing		
Report Author	Karen Rule, Executive Director of Nursing		
Executive Summary	The corporate Duty of Candour Policy is reviewed as a minimum every three years to ensure it reflects current legal and regulatory requirements. The current policy is due for review October 2019. The corporate policy meets the current requirements of the Duty of Candour legislation. It sets out the management of Duty of Candour within the Trust in accordance with the regulations. Minor changes were required to the policy at this time. The policy has been reviewed to ensure it reflects our current organisational structures and provides sufficient clarity in regards to special circumstances which are detailed at Section 5. This report therefore summarises the review and refresh of the corporate Duty of Candour policy. The Board is requested to approve the policy with a review date of October 2020.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Committees or Groups at which the paper has been submitted	Executive Group 16 October 2019		
Resource Implications	None		
Legal Implications/	No change to existing legal or regulatory requirements.		

Regulatory Requirements				
Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	The Board is asked to approve the corporate Duty of Candour Policy.			
	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Corporate Policy: Duty of Candour			

1 Executive Overview

1.1 The Duty of Candour Policy is one of twelve corporate policies.

1.2 The Duty of Candour is a statutory (legal) duty to be open and honest with patients (or 'service users'), or their families, when something goes wrong that appears to have caused or could lead to significant harm in the future.

1.3 The main purpose of the Trust policy is to safeguard the quality and consistency of communication when patients are involved in an incident by ensuring that, if they experience harm (moderate, severe or die unexpectedly), patients/patients relatives and/or their carers receive the prompt information they need to enable them to understand what has happened; that an apology is offered; and that patients/patients representative and/or carers are informed of the action the Trust will take to try and ensure that a similar type of incident does not recur.

1.4 This policy acts as a step by step guide to assist staff through the process, it also provides guidance on how to deliver an open and honest response

1.5 The corporate Duty of Candour policy meets the requirements of the current Duty of Candour legislation. However greater clarity is required in regards to special circumstances, such as management of historic incidents identified through mortality reviews or look back reviews. This has been incorporated into the policy at Section 5.

1.6 This report therefore summarises the review and refresh of the corporate Duty of Candour policy.

2 Policy review and changes

2.1 The Trust last published a corporate Duty of Candour Policy in September 2016. The policy is now due for review.

2.2 The policy has been reviewed to ensure it reflects our current organisational structures and provides sufficient clarity in regards to management of historic incidents. Minor changes were required in this review:

- 2.2.1 Front cover: Author and Document owner
- 2.2.2 Section 3: Update of definitions
- 2.2.3 Section 5: Addition of section for special circumstances to provide guidance for staff including historic incidents
- 2.2.4 Sections 6 & 7: Addition of Duty of Candour process and appendix
- 2.2.5 Section 9: Update of monitoring and review section
- 2.2.6 Throughout document: Change of Directorates to Divisions

2.3 The policy review date has been reduced to 12 months. This will enable any changes required to the corporate Serious Incident Policy, following the publication of the new national serious incident framework, to be considered at the same time.

3 Next Steps

3.1 The Board is requested to approve the policy with a review date of October 2020.

3.2 Should changes be made to the Duty of Candour regulations before this date the policy will be reviewed early.

CORPORATE POLICY - Duty of Candour Policy

Author:	Quality and Patient Safety Team
Document Owner:	Head of Quality and Patient Safety
Revision No:	6.0
Document ID Number	POLCGR064
Approved By:	
Implementation Date:	October 2019
Date of Next Review:	October 2020

Duty of Candour Policy

Document Control / History	
Revision No	**Reason for change**
5	Full review of policy and introduction of Duty of Candour SOP
6	Full review of policy including additional guidance

Consultation
Quality Improvement Committee - September 2016
Executive Committee - 21 September 2016
Trust Board – September 2016
Executive Group – 16 October 2019

Duty of Candour Policy

Table of Contents

Duty of Candour Policy

Must be read in conjunction with the Duty of Candour Standard Operating Procedure

Also to be read in conjunction with any policies listed in Trust Associated Documents.

1 Introduction

1.1 Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves apologising and explaining what happened to patients who have been harmed as a result of their healthcare treatment. It ensures that communication is open, honest, and transparent and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers (National Patient Safety Agency, 2009).

1.2 The Duty of Candour process is a legal duty that was introduced in November 2014 (ref: regulation 20 of the health and social care act 2008 (Regulated Activities) Regulations 2014) to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment where they have experienced significant harm.

1.3 A professional duty of candour also applies individually to healthcare professionals, who under GMC/NMC codes of conduct, have a responsibility to apologise and explain the facts to patients/service users when events go wrong, regardless of the severity of the incident.

1.4 The primary concern of Duty of Candour is to ensure that the patient and or their family/carer are told about patient safety incidents that have affected them. That they receive a genuine apology, are kept informed of investigations and are supported to deal with the consequences.

2 Purpose / Aim and Objective

2.1 The policy aims to improve the quality and consistency of communication when patients are involved in an incident by ensuring that, if they experience harm (moderate, severe or die unexpectedly), patients/patients relatives and/or their carers receive the prompt information they need to enable them to understand what has happened; that an apology is offered; and that patients/patients representative and/or carers are informed of the action the Trust will take to try and ensure that a similar type of incident does not recur. This policy, in conjunction with the documents listed in the Associated Documents section also aims to create an environment where patients and/or their carers, healthcare professionals and managers all feel supported when things go wrong.

2.2 A further aim of this policy is to inform staff that an apology is not an admission of liability, it is however a legal expectation of the Duty of Candour.

2.3 This policy acts as a step by step guide to assist staff through the process, it also provides guidance on how to deliver an open and honest response.

2.4 Patient safety incidents can have distressing and emotional consequences for patients, families and carers but can also be distressing for the health care professionals and staff involved. Being open about what happened and discussing patient safety incidents compassionately can help both patients and staff to cope better with the aftereffects of the incident.

3 Definitions

3.1 Notifiable Patient Safety Incident

3.1.1 Regulatory Duty of Candour applies to patient safety incidents that result in moderate or severe harm or unexpected death. It does not apply to low harm, no harm or near miss incidents but this does not negate the requirement to inform the patient if appropriate as part of professional Duty of Candour

Notifiable safety incident means any unintended or unexpected incident that occurred in respect of a service user during the provision of a regulated activity that, in the reasonable opinion of a health care professional, could result in, or appears to have resulted in:

- The death of the service user, where the death relates directly to the incident rather than to the natural course of the service users' illness or underlying condition, or
- Severe harm, moderate harm or prolonged psychological harm to the user
- Serious Incidents / Never Events regardless of level of harm

3.2 Definitions of harm:

3.2.1 Grade and definition of patient safety incident:

No harm
Impact prevented – any patient safety incident that had the potential to cause harm but was prevented, resulting in no harm to people receiving NHS-funded care.
Impact not prevented – any patient safety incident that ran to completion but no harm occurred.

Low harm
Any patient safety incident that required increased observation or minor treatment

and caused minimal harm, to one or more persons receiving NHS-funded care.

Minor treatment is defined as first aid, additional therapy, or additional medication. It does not include any extra stay in hospital or any extra time as an outpatient, or continued treatment over and above the treatment already planned. Nor does it include a return to surgery or re-admission.

Moderate harm
Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care.

Moderate increase in treatment is defined as a return to surgery, an unplanned readmission,a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another area such as intensive care as a result of the incident, including prolonged pain and/or prolonged psychological harm which the service user has or is likely to experience for a continuous period of at least 28 days.

Severe harm
Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
Permanent harm directly related to the incident and not related to the natural course of the patient's illness or underlying condition is defined as permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage.

Death
Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care. *The death must relate to the incident rather than to the natural course of the patient's illness or underlying condition.*

Psychological harm

Duty of candour applies to occasions when a service user has or is likely to experience psychological harm as a result of an incident for a continuous period of at least 28 days.

On occasions psychological harm may not be recognised at the time of the incident or until after the 28 day period. On these occasions a new incident report is required that documents the presence of psychological harm and duty of candour actions are required.

4 Implementation and procedure

4.1 Once a notifiable patient safety incident is reported on Datix this will trigger the duty of candour statutory requirements.

4.2 Where the patient has died, lacks mental capacity or is under 16, and is not competent to make treatment decisions, the notification must be given to a "relevant person", who can be anyone lawfully entitled to act on their behalf. If the relevant person has died and there is nobody who can lawfully act on their behalf, a record of this should be kept.

4.3 If the relevant person does not wish to communicate with the provider, their wishes must be respected and a record of this must be kept.

4.4 Occasionally an incident may not be discovered at the time it happens. A delay in discovering an incident does not mean that duty of candour requirements do not apply. *(Refer to section 5.0 Special Circumstances)*

4.5 Should an incident be identified that meets the duty of candour requirements, but which relates to care delivered by another provider, that provider is responsible for implementing duty of candour. A Datix incident report should be completed, and the Central Quality and Patient Safety Team alerted who will then inform the other provider.

5 Special circumstances

5.1 The approach to Duty of Candour/ Being Open may need to be modified according to the relevant person's personal circumstances.

5.2 On occasions incidents meeting the Duty of Candour threshold may be identified a significant period of time post the event, on these occasions there should be a decision made on a case by case basis. There will need to be a thorough review of all patient records, previous documentation and previous communications with the patient/next of kin/family/carer to aid with decision making, including whether or not completing Duty of Candour would cause further harm.

5.3 Decision making on a case by case basis will be made by the Senior Divisional Leadership team who will be required to seek approval with the decision from a member of the Executive Team. A formal decision must be documented by the Division within the patient records and reflected on the incident report form. Although these incidents may be identified a significant period of time after the event the 10 working day timeframe still applies from the date the incident was discovered.

When Patient/Service User Dies

5.4 When a patient safety incident has resulted in a death it is crucial that communication is sensitive, empathic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened. The relevant person's family and/or carers will probably need information on the processes that will be followed to identify the cause(s) of death. They will also need emotional support. Establishing open channels of communication may also allow the family and/or carers to indicate if they need bereavement counselling or assistance at any stage.

Usually, the Duty of Candour/Being Open discussion and any investigation occur before the coroner's inquest. But in certain circumstances the healthcare organisation may consider it appropriate to wait for the coroner's inquest before holding the Duty of Candour/Being Open discussion with the relevant person's family and/or carers. The coroner's report on post-mortem findings is a key source of information that will help to complete the picture of events leading up to the relevant person's death. In any event an apology should be issued as soon as possible after the relevant person's death, together with an explanation that the coroner's process has been initiated and a realistic timeframe of when the family and/or carers will be provided with more information.

Children

5.5 The legal age of maturity for giving consent to treatment is 16. It is the age at which a young person acquires the full rights to make decisions about their own treatment and their right to confidentiality becomes vested in them rather than their parents or guardians. However, it is still considered good practice to encourage competent children to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. To do this a Fraser competence assessment will need to be undertaken. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the Duty of Candour/Being Open process after a patient safety incident. The opportunity for parents to be involved should still be provided unless the child expresses a wish for them not to be present.

Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents alone or in the presence of the child. In these instances the parents' views on the issue should be sought. More information can be found on the Department of Health's website: www.dh.gov.uk

When a child is referred to Children's Services by Trust staff when there are child protection concerns, sometimes parents/children complain about this or refuse to

give consent for the referral to be made. A child is afforded protection under the Children Act 1989 until they are 18 years of age. The Children Act 2004 now places a duty on staff to respond appropriately in order to safeguard children. Where there is reason to believe a child may be suffering, or is likely to suffer significant harm, a referral will be made to Children's Services. In most cases consent will be obtained from the parent/young person prior to referral. If consent is refused and the professional still believes the child to be at risk, the referral will be made without consent where it is deemed in the best interests of and in order to protect the child.

Patient/Service User with Mental Health Issues

5.6 Duty of Candour/Being Open for patients/service user with mental health issues should follow normal procedures, unless the relevant person also has cognitive impairment (see below). The only circumstances in which it is appropriate to withhold patient safety incident information from a mentally ill patient is when advised to do so by a consultant psychiatrist who feels it would cause adverse psychological harm to the relevant person. However, such circumstances are rare and a second opinion (by another consultant psychiatrist) would be needed to justify withholding information from the relevant person. Apart from in exceptional circumstances, it is never appropriate to discuss patient safety incident information with a carer or relative without the express permission of the relevant person. To do so is an infringement of the relevant person's human rights.

Patients/Service User with Cognitive Impairment

5.7 Some individuals have conditions that limit their ability to understand what is happening to them. They may have authorised a person to act on their behalf by an enduring power of attorney. In these cases steps must be taken to ensure this extends to decision making and to the medical care and treatment of the patient. The Duty of Candour/Being Open discussion would be held with the holder of the power of attorney. Where there is no such person the clinicians may act in the relevant person's best interest in deciding who the appropriate person is to discuss incident information with, regarding the welfare of the relevant person as a whole and not simply their medical interests. However, the relevant person with a cognitive impairment should, where possible, be involved directly in communications about what has happened. An advocate with appropriate skills should be available to the patient to assist in the communication process.

Patients/Service User with Learning Disabilities

5.8 Where a relevant person has difficulties in expressing their opinion verbally, an assessment should be made about whether they are also cognitively impaired (see above). If the relevant person is not cognitively impaired they should be supported in the Duty of Candour/Being Open process by alternative communication methods (i.e., given the opportunity to write questions down). An advocate, agreed on in consultation with the relevant person, should be appointed. Appropriate advocates

may include carers, family or friends of the patient. The advocate should assist the patient during the Duty of Candour/Being Open process, focusing on ensuring that the patient's views are considered and discussed.

Patients/service User who do not Agree with the Information Provided

5.9 Sometimes, despite the best efforts of care staff or others, the relationship between the relevant person and/or their carers and the care professional breaks down. They may not accept the information provided or may not wish to participate in the Duty of Candour/Being Open process. In this case the following strategies may assist:

- Deal with the issue as soon as it emerges.
- Where the relevant person agrees, ensure their carers are involved in discussions from the beginning.
- Ensure the relevant person has access to support services.
- Where the senior professional is not aware of the relationship difficulties, provide mechanisms for communicating information, such as the relevant person expressing their concerns to other members of the team.
- Offer the relevant person and/or their carers another contact person with whom they may feel more comfortable. This could be another member of the team or the individual with overall responsibility for risk management.
- Use a mutually acceptable mediator to help identify the issues between the organisation and the relevant person, and to look for a mutually agreeable solution.
- Ensure the relevant person and/or their carers are fully aware of the formal complaints procedures.
- Write a comprehensive list of the points that the relevant person and/or their carer disagrees with and reassure them you will follow up these issues.

Patient/Service User with a Different Language or Cultural Considerations

The need for translation and advocacy services, and consideration of special cultural needs (such as for patients/service user from cultures that make it difficult for a woman to talk to a male about intimate issues), must be taken into account when planning to discuss patient safety incident information. It would be worthwhile to obtain advice from an advocate or translator before the meeting on the most sensitive way to discuss the information. Avoid using 'unofficial translators' and/or the relevant person's family or friends as they may distort information by editing what is communicated.

With Different Communication Needs

A number of patients/service users will have particular communication difficulties, such as a hearing impairment. Plans for the meeting should fully consider these needs.

Knowing how to enable or enhance communications with a patient is essential to facilitating an effective Duty of Candour/Being Open process, focusing on the needs of individuals and their families and being personally thoughtful and respectful.

6 Duty of Candour process

6.1 Within 10 working days of the incident:

- An initial verbal apology should be made by an appropriate manager from within the service where the incident occurred, delivered in person, providing all facts known at the time and explaining what actions are being taken and next steps.

- The decision about who is most appropriate to provide the notification and/or apology will take into account seniority, their relationship to the service user and their experience and expertise in the type of notifiable incident that has occurred.

- The verbal apology should be followed by written notification (letter)

- Evidence that an apology has been made in line with duty of candour requirements should be recorded in the appropriate section on the Datix incident report.

- Support should be provided to the patient, their families or carers after the incident, throughout the investigation and on-going as required including providing the patient or their family with the contact details of an identified person who will coordinate communication and be a single point of contact.

- Commence an investigation into the incident.

- The patient/family should be informed if the incident meets the criteria and is being investigated as a serious incident. Whilst duty of candour requirements apply to Serious incidents, timescales for investigation may vary and the patient /family should be informed of expectations and that investigation may take up to 60 days.

6.2 Within 5 working days of the investigation report being closed by the CCG:

- Final reports must be reviewed and approved for release and suitably redacted if required.
- Approved, final reports must be shared with the patient/relevant person and a copy
- made available in a manner of their choosing, for example email or printed copy. Example letter templates are provided.

- The patient/ relevant person must be provided with an opportunity to discuss the findings.
- The service must commence actions to implement recommendations identified through the investigation.

6.3 Documenting all communication

Throughout the Duty of Candour process it is important to maintain clearly documented records of:

- Dates when Duty of Candour discussions took place with the patient/family/ carers
- Dates of attempts and methods made to contact the patient/family/carers
- Time, place, date and names of who attended relevant meetings/ discussions
- Plan for providing further information and key contact for this
- Questions raised by the patient/ family/ carer to be addressed within the investigation
- Plans for follow up meetings and sharing of investigation findings
- Progress notes and accurate summary of all the points explained to the patient/ family/ carers
- Copies of letters sent to the patient/ family/ carers
- Evidence of completion of Duty of Candour and notes of meetings must be stored within the Datix incident report.

7 Appendix 1 – Duty of Candour process

Does Statutory Duty of Candour need to be applied?

Is this a Patient / Notifiable Safety incident?
Defined as any incident that is unintended, or unexpected, which could have, or did lead to harm for one or more patients receiving NHS care.

No → Statutory Duty of Candour **Not applicable**

Yes

What was the level of harm caused? i.e. the severity of the incident, harm caused by an act or omission that could result, in or appears to have resulted in either:
Death
Serious harm
Moderate Harm OR
Prolonged Psychological Harm*

Yes

Statutory Duty of Candour is applicable.

The DOC question set on Datix must be completed to demonstrate that the following actions have been carried out and we are compliant against the regulation.
1. A verbal apology and explanation provided to the service user/NOK **within 10 working days** of the incident being reported onto Datix, ideally face to face.
2. A written summary which is sent/given to the service user/ NOK which reiterates what was said in person i.e. an apology and explanation which may include details of an investigation, meetings etc. A copy of which must either be uploaded onto Datix.
3. The service user/ NOK must receive a copy of the final investigation report within 5 working days of the report being signed off.

If any of the above is declined or you are unable to make contact, this must be recorded on Datix.

- Compliance against this regulation is checked weekly. Non- compliance is reported monthly.
- If finally approving incidents ensure the severity rating is correct before closing off.

Yes

What was the level of harm caused?
I.e. the severity of the incident, harm caused by an act or omission that could result, in or appears to have resulted in, either:

- **Minor Harm***
- **No Harm ***
- **Near Miss***

**Minor harm, no harm and near miss incidents declared as Serious Incidents meet the criteria of a notifiable safety incident and Duty of Candour must be applied.*

No

Statutory Duty of Candour Not applicable
(if severity rating is correct)

- However ALL healthcare professionals also have a professional duty to be open and honest with patients regardless as to the level of harm caused following an incident and this includes near misses.

8 (Duties) Roles & Responsibilities

This policy is aimed at all healthcare staff. The following responsibilities and accountabilities have been identified and confirmed.

8.1 Trust Board and Executive Team

The Trust Board and the wider Executive Team is responsible for:

8.1.1 Responsible for setting the strategic direction for the organisation, including for the implementation of the Duty of Candour.

8.1.2 Actively championing the "Being Open and Duty of Candour" process by demonstrating commitment to openness, honesty and transparency in all aspects of patient care and fostering a learning, supportive, fair and just safety culture.

8.1.3 Ensuring that recommendations and actions identified from patient safety incidents are implemented and their effectiveness reviewed.

8.2 Medical Director and Director of Nursing

They are responsible for:

8.2.1 Conveying to medical, nursing and other health care professionals the importance of complying with both the regulatory and professional duty of candour; and

8.2.2 Raising awareness of the process, ensuring that the requirements for sharing information under both the Duty of Candour and Open & Transparent processes are met.

8.3 Associate Director of Quality and Patient Safety

The Associate Director of Quality and Patient Safety is responsible for:

8.3.1 Oversight of the effective systems and processes to ensure that there is timely notification and communication to patients or their representatives.

8.3.2 Work closely with the Medical Director and Director of Nursing to ensure regulatory compliance of the Duty of Candour is met.

8.3.3 Providing advice to health professionals and managers on meeting the Duty of Candour.

8.4 Quality and Patient Safety Team

8.4.1 Facilitate the implementation of the Duty of Candour systems and processes by working with the Division staff.

8.4.2 Measure organisational compliance with regulatory Duty of Candour

8.4.3 Providing training or arranging for training to be provided on the Duty of Candour.

8.4.4 Ensuring that the Being Open and Duty of Candour Policy and the Duty of Candour Guidance is kept up to date to comply with current regulation and recognised best practice

8.5 Directors of Operations, Divisional Directors of Nursing and Divisional Medical Directors

The Divisional management team is responsible for:

8.5.1 Ensuring that health professionals within their directorates comply with both the regulatory and professional duty of candour by following this policy.

8.5.2 Liaising with the Patient Safety Team regarding compliance with this policy.

8.5.3 Be responsible for implementing training sessions within their directorates and raising awareness of the Duty of Candour with their relevant staff

8.6 Divisional Governance Managers:

Divisional Governance Managers are responsible for:

8.6.1 The coordination of communication with patients and patient representatives for Duty of Candour in relation to incoming complaints and incidents.

8.6.2 Ensuring that a corresponding entry and documentation is made on the Incidents module of Datix and that the responsible senior clinician initiates the Duty of Candour procedure.

8.6.3 Ensure that relevant staff are attending Duty of Candour training sessions.

8.7 General Managers, Heads of Nursing and Clinical Directors

The Care Programme management team is responsible for:

8.7.1 Ensuring the principles of being open and the Duty of Candour are followed in their service

8.7.2 Making the initial disclosure of harm as soon as possible after the incident (usually within 48 hours of the incident and definitely no longer than 10 working days after the incident being reported onto Datix).

8.7.3 Apologising to the patient/family/carer, giving an initial explanation of the incident which is known at that point.

8.7.4 Signposting the patient/family/carer to appropriate support.

8.7.5 Discussing the investigation process with the patient/family/carer and asking if they have any concerns regarding the investigation and conveying these concerns to the investigator(s) if not present.

8.7.6 Agreeing an ongoing point of contact with the patient/family/carer

8.7.7 The Duty of Candour letters must be completed by the directorate Governance Manager/lead supported by the senior clinician involved in the patients care within 48 hours of the incident and filed in the patient's notes; they must also be attached to the relevant Datix report to evidence compliance. The first letter is completed after the verbal meeting. The second letter is completed following the meeting where the investigation results are discussed.

- Letter one is to inform the patient/patient representative of the incident and to apologise and inform them that an investigation will be taking place, providing them with a key contact and opportunity to raise questions to be including within the investigation
- Letter two is to provider a further apology and inform the patient/patient representative of the findings from the investigation and how lessons will be learnt

8.7.8 Ensuring all staff involved in an incident, including non-clinical staff, staff from other teams and locum staff are debriefed and signposted to further sources of support if required for example counselling.

8.8 All staff

8.8.1 All cases of moderate harm, severe harm, death or prolonged psychological trauma (at least 28 days) must be promptly escalated to the senior clinician present at that time, for initiation of the Duty of Candour procedure.

8.8.2 Every member of staff has a duty to ensure all patient safety incidents are promptly reported using the Trust incident reporting system (Datix).

8.8.3 To report notifiable safety incidents using the trust Datix electronic incident reporting system and complete the duty of candour question set

8.8.4 All staff should be sensitive to peers involved in an incident and provide a supportive environment.

9 Monitoring and Review

What will be monitored	How/Method	Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Ensure the Trust complies with the Duty of Candour Policy following all incidents of moderate harm and more severe incidents.	Audit of Datix records for evidence of completion of Duty of Candour	Monthly	Quality and Patient Safety Team	IQPR / PRM	Where gaps are recognised actions plans will be put into place to improve compliance
Ensure the Trust complies with Regulation 20 Duty of Candour and the Professional Duty of Candour.	Compliance report as part of wider monitoring report.	Monthly	Head of Quality and Patient Safety	IQPR / PRM	Where gaps are recognised actions plans will be put into place to improve compliance
That the Being Open and Duty of Candour Policy and SOP continue to meet regulatory requirements and best practice.	Keep abreast of regulatory changes and best practice from CQC guidance	On-going	Head of Quality and Patient Safety		The policy will be updated when there is a requirement to do so following regulatory and/or best practice changes.

10 Training and Implementation

10.1 E-learning package directing staff through the principles and concept of Duty of Candour and Being Open.

10.2 Directorate Governance Managers will be responsible for implementing training sessions within their directorates and raising awareness of the Duty of Candour with their relevant staff.

11 Equality Impact Assessment Statement & Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide “evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]”; in effect to undertake equality impact assessments on all procedural documents and practices. Authors should use the Equality Impact Toolkit to assess the impact of the document.

In the first instance this will mean screening the document and, where the screening indicates, completing a full assessment. The Toolkit can be found on the Trust website http://www.medway.nhs.uk/our-foundation-trust/publications/equality-and-diversity/equality-impact-assessments/

A document will not be considered approved until the author has confirmed that the screening process has been carried out and where required a full impact assessment has been completed. Where a full assessment is completed this should be submitted along with the document for approval.

12 References

Document	Ref No
References:	
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	Regulation 20
Care Quality Commission: Regulation 20: Duty of candour Information for all providers: NHS bodies, adult social care, primary medical and dental care, and independent healthcare	March 2015
CQC Provider Handbook: NHS and independent acute hospitals (KLOE)	S2 Prompt 1 W3 Prompt 9
Joint Statement from the Chief Executives of statutory regulators of healthcare professionals – Openness and honesty – the professional duty of candour	http://www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf
2014/15 NHS Standard Contract: Service Conditions	http://www.england.nhs.uk/nhs-standard-contract/
NPSA: Being Open Framework (2009)	http://www.nrls.npsa.nhs.uk/resources/collections/being-open/?entryid45=83726
Trust Associated Documents:	
Duty of Candour Guidance	GUCGR021
Risk Management Policy	POLCGR065
Maternity Risk Management Strategy	STRCGR006
Risk Management Standing Operating Procedure	SOP0064
Serious Incident Policy	POLCGR071
PALS & Advocacy Policy	POLCPCM018
Complaints Policy	POLCGR005
Respect Countering Bullying in the Workplace Policy	POLCHR002

END OF DOCUMENT

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Corporate Policy - Information Governance Framework	**Agenda Item**	**9.3**
Lead Director	Morfydd Williams, Executive Director of IT Transformation		
Report Author	Rachel Adams, Interim Information Governance Manager and Acting Data Protection Officer		
Executive Summary	All NHS organisations are required to evidence how Information Governance is managed in there organisation. This policy shows how it is managed at Medway. The format to this framework is similar to previous years however the supporting policies, procedures and guidance is in line with the General Data Protection Regulations (GDPR), Data Protection Act 2019(DPA 2018) and the National Data Guardian Review (NDG review)		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Committees or Groups at which the paper has been submitted	Information Governance Group 30 September 2019 and the Executive group 16th October 2019		
Resource Implications	This policy does not require additional resources.		
Legal Implications/Regulatory Requirements	This is required to the Data Security and protection toolkit. Failure to comply with the GDPR could lead to fines of up to 20 million years.		
Quality Impact Assessment	Quality impact assessment not required for this policy.		
Recommendation/ Actions required	The Board is asked to approve the Corporate Information Governance Framework		

	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Appendix 1 – Corporate Information Governance framework			

Medway NHS Foundation Trust
Corporate Policy: Information Governance and Framework

Author:	Rachel Adams, Interim Information Governance Manager and Acting Data Protection Officer (DPO)
Document Owner	Morfydd Williams, Director of IT Transformation
Revision No:	4
Document ID Number	POLCGR129
Approved By:	Executive Group
Implementation Date:	November 2019
Date of Next Review:	November 2020

Medway NHS Foundation Trust
Information Governance Policy

Document Control / History	
Revision No	**Reason for change**
1	New document combined Information Governance Framework, Policy and Strategy
2	Annual review 2017
3	Annual review 2018, inclusion of GDPR, revision from IG toolkit to DSP toolkit
4	Annual review 2019, removal of IG Strategy, and change of owners, inclusion of well lead CQC requirements

Consultation
SIRO
Executive Group
Information Governance group September 2019

Medway NHS Foundation Trust
Information Governance Policy

Table of Contents

Medway NHS Foundation Trust
Information Governance Policy

To be read in conjunction with any policies listed in Trust Associated Documents.

1 Introduction

1.1 Information Governance (IG) is, at its simplest, a framework that draws together statutory, mandatory and best practice standards about the management of information - whether personal (patient or staff) or corporate. Good quality information is at the heart of decisions made by staff, not only in terms of patient care but also in the management of the organisation and maintaining public confidence in the services that the Trust provides.

1.2 The Trust is required to evidence its compliance with these standards through the Data Security & Protection (DSPT), which sets a route map for self-assessment and improvement against set criteria year on year in addition to performance against data security.

1.3 As Information Governance is also now part of the Well-led stream of the CQC the Trust must also provide assurances that on-going audits of best practise are being adhered to.

2 Purpose / Aim and Objective

2.1 **Information Governance Framework and Policy Statement**

Medway NHS Foundation Trust has defined governance structures laid out in the IG framework. These set the governance, accountability and responsibilities for ensuring it maintains and improves standards of IG compliance aligned to an IG strategy that evidentially supports the DSPT requirements.

2.2 The Policy framework ensures that key compliance areas provide the Senior Information Risk Owner (SIRO) with timely, reliable and fit for purpose information to meet reporting requirements, to support legislative and regulatory compliance and to assist in management decision making. Trust managers will provide commitment and leadership in respect of IG and ensuring information is accurate, robust and timely.

2.3 Assurances will be provided to the Trust Board through reports from the Information Governance team and DPO (Data Protection Officer) - these reports will promote openness and transparency in how the Trust is progressing against the DSPT requirements, and highlight key areas of risk and non-compliance.

2.4 The Trust aims to 'Be the BEST' in everything it sets out to, and this extends to embedding IG at the heart of how it protects, manages and uses patient, staff and corporate information.

2.5 Ensure that we are able to evidence to the CQC that the Trust is well led in Information governance and we can evidence that we meet best practise principles in relation to::

- Availability: Data must be available when and where it is needed. It must be made accessible swiftly and securely for staff as well as within and between organisations
- Integrity: The data must be valid and trustworthy, relevant, up to date, and protected from loss, damage, and unauthorised alteration.
- Confidentiality: Personal identifiable data must be handled and used

3 Policy Framework

3.1 **Medway NHS Foundation Trust** is committed to complying with statutory, mandatory and best practice requirements through a supporting framework of documents:

Information Security Policy POLCGR018 - Information Security Policy The Trust's Information Security policy is a high level document that utilises a number of controls to protect the organisation's information. The controls are delivered through policies, standards, processes, procedures, supported by tools and user training.
USB, Removable Media and Media Destruction Policy POLCGR086 - USB, Removable media and Media Destruction Policy This policy supports the Information Security Policy to ensure that strict procedures are followed to prevent patient and staff personal data is not compromised, lost or stolen through the use of removable media.
Records Management & Lifecycle Policy STRCGR002 - Records Management & Lifecycle Policy The Trust's records are its corporate memory, providing, evidence of actions and decisions, and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver services in consistent and equitable ways. This document governs the cycle of records from their collection to disposal.

Data Protection Policy POLCGR007 - Data Protection Policy This policy provides a framework for the Trust to ensure compliance with its confidentiality obligations, and in particular the General Data Protection Regulation (GDPR) and the Data Protection 2018. The Trust, as a Data Controller, has a legal obligation to comply with all appropriate legislation with regard to the processing of personal data. It also should comply with guidance issued by the Department of Health, NHS England, other advisory groups to the NHS, and guidance issued by professional bodies. This includes the Trusts responsibilities for completing Data Privacy Impact assessments when we are using new systems or using patients or staff information in a different way SOP0363-Conducting a DPIA
Freedom of Information Policy POLCGR009 - Freedom of Information Act 2000 Policy This policy provides a framework for the Trust to ensure compliance with the FOIA, Re-use of Public Sector Information Regulations 2005 and the Environmental Information Regulations 2004
Use of Cameras, video and audio recorders on Trust premises GUCGR023 - Use of cameras video and audio recorders on Trust premises Policy and Procedure This guidance ensures that patient images remain confidential and for the purposes of helping with the assessment and evaluation of a patient's condition through the use of clinical photography; and service users and patients do not make recordings (covert or otherwise) of other patients, or staff engaged in clinical interventions with patients.
Secure Transfer of Information Policy POLCGR077 - Secure Transfer of Information Policy This policy governs the transfer of patient identifiable or staff identifiable information. Its aim is to ensure such transfers meet Caldicott principles in preventing information becoming lost in transit, erroneously sent to the wrong person or sent to the correct destination but in an insecure manner.
Acceptable Use of Trust Information Systems and Assets POLCGR113 - Acceptable Use of Trust Information Systems and Asset Policy The aim of this policy is to ensure the proper use of the Trust's NHS information systems and assets and make users aware of what the Trust deems to be acceptable and unacceptable use of these.
Data Assurance Policy POLCOM037 - Data Quality Policy This policy describes why Data Quality and assurance is important to the Trust; where responsibilities for maintaining and improving Data Quality lie; the means by which its continual improvement will be effected; and the processes which will ensure that the Board can be assured over the effectiveness of the systems,

processes and controls over reported performance information.
Network Security Policy POLCGR082 - Network Security Policy This policy sets out the goals of protecting systems from misuse and keeping them available to users. It aims to ensure the confidentiality, integrity and availability of the Trust's information assets.
Registration Authority (RA) Policy POLCGR093 - Registration Authority This policy applies to all processes, procedures and activities carried out by the RA in relation to Trust systems which require Smartcard

4 Roles and Responsibilities

4.1 Trust Board

4.1.1 The Trust Board is ultimately responsible for ensuring that the Trust corporately meets its legal responsibilities and for the adoption of internal and external governance requirements.

4.1.2 The Trust Board is responsible for approving the Trust's Corporate Policy for information governance.

4.1.3 The Trust Board is responsible for reviewing reports from the SIRO, Data Protection Officer (DPO) and Caldicott Guardian to the Board on information governance arrangements.

4.1.4 The Trust Board is responsible for understanding the statutory framework and assuring itself on the adequacy of the Trust arrangements for meeting requirements.

4.2 Chief Executive

4.2.1 The Chief Executive has overall responsibility for ensuring that sufficient resources are provided to support information governance requirements.

4.3 Caldicott Guardian

4.3.1 The Medical Director is the Trust's Caldicott Guardian who is responsible for ensuring that MFT satisfies the highest practical standards for handling patient identifiable information. The role encompasses:

- acting as the 'conscience' of MFT;
- facilitating and enabling information sharing and advising on options for lawful and ethical processing of information;
- representing and championing Information Governance requirements and issues at Board level;

- receiving training as necessary to ensure they remain effective in their role as the Caldicott Guardian;
- ensuring that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff; and
- overseeing all arrangements, protocols and procedures where confidential patient information may be shared with external bodies both within, and outside, the NHS.

4.4 Director of IT transformation and Senior Information Risk owner (SIRO)

4.4.1 Is the designated Director for Information Governance with responsibility for ensuring that the Trust has plans and policies in place to fulfil the requirements of the statutory framework;

4.4.2 Is the Chair of the Information Governance Group, ensuring upward reporting to the Executive Group;

4.4.3 acts as champion for information risk on the Board and provides written advice to the Accounting Officer on the content of the Organisation's Annual Governance Statement in regard to information risk;

4.4.4 understands how the strategic business goals of MFT and how other NHS organisations' business goals may be impacted by information risks, and how those risks may be managed;

4.4.5 implements and leads the NHS Information Governance risk assessment and management processes within MFT;

4.4.6 advises the Board on the effectiveness of information risk management across MFT; and

4.4.7 Is the Trust Senior Information Risk Owner (SIRO) with responsibility for fulfilling the requirements of the role.

4.5 Director of IT Transformation

4.5.1 The formulation and implementation of ICT related policies and the creation of supporting procedures, and ensuring these are embedded within the service developing, implementing and managing robust ICT security arrangements in line with best industry practice;

4.5.2 Effective management and security of Trust

- resources, for example, infrastructure and equipment;
- Developing and implementing a robust IT Disaster Recovery Plan;

- Ensuring that ICT security levels required by NHS Statement of Compliance are met;
    - Ensuring the maintenance of all firewalls and secure access servers are in place at all times, and;
    - Ensuring the provision of Information Asset Owners for the ICT infrastructure with specific accountability for computer and telephone equipment and services that are operated by corporate and clinical work force, e.g. personal computers, laptops, personal digital assistants and related computing devices, held as a NHS asset.

4.6 Chief Operating Officer for Care Groups (Planned and Unplanned)

4.6.1 The Chief Operating Officer (Planned Care) is responsible for the management and delivery of the function of health records management in accordance with information governance policies.

4.6.2 Ensure staff within their areas are following Trust policies and guidance and are operating there services in a safe and effective way when it comes to Information Governance.

4.7 Information Governance Group

4.7.1 This Group is established on the authority of the Executive Group to assist the Trust Board in fulfilling its responsibilities in relation to information governance. Its purpose is to monitor and co-ordinate implementation of the Information Governance Policy and the DSPT - requirements and other information related legal obligations. Terms of Reference setting out the full responsibilities of the Group are available here.

4.8 Information Asset Owners (IAO), who will:

4.8.1 lead and foster a culture that values, protects and uses information for the success of MFT;

4.8.2 know what information comprises or is associated with the asset, and understands the nature and justification of information flows to and from the asset;

4.8.3 receive training as necessary to ensure they remain effective in their role as an Information Asset Owner;

4.8.4 know who has access to the asset, whether system or information, and why, and ensures access is monitored and compliant with policy; and

4.8.5 understand and address risks to the asset, and provide assurance to the SIRO.

4.9 **The Information Governance Manager, who will:**

4.9.1 maintain an awareness of Information Governance issues within MFT

4.9.2 act as the operational lead for delivery of the Information Governance agenda;

4.9.3 Manage the information governance team;

4.9.4 review and update the suite of Information Governance policies, strategies, framework and guidance in line with local and national requirements;

- review and audit all procedures relating to this policy where appropriate on an ad-hoc basis; and
- ensure that staff are aware of the requirements of the policy.
- Providing expert advice and guidance to all staff on all elements of Information Governance.
- Developing internal Information Governance policies and procedures to meet NHS information governance guidance and legislation.
- Developing Information Governance awareness and training programmes for staff.
- Ensuring compliance with Data Protection, Information Security and other information related legislation.
- Co-ordinating the response to freedom of information requests.

4.10 **Line Managers**

4.10.1 Line managers are responsible for ensuring that the Information Governance Policy is implemented within their group or directorate.

4.11 **All Staff**

4.11.1 All staff are responsible for adhering to the policy and fulfilling mandatory training requirements.

5 Monitoring and Review

What will be monitored	How/Method / Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Information Governance Manager	SIRO & IG Group	Where gaps are recognised action plans will be put into place
Compliance with the Trust's DSPT requirements	Managed via (1) quarterly feedback to the IG Group (2) Half year SIRO reports to Board	(1) IG Manager (2) Head of Integrated Governance and Legal	(1) The IG Group (2) The Executive Group	Where gaps are recognised action plans will be put into place

6 Training and Implementation

6.1 To support the implementation and embedding of the IG policy and procedures;

6.1.1 Mandatory e-learning training supported by face to face sessions available to all staff;

6.1.2 Bespoke training for dedicated cohorts and staff groups.

7 Equality Impact Assessment Statement & Tool

7.1 All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to "set out arrangements to assess and consult on how their policies and functions impact on race equality." This obligation has been increased to include equality and human rights with regard to disability, age and gender.

7.2 The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. This document was found to be compliant with this philosophy.

7.3 Equality Impact Assessments will also ensure discrimination does not occur on the grounds of Religion/Belief or Sexual Orientation in line with the protected characteristics covered by the existing public duties.

9 References

Document	Ref No
References:	
NHS Digital Data Security & Protection toolkit	
General Data Protection Regulation (GDPR) and the Data Protection 2018	
Freedom of Information Act 2000	
Information Security Management ISO 27001:2005	
Information Governance Alliance Code of Practice on Records Management	
NHS Confidentiality Code of Practice	
Trust Associated Documents:	
POLCGR079 - User Access Management Policy	POLCGR079
Disclosure of Medical Records SOP Disclosure of Medical Records	SOP
OTCGR139 - Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation	OTCGR139
OTCGR004 - Code of Conduct For Staff in Respect of Confidentiality	OTCGR004
OTCGR040 - Kent and Medway Information Sharing Agreement	OTCGR040

END OF DOCUMENT

Meeting of the Board of Directors in Public
Thursday, 07 November 2019

Title of Report	Corporate Policy: Human Resources and Organisational Development	**Agenda Item**	**9.4**
Lead Director	Leon Hinton, Executive Director of HR and OD		
Report Author	Leon Hinton, Executive Director of HR and OD		
Executive Summary	All policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) are under one of the overarching Policy Areas with a high-level Board-approved Corporate Policy covering each area. The Corporate Policy is intended to be a high-level overview of the organisation's policy in the relevant area, with the detailed instructions/guidance being laid out in supporting documentation which is reference in the Corporate Policy and therefore linked to the overarching document. Accordingly, the Corporate Policy for Human Resources and Organisational Development has been updated and is attached for Board approval. Changes include updating the policy list to include the appraisal and pay progression policy; death in service procedure; overpayment policy; secondary employment procedure; alcohol and substance misuse procedure; work experience manager's procedure; employing staff in the reserve forces procedure; and, travel and expenses procedure.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Executive Group Human Resources and Organisational Development Senior Team.		
Resource Implications	Not applicable		
Legal Implications/Regulatory Requirements	Individual Trust policies are subject to regular review to ensure compliance with legal and regulatory requirements.		

Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	The Board is asked to approve the updated Corporate Policy for Human Resources and Organisational Development.			
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☐
Appendices	Corporate Policy for Human Resources and Organisational Development.			

Medway NHS Foundation Trust
Corporate Policy: Human Resources and Organisational Development

Author:	Executive Director of HR & OD
Document Owner	Executive Director of HR & OD
Revision No:	3
Document ID Number	POLCHR046
Approved By:	Trust Board
Implementation Date:	November 2019
Date of Next Review:	November 2020

Document Control / History	
Revision No	**Reason for change**
1	New document
2	Annual revision, policy list updated
3	Annual revision, policy list updated

Consultation
JSC (for policy items)
Executive Group
HR Senior Team

Table of Contents

To be read in conjunction with any policies listed in Trust Associated Documents.

1 Introduction

1.1 Human Resources and Organisational Development (HR & OD) supports Medway NHS Foundation Trust achieve the Best of Care through the Best of People. The department supports excellent patient care through the recruitment, retention and development of all employees. The HR & OD directorate also focuses on employee engagement and helps shape the culture of the Trust.

1.2 The directorate also ensures compliance with employment legislation and best practice when dealing with any workforce issues.

2 Purpose / Aim and Objective

2.1 The purpose and aim of this document is to provide an overview of the key elements of HR & OD and to identify through supporting policies and procedures the various employment legislation and local processes to which the directorate is expected to work to.

The key elements of the HR & OD Directorate are:

- HR Strategy and Planning; this includes Employee Relations, Workforce Intelligence, Occupational Health and Tiny Tugs Nursery;
- HR Resourcing; this includes Resourcing, Temporary Resourcing, Medical Resourcing and e-Rostering;
- Organisational Development; this includes learning and development.

2.2 The objective of this document and all supporting policies and procedures is to identify, at high level and in detail, the relevant employment legislation and standards which govern the provision of HR and OD services, and to provide all Trust staff with detailed guidance, references and clarity on a range of topics relating directly to HR and OD service provision.

2.3 The Trust aims to 'Be the BEST' in everything it sets out to, and this extends to the management of staff who are at the heart of the Trust and its commitment to patient care.

3. Policy Framework

3.1 **Medway NHS Foundation Trust** is committed to complying with statutory, mandatory and best practice requirements through a supporting framework of documents:

Employee Relations
Appraisal and Pay Progression Policy (POLCHR050) **Appraisal and Pay Progression Procedure (SOP0500)** **Appraisal Guidelines (GUCHR007)** **Appraisal Form (OTCHR063)**
Respect - Countering Bullying in the Workplace Policy (POLCHR002) **Respect - Countering Bullying in the Workplace Procedure (SOP0168)**
Grievance Policy (POLCHR003) **Grievance Procedure (SOP0249)**
Performance Management Policy (POLCHR004) **Performance Management Procedure (SOP0227)** **Probationary Period Procedure (SOP0252)** **Medical and Dental Policy for Managing Conduct, Capability and Health (PROCHR004)**
Organisational Change Policy (POLCHR005) **Organisational Change Procedure (SOP0242)**
Death in Service Procedure (SOP0484)
Dress Code and Uniform Policy (POLCHR047)
Long Service Recognition Policy (POLCHR009)
Salary and Expenses Overpayment Policy (POLCHR040)
Professional Registration Procedure (SOP0248)
Secondary Employment Procedure (SOP0273)
Worklife and Family Policy (POLCHR019a) **Flexible Working Procedure - Worklife Balance (SOP0250)** **Paternity Leave Procedure (SOP0274)** **Parental Leave Procedure (SOP0275)** **Maternity Leave Procedure (SOP0276)**

Carer Dependant Leave Procedure (SOP0277) Other Leave Procedure (SOP0278) Adoption Leave Procedure (SOP0279) Career Break Policy (POLCHR034) Annual Leave Procedure (SOP0287) Medical Staff Leave Procedure (SOP0290)
Managing Work Related Stress Policy (POLCHR021)
Partnership Agreement Between Medway NHS Foundation Trust and NHS Trade Unions Policy (POLCHR030)
Inclusion Policy (POLCHR044) Disability in Employment Policy (POLCHR045)
Disciplinary Policy (PROCHR002) Disciplinary Procedures (SOP0226) Bank Worker Disciplinary Procedure (SOP0320) Allegations against Trust staff involving a Vulnerable Adult or Child Procedure (SOP0318)
Exit Procedure (SOP0317)
Occupational Health
Occupational Health Clearance and Immunisations for New Healthcare Workers Guidelines (GUCGR015)
Avoidance and Management of the Effects of Latex Allergy Policy (POLCGR002) Avoidance and Management of the Effects of Latex Allergy Screening Questionnaire for Employees at Risk of Increase Occupational Latex Exposure (OTCHR037) Avoidance and Management of the Effects of Latex Allergy Procedure (SOP0237)
Prevention and Management of Tuberculosis in Health Workers Policy (POLCPCM076) Prevention and Management of Tuberculosis in Health Care Workers Procedures (SOP0241) Prevention and Management of Tuberculosis in Health Care Workers - Annual Tuberculosis Symptom Questionnaire (OTLS030)
Misuse of Drugs and Alcohol Policy (POLCHR013)

Alcohol & Substance Misuse Procedure (SOP0464)
Management and Procedure for the Provision of Post Exposure Prophylaxis (PEP) following a Sharps or Blood/Body Contamination Incident (POLCS014)
Organisational Development
Statutory and Mandatory Training Policy (PROCHR006) On Boarding 1 - Final Preparations for New Starter Joining the Trust (SOP0209) On Boarding 2 - MFT Welcome (SOP0210) On Boarding 3 - Role Relevant Training and NSDWR (SOP0211) On Boarding 4 - Settling and Performing into the Role (SOP0213) On Boarding 5 - Performing into the Role (SOP0214)
Apprenticeship Policy (POLCHR043)
Work Placement - Work Experience Policy (POLLHR001) Work Placement – Work Experience Managers Procedure (SOP0352)
Appraisal and Revalidation of Medical Staff Policy (POLCHR037)
Study Leave and Funding Policy (POLLHR002) Study Leave and Funding Procedure (SOP0322)
Resourcing & Rostering
Recruitment Policy (POLCHR039) Recruitment Procedure (SOP0178) Secondment Procedure (SOP0180) Disclosure and Barring Service Check Procedure (SOP0177) Managers Guide to Checking - Duty of Care - Documents (SOP0013) Employing Staff in the Reserve Forces Procedure (SOP0485)
Temporary Workforce Policy (POLCHR042) Temporary Workforce - Principles of Engagement Guidance (GUDCHR001)
Fit and Proper Persons Policy (POLCHR041) Fit and Proper Persons Procedure (SOP0174)
Job Evaluation Policy (POLCHR036)
eRostering Policy (POLCNM017)

eRostering Procedure (SOP0385)
Remediation of Medical Staff Policy (POLCM006)
Honorary Contracts Procedure (SOP0179)
Removal and Relocation Expenses Procedure (SOP0319)
Travel and Expenses Procedure (SOP0400)
Employment Terms and Conditions – Local Terms and Conditions

4. Roles and Responsibilities

4.1 Trust Board

4.1.1 The Trust Board is ultimately responsible for ensuring that the Trust corporately meets its legal responsibilities.

4.1.2 The Trust Board is responsible for approving the Trust's Corporate Policy for HR & OD.

4.2 Chief Executive

4.2.1 The Chief Executive has overall responsibility for ensuring that sufficient resources are provided to support HR & OD requirements.

4.3 Executive Director of HR and OD

4.3.1 Has overarching responsibility for the effective and efficient management and delivery of all HR & OD services within the Trust and for development of policies and procedures in support of these functions.

4.3.2 Ensure that all policies and procedures are in line with relevant employment legislation and best practice.

4.3.3 Development of the People Strategy that all policies and procedures underpin.

4.3.4 Advises the Board on the effectiveness of HR & OD management across MFT.

4.4 Deputy Director of HR & OD

4.4.1 Has responsibility for ensuring that Employee Relations processes are fair and thorough; following policies and procedures accordingly;

4.4.2 Ensuring that Workforce Intelligence is accurate and readily available when required. Also, to ensure that ESR is fit for purpose and utilised effectively to bring efficiency to payroll processing and workforce information;

4.4.3 Leading an effective occupational health service provision across the Trust;

4.4.4 Has responsibility for the onsite nursery, Tiny Tugs, ensuring that the service is run safely, efficiently and in line with relevant legislation.

4.5 Group Head of HR - Resourcing

4.5.1 Has responsibility for ensuring that all resourcing functions (including medical staffing, temporary staffing and rostering) processes are fair and thorough; following policies and procedures accordingly;

4.5.2 Ensure all resourcing policies and procedures are in line with relevant employment legislation and best practice;

4.5.3 Monitor all resourcing policies to ensure compliance across the Trust.

4.6 Group Head of OD

4.6.1 Has responsibility for ensuring that all Organisational Development processes are fair and thorough ensuring equity of access; following policies and procedures accordingly;

4.7 HR and OD Team

4.7.1 The whole HR & OD Team are responsible for:

- Providing expert advice and guidance to all staff on all elements of HR & OD;
- Developing internal HR and OD policies and procedures to meet employment legislation, Agenda for Change and best practice;
- Developing HR and OD awareness and training programmes for staff;
- Ensuring compliance with policies, procedures, legislation and best practice.

4.8 Line Managers

4.8.1 Line managers are responsible for ensuring that the HR & OD Policy is implemented within their group or directorate;

4.8.2 They are also responsible for seeking advice from a relevant member of the HR and OD team if they are unsure about the application of a policy or procedure;

4.8.3 Line managers should discuss any concerns they have regarding their staff with a relevant member of staff as soon as the issue arises.

4.9 All Staff

4.9.1 All staff are responsible for adhering to all HR & OD policy.

5. Monitoring and Review

What will be monitored	How/Method / Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Deputy Director of HR and OD		Where gaps are recognised action plans will be put into place

6. Training and Implementation

6.1 To support the implementation and embedding of HR and OD policies and procedures;

- Bitesize training sessions for staff on different policies will be run regularly;
- Bespoke training and coaching for managers will be delivered on an ad hoc basis.

7. Equality Impact Assessment Statement & Tool

7.1 All public bodies have a statutory duty under the Race Relation (Amendment) Act 2000 to "set out arrangements to assess and consult on how their policies and functions impact on race equality." This obligation has been increased to include equality and human rights with regard to disability, age and gender.

7.2 The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. This document was found to be compliant with this philosophy.

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9 References

Document	Ref No
References:	
Trust Associated Documents:	
See framework	

END OF DOCUMENT