Medway NHS Foundation Trust

Papers for the Trust Board Meeting in Public

Thursday, 05 September 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, 05 September 2019 at 12.30pm – 3pm

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

Item	Subject	Presenter	Page	Time	Action
1.	Patient Story	Director of Nursing	Verbal	12:30	Note
2.	**Preliminary Matters**				
2.1	Chair's Welcome and Apologies	Chairman	Verbal	12:50	Note
2.2	Quorum	Chairman	Verbal		Note
2.3	Conflicts of Interest: i. Register of Interest ii. Declaration of Interest	Chairman	5 -		Note
3.	**Minutes of the previous meeting and matters arising**				
3.1	Minutes of the previous meeting held on 3 July 2019	Chairman	9	12:55	Approve
3.2	Matters arising and actions from last meeting	Chairman			Discuss
4.	**Standing Reports and Updates**				
4.1	Chair's Report	Chairman	Verbal	13:00	Note
4.2	Chief Executive's Report	Deputy Chief Executive	21		Note
4.3	Strategy i. Sustainability and Transformation Plan Update ii. Transformation Programme Update	Deputy Chief Executive Director of Transformation	Verbal 25		Discuss Note
5.	**Quality**				
5.1	Integrated Quality and Performance Report	Director of Nursing/ Medical Director/ Chief Operating Officer	69	13:30	Discuss
5.2	Quality Assurance Committee Assurance Report	Quality Assurance Committee Chair	103		Note
5.3	Maternity Services Report	Director of Nursing	107		
6.	**Finance and Performance**				
6.1	Finance Report - Month 4	Director of Finance	123	13:50	Discuss
6.2	Finance Committee Assurance Report	Finance Committee Chair	129		Note
6.3	Communications and Engagement Report	Director of Communications and Engagement	131		Note
7.	**People**				
7.1	Workforce Report	Director of HR and OD	137	14:10	Note

Agenda

8.	**Assurance Reports**				
8.1	Integrated Audit Committee Annual Report	Integrated Audit Committee Chair	151	14:20	Note
8.2	Integrated Audit Committee Assurance Report	Integrated Audit Committee Chair	155		Note
9.	**Annual Reports**				
9.1	Infection Prevention and Control i. Infection Prevention and Control Annual Report ii. Self-assessment against the Health and Social Care Act 2008	Medical Director	157 223	14:30	Note
9.2	Medical Appraisal and Revalidation Annual Report	Medical Director	261		Approve
9.3	Organ Donation Committee Annual Report	Organ Donation Committee Chair	281		Note
10.	**Policies and Strategies**				
10.1	Corporate Policy: Modern Slavery	Director of HR and OD	329	14:55	Approve
11.	**Other Business**				
11.1	Council of Governors' Update	Governor Representative	Verbal	15:00	Discuss
11.2	Any other business	Chairman	Verbal		Note
11.3	Questions from members of the public	Chairman	Verbal		Discuss
12.	**Date and time of next meeting: 7 November 2019, 12.30pm-3pm, Trust Boardroom**				

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TRUST BOARD REGISTER OF INTERESTS

SEPTEMBER 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

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Minutes of the Trust Board of Directors Meeting in Public

Wednesday 3 July 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 Mark Spragg	Non-Executive Director
	Mr Ewan Carmichael	Non-Executive Director
	Mr James Devine	Chief Executive
	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:	Dr Diana Hamilton-Fairley	Executive Director of Strategy
	Mr Gary Lupton	Executive Director of Estates and Facilities
	Ms Morfydd Williams	Executive Director of IT Transformation
	Ms Gurjit Mahil	Chief Operating Officer - Planned Care
	Mr Harvey McEnroe	Chief Operating Officer - Unplanned and Integrated Care
	Ms Glynis Alexander	Executive Director of Communications and Engagement
Attendees:	Mr Nick Chambers	Associate Director of Transformation *(Item 4.3ii only)*
	Ms Brenda Thomas	Company Secretary (minutes)
	Ms Doreen King	Governor Board Representative
	Mr Glyn Allen	Lead Governor
Apologies:	Mr Jon Billings	Non-Executive Director
	Mr Adrian Ward	Non-Executive Director
Observers:	Two governors One member of the public	

01/19 Patient Story

1.1 The Chairman reported that on this occasion, the patient story would be dealt with in another forum within the hospital.

02/19 Preliminary Matters

2.1 Welcome and Apologies for absence

2.1.1 The Chairman welcomed everyone to the meeting and 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 2 May 2019 were **APPROVED** as an accurate record of the meeting.

3.2 Matters Arising and Action Log

3.2.1 The following actions on the action log were agreed to be closed: **TB/2019/007** (to be reviewed via the BEST flow programme), **TB/2019/014, TB/2019/015, TB/2019/016, TB/2019/017, TB/2019/018, TB/2019/020, TB/2019/021** and **TB/2019/022**.

3.2.2 Updates were provided for the following actions:

i. TB/2019/002 - This item remained open, as the Quality Assurance Committee development session was cancelled.

ii. TB/2019/019 - David Sulch reported compliance with these specialties; however, non-compliance for other specialties (urology/ trauma and orthopaedics) was flagged. A letter would go out to remind relevant staff of their responsibilities. An offline report on the justification for non-compliance. Remains open.

iii. TB/2019/024 - Gurjit Mahil reported that this has been actioned for midwives, confirming their adherence to the policy. David Sulch to action for consultants.

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 that whilst there was no patient story, patients need to be listened to and appropriate actions taken to improve patient care. He further noted as follows:

a) Quality underpins all programmes of work and is now one of our five strategic objectives. The 'not just a number' campaign reminds all staff in the hospital of their responsibility to serve patients

b) The same day emergency centre (SDEC) is now open, with instant positive impact

c) Good progress is being made on transformation, ensuring that patients' lives are not put at risk when introducing new systems. The BEST Flow programme is a good example of transforming the way care is being provided to ensure a better experience for patients, reducing waits and ensuring patients get the right care in a timely way.

d) The Trust's core strategies (Clinical, People and Quality) which describe the ambitions for the hospital over the next three years have been developed

e) In spite of a challenging few days of very high temperatures impacting on the health of some members of the community, an improvement in the pathway was seen.

4.1.2 The Chairman thanked Stella Dick and Alastair Harding for their contributions during their terms in office as governors, the latter as Lead Governor. Glyn Allen was welcomed as the new Lead Governor following an election process. Doreen King would continue in the role as

Board Governor Representative until September 2019 when the role expires. Katy White was elected as the new governor for Medway following governor elections. Further elections would be conducted in the autumn for the unfilled constituents.

4.2 Chief Executive's Report

4.2.1 James Devine, Chief Executive, highlighted the following key issues:

a) The introduction of the SDEC, which is part of the NHS Long Term Plan, has made a positive impact
b) The breast cancer two-week wait performance has improved significantly in line with the Trust's trajectory. The right resources have been employed to ensure sustained improvement. No patient harm was reported during the period of poor performance
c) The BEST Flow programme is one of the six key transformation programmes identified for 2019/20
d) The Chief Executive Scholarship for Brilliance and Best Place to Work programme have been launched. Results of the latter would be provided at a future Board meeting
e) The #NotJustANumber awareness campaign has been launched
f) The Best of People Awards was held in June to celebrate staff, as was the National Volunteers' Week
g) Professor Michael West gave the key note speech at the Making Medway Brilliant Conference
h) Car parking application permit process relaunched for full implementation on 1 August
i) Various awards, including British Medical Journal (BMJ), Health Service Journal (HSJ) and Parliamentary were highlighted.
j) Julie Nerney has been appointed as Chair for Kent and Medway NHS and Social Care Partnership Trust, taking over from Andrew Ling who is stepping down after eight years
k) The interim NHS People Plan has been published
l) Amanda Pritchard has been appointed as the new NHS Chief Operating Officer.

4.2.2 He reiterated that despite all the challenges faced, quality of care is paramount and is always the driver in the decision making of the Trust.

4.3 Strategy

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

4.3.1 Diana Hamilton-Fairley, Executive Director of Strategy, presented the report and gave a verbal update from the proceeds of the STP Programme Board, covering Estates Strategy; development of primary care networks; progress on the implementation of the local care model; and financial position at year end 2018-19 and month 1 of 2019-20. The year-end actual position was adrift by £46m (£123m actual deficit against a planned deficit of £77m), with Medway Foundation Trust's financial position improving the overall position. The Estate Plan was approved by the Programme Board, with the need highlighted for a link between clinical estate and Estate Strategy. Local care is progressing well, with multi-disciplinary teams meeting regularly.

4.3.2 The Board was asked to approve the final version of the project initiation document (PID), which outlined the steps to be taken to create a single strategic commissioning for Kent and Medway aimed to be achieved by April 2020. It also includes how integrated care partnership (ICP) would be developed as a system.

4.3.3 **The Board delegated authority to the Chairman to sign off the PID on behalf of the Board, prior to which a thorough review would be carried out.**

4.3(ii) Transformation Programme Update

4.3.4 Nick Chambers, Associate Director of Transformation, presented the report. The Trust's core strategies have been drafted. The Transformation Operational Board is now well-established and meets fortnightly to oversee the full portfolio of transformation programmes. The Cost Improvement Programme (CIP) is favourable to plan by £74,000 at month two and remain focussed to deliver the target. The Trust has delivered £2.25 million in efficiencies in the first two months of the year. These efficiencies are not at the expense of quality of patient care. To further strengthen the existing Quality Impact Assessment (QIA) process, a weekly QIA Panel has been established to be chaired by the Medical Director and Director of Nursing. £19.4 million of CIPs has been identified for delivery in 2019/20, against a target of £18.0

million, comprising 115 schemes. A robust process is in place to support staff to deliver on these schemes and highlight areas of risks. Actions have been put in place to address the concern regarding the achievability of the CIP forecast for theatres closure and outpatients transformation. The actions in place to deliver on the quality and continuous improvement programme were highlighted.

4.3.5 Harvey McEnroe, Chief Operating Officer - Unplanned and Integrated Care, explained the BEST Flow programme, which is a nationally mandated programme and is the largest component of the improvement plan. This is in its deployment phase. A paper will be taken to the Finance Committee to make a decision on proceeding to phase two. The other component parts of the plan are Intensive Support Team (IST) and integration improvement. Overall, good progress is being made.

4.3.6 James Devine cautioned that whilst the first two months have been favourable, the CIP gets more challenging for the rest of the year; therefore, a month-on-month achievement should not be expected. Ian O'Connor, Executive Director of Finance, added that although the teams are working to mitigate the £3.597 million marked as red schemes, no assurance could be given on achieving those schemes.

4.3.7 In relation to the query on maintaining good practice and improvement, Nick Chambers noted that the key is having a consistent approach and involving staff with responsibility for the processes in the design stage. There is confidence in the methodology and investment in people to deliver.

4.3.8 **The Board noted the report and received assurance on the progress made.**

05/19 Quality

5.1 Integrated Quality and Performance Report (IQPR)

5.1.1 Karen Rule, Executive Director of Nursing, introduced the report, with input from the Executive Medical Director. The reporting and validation of data has been brought forward, enabling the most recent performance data to be presented. The associated piece of work to review the metrics and associated targets was completed after the report was produced. A revised report would be made available to the Board. The following key issues were highlighted from the report:

a) Bed occupancy was regularly in excess of 100%
b) The unplanned and integrated care directorate continued to deliver sustained improved falls performance, having put in place a number of initiatives to improve performance
c) The Trust is within trajectory for c.difficile relating to infection prevention and control (IPC), though not repeated for MRSA bacteraemia, for which a case was reported in May and the full post infection review (PIR) is awaited
d) Two Never Events were reported both pertaining to retained foreign object. These were unusual events that do not meet the criteria for Never Events. The Quality Assurance Committee discussed these in detail. The outcome of the final investigation is awaited
e) Fractured neck of femur (FNoF): significant improvement has been seen over the last few months on best practice tariff performance. Time to theatre has been a challenge; however, June data suggests potential 90%
f) Venous Thromboembolism: improvement has been seen, with 90.52% achieved in May
g) Stroke snap rating up to D from E, but remains a challenge.

5.1.2 Karen Rule assured the Board that the IPC improvement plan in place would be delivered over a number of months with support from NHS Improvement (NHSI). IPC is ranked high on the quality priorities. The Board requested more visibility of IPC from the IQPR to provide assurance, together with an update on the Care Quality Commission (CQC) position - outstanding issues on the last report with progress and current state of compliance. **Action: TB/2019/025.** The Board was pleased to see an improved position on the appraisal rate.

5.1.3 In relation to the relationship between theatre utilisation and capacity, it was noted that a range of initiatives have been introduced to remove some of the fluctuations in the past. These changes are deemed sustainable.

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

5.2 Quality Assurance Committee Assurance Report

5.2.1 Ewan Carmichael, Non-Executive Director, talked through the report. The key highlight was for the Board to note that the Quality Assurance Committee Chair will be the Non-Executive Director Safeguarding Lead.

5.2.2 In relation to revisiting the reporting of duty of candour, Karen Rule assured that this is within the CQC preparedness work and embedded within day-to-day practice.

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

5.3 Learning from Deaths

5.3.1 David Sulch, Executive Medical Director presented the report to assure the Board that the Trust has a robust process in place for reporting, reviewing and learning from deaths. 1412 patients died in the Trust between 1 April 2018 and 31 March 2019. Structured Judgement Review (SJR) is being undertaken for circa 25 percent of those patients. Outlier groups highlighted through the Hospital Standardised Mortality Ratio (HSMR) have been reviewed and investigated. Significant improvement has been seen in HSMR such that the Trust is no longer an outlier in relation to the national position. Over the last two years, the mortality rate for FNoF patients have been halved, with recent data showing HSMR of 80 and accrued mortality of five percent, compared to year ending January 2017 when HSMR was 129 and accrued mortality 9.6 percent. Pneumonia continues to be an area of concern and there is an ongoing prospective audit for all pneumonia deaths to be reported to the Mortality and Morbidity Committee (MMC). This process of early review will merge into the medical examiner model once funding is confirmed.

5.3.2 It was noted that the Trust is achieving the target for the learning disabilities deaths in relation to stage two reviews and there is regular feedback to the MMC.

5.3.3 **The Board was assured of the progress made on mortality.**

06/19 Finance and Performance

6.1 Finance Month Two Report

6.1.1 Ian O'Connor, Executive Director of Finance, presented the report for May which showed a year to date deficit of £8.3million (excluding Provider Sustainability Funds (PSF), Marginal Rate Emergency Tariff (MRET) and Financial Recovery Funds (FRF). Operationally, this is adverse to the current operational plan by £200,000. Against the declared plan with NHSI, the Trust is £970,000 ahead of plan. The delivery of CIPs is crucial in achieving the year end forecast of £22.3million deficit.

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

6.2 Finance Committee Assurance Report

6.2.1 Jo Palmer, Senior Independent Director highlighted key areas from the report. The risk register and their mitigating actions are thoroughly reviewed. CIP plan remains an area of focus. Majority of the contingency remains intact as cautious steps are taken to ensure the financial change is sustainable. The difficulties reconciling the Aspyre schemes to the ledger have been resolved. A review is being undertaken on the Capital Plan with further robust review to be undertaken. The International Financial Reporting Standards 16 escalation and tracking of the urology robot were transferred from the Integrated Audit Committee.

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 key areas. Engagement with staff continued in transformation projects under the Better, Best, Brilliant (BBB) improvement programme, with overarching communications plan and supporting materials for the next phase of the programme developed. A number of senior manager, staff briefings and a staff conference were held as part of engagement with staff. The 'Making a Difference' campaign, which offers staff the opportunity to 'bid' for funding to make small improvements to their working lives, has proved popular. There was good recent TV coverage around the diabetes nurse and launch of the Trust's rainbow badge scheme. There were national award nominations for a number of staff for various categories. A range of key messages were shared widely across social media.

The Trust remains Kent's most followed acute Trust on Twitter and Instagram. Governors were supported on a range of engagement activities and there was focus on engaging with older members of the local population. Support was also provided to the Clinical Commissioning Group (CCG) on a number of focused groups and engagement events. A tour of behind the scenes for members has been arranged.

6.3.2 Jo Palmer urged members to sign up to the rainbow scheme in support of the Lesbian, Gay, Bi-sexual and Transgender (LGBT) community.

6.3.3 **The Board noted the Communications Report**.

6.4 Seven Day Hospital Services Board assurance Framework

6.4.1 David Sulch presented the latest review of the Seven Day Hospital Services, a nationally driven quality improvement initiative built on 10 clinical standards, to support providers of acute services to tackle the variation in outcomes for patients admitted to hospitals in an emergency at the weekend across the NHS in England. Providers are required to submit an assessment on the four prioritised clinical standards to NHS England. The key area of challenge for the Trust remains standard two: Time to initial consultant review. This would be closely reviewed. In relation to standard 8: Ongoing daily consultant-directed review, it was clarified that the consultant cardiology cover for cardiac pacing is available 24hours, seven days a week, and not ad hoc as stated in the report. It was noted that the challenge with consultant's availability for seeing patients when they visit hospital is across the whole week and not limited to the weekend. The issues encountered at weekend reflect the general lower levels of staff, particularly medical staff for patient flow. Discharge is one of the key focus of the BEST flow programme. There is no financial impact on failing to meet these standards.

6.4.2 **The Board noted THE progress to date with implementing the Seven Day Service self-assessment framework and associated actions and confirmed support to receiving bi-annual assurance reports against the Seven Day hospital Services compliance.**

07/19 People

7.1 Workforce Report

7.1.1 Leon Hinton, Executive Director of HR and OD presented the workforce report highlighting key areas. 21 whole time equivalent (WTE) nurses and midwives joined the Trust on a substantive basis. Turnover and sickness were largely stable. Appraisal and statutory mandatory training rates both improved, at 91.44 percent and 88.64 percent respectively. The aim is to get to 90 percent at the end of 2019/20 and the Trust is on course (surpassing for appraisal) to achieve this trajectory. There was a decrease in agency usage at three percent, £1.1million below NHSI target on agency spend and one percent increase in substantive pay bill. The Trust has worked in partnership with NHSI to identify and implement a number of nursing retention initiatives. The lessons learnt will be used across different staff groups. The Trust will commence publishing Nursing Stability Index rate. The Staff Survey Action Plan included as part of the report was noted.

7.1.2 At the last Board meeting, there was an action to investigate correlation or causality between reason for leaving and staff survey results. An analysis has been undertaken and the results show there is no causality between survey results and leaving reasons.

7.1.3 It was noted that accommodation for nurses is not significantly mentioned in any of the exit interviews. Furthermore, it was noted that the workforce report focuses mainly on nursing, for which stability index is now steady. A request was made to move focus to other health professions and staffing areas with high vacancy rate, whilst keeping sight of nurses. **Action: TB/2019/026.**

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

7.2 Workforce Race and Equality Standard Report

7.2.1 Leon Hinton presented for approval the Annual Workforce Race Equality Standard (WRES) for 2019 prior to publication by 31 July 2019. The key findings of the nine performance indicators were highlighted. Performance against most of the WRES indicators has stabilised compared to 2018. The makeup of the Board has not significantly changed. Actions to improve performance must be published on the Trust website in September 2019. A

summary of proposed actions was noted, which would be worked up in further detail by the Trust's Inclusion Steering Group before September 2019.

7.2.2 In relation to drawing correlation from the WRES to the staff survey, it was noted that some of the indicators are directly taken from the national dataset for the staff survey.

7.2.3 **The Board approved the Workforce Race Equality Summary for submission to the NHS England WRES Portal and the Trust's website.**

7.3 Workforce Disability Equality Standard Report

7.3.1 Leon Hinton presented for approval the Workforce Disability Equality Standard (WDES) Report. It is now a mandatory requirement in NHS standard contracts (Schedule 6a) to report on the WDES, including sign-off at Board level before 31 July each year. The key findings for the 10 performance indicators were noted. The assessment indicated that five percent of employees have declared that they are disabled, 77 percent have declared that they are not disabled, and 18 percent have not declared whether or not they are disabled. No employee on Agenda for Change band 8B or above has identified as disabled. There is no a action plan since this is the first year of reporting and no benchmarking data is available.

7.3.2 It was noted that the system is self-reporting and there is no external criteria set for reporting. The percentage of staff with disability reporting to have experienced bullying and harassment is normally higher than non-disabled staff. Doreen King requested looking into the possibility of high reporting by people registered as disabled. **Action: TB/2019/027.**

7.3.3 **The Board approved the Workforce Disability Equality Summary for submission to NHS England and upload on to the Trust's website.**

7.4 Safe Staffing (Inpatients) Review

7.4.1 Karen Rule presented the report to provide assurance that the nursing establishments within inpatient areas are sufficient to provide safe and effective care to patients. The six monthly review followed established processes for previous reviews using guidance from the National Quality Board, evidence based tools, incorporated professional judgement and patient outcome from clinical areas. A full review of inpatient wards was undertaken over a seven day period. The outcome of the review is that unplanned and integrated care requires 3.73 WTE uplift in nurse staffing, with no additional funding required, whilst planned care requires 7.99 WTE uplift in nurse staffing with additional funding of £503,000. It has been agreed that funding should be sought in the first instance through further improvements within the directorate. Karen was confident that implementing the recommendations for the staffing levels will ensure the Trust is able to meet the needs of patients within the wards. There are clear escalation processes on staffing to ensure all areas are made safe. Staffing reviews have also been undertaken for the emergency department (ED) staff. New guidance issued from NHS England from 1 April requires that going forward, safe staffing reviews will include all staff within the Trust.

7.4.2 **The Board noted the outcome of the safe staffing review.**

08/19 Governance and Legal

8.1 **Board Assurance Framework**

8.1.1 Brenda Thomas, Company Secretary presented the Board Assurance Framework (BAF) for the Board to scrutinise and comment on the risk profile of the BAF and determine whether the assurances give the Board the necessary confidence that the controls put in place to manage these risks are working effectively. Following approval by the Board of a fifth strategic objective: *High Quality Care - We will consistently provide high quality care*, new risks have been raised, taking the total risks on the BAF to 15, from the previous 11. A highlight report, showing a summary of the key updates, including new risk ratings since the BAF was last reviewed was presented. The updated BAF had been discussed at the Executive Group meeting prior to submission to the Board.

8.1.2 Morfydd Williams, Executive Director of IT Transformation, clarified that the change in target dates for the capability and funding risks is the new target date to achieve the revised scores.

8.1.3 **The Board noted the Board Assurance Framework.**

8.2 Integrated Audit Committee Assurance Report

8.2.1 Mark Spragg presented the report which was taken as read. The main highlight was the signing off of the 2018/19 Annual Report and Accounts following delegated authority from the Board. It was noted that the external auditors were commendable of the finance team for an excellent audit.

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

8.3 Freedom to Speak Up Update

8.3.1 James Devine presented the report, which was the first to the Board. The report summarised the concerns raised during quarter four, 2018/19. 22 concerns were raised, of which 21 have been closed. The outstanding concern is actively being responded to. Staff are encouraged to raise concerns. Themes are being reviewed, with no particular theme identified and no issues for concern. Benchmarking data with other organisations was noted. A Lead Guardian has been appointed, following the departure of the Lead Guardian for a clinical role within the Trust.

8.3.2 The Chairman assured the Board that concerns raised are taken seriously and dealt with swiftly. The Board will receive quarterly reports going forward.

09/19 Strategies

9.1 Core strategies

9.1.1 Glynis Alexander introduced the summary of the Clinical Strategy; People Strategy and Quality Strategy for 2019-22, which have been written with engagement from staff and stakeholders and have been discussed by the Board during their development sessions. The summary document and interactive PDF aim to provide a clear, brief summary of the content of the three strategies for audiences to gain a general understanding. The strategies are available for those who wish to read the full detail.

9.1.2 Diana Hamilton-Fairley, Leon Hinton and Karen Rule talked through the strategies.
The Clinical Strategy, the first for the Trust, is the main driver of planning and transformation of the Trust's services. This strategy is built on the vision and values of the Trust. The Trust will provide high quality consultant-led services for the people of Medway and Swale as the major acute hospital in an integrated healthcare system. The Clinical Strategy will be implemented with the priorities and goals of the Quality Strategy at its core.
The Quality Strategy, also the first for the Trust, is the Trust's plan to achieving its strategic objective of making the delivery of consistent, high quality care a priority for all staff and will be delivered through three domains: Best quality design, Best quality improvement System and Best quality focussed delivery. Quality and patient safety is the Trust's top priority. The Quality Assurance Committee will monitor the delivery of the Quality Strategy.
The People Strategy furthers the outcomes of the 2017-19 Workforce Strategy and details delivery of enabling staff to be brilliant and achieve brilliant outcomes through three domains, best of people, best culture and best future.

9.1.3 The Chairman noted this was a great achievement with a powerful and positive message that should be positioned right and communicated.

9.1.4 **The Board noted the summary of the Clinical, People and Quality Strategies.**

10/19 Annual Reports

10.1 Medical Education Annual Report

10.1.1 David Sulch presented the report which covered medical education activity for 2018/19. The report was taken as read. There was excellent feedback across a number of specialities from trainees and concerns raised by foundation trainees, particularly relating to winter working pressures have been addressed, with a fully compliant medical rota now in place. Medical Training Initiative trainees were recruited, leading to resolution of Registrar rota gaps in medicine. Another achievement was the return of the Pre-Registration Pharmacists to the Trust. Since the quality visit in May 2018, all emergency medicine actions have been closed and all medicine actions by the Patch Dean, with the exception of the action relating to the lack of progress in implementing hospital at night have been closed.

10.1.2 **The Board noted the Medical Education Annual Report.**

10.2 Research and Innovation Annual Report

10.2.1 David Sulch presented the 2018-19 Research and Innovation Annual Report which outlined progress and achievements over the last 12 months. The report was taken as read.
For the fifth consecutive year, the Trust remained the highest performing Trust at recruiting patients into clinical trials in Kent, Surrey and Sussex Clinical Research Network. Although overall performance is excellent, some areas are fairly patchy. Professor Ranjit Akolekar has been recently appointed as the Clinical Lead for the Research and Innovation Department.

10.2.2 **The Board noted the Research and Innovation Annual Report and conveyed thanks to the team for the great achievement.**

11/19 Other Business

11.1 Council of Governors' Update

11.1.1 Doreen King, Board Governor Representative commended Glynis Alexander and Krishna Devi, Community Engagement Officer for the positive work with governors and conveyed thanks to them on behalf of the governors.

11.1.2 She reported that there have been requests from the public to publish waiting times in clinics to aid patients' planning. **Action: TB/2019/028**. Glynis Alexander commented that feedbacks are uploaded directly into Datix for visibility by the directorates.
Furthermore, she requested looking into the possibility of sourcing more therapy pets which have proved to have a positive impact. **Action: TB/2019/029.**

11.2 Any Other Business

11.2.1 Rainbow badges: these are available for pick up from various locations within the hospital.

11.2.2 Farewell: The Chairman, on behalf of the Board bade farewell to Dr Diana Hamilton-Fairley, Executive Director of Strategy, who was attending her last Board meeting as she will proceed on retirement. He thanked Diana for bringing a vast range of talent to the Medical Director's role (when she assumed the role) and a number of other areas, including support to the medical school; work on the STP, ICP and integrated care system (ICS); and the Medilead programme, providing continuity, expertise and vision. Diana will be chairing one of the Medway and Swale ICP workstreams.

11.3 Questions from members of the public

11.3.1 There were no questions from members of the public.

12/19 Date and time of next meeting

12.1 The next Board Meeting in Public will be held on Thursday, 5 September 2019 at 12.30pm in the Trust Boardroom, Post Graduate Centre, Medway NHS Foundation Trust.

12.2 The meeting closed at 3.50pm.

These minutes are agreed to be a correct record of the Trust Board Meeting in Public of Medway NHS Foundation Trust held on 3 July 2019

Signed …….. Date …….
Chair

Board of Directors in Public
Action Log

Agenda Item: 3.2
Date: Thursday, 05 September 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
10-Jan-19	TB/2019/002	**Integrated Quality and Performance Report** Detailed discussion at the Quality Assurance Committee on the challenges of mixed sex accommodation and the way forward.	02-May-19	Karen Rule Executive Director of Nursing	Discussed at the Quality Assurance Committee development session in August.	**Green**
07-Mar-19	TB/2019/011	**Safe Working Hours Annual Report** Give consideration to producing a consolidated picture of the medical workforce to ensure that workforce is fit for purpose.	02-May-19	Dr David Sulch Executive Medical Director	Captured within the Workforce report	Green
02-May-19	TB/2019/019	**Annual Health and Safety Report** Follow up the non-compliance with personal protective equipment (PPE) or dosimetry badges by cardiologists and radiologists. (**3 July - Compliance with these specialties was noted; however, non-compliance for other specialties (urology/ trauma and orthopaedics) was flagged. Letter to be issued to remind relevant staff of their responsibilities**).	03-Jul-19	Dr David Sulch Executive Medical Director	Letter sent to staff.	Green
02-May-19	TB/2019/023	**Workforce Report** Produce six monthly review of progress against milestones per programme for the staff survey action plan.	05-Sep-19	Leon Hinton Executive Director of HR and OD	On the agenda	Green
02-May-19	TB/2019/024	**Conflicts of Interest Policy** Conflicts of interest policy - follow up with Consultants to ensure compliance with the policy.	03-Jul-19	Dr David Sulch Executive Medical Director	This has been actioned	Green
03-Jul-19	TB/2019/025	**Integrated Quality and Performance Report** More visibility of infection prevention and control from the IQPR to provide assurance. Update on the Care Quality Commission position - outstanding issues on the last report with progress and current state of compliance.	05-Sep-19	Karen Rule Executive Director of Nursing	Separate and detailed infection prevention and contro reports are being presented by the Director of Infection Prevention and Control. Verbal update to be provided at the meeting on the second action.	
03-Jul-19	TB/2019/026	**Workforce Report** Focus report on other health professions and staffing areas with high vacancy rate, whilst keeping sight of nurses.	05-Sep-19	Leon Hinton Executive Director of HR and OD	Part of the Workforce report	Green
03-Jul-19	TB/2019/027	**Workforce Disability Equality Standard Report** Look into the possibility of high reporting by people registered as disabled	05-Sep-19	Leon Hinton Executive Director of HR and OD	Leon Hinton met with Doreen King to discuss disability equality.	Green

Board of Directors in Public
Action Log

Agenda Item: 3.2
Date: Thursday, 05 September 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	Update to be provided at the meeting.	
03-Jul-19	TB/2019/029	**Council of Governors' Update** Look into the possibility of sourcing more therapy pets	05-Sep-19	Harvey McEnroe Chief Operating Officer	The Trust currently has therapy dogs attending regularly - Yazzi, a retired guide dog and an Ambassador for Guide dogs and Fred. Lola from Canine Concern attends every now and then. Therapy Pets services have been contacted to look into having other animals, possibly rabbits.	Green

Agenda Item 4.2

NHS
Medway
NHS Foundation Trust

Chief Executive's Report – September 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

During July and August we saw attendances at our Emergency Department (ED) rise to an unprecedented level for summer months, putting pressure on the urgent and emergency care pathway.

Our ED team responded well, and our type 1 (ED) performance held up and even improved. However, a combination of factors in MedOCC challenged this part of the pathway, meaning that overall our performance dipped. We have discussed this with our system partners to address the longer waits experienced by patients over this period.

On a more positive note, I am pleased to say that we have continued to see improvement in relation to the breast cancer two-week wait standard, an area in which we had performed poorly earlier in the year.

Transformation

Our transformation work, under the strapline 'Making Medway Brilliant', is progressing well. Staff are supported through our continuous improvement programme – yellow belt and white belt training – to lead projects. Improvement huddles are held in teams across the hospital at which staff propose improvements which are then scoped, pursued and delivered.

A number of projects are delivering improvements while achieving efficiencies, leading to a better experience for our patients which at the same time saving money. Quality Impact Assessments are carried out before any project begins to ensure high quality is maintained with a positive impact on patients.

The biggest focus has been on our Best Flow programme to improve the experience of patients not just in our ED, but throughout the hospital to the point of discharge. This has included the introduction of our Same Day Emergency Care centre.

Car parking

Our new parking permit scheme for staff was introduced on 19 August following a period in which applications for permits were assessed against certain criteria, including distance to work. Some staff subsequently went through an appeals process.

The aim of the exercise was to use onsite parking much more efficiently, create a fairer and more transparent system, and reduce our reliance on the Dockside car park and shuttle bus service. We have engaged with staff throughout the process and responded to feedback.

Staff who do not wish to drive or who do not qualify for on-site parking can take advantage of sustainable travel options, such as cycling to work, and car sharing. We have also negotiated free bus travel for staff who live close the hospital, which was due to start at the beginning of September.

Friends and Family Test

The Trust carries out its staff Family and Friends test across three quarters of the year, with the full staff survey in the final quarter.

The staff's response to recommending the Trust as a place to work has seen a 7 per cent increase (to 18 per cent) for those extremely likely to recommend, with a corresponding 3 per cent decrease (to 9 per cent) for staff who are very unlikely to recommend.

In total 55 per cent of staff are either likely or very likely to recommend the Trust as a place to work (up 6 per cent since last quarter). This represents the highest score in two years.

There has been a similar improvement to staff recommending the Trust as a place for treatment with a 12 per cent increase (to 27 per cent) for those extremely likely to recommend; the extremely unlikely remains unchanged at 6 per cent.

In total 68 per cent of staff are either likely or very likely to recommend as a place for treatment (up 3 per cent since last quarter). Although we would clearly like to see a better response, it is very encouraging to see the figures improving in this way.

Leadership update

The Board will be aware that over the past few months I have been undertaking an in-depth review of our organisational structure to evaluate gaps in our capacity and capability, and to ensure that our leadership structure was properly aligned to our strategic objectives.

After this review, I made the decision that some changes were needed to the Executive Team to ensure that the organisation has the right leadership to support staff and meet the needs of our community – this included reducing the number of executive members. I am pleased to say these changes are now complete.

Gurjit Mahil, who until the end of July was the Trust's Chief Operating Officer for planned care, has now taken on the role of Deputy Chief Executive.

We have moved to a model of having one Chief Operating Officer, as is seen in most hospitals and this role is filled by Harvey McEnroe, previously Chief Operating Officer for unplanned and integrated care.

Leon Hinton has been appointed as Executive Director of HR and Organisational Development following an external recruitment process. Leon has been in the role on an interim basis since I was appointed as Chief Executive.

Finally, I have created a new role of Director of Transformation recognising the strategic importance of this portfolio, and Jack Tabner has been appointed to this position.

Overall the number of Executive Directors has reduced by one, with Dr Diana Hamilton-Fairley leaving and James Lowell seconded to lead the development of the Medway and Swale Integrated Care Partnership.

Zero tolerance campaign

The Trust has launched a zero tolerance campaign asking local people to respect the dedicated NHS staff who care for them. This is in response to a rise in the number of incidents of violence, abuse or harassment against staff.

Over the last three years, staff at Medway Maritime Hospital have reported more than 1,800 separate incidents of violence and aggression while doing their jobs.

The most recent NHS staff survey also showed that more than 14 per cent of staff have experienced violence from patients, their relatives or the public in the last 12 months.

The vast majority of the general public treat our staff with respect and are extremely grateful for the care they receive. However, we have a zero tolerance policy for those individuals who do not.

The campaign highlights that if a member of the public commits physical or racially aggravated assault, they will be immediately excluded from our site and we will always seek police prosecution. Repeat offenders of lesser offences will also be excluded.

The awareness campaign forms just one part of a wider project being under taken by the Trust to improve the safety of staff.

Freedom to Speak Up Guardian

I am pleased to announce that we have appointed a new Freedom to Speak Up Guardian, Natasha Pritchard, who was previously a clinical sister on our Intensive Care Unit. This is an important role, and Natasha has been busy since she arrived getting to know people and assessing how we can demonstrate best practice in this area.

New recruits!

Earlier in the year our much-loved therapy dog, Cookie, retired, and staff and patients have missed having her around. I am therefore delighted to tell you that we have two new therapy dogs – Yazzy and Fred. Look out for them around the hospital!

Further afield

Stroke review

As you will recall, two applications for a judicial review of the decision about hyper acute stroke services have been lodged. These applications have now been considered by a judge who has decided that both cases will be put forward for a three-day ‘rolled up hearing’ in early December.

The court will hear both cases simultaneously. A ‘rolled up hearing’ means that the court has not yet given the claimants permission on the papers and will instead consider permission at the start of the oral hearing. If permission is granted, then they will then proceed immediately to the substantive hearing.

We are also awaiting a response from the Secretary of State for Health and Social Care following a referral by Medway Council about the decision.

Meanwhile, Maidstone and Tunbridge Wells NHS Foundation Trust announced that it was transferring its stroke service to Maidstone Hospital in the interests of patient safety. This relates to staff shortages, leading the Trust to consider the service at Tunbridge Wells Hospital at risk of being unsafe.

Ambulance service good news

In August it was announced that South East Coast Ambulance (SECAmb) had exited special measures. Care Quality Commission (CQC) inspectors found sufficient progress to make the recommendation to NHS Improvement.

A team of inspectors from CQC visited the trust in June and July 2019 to assess the quality of the core services: emergency operations centres; emergency and urgent care and the trusts out of hours and NHS 111 services. They also looked specifically at management and leadership.

The trust was rated as Good overall and for providing safe, effective, caring, responsive and well-led services. Previously the trust was rate as Requires Improvement.

Meanwhile, Kent Community Health NHS Foundation Trust was rated ‘outstanding’ by the CQC following its most recent inspection.

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	**Transformation Programme Update**	**Agenda Item**	**4.3**
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 Medway Foundation Trust's (MFT) 'Better, Best, Brilliant' transformation portfolio, including:
	
	• **Large, cross-hospital transformation programmes.** Activity within the Trust's x4 core transformation programmes continues to gather pace:
	  ○ BEST Flow (see Appendix 2)
	  ○ Service Transformation and Access Review (STAR)
	  ○ Theatres Productivity
	  ○ Quality Improvement
	
	• **The Cost Improvement Programme (CIP).** As at Month 4, the Trust has delivered £4.5m in CIP. Year to date, this is adverse to the operational plan monitored internally by £121k. There are a small number of individual efficiency schemes which are under-delivering, however clear plans are in place to rectify this position. The Programme Management Office (PMO) still forecasts that the Trust will meet the £18.0m CIP target for 2019/20.
	
	• **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.
	
	Other notable portfolio-level milestones during the previous period are as follows:
	
	• The transformation portfolio has formed a working partnership the *Digital Health. London Accelerator* (DH.LA), part of the Health Innovation Network – the Academic Health Science Network of Guy's and St. Thomas' NHS Foundation Trust. This will allow us to bring health technology small and medium-sized enterprises (SMEs) to Medway to support our digital transformation. The companies within the current cohort of the Accelerator are among the most exciting health tech start-ups globally. To begin our partnership with the DH.LA, we will be holding a series of themed 'Innovation Days' over the coming months, the first of which will focus on digital outpatient transformation.
	
	• We have increased the frequency of staff communications about		

transformation. We have established a new Transformation Newsletter. In addition, the Executive Director of Transformation authors a weekly blog, focusing on some of the practical realities of change within complex organisations.

In the next period, we will:

- Refresh our **transformation strategy** over the next 3-years. Guided by the refreshed clinical strategy, this strategy will provide a key contribution to the business plans of care groups, the Trust's Operating Plan and divisional CIP plans into next year and beyond.

- Develop a programme to improve **medical engagement and leadership**. Based on semi-structured interviews with a number of MFT clinical leaders, the Executive Director of Transformation and Medical Director will co-author a short paper setting out the current challenges and opportunities to improve how Doctors and Surgeons can be engaged, incentivised and rewarded for Making Medway Brilliant. This will form the basis of a facilitated discussion at an upcoming Executive Team's 90-Day Forum.

- **Recruit.** We have the opportunity within the team to recruit more change agents. We will be recruiting via the traditional routes, but we will also explore the possibility of seconding clinicians and operational staff into the team as an opportunity to learn improvement science and help to 'bridge the divide' between transformation and frontline, operational staff.

- Host a programme of guest, **external speakers** to inspire and energise our staff and to encourage them to look to the experience of other organisations and sectors when thinking about how we can improve MFT.

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 Operational Board (fortnightly) Transformation Assurance Group (fortnightly) Finance Committee (latest CIP report – 22 August 2019)			
Resource Implications	N/A			
Legal Implications/Regulatory Requirements	Failure to deliver the CIP 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 CIP 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	Appendix 1: Highlight reports Appendix 2: BEST Flow update			

1 Executive Overview

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

1.1.1 Large, cross-hospital transformation programmes.

- BEST Flow (see Appendix 2)
- Service Transformation and Access Review (STAR)
- Theatres Productivity
- Quality Improvement

1.1.2 The **Cost Improvement Programme** (CIP). As at Month 4, the Trust has delivered £4.5m in CIP. Year to date, this is adverse to the operational CIP plan by £121k. There are a small number of individual efficiency schemes which are under-delivering, however clear plans are in place to rectify this. The Programme Management Office (PMO) still forecasts that the Trust will meet the £18.0m CIP target for 2019/20.

1.1.3 **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. Many improvement projects are being delivered by frontline staff in 90-day project cycles, which all align directly to the Trust's strategic objectives.

1.2 Also included (Section 5) is an update on several other portfolio-level milestones:

1.2.1 The Trust's partnership with the Digital Health.London Accelerator

1.2.2 The recent communications drive, which includes a new newsletter and regular blog about the complexities and practical realities of change

1.3 This report also sets out (Section 6) the next steps for transformation over the coming months.

2 Transformation Programmes

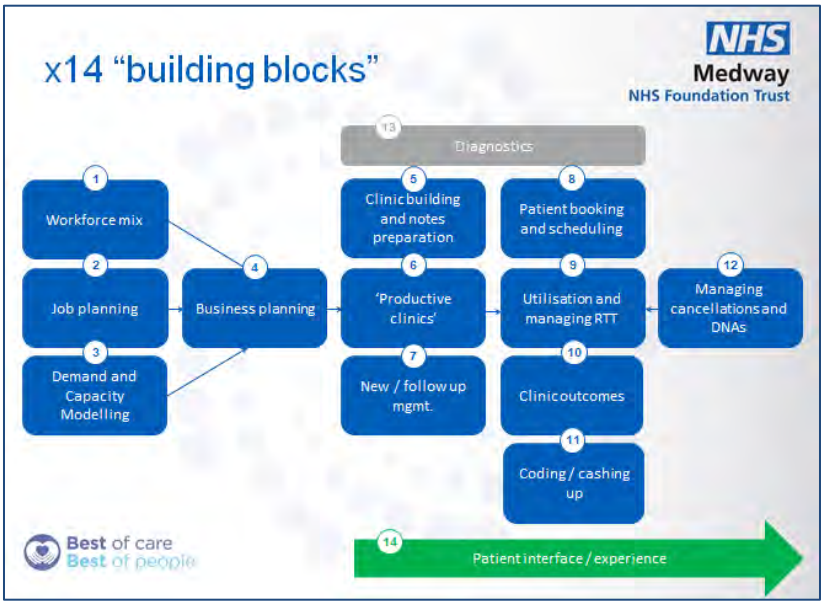
2.1 The Transformation Operational Board continues to oversee the delivery of the priority cross-hospital transformation programmes agreed by the Executive Team. See **Appendix 1** for **Highlight Reports** for all programmes and enabling strategies, as discussed at the Transformation Assurance Group.

2.2 See **Appendix 2** for a detailed update on the **BEST Flow Programme**; the Trust's flagship transformation programme in 2019/20. The initial diagnostic phase of the programme has concluded. This 'One Version of the Truth' (OVT) has now been shared at x2 whole-system summits. Alongside this, the Trust has progressed a number of operational improvements which have demonstrably improved our Type 1 ED performance as well as increased our number of safe discharges per day. These improvements can be attributed to focused work on the efficacy of Board and Ward Rounds; improvements to how the Site Team operates; daily 'stranded patient' reviews focusing on our patients who, without intervention, can wait for an unnecessarily long period prior to discharge; and the development of the Same Day Emergency Care (SDEC) pathway. The programme will now accelerate operational work on the Integrated Discharge Team, and address reporting and productivity issues that have been surfaced relating to the MedOcc (on-site GP function provided by Medway Community Healthcare). More detail can be found in Appendix 2.

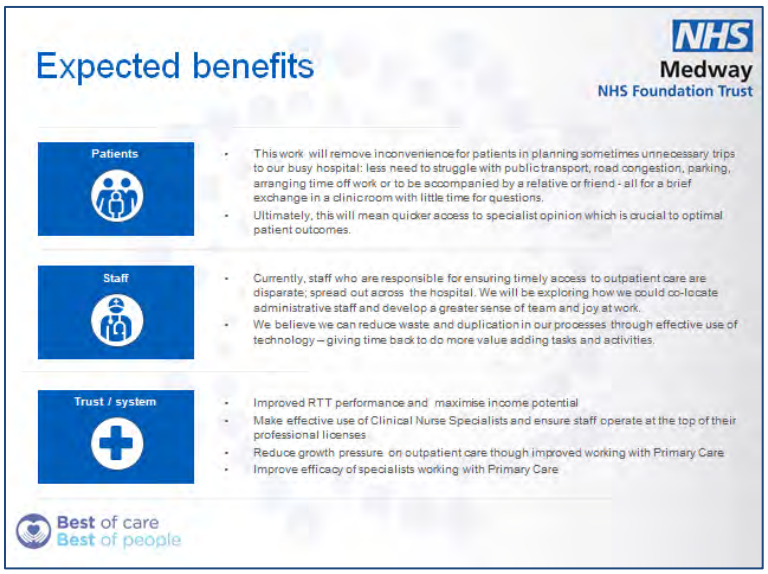
2.3 **STAR Programme mobilises:** During this last period, we have mobilised the Service Transformation and Access Review (STAR programme) led by Dr David Sulch, Medical Director. Our expectation is

that this programme will mean that patients who need to be seen by a specialist in hospital will be seen quicker. We know our performance against the Referral to Treatment standard (sometimes referred to as 18 weeks) must improve. This programme will enable us to do that by removing the waste and duplication from our internal processes, and by modernising our outpatient services through new technologies and smarter clinical pathways.

2.4 We will be exploring the role technology can play, for instance virtual consultations and tele-health for managing long-term conditions. We will be making the most of our skilled Clinical Nurse Specialists to reduce the dependency on Consultants and the bottle-necks that can exist as a result. We will be working to better connect up GPs with Consultants for quick advice over the telephone. We will be considering the role peer support networks can provide in offering patient-to-patient reassurance after a hospital procedure, only coming to hospital for a visit to clinic if they request one.



2.5 Furthermore, this is an investment in our staff. Currently, staff who are responsible for ensuring timely access to outpatient care are disparate; spread out across the hospital. We will be exploring how we could co-locate administrative staff who provide such crucial support to clinical staff as well as often being the first interface between patients and the Trust. Through this, we believe we can reduce waste and duplication in our processes across the x14 building blocks – see above. This Central Access Team concept works incredibly well in other hospitals and the evidence suggests it makes the working environment for those staff much more fun and dynamic, supported by the right tools and IT.



3 Cost Improvement Programme

3.1 As at Month 4, £4.5m has been delivered in cost improvements, adverse to our operational plan by £121k. A total of 22 schemes under delivered by a total of £476k. In contrast 20 schemes over-delivered this month, resulting in the £121k residual variance.

3.2 Based on the re-phasing of some schemes and the progress to develop a pipeline of further efficiencies, we remain confident that we will deliver the target of £18m in cost improvements this year.

3.3 The 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. The PMO continues to support colleagues with finalising a good pipeline of new schemes.

3.4 The recommendations from the recent NHSI/E review of the PMO and CIP infrastructure have all been actioned and/or are ongoing focus areas within the team.

3.5 During the next period, in conjunction with business planning, we will begin planning for next year's CIP, informed by the recently published *Drivers of the Deficit* report.

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 all align directly to the Trust's strategic objectives.

Improvement huddles

Final Yellow Belt presentations

5 Key Milestones

5.1 **Digital Health. London Accelerator partnership.** The transformation portfolio has formed a working partnership the Digital Health.London Accelerator , part of the Health Innovation Network – the Academic Health Science Network of Guy's and St. Thomas' NHS Foundation Trust. This will allow us to bring health technology small and medium-sized enterprises (SMEs) to Medway to support our digital transformation. The companies within the current cohort of the Accelerator are among the most exciting health tech start-ups globally. To begin our partnership with the DH.LA, we will be holding a series of themed 'Innovation Days' over the coming months, the first of which will focus on digital outpatient transformation.

5.2 We have increased the frequency of staff communications about transformation and the communications team has produced a new Transformation Newsletter. In addition, the Executive Director of Transformation authors a weekly blog, focusing on some of the practical realities of change within complex organisations.

Transformation newsletter

Transformation blog

6 A Forward Look

6.1 In the next period, we will:

6.1.1 Refresh our **transformation strategy** over the next 3-years. Guided by the refreshed clinical strategy, this strategy will provide a key contribution to the business plans of care groups, the Trust's Operating Plan and divisional CIP plans into next year and beyond.

6.1.2 Develop a programme to improve **medical engagement and leadership**. Based on semi-structured interviews with a number of MFT Doctors and Nurses, the Executive Director of Transformation and Medical Director will co-author a short paper setting out the current challenges and opportunities to improve how we can engage, incentivise and reward clinicians for Making Medway Brilliant. This will form the basis of a facilitated discussion at an upcoming Executive Team's 90-Day Forum.

6.1.3 **Recruit**. We have the opportunity within the team to recruit more change agents. We will be recruiting via the traditional routes, but we will also explore the possibility of seconding clinicians and operational staff into the team as an opportunity to learn improvement science and help to 'bridge the divide' between transformation and frontline, operational staff.

6.1.4 Host a programme of guest, **external speakers** to inspire and energise our staff and to encourage them to look to the experience of other organisations and sectors when thinking about how we can improve MFT.

7 Conclusion and Next Steps

7.1 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.

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

NHS
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Appendix 1

Transformation portfolio highlight reports:
- Programmes
- Enabling strategies

August 2019

Best of care
Best of people

NHS
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TRANSFORMATION PROGRAMMES – HIGHLIGHT REPORTS

Best of care
Best of people

Highlight report – BEST Flow

Date: 16th August 19
Programme: **Best Flow**
Gateway: *Delivery*

SRO: Harvey McEnroe
RO: Kevin Cairney
TT Lead: Doug McLaren

Status:

NHS Medway NHS Foundation Trust

Activities since last update

- **Full Capacity Protocol (FCP)–** Both co-design workshops haven taken place, early draft dashboard built, early draft protocol written
- **SDEC Business case-** Near complete business case circulated for initial comments
- **60 day plan-** Aspirations of 60 day plan presented at BEST Flow Working Groups 8th August and 15th August
- **Stranded Patient Reviews-** Commenced 13th August, effectiveness reviewed anecdotally at BEST Flow Working Group 15th August
- **FCP project plan –** completed and circulated (on track to deliver)

Upcoming Milestones / Gateways

1. 19th August – Draft FCP ready for comment
2. Wake Up Medway launched – w/c 19 August
3. 22nd August- 60 day plans to be presented at BEST Flow Working Group
4. 28th – 30th August – Long Length of Stay Intervention event - MADE style event focused on ≥14 day LOS patients. ***See page 5***

Highest Risks

Stranded patients and super-stranded patient numbers are high
Mitigation: Accelerate work of IDS/IDT

Highest Priority Actions

Type 3 (MedOCC) performance recovery to exceed 95%
Joint working group (MCH / MFT) established to take urgent actions (Owner: HMc)
NHSi planned to complete walkthrough 15th August

Best of care
Best of people

Risks: Low risk | Moderate risk | High Risk | Extreme Risk

Milestones/ Actions: Completed | On Track | Significant risk of delay

Highlight report – STAR

Date: 16/08/2019
Programme: STAR
Gateway: Design

SRO:David Sulch
RO: Various for workstreams
TT Lead: Jacqui Leslie

Status:

NHS Medway NHS Foundation Trust

Activities since last update

- CCG re-design work ongoing. Definition of scope of work of STAR vs outpatients transformation
- Key messages circulated to Clinical Council (but no discussion due to other key business)
- Approval to recruit Head of Access

Upcoming Milestones / Gateways

1. Complete OVT
2. Initial session with CCG colleagues
3. Listening session with service leads to be arranged following end of holiday period
4. Define KPI's after discussion with service leads

Highest Risks

Ability to focus on programme in face of multiple priorities

Highest Priority Actions

Immediate issue being reported by clinicians wrt missing notes for outpatient appointments

Best of care
Best of people

Risks: Low risk | Moderate Risk | High Risk

Milestones/ Actions: Completed | On Track | Significant risk of delay

Highlight report – Theatres Productivity

Date: 16 August 2019
Programme: Theatres
Gateway: Design

SRO: Gurjit Mahil
RO: Graeme Sanders
TT Lead: Alex Hayes

Status:

Activities since last update

- Quality Impact Assessment presented for approval at QIA Board for approval and accepted.
- Detailed 'draft' project plan developed for the theatres programme and circulated for comment within planned care. (attached below)
- Workstream groups developed to support the programme and circulated for comment. (attached below)
- Surgical specialities are undertaking a demand and capacity modelling exercise for the utilisation of 9 theatres

NB The project plan will be developed beyond October when workstreams go live and detailed actions are determined.

Upcoming Milestones / Gateways

1. 19th August - Surgical specialties to provide robust plans for revisions to operating rotas to accommodate the reduction in theatres from 10 to 9.
2. Wkc 27th August - Project Board kick-off and workstreams' implementation.
3. 2nd September – Closure of Theatre 5..

Highest Risks

Theatre closure CIP delivery is a risk given later start following QIA process

Highest Priority Actions

Refresh programme plan and stand up internal governance

Best of care
Best of people

Risks: Low risk | Moderate Risk | High Risk

Milestones/ Actions: Completed | On Track | Significant risk of delay

Highlight report – Quality Improvement

Date: 16 August 2019
Programme: Quality Improvement
Gateway: Delivery

SRO: Karen Rule,
RO: Jane Murkin
TT Lead: Nick Chambers

Status:

Medway NHS Foundation Trust

Activities since last update

- Quality Priorities (QP) being addressed in other programmes identified: SDEC, SSA, Transfer of Care Concerns, 7 day services. All to report within the relevant programmes.
- Meeting with all QP Leads to scope position in relation to current performance and to identify areas/ services of focus for improvement
- Development of outstanding improvement plans
- Submission of Q1 CQUIN data to CCG

Upcoming Milestones / Gateways

1. Complete prioritisation of improvement projects and gain agreement and support from Divisional Leadership teams (by 31/08/19)
2. Trust wide QI engagement event September 2019
3. Formal reporting to QAC from September 2019

Highest Risks

Risk:
- Maintaining momentum / focus on the programme

Mitigations:
- Effective SRO & RO leadership and governance arrangements
- Project leads engaged and supported
- Executive and Divisional leadership team support for the programme

Highest Priority Actions

- Completion of data and reporting packs for each QP
- Finalise reporting cycle for each QP domain

Risks Low risk | Moderate Risk | High Risk

Milestones/ Actions Completed | On Track | Significant risk of delay

NHS
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ENABLING STRATEGIES – HIGHLIGHT REPORTS

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Highlight report – Digital & IT

Date: 20/08/2019
Programme: Digital Strategy
Gateway: N/A

SRO: Morfydd Williams
RO: Dependent on project
TT Lead: N/A

Status :

NHS Medway NHS Foundation Trust

Activities since last update

The digital enabling strategy is made up of a portfolio of programmes to upgrade and improve our infrastructure, better utilise our clinical systems and introduce new systems and technology. It also supports the enabling estates strategy.

- Quality Strategy: ExtraMed weekend handover is now live. Replacing the paper process with electronic and providing a full audit trail.
- Quality Strategy: Work is continuing on electronic nursing assessment with a planned live date in mid-August.
- Clinical Strategy: New commissions have been accepted to provide dashboard in ED Majors and SDEC to provide patient waiting times.
- Quality Strategy: Pilot is being scoped to use computer robots to support routine activities in patient services, for example RTT
- Clinical Strategy: Wireless upgrade continues across the Trust – this will support future deployments of ExtraMed functionality e.g. Mobile Medic
- Clinical Strategy: EDRMS pilot of the new paperless case note to begin on 9th September in the Sleep service.

Upcoming Milestones / Gateways

- 23 August: Decision to be made by theatres on which system to use: Galaxy or move onto the PAS theatres module.
- 23 August: Options appraisal to be completed for the replacement of switchboard
- 30 August Decision to be made by maternity on the way forward regarding continued use of Euroking.
- 09 September go-live for EDRMS pilot

Highest Risks

Switchboard is very old technology which became very over heated in the recent heatwave. Extra cooling has been installed. An options appraisal on replacement has been commissioned, with a view to take a business case to the capital group.
The rate of roll-out of the EDRMS is dependent on the pace of scanning. Business case to be prepared to out-source scanning of notes.

Highest Issues

GP Pilot sites will conclude in September, and roll-out of order comms in the Trust will continue until beginning of December, therefore having a paperless go-live date in Winter pressures

Best of care
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Risks: Low risk | Moderate Risk | High Risk

Milestones/ Actions: Completed | On Track | Significant risk of delay

Highlight report – Continuous Improvement

Date: 2nd August 2019
Programme: CI Enabling strategy
Gateway: Delivery

SRO: James Devine
RO: Nick Chambers
TT Lead: Adam Walton

Status:

Medway NHS Foundation Trust

Activities since last update

- **ICP Yellow Belt training –** inaugural training across our ICP, members of MCH, CCG and MFT
- **ICP system workshop** – inaugural system wide workshop to improve care for +3 LTC patients
- **Improvement system –** now in place throughout Surgical and Frailty wards
- Yearly target for YB training now met at 150

Upcoming Milestones / Gateways

1. Improvement System to be delivered across Finance teams – August
2. Continuation of Yellow Belt training across the ICP – next date in October
3. First milestone of the +3 LTC workshop

Highest Risks

Lack of training spaces for ICP
Coordination of rooms across the system with colleagues from partnering organisation

Highest Priority Actions

Collaborate with ICP colleagues to share training resource

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Risks: Low risk | Moderate Risk | High Risk

Milestones/ Actions: Completed | On Track | Significant risk of delay

Highlight report – Estates

Date: 5th August 2019
Programme: Estates Strategy
Gateway: Delivery

SRO: Gary Lupton
RO: TBC

Status:

NHS Medway NHS Foundation Trust

Activities since last update

- Creation of early draft Estates Strategy
- Review of key site tenant and their plans

Upcoming Milestones / Gateways

1. Completing first draft - end of August 2019
2. Ensure draft aligns with approved strategies – end of September 2019
3. Receive latest bed modelling from HM team – end of August 2019

Highest Risks

Ensure alignment to Clinical Strategy
Mitigation: Regular discussion at TOB and with Medical Director

Highest Priority Actions

Working with ICP colleagues, collate the Medway & Swale property portfolio, looking at optimising clinical and non clinical space

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Risks: Low risk | Moderate Risk | High Risk

Milestones/ Actions: Completed | On Track | Significant risk of delay

Highlight report – Communication & Engagement

Date: 16 August 2019
Programme: Comms & Engagement
Gateway: Delivery

SRO: Glynis Alexander
RO: TBC
TT Lead:

Status:

Medway NHS Foundation Trust

Activities since last update

- **Engaging staff** – senior manager meeting focus on embedding quality (ahead of CQC)
- **Showcasing success** – Making Medway Brilliant first newsletter drafted and approved
- **Motivating and inspiring change –** thought leadership blogs shared with staff by email and on intranet
- **Stakeholder engagement** – briefings with two MPs covering transformation (esp flow) and priorities.

Upcoming Milestones / Gateways

1. Transformation newsletter to be distributed to staff – hard copy and electronic.
2. Stakeholder engagement – presentation to council scrutiny committee 20 August on our priorities and transformation programme.
3. Staff briefing 27 August

Highest Risks

Multitude of messages – using newsletter to cover several areas of focus.
Lack of engagement by staff – will require repetition and use of multiple channels.

Highest Priority Actions

Outpatients programme – engaging staff through direct contact.
Raising awareness of breadth of transformation programme, through newsletter.

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Best of people

Risks: Low risk | Moderate Risk | High Risk

Milestones/ Actions: Completed | On Track | Significant risk of delay

Medway NHS Foundation Trust

Appendix 2

BEST Flow update, August 2019

Harvey McEnroe
Chief Operating Officer

Jack Tabner
Executive Director of Transformation

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Best of people

NHS Medway

The story of the last few weeks

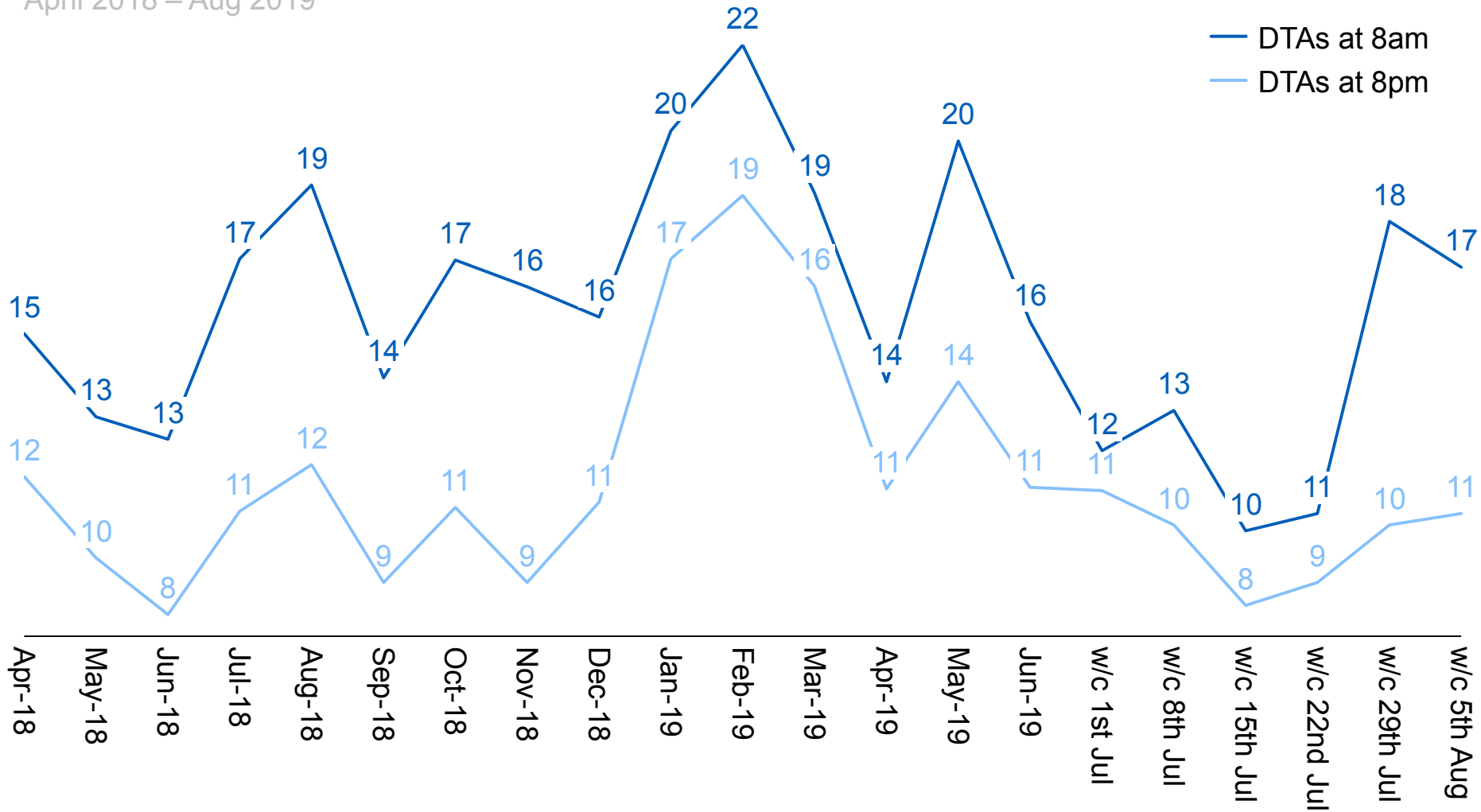
Our short term plan

NHS Medway

After an improvement in June and July, the DTA position has worsened significantly in the last 2 weeks

Average number of daily DTAs,

April 2018 – Aug 2019

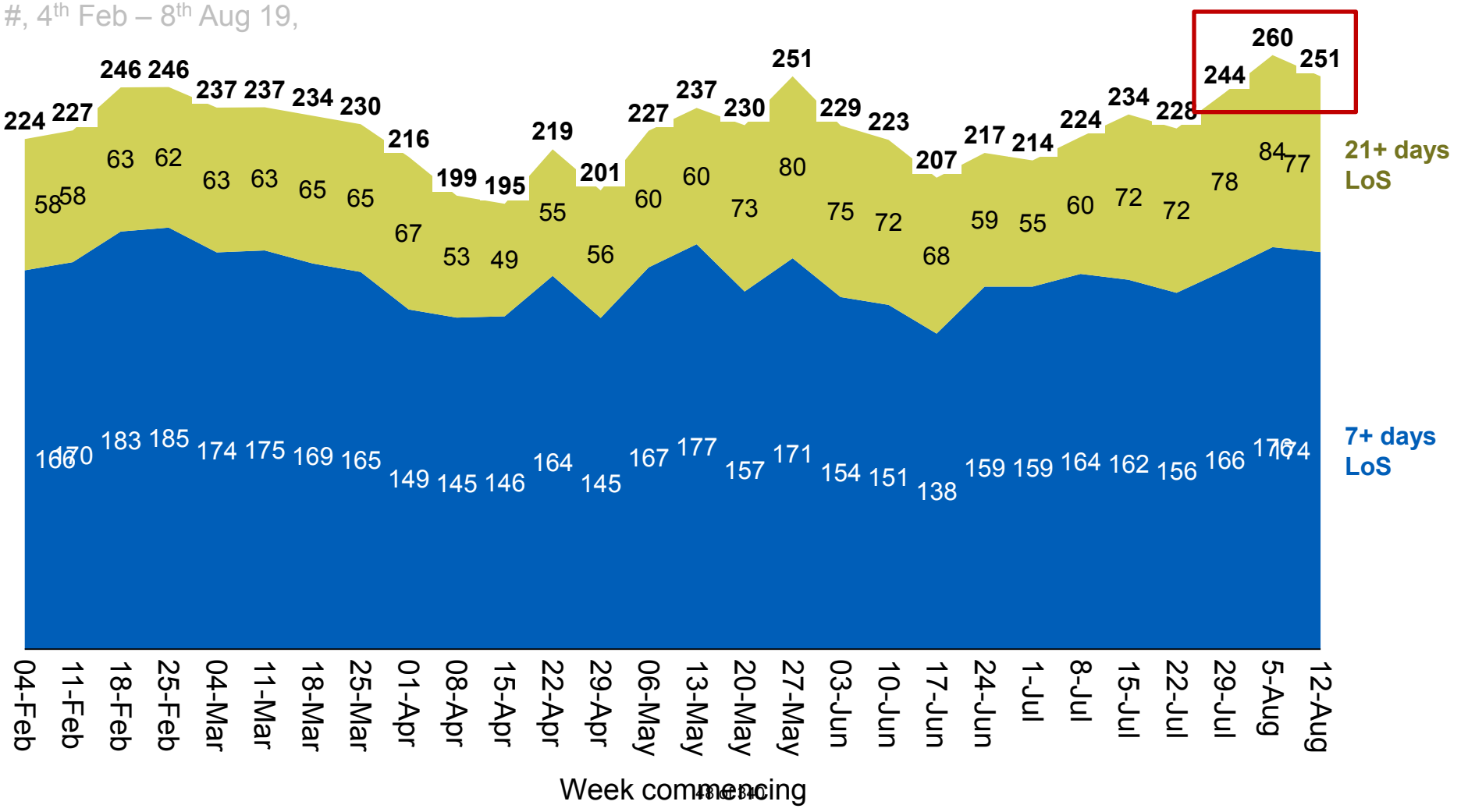


transformation nous

NHS Medway

Stranded and super-stranded patients are at their highest this year, taking up ~1 ward's worth more than in April-June

Average daily number of stranded patients (LoS 7+ days) and super-stranded (21+ days) by week, #, 4th Feb – 8th Aug 19,



Source: UEC Dashboard South Region

NHS Medway

Despite mobilisation and challenge, an increase in activity and the stranded patient position has offset our efforts over the last two weeks

Intensified efforts

- TN supported implementation is in full swing
- Board Round improvements are ongoing with additional support and challenge to delays
- Upgraded site processes to improve operational grip
- Increased exec involvement and participation
- Daily line by line stranded review led by senior nurses

Increased discussions at system level

- Increased the challenge and the involvement with partners to decrease stranded position
- We are asking them for intensive support and faster decisions for medium long term to set the 'battle rhythm'
- Limited action and tangible results yet

However….

- MFT number of bed blocked by **stranded patients has increased from ~220 to ~250**
- Blocked beds +15%
- Discharges for entire bed base has fallen from 53 to 50 (-6%)

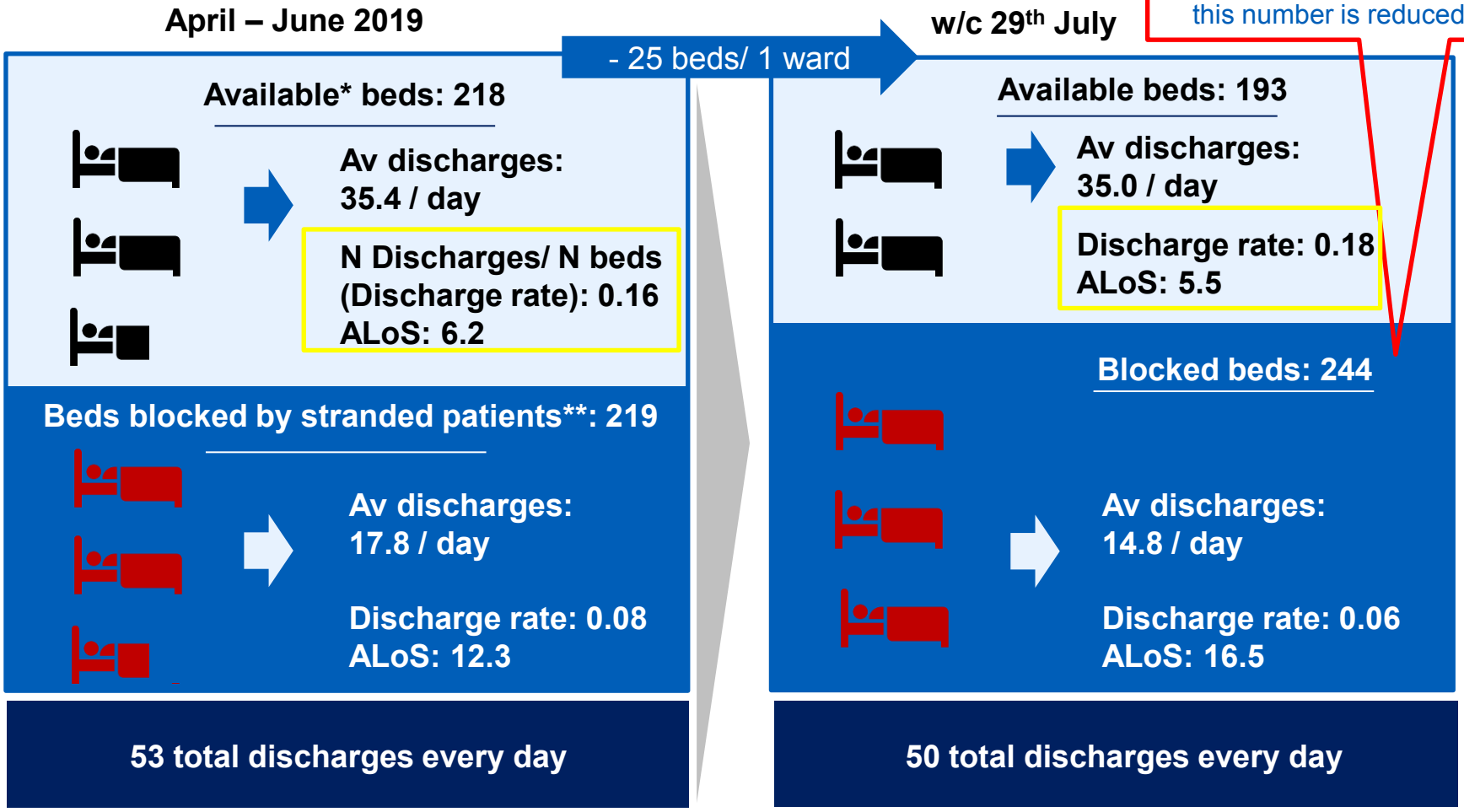
Stranded pts has gone up more than discharges gone down

Source:

NHS Medway

Stranded pts number has increased, squeezing space available for daily hospital ops and limiting the impact of our intensified effort

Last week this was 260 – we cannot improve discharges as needed until this number is reduced



*Available beds = beds not blocked by patients LOS > 7 days; **LOS > 7 days

Source: Trust IP and TN team analysis; total bed base for NEL patients, exc paeds and short stay = 446

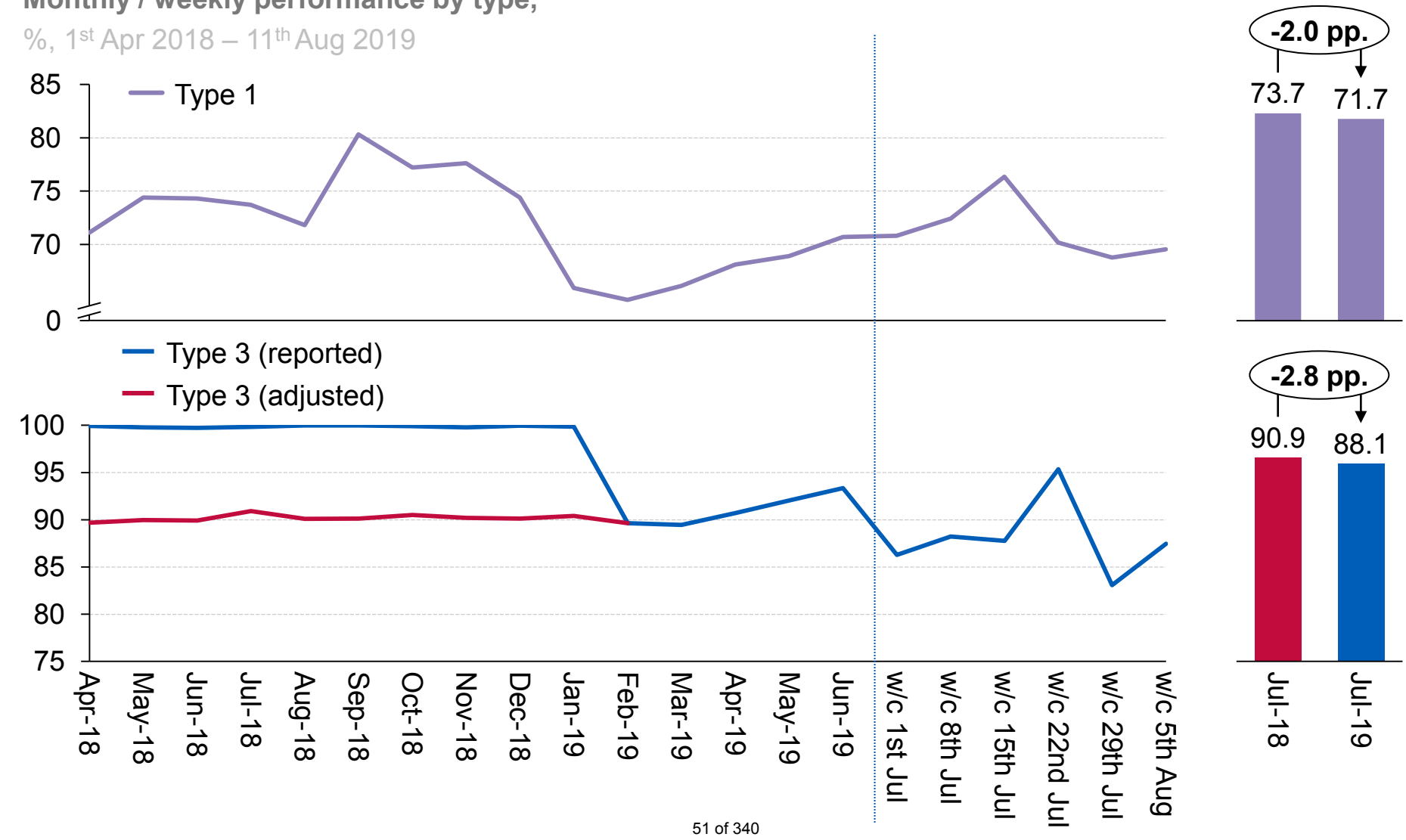
transformation nous

NHS Medway

T1 performance had been improving before the last 2 weeks. T3 is more challenged than ever

Monthly / weekly performance by type,

%, 1st Apr 2018 – 11th Aug 2019



Source: MFT DSIT reports

NHS Medway

Compared to SEL hospitals, our T1 is close to the best performer and has improved relative to others. We're an outlier in T3 though

Daily performance by type, MFT vs SEL,

%, 5th Aug 2019 – 11th Aug 2019

We don't yet have the data for neighbouring hospitals, but will conduct similar comparison once we do

Type 1

	DH	PRUH	GSTT	UHL	QEH	MFT
Previous month (July)	57.08%	64.95%	77.14%	73.11%	57.37%	72.14%
w/c 22nd Jul	61.70%	71.79%	77.60%	71.45%	59.40%	70.18%
w/c 29th Jul	53.61%	75.89%	79.72%	67.50%	56.07%	68.77%
05-Aug-19 (Mon)	64.81%	64.63%	83.96%	72.32%	61.81%	76.31%
06-Aug-19 (Tue)	57.67%	52.63%	75.32%	69.66%	67.36%	84.32%
07-Aug-19 (Wed)	65.09%	50.58%	77.57%	62.86%	69.55%	79.35%
08-Aug-19 (Thu)	78.69%	57.54%	76.79%	79.89%	65.63%	77.69%
09-Aug-19 (Fri)	67.46%	47.09%	80.86%	62.60%	71.31%	70.97%
10-Aug-19 (Sat)	53.14%	40.11%	81.55%	78.99%	66.96%	82.33%
11-Aug-19 (Sun)	66.94%	43.06%	71.50%	66.26%	74.09%	78.17%
Month to date (Aug)	62.61%	49.54%	78.52%	71.58%	71.48%	69.18%

In T1, we're catching up with top performers

Type 3

	DH	PRUH	GSTT	UHL	QEH	MFT
Previous month (July)	80.81%	96.55%	99.77%	92.88%	95.50%	89.35%
w/c 22nd Jul	82.84%	97.28%	99.50%	92.67%	93.64%	70.18%
w/c 29th Jul	73.72%	98.34%	100.00%	91.36%	95.50%	68.77%
05-Aug-19 (Mon)	71.29%	93.98%	100.00%	100.00%	84.40%	75.68%
06-Aug-19 (Tue)	70.00%	99.43%	100.00%	98.45%	84.26%	96.49%
07-Aug-19 (Wed)	86.23%	97.16%	100.00%	84.44%	97.77%	87.02%
08-Aug-19 (Thu)	95.45%	99.35%	100.00%	95.29%	96.62%	85.89%
09-Aug-19 (Fri)	95.39%	98.68%	100.00%	99.44%	96.77%	82.19%
10-Aug-19 (Sat)	88.57%	99.37%	100.00%	100.00%	95.07%	97.92%
11-Aug-19 (Sun)	92.00%	95.98%	100.00%	100.00%	98.10%	86.94%
Month to date (Aug)	83.88%	98.29%	100.00%	97.49%	93.77%	85.34%

In T3, we are distant from the pack and on par with the other worst performer (DH)

Source: SEL performance report, MFT DSIT report

transformation nous

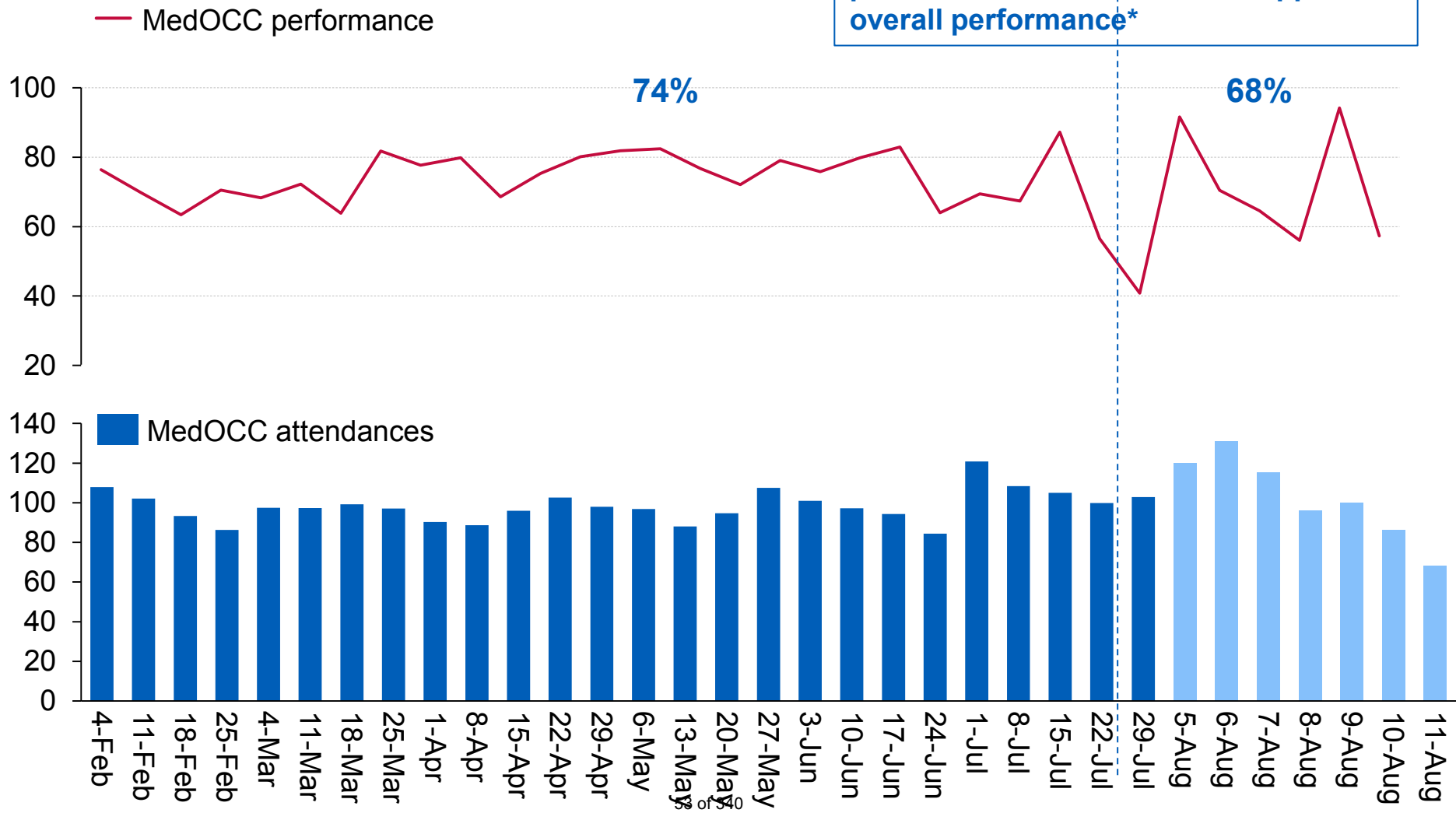
NHS Medway

MedOCC performance is not getting better and is inconsistent

Avg daily MedOCC attendances and performance by week,

/ %, 4th Feb 2019 – 11th Aug 2019

Given MedOCC accounts for approx. 20% of our total attendances, its current performance costs us almost 6pp in overall performance*



* Current performance vs. the average performance of T3 nationally of 99%

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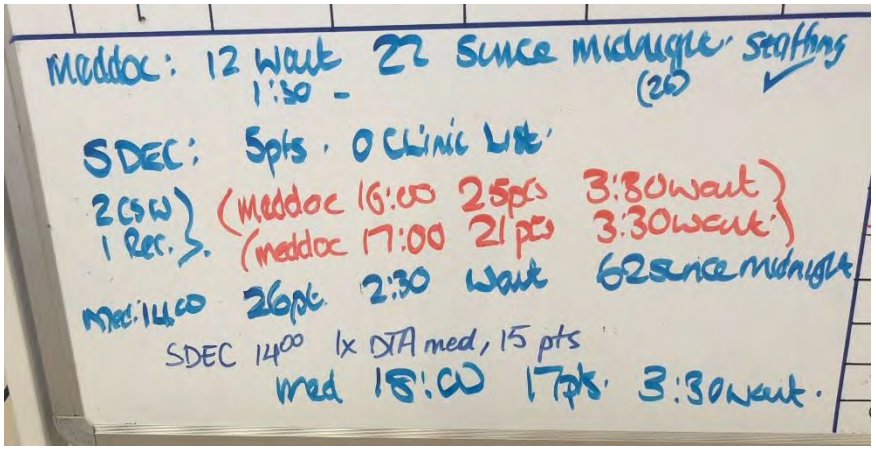
MedOCC performance remains challenged

Example:
On Wednesday, we paused streaming to MedOCC as the wait time increased. Despite this, they did not get on top of their wait time



SDEC:
2pm: 26pts waiting, 2hr30 wait
4pm: 25pts waiting, 3hr30 wait
5pm: 21pts waiting, 3hr30 wait
6pm: 17pts waiting, 3hr30 wait

In the last few weeks, we have frequently (almost every day) interrupted streaming to MedOCC for one or more hours.

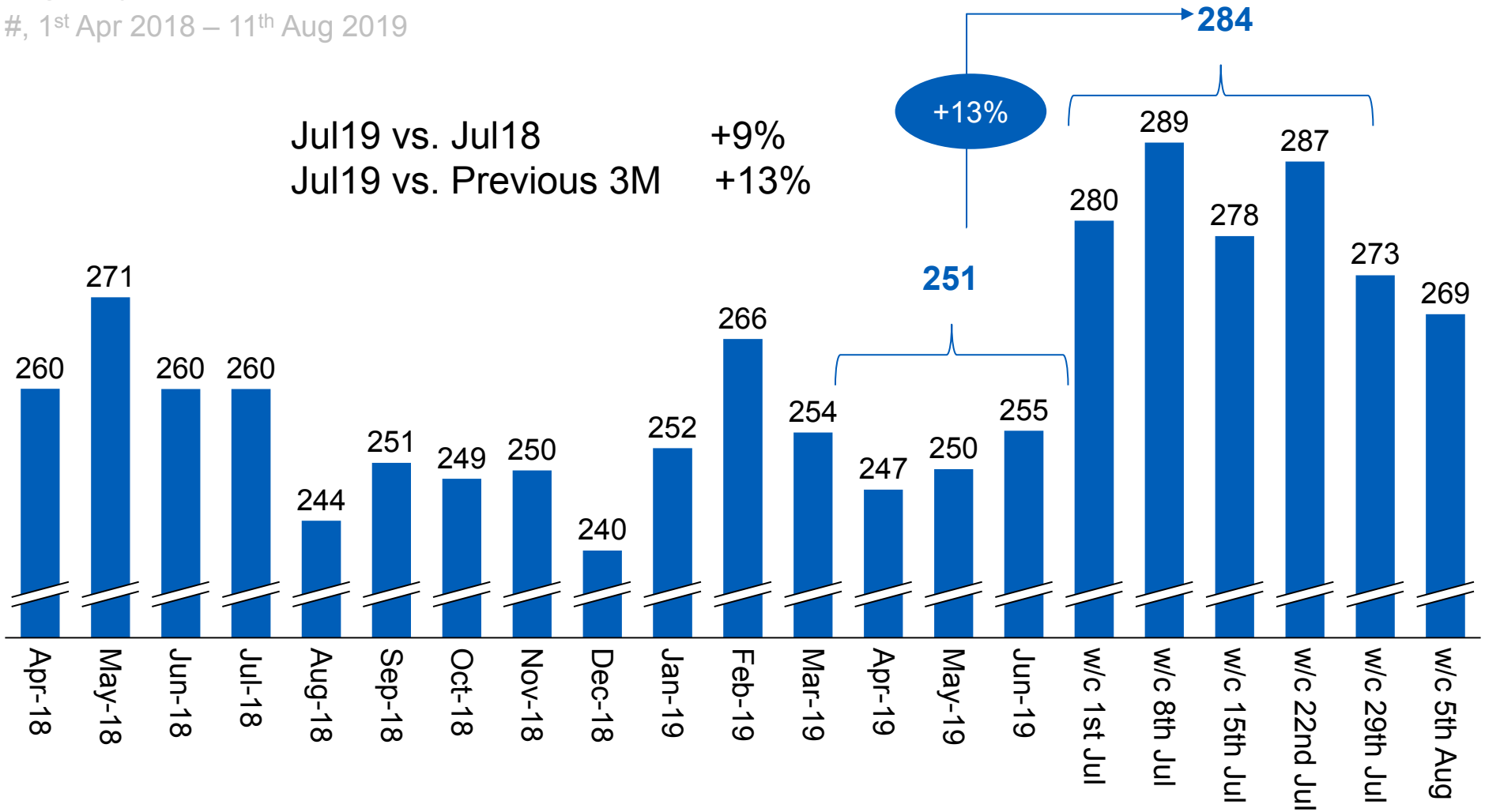
- Unable to meet demand
- Inconsistent performance regardless of attendance numbers
- No significant and sustained improvement despite additional resources
- Still data collection and validation issues

NHS Medway

T1 attendances were up significantly in July, and have only slightly decreased in the last 10 days

Avg daily A&E attendances (T1),

#, 1st Apr 2018 – 11th Aug 2019



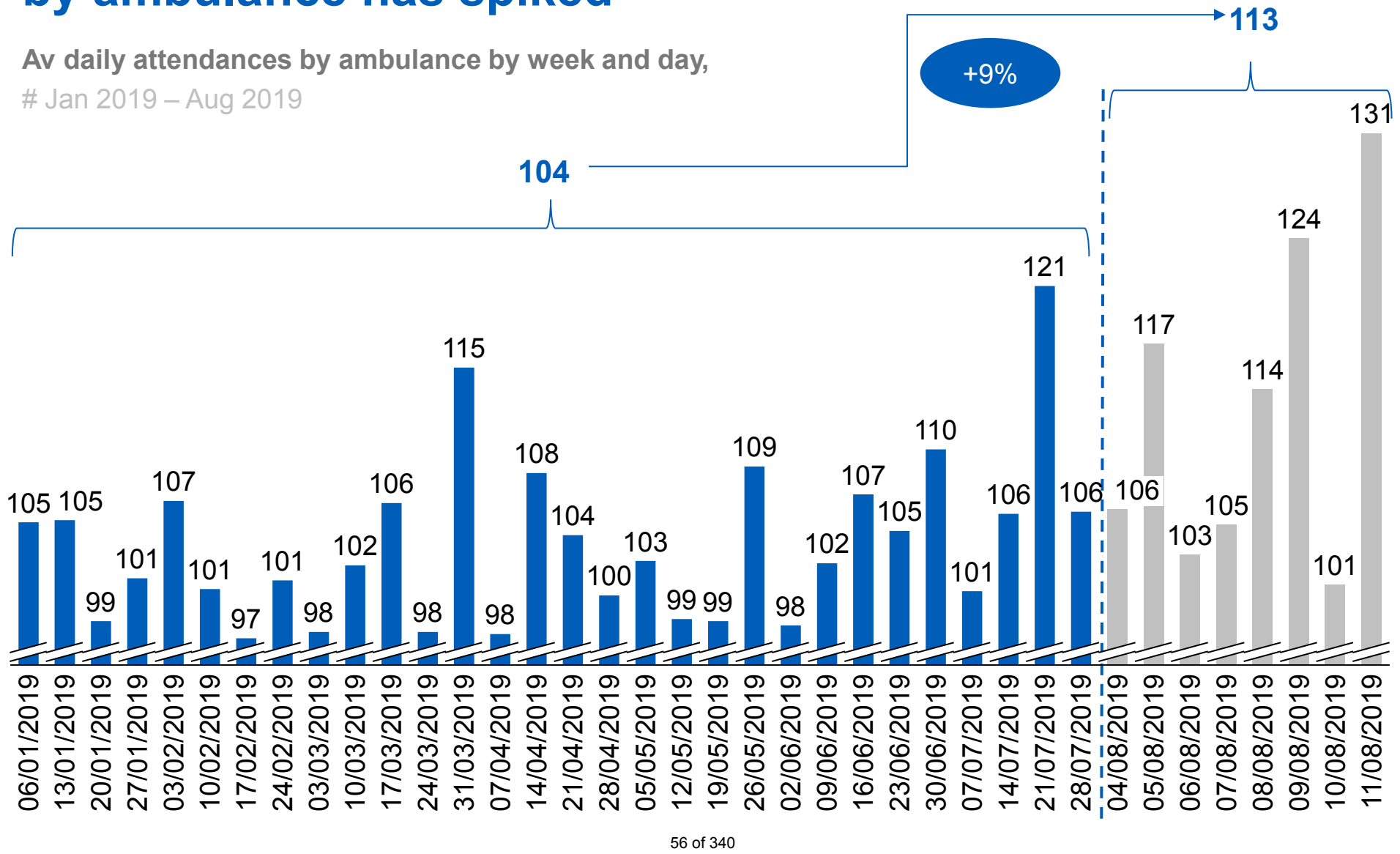
 Source: MFT ED data

NHS Medway

In the last two weeks the average number of arrivals by ambulance has spiked

Av daily attendances by ambulance by week and day,

Jan 2019 – Aug 2019



 Source: MFT ED data and DSIT daily reports

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NHS Medway

The story of the last few weeks

Our short term plan

transformation nous

NHS Medway

Our immediate focus needs to be to up the rhythm and effectiveness of daily operations while implementing the following initiatives

Site management & Huddles

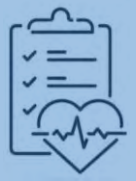
Ward operations

Immediate focus that needs to take us to the national average and beyond

Supported discharge

Frailty capacity

Frailty - FEAT



The following initiatives need to be worked up in detail implemented

Acute medicine Rota

SDEC Hot

Full capacity protocol

Improvement initiatives

Operational discipline focus

58 of 340

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Our 15-day priorities aim to give us “breathing space”

Supported discharges: Internal processes and system

- Twice weekly operational sessions focusing on over 21 day patients with community support
- Use all of available capacity! New process agreed and starting on Monday for Home First. Everyday we need to be aiming to fill out 8 home first slots
- Redesigned permanent stranded process to reach all wards, including building a feedback loop of actions

Site and wards

- **Embedding unplanned huddle** (established at the end of the OVT) and **planned huddle** (started this week)
  - Daily challenge and problem solving to expediate discharge and set a new ‘operational rhythm’
  - Focus on ‘re learning’ patient pathways by moving the right patient to the right bed
  - Use of targets and bed balance to drive hospital, programmes and wards to meeting their ‘demand’
- **Embedding new board round SOP across phase 1 wards and phase 2 wards and attendance at phase 3 wards (i.e. all wards)**
  - Building hospital picture (mental screens of not just pts on a ward but all patients who need a bed)
  - Identifying MO patients and providing challenge of why this patient needs an acute bed
  - Identifying specific actions and then following up those actions
  - Use of visual tools to record and follow up on actions and drive accountability
  - Focus on opportunity in terms of failed daily discharges due to (EDNs, TTO, etc)

SDEC

- Introduce use of Symphony to track patients
- Move 2 registrars from ED to SDEC to eliminate issue with retrograde flow and prepare for increased activity from 1st September

Review non essential meetings for the next two weeks to allow teams to focus on operations

15-day plan on stranded patients

1. Discharge “market place” (29th of August)
2. Daily review of patients over 7 days for 2 weeks
3. Trial of 2 other wards engaging with daily MF meeting with 10 minute slot at beginning of meeting

Source:

15-day

NHS Medway

The 'Discharge Marketplace' event at MFT will be a standalone event with the aim to reduce stranded patient numbers by half

DAY -7 (Week of 19th Aug 2019)

Preparatory Comms

- The plan for the event is communicated across the Trust and partners a week ahead of time
- A snapshot DPTL list (patients over 14d LoS) is distributed to all teams, and serves as a guide to help teams plan for extra resourcing and optimise processes

DAY 1 (Wed 28th Aug 2019)

"Preparation Day"

- A refreshed DPTL list is emailed to MFT teams and community partners in the morning
- All internal and external teams to prepare for and execute the pre-prepared solutions

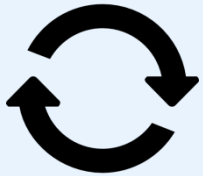
DAY 2 (Thu 29th Aug 2019)

"Action Day"

- MFT and community colleagues meet to collectively review each patient in turn and share solutions
- Each patient is matched to a discharge destination / service
- The discharge plan is put in place with immediate effect

DAY 3 (Fri 30th Aug 2019)

"Closing the Loop"



- Allocated leads per ward ensure that the discharges have been completed
- Any outstanding issues are escalated as appropriate

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In addition we have started a daily reviews of stranded patients as part of the 15-day plan

Start: 10am, Tues 13th Aug

Duration: 3 weeks, every morning

Objective:

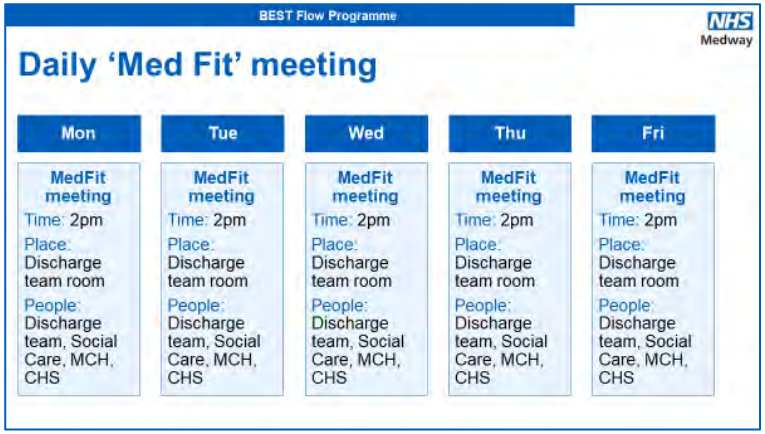
- Reduce number of super-stranded (21d+) patients by half
- Reduce number of stranded patients (7d+) to mitigate risk of becoming super-stranded

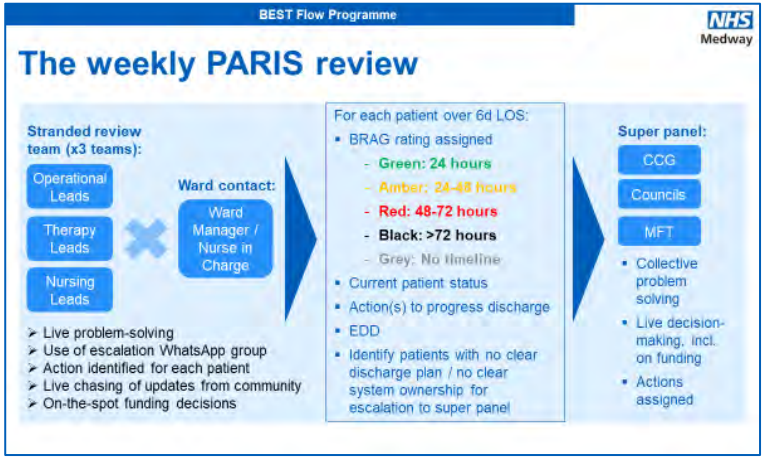
Each ward is allocated 10 mins to provide discharge plans/updates for each patient 7d+ LoS (whether MF or not)

10:00 TOP wards
10:30 Specialty wards
11:00 AEC wards
11:30 Surgery wards

- The Review Team stays consistent throughout the week, so that follow-up is more effective
- Wards return the next day to provide updates on discharge plans
  - IDT/Discharge Team also provide updates on complex cases
  - Issues are escalated to internal/external teams as appropriate
- TN will collect data on wait/delay reasons and community services required

Teams have agreed to trial a 'Med Fit Plus' meeting that invites wards to develop detailed discharge plans with the IDT and Discharge Team





2x weekly 'Med Fit Plus' meeting

- Ward representative meets discharge team and IDT to discuss all patients who are (or are anticipated to become) complex
- Together, teams devise detailed, discharge plan for each of these patients and problem-solve any (anticipated) blockages
- Actions are reviewed together twice weekly to ensure that discharge plans are progressing

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The main initiatives in the 15-day plan

1 Supported discharges

- Agree with partners the way forward to reach the right "battle rhythm"
- Make process more effective (current PARIS not working)
- Improve spec of IDS
- Start conversations about a TOCC-style model

2 Frailty capacity - Wakeley

- Cohort currently outlying Frailty patients on Wakeley
- Ward to be under Frailty and Specialty (not AM)
- Focus AM on 2 wards
- Facilitate ownership of Frailty patients
- SAFU to be used for intended purpose of assessment + short stay

3 Frailty - FEAT

- Create team at the front to receive and direct patients on right pathway
- "Feed" SAFU
- Early MDT intervention
- Improved more coordinated way of working

4 Acute Medicine rota

- Move to a "T0-T3" model, to ensure continuity of care for patients for the 1st 72 hours in the hospital

5 SDEC Hot

- Increase number of "hot" patients going through SDEC
- Increase hours of service
- Improve staffing to ensure closing on time with no "leftover" patients
- Introduction of Symphony

6 Full Capacity Protocol

- Whole hospital FCP, signed up to by all programmes at operational and clinical level
- Clear KPIs with forecasting power to anticipate issues

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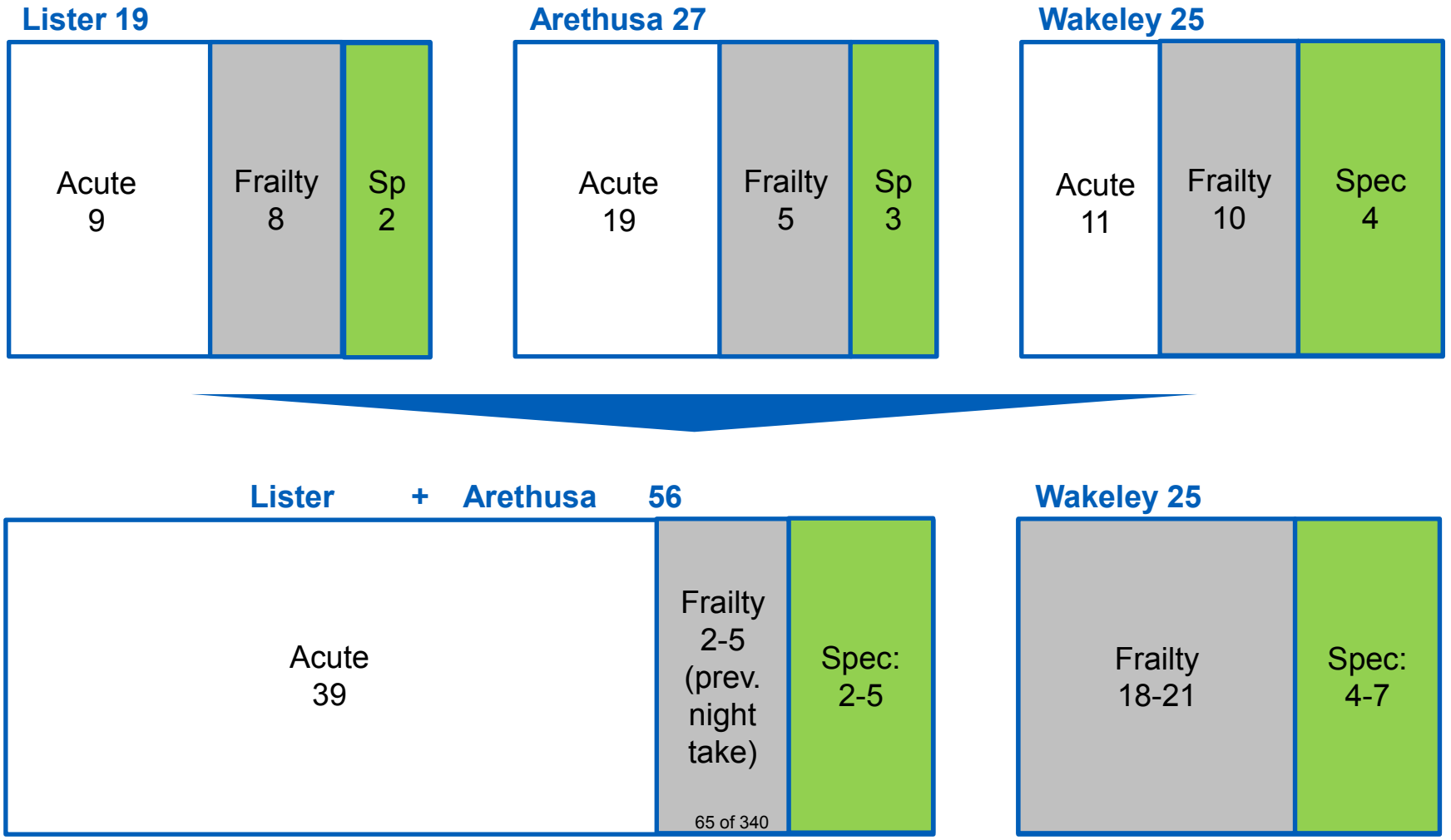
Cohorting patients to make ownership and care easier

We should allocate a portion of Wakeley as additional Frailty bed base while waiting for the benefits of the work on stranded patients / supported discharges to kick in. This would free AM from ownership of Wakeley and allow them to focus on their two key wards.



21 Average of Mon-Wed 12-14/8

NHS Medway

Co-horting of Frailty on Wakeley: Frailty will produce a plan by end of this week

- Numbers indicate it should fit – it might not be perfect…but it will be better than current (TN to refine model and confirm with teams)

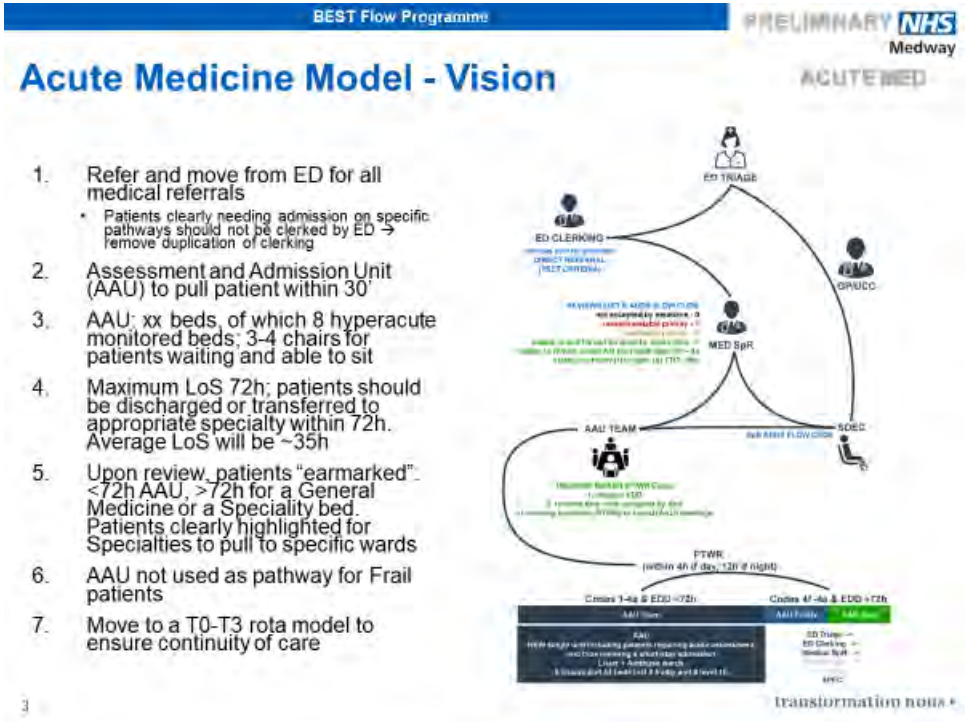
- We will need a clear, strong SOP (Frailty/AM/Site) to:
  - Determine which patients go where
  - How do deal when flow to Frailty or specialty wards is delayed (how to prioritise patients, who looks after patients)

- Frailty assessment: restore SAFU for its intended use as much as possible

- Does this require changes in staffing/resources? (Frailty team to make a proposal)

- Strong Site management of the pathway to ensure right patients to SAFU and Wakeley (to be managed though daily huddles)

Acute Medicine vision: what can we do in the next 15 days?



1. **Move to a T0-T3 rota model** to ensure continuity of care
2. **Refer and move from ED** for all medical referrals
   - Patients clearly needing admission on specific pathways should not be clerked by ED → **remove duplication of clerking**
3. **Assessment and Admission Unit (AAU – Lister and Arethusa)** to pull patient within 30'
4. **Maximum LoS 72h**; patients should be discharged or transferred to appropriate specialty within 72h. Average LoS will be ~35h
5. **Upon review, patients "earmarked":** <72h AAU, >72h for a General Medicine or a Speciality bed. Patients clearly highlighted for Specialties to pull to specific wards
6. **Frail patients**: only on AAU for assessment when cannot be pulled directly by Frailty; to be pulled to Frailty bed base asap
7. **AAU "coordinator"** to manage flows to AAU from ED and from AAU to other wards (To be agreed)

Implementation relies on successfully reducing the n of Frail patients on the AAU

When in "full swing", AAU will be the "engine" of the pathway and will be a busy ward with a key role

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transformation nous

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Suggested KPIs for these initiatives

Initiative	Proposed KPIs	Responsible officers
Supported discharges	▪ 7+ patients to be below 180 (245 on the 2/8/19)	Nursing: Tarina Operations: Kevin
Frailty capacity	▪ Frailty outliers on Lister and Arethusa (Frailty patients >72h)	Clinical: Sanjay Ops: Beki
FEAT	▪ LoS reduction in SAFU ▪ 75% eligible pts out of ED in 2hrs	Clinical: Sanjay Nursing: Karen Ops: Beki
Acute medical model	▪ 35% daily discharge rate ▪ Only 5% patients on unit for greater than 72hrs	Clinical: Paul Kitchen Operations: Kevin
SDEC 'hot': 1st of September	▪ 75% of hot activity in SDEC is from ED ▪ Follow up ratio as defined per business case ▪ Other KPIs: Pt seen per hour (TBA), conversion rate 10-30%, mean LoS less than 3hrs, triage less than 15 minutes	Clinical: Mo Nursing: Claire Hughes Operations: Doug McLaren
Full capacity protocol	▪ Reduction in ambulance handovers (<60 minutes) ▪ 4hr performance	Clinical: Paul K Nursing: Karen M Operations: Kevin

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	Integrated Quality and Performance Report	**Agenda Item**	**5.1**
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 July 2019 operational and quality performance across key performance indicators. The summer months have remained very busy and staff have worked hard to deliver high quality care and good operational performance to ensure patients are seen and treated safely and promptly. Our Infection Prevention and Control (IPC) performance is reported in detail to Board this month. Of note for July we reported one MRSA bacteraemia bringing us to a total of 3 against a trajectory for the year of no more than 4.The report from the Director of Infection Prevention & Control will present the detail of our IPC improvement plan. Our Hospital Standardised Mortality Ratio (HSMR) of 104 means we are not a national outlier for mortality and we have seen a significant improvement in mortality for our frail patients in the week. The focus of ongoing mortality review work is for our frailty patients at the weekend with mortality at 116 compared to 100 for week days. The work undertaken by the Medical Director to review a suspected link between mortality and long patient waits in the Emergency Department (ED) has not been substantiated. Good improvement in the rate of falls has been reported. This improvement has been supported by improved compliance with falls documentation, at 91% in July. Pressure ulcer acquisition is within our mean rate more there is more work to be done to reduce our rates, particularly on Pembroke Ward which reported the highest number of pressure ulcers in July. The Trust is participating in a NHS Improvement (NHSI) pressure ulcer collaborative which launches on 4 September. Reducing our same sex accommodation breached remains challenging but we are focusing our work in the right area; critical care. To support our work to improve patient experience and achieve improved Friends and Family Test (FFT) scores, we are in discussion with Lesley Goodburn, Senior Improvement Manager, NHSI. Lesley has recently supported South East Coast Ambulance Service (SECAmb) and other Trusts working to elevate their patient experience work. The first step will be for the Trust to complete a self-assessment against the national patient experience framework and to then share a draft action plan with Lesley.		

	Electronic Discharge Notification (EDN) performance remains unsatisfactory and a refreshed work stream has been set up to accelerate the pace of change required to improve performance. 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. The Venous thromboembolism (VTE) process put in place some months ago has delivered sustained change but the holiday period and the number of ward clerk vacancies has identified a need to train additional staff in VTE assessment documentation. This is in place. Escalation beds have remained open to support timely admission and treatment on non-elective patients. In addition we have seen an increase in medically fit patients and an increase in Length of Stay (LOS). Daily bed by bed reviews are being undertaken to maximise discharge numbers with a view to closing escalation beds as soon as possible. On a positive note a reduction in medical outliers has resulted in the Sunderland Day Care centre (SDCC) being used less for displaced surgical patients which has a positive impact on patient experience and minimises risk. The Trust did not meet the 4 hour performance standard; however Type 1 performance has seen an improvement from the June position. 18 weeks referral to treatment (RTT) performance remains steady at 82% but below trajectory with working groups underway in order to improve. An improved performance for Diagnostics was seen in July achieving 95%; however endoscopy capacity remains a concern. Cancer performance has significantly improved in June to 90% (2week wait) and 82% (62 day), with a projection to achieve national standards within the next quarter. We have maintained compliance with Trust target for appraisal and statutory and mandatory training, which indicates better engagement of all staff with these essential requirements to ensure we have a competent workforce.	
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

July 2019

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EXECUTIVE SUMMARY

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NHS Medway NHS Foundation Trust

EXECUTIVE SUMMARY

Safe:
The Trust continues to comply with the Infection Control Improvement Plan. The Trust has seen 4 cases of MRSA Bacteraemia since April 2019, within the agreed trajectories. There has been further work carried out into the C. Diff and E. Coli infection cases, with executive representation at each Post Infection Review (PIR) Meeting. The Trust has reported a steady reduction in the HSMR reaching 104, which is not an outlier. Falls documentation has improved to 91% in July.

Caring:
The recommended rates for our Outpatients and Maternity services remains above the national average, however, as a Trust we are aware we need to improve the response rates and also the ED FFT rates. The MSA breaches remain high, in particular this is caused by the Critical Care step downs, this is a clear focus area within the Best Flow Programme. EDN completion within 24 hours now has a specific working group tasked to ensure completion and to resolve identified IT issues.

Effective:
The #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. The VTE process put in place some months ago has delivered sustained change but the holiday period and the number of ward clerk vacancies has identified a need to train additional staff in VTE assessment documentation.

Responsive:
The Trust did not meet the 4 hour performance standard, however Type 1 performance has seen an improvement from the June position. 18 weeks RTT performance remains steady at 82% but below trajectory with working groups underway in order to improve. An improved performance for Diagnostics was seen in July achieving 95%, however endoscopy capacity remains a concern. Cancer performance has significantly improved in June to 90% (2ww) and 82% (62 day), with a projection to achieve national standards within the next quarter.

Well Led:
We have maintained compliance with Trust target for appraisal and statutory & mandatory training, which indicates better engagement of all staff with these essential requirements to ensure we have a competent workforce.

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SAFE

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Safe

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SAFE

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	12M	Trend
Harm Free Care	Falls Per 1000 Bed Days	6.6	#	4.03	3.63	3.96	4.02	4.47	5.2	7	4.55	4.73	4.74	5	4.19	4.61	
	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	1.0	#	0.06	0.06	0	0	0.12	0.24	0	0	0.2	0.06	0	0	0.06	
Incident Reporting	Never Events	0.0	#	0	0	0	1	0	0	0	0	0	2	0	0	3	
	No of SIs on STEIS	90.0	#	15	4	10	6	6	7	6	4	5	20	8	11	102	
	% of SIs Responded To In 60 Days	-	%	100	100	100	93.33	100	100	100	100	100	100	100	100	99.07	
Infection Control	MRSA Bacteraemia (Trust Attributable)	5.0	#	3	0	1	0	1	0	0	0	0	1	1	1	8	
	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	43.0	#	-	-	-	-	-	-	-	-	3	2	7	5	17	
	C-Diff: Hospital Onset Hospital Acquired (HOHA)	-	#	-	-	-	-	-	-	-	-	3	2	1	1	7	
	E-coli (Trust Acquired) Infections	30.0	#	4	6	2	4	4	4	7	3	5	4	6	6	55	
Mortality	Crude Mortality Rate	2.5	%	1.31	1.44	1.41	1.35	1.14	1.29	1.51	1.92	1.5	1.9	1.78	1.46	1.49	
	HSMR (All)	100.0	%	114.41	116.17	113.3	111.38	109.91	107.35	103.88	104.15	103.54	-	-	-	109.44	
	HSMR (Weekday)	100.0	%	114.87	116.25	112.54	111.23	109.28	105.46	100.66	100	100.27	-	-	-	107.95	
	HSMR (Weekend)	100.0	%	112.5	115.22	114.8	111.13	110.79	111.79	112.74	115.81	112.27	-	-	-	113.01	
	SHMI	1.0	#	1.06	1.06	1.06	1.1	1.1	1.1	1.09	1.09	-	-	-	-		

Safe Commentary:

There have been three MRSA bactearemia year to date, one in July. We remain within trajectory. MRSA improvement plan is in place and being actioned to provide controls and implement preventative measures.

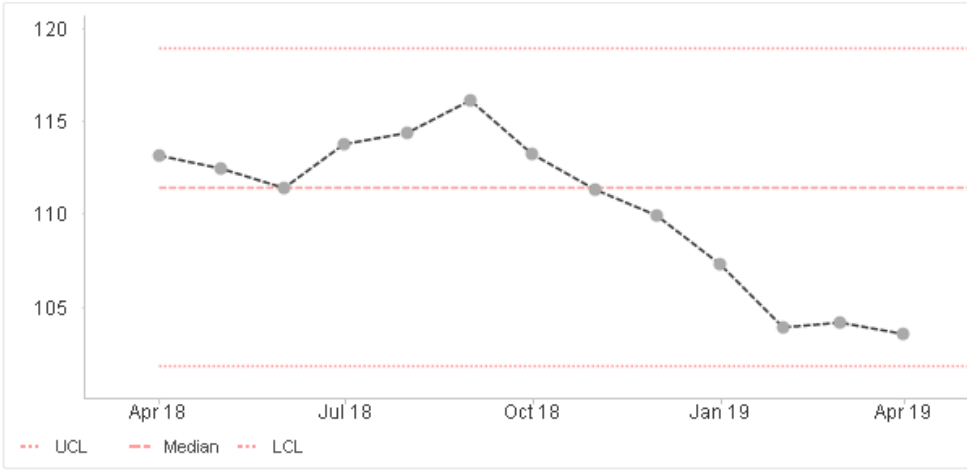
MFT are three cases over trajectory for Clostridium difficile infection cases. A new guideline has been drawn up and training for staff is ongoing ahead of 2nd September launch date.

To identify the causes and source of E.coli blood stream infections, MFT will be implementing post infection reviews on these cases from next month.

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

Safe – Total HSMR Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19
Mortality	HSMR (All)	100.0	%	114.41	116.17	113.3	111.38	109.91	107.35	103.88	104.15	103.54



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

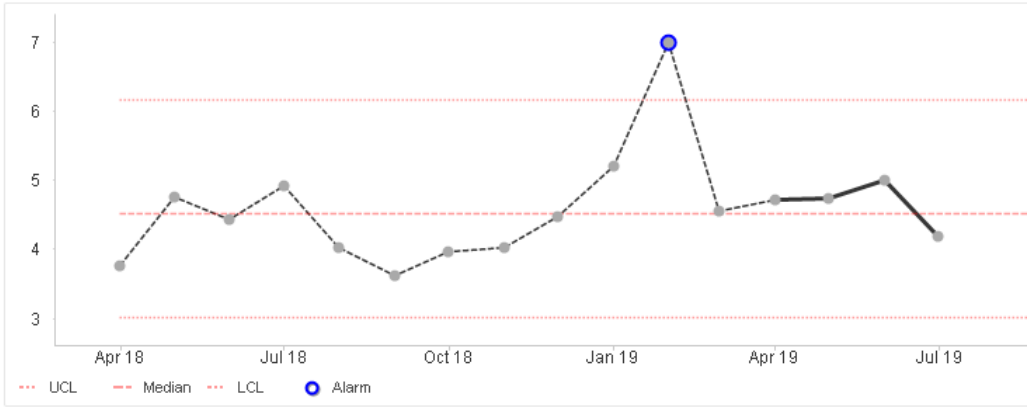
There has been a steady reduction in HSMR over the most recently available 6 months data. The HSMR now sits at 104, which is not a national outlier.

The major change in terms of mortality appears to have resulted from a significant improvement in the mortality for frail patients admitted during the week. There has not been an improvement in HSMR for frail patients admitted on Saturday or Sunday however. This now means that the Trust's HSMR for Saturday and Sunday admissions is 116 compared to 100 for those admitted during the week. Further work is in progress to review the possible reasons for this.

The previously suspected link between mortality and waiting times for a bed in ED has not been substantiated by further work. Mortality has improved at a time when the waiting times in ED have remained constant.

Safe – Falls Per 1,000 Bed Days Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Harm Free Care	Falls Per 1000 Bed Days	6.6	#	4.03	3.63	3.96	4.02	4.47	5.2	7	4.55	4.73	4.74	5	4.19



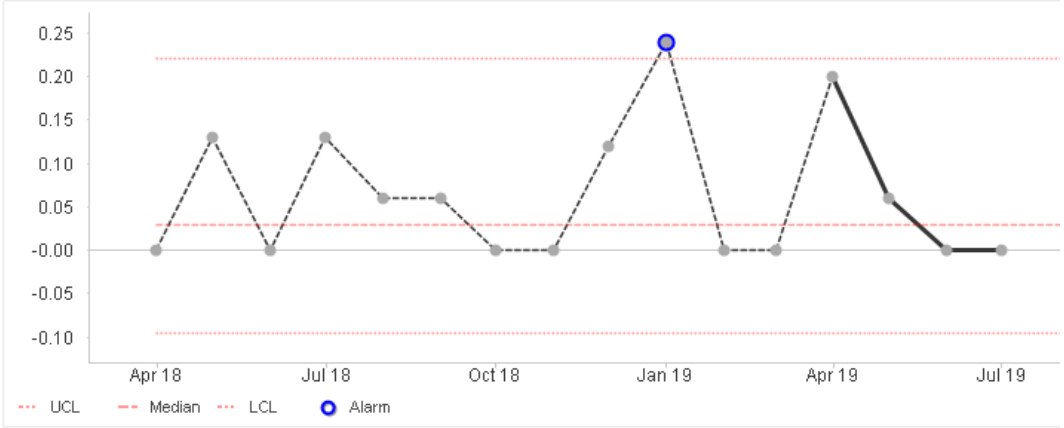
Falls Definition:

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 July there were 68 in patient falls. 14 falls (21%) related to patients with a diagnosis of Dementia and 11 falls (16%) related to patients with a history of alcohol excess The total number of falls per occupied bed days and the number of falls with harm per occupied bed days remained below the national target The falls CQUIN achieved 46% compliance of older inpatients receiving key falls prevention actions.	Availability of falls equipment has been reviewed and identified a need for additional falls alarms. These will be purchased. Targeted support from the falls specialist team is in place to support the assessment and care of the patient groups at higher risk of falls. There is an going programme of work to improve the recording of falls assessments and lying and standing blood pressure. Trust wide compliance for the falls documentation audit was 91% in July, a 6% improvement from April.

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

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



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 July the total number of pressure ulcers acquired in hospital were 15.There were no moderate or severe harms in July. The total number of pressure ulcers per occupied bed days was below our mean rate. In July our highest incident ward was Pembroke and the highest anatomical location being the heels. Point prevalence audit results were 63% and ASSKINg audit results were 65%	Training for pressure ulcer prevention and management continues to be available on a monthly basis with additional support provided to Pembroke ward. Audit results are discussed at Care Programme and nursing performance reviews and corrective actions agreed to support improvement. All pressure ulcers that have been acquired in month are reviewed and any new learning is fed into an overarching trust pressure ulcer improvement plan. The Trust has been accepted onto a NHSI Pressure Ulcer Collaborative which commences with a launch event on 4 September. Post launch the Trust improvement plan will be updated and trajectories for improvement set.

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CARING

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Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	12M
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	259	216	252	192	248	234	252	147	85	107	97	139	**2228**
	MSA %	0.0	%	1.7	1.44	1.62	1.32	1.63	1.48	1.75	0.94	0.59	0.7	0.66	0.9	**1.23**
	% of EDNs Completed Within 24hrs	100.0	%	48.09	49.44	49.12	49.71	49.86	46.58	47.3	47.52	49.27	49.34	49.78	48.19	**48.69**
	Inpatients Friends & Family % Recommended	85.0	%	83.9	84.45	86.47	86.21	81.98	85.05	76.33	85.59	85.6	84.41	83.66	88.01	**84.6**
	Inpatients Friends & Family Response Rate	22.0	%	21.71	22.55	21.54	22.7	19.45	19.69	12.1	20.64	15.83	18.51	20.65	20.72	**19.83**
ED Care	ED Friends & Family % Recommended	85.0	%	77.03	80.65	80.48	78.86	71.97	72.05	72.18	75.56	73.34	73.14	72.58	72.9	**74.94**
	ED Friends & Family Response Rate	22.0	%	14.08	15.58	14.14	13.94	14.01	13.99	13.23	13.42	10.64	12.35	13.45	12.96	**13.47**
Maternity Care	Maternity Friends & Family % Recommended	85.0	%	99.26	98.82	100	100	95.19	97.64	99.6	99.66	100	100	99.6	99.29	**99.17**
	Maternity Friends & Family Response Rate	22.0	%	28.32	17.67	22.71	23.62	28.15	32.81	38.67	31.78	29.77	28.88	11.01	23.56	**25.47**
Outpatients Care	Outpatients Friends & Family % Recommended	85.0	%	89.91	89.12	89.93	90.93	91.63	90.28	89.48	91.14	89.23	89.77	89.42	89.9	**90.03**
	Outpatients Friends & Family Response Rate	22.0	%	14.7	14.24	13.56	13.94	13.06	14.78	14.83	14.15	10.32	12.87	12.75	12.91	**13.45**

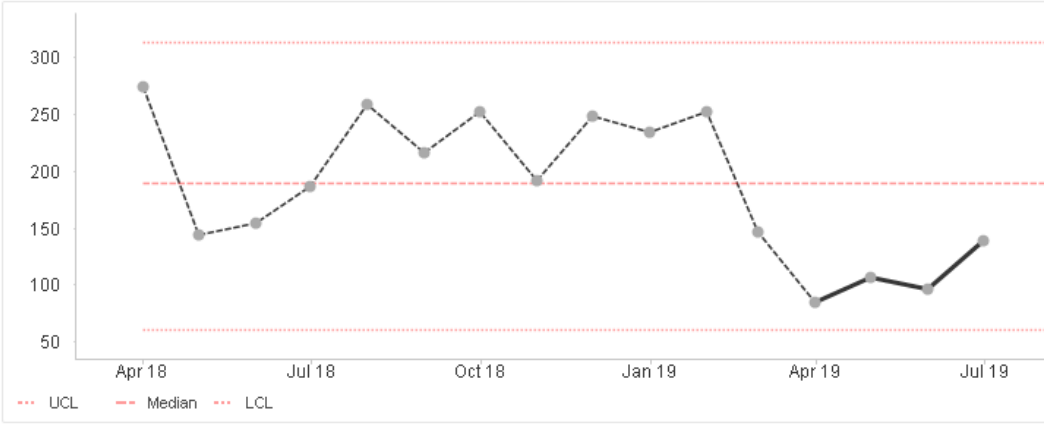
Caring Commentary:

In regard to the Friends and Family Test for inpatients, we have made some changes which we hope will make an impact on the response rate and would recommend rates going forward. These include helping wards to identify how many additional responses they would require to achieve the target. Some areas only require to achieve a few more responses each month which seems achievable. There has been an increase in training staff and raising overall awareness of the benefits of accessing patient feedback in this way. There has also been a change to the content of the text message received by patients ,making it clear that patient feedback goes to the staff who provided the care. The Emergency Department response rate remains consistently above the available national data for June 2019 and the ED team are looking at ways to increase the 'would recommend' rate. Maternity exceeds the target for both response rate and 'would recommend' rate. In regard to outpatients there is no national response rate target and advise has been given to the outpatients team to cease the paper survey's which do not get captured on the FFT system as this will likely increase responses from patients when they are contacted by phone or text.

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

Caring – Mixed Sex Accommodation Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	259	216	252	192	248	234	252	147	85	107	97	139



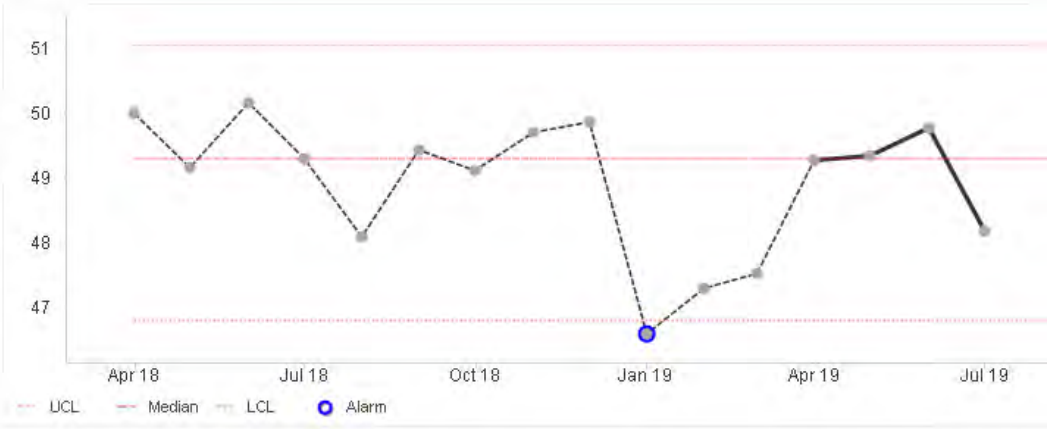
Commentary	Risks & Mitigating Actions
July showed an increase in Same Sex Accommodation breaches. The majority of the breaches remain within our critical care units and the number of breaches increased in relation to more patients being considered able to step down to level one accommodation. Due to capacity issues the Trust was unable to support timely discharge for these patients from the units. The breaches affected approximately 50 patients and the number of days reflects patients who breached on successive days.	The focus is on the Best Flow programme to support Same Sex Accommodation across all our units. CC will utilise bays and side rooms where possible to keep patients in single sex areas, however this does still lead to delayed discharge from CC. MSA is reported on the site report and days of MSA are on display in site office.

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.

Caring – Electronic Discharge Notification (EDN) Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Admitted Care	% of EDNs Completed Within 24hrs	100.0	%	48.09	49.44	49.12	49.71	49.86	46.58	47.3	47.52	49.27	49.34	49.78	48.19



Commentary
Risks & Mitigating Actions

The EDN completion continues to be at a suboptimal level though there has been some improvement in UIC directorate achieved 68.81% in June. 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 improvement will take effect as of August 19 at junior doctor level, with 4 based on each medical ward, and thus further improvements are expected.

A number of pieces of work were carried out in 2018, particularly a review of the completion of EDN's for deceased patients. However these actions have not made any noticeable difference to the EDN completion rate. The completion rates is directorate and programme dependent, with excellent completion rates in Peri-operative and Critical Care and very poor rates in Specialist Medicine- consistently below 30%. Issues contribution to this include some problems with junior doctor resource on some of the downstream medical wards-Keats and Will Adams being particularly affected by this.

We have set up a Working Group in the Effective Discharge Workstream in order to accelerate the pace of change on EDN completions.

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.

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Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	12M
Best Practice	7 Day Readmission Rate	10.0	%	4.69	4.65	4.38	4.14	4.56	4.31	4.49	4.22	4.64	4.39	4.57	-	**4.45**
	30 Day Readmission Rate	10.0	%	9.89	10	9.84	10.53	10.46	9.25	9.97	9.37	10.46	9.42	9.67	-	**9.89**
	Discharges Before Noon	25.0	%	15.8	16.19	14.07	15.38	17.4	15.41	16.11	15.85	13.93	14.74	14.65	15.29	**15.4**
	Fractured NOF Within 36 Hours	100.0	%	70.6	57.1	67.7	45.2	46.9	45.5	71.4	85.7	75	61.7	60	-	**62.44**
	VTE Risk Assessment % Completed	95.0	%	66.98	59.98	55.6	58.19	50.57	74.46	88.65	90.46	95.3	92.67	90.29	90.87	**80.1**
Maternity	Elective C-Section Rate	13.0	%	11.97	12.77	13.54	13.32	9.71	13.2	12.97	11.63	13.26	13.59	13.04	14.56	**12.81**
	Average occupancy	15.0	%	17.09	20.24	18.96	16.82	20.47	20.05	21.45	21.45	17	15.53	16.91	18.14	**18.64**
	Total C-Section Rate	28.0	%	29.06	33.01	32.51	30.14	30.18	33.25	34.41	33.07	30.26	29.13	29.95	32.7	**31.46**
	Number of Deliveries (Count of Mothers)	-	#	468	415	443	428	381	409	401	387	347	412	414	419	**4924**
	12+6 Risk Assessment	90.0	%	81.4	81.58	83.33	83.84	85.19	82.52	82.47	87.21	-	-	-	-	**83.43**
Stroke	Stroke SSNAP Rating *	B	-	E	E	E	E	E	D	D	D	-	-	-	-	
	% of Pts Seen by Stroke Cons in 24 Hours *	95.0	%	35.87	35.87	41.25	41.25	41.25	31.13	31.13	31.13	-	-	-	-	**35.58**
	Stroke Pts Scanned Within 1 hour *	90.0	%	35.87	35.87	48.75	48.75	48.75	42.45	42.45	42.45	-	-	-	-	**42.86**

Effective Commentary:

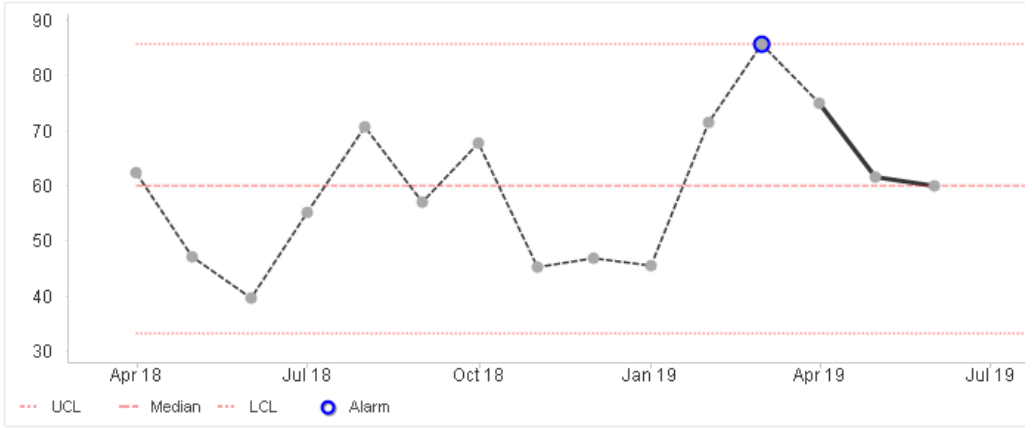
Stroke SSNAP rating has improved largely related to better data capture (the Trust formerly rated D on SSNAP prior to data collection issues in 2018).

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

Effective – Fracture Neck of Femur Spotlight Report

NHS Medway NHS Foundation Trust

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Best Practice	Fractured NOF Within 36 Hours	100.0	%	70.6	57.1	67.7	45.2	46.9	45.5	71.4	85.7	75	61.7	60



Commentary
Risks & Mitigating Actions

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

There was a dip in our time to surgery for the month of May and July 2019. This was due to increased demand placed on trauma list and increased number of patients and children with other non-hip fractures.

Actions taken:

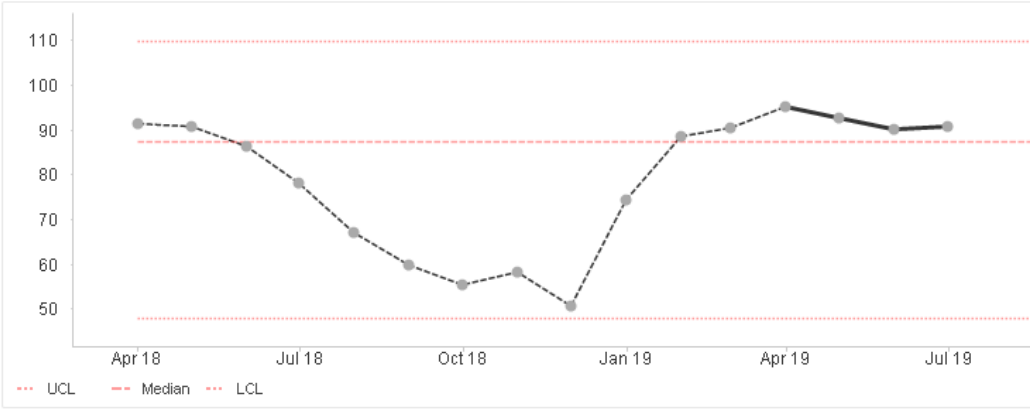
1. We are constantly reviewing our data and performance. We have learnt from our performance in May and July 2019 and pre-emptively planning to create extra trauma lists/evening lists to accommodate hip and other fractures in forthcoming summer months
2. Emphasis on optimisation of patients pre-operatively
3. Finalisation of the anti-coagulation pathway for hip fractures
4. Presentation in the orthopaedic departmental M&M meeting regarding our performance and steps are being taken to improve our performance
5. Improve awareness and importance of timely surgery to junior doctors during their induction

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		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Best Practice	VTE Risk Assessment % Completed	95.0	%	66.98	59.98	55.6	58.19	50.57	74.46	88.65	90.46	95.3	92.67	90.29	90.87



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 18 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 rosters and further training being undertaken. **Examples of Improving Practices:** • Lister ward has improved compliance by 10% from • Engagement of the consultants and junior medical team increased through Trust Induction and Ward visibility of VTE nurse	**Risks:** • VTE deliver 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 • VTE Nurse and Thrombosis Lead (Consultant) engaging with Junior Doctors at Induction to capture awareness and expectation • VTE Nurse and Thrombosis Lead working with approved set of KPIs

NHS
Medway
NHS Foundation Trust

RESPONSIVE

Best of care
Best of people

Responsive – Non-Elective

NHS Medway NHS Foundation Trust

RESPONSIVE

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	12M
Bed Management	Bed Occupancy Rate	92.0	%	89.66	90.91	90.22	87.21	88.77	90.61	91.38	88.66	83.87	84.93	87.2	88.17	**88.44**
	Average Elective Length of Stay	5.0	#	1.96	2.72	2.72	2.02	2.48	2.02	2.25	2.15	2.24	2.79	2.12	1.9	**2.29**
	Average Non-Elective Length of Stay	5.0	#	8.25	8.43	8.5	8.33	8	9.23	8.79	8.61	8.72	8.56	8.46	8.4	**8.53**
	Escalation Beds Open Point Prevalence in Month	0.0	#	331	327	775	750	340	775	700	775	750	775	182	185	**6665**
	Delayed Transfer of Care Point Prevalence in Month	-	#	162	153	164	385	302	228	243	321	373	347	281	-	**2959**
	% of Delayed Transfer of Care Point Prevalence in Month	3.5	%	1	0.96	0.98	2.46	1.88	1.36	1.59	1.95	2.45	2.16	1.82	-	**1.68**
	Medically Fit For Discharge Point Prevalence in Month	-	#	3465	3285	3234	3060	2991	3211	3345	3663	3379	3060	2829	3114	**38636**
	% Medically Fit For Discharge Point Prevalence in Month	7.0	%	21.49	20.54	19.38	19.52	18.57	19.2	21.89	22.22	22.18	19.07	18.37	19.18	**20.12**
ED Access	ED 4 Hour Performance All Types	95.0	%	85.92	90.2	88.77	88.95	87.34	83.03	77.08	77.81	79.6	80.6	81.84	80.8	**83.46**
	ED 4 Hour Performance Type 1	95.0	%	71.79	80.32	77.24	77.63	74.42	65.94	64.75	66.1	68.09	68.85	70.53	74.09	**71.65**
	ED 12 hour DTA Breaches	0.0	#	10	0	13	0	1	5	16	1	7	48	11	4	**116**
	Median Time to ED Clinician (60mins)	60.0	#	35	33	36	36	40	48	53	48	37	38	36	36	
	Median Time to Ambulance Assessment (15mins)	15.0	#	4	3	4	3	3	3	4	4	4	4	4	4	
	30 Mins Ambulance Handover Delays	0.0	#	455	321	332	261	315	364	449	423	346	408	450	378	**4502**
	60 Mins Ambulance Handover Delays	0.0	#	54	17	18	8	72	192	212	133	105	98	108	66	**1083**
	Number of ED arrivals by Ambulance	-	#	3018	2941	3124	3278	3500	3475	3088	3346	3391	3379	3302	3577	**39419**
	ED Conversion Rate	20.0	%	25.36	25.48	25.71	23.06	24.74	22.15	20.3	21.78	24.74	24.78	25.19	21.36	**23.68**

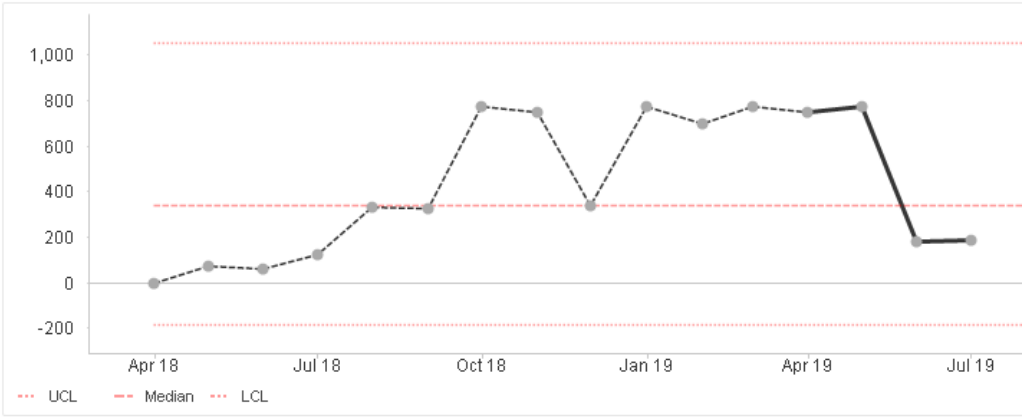
Responsive – Non-Elective Commentary:

The level of bed occupancy shows an in month increase with an decrease in the number of strand patients daily average 7+ days 39.39% (n159) 21+ 15.72% (n 63). The number of medically fit for discharge also report and increase this month. However there has been a slight reduction the non admitted LOS for the 4th month running . A short programme of bed by bed reviews is being under taken daily by the care groups for all patient with a LOS of greater than 7 days the maximise discharges and reduce the length of stay prior to a discharge market event . Reviewing this month indicators would suggest improved usage of beds and through put of patients.

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

Responsive – Escalation Beds Open Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Bed Management	Escalation Beds Open Point Prevalence in Month	0.0	#	331	327	775	750	340	775	700	775	750	775	182	185



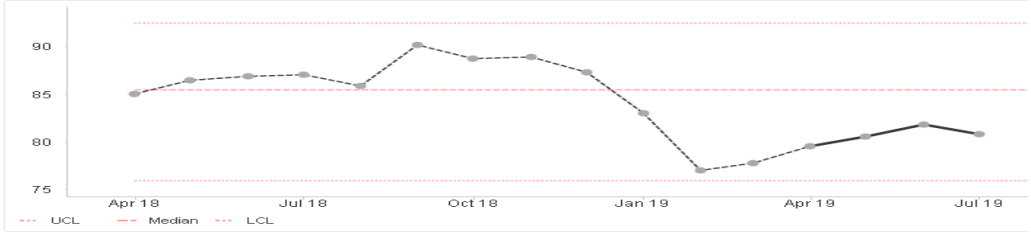
Commentary	Risks & Mitigating Actions
The number of stranded and super stranded patients remain higher than predicted this has lead to the reopening of Dickens as an escalation ward to a maximum in month of at times 16 beds. Ongoing TN support into site huddle and programme huddles to give assurance on discharges Continued reduction in medical outliers has lead to a reduction in the use of SDCC to accommodated displaced surgery patients	Daily review of patients occupying the escalation beds is on going. The risk of the ward remaining open for an extended period of time is being mitigated by the hospital discharge team identifying suitable patients to transfer to the ward. Reviews in the site huddles with a view to proactively closing this capacity and not reusing the beds . A programme of bed by bed reviews is being under taken daily by the care groups for all patient with a LOS of greater than 7 days the maximise discharges and facilitate the closure of this additional capacity.

Escalation Beds Definition:

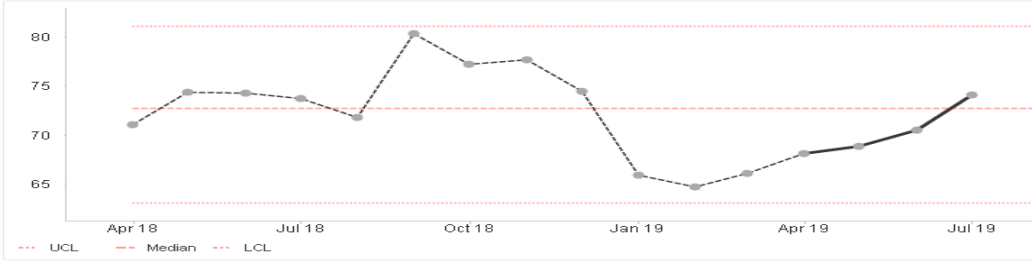
An escalation ward is defined by the NHS as a temporary ward or bed used by a Trust to support capacity in times of high demand to create additional capacity. It is acknowledged that patients “boarded” on an escalation ward are more likely to have poorer experience and high delays in discharge. These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

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

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
ED Access	ED 4 Hour Performance All Types	95.0	%	85.92	90.2	88.77	88.95	87.34	83.03	77.08	77.81	79.6	80.6	81.84	80.8



Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
ED Access	ED 4 Hour Performance Type 1	95.0	%	71.79	80.32	77.24	77.63	74.42	65.94	64.75	66.1	68.09	68.85	70.53	74.09



ED 4 Hour Local Trajectory

		Apr-19	May-19	Jun-19	Jul-19
ED - 4 Hours Type 1	Actual	68.10%	68.87%	68.85%	74.09%
	Planned	68.13%	77.21%	82.28%	83.22%
	Variance	-0.03%	-8.34%	-13.43%	-9.13%
ED - 4 Hours All Types	Actual	79.66%	80.77%	80.60%	86.66%
	Planned	79.66%	83.05%	87.76%	90.00%
	Variance	0.00%	-2.28%	-7.16%	-3.34%

Commentary	Risks & Mitigating Actions
Type 1 continued to see an improvement despite increased demand driven through the closure of Balmoral Gardens MIU and the heatwave towards the end of July. Type 3 performance remains challenged due to the issues with ongoing MedOCC. Streaming is now routinely being stopped to MedOCC to ensure patients are seen as soon as possible, although this places additional demands on ED.	• Type 3 recovery plan being monitored via JMB with oversight by UCOG an LAEDB • New Acute Medical Model being drafted for implementation in Sept to improve admitted performance • CCG funded extension to streaming in place to mitigate against additional activity driven by closure of Balmoral MIU • Plan to increase take of ED patients into SDEC through agreed pathways from September • 2hr ED Safety Huddles to be implemented during September to manage flow and ensure breach risks are escalated and managed. • Recruitment of a 'flow co-ordinator' and 'Traffic Control' Nurse to manage flow from the front door ensuring patients receive the right care based on need and current capacity to avoid unnecessary waits and ensure demand is spread appropriately

Responsive – Elective

NHS Medway NHS Foundation Trust

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Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	12M
Diagnostic Access	DM01 Performance	99.0	%	98.2	99.24	99.54	98.76	97.4	96.85	98.92	98.7	95.41	93.72	92.03	95.87	**96.92**
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	82.55	81.77	82.59	82.62	80.97	80.84	80.25	80.75	83.08	83.27	82.5	82.35	**81.93**
	18 Weeks RTT Over 52 Week Breaches	0.0	#	12	11	12	9	13	20	27	37	8	5	3	3	**160**
	Daycase Rate	85.0	%	66.07	64.89	66.73	63.51	63.79	68.18	68.94	65.89	66.4	66.39	66.79	65.6	**66.1**
	DNA Rate	10.0	%	8.54	8.87	8.7	8.49	8.71	8.46	8	7.73	7.8	7.78	8.08	8.13	**8.29**
	First to Follow Up Ratio	-	#	1.14	1.16	1.16	1.18	1.2	1.16	1.2	1.18	1.19	1.15	1.14	1.14	**1.17**
Theatres & Critical Care	Operations Cancelled By Hospital on Day	0.0	#	11	17	29	24	52	46	51	14	41	15	29	26	**355**
	Cancelled Operations Not Rescheduled < 28 days	0.0	#	1	3	2	6	17	23	22	17	8	7	2	5	**113**
	Urgent Operations Cancelled for the 2nd Time	0.0	#	0	0	1	1	0	0	0	0	0	0	0	0	**2**
	Critical Care Occupancy Rate	92.0	%	94.44	90.69	96	94.02	94.55	98.78	94.95	95.88	84.83	89.21	89.54	86.21	**92.43**

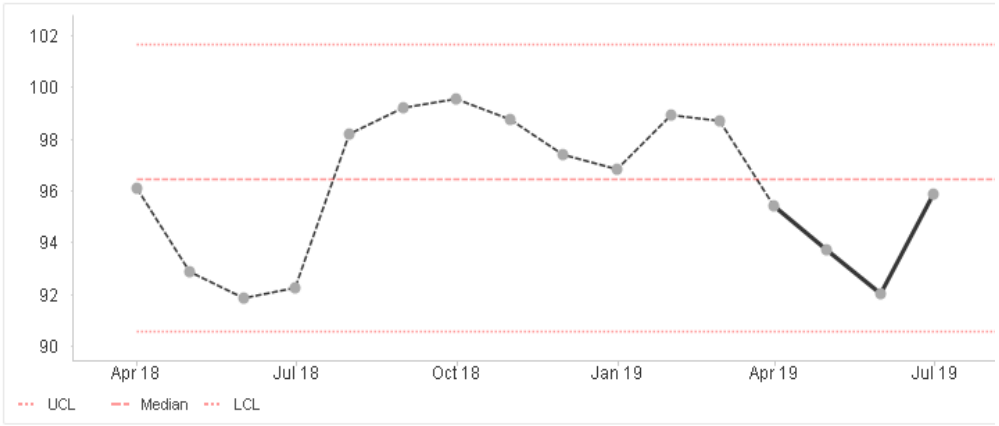
Responsive – Elective Commentary:

The Trust reported a final RTT 18 week position of 82.35% for the month of July 2019 slightly up on previous month however down on trajectory. 52 week breaches are on trajectory and expected to remain on trajectory for the rest of the year.

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

Responsive – DM01 Performance Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Diagnostic Access	DM01 Performance	99.0	%	98.2	99.24	99.54	98.76	97.4	96.85	98.92	98.7	95.41	93.72	92.03	95.87



DM01 Local Trajectory:

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

Commentary

DM01 performance fell in the latter half of the 18/19 year and has continued to fall in the first quarter of 19/20, driven predominantly by:

- MRI demand (clinically indicated)
- Changes to NICE guidance for imaging cancer
- Increase in Gastro scope demand
- Increase in Colonoscopy demand
- Loss of third party provider capacity for scopes due to long term facilities issue / inhouse due to pensions issue

However, improvement is noted in July 19 and is forecasted to continue to improve, due to increased MRI capacity. Unfortunately due to significant capacity issues in Endoscopy it will remain challenging 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 DM01 performance e.g.

- Weekly 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

Risks & Mitigating Actions

Risks:

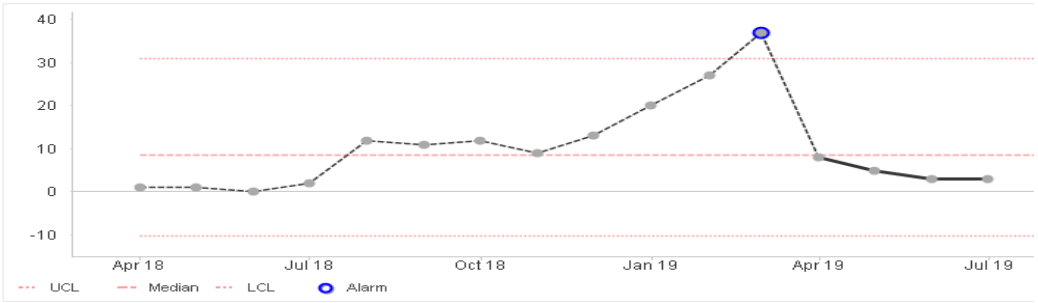
- Capacity (Routine)
  - MRI
  - Gastro (Upper and Lower GI)
- Consultant vacancy – Endo / Colo
- Reporting capacity within Radiology

Mitigations:

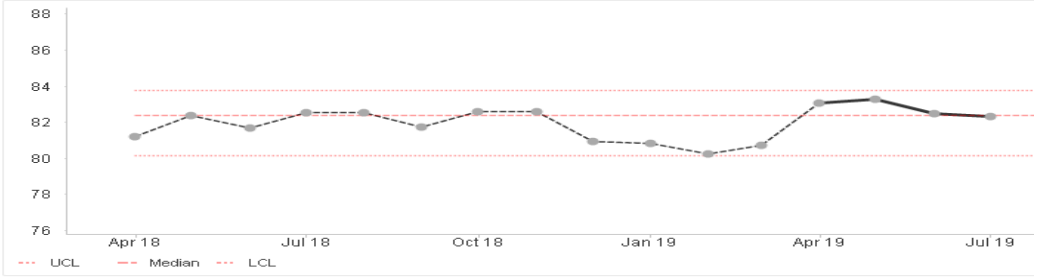
- A Review and refresh of interventions in all specialties for 19/20, in line with clinical strategy and RTT for each DM01 area **(complete)**
- 10 weeks of additional MRI van capacity purchased + ongoing long term increase of mobile from 7 to 10 days **(complete)**
- Enhanced Capital expansion plan 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 services undertaking a demand & capacity exercise
- Urodynamics machine delivered to site
- Additional GA & Paed lists running for MRI
- Source NHS Locum Gastroenterologist to undertake lists OOH / undertake clinics to release substantive Consultants to complete lists
- Advertise and recruit Consultant Radiologists

Responsive – RTT Performance Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Elective Access	18 Weeks RTT Over 52 Week Breaches	0.0	#	12	11	12	9	13	20	27	37	8	5	3	3



Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	82.55	81.77	82.59	82.62	80.97	80.84	80.25	80.75	83.08	83.27	82.5	82.35



RTT Local Trajectory :

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

Commentary	Risks & Mitigating Actions
The Trust reported a final RTT 18 week position of 82.35% for the month of July 2019 slightly up on previous month however down on trajectory.	Services have been asked to review trajectories and provide action plans for all areas that are not compliant. In addition every service has been asked to complete a full NHSI demand and capacity model. As part of the work undertaken by the Intensive Support Team (IST) at NHSI, there is an expectation that the RTT Demand and Capacity Models are used as live documents and regularly updated.

Responsive – Cancer & Complaints

NHS Medway NHS Foundation Trust

RESPONSIVE

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	12M
Cancer Access	Cancer 2ww Performance	93.0	%	72.61	65.19	68.13	73.11	88.35	72.87	73.01	61.66	83.39	88.69	90.12	-	75.57
	Cancer 2ww Performance - Breast Symptomatic	93.0	%	88.89	90.74	75.76	72	44.3	7.61	6.33	41.51	70.67	89.19	84.93	-	57.1
	Cancer 31 Day First Treatment Performance	96.0	%	96.6	100	94.77	96.62	95.51	89.31	87.5	95.45	94.62	94.59	92.59	-	94.34
	Cancer 31 Day Subsequent Treatments (Surgery)	94.0	%	100	95.24	92.59	89.66	89.47	75.76	75	73.91	82.61	73.91	100	-	85.43
	Cancer 31 Day Subsequent Treatments (Drugs)	98.0	%	100	100	100	93.94	100	100	100	100	100	100	96.08	-	98.73
	Cancer 62 Day Treatment - GP Refs	85.0	%	79.17	80.47	83.85	81.7	83.64	79.75	67.42	75	76.69	71.67	82.14	-	78.36
	Cancer 62 Day Treatment - Screening Refs	90.0	%	81.13	89.13	83.33	63.41	71.79	51.52	42.86	92.31	94.59	100	90.48	-	78.57
	Cancer 62 Day Treatment - Cons Upgrades	-	%	78.38	79.31	74.19	90.63	81.82	67.65	84.38	80.77	73.33	86.96	68.42	-	79
	104 Day Cancer Waits	0.0	#	7	4	4	3	6	3	6	9	5	7	6	-	60
Complaints Management	Number of Complaints	41.0	#	64	51	65	57	64	67	69	71	57	81	62	74	782
	% Complaints Responded to Within 30 Days	85.0	%	50.88	75.51	87.18	68.89	84.48	94.83	98.08	65.52	56.86	71.19	66.67	73.97	74.2

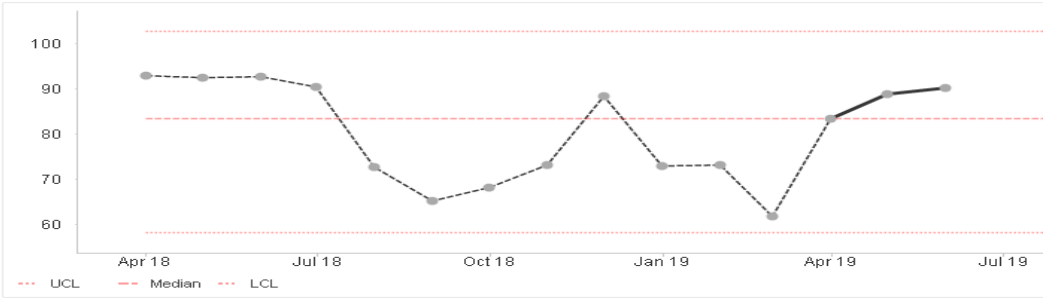
Responsive – Cancer & Complaints Commentary:

The Trust reported a final 2ww position of 90.12% for the month of June 2019, the highest reported position this year but short of overall trajectory. Cancer 62 day was also not compliant but again up on last 6 months to 82.14% overall.

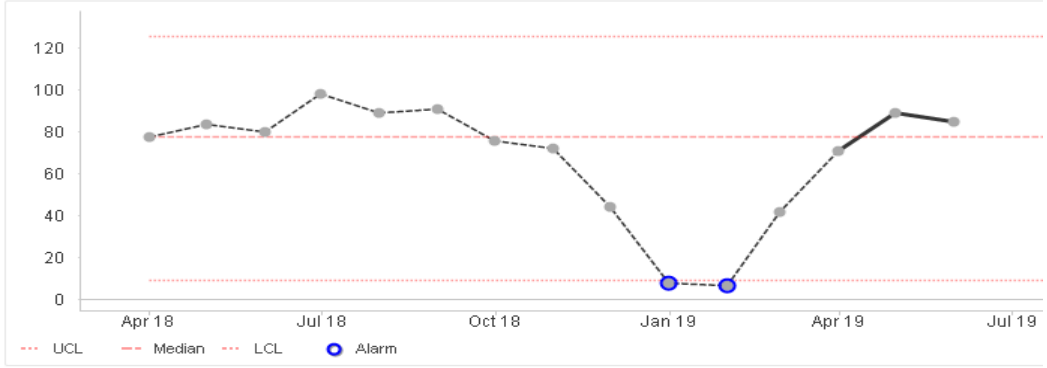
RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Responsive – 2 Week Wait Performance Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Cancer Access	Cancer 2ww Performance	93.0	%	72.61	65.19	68.13	73.11	88.35	72.87	73.01	61.66	83.39	88.69	90.12



Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Cancer Access	Cancer 2ww Performance - Breast Symptomatic	93.0	%	88.89	90.74	75.76	72	44.3	7.61	6.33	41.51	70.67	89.19	84.93



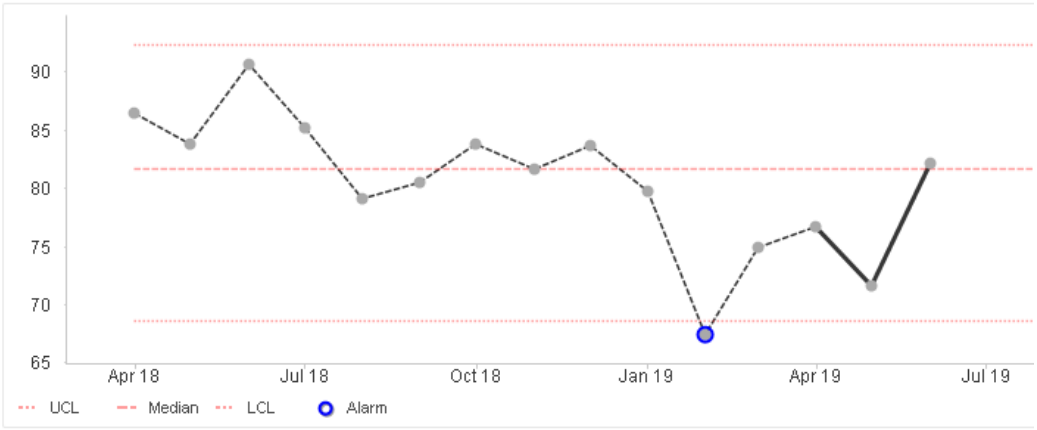
2 Week Wait Definition:

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 a final 2ww position of 90.12% for the month of June 2019, the highest reported position this year but short of overall trajectory.	Cancer PTL meetings will continue to monitor. Demand and capacity models to be introduced from 29th August.

Responsive – 62 Day Wait GP Performance Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19
Cancer Access	Cancer 62 Day Treatment - GP Refs	85.0	%	79.17	80.47	83.85	81.7	83.64	79.75	67.42	75	76.69	71.67	82.14



Cancer Local Trajectory :

		Apr-19	May-19	Jun-19
Cancer - 62 Days	Actual	76.69%	71.67%	82.14%
	Planned	77.10%	77.80%	86.50%
	Variance	-0.41%	-6.13%	-4.36%
Cancer - 2 Week Waits	Actual	83.39%	88.69%	90.12%
	Planned	87.10%	89.10%	93.90%
	Variance	-3.71%	-0.41%	-3.78%

Commentary	Risks & Mitigating Actions
Cancer 62 day was not compliant but again up on last 6 months to 82.14% overall	Continued support from NHSI in place looking at main tumour groups. Contained engagement with CCG achievement of performance targets. Introduction of cancer deep dive project board which is being fully supported by transformation team looking at stratified pathways. Introduction of cancer holders to be introduced from September 2019.

NHS
Medway
NHS Foundation Trust

WELL-LED

Best of care
Best of people

Well Led

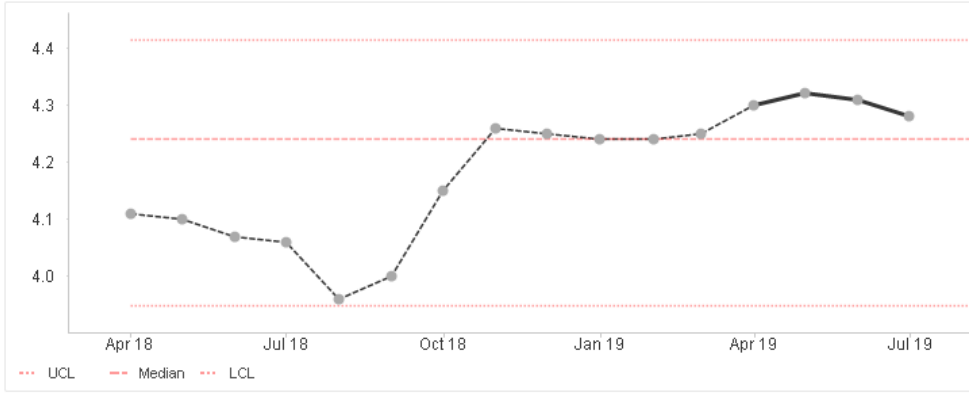
Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	12M
Staff Experience	Staff Friends & Family - Recommend Place to Work	62.0	%	43.2	43.2	-	-	-	49.34	49.34	49.34	-	-	-	-	**47.81**
	Staff Friends & Family - Recommend Care of Treatment	79.0	%	65.22	65.22	-	-	-	67.93	67.93	67.93	-	-	-	-	**67.25**
Workforce	Appraisal % (Current Reporting Month)	85.0	%	81.47	80.01	81.01	81.3	81.3	82.8	83.2	84.43	88.66	90.59	91.41	91.43	**84.78**
	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	3.96	4	4.15	4.26	4.25	4.24	4.24	4.25	4.3	4.32	4.31	4.28	**4.21**
	Short Term Sickness Rate (Current Reporting Month, FTE%)	1.5	%	1.97	1.98	2	2	1.97	1.96	1.98	1.93	1.93	1.93	1.92	1.93	**1.96**
	Long Term Sickness Rate(Current Reporting Month, FTE%)	2.5	%	1.99	2.02	2.15	2.74	2.28	2.28	2.26	2.32	2.37	2.4	2.39	2.35	**2.29**
	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0	%	11.77	10.47	12.05	12.35	12.02	12.34	12.21	12.52	11.73	12.36	12.57	12.44	**12.07**
	Contractual Staff in Post (FTE) (Current Reporting Month)	-	#	3761	3766	3595	3779	3768	3765	3798	3786	3681	3701	3764	3896	
	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	**82.76**
	Agency Spend as % Paybill (Current Reporting Month)	4.0	%	4.66	5.74	5.11	5.01	5.61	3.69	3.69	4.06	4	2.82	3.09	3.77	**4.27**
	Agency Spend as % Paybill (Financial Year YTD)	4.0	%	4.78	4.46	4.52	4.04	4.63	5.68	5.5	5.37	5.29	5.11	3.3	3.42	**4.68**
	Bank Spend as % Paybill (Current Reporting Month)	9.0	%	8.4	13.22	12.44	12.4	11.86	12.77	12.77	10.93	13.26	12.13	10.93	11.71	**11.9**
	Bank Spend as % Paybill (Financial Year YTD)	9.0	%	8.45	13.19	12.57	12.4	12.34	11.95	12.03	12.15	12.88	12.54	12.11	12	**12.05**
	Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	75.0	%	73	73	76	79	79	74	78	79	79	76	71	74	**75.92**
Financial Position	Variance from Plan	0.0	%	1.3	0.8	-7	-7.8	-8.6	-18.4	-16.4	13	17.8	-4.5	-1.9	-5	
	Liquidity Ratio	2.0	#	0.49	0.49	0.49	0.52	0.47	0.42	0.42	0.32	0.36	0.4	0.41	0.37	
	Cash Actual (in $m)	1.4	#	9.9	7.4	4.4	8.6	13.7	7.5	8.2	10.8	17	29.2	26.4	26.2	
	Overall Underlying Financial Surplus / Deficit (in £m)	0.0	#	-21.6	-25.5	-29.9	-32.9	-36	-42	-43.6	-46.8	-4.6	-8.3	-12.2	-16.8	
	Capital Spend Vs Plan	0.0	%	59.7	63.4	64.5	67.8	70.9	72.1	72.8	63.3	0	-15.3	7.1	0.1	
	Cost Improvement Plans (CIPS) - Var to Plan YTD (in £'000)	0.0	#	1500	1788	2357	1544	1020	894	423	0	-68	74	69	-121	

Well-led:

Appraisal completion rate, at 91.43% is up (0.02%) compared to June and is remains above the Trust's target (85%).
Overall Sickness absence rate at 4.28% has decreased (0.03%) and is above the tolerance level of 4%. Short term sickness absence at 1.93% and Long term sickness absence, at 2.35%, remain static. The ratios of long-term sickness to short-term sickness remain broadly even.
Voluntary Turnover at 12.44% has decreased (0.13%) compared to June and remains above the tolerance level of 8%.
StatMan compliance at 89.70% continues to increase and sits above the Trust's target of 85%
YTD Agency spend (as a percentage of pay bill) is 4.68%. 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 12.05%. Total YTD temporary spend sits at 16.73% which is above the Trust's target of 11.00%
Temporary staffing fill rate for Nurse and Midwifery at 74% saw an increase of 3% and is below YTD Average.

Well Led – Total Sickness Rate Spotlight Report

Domain	KPI Name	Target		Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19
Workforce	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	3.96	4	4.15	4.26	4.25	4.24	4.24	4.25	4.3	4.32	4.31	4.28



Commentary	Risks & Mitigating Actions
Overall Sickness absence rate at 4.28% remains static but remains above the Trust's tolerance level of 4%. Short term sickness absence remains static at 1.93% whilst long term absence has decreased slightly to 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 SS133000	90%	92%	96%	101%	6.52	29.25%	18.26%
Bronte Ward AA143000	100%	87%	100%	98%	7.47	20.99%	32.64%
Byron Ward AA800000	76%	125%	99%	118%	6.1	22.58%	18.98%
CCU AA156000	72%	87%	100%		14.29	22.86%	-16.28%
Delivery Suite WV226000	100%	100%	100%	100%	25.75	5.44%	n/a
Dickens Ward AA8100000	19%	17%	34%	40%	2.93	n/a	n/a
Dolphin (Paeds) WN102000	88%	98%	102%	106%	19.51	12.33%	5.80%
Harvey Ward AA802000	90%	99%	113%	133%	7.89	25.11%	25.32%
ICU AA152000	79%		81%		27.77	15.81%	0.00%
Keats Ward AA132000	76%	144%	98%	159%	7.06	30.02%	16.66%
Kent Ward WV226000	100%	99%	97%	98%	10.97	See delivery suite	See delivery suite
Kingfisher SAU SS253000	90%	98%	94%	111%	17.13	37.49%	2.44%
Lawrence Ward AA302000	99%	99%	99%	99%	8.49	24.23%	24.99%
Lister Assessment Unit AA100000	65%	68%	97%	89%	7.77	45.71%	14.59%
McCulloch Ward SS453000	84%	89%	96%	105%	6.03	24.99%	-0.94%
Medical HDU AA102000	92%	93%	93%		19.55	10.44%	14.57%
Milton Ward AA803000	79%	97%	99%	141%	6.85	33.44%	31.87%
Nelson Ward AA202000	81%	85%	100%	100%	5.66	18.01%	13.89%
NICU WN202000	82%	66%	84%	0%	13.59	10.56%	44.70%
Ocelot Ward WV102000	95%	71%	100%	106%	7.99	19.86%	12.20%
Pearl Ward WV226000	100%	100%	100%	100%	8.24	See delivery suite	See delivery suite
Pembroke Ward SS113000	92%	114%	97%	165%	8.67	25.77%	10.08%
Phoenix Ward SS513000	81%	87%	98%	95%	5.64	12.28%	7.95%
Sapphire Ward AA812000	95%	94%	96%	112%	7.1	n/a	n/a
SDCC ST303000	79%	76%	117%	104%	11.17	n/a	18.03%
Surgical HDU AA153000	95%	85%	99%		16.04	13.33%	24.24%
Tennyson Ward AA807000	90%	114%	97%	145%	6.38	26.27%	11.25%
The Birth Place WV226000	95%	100%	96%	97%	19.49	See delivery suite	See delivery suite
Victory Ward SS433000	69%	77%	74%	95%	9.65	32.78%	0.03%
Wakeley Ward AA103000	88%	101%	122%	108%	6.79	7.22%	13.70%
Will Adams Ward AA122000	82%	121%	101 of 340	137%	6.83	9.88%	9.82%
Trust total	**83.90%**	**92.40%**	**94.70%**	**113.50%**	**8.79**	**22.22%**	**17.97%**

Meeting of the Board of Directors in Public

Thursday, 05 September 2019

Assurance Report from Committees

Title of Committee:	Quality Assurance Committee	**Agenda Item**	**5.2**
Committee Chair:	Ewan Carmichael deputising for Jon Billings		
Date of Meeting:	Friday, 26 July 2019		
Lead Director:	Karen Rule, Director of Nursing		
Report Author:	Karen Rule, 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 June 2019, there was a couple of areas highlighted: *Infection Control*: this is a serious issue the Trust with 3 cases of topical MRSA and 17 cases of C-Diff. Medical Director has written to both Divisions stating that no staff member can work after the 1 August 2019 who is not compliant with hygiene training. *Stroke*: From end of September 2019 all Maidstone and Tunbridge Wells services will be delivered from the Maidstone site. This should have no immediate impact on NHS Medway Foundation Trust (MFT) or Darent Valley hospitals.	**White**
2. Corporate Quality Risks The Committee was given an update on the following risks: *Safe Nurse Staffing*: Both Directorates have reviewed their level of risk. The Trust currently has the most substantive number of nurses now and	**Amber/Green**

a continuing improvement in the fill rates. This risk will be adjusted down because of this. Areas of the most positive impact are; Retention initiatives and the focus on overseas recruitment. *Safe Medical Staffing*: MFT is better now than ever with staffing, although there are still pressures in some consultant recruitments. Difficult to recruit consultants in areas such as respiratory, cardiology, interventional radiology. Locum pool staff is stable. Pharmacy vacancy rate has dropped from 48% to 6.8%. Cultural programme and leadership approach change is what has driven this positive change. *Patient Flow/Operational Performance*: On the 26 July it was Week Two of the programme deployment and MFT was ahead of trajectory. Key Highlights: - Attendance has been the highest it has been all year in comparison to 2018. - MFT has seen more patients in the last four weeks than at any time through the year including peaks last winter, both on an occupancy and activity level. - MFT currently the best Type 1 performer in the region and against its peer group in the last seven days. MFT has outperformed Great Ormond Street, St Thomas' and St Georges hospitals. - MFT is top of the pack Type 1 and middle of the pack Type 3 in performance. - Decrease in the 08:00 Decision to Admit (DTAs). This is important piece of information, as it is an indicator of how many empty beds you start and end the day with. - MFT is doing the things the Team said they would do and is on trajectory for Type 1 but off trajectory for Type 3. Nationally MFT is the worst performing on Type 3 GP Referral data set. This is for two known reasons, the validation process (how we count things) and Medoc/Balmoral closure. - Outliers; no more than nine now comparable to 23 this time last year. MFT is now reporting below average. Patients are now getting to the right bed in the right amount of time, first time in less time. Three months of good trend data now to report on.	
3. Mortality and Morbidity Report The Committee was asked to note MFT's Standardised Hospital-level Mortality Indicator (SHMI) for the period February 2018 – January 2019 which is 1.09, and the Hospital Standardised Mortality Ratio (HSMR) for the period April 2018 to March 2019 which is 104.6, these are within the 'as expected' range for the reporting period. HSMR continues to highlight Pneumonia as an outlier, however it should be noted that the SHMI for Pneumonia diagnosis group has remained in the 'as expected' range during the period in which it has been an outlier for HSMR. More work to be done, this remains and area for focus.	**Amber/Green**
4. Triangulation of Complaints Incidents and Coroner Cases The Committee was presented on the Triangulation of Data for Organisational Learning and Improvement. Data on claims, serious incidents, complaints and coroners was given. MFT received 30 claims during the course of 2016 to 2019. Next steps were discussed as follows: - Detailed review for theming, organisational learning and improvement purposes	**Green**

- Reporting to the Quality Assurance Committee with recommendations - Changes to process and paperwork - Learning and improvement framework aligned to the Quality Strategy A bi-annual report on this will be developed and an update at the next Committee meeting in September.	
5. Quality Improvement Plan 2019/20 The Committee was informed that the draft plan will be with Karen Rule by mid-August. With a launch planned in September 2019. The launch will focus on what we are doing and why. From September 2019 there will be regular reports on Quality Transformation.	**Green**
6. CQUIN Update – 2018/19 Achievement The Committee was updated that the base line concern is with alcohol and tobacco. The CQUIN Programme for 2019/20 there are five programmes – two of the five have already been submitted.	**White**
Decisions made None	
Further Risks Identified All risks are captured within the risk register and the BAF.	
Escalations to the Board or other Committee None	

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	**Maternity Clinical Negligence Scheme for Trusts - 10 Safety Actions: Trust Self-Assessment and Declaration 2019**	**Agenda Item**	**5.3**
Lead Director	Karen Rule, Executive Director of Nursing		
Report Author	Dot Smith, Head of Midwifery Karen Rule, Executive Director of Nursing		
Executive Summary	The Department of Health Safer Maternity Care: next steps towards the national maternity ambition (October 2016) and the National Maternity Safety Strategy - Progress and Next Steps (November 2017) set out the national ambition to reduce the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030. Ten safety actions have been published to support this ambition. A paper was presented to the meeting of the Board of Directors in Private held Thursday 1 August 2019 which set out the Trusts self-assessment of compliance against the ten safety actions. At the time of writing the report the maternity service was fully compliant with nine of the ten actions. A verbal update confirming compliance against the outstanding action, safety action 9 (staff training) was provided. The Executive Director of Nursing advised the Board that the training evidence would be reviewed to ensure it supported a self-declaration of compliance. A final quality assurance check of all evidence would be undertaken prior to submission of the self-declaration. The Board • Approved the Trust self-assessment as presented • Delegated authority to the Chief Executive Officer to sign the Board self-declaration once the training evidence had been reviewed and assurance had been provided by the Executive Director of Nursing on the supporting evidence for all actions. This paper provides an update to the Board of Directors in regards to the Trust submission. The quality assurance check has been completed and the self-assessment evidence document has been updated. (Appendix 1). The amendments to the previous self-assessment document are as follows; **Safety action 1:** Additional information has been included to provide more vigorous evidence of compliance with the standards for reporting and reviewing still births.		

<table>
<tr><td></td><td colspan="2">Safety action 8: Training compliance has been confirmed.

The Trust has evidence to support a self-declaration of compliance with the ten safety actions.

An updated Trust self-assessment was presented to the Chief Executive Officer (CEO) for review and approval. This was also shared with the commissioners of the Trusts maternity services in accordance with NHS Resolution guidance.

This CEO signed the Trust self-declaration on behalf of the Board of Directors and this was submitted to NHS Resolution by the deadline of noon on Thursday 15 August 2019. (Appendix 2)

NHS Resolution are now reviewing all submissions and will notify Trusts of the outcome on 30 September 2019.</td></tr>
<tr><td rowspan="5">Link to strategic Objectives 2019/20</td><td>Innovation: We will embrace innovation and digital technology to support the best of care</td><td>☐</td></tr>
<tr><td>Finance: We will deliver financial sustainability and create value in all we do</td><td>☐</td></tr>
<tr><td>People: We will enable our people to give their best and achieve their best</td><td>☐</td></tr>
<tr><td>Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership</td><td>☐</td></tr>
<tr><td>High Quality Care: We will consistently provide high quality care</td><td>☒</td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="2">Previous paper presented at Executive Group meeting and Board of Directors Private Meeting.</td></tr>
<tr><td>Resource Implications</td><td colspan="2">Not applicable.</td></tr>
<tr><td>Legal Implications/ Regulatory Requirements</td><td colspan="2">None.</td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="2">Not applicable.</td></tr>
<tr><td rowspan="2">Recommendation/ Actions required</td><td colspan="2">The Board of Directors are requested to note the content of this report.</td></tr>
<tr><td colspan="2"><table><tr><th>Approval
☐</th><th>Assurance
☐</th><th>Discussion
☐</th><th>Noting
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Appendices	Appendix 1: Medway NHS Foundation Trust – Self Assessment, Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, 10 Safety Actions.

1 Executive Overview

1.1 The Department of Health *Safer Maternity Care: next steps towards the national maternity ambition* (October 2016) set a challenging ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030.

1.2 A subsequent document, *The National Maternity Safety Strategy - Progress and Next Steps (November 2017)* sets out the expectation that progress is quickly made to achieve the ambition of a 20% reduction in rates by 2020.

1.3 Ten safety actions have been identified to support achievement of this ambition. If Trusts can evidence compliance with all ten safety actions a 10% reduction on their Clinical Negligence Scheme for Trusts (CNST) premium will be applied. For Medway NHS Trust this equates to £375k.

1.4 A paper was presented to the Board of Directors Meeting in Private held Thursday 1 August 2019 which set out the Trusts self-assessment of compliance against the ten safety actions. At that time the maternity service was fully compliant with nine of the ten actions.

1.5 A verbal update of compliance against the outstanding action, safety action 9 (staff training) was provided at the meeting. The maternity service had confirmed in writing the requirements of safety action 9 had been met on 31 July 2019.

1.6 The Executive Director of Nursing advised the Board that the training evidence would be reviewed to ensure it supported a declaration of compliance. A final quality assurance check of all evidence would also be undertaken prior to submission of the declaration.

1.7 The Board approved the Trust declarations as presented and delegated authority to the Chief Executive Officer (CEO) to sign the declaration once the training evidence had been reviewed and assurance had been provided by the Executive Director of Nursing on the supporting evidence for all actions.

2 Current Status

2.1 The quality assurance check has been completed and the self-assessment document (Appendix 1) has been updated. The amendments to the previous document are as follows;

Safety action 1: Additional information has been included to provide more vigorous evidence of compliance with the standards for reporting and reviewing still births.

The maternity service can evidence compliance with the Perinatal Mortality Review Tool (PMRT) standards as identified by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK).

a) *Review of 95% of all deaths of babies suitable for review, using the PMRT, occurring from Wednesday12 December 2018, have been started within four months of each death.*

During the reporting period (December 2018-June 2019) there were four cases which have been reviewed and reported on with supporting minutes and actions agreed on the following dates:

- 22 January 2019
- 26 March 2019
- 18 June 2019

Quarter 4: 2018/19	Number of Stillbirths
December	0
January	2
February	0
March	2
Quarter 1: 2019/20	
April	0
May	0
June	0

100% of all still births were reviewed using the PMRT with the review commenced within four months of death. All reports are available as evidence.

b) *At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.*

All stillbirths are reviewed by a multidisciplinary team which includes external support form a Consultant, Obstetrics and Gynaecology from Maidstone and Tunbridge Wells

100% of cases were discussed at a stillbirth review meeting and a report produced within four months of each death. All reports are available as evidence.

c) *In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.*

All families meet with the Bereavement midwife following their birth and then again at a six weeks postnatal still birth follow up appointment with the Consultant, Fetal Medicine Lead. During these contacts the families are made aware of the stillbirth review and reporting process and they are invited to give feedback and raise concerns about their care.

In 100% of cases parents were informed of the review and their input sought. This is evidenced on the PMRT and also within the patient records.

In the reporting period the Still Birth reviews did not identify any learning relating to the individual cases therefore case specific actions plans were not required. However the service has identified improvements to be made in general processes and these have been included in an action log.

Going forward the maternity service will provide quarterly reports to the Trust Board that include details of all deaths reviewed and consequent action plans. The quarter 2, 2019/20 report will be completed by the end of October 2019 and available to be presented at the nearest board meeting or sub-committee.

Safety action 8: Training compliance has been confirmed as 90% or more for each staff group. Training records are available as evidence.

Staff group	% compliance
Consultant Obstetricians	92%
Obstetric Registrars	100%
Senior House Officers	91%
Consultant Anaesthetists	100%
Anaesthetic Registrars	100%
Midwives	92%
Maternity Support Workers	93%
Theatre Staff	90%

2.2 The maternity service is compliant with all ten safety actions. Action plans are not required to support delivery of any non-compliant safety actions.

2.3 The updated Trust self-assessment and self-declaration have been presented to the CEO for review and approved.

2.4 The Trust self-declaration of compliance has been signed by the CEO on behalf of the Board of Directors and submitted to NHS Resolution prior to the submission deadline of noon on Thursday 15 August 2019.

2.5 NHS Resolution will notify the Trust of the outcome of the submission on 30 September 2019.

Appendix 1: Updated 13 August 2019

Medway NHS Foundation Trust – Self-Assessment of progress against the Clinical Negligence Scheme for Trusts (CNST) Incentive Scheme - Maternity Safety Actions

SECTION A: Evidence of Trust's progress against 10 safety actions:

Please note that trusts with multiple sites will need to provide evidence of each individual site's performance against the required standard.

Safety action – please see the guidance for the detail required for each action	Evidence of Trust's progress	Action met? (Y/N)
1). Are you using the National Perinatal Mortality Review Tool (NPMRT) to review perinatal deaths?	NPMRT was implemented in March 2018 and is evidenced in the maternity change register. There are currently 5 cases from 12/12/2018 to 15/8/2019 which qualified for review using the NPMRT. MFT process includes a bimonthly still birth meeting review meeting chaired by Lead FMU consultant. Each case is discussed in detail following a rapid clinical case review using the NPMRT tool. 3 cases have been reviewed at the bi monthly meeting and all cases have been submitted via NPMRT. The next review will be held on 18/6/19 and will review the remaining current cases ready for submission using NPMRT. Evidence available on request: • Confirmation of implementation of process on the Directorate change register • Terms of reference of the Stillbirth Review Meeting • Minutes of the Stillbirth Review Meeting • Spreadsheet of all stillbirths qualifying for NPMRT review. • NHS Resolution will also use data from MBRRACE to verify the Trust's progress against this action.	**Y**

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<tr>
<td colspan="2">Are you meeting the PMRT standards:</td>
<td>During the reporting period (December 2018-June 2019) there were four cases which have been reviewed and reported on with supporting minutes and actions agreed on the following dates:
• 22/1/19
• 26/3/19
• 18/6/19

<table>
<tr><td>Quarter 4: 2018/19</td><td>Number of Stillbirths</td></tr>
<tr><td>December</td><td>0</td></tr>
<tr><td>January</td><td>2</td></tr>
<tr><td>February</td><td>0</td></tr>
<tr><td>March</td><td>2</td></tr>
<tr><td>Quarter 1: 2019/20</td><td></td></tr>
<tr><td>April</td><td>0</td></tr>
<tr><td>May</td><td>0</td></tr>
<tr><td>June</td><td>0</td></tr>
</table>
</td>
<td></td>
</tr>
<tr>
<td>a)</td>
<td>Review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death</td>
<td>100% of all still births were reviewed using the PMRT with the review commenced within four months of death.

Evidence available
• Minutes of Still Birth Review meetings
• Still Birth Review reports</td>
<td></td>
</tr>
<tr>
<td>b)</td>
<td>At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby</td>
<td>All stillbirths are reviewed by a multidisciplinary team which includes external support form a Consultant, Obstetrics and Gynaecology from Maidstone and Tunbridge Wells

100% of cases were discussed at a stillbirth review meeting and a report produced within four months of each death.</td>
<td></td>
</tr>
</table>

	died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.	Evidence available • Minutes of Still Birth Review meetings • Still Birth Review reports • Action plans	
c)	**In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.**	All families meet with the Bereavement midwife following their birth and then again at a six weeks postnatal still birth follow up appointment with the Consultant, Fetal Medicine Lead. During these contacts the families are made aware of the stillbirth review and reporting process and they are invited to give feedback and raise concerns about their care. This is evidenced on the PMRT and also within the patient records. In 100% of cases parents were informed of the review and their input sought. Evidence available • Still Birth Review (PMRT) • Documentation within patient records Four cases have been reported to date for quarter 2, 20219/2020. PMRTs are scheduled to be completed for the next Still Birth Review meeting on 24/09/2019.	
2). Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?		Medway submit data monthly to MSDS. We are 100% compliant for the first 3 mandatory standards. We have achieved 17/19 compliance on the 19 further standards (when 14/19 is the minimum required). Monthly submissions are presented as evidence for the period of October 2018 to April 2019. The Department is currently upgrading the Euroking database so that it can directly and accurately pull all the data required for MSDS. Evidence available: • NHS Resolution will also use data from NHS Digital to verify the Trust's progress	**Y**

	against this action. • Data submission validation	
3). Can you demonstrate that you have transitional care facilities that are in place and operational to support the implementation of the ATAIN Programme?	Medway Foundation Trust has had a purpose built co-located transitional care (TC) bay consisting of 8 beds since 2007. In response to feedback from mothers it was refurbished in 2016. TC is staffed 24/7 by a neonatal nurse, neonatal registrar and maternity support worker (MSW). A midwife will support the MSW and provide assistance and escalation should there be concerns about maternal wellbeing. The supporting evidence: • TC guideline • ATAIN action plan • Safety and quality minutes and action log.	**Y**
4). Can you demonstrate an effective system of medical workforce planning to the required standard? **Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps.** **b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.**	There were no red flags in the GMC survey and therefore we were not asked to respond to the Trust board. That said, the unit has been proactive allocating a four hour session per week to one of our consultants for rota management. This is to ensure equal distribution of the training opportunities based on their requirements. The ACSA anaesthetic lead is due to present the compliance with standards in October 2019 Supporting evidence: • Survey results demonstrating no action plan is required • Anaesthetic Rotas to demonstrate compliance with ACSA standards	**Y**

5). Can you demonstrate an effective system of midwifery workforce planning?	The Head of Midwifery has used Birth-rate plus which recommended a ratio of 1:26 based on the antenatal, intrapartum and postnatal pathways of care. The evidence available includes: • Birth-rate plus review 2019 • Hands on help business case • Dashboard March 2019 • Maternity closures review. • Pool post business case • Bi-annual report • Delivery Suite staffing guideline • Specialist Midwives review	**Y**

6). Can you demonstrate compliance with all 4 elements of the Saving Babies' Lives (SBL) care bundle?	The Maternity Transformation Board met on Monday 13 May 2019 to share compliance with regard to the SBL agenda. The minutes are available as evidence on request and demonstrate that all four standards are being met.
	
	Further evidence includes:
	
	• Reducing Still Births Care Bundle Survey 11
	• The Maternity Safety Strategy which sites the goals and objectives as:
	  ▪ Smoking Cessation
	  ▪ Management of Reduced Fetal Movements
	  ▪ Management of Small for Gestational Age
		Y

	▪ CTG Monitoring • Smoking Audit March 2019 which provides assurance with CO testing at booking and delivery. • The Maternal Smoking Strategy • CTG training compliance • Fresh eyes audit 2019 • The department does not follow the GAP and Grow pathway. Our local management pathway is that all women are offered a scan at 36 weeks to detect small for gestational age babies. An audit performed in 2017.	
7). Can you demonstrate that you have a patient feedback mechanism for maternity services, such as the Maternity Voices Partnership Forum, and that you regularly act on feedback?	There is a recently appointed MVP for Kent and Medway. The Terms of Reference (ToR) for this Group are available. The MVP representative is due to meet with the Head of Midwifery on 20/6/19 In the absence of an MVP the department has utilised feedback from women from complaints, PALS contacts (Patient Advice and Liaison), debriefs and the Friends and Family Test. Further involvement of user groups is demonstrated in the audits for infant feeding and the Maternity Survey action plan in response to the latest Picker Report. Evidence available: • ToR MVP • Picker report and action plan • PALS data • F&F report • Change table for patient feedback and debrief • Health Watch spotlight report	**Y**

8). Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Following the partial achievement for last year's submission, the sub-directorate was funded by CNST to provide backfill in order to achieve full compliance. Since April 2018, Maternity Support Workers have also attended obstetric emergency training. All staff groups are compliant with training at 90% or above • Consultant Obstetricians 92% • Obstetric Registrars 100% • Senior House Officers 91% • Consultant Anaesthetists 100% • Anaesthetic Registrars 100% • Midwives 92% • Maternity Support Workers 93% • Theatre Staff 90% Evidence available: • Training tables to demonstrate compliance • Training programme • Attendance lists	**Y**
9). Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	At Medway the executive sponsor is the Executive Director of Nursing (DoN) who meets regularly with the Trust Safety Champions, either one to one or at regular maternity meetings. Key Issue Reports relating to maternity safety have been presented at the Programme / Service Performance Review Meetings. Any concerns or risks are also escalated through Datix.	**Y**

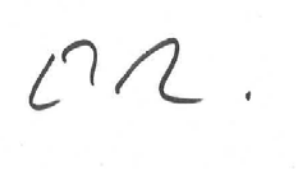
	Evidence available: • Staff survey results • Safety agenda • Safety strategy • Maternity Transformation Assurance Board: ToR, work flow, actions. • Transformation agenda	
10). Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	There are 9 babies that met the criteria for this scheme and they have all been reported. The 9 completed Early Notification forms are available on request. Evidence available: • Database for notification scheme	**Y**

SECTION C: Sign-off

……..

For and on behalf of the Board of Medway NHS Foundation Trust confirming that:

- **The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets the required standards and that the self-certification is accurate.**
- **The content of this report has been shared with the commissioner(s) of the Trust's maternity services**
- **If applicable, the Board agrees that any reimbursement of CNST funds will be used to deliver the action(s) referred to in Section B**

Name:	**James Devine**	**Name:**	**n/a**
Position:	**Chief Executive Officer**	**Position:**	**n/a**
Signature:		**Signature:**	n/a
Date:	**13 August 2019**	**Date:**	**n/a**

We expect trust Boards to self-certify the Trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group escalate to the appropriate arm's length body/NHS System leader.

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	Finance Report July 2019	**Agenda Item**	**6.1**
Lead Director	Ian O'Connor, Executive Director of Finance		
Report Author	Yasmin Ahmed, Deputy Director of Finance		
Executive Summary	This paper reports the July 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 22 August 2019		
Resource Implications	Not Applicable		
Legal Implications/Regulatory Requirements	Month 4 year to date favourable to NHSI control total by £611,000.		
Quality Impact Assessment	Confirm and challenge sessions and additional cost improvement opportunities continue to be developed and managed through the established Quality Impact Assessment Framework.		
Recommendation/ Actions required	The Board is asked to note the financial position as at 31 July 2019 is a £611,000 favourable variance reported against the financial plan that adjusts to a £985,000 adverse variance when compared to the improvements expected against the current cost improvement plan.		

Approval	Assurance	Discussion	Noting
☐	☐	☐	☒

Appendices	Appendix 1 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 flash report detailing key performance indicators is attached at Appendix 1 and was circulated on 7 August 2019. It sets out a series of individual metrics designed to show progress over time and assess the risks associated with operational performance and the impact on the Trust's financial position.

2 Income and Expenditure

2.1 To the end of July the Trust is reporting a year to date deficit of £16.9 million (excluding Provider Sustainability Funds (PSF), Marginal Rate Emergency Tariff (MRET) and Financial Recovery Funds (FRF). Operationally this is adverse to the current operational plan by £985,000 as shown in Table 1. Against the declared plan with NHSI the Trust is £611,000 favourable to plan. This will merge with the operational plan over the course of the year.

2.2 July's in month performance is a deficit of £4.6 million excluding PSF, MRET and FRF adverse to plan by £841,000. The adverse deficit variance arises as a result of non-delivery of baseline budget (£0.21 million), cost improvement plans falling behind expectations (£0.19 million) and reduced clinical income (£0.44 million) as a result of activity being lower than planned levels.

2.3 Overall the forecast to the end of the year remains the delivery of the £22.0 million deficit.

2.4 PSF, MRET and FRP income in July is £2.8 million favourable to plan by £580,000. The favourable variance relates to additional income received for achieving the 2018/19 control total. This 2018/19 bonus has a cash benefit but will not provide a benefit in measuring performance against 2019/20 control totals and hence is removed in the memorandum table below.

Table 1	Month 4			Year to Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Clinical Income	22,345	21,325	(1,020)	88,823	86,889	(1,934)
Other Income	1,939	2,086	147	7,755	8,154	399
Pay	(17,368)	(17,180)	188	(70,059)	(68,982)	1,077
Non pay	(9,414)	(9,686)	(271)	(37,263)	(38,190)	(927)
EBITDA	**(2,498)**	**(3,455)**	**(957)**	**(10,744)**	**(12,128)**	**(1,385)**
Non Operating Expenses	(1,289)	(1,173)	116	(5,121)	(4,722)	399
Surplus/(Deficit) before PSF/MRET/FRF	**(3,787)**	**(4,629)**	**(841)**	**(15,865)**	**(16,850)**	**(985)**
PSF/MRET/FRP	2,196	2,776	580	7,712	8,292	580
Operational Surplus/(Deficit)	**(1,591)**	**(1,853)**	**(261)**	**(8,153)**	**(8,558)**	**(405)**
CIP Rephasing	(233)		233	(1,593)		1,593
Surplus/(Deficit)	**(1,824)**	**(1,853)**	**(28)**	**(9,746)**	**(8,558)**	**1,188**

Memo	Month 4			Year to Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
18/19 PSF & Donations Adjustment	15	(568)	(583)	60	(517)	(577)
NHSi Control Total Surplus/(Deficit)	**(1,810)**	**(2,421)**	**(611)**	**(9,686)**	**(9,075)**	**611**

3 Cost Improvement Programme

3.1 For the first time in a number of months the targeted cost improvement programme has fallen behind trajectory and is reporting an adverse variance against plan of £190,000. This is in large due to delays in mobilising the out-patients transformation scheme. Overall year to date delivery is £4.6 million and the PMO is confident the annual forecast delivery remains in line with plan at £18.0 million.

4 Capital

4.1 Capital expenditure year to date is £2.95 million which is in line with the original plan. As detailed schemes are finalised it is likely that the plan will need to be reprofiled at scheme level but will remain within the overall annual plan of £23.7 million as agreed and submitted to NHS Improvement.

Table 2

	Month 4 (July)			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Backlog Maintenance	250	(20)	270	1,550	336	1,214
Routine Maintenance	0	0	0	0	8	(8)
Plant/Equip/Trans/Fits/Other	280	9	271	560	221	339
Fire Safety	0	1,210	(1,210)	243	1,603	(1,360)
IT	200	(594)	794	600	477	123
New Build - Land, Build, Dwell	0	280	(280)	0	305	(305)
Capital Programme Totals	**730**	**885**	**(155)**	**2,953**	**2,950**	**3**

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

6 Recommendation

6.1 The Board is asked to note the financial position as at 31 July 2019 is a £611,000 favourable variance reported against the financial plan that adjusts to a £985,000 adverse variance when compared to the improvements expected against the current cost improvement plan.

I&E Deficit £m

	Apr	May	Jun	Jul	RATING
Plan	(3.4)	(2.2)	(2.3)	(1.8)	
Actual	(2.8)	(1.8)	(1.9)	(2.4)	
Variance	0.6	0.4	0.4	(0.6)	

The Trust has incurred a deficit of £2.4 million for Month 4, adverse to plan by £0.6 million mainly due to reduced activity in outpatients and CIP not delivered. Holding £1.2 million provision for optimism bias

Capital Expenditure YTD (£m)

	Apr	May	Jun	Jul	RATING
Plan	0.0	(0.5)	(2.2)	(3.0)	
Actual	0.0	(0.5)	(2.1)	(3.0)	
Variance	0.0	(0.0)	0.1	0.0	

19/20 Capital Expenditure is largely on plan.

CIP Delivery Current Plan £m

	Apr	May	Jun	Jul	RATING
Plan	1.3	0.9	0.9	1.6	
Actual	1.1	1.1	0.9	1.4	
Variance	(0.2)	0.2	0.0	(0.2)	

CIP Delivery is £1.4 million in month which is adverse to plan by £0.2 million mainly due to the Theatres and Outpatient schemes not delivering as planned.

Cash Actual £m

	Apr	May	Jun	Jul	RATING
Plan	5.0	5.0	5.0	5.0	
Actual	17.0	29.2	26.4	26.2	
Variance	12.0	24.2	21.4	21.2	

The cash balance held at 31st July 2019 was £26.2 million, £21.2 million higher than plan. This is due to a revised payment profile with Commissioners which will defer the need for further borrowings until later in the financial year. This will save the Trust interest expenses and forms part of the improvement plan.

Normalised Monthly Pay £m

	Apr	May	Jun	Jul	RATING
Plan	(17.5)	(17.6)	(17.7)	(17.4)	
Actual	(17.1)	(17.1)	(17.1)	(17.2)	
Variance	0.4	0.5	0.6	0.2	

Normalised pay expenditure in month is £17.2 million and favourable to plan. Deterioration from last month due to CIP non delivery.

Normalised Monthly Agency Expenditure £m

	Apr	May	Jun	Jul	RATING
Plan	(0.7)	(0.7)	(0.7)	(0.6)	
Actual	(0.7)	(0.5)	(0.5)	(0.6)	
Variance	0.0	0.2	0.2	(0.0)	

Agency Spend is £0.6 million, in line with plan.

Better Payment Practice Code (BPPC by Volume (%)

	Apr	May	Jun	Jul	RATING
Plan	95.0	95.0	95.0	95.0	
Actual	43.20	55.00	55.0	55.0	
Variance	(51.8)	(40.0)	(40.0)	(40.0)	

BPPC percentages remain the same as last month and are low due to slow invoice approval and a backlog of aged creditors. As these invoices are paid they bring the %'s down. Currently all approved invoices are being paid as soon as they become due, aged creditors are paid immediately when approval is given.

All Aged Creditors 60+ Days (£m)

	Apr	May	Jun	Jul	RATING
Actual	4.4	3.4	6.1	5.8	

Creditors balances in excess of 60 days are £5.8 million. £2.7 million NHS, £3.0 million Non NHS. The high level relates to a number of contractual issues to be resolved before invoices can be approved, an increase in the level of purchase order mismatches and slow approval of Non PO Invoices. Finance are working with Directorates to clear these issues.

All Aged Debtors 60+ Days (£m)

	Mar	Apr	Jun	Jul	RATING
Actual	14.3	13.2	12.2	14.0	

Debtor balance in excess of 60 days has increased to £14m. Local CCGs are delaying paying High Cost Drugs invoices causing this rise. Finance are working with these debtors to resolve queries.

Going in the right direction

Going in the wrong direction

Glossary of Terms:

I&E	Income and Expenditure
CIP	Quality Cost Improvement Programme
YTD	Year-to-Date

Meeting of the Board of Directors in Public

Thursday, 05 September 2019

Assurance Report from Committees

Title of Committee:	Finance Committee	**Agenda Item**	**6.2**
Committee Chair:	Joanne Palmer, Senior Independent Director		
Date of Meeting:	Thursday, 22 August 2019		
Lead Director:	Ian O'Connor, Executive Director of Finance		
Report Author:	Brenda Thomas, Company Secretary		

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 Four Report The Committee discussed the Month four figures. The Trust reported £611,000 favourable variance against the financial plan of £600,000, that adjusts to a £985,000 adverse variance when compared to the improvements expected against the current cost improvement plan (CIP). The Committee separately discussed the financial position for the unplanned and integrated care and planned care divisions.	**Green**
2. Reference Cost Submission The Committee approved the Trust's Reference Cost Submission for 2018/19, recognising that this is subject to further refinement by NHS Improvement.	**Green**
3. Finance Risk Register The Committee discussed the refreshed finance risk register particularly noting the removal of the risk relating to finance team staffing, as all posts have been permanently recruited to.	**Amber/Green**

4. Cost Improvement Plan - Month four The Committee received the month four cost improvement plan (CIP). As at month four, the CIP has delivered £4.5million against an operational CIP plan of £21million, adverse to plan by £121,000, largely driven in the planned care division. The Committee was assured that the Trust is on track to achieve the £18million CIP target, albeit focused work is required particularly in planned care.	**Amber/Green**
5. Capital Plan 2019/20 Capital expenditure for the period to July 2019 was £2.95 million in line with plan. The current direction is to spend to original plan, although there was a request to reduce capital, which was reversed nationally. The trajectory on spend was noted. The Capital Group, which has been reinstated, would review and monitor the list of projects to ensure delivery on spend.	**Green**
6. Emergency Department Water Mist System The Committee received a report which outlined the current situation regarding the installation of a low pressure water mist system in the new emergency department modular building, which is an additional level of fire safety protection. This has been extensively discussed at the Fire Assurance Group and approved by the Executive Group.	**Green**
7. Fire Safety Improvement – Application for Additional Funding The Committee discussed an application for additional funding for fire safety improvement work.	**White**
8. Self-assessment/Review of Effectiveness The Committee reviewed its effectiveness for 2018/19. The Committee Chair and Executive Director of Finance would go through the areas highlighted for improvement and report back to the Committee as to how to progress. The Committee agreed to make provision for five minutes at the end of each meeting to discuss outcomes and reflect back on decisions made and what worked well.	**Amber/Green**
9. Project Updates <u>Service Transformation and Access Review (STAR) Programme</u> The Committee received an update on the STAR programme which is a joint piece of work between the Medway and Swale Transformation Board and the Commissioner. The expectation of this programme is that patients who need to be seen by a specialist in hospital will be seen quicker, thereby improving Referral to Treatment (RTT) performance standard. <u>Electronic Documents Records Systems (EDRMS)</u> The Committee received an update on the EDRMS project, which is designed to replace the blue patient case notes with an electronic patient note; noting the key issues which need to be addressed.	**White**
Decisions made 1) Approval of the Trust's Reference Cost Submission for 2018/19, recognising that this is subject to further refinement by NHS Improvement.	
Further Risks Identified All risks are captured within the risk register and the Board Assurance Framework.	
Escalations to the Board or other Committee 1) None	

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	Communications and Engagement	**Agenda Item**	**6.3**
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 We have developed an overarching communications plan and supporting materials for the next phase of our transformation programme. This includes the first edition of the 'Making Medway Brilliant' newsletter and a booklet to provide a detailed explanation of the programme and strategic objectives.

2.2 Members of the communications team are supporting the transformation priority programmes with dedicated communications and engagement plans.

2.3 The team has created vinyl displays defining our values and priorities and a mosaic featuring more than 500 staff. These have now been installed across the site and have been well-received by staff.

2.4 Executive colleagues continue to visit wards and other areas of the hospital as part of Gemba 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.

2.5 The monthly staff briefings with James Devine have continued with very good attendance and engagement from staff. The team has used hand-held technology to provide staff with an opportunity to ask questions anonymously during the session. This resulted in more than 20 questions being asked at the last staff briefing.

2.6 The team continues to support the You Are the Difference programme, raising awareness of training sessions, recruiting ambassadors and encouraging staff to complete recognition cards for colleagues.

2.7 The last three months have involved a programme of communications in support of the car parking project to ensure all staff were aware of the need to reapply for their permit and clear of the ongoing process.

2.8 We launched a zero tolerance campaign aimed at reducing the numbers of staff experiencing verbal or physical abuse from the public. The campaign aims to highlight to our community that this behaviour will not be accepted, it also ensures that staff understand that they have Trust support in dealing with these issues.

2.9 A communications survey is underway to gain a greater understanding of the communication channels that are effective in engaging staff. At time of writing, there have been more than 200 responses.

2.10 We are also using communications channels to encourage staff to gather details from the European Health Insurance Cards (EHIC) of our overseas visitors. This enables the Trust to claim back payment for the treatment provided, as well as an additional 25 per cent of the tariff.

2.11 We have continued to work with teams to promote the eDRMS project internally, which will enable clinicians to see more patient information electronically and reduce paperwork.

3 Media

3.1 During July and August the communications team dealt with more than 20 interactions with local, regional and national media. These included reactive responses to media queries and proactive approaches by the team to promote good news stories.

3.2 Positive news included excellent coverage both in the printed media and on television (BBC South East and Meridian) of the Trust's zero tolerance campaign. There was also television coverage about the hospital's new therapy dog Yazzy, good printed coverage on the Trust bucking the trend regarding dementia screening, and the research team's success in recruiting patients.

3.3 On a less positive note, local media covered patients' poor experiences in the Same Day Emergency Care (SDEC) centre and issues with long waits in MedOCC.

3.4 In other news, there has been press coverage about the launch of the Rainbow Badge, Amanda Epps' visit to Downing Street, the charity Superhero run and a donation of fans and water during the recent heatwave. Press releases were also sent about the Trust mosaic and the upcoming Annual Members' Meeting.

4 Social Media

4.1 Medway has continued to grow its following across all social media channels, maintaining its position as Kent's most-followed acute Trust on both Twitter and Instagram, and passed the milestone 5,000 follower mark on Twitter.

4.2 Key messages shared widely across social media since the last update included the Trust's NHS Rainbow Badge scheme pledge, the launch of our zero tolerance campaign, and the installation of special hospital artwork celebrating the important contribution of our staff in providing care to the local community.

4.3 In-house videos produced by the Communications team proved popular on social media and were seen by more than 30,000 users. These covered the visit by NHS England and Improvement Chief Pharmaceutical Officer Dr Keith Ridge, the inaugural 'Behind the Scenes' members' event, the arrival of the Trust's new therapy dog, charity celebrations to mark the 71st anniversary of the NHS, and the Trust's commitment to the Hello My Name Is campaign.

4.4 Across all channels, our posts received a sustained number of views since the last update – approximately 122,000 on Facebook and 210,000 on Twitter. This compared to 150,000 on Facebook and 185,200 on Twitter last time.

4.5 Medway's social media account followers now total 5,163 on Twitter (up from 4,935 at the last update), 7,086 on Facebook (up from 6,957) and 1,632 on Instagram (up from 1,532).

5 Community engagement

5.1 Governors

5.1.1 Between the beginning of July and end of August our Governors have continued to proactively engage with our community.

5.1.2 All feedback received from through this engagement is reported back into the Trust through Board reports, Council of Governor meetings and at Patient Experience Group meetings.

5.1.3 Governors reported a number of interactions where people complimented the service and care they received.

5.1.4 Constituents advised that access to services remained a challenge across the whole health system. People spoke of the challenges they have in navigating the 'choose and book' system.

5.1.5 Concerns were voiced over anticipated changes to stroke services following the recent consultation.

5.1.6 Two people shared their experience of triage between the Emergency Department and MedOCC and delays experienced in accessing treatment.

5.1.7 Governors met with constituents in Sittingbourne where concerns were raised over transport links to the hospital supporting their argument for a local acute hospital.

5.1.8 Some constituents were loyal to their local community hospital and historical negative views of Medway Maritime Hospital prevailed, although there was also praise for hospital staff. It was felt more frontline staff was needed to deliver quality care.

5.1.9 Some Swale patients spoke of experience of having to arrive two to three hours early so that they were able to park. Medication waits, and the lack of a support group for people with MS were also raised.

5.2 Community engagement for services reviewed.

5.2.1 In collaboration with Medway Clinical Commissioning Group the Trust held a focus group with Haematology patients as part of the outpatient services review. Patients spoke very highly of the staff and the service provided. They described the service as excellent.

5.2.2 Areas for improvement included shorter waiting times, improved facilities to have blood taken in the community and hospital. Patients asked for blood processes to be standardised.

5.2.3 When their condition was stable, some patients were happy to be reviewed through telephone appointments, whereas others wanted to continue to have face to face appointments.

5.2.4 Suggestions were made for more education for GPs to monitor and support patients' conditions.

5.3 Member engagement

5.3.1 In July we opened our doors to our members and invited them to have a look behind the scenes at the hospital with an 'open day', the first such event we had held. People were able to visit unseen areas such as the Medical Gas Building, Emergency Generator House and Clinical Engineering and see the 'nuts and bolts' behind the safe running of the hospital's operations.

5.3.2 Our Simulation Department then provided an insight into how our clinicians are trained using advanced, lifelike manikins, in a range of simulation scenarios.

5.3.3 The Trust's simulation staff work hard to provide high-quality, educational exercises for our clinicians, and members told us they were impressed to see this first-hand and by the levels of modern training on offer, which helps to improve experiences for our clinicians and patients.

5.3.4 The tour ended with a question and answer session with Chief Executive James Devine, who was quizzed on a range of topics including future plans for the hospital, car parking, supporting staff well-being, and career opportunities at the Trust.

5.3.5 Members concluded the session by telling us they were 'pleased to have participated', were 'better informed about the back room operations delivered by unsung heroes', were 'positive and confident that things were improving', and were 'extremely optimistic for the future of their local hospital'.

5.3.6 Following this event six people registered their interest to be involved with simulation training and assisting in clinician education.

5.3.7 In November our members will have the chance to hear about the role of pharmacy, the safe use of medicines and the transformational work being undertaken to improve patient experience, quality and patient safety.

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	**Workforce Report**	**Agenda Item**	**7.1**
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 280 candidates to date; 164 of these candidates have commenced in post over the last 12 months. Trust turnover has increased at 12.44% (+0.03%) from 12.41%, sickness absence at 4.28% (-0.01) compared to the month of June is above the Trust's tolerance level of 4%, and appraisal compliance has increased to 91.43% (+0.12% from 91.31%) and is above Trust target of 85%. Statutory and Mandatory training is at 89.50% (-0.06% from 89.56%) and is meeting the Trust target of 85%. The percentage of pay bill spent on substantive staff in July at (84%) decreased (-2% from 86%) compared to the month of June. The percentage of agency usage at 4% increased (+1 from 3%) compared to the month of June. The percentage of pay bill spent on bank staff at 12% (+1% from 11%) has increased compared to June.		
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		

<table>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="4">Staffing levels and use of temporary/agency workers have been identified as 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.

2 Recruitment

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During July 2019, 24 full time equivalent (FTE) registered nurses and midwives joined the Trust on a substantive basis, alongside 15 FTE substantive clinical support workers/maternity care assistants, see table 2.

2.2 In July 2019, 17 international nurses commenced training for the Objective Structured Clinical Examination (OSCE) exam they will take the exam on 26 August 2019. To date a total of 137 international nurses have taken the OSCE exam. The Trust has a first attempt pass rate of 82.5% and an overall success rate of 99.2%.

2.3 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Six Cpl international nurses have commenced in post, with 10 in the pipeline. Forty eight HCL nurses have also commenced in post. Forty five 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 year 2019/2020.

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 recruitment pipeline via all our partner agency providers.

Agency Provider	Commenced	Pipeline	Agency total	Anticipated new starters over the next 12-months from pipeline
Total	164	280	655	156

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

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

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses and midwives	34 (20 NHS Jobs/open days and 14 international nurses via skype)	24	15
Clinical support workers/Maternity Care Assistants	28 (Clinical Support Workers)	15	4

(Table 2: Nursing starters and leavers July 2019)

2.6 During July a total of 5 medical staff 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. The 9 junior doctors who left the Trust were all Trust doctors leaving for a number of reasons including some having obtained deanery training positions to commence placements in the month of August 2019 in other NHS organisations. At present consultant recruitment is taking place for the following specialities Microbiology, Rheumatology, Gastroenterology, Anaesthetics and Haematology. As at end of July 2019 the Trust had 18.74 FTE vacant consultant posts and 14.90 vacant junior doctors' posts.

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

Role	Offers made in month	Actual starters	Actual leavers
Medical Consultants	0	1	1
Junior doctors (including doctors in training)	45	4	9

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

2.7 During July a total of 3 Allied Health 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 July 2019

Role	Offers made in month	Actual starters	Actual leavers
Physiotherapists	1	1	1
Occupational Therapists	0	1	1
Dieticians	0	1	0
Radiographers	**0**	**1**	**1**

(Table 4: AHP starters and leavers July 2019)

2.8 During July a total of 2 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 July 2019

Role	Offers made in month	Actual starters	Actual leavers
Pharmacy Technicians	3	1	0
Pharmacists	1	0	1
Operating Theatre Practitioners	3	1	1

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

3 Directorate Metrics

3.1 The table below (table 6) shows performance across five core indicators by the divisions. Turnover, at 12.44% (+0.03% from 12.41%), 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 4.28% (-0.01 from 4.29%) 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.

		Trust			Corporate			Estates & Facilities			Planned Care			Unplanned & Integrated Care		
	Trust Target	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend
Turnover rate (Voluntary, 12-month rolling)	8.0%	12.4%	▲		15.9%	▼		7.5%	▲		12.1%	▲		13.5%	▲	
Vacancy rate	12.0%	13.1%	▼		8.1%	▲		14.6%	▼		12.9%	▲		14.6%	▼	
Sickness rate (12-month rolling)	4.0%	4.3%	▼		2.7%	▼		6.6%	▲		4.4%	▲		3.9%	▼	
Statutory & Mandatory Training	85.0%	89.5%	▼		96.1%	▼		87.9%	▲		89.7%	▼		88.3%	▼	
Medway Appraisal	85.0%	91.4%	▲		92.2%	▲		87.6%	▼		94.7%	▼		88.6%	▲	
Agency costs (as % of total paybill)	11.0%	3.8%	▲		1.9%	▲		0.7%	▲		2.5%	▲		4.9%	▲	
Bank costs (as % of total paybill)		11.7%	▲		3.1%	▲		8.6%	▲		8.7%	▼		16.9%	▼	
Substantive costs (as % of total paybill)	89.0%	84.5%	▼		95.0%	▼		90.7%	▼		88.9%	▲		78.3%	▼	
Stability Index (12-month rolling, >12M)	TBC	83.6%	▲													
Leavers citing "Work/Life Balance" 12 month rolling	TBC	79	▲													

(Table 6: Key Workforce Metrics)

3.2 The Trust appraisal rate stands at 91.43% (+0.12% from 91.31%) 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 89.50% (-0.06% from 89.56%) 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.

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

Directorate >> Programme	Compliance %
Corporate	91.83%
>> Communications	98.61%
>> Finance	97.46%
>> Human Resources and Organisational Development	98.50%
>> IT	98.81%
>> Medical Directorate	83.02%
>> Nursing Directorate	83.54%
>> Strategy, Governance and Performance	99.43%
>> Transformation	96.30%
Estates and Facilities	91.98%
>> Estates and Facilities Management	100.00%
>> Hard Facilities Management	98.22%
>> Soft Facilities Management	90.91%
Planned Care	89.21%
>> Cancer Services	92.02%
>> Perioperative and Critical Care	91.60%
>> Planned Care Infrastructure	90.51%
>> Surgical Services	83.37%
>> Women's and Children's Health	90.13%
Unplanned and Integrated Care	87.77%
>> Diagnostics and Clinical Support Services	89.82%
>> Specialist Medicine	88.96%
>> Therapies and Older Persons	90.12%
>> Unplanned and Integrated Care Management	90.50%
>> Urgent and Emergency Care	83.75%

(Table 7: StatMan compliance profile)

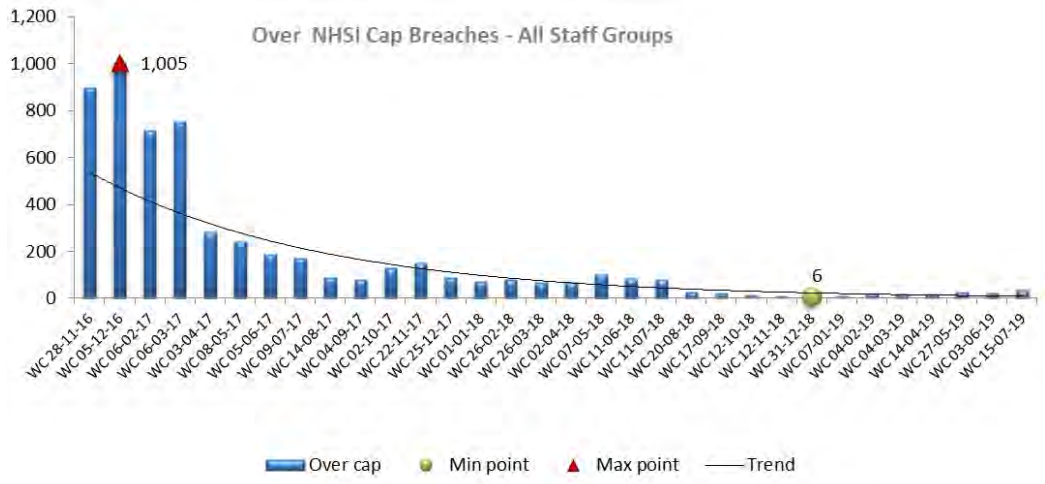
4 Temporary Staffing

4.1 Table 8 below demonstrates that temporary staffing expenditure increased in July 2019 compared to June 2019.

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

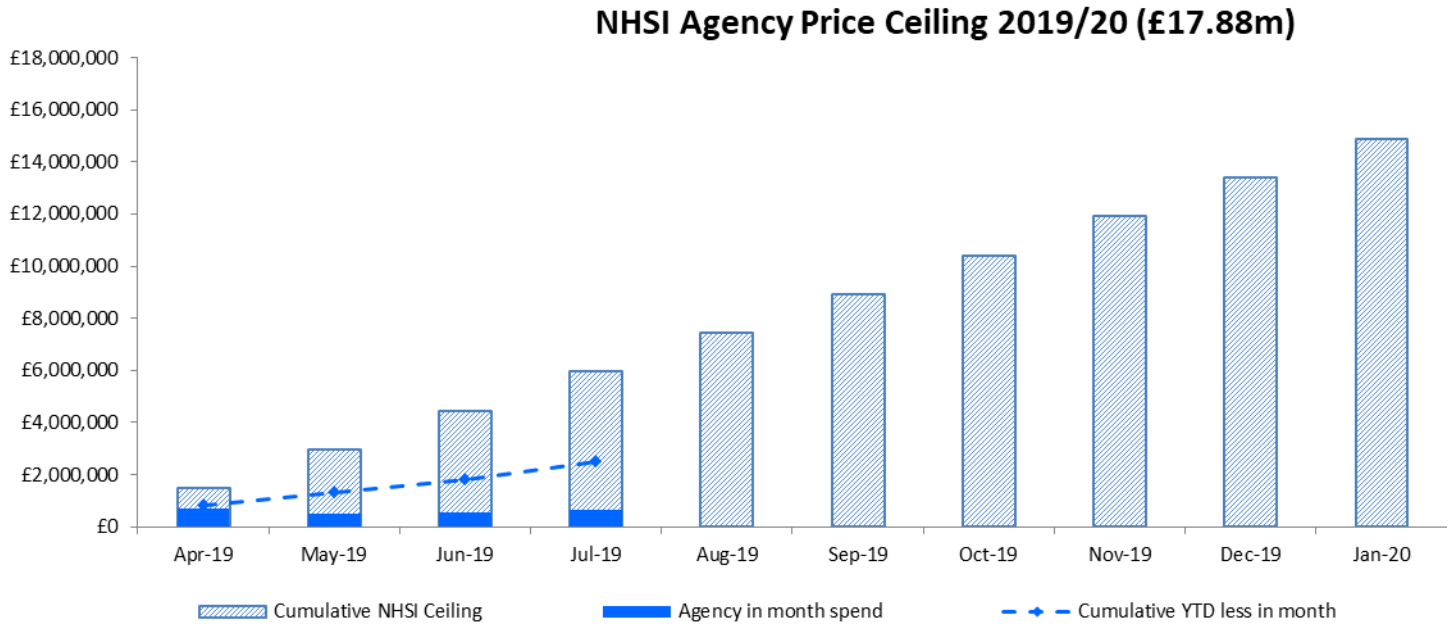
(Table 8: Contractual profile)

4.2 The agency cap breaches across all staff groups have remained stable as illustrated in chart 1 below. During the month of July 2019 the Trust reported an average of 36 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 4 agency spend, the Trust is £3.6m 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
Cumulative NHSI ceiling target	£14,490,000	£14,490,000	£14,490,000	£5,960,000
Agency in month actual spend	£684,291	£497,825	£527,624	£648,359
Cumulative below ceiling	£805,709	£1,182,116	£2,638,842	£3,601,865

(Table 9: NHSI agency ceiling performance)

4.5 Temporary nursing demand increased in July 2019 compared to June 2019 (8,519 shift requests in July 2019 compared to 8,151 shift requests in June 2019). The fill rate was 73%. Medical locum demand also increased in July 2019 compared June 2019 (1,262 shift requests in July 2019 compared to 1,216 shift requests in June 2019). The overall fill rate for nursing and medical locum was 87%.

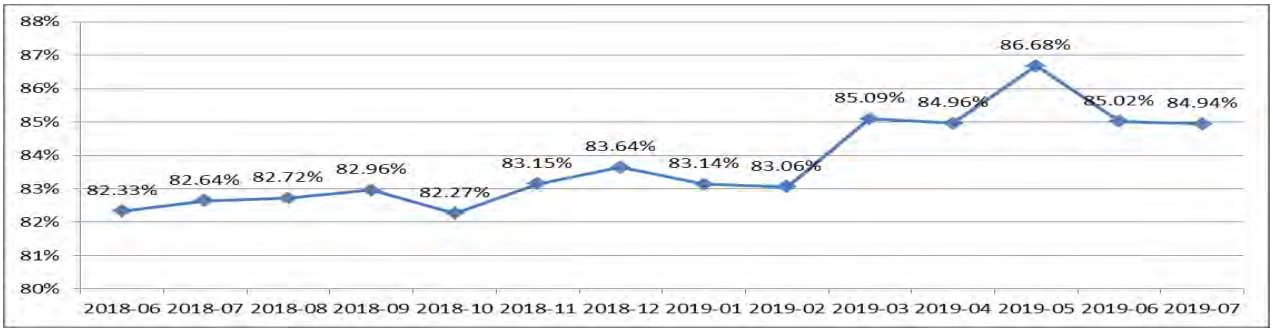
5 NHSI Nursing Retention

5.1 In 2018 the Trust successfully applied to be part of NHSI nursing retention direct support programme cohort 4. As part of this programme, the Trust has worked in partnership with NHSI to identify and implement a number of retention initiatives. The Executive Director of Nursing and Executive Director of HR and OD are sponsors of this programme and the Associate Director of Nursing and Deputy Director of HR and OD are supporting the delivery of the initiatives. A working group made up of the Head of Resourcing, Nursing and Midwifery Workforce Lead, Co-Clinical Directors, Matron, Ward Sisters and Charge Nurses is in place to support the implementation of the identified retention initiatives. The approach being taken is that this is a clinically-led programme.

5.2 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.

5.3 As part of monitoring the impact of retention initiatives, the Trust will start publishing Nursing Stability Index rate. The table and graph 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)

6 You are the Difference

6.1 After the second phase of the, 'You are the Difference' (YatD) programme which took place from January to May 2019, moves to embed 'making a difference' into everyday working practices across the Trust commenced. This is being done through the facilitation of further sessions with Alf

Dunbar and is now embedded as part of the corporate induction programme and forms part of the F1 and F2 doctors' induction.

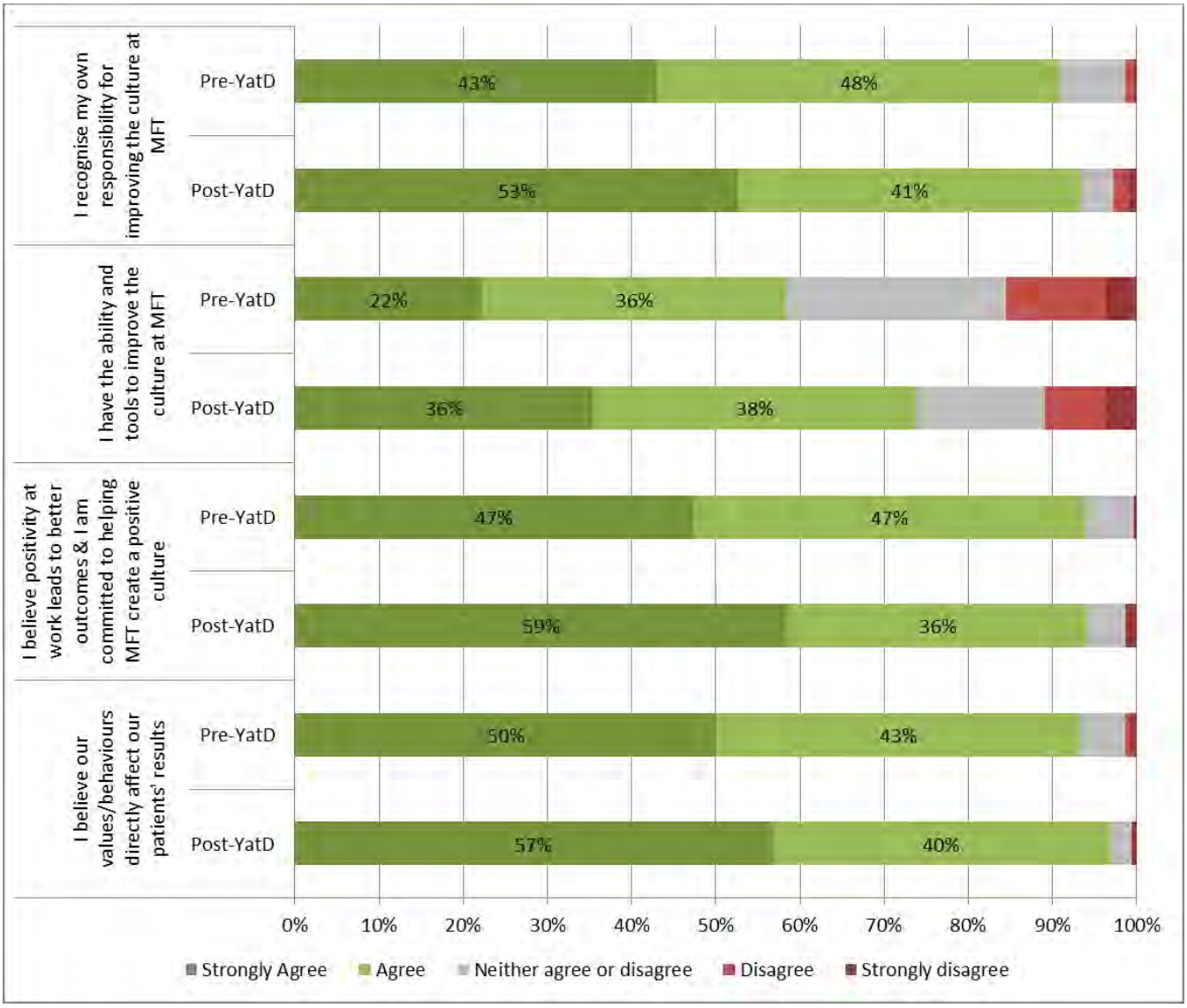
	Phase 1	Phase 2	Ongoing	Total
Number of staff sessions	31	27	17	**75**
Number of staff attended	831	271	267	**1369**
Number of Manager sessions	30	9	3	**42**
Number of Managers attended	**285**	**17**	**27**	**329**

(Table 11: YatD attendance)

6.2 Upcoming actions to further the embedding of YatD include:

1. Facilitation of local YATD Sessions in the wards (August 2019);
2. Increasing the number of YatD ambassadors (already increased from 29 to 40) to assist with local YatD facilitation;
3. Promote and encourage the use of the YATD Recognition Cards via weekly messaging and social media.

6.3 Measuring the direct impact on individuals' pre and post sessions is captured and represented in chart 3 below. All indicators report an improved engagement score with attendees and a shift to positive for individuals understanding their own contribution to the culture of the hospital, but also their role and ability to make the improvements. Across all measures, there is a swing of +5.4% following the session. A percentage of attendees do not recognise their role and ability to make improvements to the culture, work continues to facilitate sessions locally and at divisional level.



(Chart 3: YatD impact analysis)

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. Our Trust is embarking on a new way of engaging staff, so that we not only hear what we think needs to change, but also we can get ideas from staff about how we can change for the better. It attracted just over 700 participants from across the organisation, this equates to approximately 19% of the workforce (profiled as below).

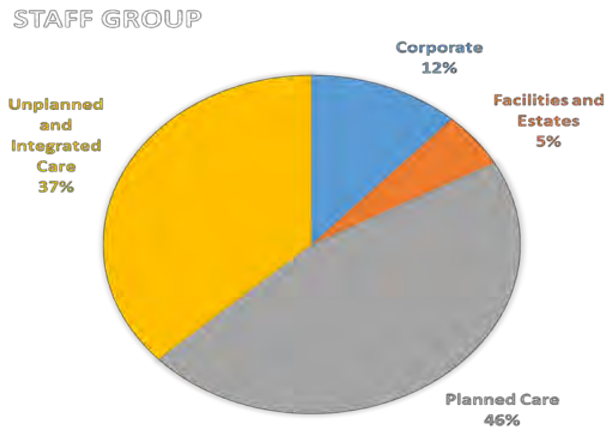


Figure 1: Workforce by division

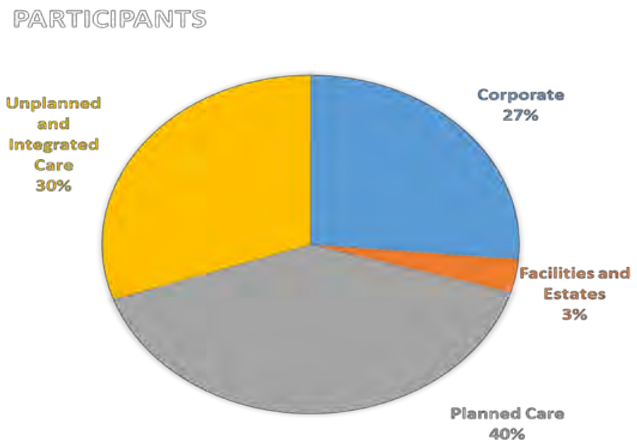


Figure 2: Workshop participants

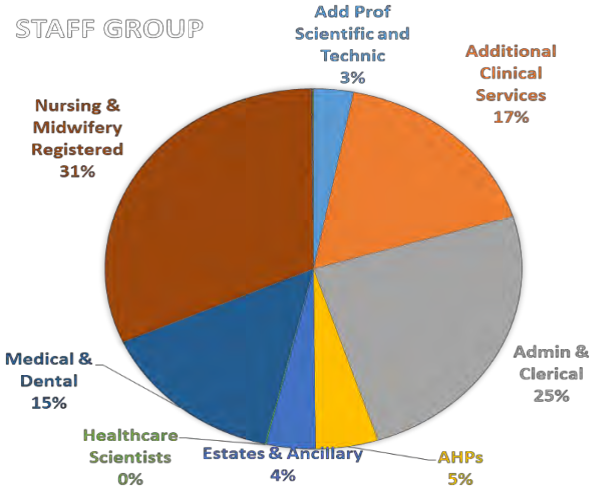


Figure 3: Total workforce by staff group

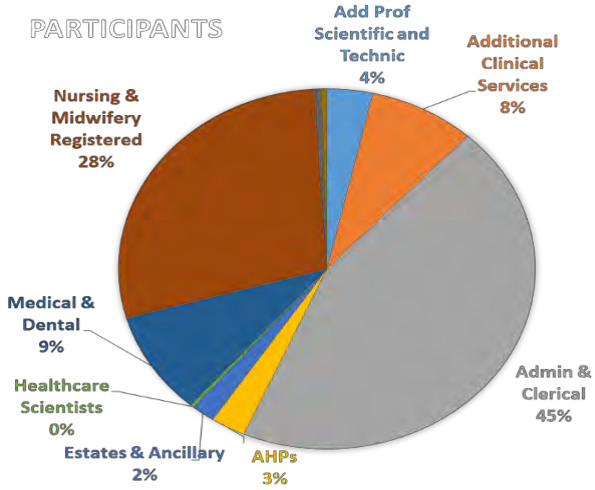


Figure 4: Participants by staff group

7.2 4828 contributions shared conversations which included a combination of ideas, comments, and votes. The table below demonstrates the distribution of contributions.

Theme	Ideas	Comments	Votes
Leading and managing better	73	267	2011
Making our time at work more meaningful	25	60	568
Making our workplace fit for purpose	49	214	1414
Total	147	541	4828

(Table 12: Thematic voting from CleverTogether)

7.3 The three highest topic areas included two under ‘making our workplace fit for purpose’ and one under ‘leading and managing better’. The most voted items under ‘making our workplace fit for purpose’ was a discussion regarding staff access to gym and fitness centre wellbeing benefits with 47 votes and 17 comments followed by the subject of staff parking with 33 votes for the points raised and 25 comments. Under the topic of ‘leading and managing better’, the highest voted item praised the Chief Executive’s style since commencing with 36 votes and 22 comments.

7.4 Next steps will include Clever Together providing a plan and key findings in September 2019 this will inform the next phase which will be to develop the delivery of actions plans from the reports.

8 NHSI Culture and Leadership

8.1 Our current culture and engagement action plan has been modelled on the NHSI culture and leadership toolkit. We are now working with NHSI on an Improvement Culture and Leadership Programme, this will assist Medway to continue delivering high-quality care and value for money while supporting a healthy and engaged workforce, providing continuous improvements and helping the board assure their governance on the 'culture and capability' domain of the well-led framework and improve their results in governance reviews. The Programme is in three phases:

8.1.1 The Discovery Phase which will help diagnose our current culture using existing data, board, staff and stakeholder perceptions and knowledge, and workforce analysis. It is an assessment of the current culture and leadership which is used to inform the design stage.

8.1.2 A Design Phase that will help us create a strategy to develop our organisation's culture and leadership.

8.1.3 The Delivery of the strategies created during the Design Phase.

9 Staff Survey Action plans

9.1 Following the design of local staff survey action plans through March and April, the following actions have been completed:

9.1.1 Planned care have fully implemented and maintained seven of their original actions, a list of current actions is listed in table 13;

9.1.2 Unplanned and integrated care have fully implemented four of their original actions, a list of current actions is listed in table 13:

DIRECTORATE PROGRAME	PRIORITISE 3 AREAS FOR ACTION	TIMESCALES	STATUS / NEXT STEPS
PLANNED CARE			
PERI-OPERATIVE			
	Drop in sessions with the triumvirate for all staff once a month	Immediately	Completed and Awaiting new action
	Develop career pathways for staff to enable them to understand what development is required to enable them to progress at Medway	By the end of July	In progress
	Increase utilisation of the YATD/Trust value recognition cards and continue to nominate staff for employee of the month every month	Immediately	Completed and Awaiting new action
WOMEN AND CHILDREN			
	Purchase 2 banners promoting the RCM Midwifery Service of the Year so that they can be placed across the Trust highlighting the excellent service available to women	By end of April	Completed and Awaiting new action
	Download Airwatch onto the Community Midwives smart phones to enable them to be used within the community setting	By the end May	Completed and Awaiting new action
	Develop a transparent process for applying	By the end of July	In progress
SURGICAL SERVICES			
	Nominate at least one member of staff for employee of the month within Surgical Services every month and ensure this is communicated to the member of staff	Immediately	Completed and Awaiting new action
	Clinical Co-Director and Matrons will meet with new starters on the wards as part of their induction as a welcome	Immediately	Completed and Awaiting new action
	Triumvirate open sessions with staff once a month and implementation of regular team meetings	Immediately	Completed and Awaiting new action
CANCER SERVICES			
	Arrange for Gary Lupton and Gurjit Mahil to attend a team meeting to discuss the space issues and the Estates strategy for the whole programme	End of June 2019	Started Meeting took place on 30th May Awaiting outcome of Estates Review
	Explore the opportunity of laptops and mobile phones for the team given the lack of space for working and confidential conversations for CNS team and resolve telephone issues in the referral office (i.e. through use of a splitter)	End of June 2019	Started Cannot be actioned until they know where they are moving to
	Secure keypad for the door between Imaging and BSU to ensure safety of staff and patients	End of July 2019	Started Not required if moving.
UNPLANNED CARE			
THERAPIES AND OLDER PERSONS			
	Quarterly listening events – enable drop in sessions with the "Quad" programme management team. Providing the opportunity of staff from nursing, medical and therapy departments to feedback thoughts, views and feelings on team performance, morale, frustrations and good news.	First listening event to be held within next 1 month	Completed and Awaiting new action
	Weekly programme Huddles - to review and ensure that all clinical areas are completing appraisals and ensuring that staff have the right skills and knowledge (Stat/Man training). Review sickness, vacancies and review how as a programme we can support our staff, to share good news stories and recognition of good work.	First weekly huddle to be held within next 2 weeks	Completed and Awaiting new action
	Frailty Forum- a new forum to bring together all disciplines to share learning, knowledge and experience. A time to reflect on what hasn't gone so well and what has. An opportunity to share patient stories, learning from experience and case studies.	First frailty forum to be arranged within the next 3-6 months	In progress
DIAGNOSTIC AND CLINICAL SUPPORT SERVICES			
	Morale, Training & Development, Growth and Personal Development to be advertised and actively encouraged; Workforce Development Strategy for each service to be developed, shared and implemented	31.08.19	In progress
	Delivery of structured and regular team meetings/huddles (to include feedback on learnings, internal adverts, H&WB)Departmental updates via email / paper	All services go live from July 2019	In progress
	Staff engagement in Service Development Monthly Programme Triumvirate 'surgery' Ideas and suggestions by all at any time – reviewed at steering group led by HoOP and staff groups represented Engagement with Transformation Team when needed	Surgery go live June 19; Steering Group go live July 19	In progress
URGENT AND EMERGENCY CARE			
	Transformational Huddle Weekly Listening /improvement huddle (staff recognition, updates, new ideas, appraisals ,statman)		In progress
	Professional Development / career opportunities Training and development opportunities (Number/ % of staff trained in each ward/ area quarterly report to be submitted to programme boards)		In progress
	Exit Interviews Ward areas - every resignation to go the Clinical Co Director / Matron face to face exit interviews to get the feedback for improvement		In progress
PECIALIST MEDICINE PROGRAM			
	Weekly staff drop in session with the programme management team		Completed and Awaiting new action
	Transformational Huddle Weekly Listening /improvement huddle (staff recognition, updates, new ideas, appraisals ,statman)		In progress
	Exit Interviews Every resignation to go the Clinical Co Director, face to face exit interviews to get the feedback for improvement		In progress
CORPORATE			
TRANSFORMATION			
	Hold 'Don't be a boiling frog!' team session and form Health & Wellbeing Action Plan	In June	
	Develop clearer policy on working from home for our team – supported by tools which facilitate effective flexible and remote working	July	
	Introduce new performance calendar and development infrastructure, bespoke for a transformation / improvement team	By August	
SOFT FM			
	Nominate at least one member of staff for internal employee of the month scheme in Soft FM	End of June	
	Head of Hotel Services told hold quarterly open forums for all staff to attend Senior leadership team to attend improvement huddles once per month	End of July	
	Improvement huddles to take place in each team	End of July	
Hard FM			
	Health & Safety presence at team meetings	End of June	
	Arrange for Toolbox Talks with all staff groups	End of July	
	Health & Safety to consult and discuss with Estates staff regarding lone working concerns	End of July	
IT			
	Making use of internal training opportunities for whole team.	12 months	
	Improve strategic planning and alignment across Transformation Team, IT and Trust.	12 months	
	Link with OL&D on the most beneficial way to support staff, so as to minimise stress and improve morale.	3 months	
	Arrange regular whole team meetings, with agenda, to ensure staff inclusion	1 month	

9.2 In preparation for the 2019 staff survey, there have been a number of key actions that have already started to ensure that we are ready to conduct the survey they are as follows:

9.2.1 The Culture and Engagement team have been identified as ones within the organisation who are responsible for the survey and for communication with the Coordination Centre and Survey Contractor;

9.2.2 Quality Health Ltd has been appointed as our contractor to run the survey on our behalf;

9.2.3 The communication department have the staff survey delivery plans and will action them accordingly.

End.

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	Integrated Audit Committee Report 2018/19	**Agenda Item**	**8.1**
Lead Director	Mark Spragg, Non-Executive Director		
Report Author	Brenda Thomas, Company Secretary		
Executive Summary	The terms of reference of the Integrated Audit Committee (the Committee) states that the Committee will carry out an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities. The purpose of the report is to formally report on the work of the Committee during 2018/19.		
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	Integrated Audit Committee on 22 August 2019		
Resource Implications	None		
Legal Implications/Regulatory Requirements	The Integrated Audit Committee is responsible for providing assurance to the Trust Board on the Trust's system of internal control by means of independent and objective review of financial and corporate governance, and risk management arrangements, including compliance with law, guidance, and regulations governing the NHS.		
Quality Impact Assessment	Not required.		
Recommendation/ Actions required	The Board is asked to note the Integrated Audit Committee Report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	None		

1 Executive Overview

1.1 The terms of reference of the Integrated Audit Committee (the Committee) states that the Committee will carry out an annual review of its effectiveness and provide an annual report to the Board on its work in discharging its responsibilities. The purpose of the report is to formally report on the work of the Committee during 2018/19.

2 Purpose of the Integrated Audit Committee

2.1 The role of the Committee is central to the governance of the Trust.

2.2 The Committee is responsible for providing assurance to the Trust Board on the Trust's system of internal control by means of independent and objective review of financial and corporate governance, and risk management arrangements, including compliance with law, guidance, and regulations governing the NHS.

3 Membership and Meetings

3.1 **Members of the Committee during 2018/19**
Mr Mark Spragg (Chair)
Ms Joanne Palmer
Mr Tony Moore (resigned effective 1 April 2019)

3.2 **Attendees:**
External Auditors (Deloitte LLP)
Internal Auditors (KPMG)
Local Counter Fraud Specialist (KPMG)
Chief Executive
Director of Finance
Company Secretary

The terms of reference for the Committee set out further detailed attendance requirements. All committee meetings held during 2018/19 were quorate (quorum - at least two non-executive directors).

3.3 Attendance by Integrated Audit Committee Members in 2018/19:

Non-executive directors (members)	Percentage
Mark Spragg (Chair)	100%
Joanne Palmer	75%
Tony Moore	100%

3.4 Given there are only three Non-executive Directors (NEDs) on the Committee, with two required for a quorum, it was proposed and agreed via the Committee terms of reference that the Chair of the Board of Directors who is not ordinarily a member of the Committee may step in from time to time to complete a quorum. In addition, the Committee may co-opt an additional NED to complete a quorum if the need arises.

This will ensure that quoracy is maintained, supporting the effective management of the Committee business and oversight for the Trust. The revised terms of reference were approved by the Committee at its meeting in February 2019 and submitted to the Board for approval in May 2019.

3.5 The Committee reports to the Board after every Committee meeting.

4 Internal Controls and Risk Management

Assurance Framework

4.1 The Board Assurance Framework (BAF) is the key assurance document for the Trust. The Committee received the BAF in its new format at its meeting in February 2019, following approval at the development session of the Board in January 2019. Since then, the BAF has been presented at every committee meeting (with the exception of the meeting to approve the Annual Report and Accounts).

Internal Audit

4.2 KPMG provided internal audit service to the Trust for 2018/19.

4.3 The Committee approved the Internal Audit Plan for 2018/19 and received progress reports on the plan at every meeting.

2018/19 Internal Audit Plan Head of Internal Audit Opinion

4.4 The Internal Auditors presented their Head of Internal Audit Opinion to support the Annual Governance Statement for the 2018/19 Annual Report and Accounts. The Head of Internal Audit Opinion 2018/19 gave an overall rating of 'significant assurance with minor improvements required' on the overall adequacy and effectiveness of the Trust's framework of governance, risk management and control.

NHS Counter Fraud Service

4.5 During the reporting period, the Trust's local counter fraud services have been provided by KPMG. The Committee approved the Local Counter Fraud Plan for 2018/19. It also received reports detailing cases of possible fraud and the outcome of any investigations.

5 External Controls

External Auditors

5.1 The Trust's external auditor for 2018/19 was Deloitte.

5.2 Section C.3.3 of the Code of Governance for Foundation Trust states that '*the council of governors should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors*'.

5.3 The Trust's contract with Deloitte would expire in August 2019. The Trust tendered the external audit requirement and a compliant tender process was conducted through the CCS Framework RM3745. The Council of Governors, having been assured that due process had been followed, unanimously agreed the appointment of Grant Thornton as the Trust's External Auditors, succeeding Deloitte. Grant Thornton demonstrated they had the expertise in providing external audit services in the NHS.

External Audit Work

5.4 The Committee received regular sector development update from the external auditors and received the planning report for the audit of the year ending 31 March 2019.

5.5 Deloitte audited the Trust's 2018/19 Annual Report and Accounts. The auditors were commendable of the work of the finance team during their audit.

6 Financial Reporting

Annual Accounts

6.1 The Committee received the Trust plan for preparation of the 2018/19 Annual Report and Accounts.

6.2 The Committee, with delegated authority from the Board reviewed and approved the 2017/18 Annual Accounts.

Going Concern

6.3 The Committee, following review of the financial projections for 2018/19, satisfied itself that the Trust's Annual Accounts for 2017/18 should be prepared on a "Going Concern" basis.

Annual Governance Statement

6.4 The Committee reviewed the Annual Governance Statement for financial year 2017/18. The Committee confirmed that the Statement was consistent with the view of the Committee on the Trust's system of internal control. The Committee has systems and processes in place to enable it to undertake the same work for the preparation of the 2018/19 Annual Governance Statement.

Losses and Special Payments/ Waivers

6.5 The Committee reviewed single tender waivers (STWs) and losses and special payments.

7 Terms of Reference

7.1 The Committee's terms of reference were recently approved by the Board at its meeting on 2 May 2019.

8 Conflicts of Interest

Conflict of Interest Policy

7.1 The Committee approved the refreshed Conflicts of Interest Policy and received quarterly reports on declarations of gifts and hospitality.

9 Other Report/ Assurance

9.1 The Committee's terms of reference states that it will also seek reports and assurances from directors and managers as appropriate.

8.2 The Committee conducted a self-assessment of its performance for 2017/18, which concluded that the Committee has complied with its obligations and expectations as noted in its terms of reference, with steady progress being made on improving processes.

10 Conclusion and Next Steps

10.1 The report demonstrates that the Committee has fulfilled its terms of reference and significantly contributed to improving internal control within the Trust.

10.2 The Committee can provide the Board with assurance that, by addressing its terms of reference, it has scrutinised the levels of controls in place and that where necessary applied additional control measures in order to maintain systems of control that enable the Trust to remain compliant with its legislative and statutory duties.

Meeting of the Board of Directors in Public

Thursday, 05 September 2019

Assurance Report from Committees

Title of Committee:	Integrated Audit Committee	**Agenda Item**	**8.2**
Committee Chair:	Mark Spragg, Non-Executive Director		
Date of Meeting:	Thursday, 22 August 2019		
Lead Director:	Ian O'Connor, Executive Director of Finance		
Report Author:	Brenda Thomas, Company Secretary		

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. Internal Audit Report The Committee received the internal audit progress report summarising internal audit work since the last Committee meeting and recommendation follow up. Final reports were presented for Directorate Quality Governance internal audit; Pharmacy; and Data Quality for which eight new recommendations were raised, of which all have been accepted.	**Green**
2. Local Counter Fraud Report The Committee received and discussed the local counter fraud report.	**Green**
3. External Audit Report The Committee discussed the External Audit Project Plan and sector update, noting the key phases for the audit, with planning commencing in November/ December 2019.	**Green**

The Committee was assured that sufficient capacity during the busiest period of financial year to carry out the audit.	
4. Quarterly Gifts and Hospitality Declarations The Committee discussed the quarterly gifts and hospitality declarations, noting the low number of declarations, which could mean that sufficient declarations are not being made. The essence of the refreshed Conflicts of Interest Policy is to increase transparency. The Committee requested giving thought to what could be done differently to increase disclosure to provide assurance of accurate reporting.	**Amber/Green**
5. Corporate Risk Register The refreshed risk register was presented to the Committee for discussion. It was agreed that a debate around the Board's risk appetite is required.	**Amber/Green**
6. Losses and Special Payments The Committee received the report which highlighted all financial losses and special payment made during the period 1 April - 31 July 2019. The Committee noted the figures are quite low; therefore, a communications piece is to be done to raise awareness, in the event this is due to under reporting.	**Green**
7. Pensions The Committee received a paper on pensions and the effect of the annual tapering limit on resourcing and operations, including a brief overview of the calculation and the effect on the Trust's referral to treatment (RTT) performance. Over the last three months the number of national news articles reporting the tapering effect, and its consequential tax and operational impact, has significantly increased and still ongoing.	**White**
8. Self-assessment/Review of Effectiveness The Committee reviewed its effectiveness for 2018/19. The self-assessment identified high levels of compliance with accepted good practice. The Committee agreed to make provision for five minutes at the end of each meeting to discuss outcomes and reflect back on decisions made and what worked well.	**Green**
9. Annual Report to the Board The Committee received its annual report which is presented to the Board as a separate agenda item.	**White**
Decisions made The Committee approved the extension of the deadlines for some of the audit recommendations following extensive debate.	
Further Risks Identified All risks are captured within the risk register and the Board Assurance Framework.	
Escalations to the Board or other Committee 1) None	

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	Infection Prevention and Control Annual Report	**Agenda Item**	**9.1**
Lead Director	Dr David Sulch, Executive Medical Director		
Report Author	Dr Rella Workman, formerly Director of Infection Prevention and Control		
Executive Summary	The Board is asked to review and note the Annual Report for Infection Prevention and Control. The report reviews the Trust's position for 2018-19, detailing the performance and the current compliance against the Health and Social Care Act. The Report should be read alongside with the 2019-20 Annual Plan, which will describe in more detail the steps being taken to address the issues noted in the Report.		
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 Committee: August 2019 Infection Prevention and Control Committee: July 2019		
Resource Implications	Not Applicable		
Legal Implications/ Regulatory Requirements	The Trust has trajectories set for MRSA Bacteraemia and Clostridium Difficile which are monitored and reviewed via NHS England/ NHS Improvement and the Clinical Commissioning Group (CCG).		
Quality Impact Assessment	Not Applicable		
Recommendation/ Actions required	Review and discuss		
	Approval ☐	**Assurance** ☐	**Discussion** ☒ / **Noting** ☒
Appendices	As noted on the content page of the Annual Report.		

NHS
Medway
NHS Foundation Trust

Infection Prevention and Control

Annual Report

2018 – 2019

Best of care
Best of people

CONTENTS

Tables:

EXECUTIVE SUMMARY

An annual report is produced to provide assurance to the Trust board that a robust work, training and audit programme in Infection Prevention and Control is in place in accordance with the Health and Social care Act 2008. The programme is facilitated by an Infection Prevention and Control team, led by a Director of Infection Prevention and Control (DIPC) with active support from the executive management to deliver a safe and effective Infection Control service.

The Trust faced a challenging year in 2018-19. The infection rates for MRSA, Gram negative bacteraemia and C difficile cases rose significantly unlike previous years when we remained at or around the tolerance levels. There were 73 new MRSA acquisitions (lower than previous years) and only one cluster of three cases on one ward. There were no norovirus outbreaks identified and no other major outbreaks occurred last year. Although there were outbreaks of measles in the community and cases presented to our Emergency department, systems were in place to isolate the patients. The team also worked effectively with Community Infection Control nurses and Kent wide colleagues to share data on patients in the interest of the whole health economy.

There is a process in place to investigate and learn from these patient reviews, but the ICT struggled with engagement in patient reviews at all levels of the organisation. There were eight hospital acquired MRSA bacteraemia, all of which were avoidable and occurred as a result of disjointed consultant ownership, multiple ward moves and suboptimal nursing practice or procedures. Similar lapses in care were identified for C difficile. The issues identified were recurring themes of a governance nature which require high level engagement and commitment within Programme boards for resolution. The Infection Prevention and Control team and DIPC were working against a background of governance structures not in line with the Health and Social Care Act, where the DIPC did not report directly to the board or to the Chief Executive. Infection Control was not driven from the centre of the organisation. The four hour targets, financial pressures and the fallout from the move of the laboratory to North Kent Pathology meant that the deteriorating infection performance or lack of engagement from middle managers, medical and nursing establishment all went under the radar.

Our position in the national league tables prompted a visit from the National Health Service Improvement team, Clinical Commissioning Group (CCG) and the Sustainability and Transformation Partnership (STP) DIPC to identify issues of concern and support the trust on a constructive way forward. The trust has decided on a different formula for delivering the Infection Prevention and Control service. There is a new Head of Infection Control and a team led by the Medical Director taking on the role of the DIPC. The formula has one of the requirements of ensuring Board and Executive engagement for Infection Control.

Other governance changes need to follow so that the support and culture for IPC is fully aligned, from trust board, executive team and infection control staff, through all those working on the frontline. It is an opportune time for the new team to bring in fresh ideas and introduce smarter ways of working. The new team however will have little organisational memory, so will need to take stock and build on policies and procedures that have been formulated with the help of clinicians over several years. Also, now more than ever the Infection control nursing team and a non-microbiologist DIPC will require the support of a full time Infection Control doctor and an Antimicrobial Stewardship lead doctor to provide the technical, clinical and microbiological expertise in both areas. At the frontline the IPC team's high ward visibility and close working

with the Infection Control doctor and Antimicrobial stewardship lead would be essential to make the future of Infection Prevention and Control a success.

Dr Rella Workman
Consultant Microbiologist and Director of Infection Prevention and Control (outgoing)

Dr David Sulch
Medical Director and Director of Infection Prevention and Control (incoming)

August 2019

PERSONAL REMARKS

After leading the Microbiology and Infection Control Service at Medway for twenty-one years, I have decided to retire. The years from 2008 to 2014 were the best years for Infection Prevention and Control which made meeting infection targets easy. We reduced MRSA bacteraemia from 43 to zero and C diff from 297 to 19 at its lowest and sustained this reduction for a good few years. We were recognised by the Strategic Health Authority in Kent for leading the way in reducing MRSA bacteraemia targets and were recommended by them to help other trusts in trouble. What was the secret to this success? We had an infection control nursing team whose constant presence on the ward was appreciated by staff at every level of the organisation. The team worked collaboratively and tirelessly with consultant microbiologists and laboratory staff to deliver a timely and responsive infection control service.

I am grateful to have had the opportunity to work at Medway in the many leading roles that I have held over the years. My lasting joyful memories though will be the unique collaborative model of care provided by the extended infection control team who delivered a vibrant, robust and effective service. They made it easy for the frontline staff to discharge their responsibilities safely. I am glad to have had the privilege of working with so many well-meaning colleagues who shared my passion to do the best for patients. I wish the organisation well.

Rella Workman
June 2019

INTRODUCTION

Medway NHS Foundation Trust is committed to ensuring that effective prevention and control of healthcare associated infections (HCAIs) is embedded into everyday practice. The Trust Board recognises and agrees its collective responsibility for minimising the risks of infection and has agreed the general means by which it prevents and controls these risks and the responsibility for Infection Prevention and Control (IPC) is designated to the Director of Infection Prevention and Control (DIPC).

The IPC Annual Report, which contains the Annual IPC Plan and the Assurance Framework are the means by which the Trust Board assures itself that prevention and control of infection risks is being managed effectively and that the Trust remains registered with the CQC without conditions. The framework of the report is built around the Health and Social Care Act 2008.

The outcome of a robust and effective programme of Infection Prevention and Control results in low infection rates in the trust. There are national trajectories set for MRSA (zero), Clostridium *difficile* (19) and year on year reduction of Gram negative bacteraemia from 2016 to 2024 by 50%

Engagement of all clinicians is critical to the agenda of healthcare infections and antimicrobial practice. They have a responsibility to make it integral to their daily practice and act as custodians to this basic cause. It is anticipated that the changes to the structure of directorates and appointments of new leads with clearly defined Infection Control roles of clinicians will revitalise the engagement in this important agenda.

The Infection Prevention and Control team has worked hard to provide effective infection prevention and control service. I thank them for their continued commitment and support in producing the Annual report. The team members are

- Dr Rella Workman, Director of Infection Prevention and Control (DIPC), Consultant Microbiologist and Infection Control Doctor
- Kathryn Lawson-Hughes, Head of Infection Control, Deputy DIPC (retired March 2019)
- Krishna Khambhiata , Head of Infection Control, Deputy DIPC (joined the team in March 2019)
- Dr Vasile Laza–Stanca – Consultant Microbiologist
- Dr Dimitrios Mermerelis – Consultant Microbiologist (appointed October 2018)
- Sheila Gogah – Infection Control Matron (joined the team October 2015)
- Clair Taylor – Infection Control Nurse –(left the Trust April 2018)
- Caroline Cook – Infection Control Nurse (joined the team in March 2016)
- Michelle Clarke- Infection Control Nurse (joined the team in October 2018)
- Richard Saloka – Lead Antimicrobial Pharmacist (joined the team in January 2018)
- Lorraine Shephard, PA to Head of Infection Control (Left the Trust in November 2018)
- Joshua Wray, Administrator Assistant to Infection Control team (Joined the team in April 2019)

Dr Rella Workman
Director of Infection Prevention and Control

THE HEALTH AND SOCIAL CARE ACT

The report is structured around compliance of the ten criteria of the Health and Social Care Act 2008 in order to be a registered Healthcare Provider.

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Roles and responsibilities

IPC is the responsibility of everyone in the organisation.

Key roles and arrangements are detailed below:

1.1 Board to Ward Commitment

The Board support the Infection Prevention and Control (IPC) agenda. Board members have a collective responsibility for minimising the risk of Health Care Associated Infections (HCAI). The Executive Director with responsibility for Infection Prevention and Control is the Executive Director of Nursing. The Decontamination Lead is the Director of Clinical Operations, Planned Care Directorate. There have been a number of changes at Board level during this reporting period, including a new Chief Executive and Medical Director.

1.2 Director of Infection Prevention and Control

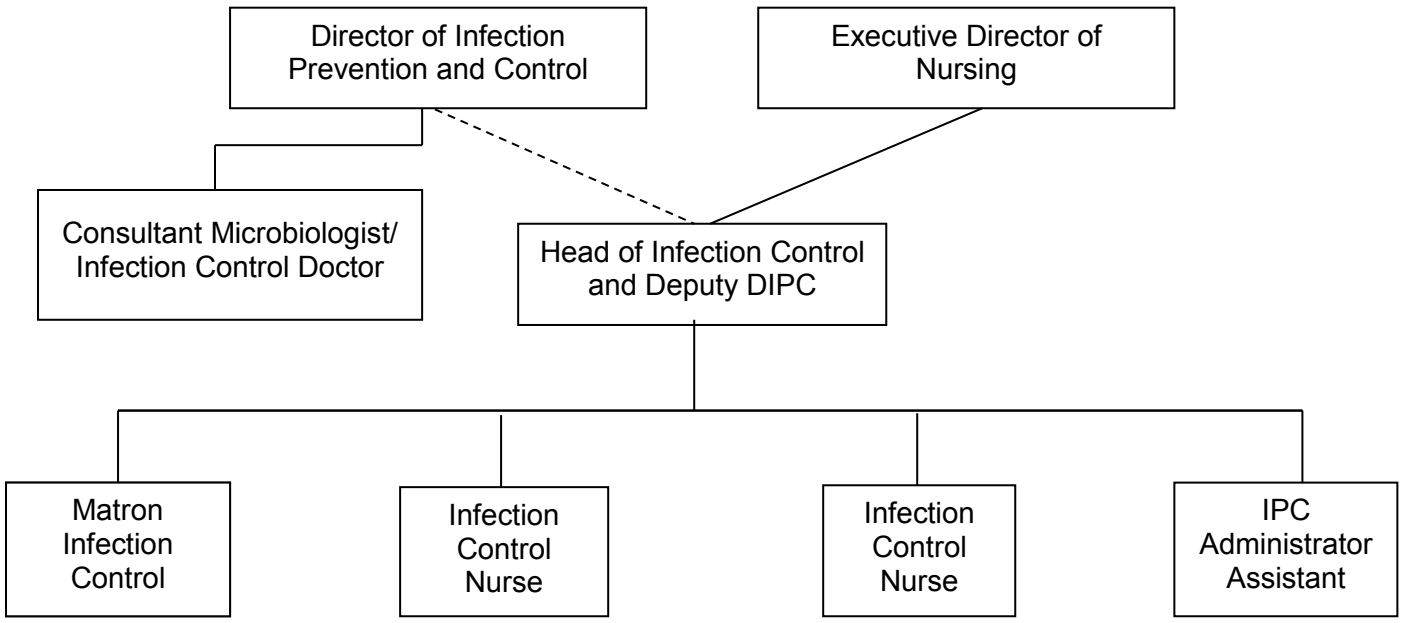
Dr Rella Workman, a Consultant Microbiologist and Infection Control doctor, was Director of Infection Prevention and Control (DIPC) during the period covered by this report, with two PA's allocated to this role.

1.3 Infection Prevention and Control Team (IPCT)

The IPC nursing team report professionally to the Executive Director of Nursing and on a day to day basis to the DIPC. Early in the financial year a member of the team left the trust followed shortly by absence of the Head of Infection Prevention Control due to illness which took her up to her retirement. The team administrative assistant also left in December 2018. We were successful in replacing the band 6 in October 2018 and the Head of Infection Prevention and Control in March 2019.

The Infection Control doctor (ICD) duties were significantly eroded as a result of the off-site NKPS laboratory. A fourth consultant microbiologist/ICD business case was drawn up, but not supported due to financial pressures.

Infection Prevention and Control Team Structure



1.4 Infection Prevention and Control Link Practitioner Network

The IPC Link Network exists in order to support the function of the IPC team and is an important and effective means of disseminating information and good practice guidance. Link members act as visible role models and local IPC leaders and advocate high standards of IPC. They provide a link between their colleagues and the IPC team in order to facilitate good practice and improve standards within their team.

1.5 Assurance Framework

The Infection Control quarterly group meetings merged with Antimicrobial Stewardship (ICAS) in 2017 as the membership for both meetings were the same.

The Planned and Unplanned Programmes leads have responsibility for reporting and assessing infection control risks assisted by the Infection Prevention and Control Team. IPC action plans are monitored at monthly Programme Board Governance and Performance Review meetings with exception reporting to the quarterly Infection Control and Antimicrobial Stewardship Group (ICAS). Risks are fed into the Trust's Risk Register for review at the Quality Steering Group (QSG).

The assurance framework through these groups was set up to ensure the Board was kept informed of Infection Prevention and Control issues and risks. The DIPC provided assurance to the Quality Steering Group monthly and the Quality Assurance Committee (QAC) quarterly. The QAC is a sub-committee of the Trust Board and is chaired by a Non-Executive Director.

1.6 Monthly Statistics

Monthly statistics are prepared and disseminated widely by the IPCT which include:

- Meticillin Resistant *Staphylococcus aureus* (MRSA) Pre and Post 48 Hour (colonisation)
- Clostridium *difficile* Associated Diarrhoea Pre and Post 72 hour cases
- Meticillin Sensitive *Staphylococcus aureus (MSSA)* and Meticillin Resistant *Staphylococcus aureus* Bacteraemia (Pre and Post 48 hours)
- MRSA screening compliance, both admission and weekly
- Gram negative blood cultures (E-coli, Klebsiella and Pseudomonas)
- Extended Spectrum Beta Lactamase (ESBL) blood cultures
- Glycopeptide Resistant Enterococci (GRE)
- Carbapenemase Producing Enterobacteriaceae
- Hand hygiene audit results (obtained from Ward managers and departmental leads)
- Commode audit results
- Patient management review audit scores
- Saving Lives High Impact Interventions compliance scores for urinary catheters, peripheral vascular devices and central venous devices
- Enhanced measures

1.7 Infection Control and Antimicrobial Stewardship Group (ICAS)

ICAS provides assurance in both areas to the Board. The group is chaired by the DIPC and meets quarterly. The Terms of Reference have been reviewed

Appendix 1 – Terms of Reference Infection Control and Antimicrobial Stewardship Group

The ICAS group oversees the work plan/programmes and audits of the IPCT and Antimicrobial stewardship; it is responsible for ratifying all IPCT policies.

Appendix 2 – IPC Work Programme 2018-19
Appendix 3 – IPC Audit Programme 2018-19

ICAS reports to the Quality Steering Group quarterly, the Terms of Reference are reviewed at this group and performance and attendance monitored here.

1.8 Commissioner Reporting

There is weekly and monthly reporting to North Kent Clinical Commissioning Group (CCG) of mandatory data

- MRSA Bacteraemias
- MSSA Bacteraemias
- Clostridium *difficile* Pre and Post 72 hours
- Gram negative bacteraemia

This is in addition to real time reporting to the relevant community Trusts and Mental Health Trust of all cases. CCG representatives are invited to all post 72/48 hour patient infection reviews.

1.9 Monthly Targets

Monthly targets for MRSA bacteraemia, Clostridium *difficile* and gram negative bacteraemia reduction are monitored by the Trust Board through the Quality Steering Group and Quality Assurance Committee (QAC). The Quality Assurance Committee will seek assurance that lessons have been learnt and shared, as appropriate, following each case.

Commentary on Compliance:

1.2 The reporting mechanism of the Director of Infection Prevention and Control is currently to the Quality committees rather than to the Chief Executive and the trust board which is not compliant with the Act.

1.3 Despite the significant capacity issues the ICT continued their visibility and presence on the ward and Nursing and Midwifery Advisory Group. However the team struggled to achieve all the objectives on the annual work and audit plan. The programme leads and estates departments also did not provide the necessary action plans and assurance of how their risks were minimised.

1.3 The Infection Control doctor (ICD) duties were significantly eroded as a result of the off-site NKPS laboratory. A fourth consultant microbiologist/ICD business case was drawn up, but not supported due to financial pressures.

1.4 The link practitioners' support to ICT in promoting ward-based Infection Control practices last year was not evident due in part to staffing shortages on the ward.

1.5 The DIPC could not provide assurance to the QSG and QAC as three ICAS meetings had to be cancelled, two of which were due to black escalation. Attempts were made to reorganise these meetings but had to be cancelled because of poor representation from Programme leads. The fourth meeting also had to be cancelled at the last minute due to an accidental injury suffered by the Matron in Infection Control.

1.9 Assurance from Programme Leads of their action plans on the monthly targets were not presented to ICAS as the meetings were cancelled. Further escalation directly to the board and Chief Exec by the DIPC was also hampered by the existing reporting mechanism.

GAP Analysis: Not compliant

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

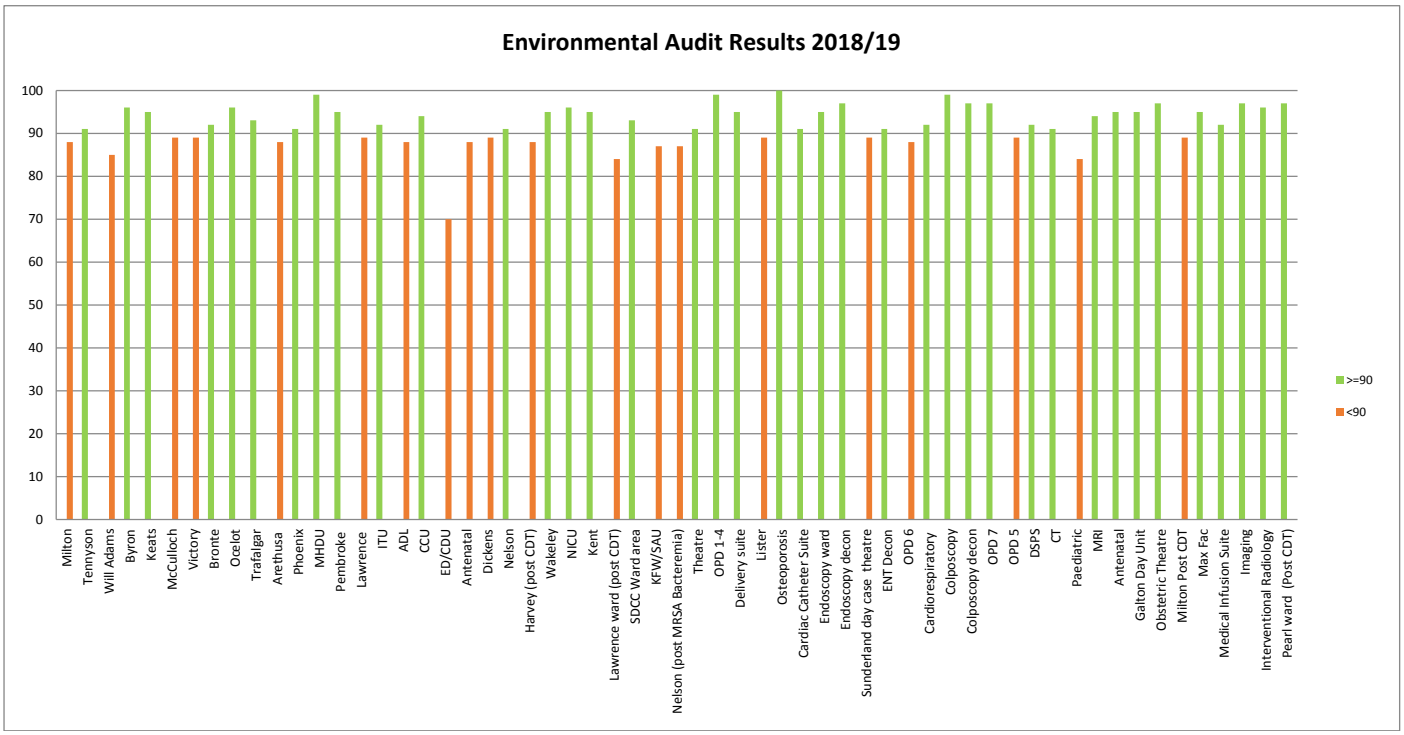
2.1 Environmental Audits

The IPCT complete their comprehensive environmental audit programme in all acute areas and non-acute areas on a quarterly basis. Enhanced audits were undertaken where cases of health care associated infections (MRSA acquisitions and C diff cases) following a period of increased incidence. Exception reporting and assurance is fed back at the ICAS meeting by the Programme Leads

Prioritisation of the highest risk areas for action is undertaken by the IPCT in collaboration with the Estates department. The environmental audits continue to highlight new and ongoing estates issues for example damage to ward flooring, walls and door frames. The two teams work collaboratively to rectify issues. The new Emergency departments opened in November 2018.

The areas listed below have all been audited by the Infection Control team on a quarterly basis during the year using adapted Infection Prevention Society audit tools:

The environmental standard score has been set for >90%. Those that did not meet the target were notified in real time through verbal and written feedback to the Programme leads for action in areas of non-compliance.



2.2 Challenges

The layout of the wards in the B and C blocks means there are no facilities to cohort/segregate affected patients in the main ward areas. This is particularly challenging when managing potential outbreaks. The inability to utilise a decant ward also makes it extremely difficult to enable essential works and refurbishment to be completed. The IPCT and Estates department strongly recommend the utilisation of the decant ward which once again must be a priority for next year. This recommendation has been accepted by the Executive team and will be addressed in a new Trust bed plan.

Bed spacing throughout many ward areas remains non-compliant. The current standard based on the Health Building note 04-01 for adult inpatient accommodation is 3.60m (width – bed centre to bed centre). This is reviewed when any changes to the ward/hospital are made and as services are redesigned. Bed spaces for critical care areas need to be greater for reasons of circulation and the equipment used in these areas.

All patient bedside lockers have been replaced in 2018.

2.3 Housekeeping (Produced by the Housekeeping team)

Overview

A service wide review of the Housekeeping Department was commissioned with the Birch Foundation in May 2017 which although undertaken was not finalised. Over the course of the next 6 months this is being revisited and a review will be undertaken by the new management team and consultancy firm which will consider the tasks, frequency, hours, productivity of staff and align these with the needs of the hospital and compliance with the National Cleaning Standards.

There has been no recruitment within the department since October 2017. These shifts are covered by bank staff many of which hold substantive posts in housekeeping.

The housekeeping staff remain committed to delivering a service that meets the needs of the patients. Due to restrictions on bank spend over the last 12 months, cleaning hours have been reduced on non-clinical areas to facilitate cleaning in clinical areas.

There is work ongoing with the catering team to enhance meal service provisions to the patients which will impact on the hostesses shift times and responsibilities.

Cleaning Audits

There has been high sickness within the audit team during 2018-2019 which has led to inconsistencies in the frequencies of audits being completed. Due to staffing issues and management changes, the 2018-19 cleaning audit programme has been inconsistently applied and monitored. The Significant and Low risk areas monitoring has been sporadic as the key focus was on Very High Risk and High Risk areas.

It has been identified by the management team that inconsistencies cannot continue and that the current set up is not without its weaknesses. There are audit tools on the market that would greatly enhance the speed and accountability of reporting procedures and subsequent follow up of actions. Procurement have been asked to source quotes and potential trials.

Following each audit, the inspected areas are issued with a copy of the audit including a scorecard and task list. The task lists are issued to the Team Leaders who address any performance issues with their staff and work to bring areas back up to standard. The new proposed structure for the Team Leaders will improve the response rate to acting on any issues that arise and also help reduce reoccurrence of low scores with regards to the cleaning element.

Table No 1: Very High Risk Annual Average Scores 2018/19

	Cleaning %	Overall %
ASEPTIC SUITE	100	100
BRONTE HDU	99	98.8
CARDIAC CATHETER SUITE	98.7	98.6
DAY SURGERY SUITE	96.8	97.5
DELIVERY SUITE	97.1	96.8
E.D. MAJORS	98	95
E.D. RESUS	97	95
ENDOSCOPY	93.6	94.3
GALTON DAY UNIT	98.9	99
ICU / CCU	95.8	96.7
LAWRENCE WARD	96.8	97.6
MAIN THEATRES	98.9	97.5
OBSETRIC THEATRES	98	99
OLIVER FISHER NEONATAL UNIT	95.3	96.3
RENAL UNIT	97.1	94.7
SUNDERLAND THEATRES	97	97
TRAFALGAR WARD	98.6	95.7
TOTAL ANNUAL SCORE	97.4	97.2

Table No 2: High Risk Annual Average Score 2018-2019

	Cleaning %	Overall %
A&E MINORS	97	98
A&E PEADS	100	99
ARETHUSA WARD	80	80
BRONTE WARD	93	94
BYRON WARD	93	95
DICKENS WARD	92	96
DOLPHIN WARD	91	91
ELIOT WARD	100	98
HARVEY WARD	87	88
KEATS WARD	92	92
KENT WARD	96	95
KINGFISHER WARD	88	85
LISTER WARD / AMU	92	93
McCuloch WARD	94	96

MEDICAL INFUSION SUITE	100	99
MEDOCC	95	95
MILTON WARD	84	86
NELSON WARD	87	88
OCELOT WARD	92	93
PEARL WARD	96	95
PEMBROKE WARD	85	85
PENGUIN ASSESSMENT UNIT	98	97
PHOENIX WARD	92	92
SAPPHIRE WARD (6 months data)	88	90
SUNDERLAND DAY UNIT	94	93
SURGICAL ADDMISSION UNIT	87	86
TENNYSON WARD	91	92
THE BIRTH PLACE	99	99
VICTORY WARD	95	94
WAKELEY WARD	91	93
WILL ADAMS WARD	85	85
TOTAL ANNUAL SCORE	92	92

To note: Victory ward was previously a Very High Risk ward but the nature of the ward has changed and therefore downgraded to High Risk. ED Majors was previously categorised as High Risk and has been moved to Very High Risk.

Infected Discharge Cleans

Response to requests for infected discharge cleans increased 12% in 2017/18 from previous year however 2018/2019 saw a 12% reduction in cleans requested and actioned. This is due to the number of increased incidence of infections or outbreaks has reduced when compared to previous years The Trust continues to use the UVC and HPV machines to further enhance the cleaning regime on the wards. Housekeeping and Infection Control are to review the process for requesting deep cleans, categorising discharge cleans and methods of cleaning in 2019/2020.

Response staff have attended training and been certified to use this specialist machinery and attend refresher training as required. Staff have swipe badges to activate machines which enables tracking of operators and generates an email to confirm full completion of machine cycle.

The team continue to experience some issues with bed spaces not being ready for staff to commence clean with nursing responsibilities not being fulfilled prior to the teams' attendance. This has impact on the turnaround time for the bed being released back to the Trust for patient care. There continues to be instances where on arrival to the ward the team are informed the infection is not the one that was reported to the office.

Table No 3: Number of Discharge Cleans

	2017- 2018	2018-2019
April	489	508
May	527	519
June	550	469
July	539	513
August	469	459
September	449	392
October	608	449
November	536	468
December	453	499
January	533	516
February	433	415
March	511	470
Totals	6097	5677

Management and Supervision

The current structure is under review; new Head of Housekeeping appointed January 2019 following retirement of previous manager in January 2018. The post of Assistant Housekeeping Manager was recruited to internally in April 2019.
Senior management are currently reviewing the role and responsibilities of the Team Leaders and the requirements for moving the service forward. The objective is to increase the supervision and support of staff on the front line to provide a more proactive service with increased checks and training for staff. Proposals have been submitted to HR with regards to the Team Leader structure.

Once this new structure is implemented the review will commence of the staffing structure with a focus on the hours allocated to wards and departments taking into account the requirements of areas.

There are several reasons for the proposed changes which include;

- Housekeepers can focus on fulfilling the duties of their role during their shift, rather than covering Hostess duties
- Additional Housekeepers added into the pool will help the department meet service demand and reduce need for temporary staff
- Cost savings to the Trust by reducing the amount of enhancements paid for unsociable hours
- Managers and team leaders are more accessible to staff
- Improved Housekeeping service for the Trust due to increased productivity and efficiency
- Improved patient and visitor experience
- Effective utilisation of resources in line with current service requirements

Table No 4: PLACE Cleanliness Domain

Cleanliness Domain	Score Achieved	National Average
2016	98.8%	98.1%
2017	94.7%	98.4%
2018	98.06%	98.5%

The assessment of cleanliness covers all items commonly found in healthcare premises including patient equipment, toilets, showers, furniture, floors and other fixtures and fittings.

Medway up 3.4% on 2017 and just 0.44% below the national average
The Trust achieved 98.06% which is slightly below the national average of 98.5%. The Trust performed slightly below its neighbouring trusts across the county. The Trust cleaning metric has increased 5% from a below average 93.03% when PLACE began in 2013.

Commentary on Compliance:

The environmental audit carried out by the ICT is not consistent with the high scores shown by the Housekeeping team. In fact ICT were concerned that the Hydrogen Peroxide Vapour disinfection machines procured specifically for the purpose of deep cleans were not used after each case of C diff, Carbapenamase producing enterobacteraciae, GRE and patient with diarrhoea and vomiting for almost three months. A fresh programme of works needs to be implemented to improve the independent audit scores carried out by IPCT.

The bed spaces are not compliant

Issues with the cleaning standards of the ward environment and clinical practices on the ward were also observed by the NHSI team during their visit in May 2019

GAP ANALYSIS : Partially compliant

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

3.1 Antimicrobial prescribing.

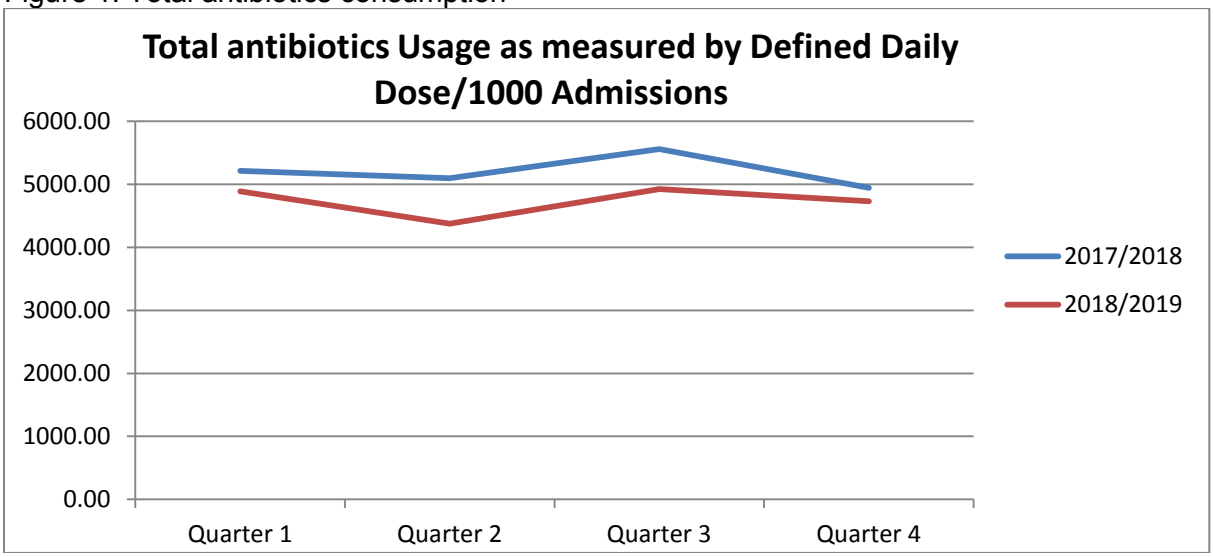
There were severe shortages in the Pharmacy department this past year which meant that a work and audit programme in antimicrobial prescribing and stewardship was difficult to achieve. The focus was limited to achieving the CQUIN target

3.2 Reducing the impact of serious infections [CQUIN 2]

One of the key indicators of this CQUIN was a reduction in antimicrobial usage (CQUIN 2d). Metrics used included a reduction in total antibiotics usage, carbapenems, piperacillin-tazobactam and an increase in the proportion of antibiotics within the Access group of the AWaRe category.

A 2.73% reduction in total antibiotics usage was achieved in 2018-2019 financial year benchmarked against 2017-2018 usage superseding the 1% reduction target.

Figure 1: Total antibiotics consumption



A comparison in the usage of broad spectrum antibiotics (carbapenem and piperacillin-tazobactam) between 2017-2018 and 2018-2019 showed 22% and 41.9% reductions respectively in figures 2 and 3 below.

Figure 2: Total consumption of carbapenems

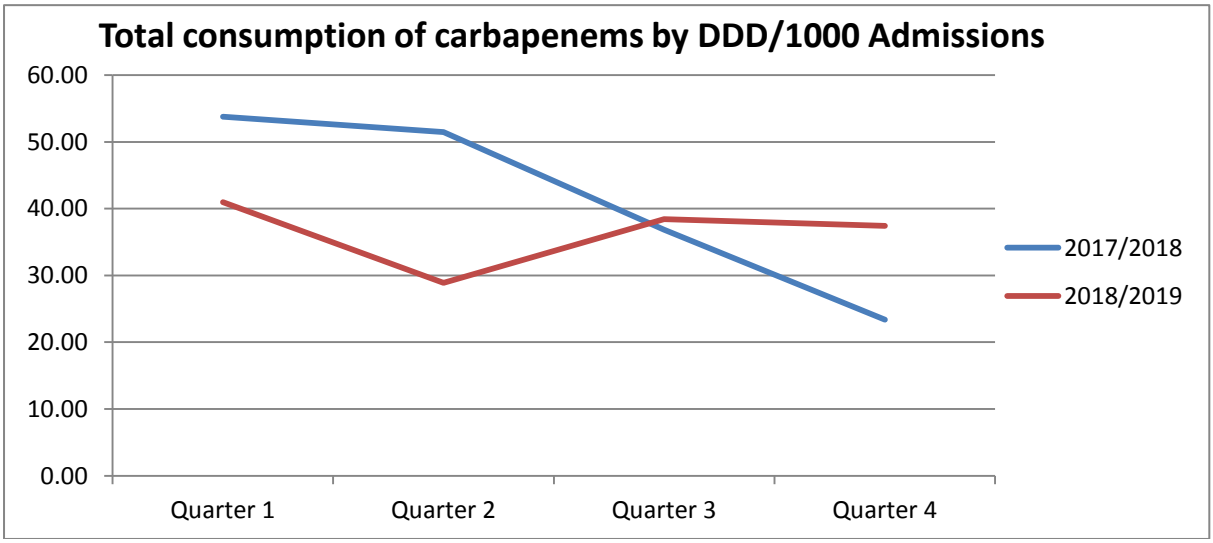


Figure 3: Total consumption of piperacillin-tazobactam

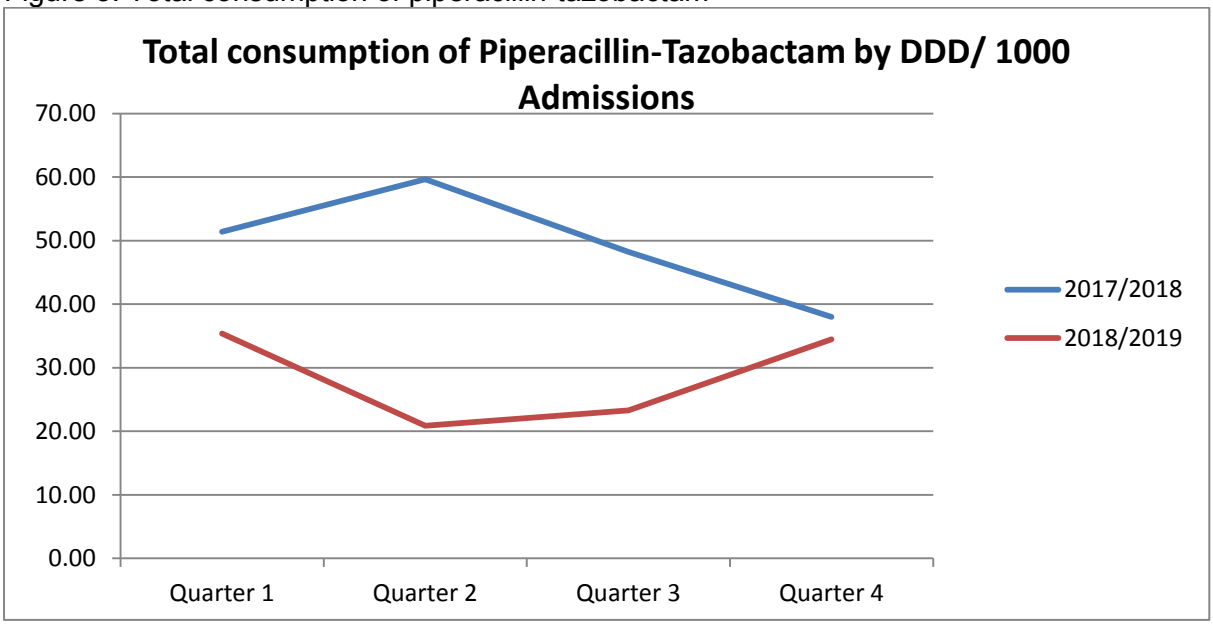
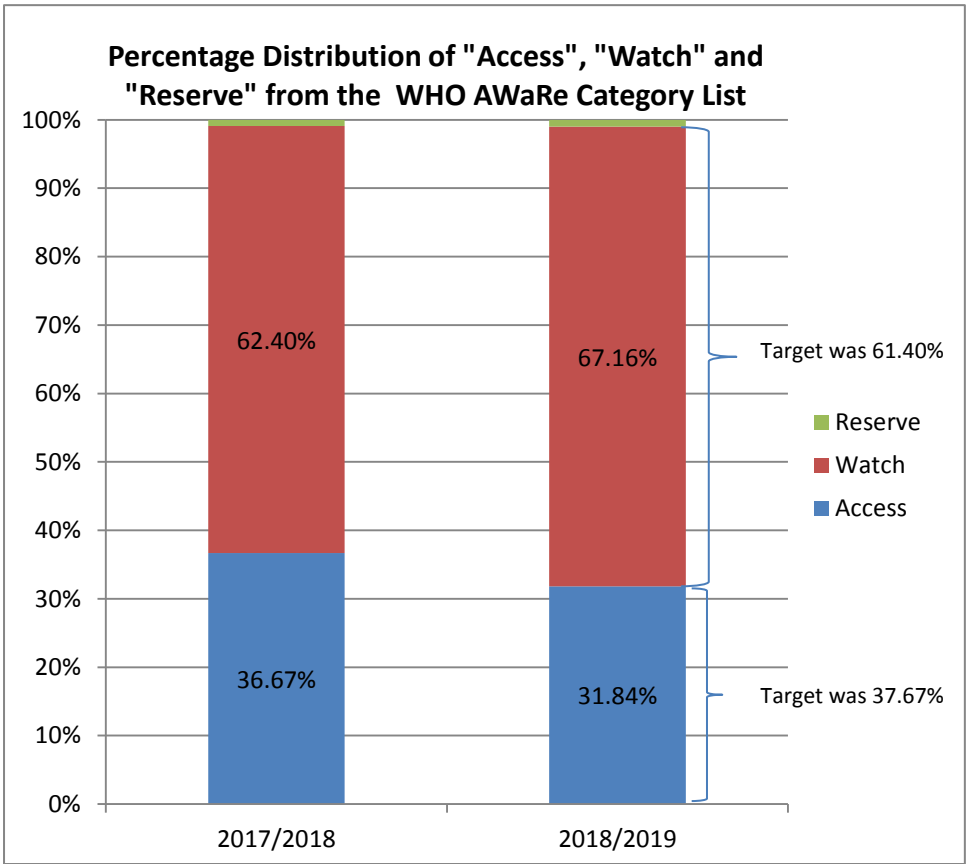
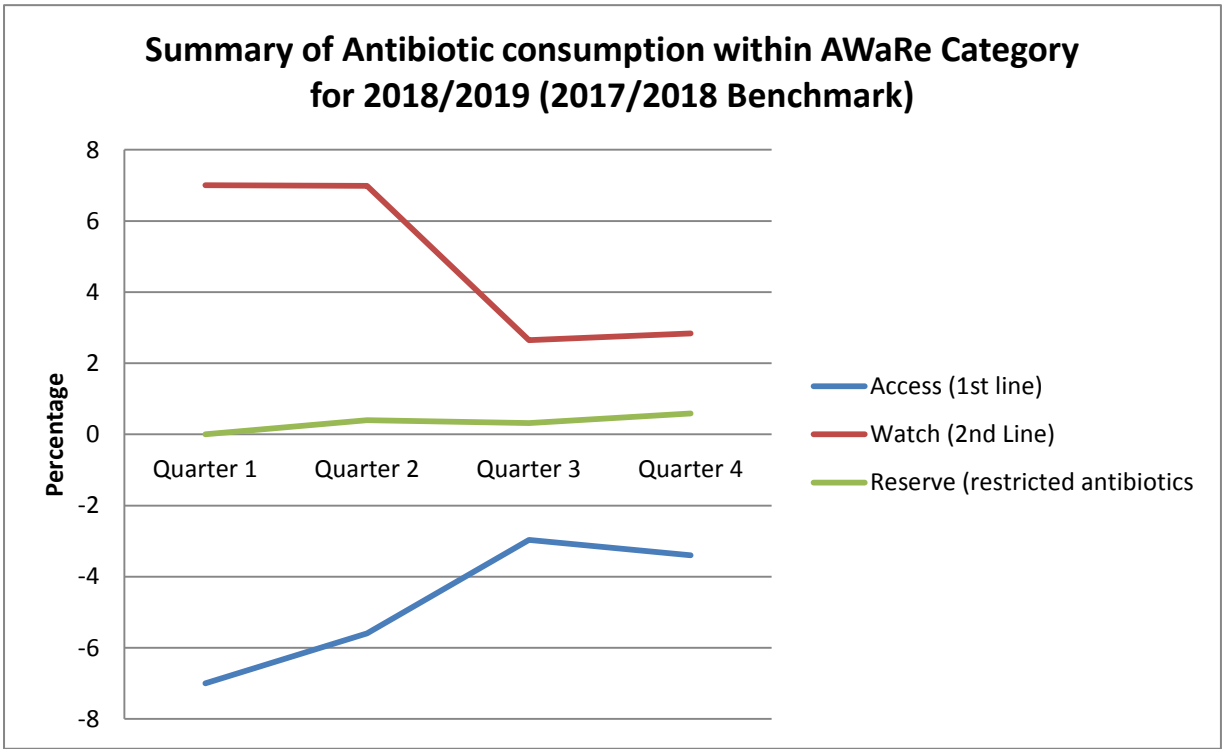


Figure 4: Percentage Proportion distribution in antibiotics usage from the WHO AWaRe category



The fourth metric for measuring reduction in antimicrobial usage was a 1% increase in the use of first line antibiotics and a 1% decrease in second line antibiotics. Although this was not achieved initially, fig. 5 shows a gradual quarterly reduction by year end.

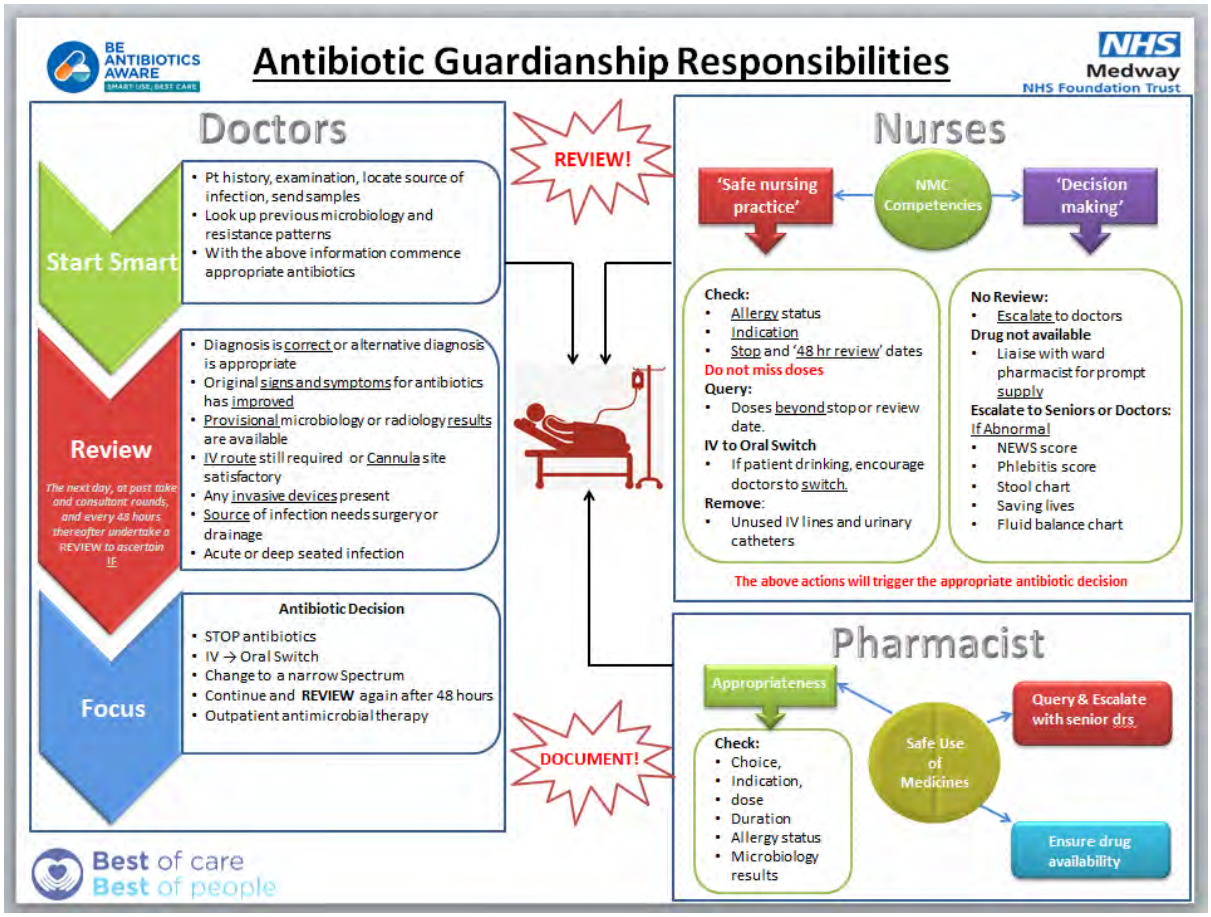
Figure 5: Showing quarterly percentage variation between 2017/2018 and 2018/2019



3.3 Summary of Antimicrobial Stewardship initiatives and proposals

- Antimicrobial Guardianship

This initiative aims to raise Trust wide awareness that prudent use of antibiotics is everyone's responsibility, summarising the key inputs of prescribers, nurses and pharmacists in ensuring safe use of antimicrobial agents across the Trust.



- Daily antimicrobial agents review
  - All patients initiated on Carbapenem and Piperacillin/tazobactam were identified by the antimicrobial pharmacist from inpatient transcription sheets. These were reviewed based on the Trust antimicrobial policy and national antimicrobial stewardship recommendations.
  - All patients on prolonged intravenous antibiotics are identified by the antimicrobial pharmacist and communicated to the ward based pharmacist for escalation for review.
  - All non-compliant prescriptions and restricted antibiotics without a microbiologist approval were highlighted to the microbiologist via email by the antimicrobial pharmacist. These patients were followed up during the daily antimicrobial stewardship ward round by the Consultant microbiologist(s) and antimicrobial pharmacist.

- Drug chart redesign
  Amendments to the antimicrobial session of the drug chart have been approved by the medicines management group with a proposed implementation date of July 2019. These changes are aimed at improving the proportion of prescribed antibiotics reviewed within 72 hours by empowering various healthcare practitioners to escalate antibiotics due for review to the prescriber.

3.4 Antifungal Stewardship (CQUIN)

In 2018-2019 £226375 was spent on antifungal of which 75.89% was in medicine mostly for the prophylaxis of fungal infection in haematology patients.

Figure 6: Antifungal expenditure by Specialty

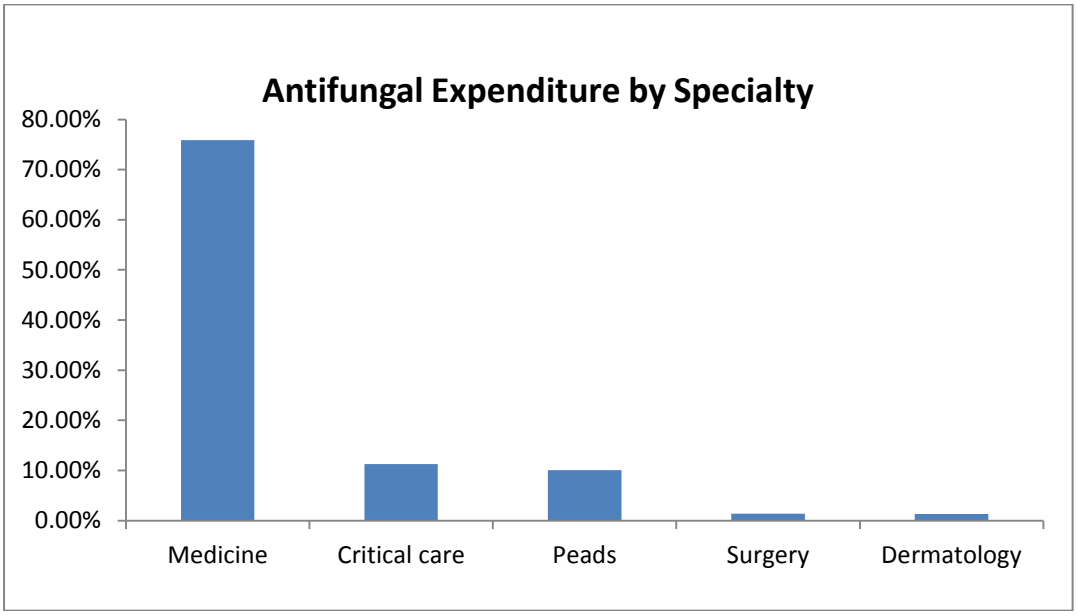
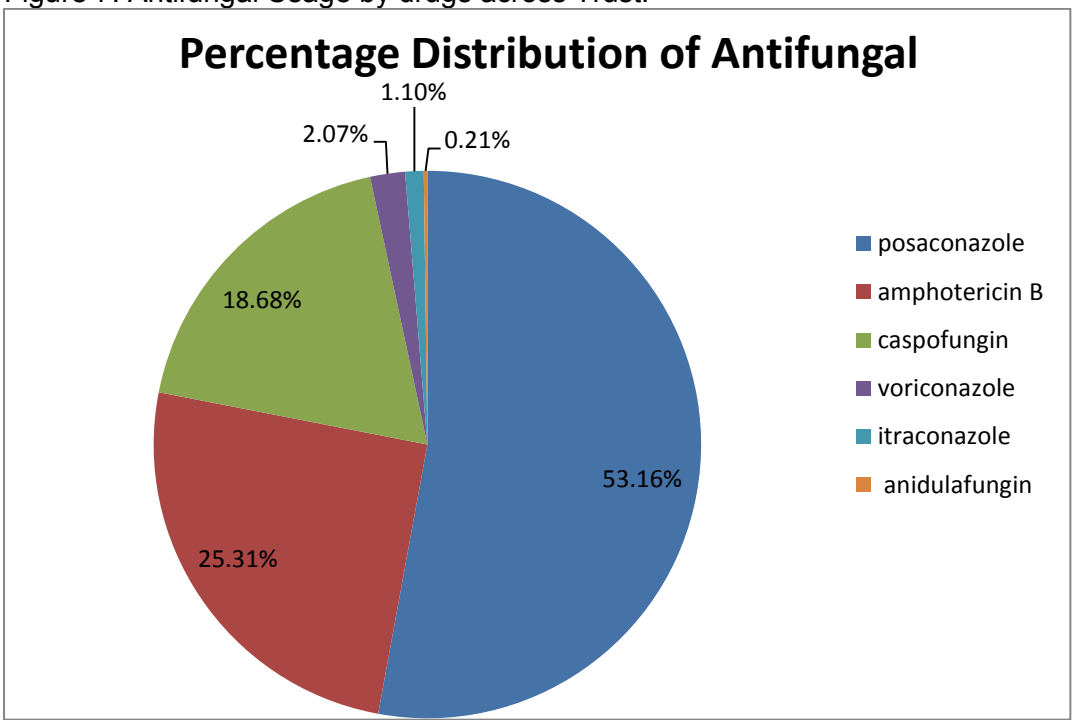


Figure 7 below shows that posaconazole accounts for 53.16% of total antifungal expenditure across the Trust. This is the current drug of choice for primary and secondary prophylaxis of fungal infections in haematology patients.

Figure 7: Antifungal Usage by drugs across Trust.



Commentary on Compliance:

Due to shortage of pharmacists and lack of engagement of clinicians and nurses, it was difficult to undertake the antimicrobial programme and audit plan as shown in Appendix 6.

GAP ANALYSIS: Partially compliant

Criterion 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.

4.1 Admissions and transfers into the Trust

It is mandatory that all patients admitted into the Trust must have clear documentation of their infection status pertaining to MRSA, C.diff, Glycopeptide Resistant Enterococcus (GRE) and Carbapenemase Producing Enterobacteriaceae (CPE), to facilitate patient placement and subsequent treatment. Lapses in this have been identified quickly and acted upon immediately, reducing the risk to patients.

Recent MRSA bacteraemia reviews have identified that admission assessment forms are not completed, compromising both placement and appropriate antibiotic management for patients

4.2 Transfers out of the Trust

Patients who are transferred to another care facility must have their infection status recorded on a transfer form. The status must also be confirmed on all internal transfers.

4.3 Collaboration

The Trust's IPCT work in close collaboration not only with the Microbiology department staff to ensure that microbiology results are fed back in real time to wards and departments, but also with our Primary Care providers, including Kent Community Healthcare, Medway Community Healthcare and Public Health England (PHE) Kent and the North Kent Clinical Commissioning Group (CCG). This ensures a two way flow of information and has demonstrated some significant improvements. There has been close collaboration with the CCG Infection Prevention Specialists to look at issues and trends as they occur. The ICT liaised with PHE over cases of measles who presented to the Emergency department. Microbiology laboratory moved to Darent Valley Hospital in April 2018, so the links need to be restored between the two departments.

4.4 Leaflets

The Infection Prevention and Control Team patient information leaflets are available in hard copies and on the intranet.

1. MRSA
2. Clostridium *difficile*
3. Norovirus (Viral Gastroenteritis)
4. Hand Washing or Rubbing
5. Guide for Visitors
6. Guide for Patients
7. Caring for your Drip
8. Extended Spectrum Beta Lactamase producing bacteria (ESBL)
9. Carbapenenemase resistant organisms
10. GDH+, C.diff toxin negative.

4.5 Information

Information is readily available and publicly displayed in clinical areas and this includes:

- Cleaning schedule for the ward/department
- Infection performance metrics, including MRSA acquisitions, CDT cases (post 72 hours) and audits undertaken by the Infection Prevention and Control nursing team.
- Infection control audit results including: commode, hand hygiene.

The information is in the process of being reviewed and will be standardised throughout the Trust in 2019-2020.

GAP ANALYSIS: Partially compliant

Criterion 5: Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

5.1 Reducing Risk of Transmission

The Trust continues to manage patients with infections to reduce the risk of transmission.

Disappointingly we breached our C.diff target of 19 by six. However, post infection reviews concluded that 8 were unavoidable and 7 were avoidable. The rest were not completed. Any non-compliance issues are addressed via directorate action plans.

It was disappointing to note that the Trust had eight cases of MRSA bacteraemia apportioned to the trust this year.

5.2 Outbreaks/Incidents

One ward had 3 cases of MRSA acquisitions. Another ward had 2 post 72 hours C diff infection in the same bay within 6 days. Both had identical strains on typing. Enhanced cleaning and increased input from the IPCT in collaboration with the ward teams ensured that these were dealt with successfully to reduce the risk of further transmissions.

There was a tuberculosis infection identified in a member of staff which required extensive contact tracing in healthcare workers. No secondary cases were identified.

The Trust had no outbreak of Norovirus 2018 -19. The key to this success was the early recognition and prompt isolation of potential and actual cases, especially in the emergency admission areas.

The IPCT participate in the daily site meetings to address ongoing concerns and help with flow. Daily infection lists are circulated by the IPCT showing the location of patients with MRSA, Clostridium *difficile*, Tuberculosis and other resistant organisms and whether or not these cases require isolation for the organism to allow for appropriate bed management.

Table No 5: Quarterly Outbreaks / Incidents 2018 to 2019

Quarter	Date Started/ Completed	Ward	Total No. of Patients Affected	Bay Closed/ Date	Ward Closed/ Date	Estimated Bed Days Lost	Nature of Outbreak (Include Organism)
1	15/10/18	Milton	3	na	na	na	2 post 72 hr CDT Increased incidence within a 6 days period Both 2 cases are non-identical 3rd one Micro confirmed stool sample was discarded
2	15/10/18	Keats	3	na	na	na	3 post 48 hr MRSA colonisation in September and October 2018 3 identical SPA tying t020
3	11/10/18	ED	N/A	n/a	n/a	n/a	Member of staff in ED confirmed Pulmonary TB

GAP ANALYSIS: Partially compliant

Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

6.1 Essential Training Infection Prevention and Control

All staff are required to complete IPC mandatory training, the level dependant on the role of the staff member.

The IPCT provide a wide range of learning opportunities both via e-learning, classroom based and outside of the classroom to meet the needs of individuals and teams across the Trust.

Infection Prevention and Control – Level 1 – 3 Years = 96.11% as of 31.03.2019
Infection Prevention and Control – Level 2 – 1 Year = 77.08% as of 31.03.2019

The mandatory training standard for Infection Control is 100%, so based on our figures, the Trust is not compliant.

6.2 Induction

All new staff must complete an online infection control e-learning package. This includes hand hygiene and inoculation injuries.

Infection control link practitioners are responsible for undertaking hand hygiene assessments of all new staff.

6.3 Other Infection Control Training

The IPCT provide ward and department based training either on request or when additional training is identified in improvement action plans.

In addition in collaboration with companies that provide equipment, company representatives have carried out training and assessment in use of sharps, cannulation and blood cultures in areas throughout the Trust.

6.4 Contractors/Estates

Contractors employed by the Trust have to be aware of IPC; all flexible staff are monitored and trained in the same way as permanent staff. Agency staffs who are employed by the Trust are employed by companies compliant with the NHS contract via Purchasing and Supply Agency (PASA), which covers training of their own staff.

Contractors for Estates all have to report via the Estates Department for a permit to work when they receive Infection Prevention and Control basic advice and sign for this information. This gives key messages on Infection Prevention and Control, for example hand hygiene.

Contractors working on site for large projects meet with the IPCT prior to contract commencement where IPC is discussed in depth and the conduct of the contractors whilst on our site; this is then monitored by the project manager. This has worked well for projects undertaken this year.

The IPCT have been closely involved with many Estates projects this year. Infection Prevention and Control issues are always given serious consideration and the Team is consulted widely to ensure full compliance with IPC policy/procedures.

6.5 Group and Committee Membership

The Trust ensures that all staff co-operate to ensure compliance with the Code as far as is reasonably practical. The IPCT sits on a wide range of committees and groups to ensure IPC is considered as necessary:

Internal:

Infection Control and Antimicrobial Stewardship Group
Nearside Patient Equipment Group
Statutory and Mandatory Training Group
Medical Devices and Equipment Management Group
Nursing and Midwifery Advisory Group
Capital Projects Group
Quality Steering Group
Quality Assurance Committee
Project groups for new builds and service redesigns

External:

North Kent Clinical Quality review group HCAI assurance group
Kent & Medway Health care associated Infection improvement group.

Commentary on Compliance:

Both level 1 and level 2 Infection Prevention & Control mandatory training did not meet the standard of 100%. This will need to form part of an improvement plan. The Infection Control Team is working with the Learning & Development Team to review the training packs for the different levels of staff within the organisation. Training and assessment of junior medical staff at Induction is also being reviewed.

GAP ANALYSIS: Partially compliant

Criterion 7: Provide or secure adequate isolation facilities.

7.1 Isolation Rooms

Management of isolation rooms is part of the daily bed management process to reduce the risk and spread of HCAI. This has been increasingly challenging due to high occupancy and the increased need for isolation of patients at risk of carrying multiresistant organisms such as Carbapenemase Producing Enterobacteriaceae. (CPE). The Trust has 127 single rooms, none of which have negative pressure capability and most of which do not have any en suite facilities, which are essential when caring for such patients. Careful placement of patients is therefore imperative.

The Infection Prevention and Control policy for Bed Management and Movement of Patients POLCOMO12 supports the risk assessment process and prioritisation for single rooms. The IPCT produce a daily list of patients with alert organisms highlighting those who despite having these organisms do not require isolation due to negative results or symptom recovery.

The new patient management system (EXTRAMED) is utilised to highlight patients requiring isolation that are not already flagged to the infection control team.

On a day to day basis the Team work closely with ward and site staff to make the most appropriate decisions on side room occupation. This often results in additional patient moves/transfers.

Commentary on Compliance:

7.1 Training needs to be carried out by ICT with Site Practitioners and ward managers to prioritise side rooms effectively based on the type of infections.
7.12 ICT to undertake regular isolation room audits.
On the day of the NHSI visit, there was evidence that risk assessment by ward staff were not undertaken in prioritising the use of the side rooms.

GAP ANALYSIS: Partially compliant

Criterion 8: Secure adequate access to laboratory support as appropriate.

8.1 Microbiology Department

The Microbiology laboratory was relocated to Darent Valley Hospital in April 2018 under a joint venture called North Kent Pathology Service (NKPS). The laboratory transfer has had a significant impact on the Infection Control service. Links that were set up and refined over several years to provide an optimal service to Infection Prevention and Control at Medway were broken. These include delay in specimen receipt, timeliness of results, complexity of IT links, lack of or timely data transfer. It will take time to address each of these issues.

The Infection Prevention and Control doctor duties and stewardship ward rounds supplied by the three consultant microbiologists were also adversely affected as the time was taken up to service an off-site laboratory instead and no back fill provided. Because of changes in protocols, staffing and test repertoire, the laboratory is yet to receive full CPA accreditation.

The daily Infection Control Nurses meeting with the Consultant Microbiologists and Antimicrobial pharmacist is an important meeting for promoting excellent collaboration on Infection Control issues. This helps to expedite timely interventions and a consistent approach in infection prevention and control management between the three microbiologists. It is also an excellent forum for restoring the broken links and systems with NKPS.

Commentary on Compliance:

8.1 Delays in specimen receipt, timeliness of results, complicated IT links, lack of or timely data transfer has had a direct impact on patient management at the ward level and the day to day operational work of the Infection Control team.
8.2 The laboratory is yet to receive full Accreditation.

GAP ANALYSIS: Partially compliant

Criterion 9: Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

9.1 Policies

The Trust has a comprehensive set of policies for Infection Prevention and Control. These policies are all approved and reviewed at ICAS. Policies are based upon national guidance and evidence where available

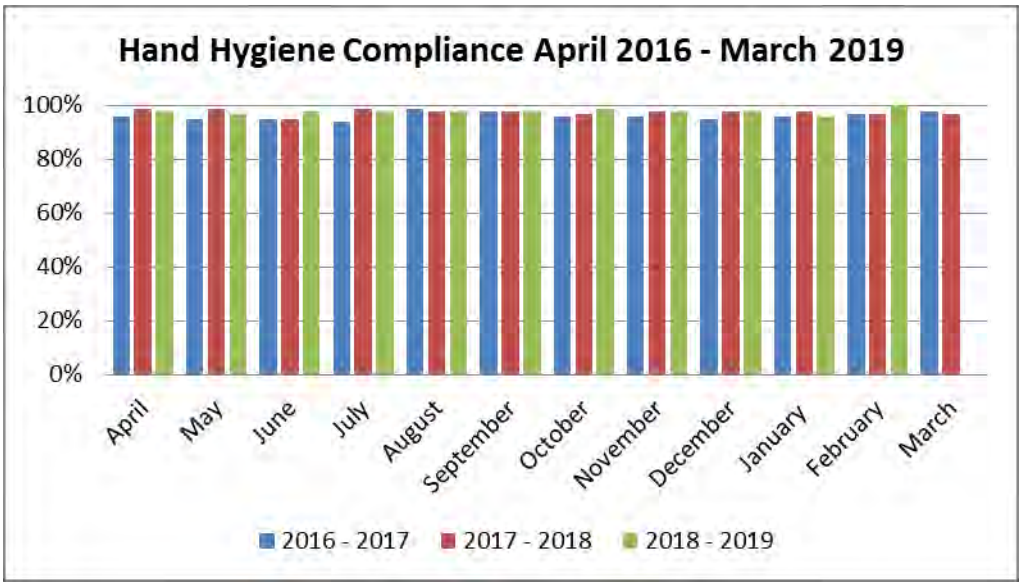
Although three out of four ICAS meetings were cancelled all the policies were reviewed and updated. Chairman's action was given for this purpose to avoid delays to the updates. However the Documentation Compliance Manager has not uploaded them to the QPulse system.

A number of the policies are audited for its compliance by the Infection Control team. eg. MRSA admission screens, environmental policies, hand hygiene, commode audits etc as shown below

See Appendix 5 – IPC Policies

9.2 Hand Hygiene (Obtained from Matrons and departmental leads)

Graph No. 1: Monthly Trust Hand Hygiene Compliance 2013 to 2019



The high scores shown here are not consistent with practice observed by the Infection Control team and by the NHSI visiting team. The audits are done by each individual department instead of peer reviewers contrary to what was expected. Going forward a more realistic approach would be for ICT or an independent person to carry out hand hygiene audits which will be part of an immediate improvement plan.

9.3 Commodes

The IPCT undertake monthly unannounced commode audits and have been trained in the process. Any area not achieving 100% is re-audited daily until the target is met. The Senior Sister/Charge Nurse is responsible for completing an action plan to address any issues identified.

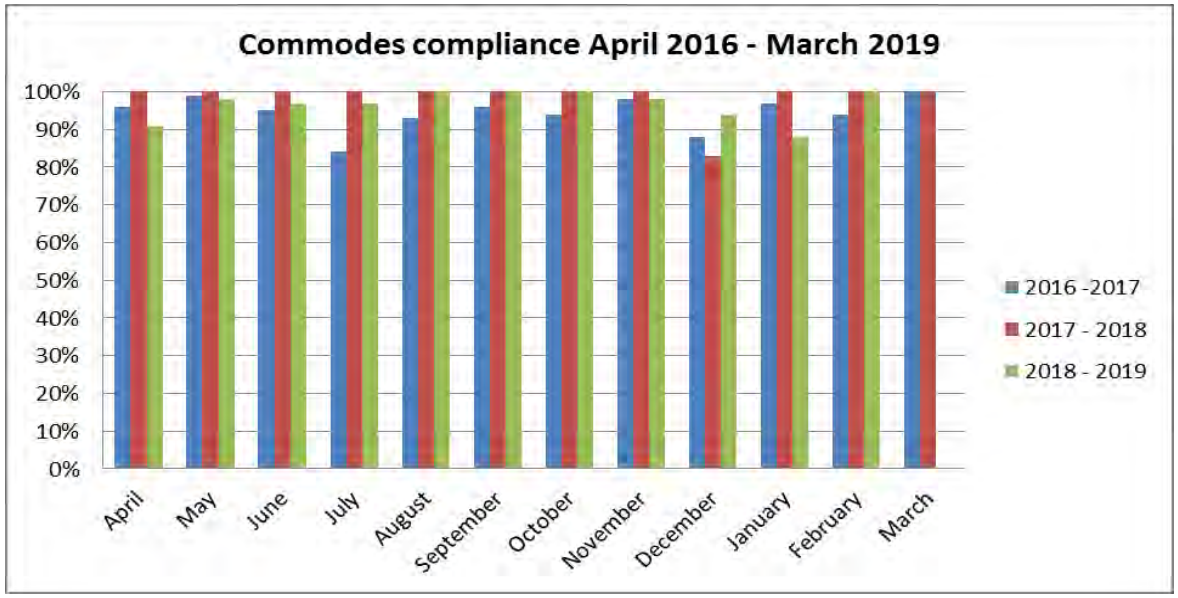
Wards have developed robust systems to ensure decontamination of commodes after each use, between patients and a daily Chlorclean as per Trust policy.

Any ward on enhanced measures has their commodes audited weekly by the IPCT.

Commode audit scores are displayed publicly and the results are also monitored by the Directorates. This has been a key strategic approach to assist in reduction of Clostridium *difficile* rates Trust wide.

The overall score for 2018–19 is 97% which is below the standard of 100% set by ICT

Graph No. 2: Monthly Trust Commode Scores 2016 to 2019



9.4 Isolation

Audit of compliance with the Isolation Policy is undertaken by the IPCT every time a patient with an infection is reviewed. This ensures early intervention and advice for this group of patients. The results of the patient reviews are fed back verbally in real time to the nurse in charge of the ward and followed up in writing to the Ward Manager, Matrons, Deputy Directors of Nursing, and Consultants where required. Non-compliance is resolved by the ward with the support of the IPCT and an action plan devised by that ward, as required. These review scores also form part of the monthly statistics. Isolation compliance also forms part of enhanced measures.

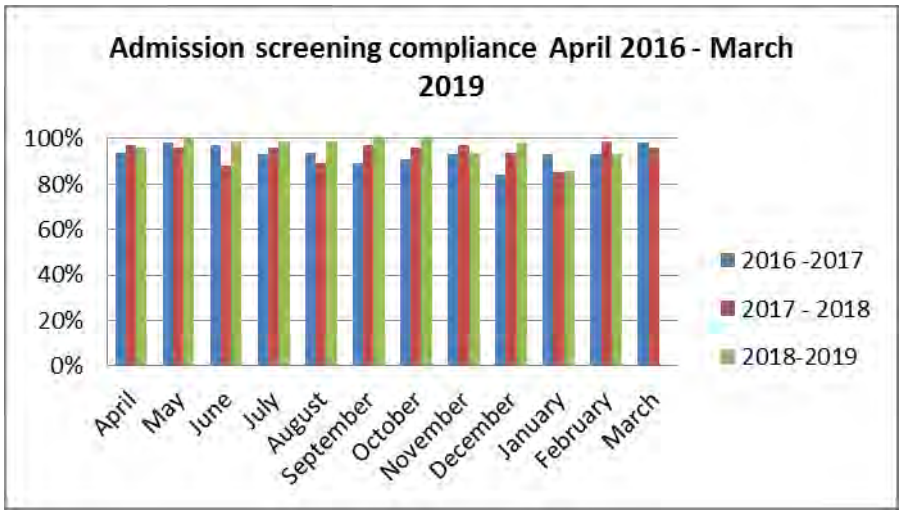
9.5 MRSA Screening

MRSA screening is undertaken as per national guidelines to:
a. Reduce the risk of transmission to other patients
b. Reduce the risk of infection on the individual

9.5.1 Admission Screening

Admission screening is mandatory for all admissions and transfers into the Trust with the exception of Paediatrics and Maternity, where only high risk patient categories are screened. Due to IT difficulties (changeover from admission software PAS to OASIS and Pathology APEX to Telepath), the IPCT were only able to undertake monthly point prevalence audit of compliance. The standard set is a minimum of 95%. This year we scored 69 % which is not a good place to be. To address this, a campaign was held in October to raise staff awareness on this mandatory function. Staffs who undertake screening must also complete screening competencies. The high number of agency staff on the ward may have also been responsible for not undertaking admission screens of all patients.

Graph No. 3: Monthly Average MRSA Admission Screening Scores 2016 to 2019

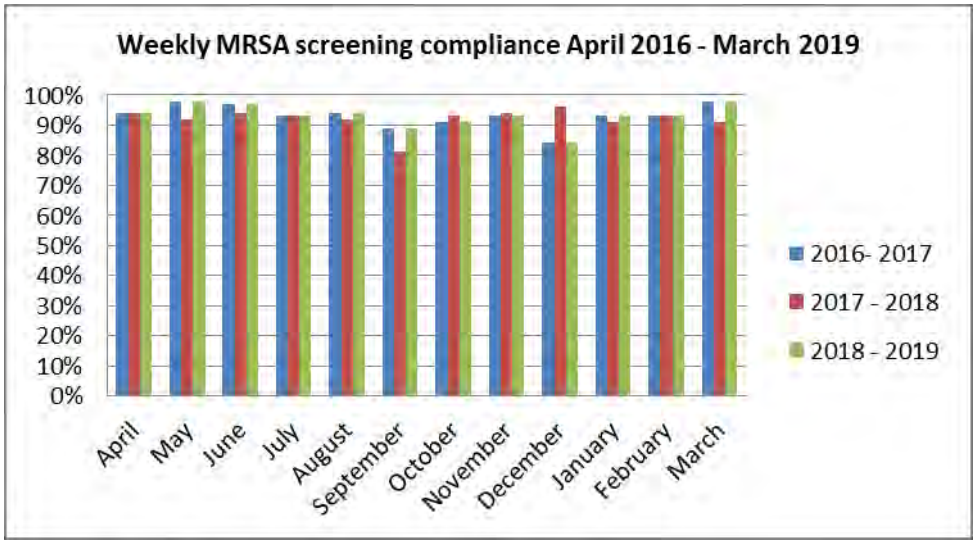


9.5.2 Weekly Screening for long stay patients

Although some trusts have dropped the universal screening approach in response to guidelines to detect MRSA acquisitions in hospitals, the ICC committee a few years back decided that the universal approach was still better than the selective approach. The evidence provided for the new guidelines was weak. All adult patients that remain in hospital for more than one week are screened for MRSA colonisation; circulated monthly as part of the data set. Paediatric and Maternity patients are only screened if they fall into a high risk category such as SCBU. Any exception to the screening is fed back in writing with the rationale to the Ward Manager, Matron and Deputy Director of Nursing for action.
The weekly screens or Post 48 hour screens are cross checked by ICT to help us identify new cases of MRSA as only new cases are indicative of cross transmission or acquired in hospital during the current admission. These are then flagged on the OASIS or SYMPHONY system in ED.

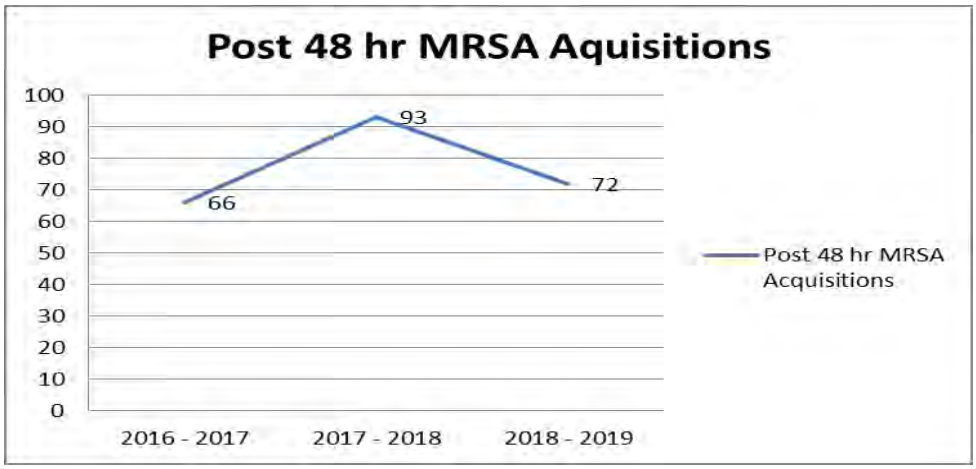
A more robust electronic data collection for admission and weekly screens need to be employed.

Graph No. 4: Monthly Average MRSA Weekly Screening Scores 2016 to 2019



9.5.3 Post 48 Hour MRSA acquisitions

Graph No. 5: Post 48 hour MRSA Acquisitions 2016 to 2019



The majority of new cases identified were in the Unplanned and integrated care directorate and shows a drop in the number of acquisitions. Again as this with the admission screens, the methodology used is not truly representative of the true picture. Likewise the high agency rate on the wards may also be responsible for the inaccurate picture. Traditionally however the acquisitions of MRSA have reduced over the years in the hospital.

With advances in IT and stabilisation of DVH laboratory, a more time effective way of data collection can be devised provided the ICT separate the new and old cases from the data filter.

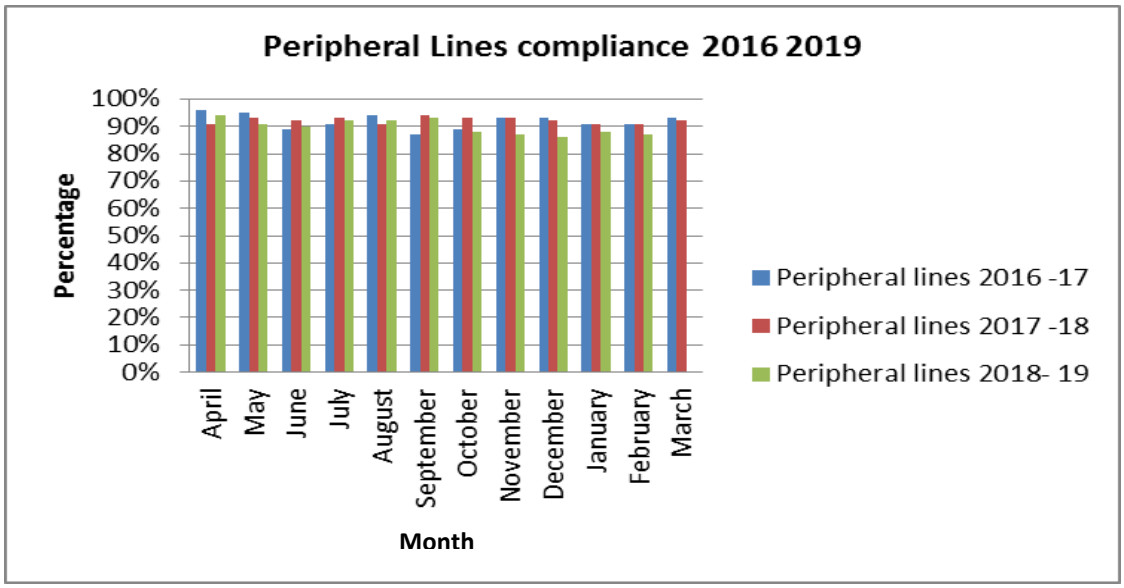
9.6 Saving Lives High Impact Interventions

The Trust continues to utilise the Saving Lives High Impact Interventions (HII) or care bundles as an important element of its Health Care Associated Infection reduction strategy. The HII's are undertaken for all patients with peripheral vascular devices, central venous devices and urinary catheters. The use of these care bundles helps to embed best practice ensuring that our patients receive the best care to reduce the risk of an infection from each and every device they have, every time they are accessed or manipulated and ensured they are removed in a timely fashion.

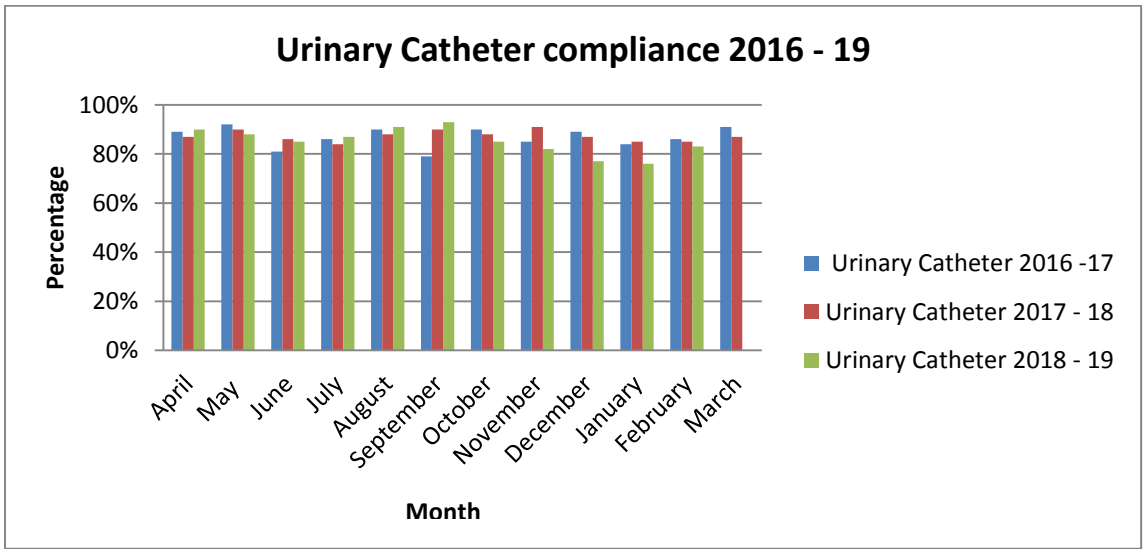
Tools have been adapted and developed by the IPCT to review this best practice for every patient with a device; compliance with this is then audited by the IPCT at least monthly and each time a patient with an infection is reviewed. When workload permits, areas with scores below 95% are re-audited weekly. A new initiative for peripheral line requirement was introduced with the acronym BSAFfE which stand for Blood or blood products; Single dose bolus, antimicrobials, Fluids, Feeding (parenteral). If patients do not fulfil any of these criteria then they either do not require a cannula or it can be removed.

- The trust overall score for urinary catheters for this year is 85% against a standard of 100%
- The trust overall score for peripheral venous catheters for this year is 90% against a standard of 100%
- The trust overall score for central venous catheters this year is 86% against a standard of 100%

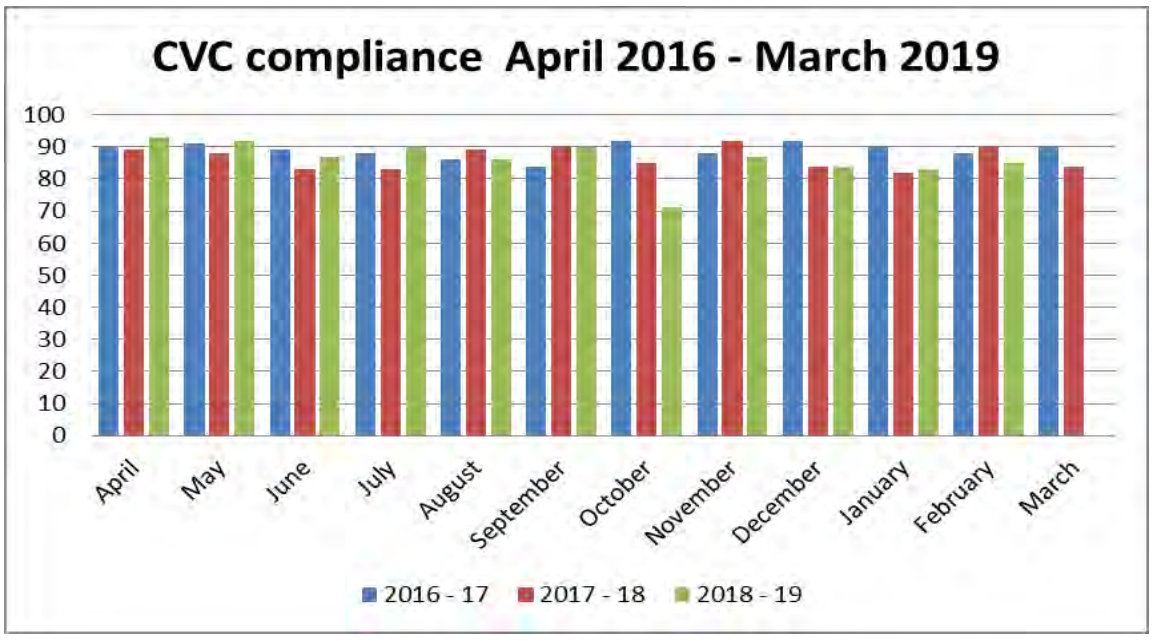
Graph No. 6: Saving Lives Compliance - Peripheral Lines Ongoing Care 2016 to 2019



Graph No. 7: Saving Lives Compliance - Urinary Catheters Ongoing Care 2016 to 2019



Graph No. 8: Saving Lives Compliance - Central Venous Catheters Ongoing Care 2016 to 2019



The Team assists in the validation of data on Catheter Associated Urinary Tract infections (CAUTI) obtained once a month, from the 'harm free care' data collection.

In April 2017, the HOUDINI protocol was introduced into the Trust. This is a nurse led program to ensure the appropriate insertion, timely removal and appropriate use of urinary catheters. The name is an acronym to help staff remember the indications for insertion and removal of catheters. If no indications are identified, consideration should be given to catheter removal, or alternative management. The evidence suggests that use of this protocol by nursing staff in the UK reduces catheter usage and CAUTI,

with usage falling by 17% in one study. However, we have not yet seen a reduction in the number of urinary catheters inserted in the Trust and the incidence of new onset catheter associated urinary tract infection has remained relatively unchanged. Although the data reconciliation is yet to be completed, early indications are that there is no change to post CAUTI cases in the Trust. This will be an area of focus in 2019-2020.

Commentary of Compliance:

1. *All the policies are due to be updated in line with the Scottish policies on Infection prevention and Control.*
2. *The high hand hygiene scores shown are not consistent with practice observed by the Infection Control team and by the NHSI visiting team. Going forward this needs to be part of an immediate improvement plan*
3. *The overall score of the commode audit is 97% which is below the standard of 100% set by ICT*
4. *An audit on the use of isolation rooms and education of Site Service Practitioners need to be undertaken*
5. *A more robust electronic data collection for admission and weekly MRSA screens need to be employed*
6. *Improvement required in Saving lives on all indwelling devices to meet 100% target*

GAP ANALYSIS: Partially compliant

Compliance Criterion 10: Providers have a system in place to manage the occupational health needs.

10.1 Occupational Health Department

The Trust has an Occupational Health Service and undertakes a comprehensive staff health screening programme including vaccinations and health surveillance The IPCT work in close collaboration with the Occupational Health Team. Last year Occupational Health were involved in contact tracing of a member of staff with TB

A flu immunisation programme was delivered in 2018-2019 and the Trust achieved a 76.2% uptake of the vaccination and met the target ambition of 75% for all Healthcare Providers in Kent & Surrey.

GAP ANALYSIS: Compliant

11 OUTCOME MEASURES: National and Local Targets

Public Health England (PHE) maintain a Data Collection System (DCS) system for Meticillin Resistant *Staphylococcus aureus* (MRSA) bacteraemia, Meticillin Susceptible *Staphylococcus aureus* (MSSA) bacteraemia, Gram-negative (*Escherichia coli, Klebsiella* spp. and *Pseudomonas Aeruginosa*) bacteraemia and Clostridium *difficile* infection (CDI).

Mandatory requirements for National Health Service (NHS) acute Trusts are to report each case of MRSA bacteraemia, MSSA bacteraemia, *E. coli* bacteraemia and CDI. The Health and Social Care Act 2008 and the Code of Practice on the prevention and control of infections and related guidance provided a requirement for NHS Trust Chief Executives to report all cases of MRSA, CDI, MSSA and Gram Negative bacteraemia to PHE.

11.1 MRSA Bacteraemia

This year there were eight trust apportioned MRSA cases, most of which were avoidable. Along with four other pre 48 hour cases, there were 12 cases related to the whole health economy. This is our worst performance since 2007. The root causes of these cases were due to delays in diagnosis and treatment of patients in a timely way. Suboptimal nursing practice and procedures were also responsible for some of these and other cases

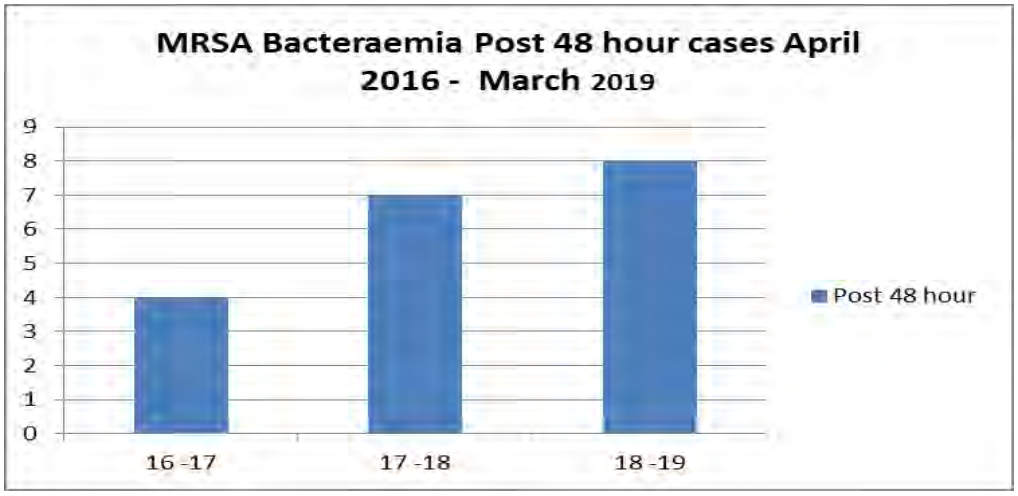
***Lessons learned from the post infection reviews include*:**

- Vancomycin not considered at the point of sepsis in chronic interstitial lung disease patient with sputum positive for MRSA.
- MRSA history not acknowledged by ED in a patient with cardiac pacemaker and therefore Vancomycin not commenced in sepsis.
- Delayed identification of source of bacteraemia due to five different teams of consultants reviewing patient over 10 days. Poor continuity of care
- No requirement to repeat blood cultures for MRSA clearance in patients when they have therapeutic vancomycin levels beyond 14 days.
- Delays in commencing decolonisation regimes
- Management and care of PICC line
- Inadequate aseptic non touch technique whilst taking blood cultures
- Since the introduction of the NICE guidelines for discharge paperwork, the infection status of patients is not included in the discharge summary. The infection status is therefore not communicated to the GP or other carers in the community.
- Issues with communication of patient's infection status especially between doctors and to consultants on ward rounds. Lack of clarity on consultant ownership.

These lessons must be embedded into practice if we are to improve and reduce the risk to our patients. The new DIPC who is also Medical Director will have to address these clinical practice issues with Consultant colleagues and ensure that multiple moves are not detrimental to patient care.

With the support of the IT department, a modified discharge summary came into force in January 2019 where the infection status of the patient is now a mandatory box to be completed by doctors. The robust completion of forms with the required information needs to be audited by ICT for compliance.

Graph No. 9: MRSA Bacteraemia Post 48 Hour Cases 2016 to 2019



11.2 MRSA Bacteraemia Post 48 Hour Reduction Trajectory

Table No 6: MRSA Bacteraemia Post 48 Hour Reduction Trajectory

Zero Tolerance

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Trust attributed	1	0	2	1	3	0	1	0	0	0	0	0	8
CCG attributed	0	1	0	1	0	0	0	0	1	0	0	1	4
Third party attributed													

(P) = provisional assignment

11.3 Clostridium *difficile* Associated Diarrhoea (CDAD)

The diagnosis of C. diff infection is based on the detection of toxin in the stools and the clinical presentation, which is usually that of diarrhoea (type 5 – 7 stool on Bristol stool chart).

Mandatory reporting of cases of C.diff are classified as pre or post 72 hours depending on the date of the sample. Therefore any sample taken after 72 hours of admission is assigned to the Trust trajectory. The Trust had 25 cases against a trajectory of 19 for this year.

All post 72 hour cases are reviewed by the IPCT and the clinical team ream responsible for the patient to determine if there have been any lapses of care. External assurance is provided when these cases are discussed at the North Kent Health Care Associated Infection (HCAI) assurance meetings that are held monthly. Of the 25 cases, many were considered to be unavoidable.

We take level 1 and 2 lapses of care seriously as we believe these would prevent progression to level 3. The main issues and lapses of care (LOC) identified from the Post Infection Reviews (PIRs) are summarised below. Directorates have action plans in place to address learning from the post infection reviews that have been convened, supported by the IPCT. However several PIR's remain outstanding. The trust target of CDAD cases for 2018-19 is no more than 19 cases. We have now breached our end of year

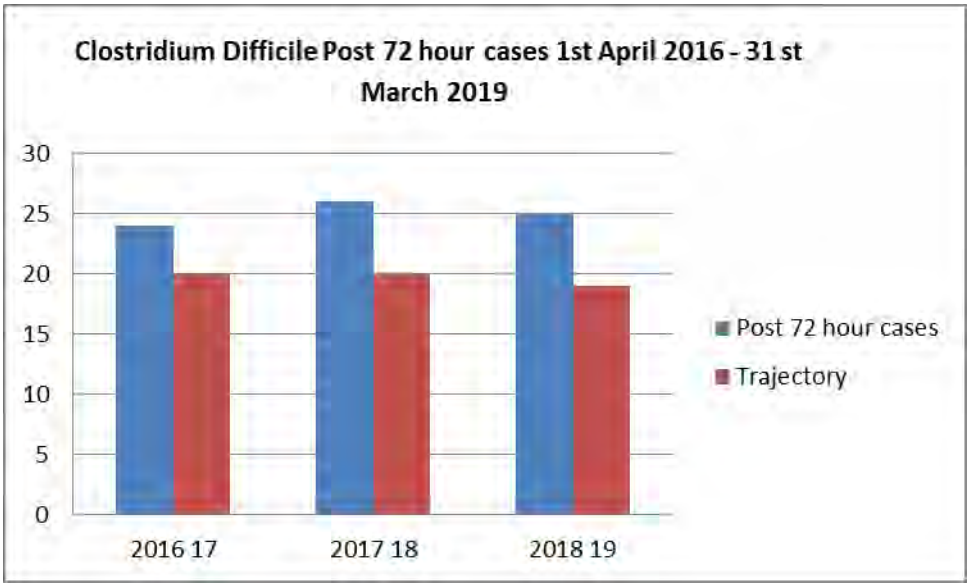
target. End of the financial year is 25 cases against a trajectory of 19. The main issues arising and lapses of care (LOC) identified from the Post Infection Reviews (PIRs) are summarised below

Table No 7: Post 72 hour Cdt cases 2018 to 2019 – update

Post 72 hour Cdt cases 2018 – 19 - update

	Date	CCG	HCAI DCS no:	Attributed to	Ribo type	Avoidable / Unavoidable	LOC level
1	030418		668763	Milton		Unavoidable	
2	080518		678031	Harvey	015	Avoidable	3
3	280518		681488	Phoenix	Not sent	avoidable	2
4	040618		684033	Lawrence	018	Unavoidable	1
5	200618		687812	Mcculloch	014	Avoidable	3
6	250618		698929	Will Adams	Not sent	Avoidable	2
7	080818		710424	Nelson	023	Unavoidable	
8	210818		713377	Byron	014	Unavoidable	
9	050918		716829	Phoenix	Not sent	Unavoidable	1
10	170918		719753	Tennyson	056	Avoidable	3
11	160918		719764	Dickens	015		
12	190918		720249	Arethusa	002	Avoidable	2
13	051018		751262	Milton	002	Unavoidable	1
14	091018		753326	Sapphire	Spor		
15	121018		754510	Milton	014	Avoidable	2
16	161018		756323	Milton	Not sent	Unavoidable	1
17	131118		818113	Pembroke	Not sent	Unavoidable	1
18	131218		828442	Milton	Not sent	Unavoidable	0
19	201218		830315	Wakeley	Not sent	Avoidable	2
20	291218		831694	Ocelot	Not sent	PIR not done	N/A
21	020119		833209	Will Adams	Not sent	PIR not done	N/A
22	190119		837952	Pearl	Not sent	Unavoidable	1
23	220119		838515	Dolphin	Not sent	Unavoidable	0
24	160319		854045	Kingfisher	Not sent	Avoidable	2
25	210319		855102	Milton	Not sent	Avoidable	1

Graph No. 10: Post 72 hour Clostridium difficile cases 1st April 2016 to 31st March 2019



11.4 CDT trajectory for 20 -18 to 2019

The trust target of CDAD cases for 2018-19 was no more than 19 cases. The Trust reported 25 cases. Epidemiological themes of the cases to 2018 19

Post 72 hour CDAD cases year 2018 19

- Planned and unplanned care majority of cases in unplanned care.
- Age range with two exceptions all between 75 and 98 years of age.
- Majority of cases on PPI's
- All current or previous antimicrobial therapy.

There have been 13 post infection reviews undertaken so far, 3 cases with level 3 lapses of care.

Disappointingly, the trends and themes from those that have been completed are the same as the previous year particularly issues with:

- Irrational antimicrobial prescribing
- Timeliness of stool samples (this will be changing nationally to within 48 hours from 72 in April 2019), and incomplete risk assessment / Time to isolation.
- Delay in empirical treatment with metronidazole.
- Conditions misdiagnosed as sepsis and therefore unnecessary antimicrobial therapy.
- No consideration of C.diff toxin as a source of infection.

Other continuing contributory factors include shortage of staff, use of locums and high occupancy rates.

Directorates have action plans in place to address learning from the post infection reviews that have been convened, supported by the IPCT.

These issues still remain, specifically re antimicrobial prescribing and stewardship. This is the key issue in reducing the risk of patients acquiring C.*diff* and must be a priority within the trust.

Action: programme governance teams to ensure PIR's are convened and assurance provided that lessons learned are and will be actioned

An antimicrobial round table event was held and facilitated by Professor Cliff Hughes, and the following actions were identified to be taken forward by the Director of Nursing and the Medical Director:

i. Accurate identification of Sepsis patients in Emergency department
ii. Ensure the correct process of escalation of Antimicrobial PGD's are followed
iii. Clinical Consultant ownership/accountability of initial diagnosis and subsequent review of infection and antibiotic management
iv. Launch of antimicrobial guardianship across all healthcare professions.
v. Assurance from Programme/Governance Leads to monitor the individual's responsibilities on the wards (process)
vi. Antimicrobial and ward pharmacists to monitor the correct prescribing practice on the wards (outputs)

Please see a summary of Hospital onset C.*diff* cases (post 72 hour) 2018 -19 below

Table No 8: Post 72 hour C diff cases 2018–2019

Clostridium *difficile April 2018 to March 2019.*													
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Pre 72 Hour	2	3	5	6	4	8	5	0	7	3	2	2	49
Post 72 Hour	1	2	3	0	2	4	4	1	3	3	0	2	25
Post 72 hour Trajectory	1	1	2	2	2	1	1	2	2	1	2	2	19

New trajectory for 2019-2020

Please note that as from April 2019, there will be a new definition of hospital onset C.diff cases, and to accommodate this definition, the target set is **43**.

1. Cases will be defined as hospital onset if positive result after 48 hours (2 days of admission – day of admission is day 1) as an inpatient.
2. Cases that are pre 48 hours but have been an inpatient in acute care within the previous 4 weeks will be considered as hospital acquired.

Infection control documentation will be revised to accommodate these changes.

11.5 Methicillin Sensitive *Staphylococcus aureus* (MSSA)

Mandatory reporting of MSSA continues. All cases are scrutinised by the IPCT. If the source of the MSSA is considered to be a surgical site infection or related to an invasive device then a post infection review will be carried out.

There were a total of 25 post 48 hour MSSA bacteraemia cases in the year. The data is yet to be reconciled with surveillance forms and will have to be analysed once this is complete.

Table. 8: MSSA Bacteraemia Pre v Post 48 Hour 2018-2019

MSSA Source

	Contaminant	CVC	Prosthetic Joint	PVC	SSI	Totals	Percentages	
Pre	4	5	1		1	11	9.57%	Community related
Post		1	1	1		3	2.61%	Hospital related
Total							12.18%	
Unknown								
Pre						25	21.74%	Community related
Post						6	5.22%	Hospital related
							26.96%	
MSSA Totals								
Pre	90							
Post	25							
	115							

11.6 ***Gram Negative*** **Blood Cultures**

From April 2017 an annual target of a 10%, 15% and 20% reduction (or greater) per year in all Gram negative blood stream infections reported at CCG level was introduced based on 2016 performance data . There is particular emphasis in reducing bacteraemia secondary to catheter associated urinary tract infections (CAUTI), as these are considered healthcare associated and can be easily targeted with interventions. Data for 2017-18 has been added as a comparator for future reference. The data for 2018-19 is yet to be reconciled with surveillance forms and will have to be analysed once this is complete.

Table. 9: Gram negative blood stream infections 2017-2018

Gram negative Blood stream infections for 2017 -2018

	E Coli	Klebsiella	Pseudomonas	Totals	Percentages		
Pre	240	55	18	313			
Post	41	17	10	68			
Total	281	72	28	381			
Pre CAUTI's	42	9	7	58	15.22%	15.22%	Community related
Post CAUTI's	19	7	6	32	8.40%	9.19%	Hospital related
Procedure related	3	0	0	3	0.79%		
Deaths	16	1	0	17			

Table. 10: Gram negative blood stream infections 2018-2019

Gram negative blood stream infections for 2018 -2019

	E Coli	Klebsiella	Pseudomonas	Totals	Percentages	
Pre	226	47	35	308		
Post	58	18	9	85		
Total	284	65	44	393		
Pre CAUTI's	25	4	8	37	9.41%	Community related
Post CAUTI's	5	2	1	8	2.04%	Hospital related
Procedure related	12	2	2	16	4.07%	
					15.52%	
Not completed						
Pre	0	0	0	0	0.00%	Community related
Post	2	1	0	3	0.76%	Hospital related
					0.76%	
Unknown						
Pre	20	5	6	31	7.89%	Community related
Post	8	2	2	12	3.05%	Hospital related
					10.94%	

Total community related	**17.30%**
Total hospital related	**9.92%**

11.7 Glycopeptide Resistant Enterococci (GRE)

The Trust continues to screen admissions to Lawrence Ward for GRE colonisation mainly as a marker of good infection control precautions on the unit. This is because patients on this unit spend inpatient time at King's where VRE is prevalent. Knowledge of their colonised status helps with timely treatment for Haematology patients.

11.8 Meningitis

All meningitis cases are notified to the Health Protection Unit in addition to the Infection Control precautions that are instigated.

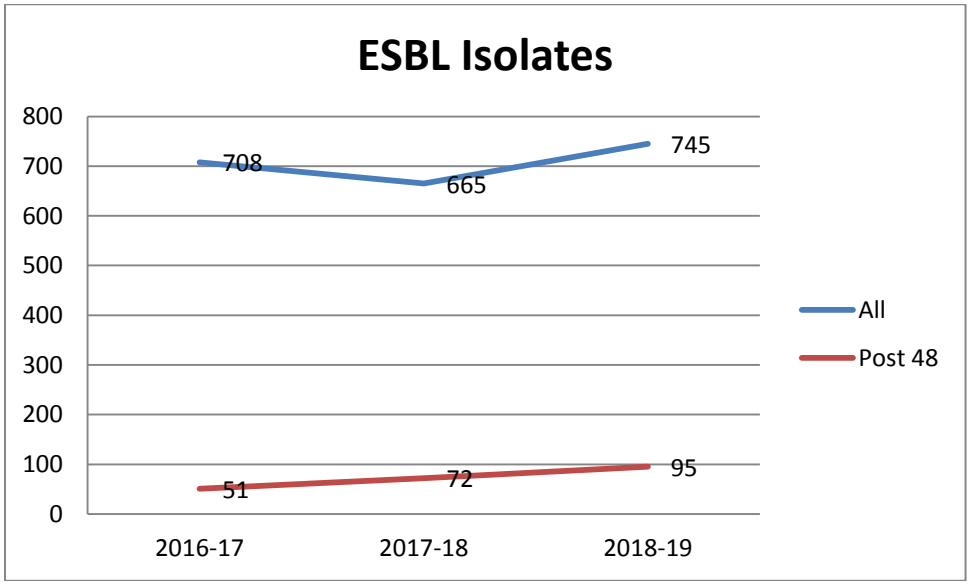
11.9 Tuberculosis (TB)

The IPCT work with the Chest team to ensure correct infection control management of TB cases are employed to prevent secondary cases. The Team review all inpatients with confirmed/suspected PTB and participate in the contact tracing exercise. Numbers have remained steady.

11.10 Extended Spectrum Beta Lactams (ESBL) – more resistant organisms

The Trust continues to see an increase in the incidence of ESBL cases across the whole health economy in urinary isolates and this is anticipated to become an increasing concern over the next few years. Cases in hospital are followed by the IPCT and isolation precautions taken as per Trust policy. This is a significant risk in the elderly population in patients with urinary catheters.

Graph No. 11: All ESBL Isolates 2016 to 2019



11.11 Carbapenemase producing enterobacteriaceae (CPE).

There have been no hospital acquired cases this year. Screening and isolation of all at risk cases continues.

Comment:

The trust breached its MRSA target by eight against a target of Zero. We also breached the C diff target of 19 by six additional cases. More importantly PIR's were not held on all of these cases due to lack of engagement.

The data for Gram negative Blood stream infections and MSSA needs to be reconciled and analysed for improvements and interventions.

The level of performance led the Trust to invite a review from NHSE/I in May. They witnessed first-hand some issues with infection control practices on the ward from Nurses and doctors. They also felt that a drive for improvement needed to come from the senior management of the organisation to turn the trust around.
Data collection, reconciliation and analysis needs to be completed and any clinical interventions will need to be actioned accordingly. This will be part of the improvement plan to be presented in September.

SUMMARY

This report demonstrates partial compliance in nine out of ten criteria. This is disappointing, given that we were compliant in all but one criterion a year ago. The current DIPC is retiring shortly. The new DIPC and Head of Infection, Prevention and Control has a lot of work to do at an organisational level to ensure systems and processes are in line with the Act so that the trust remains a registered healthcare provider

Our priorities for 2019-20 include

- Address the nine partially compliant issues relating to the Health and Social Care Act
- Respond to the findings of NHSI
- Appoint a full time new Infection Control doctor to support the team.
- Appoint an Antimicrobial pharmacist and develop a robust stewardship programme
- DIPC to lead on Consultant engagement on reducing MRSA bacteraemia and C difficile
- Nursing practices and infection Control procedures on the ward to be stepped up
- Safe Intravenous device and Urinary catheter care and maintenance programmes to be developed and implemented.

Senior management level commitment is needed at different levels of the organisation to turn the trust around. The Trust commitment to preventing and reducing the incidence and risks associated with HCAIs requires that we work with colleagues within the trust as well as the wider health system, patients, service users and carers to develop and implement a wide range of IPC strategies

The report gives consideration to the ten criteria which are set out in the table below along with our self-assessment of compliance for 2018/2019.

	Compliance criterion *What the registered provider will need to demonstrate*	Trust rating
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	Partially Compliant
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Partially Compliant
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Partially Compliant
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Partially Compliant
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Partially Compliant
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Partially Compliant
7	Provide or secure adequate isolation facilities.	Partially

		compliance
8	Secure adequate access to laboratory support as appropriate.	Partially Compliant
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Partially Compliant
10	Providers have a system in place to manage the occupational health needs	Compliant

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Appendix 1

Terms of Reference

Infection Control & Antimicrobial Stewardship Group

1. Purpose

1.1 The purpose of this group is to maintain an overview of infection prevention and control / Antimicrobial prescribing priorities within the Trust, and to link this into the clinical governance structures of directorates in order to meet the regulatory and legislative requirements associated with this area of work.

2. Constitution

2.1 The Infection Control & Antimicrobial Stewardship Group is established on the authority of the Quality Improvement Group which reports to the Executive Group.

3. Authority

3.1 The group is authorised by the Quality Improvement Group (QIG) 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 Infection Control & Antimicrobial Stewardship Group

3.2 The Infection Control & Antimicrobial Stewardship Group is also authorised to implement any activities which are in line with the terms of reference, as part of the Patient Experience Strategy work programme.

4. Accountability

4.1 The Group will report to the Quality Improvement Group which in turn reports to the Executive Group.

4.2 Any matters requiring Board approval under the Trust's Scheme of Delegation and Reservation will be submitted to the Board via the Executive Group

4.3 The Chair of the Infection Control & Antimicrobial Stewardship Group will provide a quarterly report to the Quality Improvement Group on issues and progress through the production of a Key Issues Report following each Infection Control & Antimicrobial Stewardship Group meeting.

5. Chairperson

5.1 The Chair of the Group will be the Director of Infection Prevention and Control and Antimicrobial Stewardship.

5.2 The Deputy Director of Infection Prevention and Control will be the Deputy Chair.

6. Membership

6.1 The membership of the Infection Control & Antimicrobial Stewardship Group will consist of the following:

Director of Infection Control and Antimicrobial Stewardship*
Head of Infection Control/Deputy Director of Infection Prevention and Control *
Consultant Microbiologist *
Specialist Antimicrobial Pharmacists*/Head of Pharmacy
Director of Nursing – Executive Lead
Programme Infection Control / Antimicrobial Stewardship Consultant lead
Head of Occupational Health
Head of Estates
Head of facilities
Directorate Deputy Directors of Nursing,
Chair of decontamination Group
Chair of Water safety group.

7. Attendance is expected from:

7.1 There is a requirement for members to attend all meetings and a minimum 75%. A designated deputy must attend on behalf of a member. They must come prepared and have sufficient authority to make decisions on behalf of the group member.

7.2 Other attendees from relevant directorates/ services may be invited to attend as and when appropriate.

7.3 Depending on agenda items others representatives from CCG and Kent, Surrey & Sussex, Health Protection, Public Health England Centre may be invited to attend as and when appropriate.

8. Quorum

8.1 The meeting will be quorate provided that five members are present (the Infection Prevention and Control Team* count as one member). The Clinical Directorates must be adequately represented.

9. Frequency

9.1 Meetings will be held every quarter

9.2 The Group will be convened in an emergency as required.

10. Key responsibilities

10.1 To provide assurance to the QIG that the Trust is compliant with mandatory reporting of HCAI's and statutory regulations, e.g. Health and Social Care Act 2008, Care Quality Commission, CQUIN targets etc.

10.2 Review and monitor Trust performance against national and local targets via the HCAI Key Performance Indicators (KPI) including MRSA blood stream infections and *Clostridium difficile* reduction.

10.3 To receive and approve the Infection Control and Antibiotic Stewardship work and audit programmes.

10.4 To escalate risks associated with Infection Prevention Control and Antimicrobial Stewardship issues, ensuring that there are appropriate plans in place to mitigate those risks and to ensure that these are recorded on the appropriate risk register.

10.5 Promote responsible prescribing across the Trust and receive reports on antimicrobial stewardship programme of audit, feedback, surveillance and education.

10.6 Maintain and monitor the Antimicrobial Stewardship Policy. Advise, as required, the Medicines Management Group on restricted antimicrobial consumption. Review the release of new antimicrobials and monitor its use.

10.7 To receive assurance from the Directorates that Infection Prevention and Control/antimicrobial stewardships risks are identified, discussed at their respective governance meetings and plans drawn up to mitigate the risks. This will be presented in the form of exception reports from each of the Directorates and specialist support services on a designated template report. This report should be sent to the secretary of the IPC/ AMS group one week before the meeting.

10.8 To monitor the establishment and performance of surgical site infection surveillance programme (mandatory and non-mandatory) across Surgical specialities and Obstetrics and Gynaecology.

10.9 To review and monitor the activities (including the attendance register and minutes) from the following sub-groups: the Water Safety Group and the Decontamination Group by means of receipt of a Key Issues Report following each meeting

10.10 To ratify infection control and antimicrobial policies, procedures and guidelines and maintain a rolling programme of updates

10.11 To receive and approve the Infection Control Team's Annual Report before it is presented to the QIG.

10.12 Deliver a robust assurance programme that holds directorates and support specialties to account and provide feedback to the QIG.

10.13 To work collaboratively with our CCG's on both Infection Control and Antibiotic Stewardship in the community

11. Process for Monitoring compliance with Terms of Reference

11.1 Compliance will be monitored by reports on progress, regular agenda items covering the assurance plan for the Group and by producing quarterly Key Issues Reports to the Quality Improvement Group.

12. Links to other meetings

12.1 Water Safety Group

12.2 Decontamination Group

12.3 Quality Improvement Group

13. Review Date

13.1 All Terms of Reference will be reviewed annually.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Terms of Reference	Reviewed by way of an annual report	Chair	Quality Improvement Group	Where gaps are recognised, action plans will be put into place; key issues will be escalated to the Quality Improvement Group
Programme of Work	Via Key Issues Report quarterly	Chair	Quality Improvement Group	Where gaps are recognised, action plans will be put into place; key issues will be escalated to the Quality Improvement Group
To review and monitor the activities (including the attendance register and minutes) from the following sub-groups: the Water Safety Group and the Decontamination Group	By means of receipt of Key Issues Reports following each meeting	Chair	Quality Improvement Group	Where gaps are recognised, action plans will be put into place; key issues will be escalated to the Quality Improvement Group

Appendix 2

Infection Prevention and Control Work Programme 2018 - 19

Introduction:

This work programme is a requirement under the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance. Produced for the Chief executive and trust board it describes the programme of work planned for 2018 – 1.

Priority	Action	Responsible Person	Frequency /review	Reporting/Assurance
1	To undertake mandatory reporting of all relevant organisms: C.diff; MRSA, MSSA, Gram negatives - E-Coli, Pseudomonas Klebsiella.	Head of Infection Control/ Deputy DIPC	Monthly	National HCAI Data capture system monthly. Monthly rates and audits via monthly stats to all Programmes. Quarterly to Infection control and antimicrobial stewardship group (ICAS) and QIG
1	Review the effectiveness of the MRSA bacteraemia, Clostridium *difficile* and Gram negative bacteraemia reduction strategies to meet and exceed national targets. Zero tolerance for MRSA bacteraemia No more than 19 cases of C.diff toxin Reduction of 50% E.coli bacteraemia by 2024	Head of Infection Control and Programme Leads	Monthly	Action plans to be reported by Programme leads through Quarterly report to ICAS and QIG
1	To provide an efficient, proactive Infection Prevention and Control service to meet the Trust's requirements.	Head of Infection Control/ Deputy DIPC	Quarterly	ICAS
1	To undertake surveillance of alert organisms (Resistant Organisms, Tuberculosis and Norovirus) and provide accurate timely data to the Directorates.	Head of Infection Control/ Deputy DIPC	Monthly	Monthly Stats to Programme leads Reported to ICAS quarterly
1	To undertake a comprehensive audit programme to meet the requirements of regulations and to identify areas of potential risk for the Trust (attached).	Head of Infection Control/ Deputy DIPC	Quarterly	ICAS
1	To provide Infection Prevention and Control training programme to ensure all staff receive appropriate training from induction and annual updates (including hand hygiene) and support new Trust training days.	Head of Infection Control/ Deputy DIPC	Monthly	Learning and Development report via ESR Programme leads to report training uptake quarterly at ICAS
1	Support the Directorates in undertaking PIR's/RCA's for all hospital acquired Clostridium *difficile*, MRSA Bacteraemias, SUI's and outbreaks/Incidents.	Head of Infection Control/ Deputy DIPC & IPC Team and Programme Leads	As required	Not all PIR's were complete Assurance of action plans unable to provide to ICAS, Performance review meetings

				(PRM's) and QIG
1	Clinical review by IPCT of every inpatient with MRSA / Clostridium *difficile* / GRE / CPE / GDH/ any other alert organisms colonisation or infection. Any key non compliance issues identified, IPCT will liaise with the directorates to address this	Head of Infection Control/ Deputy DIPC	Daily	Medical Notes completed in real time. Real time Verbal feedback and Written feedback to directorates Directorate action plans monitored at PRM's and exception reporting to ICAS
1	To identify and lead the management of outbreaks.	Head of Infection Control/ Deputy DIPC	As they occur	MRSA cluster meeting minutes. ICAS.
1	Provide specialist advice on decontamination issues.	Decontamination Lead	As required	Not held
1	Ensure the Trust is compliant with the CQC Registration, NHSLA compliance and provide assurance to the Trust Board	DIPC	As required	
1	Provide the strategy for antimicrobial stewardship.	DIPC	Annually	Implementation of strategy difficult due to staffing shortages and poor engagement from clinicians. To be presented at ICAS
1	Provide policy, training and education for new and emerging threats	Head of Infection Control/ Deputy DIPC	As required	Dealt with the threat of measles to prevent a potential outbreak as per PHE guidance ICAS
1	Maintain the HCAI Data Capture System data base for the Trust ensuring timely updated and enhanced fields are all entered. Antimicrobial Resistance data not uploaded by Laboratory for April 2018 to March 2019	Head of Infection Control/ Deputy DIPC and PA to Head of IPC DVH Laboratory Lead	Per case Quarterly	Monthly lock down of HCAI data by IPCT on behalf of Chief Executive DIPC after discussion with PHE
1	Complete infection prevention and control annual report	Head of Infection Control/ Deputy DIPC	Annually	ICAS
1	Introduce new Surewash ELITE machines as part of hand hygiene awareness and training throughout the trust	Head of Infection Control/ Deputy DIPC	1st quarter	Incomplete
1	Review of hand hygiene products in trust	Head of IPC and Procurement	1st quarter	Ecolab product in situ
1	Undertake Surveillance on all: Gram negative Blood Cultures with E.coli, Pseudomonas and Klebsiella. (if Catheter / invasive procedure related then PIR), liaising with CCG and community Infection control leads with the aim of reducing community acquired bacteraemia by 50% by 2021 MSSA blood cultures (if SSI or CVC related then PIR)	IPCT with Directorate Leads, Community infection control leads and CCG	As required	Completed RCA's Directorate action plans at ICAS. Presentation of issues by CCG / Community infection control at Healthcare associated infection assurance panel, fed back to ICAS
1	Review the effectiveness of antimicrobial stewardship specifically	DIPC, Lead antimicrobial	As required	Unable to provide assurance

	72 hour review, to reduce antimicrobial resistance through Antimicrobial stewardship ward rounds, point prevalence audits and audit report of antibiotic usage within each directorate.	pharmacist		due to staffing shortages and non-engagement from clinicians
2	Provide reports to Clinical Commissioning Group, Primary Care Organisation on IPC issues, as requested and other reports as required.	Head of Infection Control/ Deputy DIPC	weekly, monthly, quarterly	HCAI assurance group monthly through teleconferencing
2	Provide specialist Infection Prevention and Control advice Trust wide and attend appropriate Committees and Groups.	Head of Infection Control/ Deputy DIPC	As required	Not invited to the one decontamination meeting No water safety meeting held
2	Continue to develop Infection control link practitioners network	Infection Control Matron	Quarterly	Quarterly meetings/minutes
2	To maintain evidenced based policies that are based on national guidance ensuring these are updated and reviewed by the ICAS on a rolling basis.	Head of Infection Control/ Deputy DIPC	As required	Updated policies. Chairman's action taken as ICAS meetings cancelled. Documentation Governance lead yet to update these policies on Q pulse
2	Provide Infection Control input/liaison on all environmental, estates and housekeeping projects, policies and reviews of service as per HTM infection control in the built environment and Health and Social Care Act.	Head of Infection Control/ Deputy DIPC	As required	Hydrogen Peroxide Vapour cleaning was procured the previous year for the trust. However was not used last year by Rapid Response team due to cleaning staff shortages
3	Support the production of the annual Infection Prevention and Control Report 2018 -19	Head of Infection Control/ Deputy DIPC	Annually	ICAS and QIG
3	Infection Control Competencies: Hand Hygiene Commodes ANTT FFP3 mask fit testing MRSA Screening	Programmes clinical co directors	Annually	IC team have done annual competencies for strategic clinical ward staff who in turn train other staff

Key – Priority: 1 = Top 2 = Medium 3 = Lowest Priority

Infection Prevention and Control Team:
Dr Rella Workman, Director of Infection Prevention and Control (DIPC)
Kath Lawson-Hughes, Head of Infection Prevention and Control / Deputy DIPC, replaced by Kris Khambhiata in March 2018
Droomila (Sheila) Gogah, Matron of Infection Prevention and Control
Caroline Cook, Infection Control Nurse
Clair Taylor, Infection Control Nurse (left Trust April 2018)
Michelle Clarke, (joined the IC team October 2018)
Dr Vasile Laza-Stanca, Consultant Microbiologist
Dr Dimitrios Mermerelis, Consultant microbiologist
Richard Saloka – Antimicrobial pharmacist.

Appendix 3

Infection Prevention and Control Audit Programme
April 2018 – March 2019

The Code of practice (2008) requires that there is a programme of audit to ensure key policies are being implemented appropriately.

Audit	By Whom	Target Compliance	Frequency	Results To	Monitoring of Action Plans	Review	Complete/ Incomplete
Hand hygiene	Matrons, departmental leads	95%	Monthly or weekly of compliance less than minimum	Obtaining results from ward Matrons to populate monthly stats	Directorate governance groups. Infection Control and antimicrobial stewardship Committee (ICAS) Exception Reporting	Monthly	Peer reporting does not take place Raised at the overarching action plan
Environmental	IPCT in conjunction with ward / department managers	Minimum 90%	• All inpatient areas annually • Post HCAI / Outbreak/ Period of increased incidence • Mini audit as part of enhanced measures weekly for minimum 4 weeks post HCAI if considered avoidable	Senior Sisters Department Managers Line Manager Deputy Directors of Nursing Director of Nursing Clinical Director	Directorate Governance Group ICAS Exception Reporting	Quarterly	Incomplete
Compliance with Infection Control Policies (this includes isolation and Personal protective equipment)	IPCT	100%	Monthly: • Clostridium *difficile* • MRSA • Other alert organisms as required • All cases nursed in side rooms with potential infections	Senior Sisters Deputy Directors of Nursing	Directorate Governance Groups ICAS Exception Reporting	Quarterly	Complete
Saving Lives Compliance	IPCT	100%	Monthly: Peripheral lines Central lines Urinary catheters More frequently if scores <80%. Weekly: if ward in enhanced measures All patients with HCAI's weekly as part of patient review	Feedback In real time to clinical nurse in charge of shift. Written feedback weekly to: Senior Sisters Deputy Directors of Nursing Scores disseminated as part of monthly stats	Directorate Governance Groups ICAS Exception Reporting	Monthly Quarterly	Complete
Decontamination of	IPCT	100%	Quarterly	Department Managers	Decontamination	Quarterly	Complete

Medical Devices: Endoscopes				Decon Lead Director of Nursing	Committee ICAS		
Patient Reviews (alert organisms)	IPCT	100%	Weekly	Feedback in real time to clinical nurse in charge of shift. Written feedback weekly to Senior sisters Deputy Directors of Nursing Scores disseminated as part of monthly stats	Directorate Governance Groups	Monthly	Complete
MRSA Screening Compliance • Admission • Weekly	IPCT	100%	Monthly Weekly all inpatients with MRSA	Scores disseminated as part of monthly stats fed back to all directorates and senior managers. Nursing and midwifery strategy forum.	Directorate Governance Groups ICAS Exception Reporting	Monthly Quarterly	Incomplete
Commode Audits	IPCT	100%	Monthly (minimum) Weekly as part of enhanced measures	Senior Sisters Deputy Directors of Nursing. Part of monthly stats	Directorate Governance Groups ICAS Exception Reporting	Monthly Quarterly	Incomplete for March, otherwise complete
Audit Following HCAI: Clostridium *difficile*, MRSA Bacteraemia Acquisitions/ Periods of increased incidence /Outbreak	IPCT	100%	Response to incident / case (as required)	Senior Sisters Deputy Directors of Nursing Director of Nursing Director Clinical Ops	Directorate Governance Groups	Monthly as required	Complete
Clostridium *difficile* Patient Reviews	IPCT	100%	X2-3 Weekly each case dependent on severity of case	Senior Sister Deputy Directors of Nursing Director of Nursing	Directorate Governance	Monthly	Incomplete
Clostridium *difficile* Enhanced Measures	IPCT	95%	Weekly until audit result 95% or above –	Senior Sister Deputy Directors of Nursing GM CD Director of Nursing	Directorate Governance	Monthly	Complete
Other Infectious Organisms Patient reviews / enhanced measures	IPCT	100%	As required –	Senior Sister Deputy Directors of Nursing GM CD Director of Nursing	Directorate Governance meetings	Monthly	Complete

Admission infection status	IPCT	100%	Quarterly –	Senior Sister Deputy Directors of Nursing GM Governance Leads CD's; GM's, DCO's, MD, CQO Director of Nursing Part of monthly stats	Directorate Governance, ICAS Exception Reporting	Monthly Quarterly	Incomplete
EDN infection status	IPCT	100%	Quarterly	Ward and departmental managers. CD's; GM's, DCO's, MD,	Directorate Governance,	Quarterly	Incomplete
Compliance with local antibiotic prescribing and stewardship policies	IPCT Chief Antimicrobial Pharmacist Directorate antimicrobial champions	100% See antimicrobial audit plan	Part of patient reviews As per antimicrobial audit plan	Fed back in real time to clinical sister in charge of shift.	ICAS exception reporting.		Incomplete
Blood culture contaminants Emergency Department	IPCT	3-4%	Monthly	DDoN; Consultant Nurse ED	Directorate Governance. Exception reporting to ICAS	Quarterly	Complete
Management of sharps	IPCT	95%	Annually(by sharps box provider)		Directorate governance	May 2017	Incomplete
Static / dynamic Mattresses	IPCT / Tissue viability and equipment services	Mattresses are fit for purpose	Annually	Medical devices and equipment group	Medical devices and equipment group	Quarterly as required	Complete

Key:

IPCT	Infection Prevention & Control Team
SS	Senior Sisters
GM	General Managers
DDN	Deputy Directors of Nursing
DN	Director of Nursing
CD	Clinical Director
MD	Medical Director
NMSF	Nursing & Midwifery Strategy Forum
OH	Occupational Health
HK	Housekeeping
ICC	Infection Control Committee
NSPEG	Near Side Patient Equipment Group

Appendix 4

Infection Prevention and Control Policies

Policy Code	Policy Title	Dated	Review Date
POLCGR37-7	Isolation Policy for Patients	August 2017	August 2020
POLCGR38-6	Mattress Policy	February 2018	February 2020
POLCGR39-6	Arrangements for the Control of an Outbreak of Infection(including Norovirus) in Medway NHS Trust	December 2018	December 2021
POLCGR41-7	Policy for the Management of Suspected or Confirmed Tuberculosis (including MDR TB)	October 2017	October 2020
POLCGR42-9	Management of MRSA (Meticillin Resistant Staphylococcus aureus)	August 2015	August 2021
POLCGR43-6	Guidelines for the Management of *Clostridium difficile*	September 2015	September 2021
POLCGR44-6	Control of Infestations: Scabies, Head Lice, Pubic Lice, Body Lice	December 2015	December 2018
POLCGR45-6	Varicella Zoster Virus (VZV) Chickenpox and Shingles	June 2017	June 2020
POLCGR46-6	Viral Haemorrhagic Fever (VHF)/Ebola	February 2018	February 2020
POLCGR50-6	Guidelines for Laundry	October 2015	October 2018
POLCGR51-7	Hand Hygiene Guidelines	October 2015	October 2021
POLCGR52-6	Cleaning/Disinfection Policy	February 2018	February 2020
POLCGR53-6	Guidelines for the Management of Transmissible Spongiform Encephalopathy (TSE) including Creutzfeldt-Jakob Disease (CJD)	December 2015	December 2018
POLCGR54-6	Policy for the Prevention of Blood Borne Viruses	January 2018	January 2021
GUCPCM011-7	Preventing Infections Associated with Indwelling Urinary Catheters	August 2016	August 2019
POLCGR063-6	Meningococcal Meningitis/Septicaemia	May 2017	May 2020
POLCGR066-5	Control of Glycopeptide Resistant Enterococci (GRE)	August 2016	August 2019
POLCGR067-5	Policy for the Management of Risks Associated with Infection Prevention & Control	August 2015	August 2018
POLCGR068-4	Control of Multi-Resistant Gram Negative Bacilli	February 2018	February 2020
POLCGR069-5	Blood Culture Policy	September 2015	September 2021
POLCGR070-5	Principles of Asepsis and Aseptic Non Touch Technique (ANTT)	August 2016	August 2019

Policy Code	Policy Title	Dated	Review Date
POLCPCM026-6	Policy for the Prevention of Infections Associated with Vascular Access Devices	November 2016	November 2019
GUCPCM006-6	Guidelines for the Prevention of Infections Associated with the Insertion and Maintenance of Central Venous Devices	August 2016	August 2019
GUCPCM007-6	Guidelines for the Prevention of Infections Associated with Peripheral Venous Catheters	August 2016	August 2019
GUGR017-5	Guidelines for the Use of Faecal Management System	December 2018	December 2021
POLCGR091-3	Environmental Policies and Infection Prevention and Control	October 2017	October 2020
POLCPCM075-2	Adult Valved Peripherally Inserted Central Catheters (PICCs) Placement and Management Policy	August 2016	August 2019
POLCGR121-1	Management and Control of Carbapenemase Producing Enterobacteriaceae (new)	October 2018	October 2021
GUCGR018-2	Admission Guidelines for Suspected A/H1N1V Influenza (Swine Flu) – Adults	March 2018	March 2021
POLCGR125-2	Respiratory Viruses Policy	August 2016	August 2019
OTCOM009-5	Influenza Pandemic Plan	May 2018	May 2021

Appendix 5

Antimicrobial Pharmacist Programmes 2018– 2019

Audit	Objectives	By Whom	Target Compliance	Frequency	Results To	Monitoring of Action Plans
Prudent Antimicrobial Prescribing Audit across all 25-27 Adult Wards over 12 month period. Wards will be divided in to groups. Each group audited per quarter.	All prescription charts are reviewed; - to assess legibility - documentation of clinical indication for antimicrobial use - documentation of stop/ review date - allergy documentation - Compliance to Adult Antibiotic Guidelines - Clinical appropriateness	Antimicrobial Pharmacists/ ward pharmacists	100% 90% 80% 100% >85% 90%	Every 3 months	Antibiotic Stewardship Group and Directorates Governance Leads	DTC MMC CCG
IV to Oral Switch	To assess appropriate change from IV to oral therapy in accordance with Trust Antimicrobial Guidelines	Antimicrobial Pharmacists/ ward pharmacists	TBC Ideally >90%	As part of other audits	Antibiotic Stewardship Group and Directorates Governance Leads	DTC MMC CCG
72 Hour Review	To assess appropriate clinical review of AB therapy 72 hours after initiation	Antimicrobial Pharmacists	Variable (agreed with CCG) but our aim is >90%	Every months Data sent to CCG (till July) will discuss in July about future agreement	Antibiotic Stewardship Group and Directorates Governance Leads	DTC MMC CCG
Ad-hoc Audits to support RCA's and Outbreaks	As appropriate	Antimicrobial Pharmacists/ward pharmacists		Response to incident (Ongoing)	Relevant clinical leads concerned with areas of audit	As appropriate
Specific audits on treatment regimens	As required	Antimicrobial Pharmacists				As appropriate

Key:
DTC – Drugs and Therapeutics Committee
MMC – Medicines Management Committee

Antimicrobial education programme 2018- 2019

Education	To whom	By whom	Frequency	Comments
Pharmacy antimicrobial educational sessions	Pharmacists, Pharmacy technicians and dispensary assistants	Antimicrobial pharmacists	Every 4 months	In place
Antimicrobial teaching sessions	All Foundation doctors	Antimicrobial pharmacists	6 monthly	In place
Therapeutic drug monitoring and prudent antimicrobial prescribing Safe Prescribing – Antimicrobial Therapy	Nursing staff Induction for all new joined nurses to the Trust	Antimicrobial pharmacists	Every 2 months via nurse IV study days. Plus induction sessions for new nurses done by Junior Pharmacists. Mini tutorials to be arranged as and when required at ward level	In place Ongoing – as required

Reduction in antibiotic consumption as agreed by CCG

Key Task Area	Action Required	Action Taken
Submission of monthly consumption data to CCG Medicines Management leads to identify trends and set baseline	Manually calculate monthly DDD data for carbapenems and piperacillin-tazobactam Calculate monthly DDD data for carbapenems and piperacillin-tazobactam from 'Define' Submit data monthly to CCGs by end of the second week of each month Review data monthly in line with expenditure to match changes in consumption with usage and activity	Daily Antimicrobial ward round; All patients on restricted antibiotics identified by antimicrobial pharmacist and emailed to microbiologist on daily basis. Patients reviewed during ward round and antibiotics reviewed in line with Trust policy and sensitivities as appropriate.

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	**Self-assessment against the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance**	**Agenda Item**	**9.1(b)**
Lead Director	Dr David Sulch, Executive Medical Director		
Report Author	Gail Locock, Kent and Medway Director of Infection Prevention and Control		
Executive Summary	In April of this year, NHS Improvement, in collaboration with representatives from local Clinical Commissioning Groups undertook a focused inspection on infection prevention and control. The visit was carried out at the invitation of the Director of Nursing in response to recognised deteriorating performance in key infection prevention metrics. A two day visit was carried out and a high level report was issued at the beginning of May and the main findings indicated that there was a lack of engagement at executive and senior level for the Infection Prevention and Control agenda and no sense of urgency or pace to address the concerns. The infection control & antimicrobial stewardship group had met infrequently during 2018 resulting in a lack of assurance in this area. Poor adherence to infection prevention and control procedures was observed in areas that were visited and some wards were in poor condition. One of the key recommendations for the Trust was to undertake a self-assessment against the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. Only two criterion the Trust can currently demonstrate a high level of compliance (criterion 5 and criterion 10) which relates to prompt identification of patients at risk of an infection; and practices in Occupational Health to reduce the risk to staff in relation to infections. Criterion 2 is currently marked as TBC (to be confirmed) as due to unforeseen circumstances it has not been possible to complete this panel and gain the required assurance in time to include in this report. An accompanying improvement is included at appendix 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		☐

<table>
<tr><td rowspan="3"></td><td colspan="4">People: We will enable our people to give their best and achieve their best</td><td>☐</td></tr>
<tr><td colspan="4">Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership</td><td>☐</td></tr>
<tr><td colspan="4">High Quality Care: We will consistently provide high quality care</td><td>☒</td></tr>
<tr><td>Committees or Groups at which the paper has been submitted</td><td colspan="5">Infection Prevention and Control Committee</td></tr>
<tr><td>Resource Implications</td><td colspan="5">Nil identified</td></tr>
<tr><td>Legal Implications/Regulatory Requirements</td><td colspan="5">Compliance with the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance</td></tr>
<tr><td>Quality Impact Assessment</td><td colspan="5">Not required</td></tr>
<tr><td>Recommendation/ Actions required</td><td colspan="5">The Board is asked to: state decision required i.e. review, approve, note. [For example: The Board is asked to approve the Safeguarding Policy].</td></tr>
<tr><td></td><td>Approval
☐</td><td>Assurance
☒</td><td colspan="2">Discussion
☐</td><td>Noting
☐</td></tr>
<tr><td>Appendices</td><td colspan="5">Appendix 1: HSCA compliance criterion
Appendix 2: Trust wide improvement plan</td></tr>
</table>

1 Executive Overview

1.1 In April of this year, NHS Improvement, in collaboration with representatives from local Clinical Commissioning Groups undertook a focused inspection on infection prevention and control. The visit was carried out at the invitation of the Director of Nursing in response to recognised deteriorating performance in key infection prevention metrics.

1.2 A two day visit was carried out and a high level report was issued at the beginning of May and the main findings indicated that there was a lack of engagement at executive and senior level for the Infection Prevention and Control agenda and no sense of urgency or pace to address the concerns. The infection control & antimicrobial stewardship group had met infrequently during 2018 resulting in a lack of assurance in this area. Poor adherence to infection prevention and control procedures was observed in areas that were visited and some wards were in poor condition.

1.3 An improvement plan has been developed in response to the visit which has been agreed with the regulators.

1.4 One of the key recommendations for the Trust was to undertake a self-assessment against the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

2 Introduction

2.1 To support with the undertaking of this work, an experienced infection prevention practitioner has been seconded into the Trust for two days per week for four months. This commenced from the beginning of June.

2.2 The methodology used has been to engage with key identified executive and operational leads and support them to undertake a self-assessment against the required criteria. The leads have then been invited to present and discuss their self-assessment at a panel; panel members comprise the Medical Director / Director of Infection Prevention and Control, Director of Nursing and the Kent and Medway Director of Infection Prevention and Control. At the panels, the self-assessment scores have been scrutinised and have been either agreed and upheld or if there is insufficient evidence to support the score, the correct score has been agreed and improvement interventions agreed to be added to the Trust Wide improvement plan.

3 Findings from the Self-Assessment

3.1 The table below indicates the high level summary of the compliance with the ten criterion of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. There are a number of sub-criteria for each criterion which the Trust need to assess themselves against. These can be seen at appendix 1.

3.2 It can be seen that at present in only two criterion the Trust can demonstrate a high level of compliance (criterion 5 and criterion 10) which relates to practices in Occupational Health to reduce the risk to staff in relation to infections.

3.3 Criterion 2 is currently marked as TBC (to be confirmed) as due to unforeseen circumstances it has not been possible to complete this panel and gain the required assurance in time to include in this report.

This is to be completed on 27th August. The improvement plan for criterion 7 will also be developed at this meeting.

3.4 In order to improve compliance with the remaining criteria and Trust Wide Improvement Plan has been developed. This can be found at appendix 2.

Health and Social Care Act Compliance Assessment 2019		
Compliance requirements		**RAG (% compliance)**
Summary		
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	**75.9**
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	**TBC**
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	**61.1**
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	**78.6**
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	**100**
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	**77.8**
7	Provide or secure adequate isolation facilities.	**66.7**
8	Secure adequate access to laboratory support as appropriate.	**83.3**
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	**60.1**
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.	**96.1**

4 Collating of Evidence for each Criterion

4.1 A repository is being built to hold all evidence submitted in support of the compliance score. This repository will be passed to the Head of Infection Prevention and Control / Deputy Director of Infection Prevention and Control to continue the oversight and management.

5 Conclusion and Next Steps

5.1 Ongoing monitoring of the implementation of the Trust Wide Improvement Plan will be through the Infection Prevention and Control Committee with regular updates to the Board for assurance of progress.

Appendix 1

Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance

Criterion 1

Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.

Appropriate management and monitoring arrangements

1.1 These should ensure that:

- a registered provider has an agreement within the organisation that outlines its collective responsibility for keeping to a minimum the risks of infection and the general means by which it will prevent and control such risks;
- there is a clear governance structure and accountability that identifies a single lead for infection prevention (including cleanliness) accountable directly to the head of the registered provider;
- the mechanisms are in place by which the registered provider ensures that sufficient resources are available to secure the effective prevention of infection. These should include the implementation of an infection prevention and cleanliness programme, infection prevention and cleanliness infrastructure and the ability to monitor and report infections;
- all relevant staff, whose normal duties are directly or indirectly concerned with providing care, receive suitable and sufficient information on, and training and supervision in, the measures required to prevent the risks of infection;
- assurance is in place to ensure that key policies and practices are being implemented, updated and adhered to appropriately;
- a decontamination lead is designated, where appropriate;
- a water safety group and water safety plan are in place

Risk assessment

1.2 A registered provider should ensure that it has:

- made a suitable and sufficient assessment of the risks to the person receiving care with respect to prevention of infection;[1]
- identified the steps that need to be taken to reduce or control those risks;
- recorded its findings in relation to the first two points;
- implemented the steps identified; and
- methods and interventions in place to monitor the risks of infection to determine whether further steps are needed to reduce or control infection

Directors of Infection Prevention (In NHS Provider organisations)

1.3 The DIPC in NHS Provider organisations should:

- provide oversight and assurance on infection prevention (including cleanliness) to the Trust board or equivalent,. They should report directly to the board but are not required to be a board member;

- be responsible for leading the organisation's infection prevention team;
- oversee local prevention of infection policies and their implementation;
- be a full member of the infection prevention team and antimicrobial stewardship committee and regularly attend its infection prevention meetings;
- have the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing decisions;
- have the authority to set and challenge standards of cleanliness
- assess the impact of all existing and new policies on infections and make recommendations for change;
- be an integral member of the organisation's clinical governance and patient safety teams and structures, water safety group; and
- produce an annual report and release it publicly as outlined in *Winning ways: working together to reduce healthcare associated infection in England.* Suggestions as to what could be included in the report are provided in the template at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4064682

Infection Prevention Lead (for example adult social care, primary dental and medical care and independent sector ambulance providers)

1.4 Outside of NHS organisations, the responsibilities of the DIPC are discharged by the Infection Prevention (IP) Lead. This role will vary across adult social care, primary dental care, primary medical care and independent sector ambulance providers. The IP Lead should:

- be responsible for the organisation's infection prevention (including cleanliness) management and structure and the establishment of a water safety group;
- oversee local prevention of infection policies and their implementation;
- report directly to the registered provider;
- have the authority to challenge inappropriate practice, if appropriate, including antimicrobial prescribing practice;
- have the authority to set and challenge standards of cleanliness;
- assess the impact of all existing and new policies on infections and make recommendations for change;
- be an integral member of the organisation's governance, water safety group, and safety teams and structures where they exist; and
- produce an annual statement with regard to compliance with practice on infection prevention and cleanliness and make it available on request

Assurance framework

1.5 Activities to demonstrate that infection prevention and cleanliness are an integral part of quality assurance should include:

In NHS provider organisations

- regular presentations from the DIPC and/or the infection prevention team to the NHS board or registered provider. These should include a trend analysis for infections, antimicrobial resistance and antimicrobial prescribing and compliance with audit programmes;
- quarterly reporting to the NHS board or registered provider by clinical directors and matrons (including nurses who do not hold the specific title of 'matron' but who operate at a similar level of seniority and who have control over similar aspects of the patient or the patient's environment). What is reported on will vary according to the local arrangements.

For example it may include:

- monthly cleanliness scores (unless this is done via the estates and facilities team);
- annual Patient Led Assessments of the Care Environment (PLACE) scores plus monthly scores (where this is agreed practice); and
- contract performance measures where provision is outsourced, which will include cleanliness measures and issues of non-compliance and subsequent rectification performance;
- Information taken from the organisation's self-assessment using the NHS Premises Assurance Model (NHS PAM)
- Monthly review of antimicrobial prescribing decisions
- Observations taken from board level or other staff "walk rounds"
- Complaints relating to infection prevention (including cleanliness)

• A review of mandatory and voluntary surveillance data, including antimicrobial resistance (drug-bug combinations), outbreaks and serious incidents;
• evidence of appropriate action taken to deal with occurrences of infection including, where applicable, root cause analysis and/or post infection review; and
• an audit programme to ensure that policies have been implemented

1.6 In accordance with health and safety requirements, where suitable and sufficient assessment of risks requires action to be taken, evidence must be available on compliance with the regulations or, where appropriate, justification of a suitable better alternative. This applies to all healthcare and adult social care.

Infection prevention including cleanliness programme

1.7 The infection prevention including cleanliness programme should:

• set objectives that meet the needs of the organisation and ensure the safety of service users, health care workers and the public;
• identify priorities for action;
• provide evidence that relevant policies have been implemented; and
• report progress against the objectives of the programme in the DIPC's annual report or the Infection Prevention Lead's annual statement

Infection prevention and cleanliness infrastructure

1.8 An infection prevention infrastructure should encompass:

• in acute healthcare settings, for example, an infection prevention team consisting of an appropriate mix of both nursing and consultant medical expertise (with specialist training in infection prevention and cleanliness), other healthcare workers and appropriate administrative and analytical support, estates and facilities management and adequate information technology – the DIPC is a key member of the Infection prevention team;
• in acute settings, have a multidisciplinary antimicrobial stewardship committee to develop and implement the organisation's Antimicrobial stewardship programme drawing on Start Smart Then Focus;
• in other settings, there will be a lead who is responsible for infection prevention and cleanliness matters and has access to specialist infection control expertise;
• 24-hour access to a nominated qualified infection control doctor (ICD) or consultant in health protection/communicable disease control. The registered provider should know how to access this advice

Movement of service users

1.9 There should be evidence of joint working between staff involved in the provision of advice relating to the prevention of infection; those managing bed allocation; care staff and domestic staff in planning service user referrals, admissions, transfers, discharges and

movements between departments; and within and between health and adult social care facilities.

1.10 A registered provider must ensure that it provides suitable and sufficient information on a service user's infection status whenever it arranges for that person to be moved from the care of one organisation to another, of from a service user's home, so that any risks to the service user and others from infection may be minimised. If appropriate, providers of a service user's transport should be informed of the service user's infection status.

(Refer also to CQC guidance on compliance with Regulation 12 (2)(i) on Safe care and treatment – shared care)

Criterion 2

Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

(Refer also to section on Regulation 15 on Premises and equipment contained in the CQC Guidance for providers on meeting the regulations)

2.1 With a view to minimising the risk of infection, a registered provider should ensure that:

- it designates leads for environmental cleaning and decontamination of equipment used for diagnosis and treatment (a single individual may be designated for both areas);
- in healthcare, the designated lead for cleaning involves directors of nursing, matrons and the infection prevention team or persons of similar standing in all aspects of cleaning services, from contract negotiation and service planning to delivery at ward and clinical level. In other settings, the designated lead for cleaning will need to access appropriate advice on all aspects of cleaning services;
- in healthcare, matrons or persons of a similar standing have personal responsibility and accountability for maintaining a safe and clean care environment;
- the nurse or other person in charge of any patient or resident area has direct responsibility for ensuring that cleanliness standards are maintained throughout that shift;
- all parts of the premises from which it provides care are suitable for the purpose, kept clean and maintained in good physical repair and condition;
- the cleaning arrangements detail the standards of cleanliness required in each part of its premises and that a schedule of cleaning responsibility and frequency is available on request;
- there is adequate provision of suitable hand washing facilities and antimicrobial hand rubs where appropriate;
- there are effective arrangements for the appropriate cleaning of equipment that is used at the point of care, for example hoists, beds and commodes – these should be incorporated within appropriate cleaning, disinfection and decontamination policies; and
- the storage, supply and provision of linen and laundry are appropriate for the level and type of care

2.2 'The environment' means the totality of a service user's surroundings when in care premises or transported in a vehicle. This includes the fabric of the building, related

fixtures and fittings, and services such as air and water supplies. Where care is delivered in the service user's home, the suitability of the environment for that level of care should be considered.

Policies on the environment

Premises and facilities should be provided in accordance with best practice guidance and assured with NHS PAM or similar model. The development of local policies should take account of infection prevention and cleanliness advice given by relevant expert or advisory bodies or by the infection prevention team and this should include provision for liaison between the members of the service user's environment. Policies should address but not be restricted to:

- cleaning services;
- building and refurbishment, including air-handling systems;
- waste management;
- laundry arrangements for the correct classification and sorting of used and infected linen;
- planned preventative maintenance;
- pest control;
- management of drinkable and non-drinkable water supplies;
- minimising the risk of Legionella and other water supply and building related infections eg *Pseudomonas aeruginosa* and aspergillus by adhering to national guidance; and
- food services, including food hygiene and food brought into the care setting by service users, staff and visitors

(Refer also to Regulation 15 Premises and equipment contained in CQC Guidance for providers on meeting the regulations)

Cleaning services

2.4 The arrangements for cleaning should include:

- clear definition of specific roles and responsibilities for cleaning;
- clear, agreed and available cleaning routines;
- sufficient resources dedicated to keeping the environment clean and fit for purpose;
- consultation with ICTs or equivalent local expertise on cleaning protocols when internal or external contracts are being prepared; and
- details of how staff can request additional cleaning, both urgently and routinely

Decontamination

2.5 The decontamination lead should have responsibility for ensuring that policies exist and that they take account of best practice and national guidance. They should consider guidance under the following headings:

- Decontamination of the environment – including cleaning and disinfection of the fabric, fixtures and fittings of a building (walls, floors, ceilings and bathroom facilities) or vehicle;
- Decontamination of linen – including correct classification and sorting of used linen (e.g. soiled and fouled linen, infectious linen, heat labile linen) and disinfection of linen;
- Decontamination of equipment – including cleaning and disinfection of items that come into contact with the patient or service user, but are not invasive devices (eg beds, commodes, mattresses, hoists and slings, examination couches);

- Reusable medical devices should be reprocessed at one of the following three levels:
  - sterile (at point of use);
  - sterilised (i.e. having been through the sterilisation process);
  - clean (i.e. free of visible contamination)

2.6 The decontamination policy should demonstrate that:

- it complies with guidance establishing essential quality requirements and a plan is in place for progression to best practice;
- decontamination of reusable medical devices takes place in compliant facilities that are designed for the process of decontaminating medical devices through validated processing systems and controlled environmental conditions to ensure all potential environmental, cross-infection, handling and medical device usage risks are minimised;
- appropriate procedures are followed for the acquisition, maintenance and validation of decontamination equipment;
- staff are trained in cleaning and decontamination processes and hold appropriate competences for their role; and
- a record-keeping regime is in place to ensure that decontamination processes are fit for purpose and use the required quality systems

Note: Undertaking the actions in NHS PAM's Self Assessment Question S14 "safe and compliant with well managed systems in relation to: Decontamination Processes" will assist organisations in ensuring they have the correct assurance in place with regards to decontamination.

(Refer also to Regulation 15 Premises and equipment contained in CQC Guidance for providers on meeting the regulations)

Criterion 3

Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

3.1 Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic. These systems draw on national and local guidelines, monitoring and audit tools such as NICE guidelines, guidance on patient group directions, the TARGET toolkit in primary care and Start Smart then Focus in secondary care (SSTF).

3.2 Where appropriate, providers should have in place an antibiotic stewardship committee responsible for developing, implementing and monitoring the organisation's stewardship programme. This must be supported by strong leadership across clinical specialties but it could be part of an existing committee such as a drug and therapeutic committee rather than a new body. Membership of this committee will vary dependent on the setting but should include representation from microbiology/infectious diseases, pharmacy and the organisations' director of infection prevention and control or

equivalent. The committee should report antimicrobial stewardship activities to the Trust board via the organisation's Director of Infection Prevention and Control or equivalent.

3.3 Providers should develop a local antimicrobial stewardship policy drawing on national guidance (including the British National Formulary, Public Health England the National Institute of Care Excellence) that takes account of local antimicrobial resistance patterns. Policy should cover diagnosis, treatment and prophylaxis of common infections and prescribers should be encouraged to record allergy status, reason for antimicrobial prescription, dose and duration of treatment. Adherence to prescribing guidance and compliance with in hospital post-prescribing review at 48-72 hours should be monitored and audited on a regular basis, with data fed back to prescribers and incorporated into patient safety reporting systems to Boards and stewardship.

3.4 Providers should have access to timely microbiological diagnosis, susceptibility testing and reporting of results, preferably within 48 hours. Prescribers should have access at all times to suitably qualified individuals who can advise on appropriate choice of antimicrobial therapy.

3.5 In secondary care providers should report local antimicrobial susceptibility data (drug-bug combinations) and information on antimicrobial consumption to the national surveillance body. Surveillance information should be used by the stewardship committee or equivalent to monitor local resistance patterns and guide local prescribing policy. This information should be communicated back to prescribers in primary and secondary care to improve prescribing quality.

3.6 Providers should ensure that all prescribers receive induction and training in prudent antimicrobial use and are familiar with the antimicrobial resistance and stewardship competencies.[1]

Criterion 4

Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.

Information for service users and visitors

4.1 Information should be developed with local service user representative organisations, which could include Local Healthwatch and Patient Advice and Liaison Services (PALS).

4.2 Areas relevant to the provision of information include:

- general principles on the prevention of infection and key aspects of the registered provider's policy on infection prevention, which takes into account the communication needs of the service user;
- the roles and responsibilities of particular individuals such as carers, relatives and advocates in the prevention of infection, to support them when visiting service users;
- the importance of appropriate use of antimicrobials;
- supporting service users' awareness and involvement in the safe provision of care;
- the importance of compliance by visitors with hand hygiene;

- the importance of compliance with the registered provider's policy on visiting;
- reporting concerns relating to hygiene and cleanliness including hand hygiene;
- explanations of incident/outbreak management and action taken to prevent recurrence

4.3 Materials from national or local antimicrobial awareness campaigns could be used to develop information on appropriate antimicrobial use. Examples are included in the bibliography.

(Refer also to Regulation 9, Person Centred Care contained in CQC Guidance for providers on meeting the regulations)

Information to those providing further support or nursing/medical care

4.4 A registered provider should ensure that:
- accurate information is communicated in an appropriate and timely manner;
- this information facilitates the provision of optimum care, minimising the risk of inappropriate management and further transmission of infection; and
- where possible, information accompanies the service user

4.5 Provision of relevant information across organisation boundaries is covered by the regulation requirement 9 "Person Centred care". Due attention should be paid to service user confidentiality as outlined in national guidance and training material.[1]

Criterion 5

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

5.1 Registered providers, excluding personal care providers, should ensure that advice is received from suitably informed practitioners and that, if advised, registered providers should inform their local health protection team of any outbreaks or serious incidents relating to infection in a timely manner.

5.2 Arrangements should demonstrate that responsibility for infection prevention is effectively devolved to all groups in the organisation involved in delivering care.

5.3 In an adult social care service, General Practitioners will provide the necessary initial advice when a service user develops infection. The General Practitioner may wish to draw on local expertise in infection prevention, nd health protection.

Criterion 6

Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.

6.1 A registered provider should, so far as is reasonably practicable, ensure that its staff, contractors and others involved in the provision of care co-operate with it, and with each

other, so far as is necessary to enable the registered provider to meet its obligations under the Code.

6.2 Infection prevention would need to be included in the job descriptions and be included in the induction programme and staff updates of all employees (including volunteers). Contractors working in service user areas would need to be aware of any issues with regard to infection prevention and obtain 'permission to work'.

6.3 Where staff undertake procedures, which require skills such as aseptic technique, staff must be trained and demonstrate proficiency before being allowed to undertake these procedures independently.

Criterion 7

Provide or secure adequate isolation facilities.

7.1 A healthcare registered provider delivering in-patient care should ensure that it is able to provide, or secure the provision of, adequate isolation precautions and facilities, as appropriate, sufficient to prevent or minimise the spread of infection. This may include facilities in a day care setting.

7.2 Policies should be in place for the allocation of patients to isolation facilities, based on a local risk assessment. The assessment could include consideration of the need for special ventilated isolation facilities. Sufficient staff should be available to care for the service users safely.

7.3 Registered providers of accommodation should ensure that they are able to provide or secure facilities to physically separate the service user from other residents in an appropriate manner in order to minimise the spread of infection.

7.4 Care homes are not expected to have dedicated isolation facilities for service users but are expected to implement isolation precautions when a service user is suspected or known to have a transmissible infection

Criterion 8

Secure adequate access to laboratory support as appropriate

8.1 A registered provider should ensure that laboratories that are used to provide a microbiology service, in connection with arrangements for infection prevention (including cleanliness), have in place appropriate protocols. These laboratories should operate according to the standards required by the relevant national accreditation bodies. In adult social care, the service user's General Practitioner will arrange such testing and take responsibility for submitting specimens to the laboratory when necessary for the treatment and management of disease.

8.2 Protocols should include:

- a microbiology laboratory policy for investigation and surveillance of antimicrobial resistance and healthcare associated infections; and
- standard laboratory operating procedures for the examination of specimens
- timely reporting

Criterion 9

Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.

9.1 A registered provider should, in relation to preventing, reducing and controlling the risks of infections, have in place the appropriate policies concerning the matters mentioned in a) to y) below. All policies should be clearly marked with a review date and the review date adhered to.

9.2 A guide is given in Table 3 as to which policies may be appropriate to the regulated activities. A decision should be made locally following a risk assessment.

9.3 Any registered provider should have policies in place relevant to the regulated activity it provides. Each policy should indicate ownership (i.e. who commissioned and retains managerial responsibility), authorship and by whom the policy will be applied. Implementation of policies should be monitored and there should be evidence of a rolling programme of audit and a date for revision stated.

a. Standard infection prevention and control precautions
Preventing infections reduces the overall need to use antimicrobials and helps to reduce selection pressure for the development of antimicrobial resistance.

- Policy should be based on evidence-based guidelines, including those on hand hygiene at the point of care and the use of personal protective equipment;
- Policy should be easily accessible and be understood by all groups of staff, service users and the public.
- Compliance with the policy should be audited
- Provisions on regular refresher training, support for patients to clean their hands, and products for staff with occupational dermatitis are among the issues that should be covered in the hand hygiene policy

b. Aseptic technique
Where aseptic procedures are performed:

- clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis;
- education, training and assessment in the aseptic technique should be provided to all persons undertaking such procedures;
- the technique should be standardised across the organisation; and
- an audit should be undertaken to monitor compliance with the technique

c. Outbreaks of communicable infection

- The degree of detail in the policy should reflect local circumstances. A low risk, single-specialty facility or provider of primary care will not require the same arrangements as those providing the full range of medical and surgical care;
- Professional advice on infection prevention for regulated activities may be drawn from a number of expert sources. Table 2 outlines the most likely arrangements for the different regulated activities;
- Policies for outbreaks of communicable infection should include initial assessment, communication, management and organisation, plus investigation and control, including vaccination where appropriate;

- The contact details of those likely to be involved in outbreak management should be reviewed at least annually;
- All registered providers should report significant outbreaks of infection to their local health protection teams at an early stage, including outbreaks in service
- users who are detained under the Mental Health Act 1983, if advised to do so by suitably informed practitioners

d. Isolation of service users with an infection (see also criterion 7)

- The isolation policy should be evidence based and reflect local risk assessment;[1]
- Indications for isolation should be included in the policy, as should procedures for the infection prevention and control management of service users in isolation;
- Information on isolation should be easily accessible and understood by all groups of staff, service users and the public

e. Safe handling and disposal of sharps

Relevant considerations include:

- risk management and training in the management of mucous membrane exposure and sharps injuries and incidents;
- provision of medical devices that incorporate sharps protection mechanisms where there are clear indications that they will provide safe systems of working for staff;[2]
- a policy that is easily accessible and understood by all groups of staff;
- safe use, secure storage and disposal of sharps; and
- auditing of policy compliance

f. Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries

Measures to avoid exposure to BBV's (hepatitis B and C and HIV) should include:

- immunisation against hepatitis B, as set out in *Immunisation against infectious disease*, better known as 'The Green Book' (published by Public Health England);
- the wearing of gloves and other protective clothing;
- the safe handling and disposal of sharps, including the provision of medical devices that incorporate sharps protection where there are clear indications that they will provide safe systems of working for staff; and
- measures to reduce risks during surgical procedures

g. Management of occupational exposure to BBVs and post-exposure prophylaxis

Management should ensure:

- that any member of staff who has a significant occupational exposure to blood or body fluids is aware of the immediate action required and is referred appropriately for further management and follow-up;
- provision of clear information for staff about reporting potential occupational exposure – in particular the need for prompt action following a known or potential exposure to HIV or hepatitis B; and
- arrangements for post-exposure prophylaxis for hepatitis B and HIV

(Refer also to Regulation 19, Requirements relating to workers contained in CQC Guidance for providers on meeting the regulations)

h. Closure of rooms, wards, departments and premises to new admissions

- A system should be in place for the provision of advice from the local health protection team/DIPC/ICT for the registered provider;
- There should be clear criteria in relation to closures and re-opening;
- The policy should address the need for environmental decontamination prior to re-opening

i. *Disinfection*

The use of disinfectants is a local decision, and should be based on current accepted good practise.

j. Decontamination of reusable medical devices

- Decontamination involves a combination of processes and includes cleaning, disinfection and sterilisation, according to the intended use of the device. This aims to render a reusable item safe for further use on service users and for handling by staff;
- Effective decontamination of reusable medical devices is an essential part of infection risk control and is of special importance when the device comes into contact with service users or their body fluids. There should be a system to protect service users and staff that minimises the risk of transmission of infection from medical devices. This requires that the device or instrument set can be clearly linked in a traceable fashion to the individual process cycle that was used to decontaminate it, such that the success of that cycle in rendering the device safe for reuse can be verified;
- Reusable medical devices should be decontaminated in accordance with manufacturers' instructions and current national or local best practice guidance. This must ensure that the device complies with the 'Essential Requirements' provided in the Medical Devices Regulations 2002 where applicable. This requires that the device should be clean and, where appropriate, sterilised at the end of the decontamination process and maintained in a clinically satisfactory condition up to the point of use;
- Management systems should ensure adequate supplies of reusable medical devices, particularly where specific devices are essential to the continuity of care;
- Reusable medical devices employed in invasive procedures, for example, endoscopes and surgical instruments have to be either individually identifiable or identified to a set of which they are a consistent member, throughout the use and decontamination cycle in order to ensure subsequent traceability;
- Systems should also be implemented to enable the identification of service users on whom the medical devices have been used;
- Decontamination of single-patient use devices, i.e. that equipment designated for use only by one patient, should be subject to local policy and manufacturer's instructions

(Refer also to Regulations 15, Premises and equipment and Regulation 12 on safe care and treatment contained in CQC Guidance for providers on meeting the regulations)

k. Single-use medical devices

Policies should be in place for handling devices for single use only. Single-use medical devices should be used once and disposed of safely.

l. Antimicrobial prescribing

- Prescribing should generally be harmonised with that in the *British National Formulary* and draw on national guidance, including guidance for specific

infections such as gonorrhoea. However, local guidelines may be required in certain circumstances;
- Procedures should be in place to ensure prudent prescribing and antimicrobial stewardship. There should be an ongoing programme of audit, revision and update with feedback to management, prescribers and administrators. In healthcare settings this is usually monitored by the antimicrobial management team or local prescribing advisors. Antimicrobial pharmacists and CCG prescribing advisors can support these activities

m. Reporting of infection to Public Health England or local authority and mandatory reporting of healthcare associated infection to Public Health England

- This includes a requirement for NHS Trust Chief Executives to report all cases of MRSA, MSSA and *E. coli* bacteraemias and *Clostridium difficile* infection in patients aged two years or older that are identified in their institution. The independent sector hospitals are also expected to report cases in a similar manner. The requirements of this system will vary from time to time as directed by the Department of Health.

Health Protection (Notification) Regulations 2010

- These require attending doctors (registered medical practitioners) to notify the Proper Officer of the local authority of cases of specified infectious disease or of other infectious disease or contamination, which present, or could present, significant harm to human health, to allow prompt investigation and response. The regulations also require diagnostic laboratories testing human samples to notify Public Health England of the identification of specified causative agents of infectious disease.

n. Control of outbreaks and infections associated with specific alert organisms

This should take account of local epidemiology and risk assessment. These infections must include, as a minimum, MRSA, MSSA and *E.coli* bloodstream infections, respiratory infection, viral haemorrhagic fever, diarrhoeal outbreaks, *Clostridium difficile* infection and transmissible spongiform encephalopathies.

MRSA

The policy should make provision for:

- screening of NHS patients on emergency or elective admission to relevant high risk specialties. The arrangements for undertaking screening will be subject to local agreement;
- suppression regimens for colonised patients when appropriate;
- isolation of infected or colonised patients;
- transfer of infected or colonised patients within organisations or to other care facilities;
- antibiotic prophylaxis for surgery; and
- undertaking a post infection review (PIR) on patients with a MRSA bacteraemia

Clostridium difficile

The policy should make provision for:

- surveillance of *Clostridium difficile* infection;
- diagnostic criteria;
- isolation of infected service users and cohort nursing;

- environmental decontamination;
- antibiotic prescribing policies; and
- contraindication of anti-motility agents

Glycopeptide resistant enterococci (GRE)
The policy should make provision for:
- Identification of high-risk groups;
- Isolation and prevention of cross-infection; and
- Prophylaxis for surgical and invasive procedures

Carbapenem resistant organisms (CROs), Acinetobacter, extended spectrum beta-lactamase (ESBLs) and other antibiotic resistant bacteria
The policy should make provision for:
- surveillance and/or screening of patients at high risk of drug-resistant infection;
- procedures for managing infected patients to prevent spread of infection

Viral haemorrhagic fevers (VHF)

The policy should refer to the latest guidance from the Advisory Committee for Dangerous Pathogens (ACDP) and make provision for:
- appropriate staff to be trained in how to isolate and risk assess patients at risk of VHF;
- appropriate staff to be aware of the special measures to be taken for nursing VHF patients, and to be properly trained in the application of full isolation procedures and use and safe removal of personal protective equipment (PPE);
- patient risk assessment and categorisation;
- confirmed cases to be handled under full isolation measures in a high- security infectious diseases unit or equivalent;
- handling of patient specimens at the appropriate containment level;
- follow-up of all staff in contact with the patient at every stage of care; and
- special measures for the handling, and on-site treatment, of all waste and laundry;
- special measures for transporting patients with VHF

Creutzfeld-Jakob diease (CJD), variant CJD (vCJD) and other human prion diseases

The policy should make provision for the management of patients with, or at increased risk of, CJD/vCJD and other human prion diseases

Relevant policies for other specific alert organisms

The specific alert organisms that follow may be relevant to any unit admitting, or treating as outpatients.

Control of tuberculosis, including multi-drug resistant tuberculosis:
Isolation of infectious patients;
- Transfer of infectious patients within care organisations or to other care facilities;
- contact tracing; and
- treatment compliance

Respiratory viruses:
- alert system for suspected cases;
- isolation criteria; and

- infection prevention and control measures
- for influenza measures to avoid exposure should include immunisation, as set out in Immunisation against infectious disease, better known as 'The Green Book' (published by Public Health England)

Diarrhoeal infections:
- isolation criteria;
- infection prevention and control measures; and
- cleaning and disinfection policy

o. CJD/vCJD

Advice on the handling of instruments and devices in procedures on patients with known or suspected CJD/vCJD, or at increased risk of CJD/vCJD, including disposal/quarantine procedures, is provided in guidance from the Advisory Committee on Dangerous Pathogens (ACDP) TSE working group.

(Refer also to Regulation 15, Premises and equipment and Regulation 12 on safe care and treatment contained in CQC Guidance for providers on meeting the regulations)

p. Safe handling and disposal of waste

The risks from waste disposal should be properly controlled. In practice, in relation to waste, this involves:
- assessing risk;
- developing appropriate policies;
- putting arrangements in place to manage risks;
- monitoring, auditing and reviewing the way in which arrangements work; and
- being aware of statutory requirements and; legislative change and managing compliance

Precautions in connection with handling waste should include:
- training and information (including definition and classification of waste);
- personal hygiene;
- segregation and storage of waste;
- the use of appropriate personal protective equipment;
- immunisation;
- appropriate procedures for handling such waste;
- appropriate packaging and labelling;
- suitable transport on-site and off-site;
- clear procedures for dealing with accidents, incidents and spillages; and
- appropriate treatment and disposal of such waste

Systems should be in place to ensure that the risks to service users from exposure to infections caused by waste present in the environment are properly managed, and that duties under environmental law are discharged. The most important of these are:

- duty of care in the management of waste;
- duty to control polluting emissions to the air;
- duty to control discharges to sewers;
- obligations of waste managers;
- collection of data and obligations to complete and retain documentation including record keeping; and
- requirement to provide contingency plans and have emergency procedures in place

(Refer also to Regulation 15, Premises and equipment contained in CQC Guidance for providers on meeting the regulations)

q. Packaging, handling and delivery or laboratory specimens

Biological samples, cultures and other materials should be transported in a manner that ensures that they do not leak in transit and are compliant with current legislation. Staff who handle samples must be aware of the need to correctly identify, label and store samples prior to forwarding to laboratories. In addition, they must be aware of the procedures needed when the container or packaging becomes soiled with body fluids.

r. Care of deceased persons

Appropriate procedures should include:

- risk assessment of potential hazards;
- the provision of appropriate facilities and accommodation;
- safe working practices;
- arrangements for visitors;
- information, instruction, training and supervision; and
- health surveillance and immunisation (where appropriate)

s. Use and care of invasive devices

Policy should be based on evidence-based guidelines and should be easily accessible by all relevant care workers. Compliance with policy should be audited. Information on policy should be included in infection prevention and control training programmes for all relevant staff groups.

(Refer also to Regulation 15, Premises and equipment and Regulation 12 on safe care and treatment contained in CQC Guidance for providers on meeting the regulations*)*

t. Purchase, cleaning, decontamination, maintenance and disposal of equipment

Policies for the purchase, cleaning, decontamination, maintenance and disposal of all equipment should take into account infection prevention and cleanliness advice that is given by relevant experts or advisory bodies or by the Infection prevention team.

u. Surveillance and data collection

For all appropriate healthcare settings, there should be evidence of local surveillance and use of comparative data, where available, to monitor infection rates, antimicrobial resistance and antimicrobial consumption and to assess the risks of infection. This evidence should include data on alert organisms, and other infections where appropriate, alert conditions and wound
infection per clinical unit or specialty. When appropriate or where they exist, recognised definitions should be used.

Electronic reporting to Public Health England of clinical laboratory isolates is recommended where the appropriate information technology is in place.

There should also be timely feedback to clinical units, with a record of achievements and actions taken as a result of surveillance. Post-discharge surveillance of surgical site infection should be considered and, where practicable, should be implemented.

v. Dissemination of information

There should be a local protocol on information sharing when referring, admitting, transferring, discharging and moving service users within and between health and adult social care facilities. This is to facilitate surveillance and optimal management of infections in the wider community. Guidance on data protection legislation also needs to be observed.

(Refer also to Regulation 9, Person-centred care contained in CQC Guidance for providers on meeting the regulations)

w. Isolation facilities

There should be a policy concerning the appropriate provision and maintenance of isolation facilities. This should address:

- potential sources of infection;
- The types of isolation facility needed for different infections;
- The use of protective measures and equipment; and
- The management of outbreaks

x. Uniform and dress code

Uniform and workwear policies ensure that clothing worn by staff when carrying out their duties is clean and fit for purpose. Particular consideration should be given to items of attire that may inadvertently come into contact with the person being cared for. Uniform and dress code policies should specifically support good hand hygiene.

y. Immunisation of service users

Registered providers should ensure that policies and procedures are in place with regard to the immunisation status of service users such that:

- there is a record of all immunisations given;
- the immunisation status and eligibility for immunisation of service users are regularly reviewed in line with *Immunisation against infectious disease* ('The Green Book') and other guidance from Public Health England; and
- following a review of the record of immunisations, all service users are offered further immunisation as needed, according to the national schedule.

Criterion 10

Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

10.1 Registered providers should note that this criterion also covers staff education and training and ensure that policies and procedures are in place in relation to the prevention of infection such that:

- all staff can access occupational health services or access appropriate occupational health advice;
- occupational health policies on the prevention and management of communicable infections in care workers are in place;

- decisions on offering immunisation should be made on the basis of a local risk assessment as described in *Immunisation against infectious disease* ('The Green Book'). Employers should make vaccines available free of charge to employees if a risk assessment indicates that it is needed (COSHH Regulations 2002);
- there is a record of relevant immunisations;
- the principles and practice of prevention of infection (including cleanliness) are included in induction and training programmes for new staff. The principles include: ensuring that policies are up to date; feedback from audit results; examples of good practice; and action needed to correct poor practice;
- there is appropriate ongoing education for existing staff (including support staff, volunteers, agency/locum staff and staff employed by contractors), which should incorporate the principles and practice of prevention and control of infection. Clinical staff should have an ongoing understanding of the risk from existing, new and emerging infectious diseases and take this into account when assessing patients;
- there is a record of training and updates for all staff; and
- the responsibilities of each member of staff for the prevention of infection are reflected in their job description and in any personal development plan or appraisal

Occupational health services

10.2 Occupational health services for staff should include:

- risk-based screening for communicable diseases and assessment of immunity to infection after a conditional offer of employment and ongoing health surveillance;
- offer of relevant immunisations; and
- having arrangements in place for regularly reviewing the immunisation status of care workers and providing vaccinations to staff as necessary in line with *Immunisation against infectious disease* ('The Green Book') and other guidance from Public Health England

10.3 Occupational health services in respect of BBVs should include:

- having arrangements for identifying and managing healthcare staff infected with hepatitis B or C or HIV and advising about fitness for work and monitoring as necessary, in line with Department of Health guidance;
- liaising with the *UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses* when advice is needed on procedures that may be carried out by BBV-infected care workers, or when advice on patient tracing, notification and offer of BBV testing may be needed;
- a risk assessment and appropriate referral after accidental occupational exposure to blood and body fluids; and
- management of occupational exposure to infection, which may include provision for emergency and out-of-hours treatment, possibly in conjunction with accident and emergency services and on-call infection prevention and control specialists.

This should include a specific risk assessment following an exposure prone procedure.

10.4 Occupational health services in respect of influenza should include:

- arrangements for provision of influenza vaccination for healthcare workers where appropriate

(Refer also to Regulation 19, Fit and proper persons employed contained in CQC Guidance for providers on meeting the regulations)

Appendix 2

Health and Social Care Act 2008: Code of practice for the prevention and control of infections
Trust Wide Improvement Plan

Below is the improvement plan which has been developed by all Leads for each of the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance criterion. The plan covers the improvement actions required to improve the compliance of those sub-criteria that were scored either as 1 (non-compliant and no evidence available) or 2 (partial compliance and some evidence available) following the self-assessment exercise.

Criterion 1: Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.								
Criterion	**Compliance requirements**	**Current Arrangements / Practices**	**Improvement Plan**	**Owner**	**Evidence of compliance**	**Progress**	**Review Date**	**RAG**
1.1	The mechanisms are in place by which the registered provider ensures that sufficient resources are available to secure the effective prevention of infection. These should include the implementation of an infection prevention cleanliness programme, infection and cleanliness infrastructure and the ability to monitor and report infections.	Resources are available but the results derived from that resource is suboptimal. The Trust likely needs to recruit two microbiologists (including one to replace the recently retired former DIPC).	1. Recruit to the vacant consultant microbiologist post 2. Business case to be developed and submitted for the 4th consultant microbiologist post	VL-S / DS	Appointed consultant microbiologists	Locum consultant recruited to commence September 2019.	Dec 2019	In progress
	Assurance is in place to ensure that key policies and practices are being implemented, updated and adhered to appropriately	Of all policies listed as IPCC, many have expired and a further 8 are due to expire in August. These need a significant amount of reviewing even if the content does not need a major change. All these policies are (or are virtually) three years old. In addition, some policies required under the terms of the HSCA are not in existence. The evidence we have is that several of these policies are not being adhered to, hence our poor IPCC performance	1. Link this improvement action to improvement actions for criterion 9	KK / VL-S / DS	As in criterion 9 below	All policies have been collated and those identified for review and those identified to be written and those due for review in the very near future listed and will form part of the annual work plan for the infection prevention and control team.	Mar 2020	In progress
1.2	Made a suitable and sufficient assessment of the risks to the person receiving care with respect to prevention of infection	Risk assessments have been undertaken, although these are being reviewed and added to as further episodes of HAI are considered in the PIR process. Compliance with current processes unknown	1. Audit the use of risk assessment tools used in ED 2. Audit the use hand over document	KK	Completed audits		Mar 2020	Not yet commenced
	Identified the steps that need to be taken to reduce or control those risks	Action plan is largely developed for the IPC overview: specific MRSA and CDT actions plans are also available / being refined and completed	1. IPC overview plan to be completely implemented 2. MRSA and CDT action plans to be launched and implemented 3. HSCA improvement plan to be launched and implemented	DS / KK / VL-S			Mar 2020	In progress

	Implemented the steps identified	Several of these steps have not yet been implemented as indicated by our high rates of HAI / topical MRSA acquisition and poor results for hand hygiene audits and antimicrobial policy compliance.	1. IPC overview plan to be completely implemented 2. MRSA and CDT action plans to be launched and implemented 3. HSCA improvement plan to be launched and implemented	DS / KK / VL-S			Mar 2020	In progress
	Methods and interventions in place to monitor the risks of infection to determine whether further steps are needed to reduce or control infection	Ongoing monitoring of key performance metrics (cases of HAI, audits on hand hygiene, PPE and environment, antimicrobial stewardship) will indicate whether the action plan has been successful.	1. Continue with the auditing cycle that has been implemented 2. Review and present audit findings 3. Implement learning identified from audits	DS / KK / VL-S	IPCT have commenced audit cycle of: • Hand hygiene compliance • Isolation precautions • Cleaning/decontamination of commodes • Compliance with wearing PPE		Mar 2020	In progress
1.3	Oversee local prevention of infection policies and their implementation	Major review of IPCC policies needed as over half of these have or will shortly expire.	2. Link this improvement action to improvement actions for criterion 9	KK / Vl-s / DS	As in criterion 9 below	All policies have been collated and those identified for review and those identified to be written and those due for review in the very near future listed and will form part of the annual work plan for the infection prevention and control team.	Mar 2020	In progress
1.5	Regular presentations from the DIPC and/or the infection prevention team to the NHS board or registered provider. These should include a trend analysis for infections, antimicrobial resistance and antimicrobial prescribing and compliance with audit programmes	This has not been the case over the last 12 months	1. DIPC will report on key IPCC issues on a x3/year basis to the Board. 2. IPCC will be reviewed at Execs on a monthly basis.	DS	Evidence of reporting as set out in improvement plan		Mar 2020	In progress
	Evidence of appropriate action taken to deal with occurrences of infection including, where applicable, root cause analysis and/or post infection review	Improved function of / attendance at PIR's.	1. All cases of MRSA bacteremia to be presented to Clinical Council for discussion. 2. Themes from and selected cases of CDT also to be presented to Clinical Council. 3. Challenge expected at this forum (and at Execs) in respect of actions	DS	Evidence of themes and learning present at Execs and Clinical Council	1. MRSA themes and learning have been presented at clinical council	Mar 2020	In progress

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			being taken.					
	An audit programme to ensure that policies have been implemented	In effect in some areas (hand hygiene, environmental) but other areas (antimicrobial prescribing) require more focused work.	1. Continue with the auditing cycle that has been implemented 2. Review and present audit findings 3. Implement learning identified from audits	DS / KK / VL-S	IPCT have commenced audit cycle of: • Hand hygiene compliance • Isolation precautions • Cleaning/decontamination of commodes • Compliance with wearing PPE		Mar 2020	In progress
1.7	Set objectives that meet the needs of the organisation and ensure the safety of service users, health care workers and the public	Expectations are understood but the wide communication and enforcement of these is not sufficiently robust at present.	1. Annual infection prevention and control plan to be developed, shared, launched and implemented	DS / KK / VL-S	This will link with actions in criterion 4 below		Mar 2020	In progress
1.8	In acute settings, have a multidisciplinary antimicrobial stewardship committee to develop and implement the organisation's Antimicrobial stewardship programme drawing on Start Smart Then Focus	This committee is being revived as a separate subcommittee of IPCC	1. Re-instate the antimicrobial stewardship group 2. ASG to oversee required improvement actions and develop work plan 3. ASG to report to IPCC	DS / KK / VL-S	This will link to criterion 3 below		Mar 2020	In progress

Criterion 2: Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Criterion	Compliance requirements	Current Arrangements / Practices	Improvement Plan	Owner	Evidence of compliance	Progress	Review Date	RAG

Criterion 3: Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Criterion	Compliance requirements	Current Arrangements / Practices	Improvement Plan	Owner	Evidence of compliance	Progress	Review Date	RAG
3.1	Systems should be in place to manage and monitor the use of antimicrobials to ensure inappropriate	There are PGDs in place to ensure timely administration of antibiotics to septic patients. However, the appropriateness of the PGD or choices of antibiotics have been debated. To ensure these PGDs are used appropriately, an electronic training *sepsis leadership in acute care* has been proposed as	1. On-line (ESR) training "Sepsis leadership in acute care" has been proposed as a prerequisite to using the PGD 2. PGD for sepsis to be extended so to	PK / VL-S	ASG TORs ASG work plan Reviewed PGDs Review policy	ASG has been reformed. TORs have been agreed. Work plan being developed	Mar 2020	In progress

	and harmful use is minimised and patients with severe infections such as sepsis are treated promptly with the correct antibiotic. These systems draw on national and local guidelines, monitoring and audit tools such as NICE guidelines, guidance on patient group directions, the TARGET toolkit in primary care and Start Smart then Focus in secondary care (SSTF).	a prerequisite to using the PGD. All patients initiated on restricted antibiotics such as meropenem and Tazocin are currently being escalated to the microbiologist by the antimicrobial pharmacist for daily review. There is currently no elaborate system in place to ensure prescribed antibiotics are being reviewed promptly. A relaunch of the antimicrobial stewardship initiative and introduction of a new drug chart is intended to improve review of antibiotics within the Trust.	Acute Response Team 3. Antimicrobial stewardship ward rounds are performed to review restricted antibiotics, outcome recorded in medical notes. To record a proforma that will record all antibiotics reviewed and changes made					
3.2	Where appropriate, providers should have in place an antibiotic stewardship committee responsible for developing, implementing and monitoring the organisation's stewardship programme. This must be supported by strong leadership across clinical specialties but it could be part of an existing committee such as a drug and therapeutic committee rather than a new body. Membership of this committee will vary dependent on the setting but should include representation from	Antimicrobial Stewardship group (ASG) has suffered from poor attendance and lack of engagement thought he trust. Although for valid reasons, lack of support from ward pharmacists and insufficient time allocated for antimicrobial pharmacists activates have impeded some of the activities required for effective ASG function. Integration of ASG into IPC (ICAS) has not solved the issues. A new strategy for the AST and trust wide relaunch is under way.	1. ASG to be reinstated 2. TORs to be agreed 3. Work plan to be developed to include policy and PGD review, implementation of start smart and focus and other National recommendations	PK / VL-S	ASG TORs ASG work plan Reviewed PGDs Review policy	ASG has been reformed. TORs have been agreed. Work plan being developed	Mar 2020	In progress

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	microbiology/infectious diseases, pharmacy and the organisations' director of infection prevention and control or equivalent. The committee should report antimicrobial stewardship activities to the Trust board via the organisation's Director of Infection Prevention and Control or equivalent.							
3.3	Providers should develop a local antimicrobial stewardship policy drawing on national guidance (including the British National Formulary, Public Health England the National Institute of Care Excellence) that takes account of local antimicrobial resistance patterns. Policy should cover diagnosis, treatment and prophylaxis of common infections and prescribers should be encouraged to record allergy status, reason for antimicrobial prescription, dose and duration of treatment. Adherence to prescribing guidance and compliance with in hospital post-prescribing review at	The trust has an Antimicrobial Stewardship Policy that is in line with national requirements. Extensive local antimicrobial guidelines, covering diagnosis, treatment and prophylaxis of common infections for adults are available via Microguide (https://cms.horizonsp.co.uk/viewer/medway/adult). Guidelines for infection in children's are overseen by the paediatric/neonatal teams. Although topics are updated regularly, more recently the updating process has lagged behind recent national recommendation. Due to staffing issues there is limited data on prescriber's adherence to policies or 48 to 72 hourly reviews. A revised Antimicrobial Stewardship Group should provide leadership in addressing current shortcomings.	1. Review of the Antimicrobial Stewardship Policy by the newly established ASG	PK / VL-S	Reviewed policy launched and implemented		Mar 2020	In progress

	48-72 hours should be monitored and audited on a regular basis, with data fed back to prescribers and incorporated into patient safety reporting systems to Boards and stewardship.							
3.4	Providers should have access to timely microbiological diagnosis, susceptibility testing and reporting of results, preferably within 48 hours. Prescribers should have access at all times to suitably qualified individuals who can advise on appropriate choice of antimicrobial therapy.	Access to microbiology results is available. Negative results are issued within 48 hours from the receipt of specimens into the laboratory, positive results may take longer. However, the turnaround times have been delayed on some occasions, mainly due to staffing issues in the microbiology laboratory at NKPS. Currently these issues are addressed by the management team at NKPS but no clear solution has emerged yet. Prescribers have access to duty consultant microbiologist during normal hours or on call consultant microbiologist during out of hours for advice on antimicrobial therapy.	1. Only limited audit data is available on antimicrobial prescribing and compliance with the trust policy 2. To provide trust wide data on monthly base 3. NKPS has initiated a staffing review to address any shortcomings in staffing structure and the recommendations are due to be implemented soon. The microbiology working hours are reviewed to increase the availability during core hours rather than extended hours	NKPS GM			Mar 2020	In progress
3.5	In secondary care providers should report local antimicrobial susceptibility data (drug-bug combinations) and information on antimicrobial consumption to the national surveillance body. Surveillance information should be used by the stewardship committee or equivalent to monitor local resistance patterns and guide local prescribing policy. This information should be communicated	Antimicrobial consumption is currently being monitored within the Trust although this information is not routinely communicated to prescribers. Consumption data is only available in-house and not on national platforms such as fingertip or model hospital. Antimicrobial susceptibility data (drug-bug combinations) is provided for national surveillance systems (PHE and NHS England). We don't have a local surveillance system for the antimicrobial resistance and this issue will have to be address in common with antimicrobial pharmacist and IPCT. A revised Antimicrobial Stewardship Group should provide leadership in addressing current shortcomings.	1. Antimicrobial consumption data is not provided to national platforms (https://fingertips.phe.org.uk/) 2. Pharmacy to look into providing sufficient time for the antimicrobial pharmacist to input data into national platforms 3. Microbiology laboratory, Consultants Microbiologists, Antimicrobial pharmacist to work together to create robust surveillance data on antimicrobial resistance	Chief Pharmacists VL-S			Mar 2020	Not yet commenced

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	back to prescribers in primary and secondary care to improve prescribing quality.							
3.6	Providers should ensure that all prescribers receive induction and training in prudent antimicrobial use and are familiar with the antimicrobial resistance and stewardship competencies.	There is currently no structured training in place on antimicrobial stewardship for prescribers. An electronic training on ESR; Antimicrobial Resistance has been proposed for all clinical staff as baseline training.	1. An electronic training (ESR) Antimicrobial Resistance has been proposed for all clinical staff as baseline training.	PK / VL-S			Mar 2020	Not yet commenced
Criterion 4: Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion								
Criterion	**Compliance requirements**	**Current Arrangements / Practices**	**Improvement Plan**	**Owner**	**Evidence of compliance**	**Progress**	**Review Date**	**RAG**
4.1	Information should be developed with local service user representative organisations, which could include Local Healthwatch and PALS	We liaise regularly with Kent and Medway Healthwatch and we have an active community engagement programme. No specific evidence relating to information development though.	• Asking volunteers, PALS staff and Healthwatch to review our information leaflets for suitability and effectiveness. • Keen to train volunteers (including Trust Governors) to become 'mystery shoppers'. • Liaising with Healthwatch to seek their support for regular audits to inform the development of information for patients and visitors (and staff).	GA/KK	Included in communications and engagement plan. Also included in membership engagement plan for March 2020.	• Volunteers have been invited to be part of this work • Approached Healthwatch seeking support for comms testing and infection prevention and control audits.	End Nov 2019	In progress
4.2	General principles on the prevention of infection and key aspects of the registered provider's policy on infection prevention, which takes into account the communication needs of the user.	Leaflets are available on wards for patients and visitors.	• As above, volunteers, PALS and Healthwatch asked to reviews comms messages and materials including patient leaflet. • Survey to be launched. • Patient/public focus group to be held.	KK/GA	Visitors guide leaflet	• Discussion held with colleague responsible for patient/visitor leaflets to review content • Volunteers and Healthwatch approached (as above).	End Nov 2019	In progress
	The roles and responsibilities of particular individuals such as carers, relatives and advocates in the	In the past the Trust has developed a clean hands saves lives campaign which was promoted through the Trust's magazine, News@Medway. We also utilise an automated message on the main telephone system to support infection control and have a	The Trust is taking part in a Kent and Medway STP pilot hydration campaign and is working closely with partners to share messages with the community to raise awareness and change behaviours around hydration.	GA	Comms plan has been drafted.	Campaign has already started - see advert on back of the autumn edition of News@Medway	Jan 2020	In progress

	prevention of infection, to support them when visiting service users.	virtual nurse in the main reception.	We plan to run a campaign again ahead of winter 2019. This will include: • Magazine articles and adverts • Posters • Social media • Use of screens in public areas • Use of telephone messages when dialling into the hospital • Tannoy messages			magazine, which is distributed widely on newsstands in public areas of the hospital, at community events, and electronically on the trust website and via email to an extensive database of thousands of Trust members and contacts. Due for publication beginning of Sept 2019. Other comms to support this.		
	The importance of appropriate use of antimicrobials	This subject is covered in internal messaging to staff. We will use our external communications channels such as our regular magazine and website to convey this message. Also on our intranet – the IPC page has been updated twice in the first quarter of 2019/20.	Included in comms plan. Use existing materials to promote messages. Discussing with CCG comms to see if we can repurpose comms shared with GPs.	KK/GA	See comms plan above.	Review of existing materials and working on a plan to incorporate these into our comms plan.	Jan 2020	In progress
	Supporting service users' awareness and involvement in the safe provision of care.	Communications plan to be refreshed August 2019 to raise awareness with eye-catching messaging and visuals.	Communications plan has been refreshed and developed – see above.	GA/KK	See comms plan above.		Jan 2020	In progress
	The importance of compliance by visitors with hand hygiene	There is alcohol gel on all wards which visitors are encouraged to use. There is also currently a virtual nurse on the two main entrances, promoting hand hygiene. We use our regular magazine News@Medway to promote this. Also raised through member engagement meetings and newsletters.	Comms plan includes internal and external messages and visual reminders. Membership event planned to bring a focus to this subject. This will be promoted extensively through emails, local press, website, magazine and social media. Virtual nurse to be removed as no longer effective as an infection prevention tool.	KK/GA	See comms plan above Engagement with members to raise awareness. Meeting planned for New Year 2020.	Comms plan being rolled out from Aug 2019. Member event in calendar shared widely with members and network of contacts. Will be promoted closer to the date.	End Nov 2019	In progress
	The importance of compliance with the registered provider's policy on visiting	There is clear information on visiting times on the Trust website which also encourages visitors not to come to the hospital if they have a cold or flu, or sickness and/or diarrhoea in the past 48 hours.	Policy to be promoted with the help of the telephone message and use of our tannoy when needed.	GA	https://www.medway.nhs.uk/patients-and-public/visiting **Phone message script:-** *Please be aware that diarrhoea and vomiting (Norovirus) is making a lot of people unwell in the community at the moment.*	Comms around this reviewed and incorporated in comms plan	End Jan 2020	In progress

Appendix 2

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					Please help us to keep our patients safe by staying home if you have a cold, infection, or diarrhoea and vomiting, and only visiting when you have been symptom free for 48 hours.			
	Reporting concerns relating to hygiene and cleanliness including hand hygiene.	Audits are completed on a monthly basis and these are widely disseminated. The clinical walkaround using the Perfect Ward app also captures and reports this information. Concerns are raised by staff through the Freedom to Speak Up Guardians, and by patients and relatives through PALS.	Raise awareness internally and externally of these methods – already in place but ensure visibility and awareness.	KK		Underway	Jan 2020	In progress
	Explanations of incident/ outbreak management and action taken to prevent recurrence.	Multidisciplinary meetings are held following any incident and communications are sent widely within the organisation. Incidents, actions and learning are reported at the public Board meeting.	Need to ensure any incident/outbreak is communicated via our website/phone messages/social media when required.	GA/KK	See page 112 of board report example – https://www.medway.nhs.uk/downloads/publications/board-papers/Trust%20public%20board%20papers%20-%20July%202019.pdf	Under review to see if there is more we can do.	Jan 2020	In progress
4.3	Materials from national or local antimicrobial awareness campaigns could be used to develop information on appropriate antimicrobial use.	The Trust holds an Infection Control Awareness Week each year. This has included information stands in the main reception, social media messaging to the public and daily messaging to staff on antibiotic guardianship and infection control using information and campaign materials developed nationally.	Awareness Week also to be used as an opportunity to convey messages to the public through various comms channels – see comms plan	GA	Social media activity example from May 2019 – See also comms plan above	Activity in comms plan will enhance awareness among patients and public	Jan 2020	In progress
4.4	Accurate information is communicated in an appropriate and timely manner.	Information is conveyed to staff at appropriate times and repeated throughout the year, in formats they are able to access. We also use a number of channels to deliver messages to patients and visitors, such as our magazine, posters, answerphone message and tannoy system,		GA	See comms plan above. **Phone message script:-** *Please be aware that diarrhoea and vomiting (Norovirus) is making a lot of people unwell in the community at the moment.* *Please help us to keep our patients safe by staying home if you have a cold, infection, or diarrhoea and vomiting, and only visiting when you have been symptom free for 48 hours.*	New campaign being rolled out from Aug 2019	Nov 2019	In progress

	This information facilitates the provision of optimum care, minimising the risk of inappropriate management and further transmission of infection	Medical Director takes learning about MRSA BSIs to Clinical Council to ensure lead clinicians are fully informed and have this subject high on their radar.	Continue to ensure this is raised and discussed regularly at Clinical Council.	KK	Agenda/minutes of Clinical Council	Underway	Nov 2019	In progress
	Where possible information accompanies service user	This needs to be tested out and looked at. Volunteers and patient partner groups could potentially help test.	Already in place to some extent, eg catheter passport.	KK	Catheter passport	To be explored as part of comms plan implementation.	Jan 2020	In progress
4.5	Provision of relevant information across organisational boundaries is covered by the regulation requirement 9 'person-centred care'. Due attention should be paid to service user confidentiality as outlined in national guidance and training material.	IG and GDPR rules are implemented and followed at all times. Staff receive training on this.	Continue to ensure rules are followed and training is in place.	KK			Jan 2020	In progress
Criterion 6: Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.								
Criterion	**Compliance requirements**	**Current Arrangements / Practices**	**Improvement Plan**	**Owner**	**Evidence of compliance**	**Progress**	**Review Date**	**RAG**
6.2	Infection prevention would need to be included in the job descriptions and be included in the induction programme and staff updates of all employees (including volunteers). Contractors working in service user areas would need to be aware of any issues with regard to infection prevention and obtain 'permission to work'.	All job descriptions note the general responsibilities regarding infection, prevention and control (IPC) within for staff (evidence 6.1a). Substantive, bank and agency/contractors are required to have completed either IPC level 1, or 2 dependent on the needs of the role as assigned by the Subject Matter Expert and the line manager. Training is provided to be consistent with the requirements of CSTF (core skills training framework) to ensure quality and content of training is sufficient and control the frequency of updates to training required. CSTF compliance is also a pre-requisite for streamlining projects across the NHS for onboarding alongside the use of OLM (ESR) - see criteria 10. All policies and procedures in relation to IPC have standard sections listing responsibilities for different roles in the organisation (see appropriate evidence sets of policies across this return). Compliance with IPC StatMan is updated weekly (evidence 6.1b). Work to standardise the volunteers training and description of role is part of the action plan.	Review of volunteers policy and implementation (and audit) or agreement of values, behaviours and interactions with the Trust.	Suzanne Brooker	Evidence of agreement in use for volunteers		Oct 2019	Not yet commenced

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Criterion 7: Provide or secure adequate isolation facilities.								
Criterion	**Compliance requirements**	**Current Arrangements / Practices**	**Improvement Plan**	**Owner**	**Evidence of compliance**	**Progress**	**Review Date**	**RAG**
Criterion 8: Secure adequate access to laboratory support as appropriate								
Criterion	**Compliance requirements**	**Current Arrangements / Practices**	**Improvement Plan**	**Owner**	**Evidence of compliance**	**Progress**	**Review Date**	**RAG**
8.2	A microbiology laboratory policy for investigation and surveillance of antimicrobial resistance and healthcare associated infections	There are up to date SOPs for investigation, detection and reporting of C dificile and antibiotic-resistant organisms (MRSA, ESBL, CPE, VRE) involved in healthcare associated infections. The surveillance of healthcare associated infections is performed by IPCT or specific wards (ICU, NICU). We don't have a surveillance policy for the antimicrobial resistance and this issue will have to be address in common with antimicrobial pharmacist and IPCT.	Microbiology laboratory, Consultants Microbiologists, Antimicrobial pharmacist to work together to create robust surveillance data on antimicrobial resistance	VL-S			Mar 2020	In progress
	Timely reporting	TATs (turnaround time) key investigations like MRSA screening and C dificille testing are part of Pathology dashboard. Others are reviewed by the microbiology senior's team during regular meetings. TATs are broadly in line with national guidance, however there are regular breaches post merger between MFT and DVH microbiology. Lack of staff due to inappropriate planning for current working system and high number of resignation is the main cause. A staffing review plan is currently underway. Also the laboratory staff is looking at the changing the working pattern to alleviate some of the pressure during the weekend and out of hours working.	NKPS has initiated a staffing review to address any shortcomings in staffing structure and the recommendations are due to be implemented soon.The microbiology working hours are reviewed to increase the availability during core hours rather than extended hours	NKPS GM			Mar 2020	In progress
Criterion 9: Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.								
Criterion	**Compliance requirements**	**Current Arrangements / Practices**	**Improvement Plan**	**Owner**	**Evidence of compliance**	**Progress**	**Review Date**	**RAG**
9.3a	Standard Infection Prevention and Control Precautions	No overarching standard infection prevention and control precautions policy in place. Other policies available that cover elements this I.e. hand hygiene, sharps. Hand hygiene policy out of date October 2018 No glove usage policy	1. Develop an overarching SIPC precautions policy 2. Review hand hygiene policy to include guidance and information regarding occupational dermatitis 3. Develop a glove usage policy	IPCT	Completed policies, approved by IPCC and uploaded to Q-Pulse	Review of policies has commenced. All policies have been collated and those identified for review and those identified to be written and those due for review in the very near future listed and will form	Nov 2019	In progress

						part of the annual work plan for the infection prevention and control team.		
9.3b	Aseptic technique	Asepsis and ANTT policy out of date August 2019	1. Review policy	IPCT	Reviewed policy, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at September IPCC	Nov 2019	In progress
9.3c	Outbreaks of communicable infection	Outbreak policy and procedure does not contain contact details of those likely to be involved in outbreak management but is otherwise compliant and in date.	1. Details need to be added to policy and resubmitted to IPCC for approval	IPCT	Reviewed policy, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at September IPCC	Nov 2019	In progress
9.3d	Isolation of service users with an infection	Isolation policy does not contain information for service users and the public	1. Details need to be added to policy and resubmitted to IPCC for approval	IPCT	Reviewed policy, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at September IPCC	Nov 2019	In progress
9.3e	Safe handling and disposal of sharps	There is no clear policy regarding sharps management and prevention of an inoculation injury	1. All policies pertaining to sharps to be reviewed and ensure they meet the requirements of the HSCA	IPCT	Reviewed policy, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at September IPCC	Nov 2019	In progress
9.3f	Prevention of occupational exposure to blood-borne viruses (BBVs) including prevention of sharps injuries	Prevention of occupational exposure to BBVs policy is out of date	1. Review policy	IPCT	Reviewed policy, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at October IPCC	Nov 2019	In progress
9.3g	Management of occupational exposure to BBVs and post-exposure prophylaxis	Management of occupational exposure to BBVs and PEP policy is out of date	1. Review policy	Occ. Health Dept	Reviewed policy, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at October IPCC	Nov 2019	In progress
9.3h	Closure of rooms, wards, departments and premises to new admissions	No policy exists called closure of rooms, wards, departments and premises to new admissions. The outbreak policy and procedure contain closure information but does not completely fulfil the requirements of the HSCA	1. Details need to be added to policy and resubmitted to IPCC for approval	IPCT	Reviewed policy, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at September IPCC	Nov 2019	Not yet commenced
9.3j	Decontamination of reusable medical devices	There is not a policy called decontamination of reusable medical devices. There is a management of reusable medical devices policy but this does not cover decontamination. Elements are covered in the cleaning and disinfection policy. There is a decontamination policy but this is very out of date (review July 2012). Some elements of decontamination are contained within the medical devices training policy.	1. Review all medical devices and re-usable medical devices policies to ensure they fulfil the requirements of the HSCA	IPCT	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at September IPCC	Nov 2019	Not yet commenced

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9.3l	Antimicrobial prescribing	Antimicrobial prescribing guidelines are on microguide and not intuitive or user friendly. There is no overarching antimicrobial prescribing policy	1. Review use of microguide and improve user friendliness 2. Review overarching antimicrobial prescribing policy which is due for review August 2019	Consultant micro-biologist and Anti-microbial Pharmacist	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at October IPCC	Nov 2019	In progress
9.3m	Reporting of infection to Public Health England or local authority and mandatory reporting of healthcare associated infection to Public	There is no surveillance policy or policy regarding reporting to the National HCAI DCS	1. Develop surveillance policy and SOP 2.	KK / VL-S	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	Not yet commenced
9.3n	**Control of outbreaks and infections associated with specific alert organisms**							
i.	MRSA	MRSA policy exists. Due for review 2018	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	SG	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	In progress
ii.	Clostridium difficile	C. difficile policy exists. Due for review 2018	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	SG	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	In progress
iii.	Glycopeptide resistant enterococci (GRE)	GRE policy exists. Due for review August 2019	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	SG	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	Not yet commenced
iv.	Carbapenem resistant organisms (CROs), Acinetobacter, extended spectrum beta-lactamase (ESBLs) and other antibiotic resistant bacteria	CPE policy exists. Due for review 2018	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	SG	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	In progress
v.	Viral haemorrhagic fevers (VHF)	VHF policy exists. Due for review 2018	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	SG	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	In progress
vi.	Creutzfeld-Jakob diease (CJD), variant	CJD policy exists. Due for review 2018	1. Review policy 2. Ensure meets national and HSCA	SG	Completed policies, approved		Jan 2020	Not yet commenced

	CJD (vCJD) and other human prion diseases.		requirements 3. Implement policy and audit compliance		by IPCC and uploaded to Q-Pulse			
vii.	Control of tuberculosis, including multi-drug resistant tuberculosis: Isolation of infectious patients	TB policy exists. Due for review August 2019	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	SG	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	Not yet commenced
viii.	Respiratory viruses:	Respiratory viruses policy exists. Due for review March 2019	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	SG	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	Not yet commenced
ix.	Diarrhoeal infections:	No policy exists called diarrhoeal infections. The C. difficile policy contains some information but does not completely fulfil the requirements of the HSCA	Policy to be developed	SG	Policy, approved by IPCC and uploaded to Q-Pulse		Jan 2020	Not yet commenced
9.3o	CJD/vCJD	This needs to be included in the decontamination policy which was due for review 2012.	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	GL / BB	Policy, approved by IPCC and uploaded to Q-Pulse		Nov 2019	Not yet commenced
9.3p	Safe handling and disposal of waste	Waste policy is id date but procedure documents were due for review December 2018	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	KU / AH	Policy, approved by IPCC and uploaded to Q-Pulse		Nov 2019	Not yet commenced
9.3q	Packaging, handling and delivery or laboratory specimens	Elements exist in guidance on the staff intranet. There are SOPs in existence and in date for samples packaged in formalin. Elements are contained within pathology hand book	1. Policy and SOP to be developed	VL-S / NKPS	Policy, approved by IPCC and uploaded to Q-Pulse		Nov 2019	Not yet commenced
9.3r	Care of deceased persons	There is no policy call care of the deceased person. Elements are contained within the isolation policy which will need to be reviewed to ensure it meets the requirements of this criterion.	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	SG	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	Not yet commenced
9.3s	Use and care of invasive devices	A number of policies exist but many are due for review	1. Review policy 2. Ensure meets national and HSCA requirements 3. Implement policy and audit compliance	SG with practice dev. nurses	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	Not yet commenced
9.3t	Purchase, cleaning, decontamination, maintenance and disposal of equipment	There is no policy that exists that reflects the requirements of this criterion.	Policy to be developed	SG with NA	Policy, approved by IPCC and uploaded to Q-Pulse		Jan 2020	Not yet commenced
9.3u	Surveillance and data collection	There is no surveillance policy or policy regarding reporting to the National HCAI DCS	Develop surveillance policy and SOP	KK / VL-S	Completed policies, approved by IPCC and uploaded to Q-Pulse	Aiming for reviewed policy to be presented at December IPCC	Dec 2019	Not yet commenced

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9.3v	Dissemination of information	There is an admission and referral SOP but this does not contain any requirement to include information regarding infection status	SOP to be reviewed and to refer to key risk assessment documentation	SG / CH	Policy, approved by IPCC and uploaded to Q-Pulse		Jan 2020	Not yet commenced

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	Medical Appraisal and Revalidation Annual Report 2018-19	**Agenda Item**	**9.2**
Lead Director	Dr David Sulch, Executive Medical Director		
Report Author	Dr Kirtida Mukherjee, Responsible Officer		
Executive Summary	The purpose of this report is to: • Provide assurance to the Board regarding the discharge of Responsible Officer's Regulations particularly in relation to effective appraisal and safe revalidation recommendations. • Seek approval of the statement of compliance confirming Medway NHS Foundation Trust is in compliance with the Responsible Officer regulations. Key points are: • Arrangements for ensuring doctors are appraised to a standard that meets the requirements of the Responsible Officer Regulations and are revalidated in a timely manner are working effectively. For this reporting year, 353 out of 361 connected doctors (97.7%) had a completed appraisal. These figures compare favourably to national comparator data (appendix 3) with 97.7% appraisal completion rate for Medway NHS Foundation Trust (MFT) against a figure of 89.3% for the same sector designated bodies and 91.5% for all sectors designated bodies for 2018 - 2019. There were 64 Doctors revalidated in the reporting period with three doctors referred to General Medical Council (GMC) for non-engagement with the appraisal process. A total of 9 doctors had their revalidation recommendation deferred because of insufficient supporting evidence. • Dr Kirtida Mukherjee will be stepping down as Responsible Officer and recommendations are made below for managing the transition.		
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	
Resource Implications	To discharge statutory Responsible Officer responsibilities, there will be ongoing resources required for training of new appraisers and yearly appraisal updates for the current appraisers and training of support staff. In addition the number of doctors with connections to Medway FT has increased by 21% in the last 2 years. This increase has implications for resources required to support the appraisal process, particularly in terms of medical appraisers, the impact on the Responsible Officer and Lead Appraiser workload. The budget is sufficient for 2019 – 2020 but a review will be undertaken in 2019 to determine future resource requirements.	
Legal Implications/Regulatory Requirements	The Medical Profession (Responsible Officer) Regulations 2010 set out the statutory requirement for a Responsible Officer, Medical Appraisals and sufficient resources to support the process. This report uses those regulations as the template to provide assurance on compliance at Medway NHS Trust.	
Quality Impact Assessment	None	
Recommendation/ Actions required	The Trust Board is asked to approve this report. Following Board approval the Chairman/CEO sign off the Statement of Compliance confirming that the Trust, as a Designated Body, is in compliance with the regulation. In addition the Trust Board is advised that Dr Kirtida Mukherjee is stepping down as Responsible Officer with effect from 30 September 2019. The Board is asked to approve the appointment of Dr David Sulch as Responsible Officer with effect from 30 September 2019. Dr David Sulch meets the statutory requirements set out in the Medical Profession (Responsible Officer) Regulations 2010, namely he is a medical practitioners and has been continuously registered as medical practitioners for the previous 5 years. The appointment of Dr Sulch will bring Medway NHS Foundation Trust into the normal arrangements for Responsible Officer, namely with the Responsible Officer being the Medical Director. Dr Mukherjee will take on the role of Deputy Responsible Officer and has agreed delegated duties with Dr Sulch.	
	Approval ☒	**Assurance** ☒	**Discussion** ☐	**Noting** ☐
Appendices	Appendix 1: Comparator Report Appendix 2: Compliance Statement			

1 Executive Summary

1.1 For the appraisal year 1 April 2018 – 31 March 2019, there were 361 doctors who had a prescribed connection with Medway Foundation NHS Trust (MFT). For this reporting year, 353 doctors (97.7%) had a completed appraisal. These figures compare favourably to national comparator data (appendix 3) with 97.7% appraisal completion rate for MFT against a figure of 89.3% for the same sector designated bodies and 91.5% for all sectors designated bodies for 2018 - 2019. There were three doctors referred to General Medical Council (GMC) for non-engagement with the appraisal process. A total of nine doctors had their revalidation recommendation deferred because of insufficient supporting evidence.

2 Purpose of the Report

2.1 This report is intended to provide assurance to the Board regarding compliance with its statutory duties and those of its nominated Responsible Officer (RO) as provided in the Medical Profession (Responsible Officer) Regulations 2010.

2.2 The report forms part of the Medical Director duties to provides assurance that appraisal systems are robust, support revalidation and are operating effectively. This report gives the Trust Board an annual report on completion of the annual medical appraisals and the number of revalidation recommendations made for the year ending 31 March 2019.

2.3 A statement of compliance with Medical Profession (Responsible Officers) Regulations (Appendix 1) needs to be signed off by the chairman or CEO and submitted to NHS England.

3 Background

3.1 The Medical Profession (Responsible Officer) Regulations 2010 came into force in January 2011. The regulations designate the bodies to which they apply (including among others all NHS trusts, independent sector healthcare providers and most locum agencies) and create a ‘prescribed connection’ between a designated body and doctors contracted to it. Designated bodies are required to appoint or nominate a senior doctor - known as the RO, who in turn is given a range of statutory duties relating to the oversight of arrangements for assuring the fitness to practise of their doctors. The regulations place a duty on designated bodies to ensure they make sufficient resources available to their RO for the effective delivery of their responsibilities.

3.2 The aim of medical revalidation is to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Under this process, the RO must make a periodic recommendation to the GMC – based on the outcomes of annual whole-practice appraisals and

any other available information – that a doctor remains fit to practice and that their licence to practice should continue.

4 Designated Body

4.1 For the purpose of this report, the designated body is Medway NHS Foundation Trust.

5 Responsible Officer

5.1 The RO between April 1st 2018 and 6 September 2018 was Dr Diana Hamilton-Fairley. When she retired as Medical Director it was agreed by the Board to appoint Dr Kirti Mukherjee as RO with effect from 7 September 2018. Dr Mukherjee works collaboratively with the Medical Director to ensure that Appraisal and Revalidation process and decisions are in line with GMC requirements and Trust policy. Dr Kirtida Mukherjee, satisfies the condition for appointment to the role of RO, namely she is a medical practitioner and at the time of the appointment had been continuously registered as a medical practitioner for the previous 5 years.

6 Statutory Responsibilities of Responsible Officer

6.1 This section explains how the RO is carrying out her responsibilities as per the Medical Professional (Responsible Officer) Regulations 2010, relating to the evaluation of the fitness to practise of every medical practitioner with a prescribed connection to MFT. It should be noted that this excludes doctors in training whose prescribed connection from FY1 onward is to their respective deanery or HEE Local Education and Training Board. **The following sections relate directly to the duties set out in the Responsible Officer Regulations 2010.**

6.2 **Regular Appraisals**

6.2.1. All doctors who have a connection to MFT are given access to the Trust appraisal system (L2P) together with an appraiser and are allocated a month for completing their appraisal.

6.2.2. The appraisals are carried out using all available information relating to the medical practitioner's fitness to practise within their full scope of practice (MFT and any other organisations). All doctors who do work outside of MFT, are required to submit supporting information regarding their practice by the Responsible Officer (or delegate) of that organisation.

6.2.3. 360 multi-source feedback (MSF) is a core component of appraisal for feedback on a doctor's performance which can help in effective development of personal, team and service practice; the Trust has a programme with an external provider to ensure that all non-training doctors undertake a 360 MSF with both patients and colleagues to support their appraisal and revalidation. This must be undertaken at least once on a 5 year revalidation cycle and must be

within 2 years of the revalidation date. The Trust sets a minimum requirement of 15 responses for each MSF undertaken, which are anonymous and aggregated and any comments made are non-attributable to any individual. The responses are collated by our external provider and the 360 report is analysed against a national mean standard. 6.2.4. Once received, the report is uploaded as supporting information on e-appraisal. The doctor is asked to reflect on the results and if necessary, have a Personal Development Plan based on 360 multisource feedback. All MSF reports are reviewed by the appraisal team, upon which the appraiser and/or RO can request MSF to be repeated if deemed necessary.

6.3 Appraisal and Revalidation Performance Data

6.3.1 Prescribed Connections and completed appraisals

- As on 31 March 2019 there were 361 non-training doctors who had a prescribed connection with the Trust. This was an increase of (21%) 63 over the last two years due to increased recruitment at the Trust as well as an increase in connected doctors due to development of the Staff Bank.
- 353 non-training doctors had completed their appraisal for the reporting period 1 April 2018 to 31 March 2019. This equates to an overall 97.7% compliance.

Table 1

	Number of Prescribed Connections	Completed Appraisal (1)	Completed Appraisal (1a)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
Consultants	169	166 (98.2%)	69 (41.5%)	2 (1.1%)	1 (0.5%)	169
Staff grade, associate specialist, specialty doctor	97	96 (98.9%)	50 (52%)	1 (1%)	0	97
Temporary or short-term contract holders	65	63 (96.9%)	21 (33.3%)	0	2 (3.0%)	65
Other doctors with a prescribed connection to this designated body e.g. Bank doctors	30	28 (93.3%)	10 (35.7%)	1 (3.3%)	1 (3.3%)	30
TOTAL	361	353 (97.7%)	150 (42.4%)	4 (1.1%)	4 (1.1%)	361

Description of measures in table

1 - Appraisal meeting took place in correct month

1a - Appraisal meeting, submitted to appraiser and the appraiser has completed it within correct time period.

2 - Approval by RO for incomplete or late appraisal

3 - Unapproved incomplete or missed appraisal

6.3.2 Approved Missed or Incomplete Appraisals

Four doctors were reported as approved missed or incomplete appraisals out of which:

2 x Consultants:

- 1 appraisal relates to a doctor on maternity leave.
- 1 appraisal relates to a doctor who retired shortly after the year end.

1 x Speciality Doctors:

- 1 appraisal had an approved incomplete or missed appraisal with agreed reasons.

1 x Other doctors with a prescribed connection

- 1 appraisal had an approved incomplete or missed appraisal with agreed reasons.

6.3.3 Unapproved Missed or Incomplete Appraisals

4 doctors were reported as having unapproved or incomplete appraisals

1 was a Consultant:

- 1 consultant appraisal was incomplete with an unapproved reason. The Consultant was referred to the GMC for non-engagement.

2 were Trust Doctors and Locums:

- 2 appraisals were incomplete with an unapproved reason. Both were referred to the GMC for non-engagement.

1 was Other doctors with a prescribed connection

- 1 appraisal had an unapproved incomplete or missed appraisal as they left the trust before an appraisal could be completed.

6.4 Clinical Governance

6.4.1 It is recognised that the Trust needs to improve the access of clinical data for individual doctors to support the appraisal process. The RO/Deputy RO and Senior Appraiser continue to liaise with our Governance Data Analyst, Complaints and Datix team to ensure that individual doctors have access to serious incidents, complaints and their individual activity data to support the appraisal process.

6.4.2 Progress has been made on improving this process and an appropriate report is now available from both Planned and Unplanned Care.

6.5 Procedures to investigate concerns about a medical practitioner's fitness to practice raised by patients or staff of the designated body or arising from any other source;

6.5.1 The Trust has specific policies on Maintaining High Professional Practice

6.5.2 The Trust has a Decision Making Group made up of Senior Decision makers including the Responsible Officer, Deputy Responsible Officer and HR Director (or delegate) to review and make decisions on investigations into concerns raised about individual practitioners and services. The group meets regularly and is supported by the Head of Medical Director Services.

6.5.3 Emphasis has moved towards resolving issues informally whenever possible and no formal MHPS investigations took place between April 1 2018 and March 31 2019.

6.6 Referring concerns about the medical practitioner to the General Council;

The GMC provide advice and guidance for the RO on the threshold for raising concerns. Where there is doubt regarding the need for referral, a specified liaison officer from the GMC is consulted. The RO also has a regular quarterly meeting with the GMC liaison officer to discuss ongoing concerns and new concerns.

There were no formal concerns referred to the GMC by MFT during the reporting year. However, regular responses and support is giving to the GMC in any active investigations requiring MFT input.

6.7 Monitoring conditions and undertakings imposed (or agreed) by the GMC on a medical practitioner

The Responsible Officer ensures that there is appropriate monitoring of conditions and undertakings through agreeing local action plans with Clinical Directors / Specialist Leads and the relevant doctor. This includes ensuring that there are appropriate qualified supervisors as per GMC guidance on level of supervision for medical practitioners and that those supervisors provide periodic reports as per the undertaking. The GMC is kept informed on progress.

6.8 Make recommendations to the General Council about medical practitioners' fitness to practise (known as revalidation);

The Responsible Officer, in conjunction with the Deputy Responsible Officer and Senior Medical Appraiser, is responsible for reviewing all appraisals submitted by the appraisers for review and for making recommendations to the GMC for revalidation and renewal of a doctor's licence to practise.

The Medical Revalidation Governance Group was formed in December 2014. The main aim of this Group is to discuss all revalidation submissions to ensure that a consistent approach is taken in relation to all revalidation submissions made by the Responsible Officer. This Group currently meets bi-monthly.

6.9 Maintain records of practitioners' fitness to practise evaluations, including appraisals and any other investigations or assessments.

All appraisal records are held securely and electronically by the Medical Director's office. The Revalidation Manager and Head of Medical Director services maintain all the investigations and GMC correspondence for the doctors. The HR Department through the Directorate Business partners support the investigations and hold the personnel files of the Doctors.

7 Revalidation Recommendations

For the year ending 31 March 2019 there were 68 doctors due to revalidate.
The recommendations made were as follows:-

	Recommendation Type
64*	Revalidate – positive recommendation
9	Defer – Insufficient evidence for a recommendation to revalidate **5 were subsequently revalidated during the reporting year after submitting required evidence (included in 64 positive recommendations)*
0	On Hold - pending an investigation by the GMC
0	Missed or late recommendations

(Please note: deferral is a neutral act (i.e. it does not imply an adverse judgement against a doctor) and their licence to practise continues unaffected in the meantime).

8 Provision of Resources to the Responsible Officer

8.1 NHS England carried out an independent verification visit in October 2014. As part of this visit, they reviewed the resource available at MFT to support appraisal and revalidation. They advised on the need for a full time administrative post to support the RO and for the appointment of two senior appraisers, and the provision of sufficient funds for appraiser refreshing training, training of new appraisers, training of case investigators and training of case managers. Sufficient budget enabled the Medical Director to;

a. Recruit additional administrative resource to support RO.

b. Funding was also provided for two Lead Appraisers of which only one was appointed and subsequently the additional Lead Appraiser role was de-established.

c. Training of Case Investigators and Case Managers. There are currently 18 trained case investigators and eight case managers. The Trust intends to manage as many cases internally as possible and only use external support in exceptional situations. Best practice in safe revalidation has identified that it is essential to have these specific resources supporting the RO in the discharging of their statutory duties.

d. Provide new appraiser and refresher training. The Trust currently has 106 medical appraisers who have undertaken the approved appraisal training for enhanced medical appraisals. This number includes eighteen new doctors who were trained and appointed as appraisers in November 2018 and seven new doctors who attended external training dates.

8.2 Over the last 2 years there has been a significant increase in the number of doctors connected and therefore appraised by MFT (21% increase). In 2018-19, there were sufficient staffing resources to discharge these responsibilities however the budget for the Revalidation and Appraisal team has been reduced for 2019 – 2020 which will limit the number of new appraisers Medway can train and limit the opportunity for providing external speakers to update appraisers and this may create difficulties in future years.

8.3 There are also workforce planning issues which need to be considered with the potential retirement of key revalidation team members leading to a loss of key knowledge and resource to the organisation and there may be a requirement to recruit an additional Lead Appraiser. A workforce review will be carried out in 2019 to identify future workforce and funding requirements to provide safe revalidation particularly in the light of the 21% increase in prescribed connections.

9 Monitoring Contracts of employment / provision of services with medical practitioners;

9.1 Established HR processes are in place which have been approved by the RO to ensure
(a) that medical practitioners have qualifications and experience appropriate to the work to be performed;
(b) that appropriate references are obtained and checked;
(c) all steps necessary to verify the identity of medical practitioners are undertaken.

9.2 To ensure compliance with 9.1a-c above a Standing Operating Procedure (SOP) with the Human Resources Department is in place to ensure that all the necessary pre and post-employment checks have been undertaken for all doctors. This also applies to NHS locum appointments, Bank and temporary agency locum appointments. Where relevant, Medical Practice Information Transfer (MPIT) forms are used for all incoming non training doctors for RO to RO transfer of information. All new doctors are also required to submit a Transfer of Information form to Medical Staffing before the start of their employment in MFT.

10 Competence in English

10.1 Good medical practice (2013) states that doctors 'must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK'.

10.2 To ensure this happens the GMC assess competency in English as part of their registration process for Doctors. In addition to the GMC standard the RO Regulations 2010 (amended 2013) brought in specific statutory duties for the Designated Body and RO regarding competence in the English Language meaning the RO needs to ensure that

"medical practitioners have sufficient knowledge of the English language necessary for the work to be performed in a safe and competent manner;"

10.3 To ensure that medical practitioners have the necessary English Language skills MFT accepts the International English Language Testing System (IELTS) for all international doctor recruitment. MFT requires a score on the IELTS test of at least 7.5 which at the minimum level ensures that the doctor has operational command of English.

10.4 In addition an advanced action process during the interview has been developed, in which applicants are asked to write and speak English using case studies and assessed by an internal HR Assessor.

11 Monitoring medical practitioners' conduct and performance

11.1 The RO has put in place systems to monitor medical practitioners conduct and performance including

a) general performance information held, including clinical indicators relating to outcomes for patients;
b) Identifying any issues arising from that information relating to medical practitioners, such a variations in individual performance; (c) ensuring they take steps to address any such issues.

11.2 To ensure compliance with a-c there is an established Clinical Governance structure within the Trust which is overseen by the Medical Director / RO.

- The Healthcare Evaluation Data (HED) system (and from January 2019 the Dr Foster system) were used to provide an overview of individual consultant performance, the local specialty peer performance and the national specialty peer performance.

- Where appropriate, log books of procedures undertaken by individual doctors are uploaded and discussed within the appraisal process.

- National benchmarking data is uploaded to the appraisal and are discussed during the appraisal meeting.

- Issues that arise are managed by appropriately qualified case managers and case investigators and overseen by the Trust Decision Making Group.

12 Responding to concerns about medical practitioners' conduct or performance

12.1 The Medical Director chairs the Decision Making Group, which reviews all significant concerns and manages these under MHPS including liaising with NHS Resolution Service (formerly the National Clinical Assessment Service) and the GMC as required in each case. The RO attends this meeting.

12.2 Maintaining High Professional Standards is a direction from the Department of Health, which sets out a detailed framework of how performance issues concerning medical staff must be managed by designated bodies such as MFT.

12.3 Where action is required the RO ensures that

(a) Investigations are managed by a Case Manager with qualified Case Investigators;

There are 18 trained Case Investigators and 8 trained Case Managers in MFT who manage cases when investigations are deemed necessary. From time to time, external investigators have been commissioned when specific expertise is needed.

(b) procedures are in place to address concerns raised by patients or staff of the designated body or arising from any other source;

Complaints procedures are in place to address concerns raised by patients and where clinical concerns are identified these are then managed under the appropriate Trust policy.

Complaints raised by staff indicating clinical concerns are investigated and action taken as appropriate in line with Trust policy.

(c) any investigation into the conduct or performance of a medical practitioner takes into account any other relevant matters within the designated body;

All Case Investigations follow NHS Resolution Service best practice with terms of reference established to investigate the issues fully including where systems issues are affecting performance.

(d) the need for further monitoring of the practitioner's conduct and performance is considered and ensures that this takes place where appropriate;

As part of the Case Management of each case, there are a range of options open to the case manager including considering the need for further monitoring of the practitioner's conduct and performance and ensure that this takes place where appropriate;

(e) ensure that a medical practitioner who is subject to procedures under this paragraph is kept informed about the progress of the investigation;

Case Managers are trained to ensure that medical practitioner under investigation are kept informed about the progress of the investigation;

(f) ensure that procedures under this paragraph include provision for the medical practitioner's comments to be sought and taken into account where appropriate;

Case Managers ensure that investigations include provision for the medical practitioner's comments to be sought and taken into account where appropriate;

(g) (i) take any steps necessary to protect patients;

Consideration regarding restrictions and exclusions of practitioners are made where there is any potential risk to patient safety.

(ii) recommend to the medical practitioner's employer that the practitioner should be suspended or have conditions or restrictions placed on their practice;

Appropriate recommendations are made as stipulated.

(h) identify concerns and ensure that appropriate measures are taken to address these, including but not limited to—

(i) requiring the medical practitioner to undergo training or retraining;

(ii) offering rehabilitation services;

(iii) providing opportunities to increase the medical practitioner's work experience;

The Case Manager and potentially Capability or Conduct hearings will determine appropriate measures to support the remediation of medical practitioners including addressing any systemic issues within the designated body which may have contributed to the concerns identified;

(l) maintain accurate records of all steps taken in accordance with this paragraph.

Management of all cases is in line with Maintaining High Professional Standards (MHPS) and the Trust Remediation of Medical Staff policies and accurate records are maintained of all actions taken.

13 Governance Arrangements

13.1 All Consultants, Specialty Doctors and doctors, not in a formal training programme are required to use the e-appraisal system currently in operation in the Trust for completion of their annual appraisals. The e-appraisal system operates on a traffic light system in relation to both completion of the annual appraisal and the revalidation due date. This is monitored on a daily basis by the Medical Director's office to ensure that progress in meeting these deadlines is being maintained.

13.2 The Human Resources Department/Medical Staffing provides the Medical Director's office with a weekly list of all new non-training doctors together with a list of those non-training doctors who have left the Trust. Doctors are then added or deleted from the e-appraisal system and the GMC list as necessary to ensure the list of doctors with a prescribed connection to the Trust is as up to date as possible. All new doctors are given information on appointment explaining the requirements of appraisal and revalidation and are also contacted by the Medical Director's office and informed of the process for ensuring their annual appraisal (or before the end of their fixed term period with the Trust, whichever is the earlier) is completed.

14 Quality Assurance

14.1 Quality Assurance of the appraisal and revalidation process includes the following measures;

a) MFT's e-appraisal system incorporates an appraisee checklist of all supporting evidence covering the whole scope of practice. This must be completed before the appraisee can submit the appraisal to the Appraiser. In addition the Appraiser must complete the Appraiser checklist before submission to the RO for review. This reduces the occasions when the RO or Senior Medical Appraiser has to refer back an appraisal due to missing or incomplete supporting evidence.

b) From July 2016, the GMC requires that all doctors who undertake a recognised educational role (educational supervisors and clinical supervisors), must provide evidence as part of the appraisal process, of their ongoing professional development against the seven domains agreed by the GMC and Academy of Medical Educators "Framework for Supervisors" (2010). This has been incorporated into our e-appraisal system.

c) Appraisers are required to check compliance against the previous year's PDP and agree a new PDP with the appraisee. The appraiser then completes the appraisal summary and appraisal output declarations before submitting the appraisal electronically to the RO for review.

d) To provide assurance on the quality of the appraisals, the Deputy RO and Senior Appraiser review all appraisal forms with all supporting evidence and if any evidence is deemed missing or incomplete, the appraisal is referred back for correction and re-submission.

e) To enhance the level of assurance and provide evidence which challenges the system or the decision-making, all designated bodies are required to undergo a process to validate the status of their revalidation systems at least once in every 5-year revalidation cycle. This may be carried out by audits commissioned by the designated body, their regulators, peers or higher-level RO. NHS England last undertook an audit of the Trust's appraisal and revalidation process with particular emphasis on the core standards of the Framework of Quality Assurance in October 2014.

f) The RO Senior appraiser plus their administrative and management support have all ensured their CPD through appropriate RO training, RO network meetings and Great appraisal event.

g) The RO is involved in peer review.

h) The RO is appraised by the higher level RO as per guidance.

i) The Revalidation Governance Group, chaired by the RO, continues to meet bi-monthly.

j) MFT has been subject to an independent review by NHS England for an independent verification visit in 2014.

k) The Deputy RO and/or Senior Medical Appraiser provided a series of sessions (4 in 2018-19) to inform all new non-training doctors on the requirements for medical appraisal and revalidation. These sessions have been very well attended.

15 Policy and Guidance

15.1 The Trust has a Medical Appraisal and Revalidation Policy and a Remediation of Medical Staff Policy and Procedure. These are updated regularly to ensure all recent amendments to the RO regulations and guidance are included.

16 Access, security and confidentiality

16.1 All non-training doctors are required to use the e-appraisal system as their appraisal portfolio. All doctors have their individual login and password to access the system and only the appraiser and RO and Revalidation team can view the appraisal record and documents. The doctors are informed who can view the appraisal folders. The doctors themselves can then choose who else they may wish to share their appraisal folder with once this has been reviewed by the RO i.e. private organisations for which they undertake clinical work

17 Risk and Issues

17.1 Bank doctors are not always identified as having connection to Medway and therefore the RO may not be fully aware of concerns and there may be delays in arranging and providing appraisals.

17.2 Budget reductions and lack of 2nd Lead Appraiser role may reduce the effectiveness of the appraisal process by

- Limiting new appraiser and refresher training
- Preventing 1-1 feedback to appraisers to enhance quality of appraisals

18 Improvements and Next Steps

18.1 Improvements made since last annual report include:-

a) E-appraisal software continues to develop to further improve the quality of appraisal evidence.
b) Supporting documentation for doctors on Hospital Intranet regularly reviewed and updated – continues to be reviewed, amended and updated accordingly.
c) External New Appraiser training sessions delivered to 25 newly appointed appraisers.

d) Agreement with Governance teams to deliver individual doctor reports on Serious Incidents

18.2 Next Steps

a) Continue improvements in Clinical Governance reporting so that these can be fed into individual appraisals for reflection.
b) Appraisals to be moved forward to ensure minimum appraisals are scheduled for August, February and March (unless there are exceptional circumstances), which improved compliance rates.
c) Appraiser Refresher sessions to be arranged for all appraisers to be updated on recent updates from GMC and NHS England.
d) Introducing Standard Operating Procedure (SOP) to increase the number of doctors fully completing their appraisal in scheduled month.
e) New appraiser training in 2019-2020 to replace loss of some current appraisers.
f) Succession planning exercise to be undertaken in winter 2019/2020 to ensure resourcing is in place to future proof appraisal and revalidation process.
g) Development of CPD app linked to L2P system to improve functionality of the e-appraisal system
h) Plan with NHS England an Independent Verification visit for 2019-20.

19 Recommendation

19.1 The Board is asked to approve this report so that the CEO or Chair can sign the Statement of Compliance which is a statutory requirement.

Appendices

Appendix 1 - Comparator Reports – MFT against same and all sectors – 2018-2019

Appendix 2 - Designated Body Statement of Compliance – 2018-2019

Appendix 1 - Comparator Reports – MFT against same and all sectors – 2018-2019

2018/19 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 96	All sectors: Total DBs: 862
		Completed appraisals (1)		
2.1	Number of doctors with whom the designated body has a prescribed connection on 31 March 2019 who had a completed annual appraisal between 1 April 2018 – 31 March 2019	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	166 (98.2%)	93.5%	93.7%
2.1.2	Staff grade, associate specialist, specialty doctor	96 (99.0%)	88.8%	88.2%
2.1.3	Doctors on Performers Lists	N/A	91.4%	95.2%
2.1.4	Doctors with practising privileges	N/A	100.0%	92.7%
2.1.5	Temporary or short-term contract holders	63 (96.9%)	77.8%	81.8%
2.1.6	Other doctors with a prescribed connection to this designated body	28 (93.3%)	72.1%	87.9%
2.1.7	Total number of doctors who had a completed annual appraisal	353 (97.8%)	89.3%	91.5%

Appendix 2 Compliance Statement

Designated Body Statement of Compliance – 2018 -19

The Trust Board management team of Medway NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   CONFIRMED

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   CONFIRMED

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   CONFIRMED

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   CONFIRMED

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   CONFIRMED

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   CONFIRMED

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   CONFIRMED

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

   CONFIRMED

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

   CONFIRMED

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

    CONFIRMED

Signed on behalf of the designated body (must be signed by the Chief Executive or Chair)

Name: Signed: _____

Medway NHS Foundation Trust

Date:

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	Organ Donation Annual Report 2018-19 and Strategy for 2019-20	**Agenda Item**	**9.3**
Lead Director	Dr David Sulch, Executive Medical Director		
Report Author	Dr Paul Hayden, Clinical Lead for organ donation. Dr Gill Fargher, Chair Organ Donation Committee, Alison Hill, Specialist Nurse for Organ Donation		
Executive Summary	Organ Donation is an incredibly altruistic act that is only possible thanks to the selflessness of our donors and their families. In 2018-19, 8 patients donated their organs after death, leading to 15 patients receiving life-saving transplants. This is a slight reduction from 2017-18 but reflects the national trends which are not clearly understood. The Trust referral rate was 96% with 44 out of a potential 46 patients being referred for consideration for organ donation. The Organ Donation Committee continues to co-ordinate educational and public awareness work to promote organ donation within the Trust and to the local community. Considerable work has been undertaken over the past year to promote organ donation specifically to the BAME community, a group with low membership of the organ donor register, leading to significant delays in ethnic patients receiving organ transplants. The chair and clinical lead for organ donation were asked by the national lead for organ donation to give a lecture at a national organ donation meeting in March showcasing the proactive work being undertaken at the Trust to promote organ donation. The law regarding consent for organ donation, now known as “Max and Keira’s Law” (to reflect the importance of both the donor and the recipient) is changing next April from “opt in” to “opt out”. The organ donation committee will ensure that information is disseminated within the Trust once the publicity campaign is launched. The strategic objectives for 2019-20 are unchanged from 2018-19: • 0% missed opportunities for organ donation • Increase tissue donation referrals • Continue to promote organ donation and membership of the ODR to local community • Provide education regarding changes to national “opt out” policy for organ donation		
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	State which sub group or subcommittees have reviewed the paper with dates.	
Resource Implications	Not Applicable	
Legal Implications/Regulatory Requirements	Not Applicable	
Quality Impact Assessment	Not Applicable	
Recommendation/ Actions required	The Board is asked to note the Organ Donation Annual Report 2018-19 and Strategy for 2019-20	

Approval	Assurance	Discussion	Noting
☐	☐	☒	☒

Appendices	Appendix A: National Potential Donor Audit 2018-19 Appendix B: Sharing Hospital engagement and public promotion poster Appendix C: Financial summary

Medway NHS Foundation Trust Organ Donation Annual Report 2018-19 & Strategy for 2019 - 2020

Dr Paul Hayden	*Clinical Lead Organ Donation*
Dr Gill Fargher	*Chairman Organ Donation Committee*
Mrs Alison Hill	*Specialist Nurse Organ Donation*

Contents

Glossary

- CLOD – Clinical Lead Organ Donation
- SNOD – Specialist Nurse Organ Donation
- ODCC- Organ Donation Committee Chair
- NHSBT – NHS Blood and Transplant
- DBD – Donation after Brain Death
- DCD – Donation after Circulatory Death
- ODC – Organ Donation Committee
- PDA – Potential Donor Audit (national audit of activity by NHSBT)
- ICU/ITU – Intensive Care Unit
- ED/A&E – Emergency Department
- HDU – High Dependency Unit

Definitions

POTENTIAL DONOR AUDIT / REFERRAL RECORD	
Data excluded	Patients who did not die on a critical care unit or an emergency department and patients aged over 80 years are excluded.
Donors after brain death (DBD)	
Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates - less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SN-OD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's op-out decision via the Organ Donor Register
Consent / authorisation ascertained	Family supported expressed or deemed consent/authorisation, nominated/appointed representative gave consent, or where applicable the family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SN-OD
Approach rate	Percentage of eligible DBD families or nominated/appointed representatives approached for formal organ donation discussion
Consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
Expected consent / authorisation rate	Consent / authorisation rate adjusted for ethnicity case mix (white or BAME (black, asian and minority ethnic)), based on those patients whose family or nominated/appointed representative were approached to discuss organ donation where consent/authorisation was ascertained and patient ethnicity was known
SN-OD involvement rate	Percentage of family or nominated/appointed representative approaches where a SN-OD was involved
SN-OD consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion by a SN-OD where consented / authorisation for organ donation was ascertained

Donors after circulatory death (DCD)	
Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SN-OD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's op-out decision via the Organ Donor Register
Consent / authorisation ascertained	Family supported expressed or deemed consent/authorisation, nominated/appointed representative gave consent, or where applicable the family gave consent/authorisation
Actual DCD	DCD patients who became actual DCD as reported through the PDA
Referral rate	Percentage of patients for whom imminent death was anticipated who were discussed with the SN-OD
Approach rate	Percentage of eligible DCD families or nominated/appointed representatives approached for formal organ donation discussion
Consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
Expected consent / authorisation rate	Consent / authorisation rate adjusted for ethnicity case mix (white or BAME (black, asian and minority ethnic)), based on those patients whose family or nominated/appointed representative were approached to discuss organ donation where consent/authorisation was ascertained and patient ethnicity was known
SN-OD involvement rate	Percentage of family or nominated/appointed representative approaches where a SN-OD was involved
SN-OD consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion by a SN-OD where consented / authorisation for organ donation was ascertained
UK Transplant Registry (UKTR)	
Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by number of donors. The maximum number of solid organs that can be donated are 7 for a DBD and 6 for a DCD.
Number of organs transplanted	Total number of organs transplanted by organ type

1. Executive Summary

There were **8** successful organ donations at Medway in 2018-19 leading to **15** patients receiving life-saving organ transplants (see appendix A). This was only possible thanks to the incredible altruism of the donors and their families and the hard work of the staff at Medway, the transplant centres, and NHSBT.

The Trust continues to strive to ensure that all potential organ donors have the opportunity to donate their organs after death and identified **44** patients out of a potential **46** for organ donation (96%).

The organ donation committee is committed to improving organ donation rates with an on-going education and awareness strategy aimed at key stakeholders. Over the past year, the organ donation team has delivered simulation training on tissue donation, was asked to present nationally on our achievements at promoting organ donation within the local community, and has been busy planning a major event in September 2019 to encourage support for organ donation within the BAME community.

The strategic objectives for 2018-19 were;

- 0% missed opportunities for organ donation
- Increase tissue donation referrals
- Continue to promote organ donation and membership of the ODR to local community
- Provide education regarding changes to national “opt out” policy for organ donation

There were potentially 2 missed opportunities for organ donation (44 out of 46 potential patients referred – **96%** compliance).

Tissue donation referrals have increased from **14** in 2017-18 to **22** in 2018-19 and we have continued to work to increase this number with tissue donation simulation study sessions held for ward staff members and the addition of a tissue donation family representative to the organ donation committee along with the regional tissue donation specialist nurse educator.

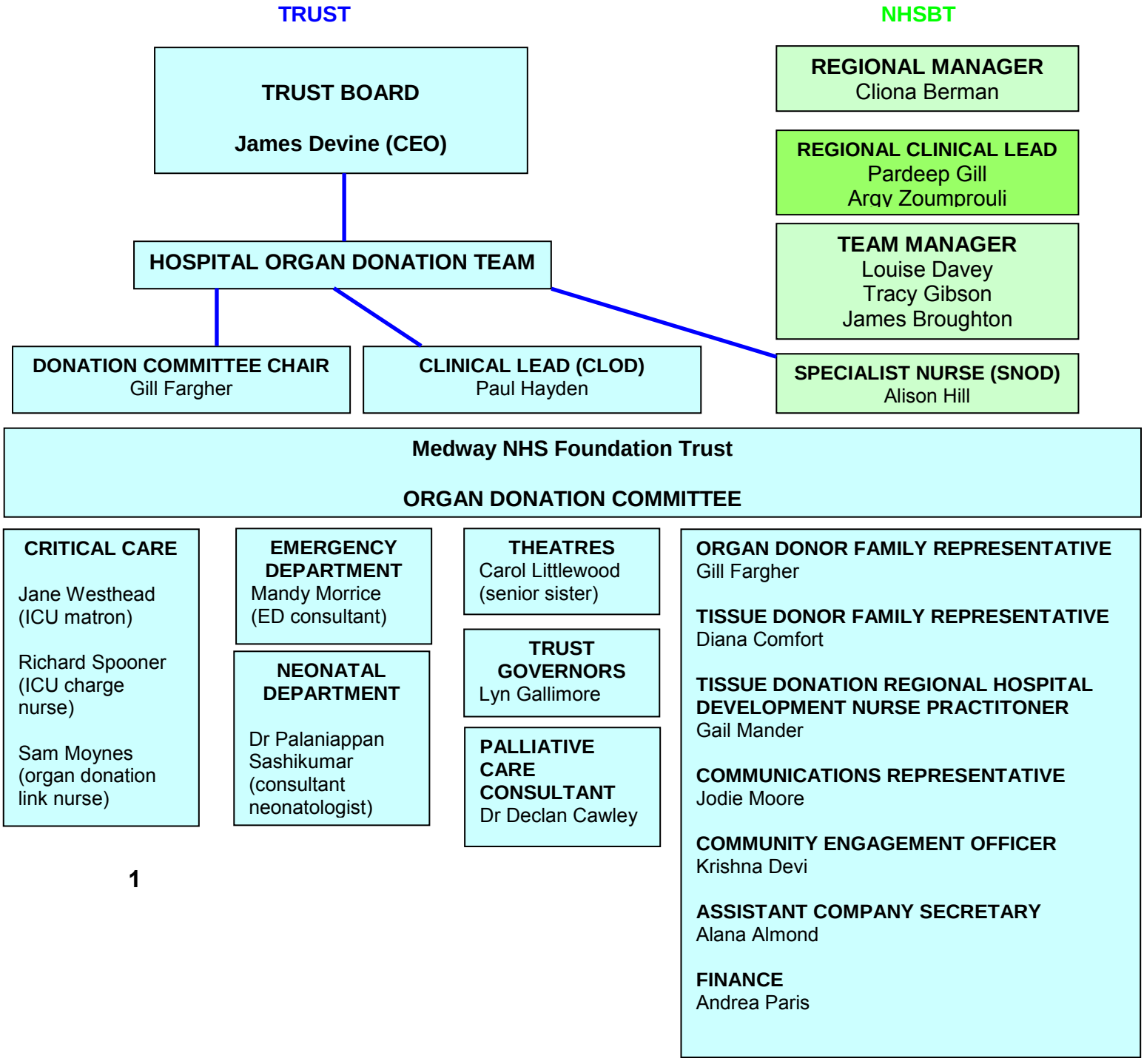
Members of the committee have continued to promote organ donation widely amongst the local community, in particular within BAME communities with extensive preparatory work for a multi-cultural seminar planned for September 2019.

The organ donation chair and clinical lead presented work at a national conference in Birmingham celebrating our achievements with regard to the promotion of organ donation (see appendix B), and also attended the biennial organ donation and transplantation congress in March where the national strategy for the change in organ donation consent was presented.

The national strategy will be presented to the trust grand round in September with promotional work continuing next year.

The strategic objectives for 2019-20 are unchanged from 2018-19 as these remain key priorities for the Trust.

2. Trust Organ Donation Team Structure



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3. Report from the Organ Donation Committee (ODC)

Medway Foundation Trust Organ Donation Committee (ODC) meets quarterly and is supported by a committed membership. The primary role of the ODC is to consider the Potential Donor Audit (PDA) ensuring that as far as possible no potential donors are missed. If this does occur, detailed scrutiny of contributory factors are identified, considered and if appropriate, addressed.

The members of the ODC, without exception, not only support the work of the committee itself but continue this work within their respective areas of responsibility and in so doing ensure that knowledge, discussion and education in organ donation is ongoing. This is invaluable and contributes to the normalisation of organ donation.

The South East regional managers from NHSBT have standing invitations to attend our Organ Donation Committee meetings and do so which greatly facilitates our collaborative working.

Medway Foundation Trust is currently a Level 2 hospital (determined by the number of organ donors annually) The Clinical Lead for Organ Donation (CLOD) Dr. Paul Hayden and I were invited to deliver a presentation on our engagement work at the national biennial Level 2 meeting in January (see appendix B). We attended the inaugural Joint Congress for the British Transplant Society and NHS Blood and Transplant (NHSBT) in March and I subsequently attended an NHSBT conference for ODC chairs.

Max and Keira's Law, also known as the Organ Donation (Deemed Consent) Bill 2017-19 or "opt-out" bill, received Royal Assent on the 15th of March 2019, giving formal confirmation that the Bill will now become law. This change in the law is expected to take place in the spring of 2020. In order to prepare for this we have ensured that presentations on organ donation include this information and will continue to do so as we approach this very significant law change.

Tissue donation has remained a strategic objective for this current year however our approach has been strengthened with a number of work streams. Training and education has been delivered in a number of ways. Half day simulation training for nurses was delivered by Dr. Paul Hayden and Dr. Declan Cawley in the simulation suite at the Trust. A further training session was delivered to the oncology nurses of Galton Day Unit by Sister Sam Moynes from critical care. Information on tissue donation for the public and for health professionals is freely available within the Trust. A screensaver promoting tissue donation will be used across the Trust shortly. We have developed good working relationships with our mortuary colleagues who undertake some of the tissue retrieval work and supported relevant further training for them.

We have welcomed a donor family representative for tissue donation to the ODC. She links regularly with NHSBT Tissue and Eye Services and so provides an absolutely invaluable source of information in addition to a unique personal perspective.

We are establishing regional and national links in tissue donation and are being supported both at the ODC and in our tissue donation work at the Trust by Gail Mander, Hospital Development Nurse Practitioner for London and the South East, who is providing expertise and considerable support.

We have received 2 invitations to deliver presentations in local secondary schools which is timely in the light of the imminent law change.

Extensive work over many months with our black, Asian and minority ethnic communities will culminate in our event in September at Canterbury Christ Church University on increasing organ donation and

transplantation among BAME communities. We have worked with Medway Diversity Forum in the development and promotion of this event as well as our keynote speakers.

I delivered a presentation to the Bengali community in April following an invitation and subsequently to an African church community to whom there is a plan to return.

We are indebted to the members of Medway Diversity Forum who have fully engaged with this work over the last year and continue to give of their time and experience in raising the profile of organ donation within their communities.

Organ donation is one of the most complex, collaborative, time critical processes to take place within the NHS. It requires the dedication, expertise and skill of a very large team of people, often working long and antisocial hours in challenging circumstances. No organ donation would take place however, without the ultimate selfless gift from donors and their families. These families have been able to look beyond their grief and dreadful loss and think of others, and to them we owe an immense debt of gratitude.

Organ donors are honoured posthumously with The Order of St. John. These awards are presented annually at a special ceremony where families are invited to receive the award for their loved one. I have been privileged to speak at the last two ceremonies for Kent. I was honoured to meet families trying to deal with devastating personal loss but whose pride in their loved one's gift of life is so very evident.

Dr Gill Fargher
ODC Chair

4. Organ Donation Rates / PDA Benchmarking 2018/19

4.1 Medway Trust overview of PDA metrics 2018-19 with 2017-18 data for comparison (see appendix A)

Whilst the total number of patients admitted to the Intensive Care Unit who may be potentially suitable for organ donation is variable, the Trust is benchmarked against other Trusts in the UK based on a number of metrics that measure performance towards nationally agreed best practice for the identification and management of potential donors. These metrics are summarised in Appendix 1 (PDA – Potential Donor Audit).

The table below shows the total numbers of organ donors based on the donor type (Donation after Brain Death: DBD versus Donation after Cardiac Death: DCD) with the previous year's data for comparison.

There were a total of **18** consented donors with **8** patients proceeding to organ retrieval leading to **15** organ transplants.

Donor type	2018-19 (2017-18)	Number of patients receiving transplants	Average number of organs donated per donor 2018-19 (2017-18)	
			Trust	UK
DBD	3 (5)	5 (10)	2.7 (2.8)	3.5 (3.7)
DCD	5 (3)	10 (6)	2.4 (2.0)	2.7 (2.7)
TOTAL	**8** (8)	**15** (16)	**2.5** (2.5)	3.2 (3.3)

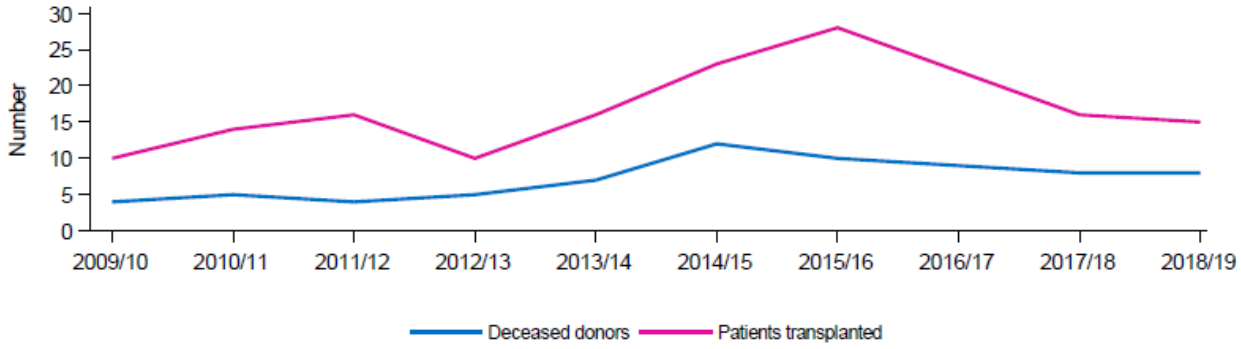
The reasons for 10 patients (2 patients multiple reasons) not proceeding to organ donation were:

- Organs deemed medically unsuitable by recipient centres 6
- Prolonged time to asystole 3
- Coroner refusal 1
- General instability 1
- Family changed mind 1

The table below shows the number of individual organs transplanted (with previous year's data for comparison in brackets)

Donor type	Number of organs transplanted by type 2018-19 (2017-18)				
	Kidney	Pancreas	Liver	Heart	Lung
DBD	3 (6)	1 (0)	2 (4)	0 (0)	0 (0)
DCD	9 (6)	1 (0)	1 (0)	0 (0)	0 (0)
Totals	12 (12)	1 (0)	3 (4)	0 (0)	0 (0)

The number of organ donors and patients transplanted has remained stable for the past couple of years (see graph below) but has declined since a peak in 2015/16. This is largely due to changes in the case-mix of patients admitted to the ICU.



Overall the Trust's metrics for the percentage of appropriate referrals and approaches to families remains positive and give assurance that potential donors are not being missed.

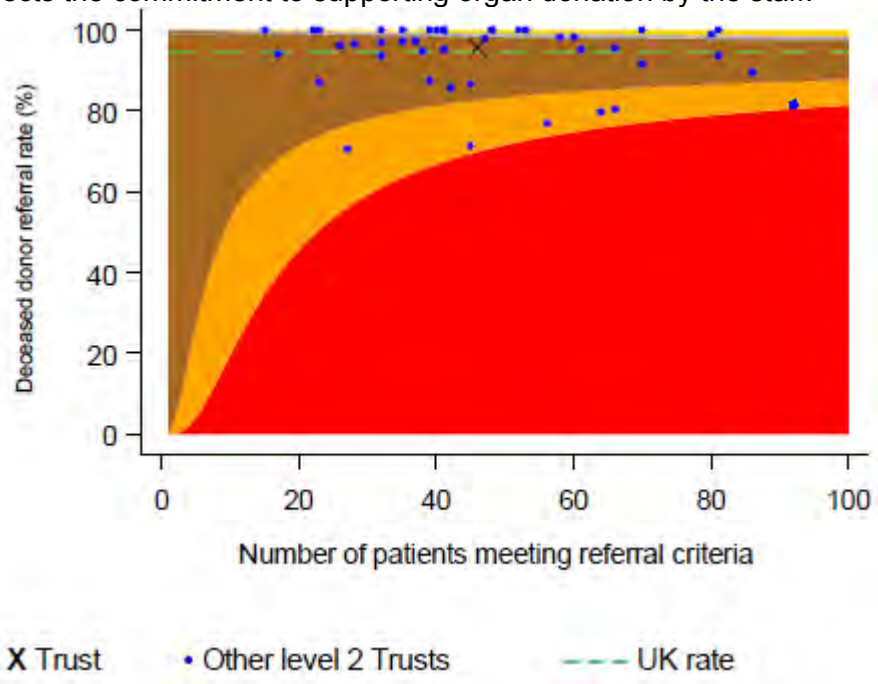
	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	10	2004	39	5974	46	7728
Referred to Organ Donation Service	10	1982	37	5539	44	7287
Referral rate %	G *100%*	*99%*	B *95%*	*93%*	B *96%*	*94%*
Neurological death tested	8	1715				
Testing rate %	B *80%*	*86%*				
Eligible donors[2]	6	1635	30	4180	36	5815
Family approached	6	1493	23	1752	29	3245
Family approached and SNOD present	6	1423	17	1527	23	2950
% of approaches where SNOD present	G *100%*	*95%*	B *74%*	*87%*	B *79%*	*91%*
Consent ascertained	4	1082	16	1099	20	2181
Consent rate %	B *67%*	*72%*	B *70%*	*63%*	B *69%*	*67%*
Actual donors (PDA data)	4	970	4	612	8	1582
% of consented donors that became actual donors	*100%*	*90%*	*25%*	*56%*	*40%*	*73%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

The graph below demonstrates that the Trust's referral rate compares well with peer Trusts. Furthermore, this "peer" group comprises predominantly large district general hospitals and teaching hospitals and reflects the commitment to supporting organ donation by the staff.



Contra-indications to solid organ transplant

There were **8** patients with medical contraindications to solid organ donation for the period April 2018-19. The reasons listed were:

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Active (not in remission) haematological malignancy (myeloma, lymphoma, leukaemia)	-	14	2	201
All secondary intracerebral tumours	-	2	-	8
Any active cancer with evidence of spread outside affected organ within 3 years of donation	1	46	5	630
HIV disease (but not HIV infection)	-	5	-	12
Human TSE, CJD or vCJD; blood relatives with CJD; other infectious neurodegenerative diseases	-	1	-	8
Melanoma (except completely excised Stage 1 cancers)	-	1	-	3
No transplantable organ in accordance with organ specific contraindications	-	7	-	234
Primary intra-cerebral lymphoma	-	-	-	5
TB: active and untreated	-	2	-	13
West Nile Virus (WNV) infection	-	-	-	1
Total	**1**	**78**	**7**	**1115**

Reasons why families did not support organ donation

The process of consent for organ donation will change next year. However, for 2018-19, the process in England remains an “opt in” process. In situations where there the patient’s views are unknown, the family are asked for their views. The Trust fully supports a collaborative process between ICU clinician and specialist nurse in organ donation, but even with their experience, some families do not support organ donation.

For 2018-19, there were **9** instances where families did not support organ donation. The reasons listed were:

- Family felt the patient had suffered enough 2
- Family did not want surgery to the body 1
- Family felt the donation process was too long 1
- Family were divided over the decision 2
- Family were not sure whether the patient would have agreed to donation 1
- Patient previously expressed a wish not to donate 1
- Other 1

5. Performance against 2018/19 Objectives

Item	Objectives for 2017/18	Outcomes
1	0% missed opportunities for organ donation	**Frequent updates about organ donation given to critical care staff.** **96% referral achieved for planned withdrawals (44 out of 46 patients). 2 patients not referred: 1 deemed medically unsuitable and 1 omission by the medical team.**
2	Increase tissue donation referrals	**An increase in tissue donations occurred from 14 in 2017-18 to 22 in 2018-19. Whilst this is a numerical increase, we know that there is significant potential to increase this further. Therefore, we will continue to develop strategies to maximise tissue donation in 2019-20**
3	Continue to promote organ donation and membership of the ODR to local community	**Multiple educational sessions for local community including presentation by ODCC to Bengali community, Trust Governors' event and Medway Diversity Forum. Preparatory work for large BAME educational event in September 2019 undertaken throughout 2018-19. Invitations to speak to local schools to increase awareness about organ donation for 2019-20.**
4	Provide education regarding changes to national "opt out" policy for organ donation	**Clinical lead and chair of ODC attended national congress on organ donation and received up to date information regarding national changes. Initial information disseminated from NHSBT but national roll out of PR has not commenced yet. Trust grand round planned for September 2019 to provide current information and act as forum for discussion within Trust. Educational sessions planned for 2019-20.**

6. Strategic objectives for 2019/20 and Monitoring Arrangements

Objectives for 2018/ 19	Actions Required to Deliver Objective	Measurable Outcome / Milestones	Delivery Lead	Risks to completion
1. **0% missed opportunities for organ donation**	Ensure 100% referral for potential DBD and DCD donors on ICU and ED Follow national best-practice for collaborative approach	PDA data	CLOD SNOD ED champion	Increased clinical workload may mean organ donation cannot proceed in suitable individuals at times of high clinical intensity
• **Increase tissue donation referrals**	Education for all ward nurses Work with regional/ national tissue donation nurse educators to strengthen internal efforts	Measure percentage referrals vs total number of deceased patients per ward. Overall target 100% but year on year targets need to be realistic.	CLOD SNOD EOL team Tissue donation link nurses ODCC	Lack of retention of ward staff to sustain efforts to inform relatives. Lack of educational sessions for staff
3. **Continue to promote organ donation and membership of the ODR to local community**	Consider potential to speak to schools Continue to work with ethnic minorities to improve ODR membership in BAME communities	Local ODR membership Family assent percentage for organ donation in ICU BAME-specific organ donation meeting	CLOD SNOD ODCC	Potential initial negative response to national changes to organ donation ("opt out" policy)
4. **Provide education regarding changes to national "opt out" policy for organ donation**	Provide relevant education in accordance with national guidelines as details of "opt out" changes are disseminated from NHSBT	Educational sessions	CLOD SNOD ODCC	Delays in relevant information being disseminated from government/ NHSBT

7. Critical Incidents

There were no critical incidents reported in 2018-19.

8. Appendices

Appendix 1: **National Potential Donor Audit Report 2018-19**

Appendix 2: **Sharing Hospital Engagement and Public Promotion Poster**

Appendix 3: **Finance Overview for 2018-19**

Appendix A

NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2018 - 31 March 2019

Medway NHS Foundation Trust

Table of Contents

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record. Issued May 2019 based on data meeting PDA criteria reported at 9 May 2019.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2018 and 31 March 2019, Medway NHS Foundation Trust had 8 deceased solid organ donors, resulting in 15 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2017/18. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2018 - 31 March 2019 (1 April 2017 - 31 March 2018 for comparison)

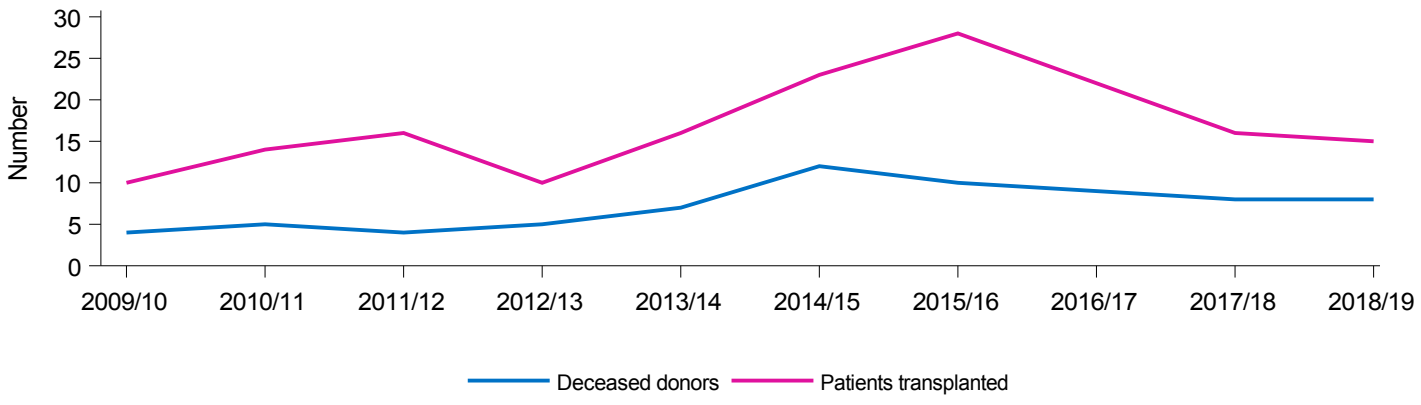
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor Trust		Average number of organs donated per donor UK	
DBD	3	(5)	5	(10)	2.7	(2.8)	3.5	(3.7)
DCD	5	(3)	10	(6)	2.4	(2.0)	2.7	(2.7)
DBD and DCD	8	(8)	15	(16)	2.5	(2.5)	3.2	(3.3)

In addition to the 8 proceeding donors there were 10 additional consented donors that did not proceed, all where DCD donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2018 - 31 March 2019 (1 April 2017 - 31 March 2018 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	3	(6)	1	(0)	2	(4)	0	(0)	0	(0)	0	(0)
DCD	9	(6)	1	(0)	1	(0)	0	(0)	0	(0)	0	(0)
DBD and DCD	12	(12)	2	(0)	3	(4)	0	(0)	0	(0)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2009 - 31 March 2019



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents specific percentage measures of potential donation activity for Medway NHS Foundation Trust.

Performance in your Trust has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. In total there were 0 patients referred in 2018/19 who are not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

Note that caution should be applied when interpreting percentages based on small numbers.

Goal: The agreed 2018/19 national targets for DBD and DCD consent rates are 78% and 72%, respectively.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2018 - 31 March 2019

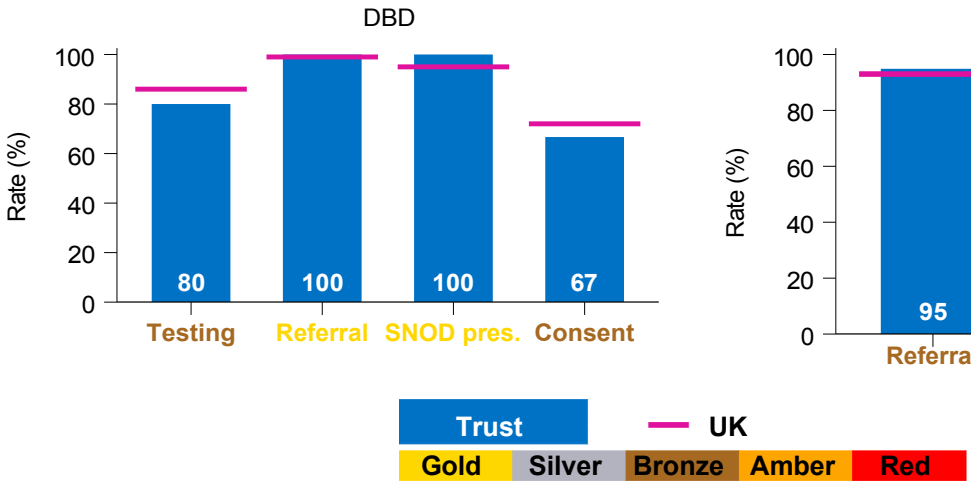


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2014 - 31 March 2019

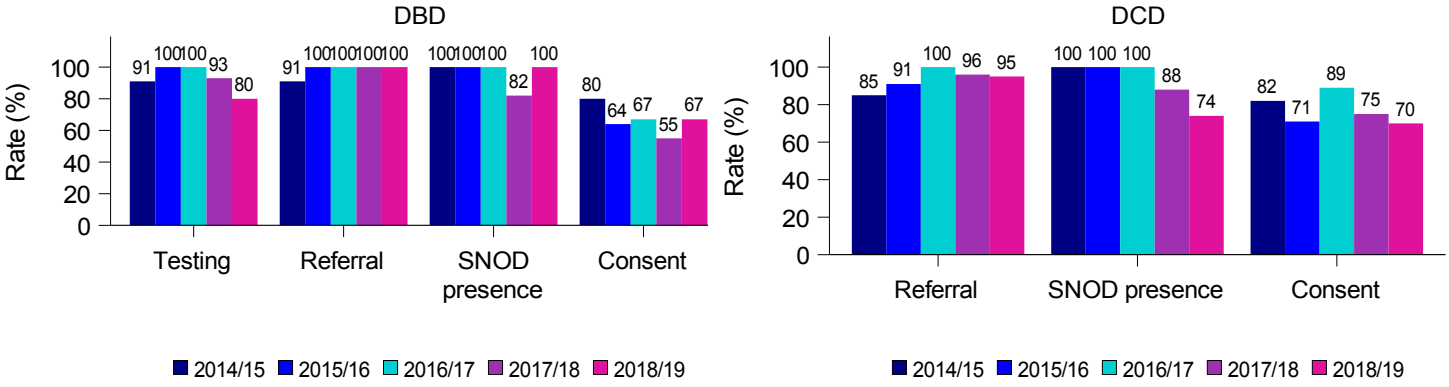


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2018 - 31 March 2019

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	10	2004	39	5974	46	7728
Referred to Organ Donation Service	10	1982	37	5539	44	7287
Referral rate %	G *100%*	*99%*	B *95%*	*93%*	B *96%*	*94%*
Neurological death tested	8	1715				
Testing rate %	B *80%*	*86%*				
Eligible donors[2]	6	1635	30	4180	36	5815
Family approached	6	1493	23	1752	29	3245
Family approached and SNOD present	6	1423	17	1527	23	2950
% of approaches where SNOD present	G *100%*	*95%*	B *74%*	*87%*	B *79%*	*91%*
Consent ascertained	4	1082	16	1099	20	2181
Consent rate %	B *67%*	*72%*	B *70%*	*63%*	B *69%*	*67%*
Actual donors (PDA data)	4	970	4	612	8	1582
% of consented donors that became actual donors	*100%*	*90%*	*25%*	*56%*	*40%*	*73%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2014 - 31 March 2019

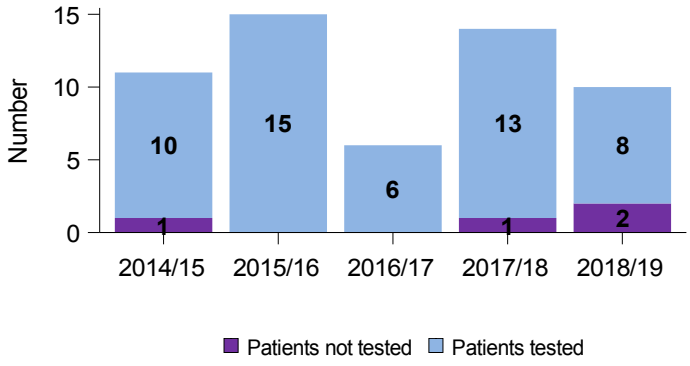


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2018 - 31 March 2019

	Trust	UK
Biochemical/endocrine abnormality	-	20
Clinical reason/Clinicians decision	1	48
Continuing effects of sedatives	-	14
Family declined donation	-	22
Family pressure not to test	1	35
Inability to test all reflexes	-	13
Medical contraindication to donation	-	10
Other	-	18
Patient had previously expressed a wish not to donate	-	5
Patient haemodynamically unstable	-	80
Pressure on ICU beds	-	1
SN-OD advised that donor not suitable	-	7
Treatment withdrawn	-	11
Unknown	-	5
Total	**2**	**289**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2014 - 31 March 2019

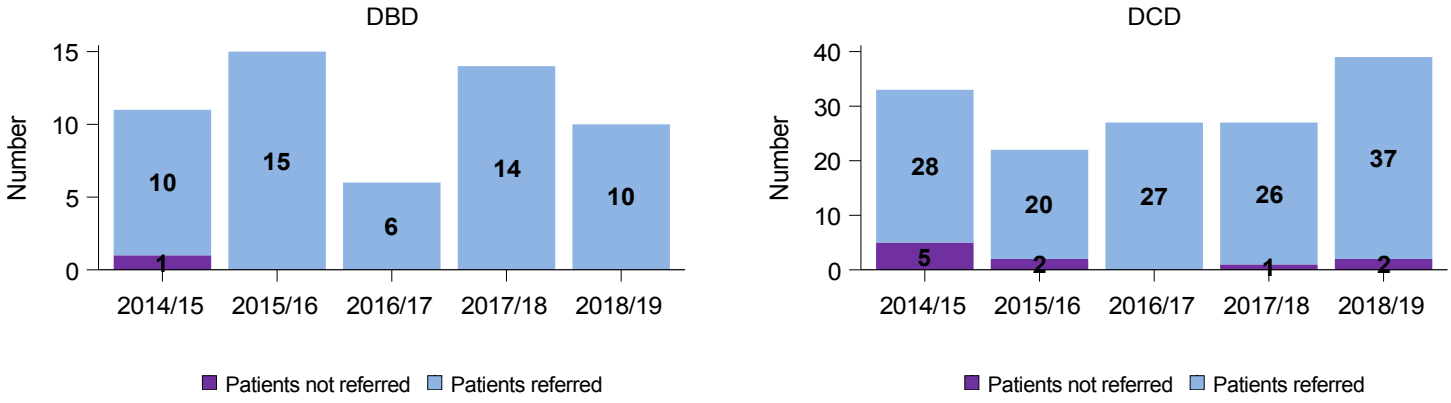


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Trust	UK	Trust	UK
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	4
Coroner/Procurator Fiscal Reason	-	1	-	2
Family declined donation following decision to withdraw treatment	-	2	-	15
Family declined donation prior to neurological testing	-	2	-	2
Medical contraindications	-	-	-	56
Not identified as a potential donor/organ donation not considered	-	11	1	215
Other	-	4	-	56
Pressure on ICU beds	-	-	-	3
Reluctance to approach family	-	-	-	2
Thought to be medically unsuitable	-	2	1	78
Thought to be outside age criteria	-	-	-	2
Total	**-**	**22**	**2**	**435**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

Table 3.3 shows the primary absolute medical contraindications to solid organ donation, if applicable, for potential DBD donors confirmed dead by neurological death tests and potential DCD donors in your Trust.

Table 3.3 Primary absolute medical contraindications to solid organ donation, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Active (not in remission) haematological malignancy (myeloma, lymphoma, leukaemia)	-	14	2	201
All secondary intracerebral tumours	-	2	-	8
Any active cancer with evidence of spread outside affected organ within 3 years of donation	1	46	5	630
HIV disease (but not HIV infection)	-	5	-	12
Human TSE, CJD or vCJD; blood relatives with CJD; other infectious neurodegenerative diseases	-	1	-	8
Melanoma (except completely excised Stage 1 cancers)	-	1	-	3
No transplantable organ in accordance with organ specific contraindications	-	7	-	234
Primary intra-cerebral lymphoma	-	-	-	5
TB: active and untreated	-	2	-	13
West Nile Virus (WNV) infection	-	-	-	1
Total	**1**	**78**	**7**	**1115**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.4 SNOD presence

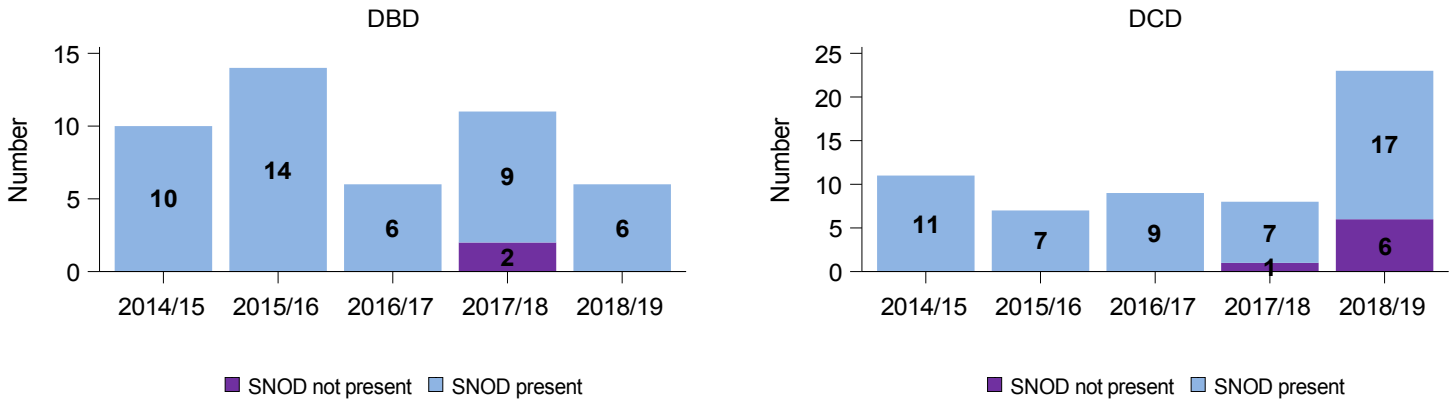
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2018/19, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 53% and 23%, respectively, compared with DBD and DCD consent/authorisation rates of 73% and 69%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known wishes of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2014 - 31 March 2019



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2019]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2019]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2019]

3.5 Consent

Goal: The agreed 2018/19 national targets for DBD and DCD consent/authorisation rates are 78% and 72%, respectively.

In 2018/19 the DCD consent rate in your Trust was 70%, less than 10 families of eligible DBD donors were approached therefore this consent rate is not presented.

Figure 3.4 Number of families approached, 1 April 2014 - 31 March 2019

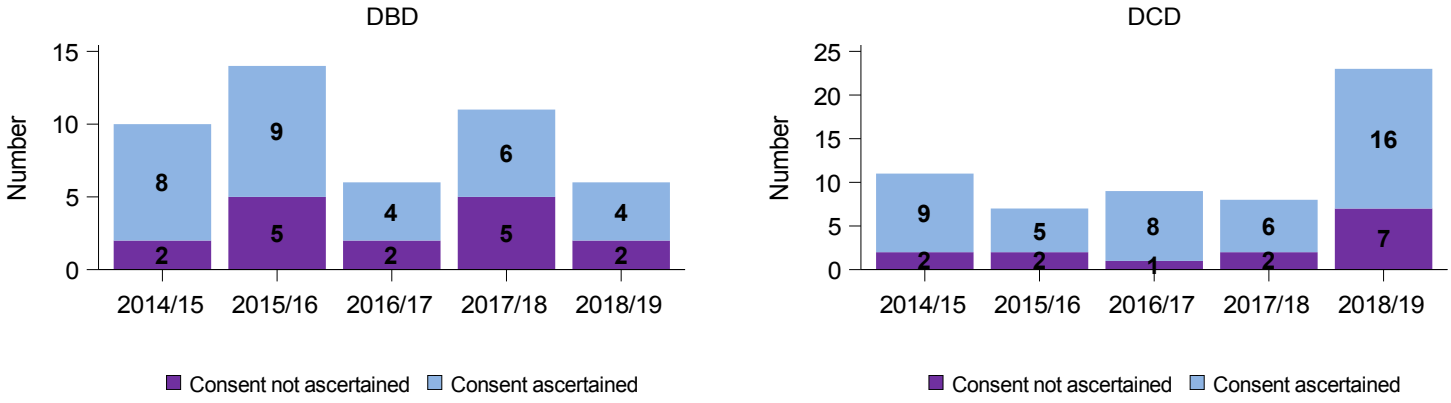


Table 3.4 Reasons given why consent was not ascertained, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Trust	UK	Trust	UK
Families concerned about organ allocation	-	4	-	-
Family concerned donation may delay the funeral	-	1	-	-
Family concerned that organs may not be transplanted	-	3	-	8
Family concerned that other people may disapprove/be offended	-	3	-	1
Family did not believe in donation	-	22	-	25
Family did not want surgery to the body	-	42	1	51
Family felt it was against their religious/cultural beliefs	-	44	-	21
Family felt the body needs to be buried whole (unrelated to religious or cultural reasons)	-	24	-	19
Family felt the length of time for donation process was too long	-	22	1	88
Family felt the patient had suffered enough	-	30	2	50
Family had difficulty understanding/accepting neurological testing	-	1	-	-
Family wanted to stay with the patient after death	-	5	-	11
Family were divided over the decision	1	25	1	31
Family were not sure whether the patient would have agreed to donation	-	78	1	123
Other	-	18	1	55
Patient previously expressed a wish not to donate	1	82	-	147
Patients treatment may be or has been limited to facilitate organ donation	-	-	-	1
Strong refusal - probing not appropriate	-	7	-	22
Total	**2**	**411**	**7**	**653**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted. The strategy for achieving this, including steps to minimising warm ischaemic injury in proceeding DCD donors, is set out in NHSBT Taking Organ Utilisation to 2020 [4].

Table 3.5 Reasons why solid organ donation did not occur, 1 April 2018 - 31 March 2019

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Cardiac Arrest	-	8	-	5
Coroner/Procurator Fiscal refusal	-	16	1	23
Family changed mind	-	8	1	18
Family placed conditions on donation	-	-	-	1
General instability	-	9	1	32
Logistic reasons	-	-	-	3
Organs deemed medically unsuitable by recipient centres	-	42	6	136
Organs deemed medically unsuitable on surgical inspection	-	5	-	10
Other	-	10	-	33
Positive virology	-	14	-	7
Prolonged time to asystole	-	-	3	219
Total	**-**	**112**	**12**	**487**

If 'other', please contact your local SNOD or CLOD for more information, if required.

[4] NHS Blood and Transplant, 2017.
Taking Organ Utilisation to 2020
[accessed 9 May 2019]

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Trust with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Trust is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Trust, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

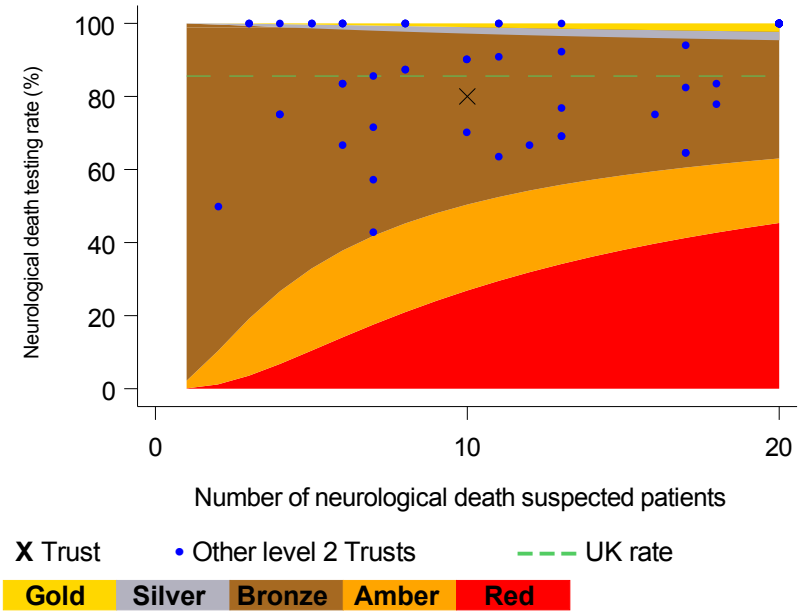
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2018 - 31 March 2019

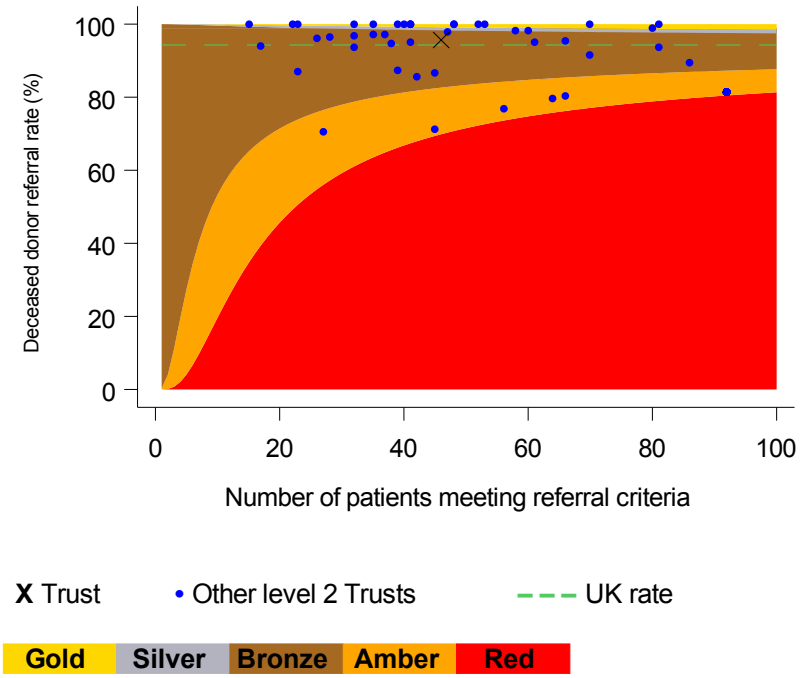


When compared with UK performance the neurological death testing rate in Medway NHS Foundation Trust was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2018 - 31 March 2019

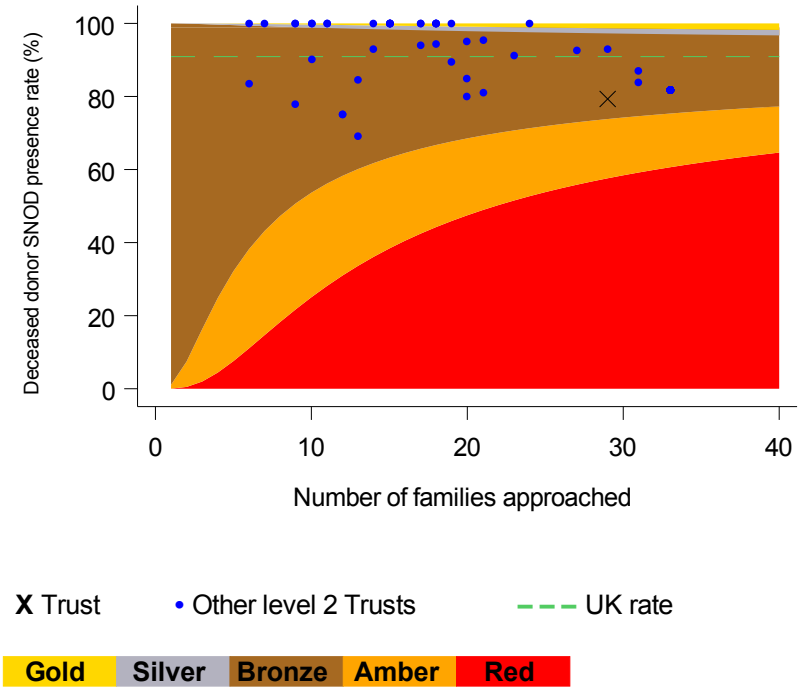


When compared with UK performance Medway NHS Foundation Trust was average (bronze) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2018 - 31 March 2019

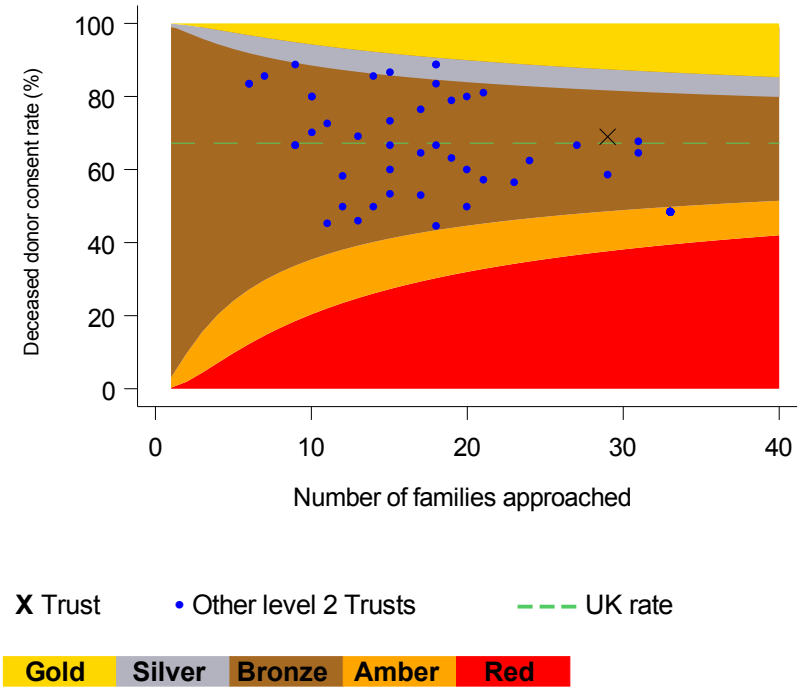


When compared with UK performance Medway NHS Foundation Trust was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Goal: The agreed 2018/19 national targets for DBD and DCD consent/authorisation rates are 78% and 72%, respectively.

Figure 4.4 Funnel plot of consent rate, 1 April 2018 - 31 March 2019



When compared with UK performance the consent rate in Medway NHS Foundation Trust was average (bronze).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2018 - 31 March 2019

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Gillingham, Medway Hospital													
A&E	0	0	-	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	10	8	80	10	100	7	6	6	6	-	4	-	4

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2018 - 31 March 2019

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Gillingham, Medway Hospital											
A&E	0	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	39	37	95	37	30	23	17	74	16	70	4

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Medway NHS Foundation Trust in 2018/19 there were 1 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

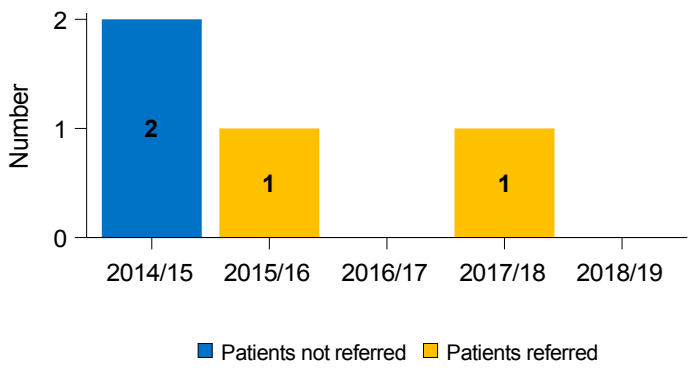
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a wish in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [5] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

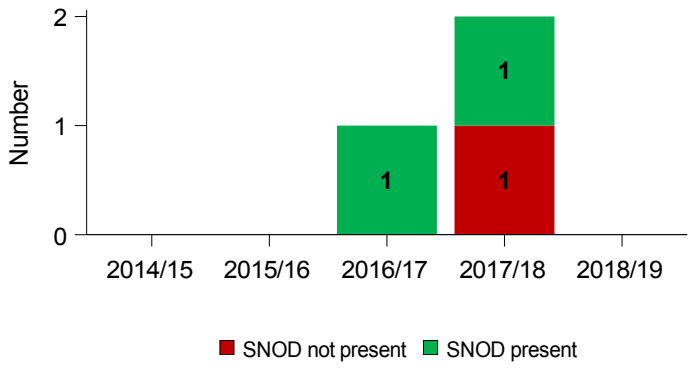
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2014 - 31 March 2019



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2014 - 31 March 2019



[5] NHS Blood and Transplant, 2016.
Organ Donation and the Emergency Department
[accessed 9 May 2019]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South East Coast*	UK
1 April 2018 - 31 March 2019		
Deceased donors	91	1,600
Transplants from deceased donors	236	3,943
Deaths on the transplant list	19	403
As at 31 March 2019		
Active transplant list	267	6,083
Number of NHS ODR opt-in registrations (% registered)**	2,096,289 (45%)	26,496,220 (41%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 4.63 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

7.2 Trust/Board Level Benchmarking

Medway NHS Foundation Trust has been categorised as a level 2 Trust. Levels were reallocated in July 2018 using the average number of donors in 2016/17 and 2017/18, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more (≥ 12) proceeding donors per year	35
Level 2	6 or more but less than 12 (≥ 6 to <12) proceeding donors per year	45
Level 3	More than 3 but less than 6 (>3 to <6) proceeding donors per year	47
Level 4	3 or less (≤ 3) proceeding donors per year	41

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2018 - 31 March 2019

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	10	8	80	10	100	7	6	6	6	-	4	-	4
Level 1	1153	995	86	1144	99	987	951	875	826	94	626	72	563
Level 2	435	361	83	431	99	355	344	313	302	96	221	71	200
Level 3	279	244	87	274	98	237	228	203	197	97	155	76	136
Level 4	137	115	84	133	97	115	112	102	98	96	80	78	71

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2018 - 31 March 2019

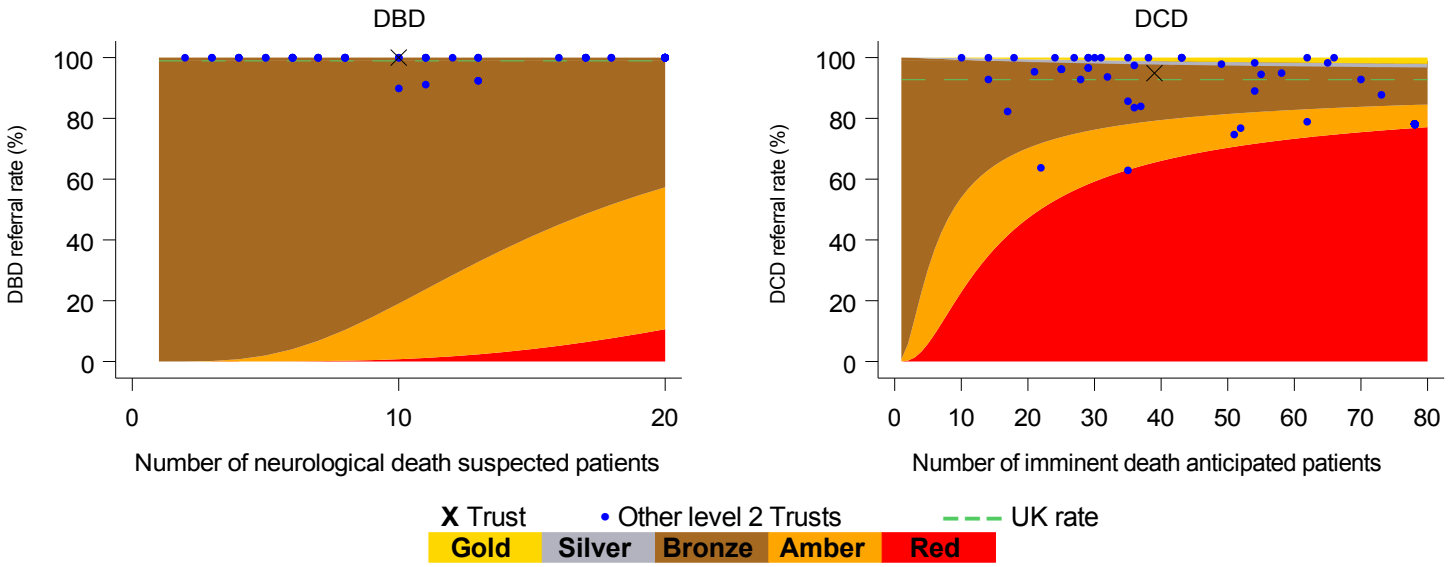
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Your Trust	39	37	95	37	30	23	17	74	16	70	4
Level 1	2570	2413	94	2336	1882	950	816	86	576	61	326
Level 2	1748	1609	92	1541	1235	446	396	89	283	63	156
Level 3	1146	1065	93	979	723	233	210	90	159	68	84
Level 4	510	452	89	441	340	123	105	85	81	66	46

7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Trust against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

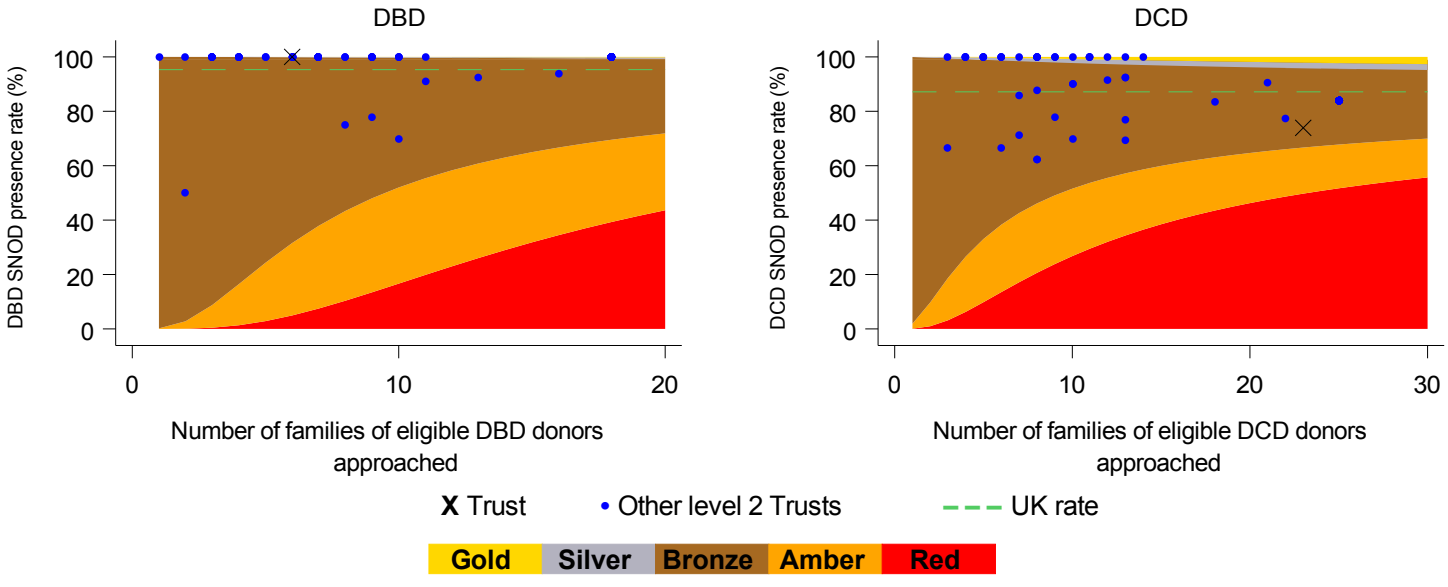
Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2018 - 31 March 2019



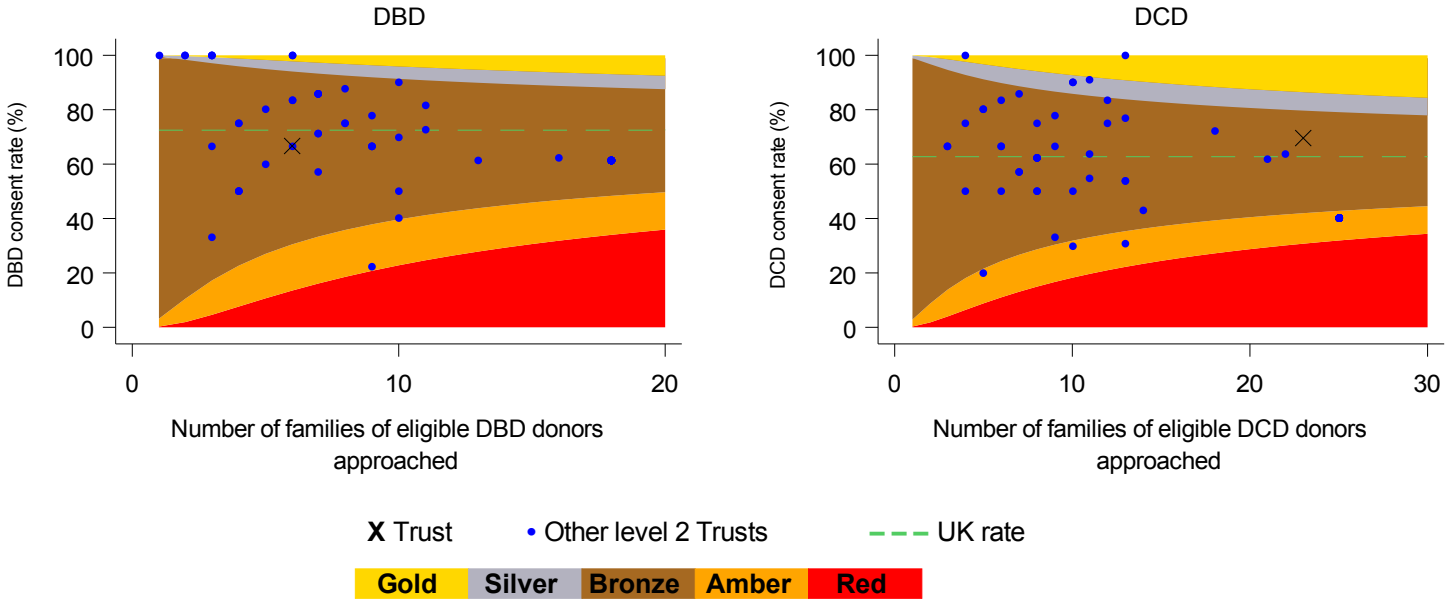
When compared with UK performance Medway NHS Foundation Trust was exceptional (gold) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2018 - 31 March 2019



When compared with UK performance Medway NHS Foundation Trust was exceptional (gold) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2018 - 31 March 2019



When compared with UK performance the consent rate in Medway NHS Foundation Trust was average (bronze) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SNOD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to support patient's expressed or deemed consent/authorisation, informed of a nominated/appointed representative, asked to make a decision on donation on behalf of their relative, or informed of a patient's opt-out decision via the ODR.
Consent/authorisation ascertained	Family supported expressed or deemed consent/authorisation , nominated/appointed representative gave consent, or where applicable family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SNOD
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within a time frame to allow donation to occur, as determined at time of assessment
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SNOD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's opt-out decision via the Organ Donor Register
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data	
Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit	
Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data	
Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures

Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

Appendix B

Sharing hospital engagement and public promotion activities

Local community

- Kent county show
- GP presentations
- Ethnic Minority Forum
- Deputy Lieutenant's speech to new UK citizens
- Salvation Army
- Trust members' event

A multi-media approach

- Local BBC news
- Hospital radio
- Local newspapers

Effective Organ Donation Committee

- Proactive leadership
- Hospital Comms involvement

Hospital education/ comms

- Buy-in from CEO and Trust board
- Commemorative artwork
- Trust board presentations
- Trust governors presentation
- Hospital Grand Round
- MDT Simulation days
- Education sessions

For further info: Paul Hayden (CLOD) paulhayden@nhs.net Gill Fargher (chair ODC) gillian.fargher@nhs.net Alison Hill (SNOD) alison.hill@nhsbt.nhs.uk

Appendix C - Financial Summary

Financial Year	TOTAL 2016-17	TOTAL 2017-18	2018 - 19 Q1	Q2	Q3	Q4	TOTAL 2018-19
Balance b/f	£0.00	£22,946.30	£45,770.09	£45,821.22	£47,766.35	£49,854.27	£45,770.09
Income							
Lead clinician	£12,392.00	£12,392.00	£3,098.00	£3,098.00	£3,098.00	£3,098.00	£12,392.00
Organ Donation Committee	£500.00	£500.00	£500.00	£0.00	£0.00	£0.00	£500.00
Donor Reimbursement	£22,946.00	£25,032.00	£0.00	£3,438.80	£3,438.80	£3,438.80	£10,316.39
TOTAL INCOME	**£35,838.00**	**£60,870.30**	**£3,598.00**	**£6,536.80**	**£6,536.80**	**£6,536.80**	**£23,208.39**
Expenditure							
Lead clinician (1PA per week)	£12,392.00	£14,187.46	£3,546.87	£3,546.87	£3,546.87	£3,546.87	£14,187.48
Ramsey metal frame chairs x8	£0.00	£0.00	£0.00	£987.84	£0.00	£0.00	£987.84
Text Book - A Journey for Nurses and Midwives	£0.00	£0.00	£0.00	£17.99	£0.00	£0.00	£17.99
Text Book - Strategies for Life Long Learning	£0.00	£0.00	£0.00	£37.04	£0.00	£0.00	£37.04
Shockproof Wall Clock	£0.00	£0.00	£0.00	£1.93	£0.00	£0.00	£1.93
Display Panel 700x565 mm	£0.00	£0.00	£0.00	£0.00	£252.00	£0.00	£252.00
North Tees & Hartlepool NHS FT Level 3 Diploma in APT for Mortuary Departme	£0.00	£0.00	£0.00	£0.00	£650.00	£0.00	£650.00
North Tees & Hartlepool NHS FT Level 4 Diploma in APT for Mortuary Departme	£0.00	£0.00	£0.00	£0.00	£0.00	£3,500.00	£3,500.00
Organ donation conference fee for Lead Clinician	£0.00	£0.00	£0.00	£0.00	£0.00	£239.40	£239.40
Organ Donation Committee expenses	£93.70	£0.00	£0.00	£0.00	£0.00	£0.00	£1,039.17
Artwork unveiling expenses	£406.00	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00
Award Presentation for artwork in the atrium	£0.00	£564.00	£0.00	£0.00	£0.00	£0.00	£0.00
Building Better Healthcare award entry for Collaborative Arts Project	£0.00	£118.80	£0.00	£0.00	£0.00	£0.00	£0.00
Hotel Room at McDonald Burlington Hotel Birmingham	£0.00	£180.00	£0.00	£0.00	£0.00	£0.00	£0.00
Lunch for candidates	£0.00	£49.95	£0.00	£0.00	£0.00	£0.00	£0.00
TOTAL EXPENDITURE	**£12,891.70**	**£15,100.21**	**£3,546.87**	**£4,591.67**	**£4,448.87**	**£7,286.27**	**£20,912.85**
NET (balance carried forward)	**£22,946.30**	**£45,770.09**	**£45,821.22**	**£47,766.35**	**£49,854.27**	**£49,104.80**	**£48,065.63**

Summary:	
Balance brought forward from previous years	£45,770.09
Total Income received in 2018-19	£23,208.39
Total Expenditure in 2018-19	£20,912.85
Organ donation fund balance 2018-19	£2,295.54
Balance to carry forward to 2019-20	**£48,065.63**

Meeting of the Board of Directors in Public
Thursday, 05 September 2019

Title of Report	Modern Day Slavery Policy	**Agenda Item**	**10.1**
Lead Director	Leon Hinton, Executive Director of HR and OD		
Report Author	Andrew Martin, Head of Employee Relations		
Executive Summary	The Modern Slavery Act 2015 requires organisations to prepare a slavery and human trafficking statement for each financial year. On 5 October 2018 the Trust published a Modern Day Slavery Policy for financial year 2018/19 in accordance with s.54 of the Modern Slavery Act 2015. For the financial year 2018/19, no reports were received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified. This report therefore summarises the review and refresh of the Trust's Modern Day Slavery Policy and the Executive and Board are requested to approve publication of the document for financial year 2019/20.		
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	None identified at this stage. Any actions should be achieved within existing resources.		
Legal Implications/ Regulatory Requirements	Section 54 of the Modern Slavery Act 2015 requires all employers to prepare a slavery and human trafficking statement for each financial year.		

Quality Impact Assessment	Not applicable			
Recommendation/ Actions required	The Board is asked to note the content of this report.			
	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Modern Day Slavery Policy			

1 Executive Overview

1.1 The main purpose of the Modern Slavery Act 2015 is to prevent slavery, servitude, forced or compulsory labour, human trafficking and exploitation offences.

1.2 Section 54 of the Modern Slavery Act 2015 requires organisations to prepare and publish a slavery and human trafficking statement for each financial year.

1.3 The Trust published a Modern Day Slavery Policy statement for financial year 2018/19 and this is due for review and publication in financial year 2019/20.

1.4 For the financial year 2018/19, no reports were received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

2 Background

2.1 The Trust last published a Modern Day Slavery Policy statement in 2018/19. Section 54 of the legislation requires an annual review and republication of the policy statement.

3 Key Findings

3.1 The Trust's Modern Day Slavery Policy was written in October 2018 and remains fit for purpose.

4 Next Steps

4.1 The Trust's Modern Day Slavery Policy has been updated for 2019/20 and in accordance with the legislation should be published on the Trust's website.

5 Action Plan

	Direction of Travel compared to:			Action	Timeframe	Responsibility
	2018	2017	2016			
1 – Formal Policy Statement	↔	↑	↑	Continue to publish policy statement on public website	Current and ongoing	Documentation Compliance Manager

6 Recommendation

6.1 It is recommended that the updated Modern Day Slavery Policy be approved for publication on the Trust's website to replace the 2018/19 version.

Modern Day Slavery Policy

Author:	Head of Employee Relations
Document Owner:	Executive Director of HR & OD
Revision No:	2
Document ID Number	POLCHR049
Approved By:	Trust Board
Implementation Date:	September 2019
Date of Next Review:	September 2020

Modern Day Slavery Policy

Document Control / History	
Revision No	**Reason for change**
1	New Policy
2	Annual refresh

Consultation
Trust Board – September 2019

Table of Contents

Modern Day Slavery Policy

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

1 Introduction

1.1 Modern slavery encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the organisation or our supply chain.

2 Purpose / Aim and Objective

2.1 This statement is made pursuant to s54 of the Modern Slavery Act 2015 and sets out the steps the Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our organisation or supply chain.

3 Definitions

3.1 Terms used in this document are defined or explained in context.

4 (Duties) Roles & Responsibilities

4.1 Trust Board

4.1.1 Are required to consider and approve this policy and support the requirements set out in the relevant legislation.

4.2 Chief Executive

4.2.1 To be accountable for the implementation of this policy and ensuring its effectiveness is continually reviewed.

4.3 Head of Safeguarding

4.3.1 To be the strategic lead within the Trust for safeguarding of adults and children

4.3.2 To facilitate policies and procedures related to safeguarding adults and children

4.3.3 To ensure advice and training about modern slavery and human trafficking is available to staff through mandatory safeguarding children and adults programmes

4.3.4 To provide assurance reports for the Executive Lead on Safeguarding Adult and Children legal compliance.

4.4 Line Managers

4.4.1 Line managers are responsible for ensuring that the Safeguarding Policies are implemented within their programmes and directorate.

4.5 All Staff

4.5.1 All staff are responsible for adhering to the policy and fulfilling mandatory training requirements.

5 Trust Statement

5.1 Our policies on slavery and human trafficking

5.1.1 The Trust is aware of our responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

5.1.2 Currently, all awarded suppliers sign up to our terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with the Trust's stance on anti-slavery. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

5.1.3 We operate a number of internal policies to ensure that we are conducting business in an ethical and transparent manner. These include:

- Recruitment policy. We operate a robust recruitment policy, including conducting eligibility to work in the UK checks for all directly employed staff, and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will
- Equal Opportunities. We have a range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and access to training and development opportunities
- Safeguarding policies. We adhere to the principles inherent within both our safeguarding children and adults policies. These are compliant with Medway multiagency agreements and provide clear guidance so that our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain

- Whistleblowing policy. We operate a Freedom to Speak Up, Raising Concerns at Work and Whistleblowing Policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals
- Standards of business conduct. This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act

5.1.4 Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials
- Random requests that the main contractor provides details of its supply chain
- Ensuring invitation to tender documents contain a clause on human rights issues
- Ensuring invitation to tender documents also contain clauses giving the Trust the right to terminate a contract for failure to comply with labour laws
- Using the standard Supplier Selection Questionnaire (SQ) that has been introduced (which includes a section on Modern Day Slavery)

5.1.5 Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

5.1.6 Supplier adherence to our values: we are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.

5.1.7 Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

5.2 Training

5.2.1 Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our compulsory staff induction training.

5.2.2 We are looking at ways to continuously increase awareness within our organisation, and to ensure a high level of understanding of the risks

involved with modern slavery and human trafficking in our supply chains and in our business.

5.3 Our performance indicators

5.3.1 We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our organisation or supply chain if:

No reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified

6 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Head of Safeguarding	Executive Lead	Where gaps are recognised action plans will be put into place
Number of reports received from staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified	Monthly	Head of Safeguarding	Executive Lead	Where reports are received action plans will be put into place

7 Training and Implementation

7.1 To support the implementation and embedding of the Safeguarding policy and procedures mandatory e-learning training supported by face to face sessions available to all staff

8 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.

9 References

Document	Ref No
References:	
Trust Associated Documents:	
Recruitment Policy	PLCHR039
Inclusion Policy	POLCHR044
Freedom to Speak Up: Raising Concerns at Work (Whistleblowing)	POLCHR014
Safeguarding Policy	POLCPCM082

10 Appendix 1 – Equality Impact Assessment

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	▪ Age	No	
	▪ Disability	No	
	▪ Gender reassignment	No	
	▪ Marriage and civil partnership	No	
	▪ Pregnancy and maternity	No	
	▪ Race	No	
	▪ Religion or belief	No	
	▪ Sex	No	
	▪ Sexual orientation	No	
2	Is there any evidence that some groups are affected differently?	No	
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	

4	Is the impact of the policy/guidance likely to be negative?	No	
5	If so can the impact be avoided?	N/A	
6	What alternatives are there to achieving the policy/guidance without the impact?	N/A	
7	Can we reduce the impact by taking different action?	N/A	

END OF DOCUMENT