Agenda

NHS Medway NHS Foundation Trust

Public Meeting of the Trust Board

Date: On 05 July 2018 at 12.30pm – 3.30pm

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

Item	Subject	Presenter	Format	Time	Action
1.	Patient Story	Director of Nursing	Verbal	1230	Note
Opening of the Meeting					
2.	Chair's Welcome	Chairman	Verbal	1300	Note
3.	Quorum	Chairman	Verbal		Note
4.	Register of Interests	Chairman	Paper		Note
Meeting Administration					
5.	Minutes of the previous meeting held on 3 May 2018	Chairman	Paper	1305	Approve
6.	Matters arising and actions from last meeting	Chairman	Paper		Discuss
Main Business					
7.	Chair's Report	Chairman	Verbal	1310	Note
8.	Chief Executive's Report	Chief Executive	Paper	1315	Note
9.	Strategy a) STP Update b) Trust Improvement Plan Better Best Brilliant	 Chief Executive Deputy Chief Executive	 Verbal Paper	1320	 Note Discuss
10.	Quality a) IQPR	 Director of Nursing & Medical Director	 Paper	1335	 Discuss
11.	Performance a) Finance Report b) Annual report on Security Management c) Operational Plan 18/19	 Director of Finance & Business Services Director of Estates Director of Finance & Business Services	 Paper Paper Paper	1345	 Discuss Discuss Discuss

Best of care Best of people

	d) Communication Report	Director of Communications	Paper		Discuss
12.	Governance a) Corporate Governance b) Board Assurance Framework c) Risk Register Board Assurance	Trust Secretary: Director of Corporate Compliance & Legal	Paper Paper Paper	1415	Assurance Assurance Assurance
13.	People a) Workforce Report b) WRES Report c) Freedom to Speak Up Self-Assessment	Director of Operational HR	Paper Paper Paper	1435	Assurance Assurance Assurance
Reports from Board Committees					
14.	Quality Assurance Committee Report	QAC Chair	Paper	1505	Assurance
15.	Integrated Audit Committee Report	IAC Chair	Paper		Assurance
16.	Finance Committee Report	FC Chair	Paper		Assurance
For Noting					
17.	Council of Governors' Update	Governor Representative	Verbal	1520	Discuss
18.	Any other business	Chairman	Verbal		Note
19.	Questions from members of the public	Chairman	Verbal		Discuss
20.	Date and time of next meeting: 6th September 2018, 12.30pm-3.30pm, Trust Boardroom				

MEDWAY NHS FOUNDATION TRUST

REGISTER OF INTERESTS FOR BOARD MEMBERS

1.	Jon Billings Non-Executive Director	• Director of Fenestra Consulting Limited • Associate of Healthskills Limited • Associate of FMLM Solutions • Chair of the Medway NHS Foundation Trust Quality Assurance Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
2.	Ewan Carmichael Non-Executive Director	• Timepathfinders Ltd • Chair of the Medway NHS Foundation Trust Charitable Funds Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
3.	Stephen Clark Chair	• Chairman Marshalls Charity • Chairman 3H Fund Charity • Non-Executive Director Nutmeg Savings and Investments • Member Strategy Board Henley Business School • Access Bank UK Limited – Non Executive Director • Chairman Advisory Council- Brook Street Equity Partner LLP • Chairman of the Medway NHS Foundation Trust • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
4.	James Devine Director of HR & OD	• Member of the London Board for the Healthcare People Management Association • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
5.	Lesley Dwyer Chief Executive	• Member of the Corporate Trustees of Medway NHS Foundation Trust Charitable Funds
6.	Diana Hamilton-Fairley Medical Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
7.	Anthony Moore Non-Executive Director	• Chair of the Medway NHS Foundation Trust Finance Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
8.	Joanne Palmer Non-Executive Director	• Director of Lloyds Bank (Fountainbridge 1) Limited • Director of Lloyds Bank (Fountainbridge 2) Limited • Director of Lloyds Halifax Premises Limited • Director of Lloyds Gresham Nominee1 Limited • Director of Lloyds Gresham Nominee 2 Limited • Director of Lloyds Commercial Properties Limited

		• Director of Lloyds Bank Properties Limited • Director of Lloyds Commercial Property Investments Limited • Director of Lloyds Target Corporate Services Limited • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
9.	Karen Rule Director of Nursing	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
10.	Mark Spragg Non-Executive Director	• Trustee for the Marcela Trust • Trustee of the Sisi & Savita Charitable Trust • Director of Mark Spragg Limited • Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
11.	Tracey Cotterill Director of Finance and Business Services	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
12.	Adrian Ward Non-Executive Director	• Trustee of the Bella Moss Foundation • Director of Award Veterinary Sciences Limited • Chair of NMC Fitness to Practice Panel • Member of the RCVS Preliminary Investigation Committee • Member of the BSAVA Scientific Committee • Member of the Medway NHS Foundation Trust Quality Assurance Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds

Meeting in Public

NHS Medway NHS Foundation Trust

Board of Directors Meeting in Public on 03/05/2018 held at Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Mrs L Dwyer	Chief Executive	LD
	Mr J Billings	Non-Executive Director	JB
	Mr E Carmichael	Non-Executive Director	EC
	Mrs T Cotterill	Director of Finance and Business Services	TC
	Mr J Devine	Deputy Chief Executive and Executive Director of HR & OD	JD
	Dr D Hamilton-Fairley	Medical Director	DHF
	Mr T Moore	Non-Executive Director	TM
	Mrs J Palmer	Non-Executive Director	JP
	Mrs K Rule	Director of Nursing	KR
	Mr M Spragg	Non-Executive Director	MS
	Mr A Ward	Non-Executive Director	AW
Attendees:	Ms G Alexander	Director of Communications	GA
	Ms L Barrow	Patient Experience Manager (Item 1 only)	LB
	Mr B Best	Acting Director of Clinical Operations	BB
	Ms R Bridger	Patient Story (Item 1 only)	RB
	Ms M Cane	Healthwatch (Item 1 only)	MC
	Ms F Egan	Deputy Director of Corporate Compliance (item 12b only)	FE
	Mr L Hinton	Director of Operational HR & OD	LH
	Ms D King	Governor Board Representative	DK
	Mr J Lowell	Director of Clinical Operations	JL
	Mr G Lupton	Director of Estates & Facilities	GL
	Ms G Marshall	Children's Continuing Care Nurse Co-coordinator (Item 1 only)	GM

	Ms E McCallum	Head of Research & Development (item 10b only)	EM
	Ms S Murphy	Trust Secretary: Director of Corporate Compliance and Legal Services	SMM
	Ms H Puttock	Minute Taker	HP

1. Patient Story

1.1 SC and KR welcomed Rachel Bridger (RB) to the meeting to present her and her daughter's story in regards to living with Congenital Central Hypoventilation Syndrome (CCHS).

1.2 RB delivered a detailed presentation on the care both her and her daughter had received and highlighted her positive experiences at the Trust.

1.3 The Board passed on their thanks to RB for her detailed presentation and DHF invited RB to meet with her to discuss adult care for the condition CCHS.

2. Welcome and Apologies for Absence

2.1 The Chairman welcomed everyone to the meeting.

2.2 Apologies for absence were noted as stated above.

3. Quorum

3.1 The meeting was declared quorate.

4. Register of Interests

4.1 The Register of Interests was noted.

5. Minutes of the Previous Meeting

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

5.2 SC noted the March board meeting had been cancelled due to snow, and advised any urgent matters had been dealt with outside of the Board meeting.

6. Matters Arising and Action Log

6.1 The Board of Directors **RECEIVED** the Action Log

6.2 It was noted actions 0395, 0397 and 0398 had been completed and closed

6.3 DK advised action 0396 on was on track for competition.

7. Chair's Report

7.1 SC welcomed colleagues from the Care Quality Commission to the meeting.

7.2 SC thanked RB for sharing her and her daughter's story and noted the importance of keeping the needs of the patient and careers at the heart of treatments plans.

7.3 SC highlighted over the past few months the Trust had been very challenged with the long winter placing great pressure on the hospital, and the snow at the end of February/beginning of March had been particularly difficult for the Trust, especially staff who found it difficult to get to work. SC payed tribute to

staff and volunteers who went out of their way to ensure they could get to the hospital to care for our patients.

7.4 SC advised Governor elections for both public and staff Governors were currently taking place and the Trust had been actively seeking people to stand, including holding a well attended welcome session for anyone who was interested in becoming a Governor. SC noted there were 15 public and staff vacancies and nominations had already opened, would close on 21 May, with voting open until 29 June and the results being declared on 2 July 2018.

7.5 SC passed on his thanks to Renee Coussens who had served the maximum number of terms of office and therefore was not able to seek re-election. SC noted Renee Coussens was known to many people within and outside the hospital for the way she had represented patients and ensured their voice is heard.

7.6 SC congratulated the League of Friends who was recently named as the overall winner in the Pride of Medway awards, and highlighted how the Trust values the League of Friends and their commitment to the hospital.

7.7 SC stated this year marks the 70th anniversary of the NHS, and the Trust would be celebrating in a number of ways, including holding a summer fair, supporting the NHS7tea and organising a photo exhibition of the NHS through the decades.

8. Chief Executive's Report

8.1 LD asked the members and attendees to take the report as read.

8.2 LD advised the Trust was currently on the second day of the Well Led CQC Inspection. LD noted the CQC inspection had been completed differently this time with a 2 day inspection on the core services, a 1 day inspection on the use of resources and a 2 day inspection on Well Led; a draft report was expected in June. LD noted a CQC Assurance Group had been formed to assist with the preparedness for the CQC Inspection.

8.3 LD noted BB and JL would discuss trajectories later in the Board meeting, however outlined the timescales that had been agreed with NHSI to meet the trajectories. LD acknowledged the hard work that had been completed by the Cancer team to ensure it met its trajectory for January 2018.

8.4 In regards to presentations at the Emergency Department, LD noted the ED still remained under pressure and advised the Trust had been awarded £1m to further develop the front door streaming model.

8.5 LD advised the Trust continued to focus on patient flow and patient's length of stay at the Trust.

8.6 LD stated during the pause of elective and day case activity, a call line was established for anyone who was concerned about their surgery being delayed. LD noted the Trust would go back to full elective and day case activity next week.

8.7 In regards to Children's Community Health Services, LD advised Medway Council and Medway CCG had awarded the contract to Medway Community Healthcare and the School Nursing Team left the Trust on 1 April 2018, and any remaining staff would TUPE over on 1 June 2018.

8.8 LD advised Ben Stevens had left the Trust on secondment and BB had taken over as Director of Clinical Operations for planned care on an interim basis, until Gurjit Mahil joins the Trust on 18 June to fill the post substantively.

8.9 LD advised GL had joined the Trust as the new Director of Estates and Facilities, and this role had now become an executive role.

8.10 In regards to achievements, LD advised a number of staff had been nominated for parliamentary awards as part of NHS70.

8.11 LD stated the Stroke Consultation had now come to a close, and Medway and Swale had the largest response rate, but the results would not be announced until July.

8.12 LD highlighted the new medical school for Kent and Medway and noted the Trust would want to gain University Hospital training status.

8.13 LD advised all Trust Chief Executives and STP leads had been invited to join a roundtable hosted by the Secretary for State for Health and Social Care to discuss NHS properties on 15 May 2018.

8.14 JB queried when planning for winter 2018 would begin and would the lessons learnt be discussed internally or system wide. LD advised the lessons learnt from winter were already being review by the A&E Delivery Board and across the NHS Trusts in North Kent. LD advised winter planning is usually completed by September, but this had been brought forward to June for this year.

9. Strategy

9a) Sustainability and Transformation Partnership (STP) Update & Budget Update

9.1 TC advised, as per the previous year, the Trust had been asked to contribute to the running of the STP and the total proposed budget for the STP for 2018/19 was £6.7m, with the Trust being asked to contribute £396k. TC advised the Board was being asked to approve the Trust's contribution.

9.2 LD noted the Trust was confident that it would be able to report back to the Board on the STP investment and benefits to the Trust.

9.3 LD advised the STP would be working on a number of cost saving initiatives including having a joint bank rate, and potential regional banks, so all Trusts have an equal opportunity to get staff when needed. TC noted any cost savings for the Trust would be monitored closely through the Cost Improvement Plan programme to ensure no savings are double counted.

9.4 The Board **APPROVED** the STP contribution.

9b) Trust Improvement Plan

9.5 JD advised 2020 had been working with the Trust over the past 12 months; however the Trust had now established its own transformation team, which would provide assurance to the Transformation Assurance Group.

9.6 JD noted a series of schemes had been identified to work towards that would meet the financial requirements for 2018/19 and updates would be provided to the Transformation Assurance Group and the Board.

9.7 JB queried how the cost improvement plans would be quality impact assessed (QIA). JD advised a five step QIA had been put together with KR and DHF, and they have to approve all QIAs.

9.8 SC emphasised the importance of the transformation programme, and how differently it was being carried out this time round, including involving clinicians from the very beginning.

9.9 TM queried why clinicians felt more engaged with transformation this time. DHF advised the clinicians had been involved from the start this time, and been given full access to the model hospital data and had been given ownership of the data. DHF noted workshops on the model hospital had also been held, and have help clinicians feel more engaged.

10 Quality

10a) IQPR

10.1 The report was taken as read. The Board was asked to note the IQPR was for March's performance.

10.2 In regards to infection control, KR advised the Trust target of CDAD cases for 2017-18 was no more than 20 cases; however the Trust had reported 24 cases. KR noted a post infection review had been undertaken for each case, with 3 cases identified of level 3 lapse of care, and these cases would incur a £10,000 fine per case.

10.3 KR noted at the end of March 2018 there was a total of 114 open serious incidents, with a number of the serious incidents with the CCG for review. KR advised the Trust and the CCG were looking at how they can work better together in regards to the closure of serious incidents.

10.4 KR advised the Trust had recognised a gap in the monitoring of compliance with Duty of Candour and this was currently being reviewed. KR noted the Trust's poor compliance with Duty of Candour was a significant risk to the Trust, as this is a legal requirement, and there are sanctions for non-compliance. KR assured the Board once the gap had been identified an immediate remedial action plan was put in place. The directorates were asked to complete a revalidation exercise and put all evidence of Duty of Candour stored locally on to Datix; since this exercise the Trust was reporting 73% compliance, with work still ongoing. KR noted a monthly audit for Duty of Candour will now be completed, which will be reported through the Quality Steering Group, to the Quality Assurance Committee. KR stated all staff must complete training on Duty of Candour on MOLLIE before the end of Quarter 1 and a letter had been sent to all relevant staff to do regarding compliance with Duty of Candour.

10.5 DHF noted compliance with Duty of Candour had improved since the new directorates had been in place; however it was compliance in 2017 that was the main concern. DHF noted in the cases that had been reviewed so far, no patient had come to harm due to a lack of application of Duty of Candour.

10.6 KR stated the Trust had a 60% reduction in pressure ulcers compared to the previous year and confirmed none of the cases of pressure ulcers that did take place were a cause of death.

10.7 KR noted the Trust remained below average for the number of falls.

10.8 In regards to Mixed Sex Accommodation, KR advised work had taken place regionally to look at the criteria for breaches, and this work had now been implemented and would be monitored across Quarter 1. KR noted it was expected the Trust would firstly see some deterioration due to the change in reporting, which would then improve.

10.9 SC noted the recently identified national NHS breast screen issue, where a number of women had been missed to screening, and queried if this had affected the Trust. DHF advised this would affect the Trust and the breast screening unit were setting up extra appointments, so any women from the local community can be seen quickly.

10.10 DK noted the number of complaints had risen, and queried if there was a link to the staff survey. KR noted nationally there is a rise in complaints from December to March, and this was the same trend as the previous three years. JD noted complaints about attitude of staff had decreased in Planned Care. It was agreed JD and KR would see if there was a link between the staff survey and rise in complaints.

ACTION: JD and KR to see if there is a link between the staff survey and rise in complaints.

10.11 BB advised the RRT performance for March was 79.82%. BB stated the national elective pause on surgery had affected the RRT, and the Trust was prioritising cancer and urgent patients. BB noted the following week, the Trust would go back to being fully operational for surgery and day cases. BB stated this time last year there was a high number of patients waiting over 52 weeks for surgery; however this year there is only one patient, and this was due to them cancelling their appointment.

10.12 JP queried how the Trust dealt with patients who had their surgery cancelled over winter. BB advised the cancellation of surgery due to the elective pause was covered in the local newspapers and a specific telephone line was set up for patients to call with concerns, and the patients were responded to within 24 hours by a service manager. BB confirmed consultants review any patients waiting a long period of time, and keep in close contact with them. JD noted this was picked up in the performance review meetings. LD advised the Trust had external validation on how it tracks people on waiting lists and had been commended for this.

10.13 TM noted there had previously been problems with doctors and consultants taking leave at the same time. JD advised the doctor project was currently being set up on ERostering, so this will provide better visibility before leave is approved, as it will show who else has already booked time off.

10.14 JL advised in regards to cancer trajectories, a clinical summit had been held in November to look at the pathway redesign for cancer and since November a lot of working has gone into ensuring the Trust meets the cancer trajectories. JL noted the Trust had achieved 100% for the 31 day subsequent treatment surgery cancer target and achiever 97.76% for the 2 week wait cancer performance.

10.15 JL advised there had been deterioration in the diagnostic performance and this was largely due to staff sickness in Radiology.

10.16 JL stated the Trust reported 82.49% for the national 4 hour standard for ED. JL noted the Trust had been looking at re-admission rates of patients who

return within 30 days after discharge, and looking at what more can be done to avoid this happening.

10.17 JL noted there had been a significant change in the number of attendances to ED, since the front door streaming was in place.

10b) Research and Development Report

10.18 SC welcomed EM to the meeting.

10.19 EM asked the members and attendees to take the report as read. EM advised the number of research projects since the previous year had decreased, however the research projects that did take place were more intensive.

10.20 EM noted the Trust had received a 5% increase in funding for cancer research, which means the Trust could recruit a further two research nurses, so more research could take place.

10.21 EM advised 5313 patients had participated in ethically approved research and the Trust had produced 90 research articles in total for 2017/18 which link to national publications.

10.22 EM highlighted a total of 30 incidents for research and development had been reported in 2017/18.

10.23 It was noted the Trust continued to work closely with the local universities in regards to research, and the was a joint post with Medway NHS Foundation Trust and the University of Greenwich, and a similar post was being created with the University of Kent.

10.24 EM noted the Research team was working to ensure it complies with GDPR and Hill Dickson has been supporting the team.

10.25 EM advised the Research team was arranging to meet with the new Kent and Medway medical school to discuss how they can work together and how the Trust could become a University status Trust.

10.26 EM stated two ex-patients of the Trust had become patient ambassadors for the research team, and were helping bring feedback from the public back into the Trust.

10.27 DK queried what difference becoming a university status Trust would make. LD advised the Trust would not lose its Foundation Trust status, but being a university teaching hospital it creates more of an attraction for clinicians wanting to work here.

10.28 SC thanked EM and the research team for the work they do and noted the importance of research being carried out.

10c) Mortality Report: Responding to deaths

10.29 DHF advised the mortality report has to come to Board every quarter and this was the third mortality report to the Board. DHF asked the Member and Attendees to take the report as read.

10.30 DHF noted the HSMR had started to rise over the last 6 months and the Trust had carried out a review into 50 cases, and not detected any themes around care, however had noted the depth of coding had slightly reduced. DHF further noted the Trust now had an End of Life Care team internally and had stopped referring patients to Medway Community Healthcare's palliative care team, but the Trust had not changed its coding and it is expected once the

coding had changed there would be a reduction in the HSMR; this will still be monitored.

10.31 DHF highlighted the Trusts' SHMI was now 1.03.

10.32 DHF noted there had been an increased in observed deaths in January, and 40 cases had been reviewed, with the majority of the patients being over 85, coming to the Trust from care homes and dying within 2 days.

10.33 EC noted attendance at the Mortality and Morbidity group varied, and need to be improved and reminded as a priority.

11 Performance

11a) Finance Report

11.1 TC asked the Members and Attendees to take the report as read.

11.2 TC advised at Month 12 the Trust reported post STF a deficit of £62.2 million, which was adverse to plan by £24.3m

11.3 TC noted the clinical income was adverse to plan by £16.9m, due to the impact of the expert determination. TC advised although some of the expert determination was found in favour of the Trust, leaving the Trust £2m better off, two large parts of the expert determination would found in favour of the CCG.

11.4 In regards to CIPs, TC advised the Trust was behind plan by £5.598m.

11.5 TC advised at month 12 the Trust was holding a cash balance of £9.7m. It was noted the new contract with the CCG required the Trust to hold a larger cash balance, and the Board would see this increase.

11.6 TC stated the balance sheet at month 12 was in negative equity, due to the high levels of loans which stood at £217m. TC confirmed cash had been drawn down from the Department of Health in the form of loans in line with the revised deficit position.

11.7 It was noted the Trust was working to reduce the number of Debtors, including aged debtors.

11.8 TC advised the capital outturn was £18m, against the plan of £21m.

11.9 TC noted the draft final accounts had been submitted at the end of April, and the external auditors were currently reviewing these. TC advised the Board need to approve the delegation of authority of the sign off the accounts to LD and SC. The Board **APPROVED** the delegation of authority to LD and SC.

11.10 JB noted the Trust's challenged position and queried if a communications plan for staff had been produced. GL confirmed communication with staff and stakeholders had already begun. LD noted staff briefings had been held for staff and an update on the Trust's financial position would be going out shortly.

11b) Control Total Update

11.11 TC advised the Trust had recently met with NHSI to discuss the revised control total, and NHSI had asked the Trust to extend its CIPs by a further £6m. TC noted NHSI were very supportive in the Trust avoiding financial special measures and would work closely with the Trust to ensure CIPs were delivered.

11.12 TC advised the Trust had agreed a control total of a deficit of £46.8m. TC noted this would be further discussed at the Finance Committee and the Transformation Assurance Group.

11c) Communication Report

11.13 GA asked the members and attendees to take the report as read.

11.14 GA noted a significant focus for internal communications had been preparing for the CQC inspection, and ensuring staff felt supported to speak openly and honestly with the CQC. It was a noted a further focus on internal communication had been finance.

11.15 GA advised the communications team had been working alongside the Organisational and Professional Development Team to engage staff in a cultural change project.

11.16 In regards to Media, GL noted the Trust continued to get a high number of enquiries from Media and have received good coverage for the stroke consultation, the new Medical school, and the Trust's fundraising activities and staff awards.

11.17 GA advised there had been a focus on Governor Elections and ensuring people knew they were taking place.

11.18 GA noted the Trust was now the most followed Acute Trust on Twitter in the region, and the Communications team was using Twitter as a way to raise awareness for campaigns and advertise events, such as Governor's Coffee mornings.

11.19 GA stated the Trust continued to work alongside the Governors to engage with the community through member's events, recruitment stands and coffee mornings. GL advised the Community Engagement Officer continued to engage with the community and target specific groups, for example ethnic groups.

12 Governance

12a) Corporate Governance Report

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

12.2 SMM advised the Human Tissue Authority undertook an inspection in October 2017 which was successful with many areas of good and innovative practice noted.

12.3 SMM highlighted the number of exercises and activity the EPRR team is involved in throughout the year, to ensure the Trust is always appropriately prepared for an emergency.

12b) Board Assurance Framework

12.4 SC welcomed FE to the meeting.

12.5 FE noted the Trust had recently identified its four strategic objectives for 2018/19 and the Board Assurance Framework for 2018/19 had been developed based on the strategic objectives and their related strategic risks.

12.6 FE advised the Board Assurance Framework had been simplified since the last Board meeting, where it was agreed the framework should be more streamlined.

12.7 It was noted the Board wanted to streamline which Committees would review which strategic objectives and its relevant strategic risks.

12.8 The board noted it was content on the progress of the Board Assurance Framework.

12c) NHSI Self-Assessment (Licence Conditions)

12.9 SMM asked the members and attendees to take the report as read. SMM advised that the Trust needed to self-certify against the conditions of its licenses annually.

12.10 TC noted this had been discussed and agreed at the Private Board meeting and should be removed from the public meeting.

12d) Emergency Preparedness, Resilience and Response Annual Report

12.11 SMM asked the members and attendees to take the report as read.

12.12 SMM noted the EPPR had two current risks, which included the instillation of the Open Scape Alarm Response System (OSCAR) which is used to cascade information when there is a major incident, and the second risk being the Trust not having enough decontamination suits.

12.13 SMM highlighted KPMG carried out an audit on EPRR in May 2017, with the outcome being a rating of significant assurance with minor improvement opportunities.

12.14 SMM noted the EPRR work plan was referenced and attached to the Emergency Preparedness, Resilience and Response Annual Report.

12.15 TM noted there were now only 4% of business continuity plans that were incomplete and this was a significant improvement.

12.16 The Board **ENDORSED** the Emergency Preparedness, Resilience and Response Annual Report.

12e) IG and General Data Protection Regulations (GDPR) Report

12.17 SMM noted the first report gave the Board an update with the Trust's preparations for the GDPR and asked the Board to take the paper as read.

12.18 SMM stated the Trust had been focusing on updating policies and privacy notices, data privacy impact assessments, data flow mapping training and the role of the Data Protection Officer.

12.19 SMM advised the Trust would not be fully complaint by the 25 May, but this would be the case across the NHS.

12.20 LD noted Hill Dickson had been assisting the Trust In ensuring it is complaint with GDPR and TC noted compliance with GDPR would be monitored through the IG Toolkit.

12.21 It was regularly updates should be given to the Non-Executive Directors on GDPR.

12.22 SMM noted the second report was an assurance paper prepared for NHSI in relation to the Trust's current position in regards to the new Data Security Protection requirements.

12.23 The Board **ENDORSED** the report.

13 People

13a) Workforce Report

13.1 LH asked the Members and Attendees to take the report as read.

13.2 LH noted the Trust continued to recruit locally, nationally and internationally and the Trust had recently engaged with international partners and had a total of 500 applicants engaged with the Trust, with an expected 163 of them to become substantive. LH confirmed the applicants engaged with the organisations had already passed the English test.

13.3 LH advised the Trust saw a net reduction in the number of nurses, however a large number of nurses had been TUPE out of the organisation, and the Trust expects to see an increase in nurses, as it had done for the previous eight months before.

13.4 It was noted there had been a slight decrease in the turnover of staff, and the sickness rate had been reduced to 4%. It was further noted the Trust had reported at 85% for both compliance with statutory and mandatory training and competition of appraisals.

13.5 LH advised the costs on agency staff had reduced from 19% in 2016/17 to 8% for 2017/18 and 80% of staff were now substantive.

13.6 LH highlighted the Trust was on target to be reporting £4m lower than the Trust's 2018/18 NHSI agency ceiling cap of £21.6m.

13.7 LH stated the unconference took place at the end of January, and mini unconferences were now taking place on the wards, for staff to see how they can improve their area.

13b) Gender Pay Gap Report

13.8 LH asked the members and attendees to take the report as read. LH advised it is a legal requirement to report on the gender pay gap annually, and noted this was not the same as equal pay.

13.9 LH noted the Trust was reporting a mean of 33.32% and a median of 24.24% for the gender pay gap, which is better nationally than other NHS Trusts.

13.10 LH advised the medical and dental had been separated against the non-medial, where you can see a large difference in the pay gap. LH noted there was a small pay gap in the non-medical, due to there being more females in lower paid roles, included housekeeping and catering, whereas there was a large pay gap in the medical and dental, due to more males progressing to higher paid roles.

13.11 JP commented that now Board was aware of this data it was important to understand why there are more women in the lower paid roles, an issue that is not just within the healthcare sector.

13c) Staff Survey Presentation

13.11 JD asked the members and attendees to take the report as read. JD noted it was requirement that the results of the staff survey are presented to the Board.

13.12 JD noted the NHS staff survey is run at the same time frame for all Trusts in the UK.

13.13 JD advised the NHS staff survey is designed to feed into 9 key themes which allows Trusts to use the results to feed into improvements plans around those themes.

13.14 JD highlighted a number of changes that were implemented following on from the 2016 staff survey, including the appointment of the Freedom to Speak Up Guardians, staff well-being initiatives being introduced, a head of equality and inclusion being recruited, awards of team and employee of the month and more substantive staff being recruited.

13.15 JD noted the Trust had a response rate of 40% which was the average response rate for acute Trusts, and of the 32 key findings, the Trust had 14 worsen and 18 remain unchanged, with the overall engagement score declining by 3% to 3.66. JD advised the Trust was the only Trust in Kent not to decrease below its 2015 position in the staff survey.

13.16 JD highlighted the top 5 ranking scores, the bottom 5 ranking scores and noted only 5 of the key findings had scored below their 2015 position.

13.17 It was noted the staff survey showed staff engagement varied across the Trust and JD highlighted the areas with low levels of engagement, and noted the Trust had already been working with those areas to ensure they were engaged. TM noted staff engagement would be crucial for the transformation works.

13.18 JD advised a number of improvement projects had been identified from the staff survey and works on these would begin shortly.

14 Membership Strategy

14.1 SM presented the membership strategy and advised the data within the strategy had been updated.

14.2 The membership strategy was **APPROVED**.

15 Quality Assurance Committee (QAC) Report

15.1 JB asked the Members and Attendees to take the report as read. JB highlighted the proposals for quality metrics for the new quality dashboard had been approved and the first draft would be presented at the June Quality Assurance Committee.

15.2 JB advised Dot Smith (Maternity) had produced an evidence set for the submission to CNST for the maternity safety actions and due to sequencing of meetings, this would be signed off outside of the Committee.

16 Integrated Audit Committee (IAC) Report

16.1 MS asked the Members and Attendees to take the report as read.

17 Finance Committee Report

17.1 TM asked the Members and Attendees to take the report as read.

18 Council of Governors' Update

18.1 DK as Governor Board Representative raised the following queries:

- What is the timescale for letters to be received by patients following an appointment where a life threatening diagnosis is given? BB advised letters are sent within 2-7 days.

- What is the Trust policy for harvested eggs where the donor/recipient reaches 40 which is the cut off time for NHS IVF treatment? DHF advised the Trust does not offer IVF treatment but the member asking should be referred back to the Centre for the area, which is Chaucer at Canterbury.

19. AOB

19.1 There was no any other business.

20. Questions from members of the public

20.1 There were no questions from the public.

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

The next Public Board will be held on Thursday 5 July 2018.
Venue: Boardroom, Post Graduate Centre, Medway NHS Foundation Trust

The meeting closed at 4.25pm

Stephen Clark: Date:
Chair

Meeting Actions Log

NHS Medway NHS Foundation Trust

Public Board **Date: 05/07/2018**

Action Log Number	Agenda Item Description	Action Due Date	Outcome	Owner	Status
0396	Director of Clinical Operations for Planned Care to meet with DK and another Governor separately on patient notes and provide feedback to Board.	05/07/2018	03/05/18 – DK advised this action was in progress	Director of Clinical Operations for Planned Care	In Progress
0399	JD and KR to investigate if there is a link between the staff survey and rise in complaints	05/07/2018		Deputy CEO and Executive Director of HR & OD and Director of Nursing	Open

Chief Executive's Report – June 2018

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

Leaving Medway

By now you will be aware that I will be leaving Medway at the end of November

This has been the most rewarding and at times challenging role I have had and I am always grateful for the support of both the Board, Governors and the staff of Medway along the way.

You often consider when is the right time to leave an organisation and the answer is that you have to be confident that I have not created a person-dependant organisation but one that now has stability of leadership at many levels and I know that the Transformation plans we have in place will create the sustainable brilliant organisation it will soon be.

CQC

As you will be aware we had our CQC inspection in April and May, in which our core services were inspected, our Use of Resources was assessed and a Well-Led review was undertaken. We have now received the draft CQC report and are checking it for factual accuracy. We are expecting the report to be published in early August at which point we will share it with staff. I think it is important to mention that we received some very positive feedback from the CQC inspection team regarding the openness, honesty and engagement from staff at the Trust.

Our financial position – control total

As you will know from communication over recent months, the Trust continues to face a significant financial challenge. We have now agreed our control total for 2018/19 with our regulators and this stands at £46.8million in deficit. This is clearly a very substantial figure and we need to achieve £21million in efficiencies to get us to that position.

Our Better, Best Brilliant improvement programme will help us to address our deficit and we can only achieve this by thinking and working differently and collaborating closely with our system partners to drive system-wide transformation.

The Model Hospital data highlights opportunities for us to improve our productivity and become more efficient while improving care, which is paramount for our patients and their families, while being essential for us in terms of stabilising our finances.

Transformation

The transformation of services is key to achieving a more financially stable position, but in order to maximise the potential of this we need to reset practices and behaviours. To support this at pace we have established our own permanent internal Transformation team.

The team is working with staff leading transformation projects, bringing a range of skills and perspectives to Medway from both the public and private sectors. The team is led by Nick Chambers, Associate Director of Transformation; Rita Lawrence, Head of Culture and Engagement and Jack Tabner, Model Hospital Programme Lead and will provide project management support and coaching so that we can improve our own capability to carry out sustainable transformation.

As I have made clear before, it is really important that we change our culture if we are really going to transform our services. We need to move away from short term fixes and look at how we can make long-term change. The Transformation Team are exactly the right people to move us into this mind-set and I am sure you will join me in offering them a warm Medway welcome.

Recent achievements and celebrating our staff

I am really pleased to say that our recent awards success at Medway has continued, with our staff being shortlisted for awards at both the Health Service Journal (HSJ) Value Awards and the Healthcare People Management Association (HPMA) Awards in June. Although we did not win on this occasion, we were highly commended in the Vivup Award for Wellbeing and the Recruitment Team of the Year Awards. We have also recently learnt that we have been shortlisted in the 'Enhancing Patient Dignity' category for the Nursing Times awards.

The Human Resources and Organisational Development team went on to achieve further success in June, winning two Lotus Awards for Employee Relations and Recruitment. These are all great achievements and highlight the amazing advances we are making in our pursuit of brilliance. I would like to congratulate all those staff who were shortlisted, and those who have won awards.

Quality and Safety Expert in Residence

I was pleased to welcome back our Quality and Safety expert in residence, Professor Cliff Hughes, who returned to the Trust to deliver a programme of seminars to staff focusing on using data to drive change, communication with patients, vulnerability and 'fear of responsibility'.

Cliff has had a distinguished career in Australia, originally as a cardiothoracic surgeon, and has won numerous awards for his work, both nationally and internationally. Cliff returned to build on the work he has undertaken in previous visits, and his knowledge and expertise will be of great benefit to our staff as we continually strive towards providing brilliant care for our patients and their families.

Beyond Medway

Kent and Medway Stroke Consultation

The consultation on the future of urgent stroke services closed on the 20 April following a high level of engagement locally: the Trust submitted a response to the consultation and Medway and Swale postcodes had the highest response rate in the county.

Responses are currently being collated and analysed before a decision is made. However, the Trust has been notified that the announcement of the final decision is now likely to be later than anticipated, with a final decision now expected in December 2018.

New Medical School for Kent and Medway

Following the announcement that a new medical school is to be located in Kent and Medway, the Trust has been engaging with Canterbury Christ Church University and the University of Kent as the design phase of the project has commenced.

Diana Hamilton-Fairley attended a stakeholder event held in June 2018 and the Trust is now progressing its application to be a designated university teaching hospital.

Roundtable discussions with Secretary of State

I have had the opportunity to meet with the Secretary of State for Health and Social Care, Jeremy Hunt, on two separate occasions in recent weeks. I was invited to join other Chief Executives, Chairs and STP leads to discuss key NHS priorities and reform in light of the Prime Minister's recent commitment to developing a long-term plan and multi-year funding settlement.

It was useful to hear first-hand from the Secretary of State, and the additional funding is very welcome. We now know that the money will be phased over five years, with higher amounts in the first two years to ensure an improved funding level to provide the level of care we are currently delivering.

NHS70 Celebrations

I have been invited to attend a special service at Westminster Abbey on 5 July to commemorate the 70th anniversary of the National Health Service when I will be accompanied by one of our junior doctors and one of our longstanding volunteers. The event forms part of a series of special celebrations to mark the occasion and appreciate the vital role the NHS plays, as well as providing an opportunity for us all to thanks NHS staff for their hard work and commitment. I am really pleased to have been invited to attend what will no doubt be a memorable occasion.

Performance Report to the Trust Board

Board Date: 05/07/2018 **Agenda item** 9b

Title of Report	**Transformation (Improvement) - Performance Report**
Prepared By:	James Devine, Deputy CEO & Executive Director of HR&OD
Lead Director	James Devine, Deputy CEO & Executive Director of HR&OD
Committees or Groups who have considered this report	Transformation Assurance Group Trust Executive Team
Executive Summary	This report summarises the progress made to date (as at M2) on the cost improvement programme. In addition, an update is provided on the work of the transformation team and the support provided on Trust wide improvement initiatives. On cost improvement, at M2 shows a 92% YTD achievement against plan. The adverse variance is largely due to one scheme starting later than planned. Against the £21m CIP target, we have now identified £22.5m (including the strategic workforce group schemes) with a PMO adjusted figure of £17.9m – representing 85% of the 18/19 target. Further schemes are currently being validated with the aim of further reducing the gap and these will be included in the next update to the transformation assurance group. The report summarises the five elements established within the transformation team in relation to Model Hospital & Getting It Right First Time (GIRFT). Further work is ongoing within particular specialities to review areas such as service efficiency, workforce and variation. This performance report includes action plans for the next stages of transformation.
Resource Implications	None at this time
Risk and Assurance	There is no change to the risks previously highlighted. The assurance mechanism remains in place; this being the assurance group.
Legal Implications/Regulatory Requirements	Financial Special Measures (linked to non-delivery of CiP)

Performance Report to the Trust Board

Improvement Plan Implication	The work of the transformation team spans across the 13 workstreams of Better, Best, Brilliant
Quality Impact Assessment	Not required at this stage
Recommendation	The Board are recommended to note the performance reported and consider as is appropriate.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

Performance Report to the Trust Board

1 EXECUTIVE SUMMARY

1.1 Cost Improvement Delivery (CIP) - As at Month 2 £1.51m savings have been delivered. This shows an overall adverse variance of £132k. Against the £21m CIP target, we have now identified £22.5m (including the strategic workforce group schemes) with a PMO adjusted figure of £17.9m – 85% of the 18/19 target.

1.2 There are 12 CIP schemes set to start delivering in June. Eight schemes have been reviewed by the Transformation CIP manager and six are confirmed to be on track for delivery.

1.3 Model Hospital & Getting It Right First Time (GIRFT) programme establishes five elements with updates provided.

1.4 Improvement project methodology and approach set for the Trust. Capability training finalised for rollout across the Trust.

1.5 This performance report includes action plans for the next stages of transformation.

2 PROGRAMME STATUS UPDATE

2.1 Progress update since last Transformation Assurance Group (TAG) meeting, 15 June 2018, we have:

- Engaged our new Cost Improvement Programme (CIP) Manager Steve Arrowsmith who joined the team 18/06/2018 – Steve will manage the Project Management Office (PMO) element of the Transformation work and report through TAG assurance of schemes;
- Engaged our new Project Lead Douglas McLaren who joined the team 18/06/18 – Doug will work on improvement projects aligned to length of stay (LoS) reduction;
- Attended Medway and Swale Transformation Board to combine the efforts of Sustainability and Transformation Partnership (STP), Quality, Innovation, Productivity & Prevention (QIPP) and Trust CIP for supported delivery and action and will co-develop the governance structure to assure successful collaboration;
- Continued working up our Trust focus of LoS reduction with Mark Hackett (Director of Financial Improvement) supporting;
- Started daily accountability meetings within the project management team to drive accountability and action;
- Set up and run the first Transformation weekly performance meeting with team to drive performance and set direction;
- Submitted the Trust assessment for freedom to speak up guardians (FTSU) and currently working on the action plan to address gaps;

- Continued to meet clinical teams in their directorates: - Children's & Women's (C&W) directorate managers, Surgical Services Programme Board, Planned Care Directorate Governance and Management Board and Patient experience teams;
- Completed the 'define' phase of wave one initial projects to start improvements ahead of the LoS reduction focus.

3 UPDATE ON CIP DELIVERY

3.1 CIP delivery – by directorate.

2018/19 CIP Forecast vs Target Month 2

Directorate Split	Unplanned Care (£'000)	Planned Care (£'000)	Corporate (£'000)	Estates (£'000)	Totals (£'000)
Target	(7,879)	(6,374)	(6,021)	(726)	(21,000)
CIP Budget as % of Expenditure Budget	5.9%	5.4%		3.1%	6.9%
Identified	(5,503)	(6,532)	(5,136)	(777)	(17,948)
Unidentified	(2,376)	158	(885)	51	(3,052)
% Identified to Target	70%	102%	85%	107%	85%
YTD Plan	(335)	(842)	(444)	(21)	(1,642)
YTD Actual	(343)	(707)	(444)	(16)	(1,510)
YTD Variance	8	(135)	0	(5)	(132)
YTD % Delivery	102%	84%	100%	76%	92%

3.2 As at Month 2 £1.51m savings have been delivered. This shows an overall adverse variance of £132k – 92% delivery YTD

3.3 Month 2 key messages- interim update ahead of month 3 actuals:

- Against the £21m CIP target, we have now identified £22.5m (including the strategic workforce group schemes) with a PMO adjusted figure of £17.9 – 85% of the 18/19 target and yet to include the additional savings from the Transformation team. There are 133 CIP schemes across 2018/19;
    - Against our identified CIP schemes across the directorates, the month 2 bottom up position is £132K short of plan. This is largely driven by safer staffing reviews (£122K) not starting in month 1.

3.4 CIP delivery – Month 3 look ahead: There are 12 CIP schemes set to start delivering in month 3. Eight schemes have been reviewed by the Transformation CIP manager and six are confirmed to be on track for delivery.

The SWG (strategic workforce group) project team is meeting fortnightly to drive progress and surface any issues. Like CIPs, SWG schemes will have a QIA (quality impact assessment) in place. The Head of Culture and Engagement has been added to the SWG

project team to ensure the cultural and staff implications of schemes are well considered before launching.

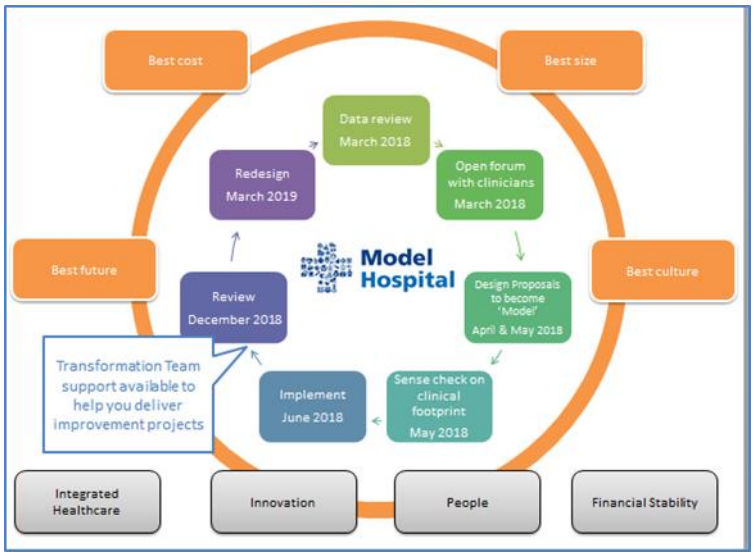
4 PROGRESS UPDATES

4.1 Model Hospital & Getting It Right First Time (GIRFT) programme – includes potential loss-making services review:

There are 5 elements to the Model Hospital & GIRFT programme within the Transformation Team. Updates have been provided below against each of these 5 elements.

4.1.1 **Working alongside clinical teams to identify, quantify and prioritise their own improvement plans, specialty by specialty**. Plans will include both in-year and longer-term reconfiguration opportunities. Where deep-dive reports have been provided (e.g. T&O), the delivery of GIRFT recommendations should also be included. The following specialties have now met with us and formed Model Hospital action plans, to be supported by the Transformation Team, as required:

Specialty	Meeting held	Focus areas within action plan
Gastroenterology	Y	• ALOS for EL admissions • Expertise at front door
Urology	Y	• DC Urethrotemy • Average days between emergency urinary retention admission & elective admission • GIRFT recommendations
ENT	Y	• Increase day case rates • GIRFT recommendations
Vascular	Y	• Improve flow from theatres to recovery, generally • Review End of Life pathway – living testament • Deliver GIRFT recommendations
Emergency Medicine	Y	• Criteria for ambulatory care follow up appointment to transform N:FU ratio
Orthopaedic Surgery	Y	• Theatres User Group re-launch – start times, touchtime utilisation • Insourced LLP weekend surgery – with productivity gains during the week • Prioritise and deliver GIRFT recommendations e.g. cemented/un-cemented, FNOFs BPT
General surgery, breast	Y	• Increase DC surgery • LoS reduction plan
Obstetrics and Gynaecology	Y	• Repatriation of consultant antenatal clinics • Increase midwife led discharges • Revive homebirth team • More ambulatory gynaecological procedures • Establish MFT as foetal medicine centre of excellence
Paediatrics	Y	• Coding review – Level 1 HDU work • Diabetes BPT reimbursement
Therapy Services	Y	• Deliver 7 day services and LoS reduction plan
Clinical Haematology / Pathology	Y	• MDT tariff in Haematology • Nuclear Medicine – OP FUs • Cancer patient follow ups coding (to reduce FA2FU penalties) • Demand management for tests working with Junior Docs and Consultants
Rheumatology	Y	• Stop providing DVH service • Review MSK triage process • Review OP Follow Ups and processes • Review how lilac slips are used
Cardiology	Y	• Review Cath Lab utilisation (audit ongoing)
Pharmacy	Y	• IV paracetamol, Sevoflarane %, Biosimilars switching (Adalimumab) • Review contract prices • DMARDs • Dose-banded chemo • Electronic Prescribing and Medicines Administration (EPMA)



The catch up productivity of £31m was presented at the last meeting. Clinical Leads and Service Managers have been tasked with delivering their action plans to the adjacent timeframe, as part of an annual cycle. These actions should contribute to the delivery of this opportunity.

4.1.2 **Identifying common threads between specialties to improve productivity and throughput, and supporting improvement projects to deliver the opportunities identified** e.g. Length of Stay reductions, demand management for tests, OP utilisation and non-value adding follow ups, product and drugs bill savings, DC rates.

4.1.3 **Articulating the future model Medway Maritime hospital portfolio of services** – and forming a plan to get there in line with the hospital's strategy and the STP clinical strategy.

4.1.4 **Identifying services that are sub-scale and/or loss-making** and supporting a structured programme of work to divest certain services that cannot be sustainably be provided on an acute hospital site and should therefore be provided elsewhere in the community.

4.1.5 **Upskilling the organisation and key staff e.g. Service Managers to use comparative benchmarking data and improve commercial awareness as part of BAU.** Training material has been developed and the central NHSI team have also provided webinar material and offered to facilitate a workshop.

Performance Report to the Trust Board

4.2 Improvement projects update from last meeting:

- On-going conversations within the Trust (at all levels) continually reinforce the view that in order for Medway to truly transform and "reset" our cultural dial.
- Feedback to date has been in the main very positive, that staff want to see and be part of a new Medway.
- We as a leadership team, and all leaders whether they are clinicians, nurses or those in a non- clinical role must feel that they are part of the next stage of our plan to brilliance.
- Further update since last meetings and on-going actions:
    - The work we want to undertake about the metrics and the culture we want to see, and feel will actively support the Better, Best, Brilliant (BBB) programme. It will take the trust to the next phase and help us create a culture of brilliance in all that we do.

4.3 Continuous Improvement in the Trust

4.3.1 Improvement Projects

- A single approach will be used for improvement project management. The methodology uses Lean and 6 Sigma tools and processes in order to provide the best standard for action and capability building to achieve this:-
- The transformation team are already following the DMAIC process for standardised improvement methodology.

4.3.2 Capability training

- Adam Walton (Transformation Capability Lead) is working to structure a full year offering of training in lean process and project management. The training consists of White Belt Plus and Yellow Belt – end June;
    - White Belt is a one day course designed to give participants the tools to deliver small scale changes in their area of work. They bring an issue to solve that is worked up during the training for delivery after.
    - Yellow Belt is a two day course designed to give participants the tools to lead and/or deliver medium sized improvement projects that may span across more than their area of control.
- All trainees will be expected to delivery an improvement as a result of the training. This will be managed by the Transformation team but the individuals will be responsible for delivery and the Directorates will be accountable for completion and support.
- A system of coaching will be set up to support the trainees as they deliver the improvement - by end July.

4.3.3 Strategy Deployment

- A ‘True North’ session with Execs is required to develop metrics and clear 3-5 year plan to enable the full workforce to align and support the Trust’s objectives will be set up at an appropriate time aligned to CIP assurance.

4.3.4 Improvement System at the front line

- As part of the improvement projects a front line improvement system will be implemented. This system will build empowerment, capability and ownership of local metrics across the trust over a period of 3-4 years.
- Training of the improvement system will take 3 months per wave that may consist of up to 6 areas in each wave.
- Timelines for starting will depend on additional resource from within the trust being dedicated for the entire roll out period and aligned to the Transformation team.

5 NEXT STEPS

5.1 The areas of focus are as follows:

5.1.1 Fully scope the improvement projects and agree the Transformation team support to achieve the targets;

5.1.2 Complete the Capability training programme and offering to the trust via ‘Mollie’ with necessary communications. Ensuring the needs of improvement project teams are met through building their capability to deliver;

5.1.3 Set the date for strategy deployment and leadership development sessions;

5.1.4 Progress sub-scale services work and bring back evaluation criteria to next TAG;

5.1.5 Further develop LoS reduction plan and schedule summit.

---Ends---

Report to the Board of Directors

Board Date: 29/06/2018 Agenda item

10

Title of Report	**Integrated Quality Performance Dashboard - Update**
Prepared By:	Associate Director of Business Intelligence
Lead Director	Executive Team
Committees or Groups who have considered this report	Draft to Quality Steering Group
Executive Summary	The purpose of this report is to inform Board Members of May's performance across all functions and key performance indicators. Key points are: • The Trust did not achieve the **four hour ED target** for May but performance has improved from 82.49% in April to 84.87% in May. The Trust recorded activity of 6.2% above planned resulting in significant challenge to keep pace with unplanned demand for non-elective services. • Only 35.8% of ambulance patients were seen within 15 minutes. The Trust receives the largest number of conveyances in the region and continues to work closely with SECAmb and NHSI to implement effective corrective actions. • There were no **12 hour breaches** in May. • **HSMR** data reported in this month's IQPR is for the period from February 2017 to January 2018. This is currently 111.1, which is within expected range. However HSMR has been climbing since the summer of 2016. An analysis of the underlying position has been undertaken which indicates a stable number of deaths and a static crude mortality rate. • This month saw a 47.45% decrease in the number of

Report to the Board of Directors

	Mixed Sex Accommodation (MSA) breaches, which totalled 144 in May. New processes to support reporting and better staff engagement in the changes to managing MSA are beginning to deliver improvement in performance and a better patient experience. • **RTT** performance has increased to 82.38% from 81.21%. This is below the national standard of 92%. Improvement trajectories have been agreed with each speciality and are reported on weekly. • All 31-day **Cancer targets** and the 62-day GP standard have been achieved in April. The 2-week wait and 62-day screening targets have not been met. The 2-week wait symptomatic breast performance has decreased by 4.89% to 77.61%. Breaches were predominantly as a result of patient choice. The 62-day GP performance was achieved in April, although performance has decreased by 7.78% to 86.42%. The 62-day screening standard was not achieved in April, which has dropped by 4.92% to 85.71%. • Diagnostic performance remains below trajectory due to significant issues with capacity within the Sonography workforce. Corrective actions include daily workforce and capacity huddles to sustain service level grip and insourcing of additional capacity for non-obstetric ultrasound • There was a 27.1% increase in the number of **falls** in May (75) compared to April (59). RCAs are undertaken for all falls and no emerging new themes have been identified. • 83 complaints were reported in the month, an increase from April's 79. There were 2 complaint returners in May.
Resource Implications	N/A
Risk and Assurance	See report

Report to the Board of Directors

Legal Implications/Regulatory Requirements	N/A			
Improvement Plan Implication	Supports the Improvement Programme in the following areas: Workforce, Data Quality, Nursing, Finance			
Quality Impact Assessment	See report as appropriate			
Recommendation	N/A			
Purpose and Actions required by the Board :	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒

NHS Medway NHS Foundation Trust

Integrated Quality and Performance Report

June 2018

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

Best of care
Best of people

Contents

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

Best of care
Best of people

10924 Patients visited our ED , which is a **6.37% increase** on the previous month, with **84.87%** seen within 4 hours, compared to 82.49% . **1573** Patients were admitted, with a **decrease** in conversion rate of **14.40%** compared to 16.17% in April.

There were **5604** total patient admissions in May, and **5464** patients were discharged.

Bed Occupancy **increased** by **0.24%** in May to **94.11%**.

3182 patients arrived at ED via ambulance which is an **1.69% increase** on last month.

35.8% Of ambulance patients were seen in under 15 minutes.

May's Story....

407 Babies were delivered in the month of May (2 less than April) with Emergency C-Section rate with a **decrease** of **0.22%** from the previous month to **17.87%.**

HSMR is **111.1** and within expected parameters (105.0 – 117.5) compared to 108.9 as reported in April.

87% of staff have had an appraisal compared to **86%** in April.

39157 Patients attended an outpatient appointment with **8.69%** DNA rate which is an increase of **0.30%** on last month.

There were **75** total falls in May, compared to **59** in April.

RTT Overall Incomplete Pathways for May was **82.38%** which increased by **1.17%** on previous month. This is below the Trust improvement trajectory. The Trust also reported **1 x 52** week waiters which remained the same compared to April.

31 day subsequent treatment surgery cancer target was achieved at **100.00%** in April (reported one month in arrears).

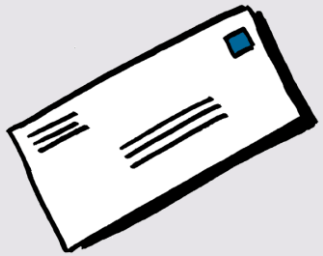
2 Week Wait symptomatic breast was below the target of **93%** in April with performance of **77.61%** - decreased by 4.89%.

2 Week Wait cancer performance for April was **92.93%** (reported one month in arrears) . This is a **1.91%** increase from April's performance.

May's Performance....

92.90% of patients waited under 6 weeks for diagnostic tests in the month of May, which has decreased by **3.21%** since April's reported performance.

We received **83** complaints in May, increasing from those received in April by **4**. The number of complaint returners remained the same at **2** in May.



There were **144** Mixed Sex Accommodation breaches in May which is a **47.45%** decrease on April's performance.

Safe

Legend: Compliant with target; Breaching target

Falls

The number of falls increased by 16 from the previous month. RCAs completed to date have not identified new themes or rising risks.

Duty of Candour (DoC)

Further to the recent review of DoC management and performance a revised reporting process has been implemented. The Trust will be reporting DOC in the IQPR 2 months in arrears. This will enable accurate reporting of performance against the NHSE Framework timelines for incident reporting.

Infection Control

MRSA acquisitions and bacteraemia

- No Trust-attributable MRSA bacteraemia cases in the month.

C Diff post 72 hours

- Two post 72-hour cases in May. Post infection review to be confirmed next month.

Serious Incidents

As at 31st May 2018 there are a total of 94 open Serious Incidents (SIs)

- subject to an active investigation – 18
- SI investigations completed and awaiting review as part of the CCG thematic analysis project – 76

Of the 18 subject to active investigation

- Open SIs within allocated timeframe – 16
- Open SIs breaching the allocated timeframe – 2
- New SIs reported on STEIS in May 2018 – 12

In line with the NHS England SI Framework (2015) and Schedule C (Quality) of the NHS Standard Contract 2017/18, the Trust is required to:

- Report 100% of all serious incidents within 2 working days of the incident being reported on Datix. Trust wide compliance for May 2018 is 42%.
- Submit a 72 hour report to the Clinical Commissioning Group (CCG) within 3 working days of the SI being reported. Trust wide compliance for May 2018 is 100%.
- Submit 100% of all serious incident final reports to the CCG within 60 working days. Trust wide compliance for May 2018 is 100%.

MORTALITY SUMMARY

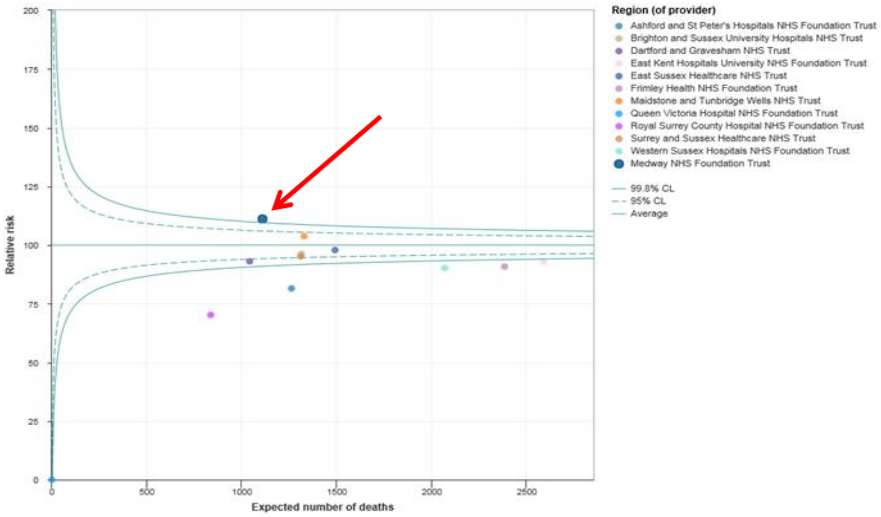
The HSMR has been gradually climbing since the summer of 2016, although the most recent month does show a reduction for the first time in over a year. Analysis of the underlying position indicates a generally stable number of actual deaths, and no change in the Trust's crude mortality rate (which has been steady at 6.5% for over a year, compared to 8% at the time the Trust was in Quality Special Measures). There has been a significant reduction in expected mortality – this is potentially driven by a number of factors, including a reduction in palliative care coding and a reduction in depth of co-morbidity coding. However the start of the rise in HSMR does correlate to the introduction of the previous medical model – this contained a number of inefficiencies which have been addressed with a refresh of the model, commencing on June 4th.

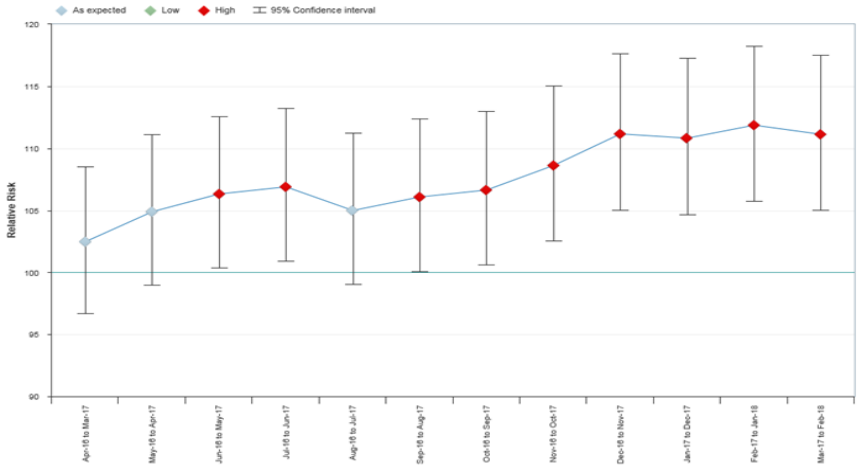
The high mortality from sepsis was audited for deaths in January, and this revealed that the majority of the patients were very poorly and nearing the end of their lives with underlying medical conditions. The fact that the SHMI continues to reduce is reassuring – this suggests that there is no excess of mortality across the whole health system for patients admitted to or recently discharged from hospital. The downward trend in mortality from acute cerebrovascular disease is encouraging, but more work needs to be carried out to optimise the service provided to newly admitted stroke patients pending the results of the Kent and Medway Stroke Review later this year.

Mortality

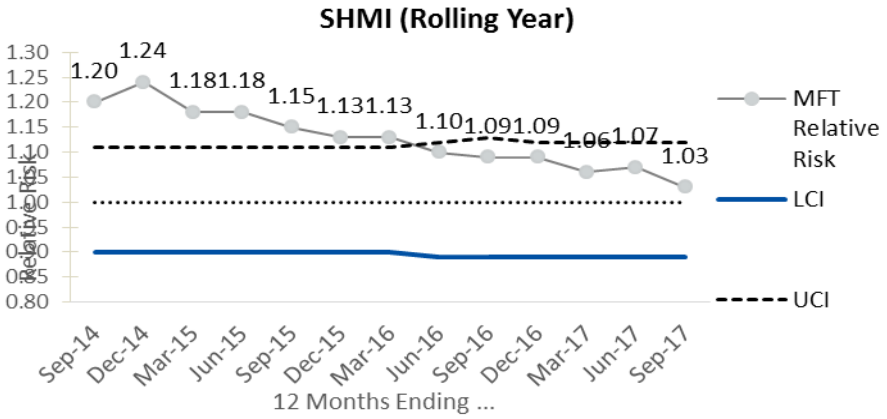
The HSMR for the period March 2017 – February 2018 is **111.1** (95% confidence interval 105.0 – 117.5). This represents a decrease from the previous rolling 12 month value of 111.9 and is highlighted as high for the seventh consecutive month by Dr Foster.

Peer comparison shows that the Trust currently has the highest relative risk in the area, and is now sitting just above the 99.8% confidence limit.

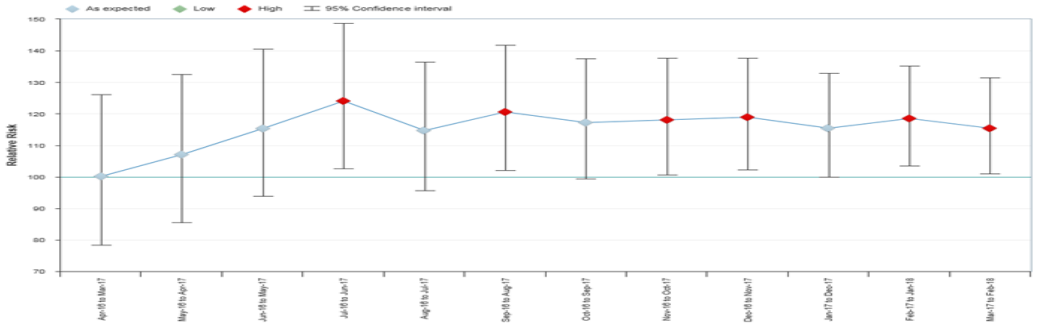




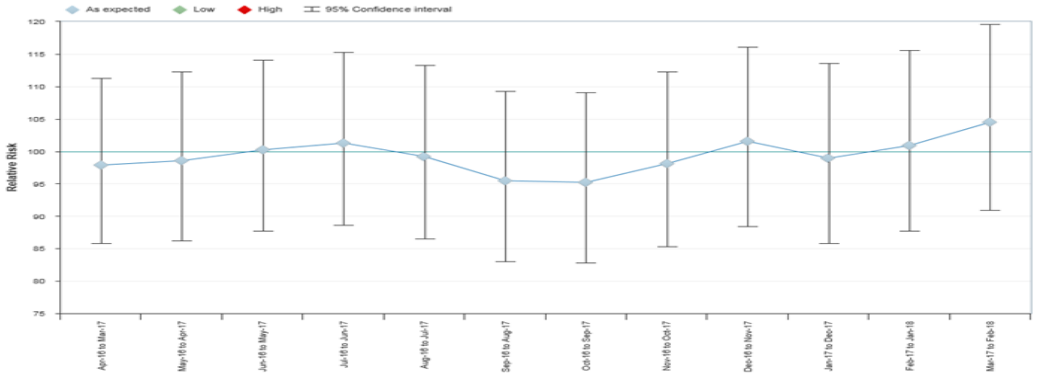
The latest Summary Hospital-level Mortality Indicator (SHMI) for the period October 2016 – September 2017 was published on 22 March 2018. The value has decreased slightly to **1.03** from 1.07 in the previous data update (for the period July 2016 – June 2017) and remains within the expected range.



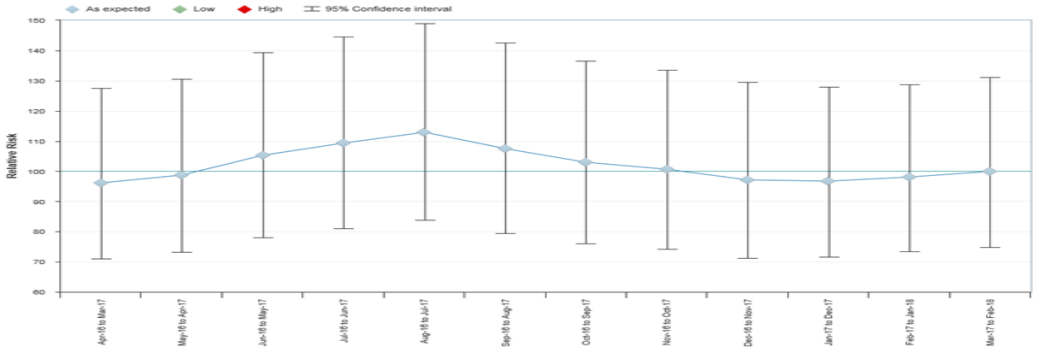
The HSMR for Septicaemia is currently **115.4** (95% confidence interval 100.9 – 131.4); this represents a slight decrease from 118.5 for February 2017 - January 2018; however, the Dr Foster May publication highlights septicaemia as an outlier for two consecutive months.



The HSMR for Pneumonia is currently **104.5** (95% confidence interval 90.9 – 119.6); this represents an increase compared to 100.9 for February 2017 – January 2018. This is the second consecutive rise in HSMR for this diagnosis group; however, the HSMR remains within the expected limits.

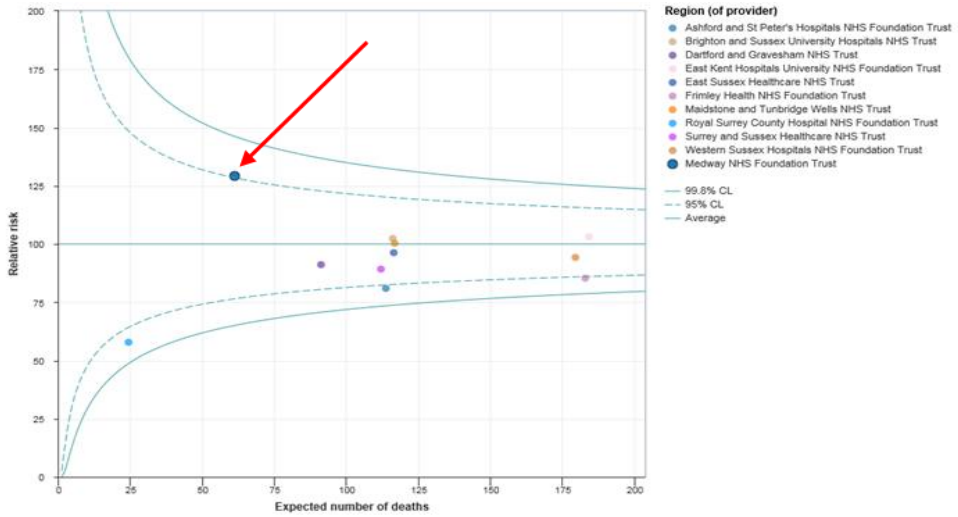


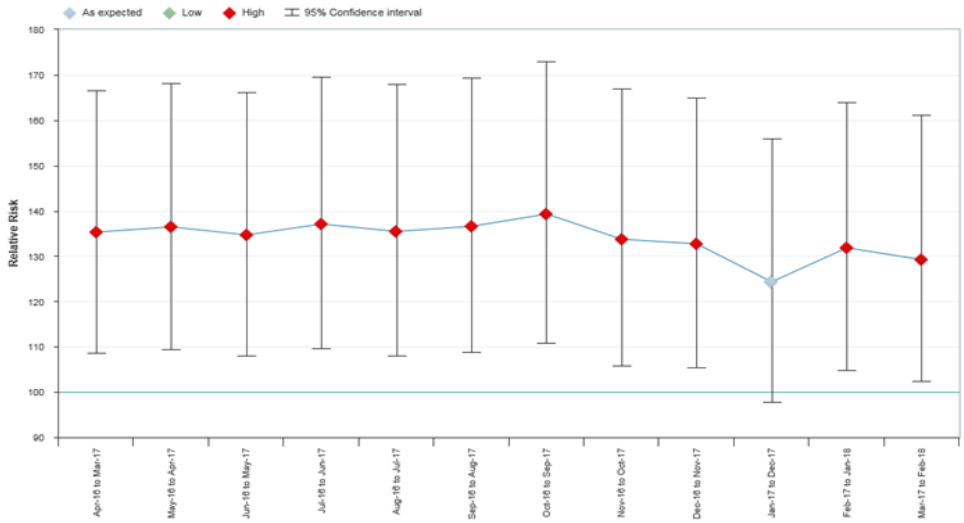
The HSMR for congestive heart failure is **100.0** (95% confidence interval 74.6 – 131.1) and is within expected limits.



The HSMR for acute cerebrovascular disease is **129.2** (95% confidence interval 102.3 – 161.1) and is once again flagged as high by Dr Foster; however, the overall trend for this diagnosis group has been downward since the rolling 12 months to September 2017.

Peer comparison for acute cerebrovascular disease shows that Medway continues to have the highest relative risk in the area, but is now within the 99.8% confidence limit, and is sitting at the 95% confidence interval.





Caring Page 24

- **Mixed Sex Accommodation (MSA) Breaches**

The higher profile within the Trust regarding MSA is improving awareness of the new process and reducing tolerance to accept breaches. The clinical teams continue to embed the recently implemented reporting process and a number of IT system issues have been resolved. This is evident on a decrease of 130 breaches from the previous month.

Responsive Page 25

- **RTT**

Our overall RTT percentage for May has closed at 82.14%, up 1.2% on last month. There was one 52 week waiter within the T&O speciality that has chosen a date over 52 weeks which will result in no harm due to the long wait. The Service Mangers from each speciality have submitted a trajectory which they report on via a weekly performance meeting.

	Reporting Date – 03/06/18			Reporting Date –10/06/18			Variance		
Total Patients with open pathways waiting less than 18 weeks	17923			17787			↓136		
Total Patients with open Pathways Waiting more than 18 weeks	3942			4073			↑131		
RTT Incomplete Performance %	Adm	Non Adm	**Overall**	Adm	Non Adm	**Overall**	Adm	Non Adm	**Overall**
	67.76	84.98	**81.97**	66.64	84.42	**81.37**	↓1.12	↓0.56	↓0.60
Total Patients Treated (Clock Stop)	**1325**			**1430**			↑105		

Cancer

April performance against the cancer waiting time standards is challenged on last month with compliant performance against all 31d targets and 62d GP referral national standards. There remains a high focus on patients who have been waiting longer than the standard.

- **2WW – The Trust is NOT compliant with the GP 2 week wait and NOT compliant for the symptomatic breast standards.**

- There were 86 breaches in April across a number of tumour sites with Brain, Children, Gynaecology, Lower GI, Lung, Skin, Thyroid and Upper GI being non-compliant.
- Breaches were predominantly as a result of patient choice.
- 22/43 of the 2 week wait breaches were booked within the target 48 hours from receipt of referral.
- There were 15 symptomatic breast breaches as a result of patient choice and clinic capacity.

- **31D - The Trust is compliant with the first definitive, subsequent drug and subsequent surgery treatments.**

- There were no reported breaches against the 31d first definitive standard.

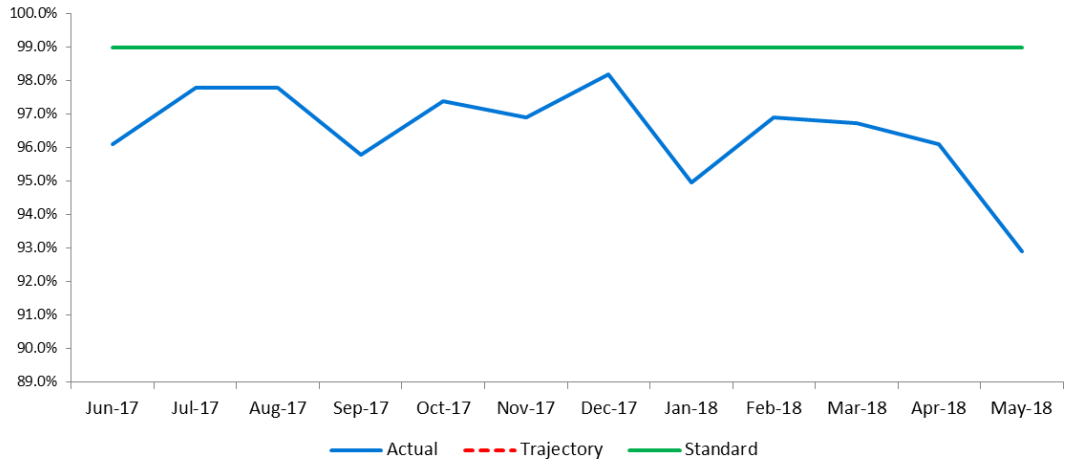
- **62D – The Trust is compliant against the GP 62 day standard and 62 day screening standard.**

- The 62 GP standard performance is 86.42% above the improvement trajectory.
- The shadow 38 day reporting performance improved the 62d standard further to 88.75%.
- There were 11 breaches against the GP 62 day referral standard. These are detailed as 0.5 Gynaecology, 2 Head & Neck, 2.5 Lower GI, 0.5 Lung, 0.5 Dermatology, 2 Upper GI and 3 Urology.
- Pathway breaches were as a result of complex pathways, imaging delays, further diagnostic tests, patient choice and delays from originating Trust.
- There are 4 breaches over 104 days and 5 breaches between 62 and 76 days.

Month	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
Actual	74.2%	80.0%	82.1%	80.1%	72.3%	74.0%	75.1%	84.8%	91.4%	85.1%	96.4%	86.4%
Trajectory												
Standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Diagnostics

Diagnostic performance remains below trajectory, with a deterioration of 3.2% in May 2018, due to significant issues with capacity within the temporary and substantive Sonography workforce.



Month	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
Performance	3.9%	2.2%	2.2%	4.2%	2.6%	3.1%	1.8%	5.0%	3.1%	3.3%	3.9%	7.1%
Actual	96.1%	97.8%	97.8%	95.8%	97.4%	96.9%	98.2%	95.0%	96.9%	96.7%	96.1%	92.9%
Standard	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

Further actions:

- Daily workforce and capacity huddles to ensure service level grip and reporting against plan.
- Weekly robust Diagnostic PTL Meeting, with focus on target driven improvement actions
- Non-obstetric ultrasound: Insourcing additional capacity from June 2018, with review of appointment timings and processes
- Commencement of digitalisation of plain film which will modernise this part of the service and greatly improve patient experience and staff working lives
- Plan for the delivery and use of electronic orders across the Trust and in the Community (commence go live in June 18)
- Further training to all administration staff working in diagnostic areas to help improve waiting list management.
- Work towards target of booking appointments no later the day 14 of pathway, to enable accurate reflection of position, and clearer understanding of action required

ED

The Trust's performance against the national 4 hour standard for May was below trajectory at 86.53% for all types. This saw a 1.43% uplift on the prior months performance.

The total number of attendances for May 18 is 10,924 in month we observed 7.3% increase above outturn for the same period last year which is 6.2% over the planned activity within the agreed operational plan. The trust has therefore struggled top keep pace with this unplanned demand for Non-elective services.

Admitted 4 hour performance was 24.75% which is an improvement of 3.12% on April's position .
The Non-admitted pathway observed a slight improvement on the previous month and ended at 89.73%.
Minors performance was 98.87% and Children's ED ended on 100% for the month.

Performance below trajectory for May is primarily through high demand and subsequent lack of internal flow from the main bed base to discharge.

The trust observed an average of 73, 4hour breaches each day. The majority of which are within Medicine and due to bed availability. (Fig 1)
The drivers for delay with discharge continue to be multifactorial and span the entire continuum both internal and external to the trust.

The transformation teams work plan will have a focus on the organisational wide length of stay reduction plan .

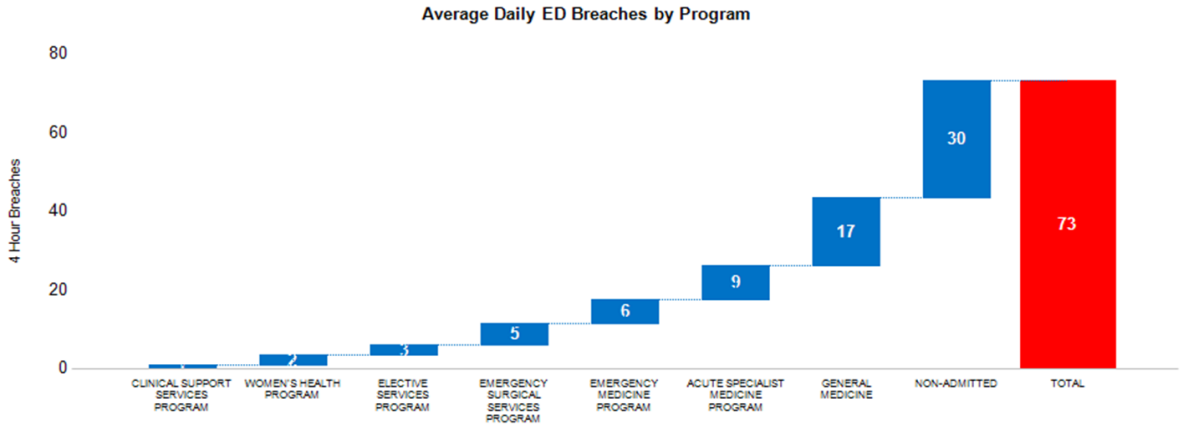


Fig 1

- **ED (cont'd)**

As a result the trust has been challenged during with an ambulance handover performance and recorded compliance of 35.8%, of transfers happening within 15 minutes.

The trust continues to receive the largest number of conveyances in the region and recorded 3182).

Operationally we have met with the SECAmb improvement team along with NHSI and are actively working together on a programme of work to address the delays and achieve the standard , this will then form part of the over arching ED recovery plan. The handover of the phase one new build will provide 4 designated bays to receive handover and rapid assessment of patients bought in by ambulance .

Detailed analysis of the breech profile has led to key interventions being identified to improve the ED performance.

The introduction of the revised medical rotas started on the 4th June which will assist in correct streaming of patients and improved focus on discharge

Well Led Page 26

Voluntary turnover (across all staff groups) has decreased to 11.5% (-0.4%) and remains above the tolerance level of 8%; turnover, is expected to continue to plateau over the next two months. Sickness absence at 3.44% has significantly reduced and below the tolerance of 4%. Ratios of long-term sickness to short-term sickness remain largely even.

Temporary staff (as percentage of paybill) at 19.6% is higher than April (+2%) and is slightly higher than year to date average. The agency component of temporary staff, at 8%, is 2.5% higher than April; but is largely in line with year to date averages. The bank component of temporary staff, at 11%, is 2.5% lower than April and is also largely in line with year to date averages. The Trust continues to meet its agency ceiling cap. Works to continue working with suppliers and clinical programmes to reduce agency expenditure are underway. In addition, the Trust continues to actively support staff moving from temporary to substantive posts.

Medway Community Paediatric services were transferred from the Trust at the end of May to Medway Community Healthcare contributing to the higher than average leavers.

Data Quality Validation Update

The Team are engaged in a variety of projects to improve systems with identified data quality issues.

Existing work projects:

- **Cancer PTL Open Pathways:** the DQ Team continues to support investigations into open cancer pathways on the Infoflex system pre 2015 period. Further to completing the initial phase 1 and 2 of the validation project in May 2018 (approx.9000 open pathways), the DQ Team have moved into phase 3 with a further 2000 records to be validated. Data validation of these records has been generated since a modification of the Business Intelligence cancer reporting service, which will contribute to an accurate service level of reporting.
- **Maternity Euroking Upgrade** – Working in conjunction with IT project team, BI and maternity team. Ensuring that data provided on monthly submission is accurate and ensuring new system when live will not impact data or patient care. Working on a maternity PTL with BI to improve patient care and department efficiency.
- **DM01** – Working with services to ensure the data on the new DM01 is clean and accurate, assisting with the data cleanse process.
- **Outsourcing** – DQ team are just starting on a small project working with BI & Finance to improve the current process of recording outsourcing activity.

Data Quality Training

- RTT decision making training being delivered to all staff that have pathway management involvement/management responsibilities. In collaboration with the training team, the RTT guideline booklet has been redesigned and is available to all staff on the intranet.

- Working with the imaging department and BI developing diagnostic DM01 training and a diagnostic PTL, with the aim of improving patient care and department efficiency.

Other DQ Validation Work:

The team continue to validate multiple data quality issues related to patient records, identified through the Data Quality dashboard. The DQ team is actively assisting the directorates looking at their RTT data, analysing and identifying trends or errors that are occurring. Regular engagement with the relevant teams is on-going, providing training, advice and support with the common goal of achieving the 92% target.

The team work in collaboration with the BI team to look at the CCG challenges that are sent through, to ensure that the data provided is accurate. Working on collaborative approach with service teams to improve DQ by DQ co-ordinators working within the services to offer support and be a visual presence.

3. Safe

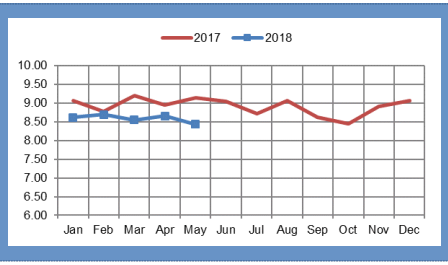
		Monthly Target	RAG Status	Trend Mar-18	Apr-18	May-18	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
1.1.3.2	NRLS Organisational Reporting Rate (6 monthly)		G	46.74 (national median 40.14)								
1.1.4	Never events	0	G	0.00	0.00	0.00	⇔	0.1				✓
1.1.4.1	Never Events - Incidence Rate	0.00%	G	0.00%	0.00%	0.00%	⇔	0.0			✓	
1.1.5	Incidents resulting in death	0	R	5.00	1.00	4.00	↑	4.1				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days)	0.30	R	0.34	0.28	0.40	↑	0.31				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days)	2.20	G	1.37	0.49	1.61	↑	1.4				✓
1.1.14	Pressure ulcers (grade 2) attributable to trust	10	G	8.00	11.00	4.00	↓	7.1				✓
1.1.15	Pressure ulcers (grade 3&4)	0	R	1.00	0.00	2.00	↑	0.9				✓
1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	0.2	G	0.07	0.00	0.20	↑	0.1				
1.1.18	Falls per 1000 bed days	6.63	G	4.18	4.13	5.03	↑	5.0				
1.1.19	Number of falls to fracture (per 1000 bed days)	0.2	G	0.07	0.00	0.20	↑	0.1				
1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.00	0.00	0.00	⇔	0.0			✓	
1.2.2	New VTEs - point prevalence in month	0.36%	G	1.02%	0.64%	0.25%	↓	0.7%			✓	
1.2.7	Emergency c-section rate	<15%	R	21.8%	18.1%	17.9%	↓	18.8%				
1.3.1	MRSA screening of admissions	95%	G	96.3%	95.5%	99.7%	↑	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	G	0.00	1.00	0.00	↓	1			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	G	1.00	1.00	2.00	↑	2			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	111.1 (105.0-117.5)							✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	115.1 (103.1-128.2)							✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	1	G	1.03 (0.89-1.12)							✓	✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

Safe Staffing – Nursing Update - Highlights

Care Hours per Patient per Day

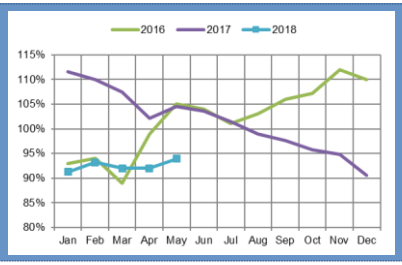
Following implementation of the recent safe staffing review recommendations we have seen a further reduction in CHPPD to 8.43.



A further ward safe staffing review will be undertaken in the autumn.

Safe Staffing

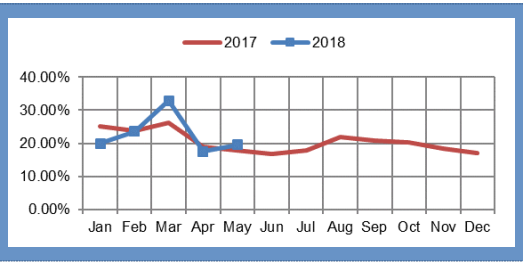
The shift fill rate was 93.9% for all shifts.



Staffing continues to be reviewed multiple times daily. Staff are redeployed when necessary to ensure wards are safely staffed.

Temporary Staffing

The Trust remains below target for Temporary Staffing.



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

Staffing Levels – Nursing & Clinical Support Workers

		Day				Night				Day		Night	
		Registered Staff		Care Staff		Registered Staff		Care Staff					
WARD	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	*Average fill rate - registered staff (%)*	*Average fill rate - care staff (%)*	Average fill rate - registered staff (%)	Average fill rate - care staff (%)
Arethusa Ward	27	2026	1285	1264	1399	1364	1310	682	905	*63%*	*111%*	*96%*	*133%*
Bronte Ward	18	1049	1008	744	797	1034	1083	740	752	*96%*	*107%*	*105%*	*102%*
Byron Ward	26	1620	1018	1302	1400	1046	1013	1046	1140	*63%*	*107%*	*97%*	*109%*
CCU	4	1085	753	0	26	713	713	0	0	*69%*		*100%*	
Delivery Suite	15	2986	2899	746	662	2976	2897	414	359	*97%*	*89%*	*97%*	*87%*
Dickens Ward	25	1563	1240	1583	1598	1023	1078	1023	1188	*79%*	*101%*	*105%*	*116%*
Dolphin (Paeds)	34	3135	3110	1824	1369	2496	2425	357	368	*99%*	*75%*	*97%*	*103%*
Harvey Ward	24	1674	862	1564	2228	1046	1016	1046	1429	*51%*	*142%*	*97%*	*137%*
ICU	9	3833	3074	0	0	3481	2954	0	0	*80%*		*85%*	
Keats Ward	27	1631	1136	1182	1426	1023	1110	726	1077	*70%*	*121%*	*109%*	*148%*
Kent Ward	24	1100	1100	607	602	708	708	648	648	*100%*	*99%*	*100%*	*100%*
Kingfisher SAU	14	1982	1447	1109	1232	1705	1633	682	745	*73%*	*111%*	*96%*	*109%*
Lawrence Ward	19	1279	1117	1049	1035	1046	1046	698	698	*87%*	*99%*	*100%*	*100%*
McCulloch Ward	29	2029	1189	1177	1221	1694	1554	682	749	*59%*	*104%*	*92%*	*110%*
Medical HDU	6	1449	1291	358	358	1403	1202	0	173	*89%*	*100%*	*86%*	
Milton Ward	27	1582	1195	1226	1620	1046	1217	1046	1210	*76%*	*132%*	*116%*	*116%*
Nelson Ward	24	1623	1158	1244	1300	1023	981	682	803	*71%*	*104%*	*96%*	*118%*
NICU	25	4097	3720	984	466	4277	3829	357	345	*91%*	*47%*	*90%*	*97%*
Ocelot Ward	12	905	786	530	611	744	744	372	372	*87%*	*115%*	*100%*	*100%*
Pearl Ward	23	1117	1076	603	601	1116	1047	372	360	*96%*	*100%*	*94%*	*97%*
Pembroke Ward	27	1870	1431	1123	1642	1705	1564	693	1160	*77%*	*146%*	*92%*	*167%*
Phoenix Ward	30	2048	1336	1179	1384	1397	1297	1067	1232	*65%*	*117%*	*93%*	*115%*
SDCC	26	2600	1352	1350	972	682	517	341	252	*52%*	*72%*	*76%*	*74%*
Surgical HDU	10	2264	2157	376	365	1987	1849	0	55	*95%*	*97%*	*93%*	
Tennyson Ward	27	1615	975	1165	1515	1035	1004	1046	1176	*60%*	*130%*	*97%*	*112%*
The Birth Place	9	1110	1065	366	366	1096	1087	372	339	*96%*	*100%*	*99%*	*91%*
Victory Ward	18	1118	828	785	756	1023	749	682	638	*74%*	*96%*	*73%*	*94%*
Wakeley Ward	25	1560	1255	1562	1541	1046	1091	1035	1058	*80%*	*99%*	*104%*	*102%*
Will Adams Ward	26	1632	1093	1124	1845	1023	1023	715	1356	*67%*	*164%*	*100%*	*190%*
Trust total	**610**	**53,577**	**41,956**	**28,120**	**30,333**	**41,958**	**39,739**	**17,524**	**20,582**	***78.3%***	***107.9%***	***94.7%***	***117.5%***

Staffing Levels – Nursing & Clinical Support Workers

	Quality Metrics / Actual Incidents							
WARD	Number of escalations of nurse staffing	Number of hospital acquired Pressure Ulcers grade	Number of Falls with moderate to severe harm	Number of patient related medication errors -	Number of complaints relating to nursing care	Post 72 Hour CDIFF Acquisitions	MRSA Colonisations Post 48 hours	MRSA Bacteraemia Post 48 Hours
Arethusa Ward	2	0	0	0	1	0	0	0
Bronte Ward	0	1	0	0	0	0	1	0
Byron Ward	1	0	0	0	0	0	0	0
CCU	0	0	0	0	0	0	0	0
Delivery Suite	4	0	0	0	0	0	0	0
Dickens Ward	0	1	0	0	0	0	1	0
Dolphin (Paeds)	0	0	0	0	0	0	0	0
Harvey Ward	3	3	0	0	0	1	0	0
ICU	1	0	0	0	0	0	1	0
Keats Ward	0	0	2	0	1	0	3	0
Kent Ward	0	0	0	0	0	0	0	0
Kingfisher SAU	0	0	2	0	1	0	0	0
Lawrence Ward	0	0	0	0	0	0	0	0
McCulloch Ward	1	1	0	0	1	0	1	0
Medical HDU	0	0	0	0	0	0	0	0
Milton Ward	3	0	0	0	1	0	0	0
Nelson Ward	0	0	0	0	1	0	0	0
NICU	1	0	0	0	0	0	0	0
Ocelot Ward	0	0	0	0	1	0	0	0
Pearl Ward	1	0	0	0	0	0	0	0
Pembroke Ward	0	0	0	0	2	0	1	0
Phoenix Ward	2	1	2	0	0	1	0	0
SDCC	0	0	0	0	0	0	0	0
Surgical HDU	0	0	0	0	0	0	0	0
Tennyson Ward	0	0	2	0	0	0	0	0
The Birth Place	6	0	0	0	0	0	0	0
Victory Ward	0	0	0	0	0	0	0	0
Wakeley Ward	0	1	0	0	0	0	0	0
Will Adams Ward	0	1	0	2	0	0	3	0
Trust total	**25**	**9**	**8**	**2**	**9**	**2**	**11**	**0**

Safe Staffing– Nursing Update KPIs

		Monthly Target	RAG Status	Trend Mar-18	Apr-18	May-18	Movement	YTD avg	Trend	Data Quality
1.5.2	Vacancy Rate (Overall)	8%	G					25.86%		
1.5.3	Total Vacancies (WTE)	TBC						400.0		
1.5.4	Vacancy Rate (Band 5)	TBC						36.16%		
1.5.5	Vacancy Rate (Band 6)	TBC						24.10%		
1.5.6	Vacancy Rate (CSW)	TBC						18.78%		
1.5.7	Nursing Starters	TBC		7	18	11	↑	12.8		
1.5.8	Nursing Leavers	TBC		34	23	34	↓	25.8		
1.5.9	CSW Starters	TBC		7	10		↑	10.3		
1.5.10	CSW Leavers	TBC		13	9		↓	9.3		
1.5.11	Rolling annual turnover rate	8%	R	11.78%	11.89%	11.54%	↑	11.29%		
1.5.16	Safe Staffing	94.00%	R	92.0%	92.0%	93.9%	↔	95.6%		
1.5.17	CHPPD	8.00	G	8.55	8.66	8.43	↑	8.70		

Commentary	Actions

4. Effective

		Monthly Target	Status	Trend						Alignment		
			Status	Mar-18	Apr-18	May-18	Movement	YTD avg	Data Quality	Carter	SOF	Country Account / CQUIN
2.5.4	Emergency Readmissions within 28 days	*10%*	R	9.83%	10.82%	11.46%	↑	12%			✓	
2.5.4.1	Emergency Readmissions within 28 days Under 65	*10%*	R	8.74%	8.95%	10.85%	↑	9%			✓	
2.5.4.2	Emergency Readmissions within 28 days 65 +	*10%*	R	11.80%	14.18%	13.28%	↓	13%			✓	
2.6	Discharges before noon	25%	R	21.96%	21.97%	21.81%	↓	19%			✓	✓

5. Caring

		Monthly Target	RAG Status	Trend Mar-18	Apr-18	May-18	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	*83%*	G	86.6%	88.2%	87.0%	↓	88%			✓	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	*65%*	G	74.7%	79.8%	76.6%	↓	82%			✓	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	*79%*	G	98.2%	99.6%	97.8%	↓	99%			✓	
3.1.3	Mixed Sex Accommodation breaches	*15*	R	202	274	144	↓	48.1			✓	
3.4.1	Number of Complaints	*45*	R	89	79	83	↑	67			✓	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	*85%*	R	47.2%				49%			✓	
3.4.3	Number of complaint returners	↓	G	1	2	2	↔	3.1			✓	

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

6. Responsive

		Monthly Target	Status	Trend						Alignment		
			Status	Mar-18	Apr-18	May-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CoLIN
4.1.1	RTT – Incomplete pathways (overall)	92%	R	79.82%	81.21%	82.38%	↑	82.14%			✓	
4.1.2	RTT - Treatment Over 52 Weeks	0	R	1	1	1	↔	27				
4.2.3	A&E 4 hour target (all Types from Nov 2017)	95%	R	82.49%	82.97%	84.87%	↑	86.64%			✓	
4.3.1	Cancer – 2 week wait (1 month in arrears)	93%	R	91.02%	92.93%		↑	85.90%				
4.3.2	Cancer - 2 Week Wait Breast (1 month in arrears)	93%	R	82.50%	77.61%		↓	89.83%				
4.3.3	Cancer - 31 day first treatment (1 month in arrears)	96%	G	98.70%	100.00%		↑	97.01%				
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	94%	G	100.00%	100.00%		↔	97.11%				
4.3.5	Cancer – 31 day subsequent treatments - drug (1 month in arrears)	98%	G	100.00%	100.00%		↔	97.42%				
4.3.6	Cancer - 62 day consultant upgrade (1 month in arrears)	N/A		72.41%	81.82%		↑	73.93%				
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	G	94.20%	86.42%		↓	78%			✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	90%	R	90.63%	85.71%		↓	86%			✓	
4.4.1	Diagnostic waits - under 6 weeks	99%	R	96.75%	96.11%	92.90%	↓	96%			✓	
4.5.8	Patients seen by a stroke consultant within 24 hours (Dec to Mar figures reported)	95%	R	51.00%	51.00%	37.70%	↓	56%				✓
4.6.1	Average elective Length of Stay	<5	G	3.30	2.52	2.43	↓	2.3				✓
4.6.2	Average non-elective Length of Stay	<5	R	7.21	6.50	6.51	↑	7.1				✓
4.6.6	Average occupancy	90%	R	90.30%	93.87%	94.11%	↑	95%				✓

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

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

7. Well led

		Monthly Target	Status	Trend						Alignment		
			Status	Mar-18	Apr-18	May-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
5.2.1	Staff Friends and Family – Recommend as place to work (Quarterly)	*62%*	R		61.0%		↑	58.0%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	*79%*	R		73.6%		↑	70.7%			✓	
5.3.7	Rolling annual turnover rate	*8%*	R	11.8%	11.9%	11.5%	↓				✓	
5.3.7.1	Executive Team Turnover Rate	*TBA*		0.0%	0.0%	0.0%	↔	3.8%			✓	
5.3.8	Overall Sickness rate	*4.0%*	G	3.87%	3.83%	3.44%	↓	3.8%				
5.3.9	Sickness rate – Short term	*3.0%*	G	1.87%	1.84%	1.85%	↑	1.9%			✓	
5.3.10	Sickness rate – Long term	*1.0%*	R	2.00%	1.99%	1.99%	↔	1.9%			✓	
5.3.11	Temporary staff % of pay bill	*15%*	R	32.9%	17.6%	19.60%	↑	19.3%			✓	
5.3.14	Starters	*N/A*		42	59	29	↓	85.1				
5.3.15	Leavers	*N/A*		86	55	100	↑	69.3				

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

8. Enablers

		Monthly Target	Status	Trend						Alignment		
			Status	Mar-18	Apr-18	May-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
7.2.1	APC – NHS number completeness (2 month in arrears)	*99%*	G	99.0%				98.9%				✓
7.2.8	A&E – Attendance disposal (2 month in arrears)	*99%*	R	97.0%				93.4%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	*11*	R	162	112		⇩	144.6		✓		✓
7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	*0*	G	0	0		⇔	0.0				
7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	*99.25*	G	64	66		⇧	102.0		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	*1%*	G	0.3%	0.3%		⇧	0.5%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	*103.50*	G	5	9		⇧	3.86				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	*0.00*	R	2.00	4.00		⇧	2.14				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	*949*	R	2260	2143		⇩	1346.0		✓		✓
7.3.13b	A&E % missing breach reason on breached attendances (1 month in arrears)	*50%*	G	100.0%	100.0%		⇔	100.0%		✓		✓
7.3.17	Cancer 2ww invalid NHS Number (1 month in arrears)	*0.25*	R	1	3		⇧	1.6		✓		✓
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	*13.25*	G	0	2		⇧	0.7		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	*0.01*	G	0.01	0.01		⇩	1%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	*2*	G	0	2		⇧	3.0		✓		✓
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	*1.25*	G	0	1		⇧	0.3		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	*1.25*	R	0	2		⇧	2.9		✓		✓
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	*1*	R	0	4		⇧	1.1		✓		✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

Report to the Board

Board Date: 05/07/2018 Item No. 11a

Title of Report	**Finance Report Month 2**
Prepared By:	Tracey Easton - Deputy Director of Finance
Lead Director	Tracey Cotterill – Director of Finance & Business Services
Committees or Groups who have considered this report	Finance Committee 28th June 2018
Executive Summary	The purpose of this report is to summarise the M2 financial performance of the Trust against the agreed plan. Key points are : 1. The Operating Plan for 2018/19 is per the agreed control total of £34.2m comprising an operational deficit of £46.8m, supported by Provider Sustainability Funding of £12.6m. 2. Month 2 has been reported as a deficit of £9.6m pre Provider Sustainability Funding (PSF). This is £0.2m favourable to the planned deficit of £9.8m pre PSF. 3. Income – Clinical income at month 2 is favourable by £0.3m. This is largely due to income for High Cost Drugs which offsets the expenditure position. Of the £246m income plan, £194.9m or 79% is covered by the block contract agreement with the North Kent CCGs and is therefore fixed for the financial year. Only £4m per month is subject to PbR (Payment by Results) activity and so the fluctuations on monthly income figures will be minimal in this financial year. 4. Activity within the block contract is being monitored to inform future contracting rounds, and to enable a system approach to demand management. 5. Other income –Other income is favorable to plan by £0.7m – in part driven by facilities income as well as the profile of educational income. 6. Expenditure – Month 2 expenditure is adverse to plan by £1.1m. Pay is adverse by £0.05m, non-pay by £1m. This is due to shortfall in CIP delivery, drugs expenditure (which is

Report to the Board

	matched by corresponding income), and clinical supplies which are not procured evenly across the year. The new stock system will assist with managing this category of spend more evenly. 7. At month 2 CIP delivery is behind plan by £0.1m which includes the delivery of £0.4m of non-recurrent CIP from various vacancies and non-pay underspends in corporate areas. 8. Cash has been drawn down from DH in the form of loans in line with the revised deficit position. The Trust is holding a cash balance of £5.6m. 9. The Trust has a Capital plan for the year of £31m. Year to date spend is £2.3m against a plan of £3.5m, with the programme being heavily weighted to the latter part of the year. 10. The balance sheet turned to a negative equity position during 2017/18 and this continues at Month 2, with a forecast further increase in net liabilities as the year progresses. This is due to the high level of loans required to support the ongoing deficit position as well as those drawn for capital requirements.
Resource Implications	As outlined
Risk and Assurance	1. CIP Delivery of £21m for 2018-19 is a risk with a level of unidentified CIP. **The Board is asked to note that actions are already being taken to improve the delivery process.** • **Benchmarking analysis of peer Trusts and the national benchmarking data are being used to identify opportunities and inform planning for 2018/19.** • **The new PMO team will be fully in place in June 2018 which will be focused on transformation and delivery of the associated savings. Some members of the team are already in place with more starting over the coming weeks.** • **The Trust has appointed a Turnaround Director to**

Report to the Board

	support the financial recovery plan. • **The Medway health partners are working on a system recovery plan that addresses financial and operational performance.** 2. The contract with the North Kent CCGs has a non-block element for CQUIN and Best Practice Tariffs which the Trust needs to earn. This equates to £6m. **The Board is asked to note that actions need to be taken to ensure that this income is received.** 3. The acceptance of the control total has provided the Trust with £12.6m of PSF income. It is assumed that, as per 2017/18, 30% of this income will be subject to achievement of the A&E target. The Trust is currently not achieving this target putting this component of the PSF income at risk. **The Board is asked to note that actions need to be taken to ensure that this income is received.** 4. Trust infrastructure and estate remains a risk due to age and condition, and lack of cash for capital investment. **The Board is asked to note that the capital programme is being managed within the capital limits, with prioritisation criteria for spend being risk based as well as invest to save.**
Legal Implications/Regulatory Requirements	Lack of achievement of the proposed control total for 2018-19 may lead to further Regulatory actions. Inappropriate Estate and insufficient Facilities lead to higher than acceptable risk to Patients, visitors and staff and could lead to further regulatory action.
Improvement Plan Implication	Financial Recovery is one of the nine programmes of Phase 2 Recovery. In year, financial stability is one of 4 programmes in Better, Best, Brilliant which includes financial recovery, commercial efficiency and estate planning.
Quality Impact Assessment	All actions will follow an appropriate QIA process

Report to the Board

Recommendation	To note the contents of the report			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☐	☒	☒	☒

Finance Report

Month 2

2018/19

Best of care
Best of people

Medway NHS
NHS Foundation Trust

Finance Report for May 2018- APPENDICES

1. Liquidity
    a. Cash Flow

2. Financial Performance
    a. Consolidated I&E
    b. Run Rate Analysis - Financial
    c. Workforce
    d. Run rate analysis Pay

3. Balance Sheet
    a. Statement of Financial Position
    b. Trade Receivables
    c. Trade Creditors

4. Capital
    a. Capital Summary

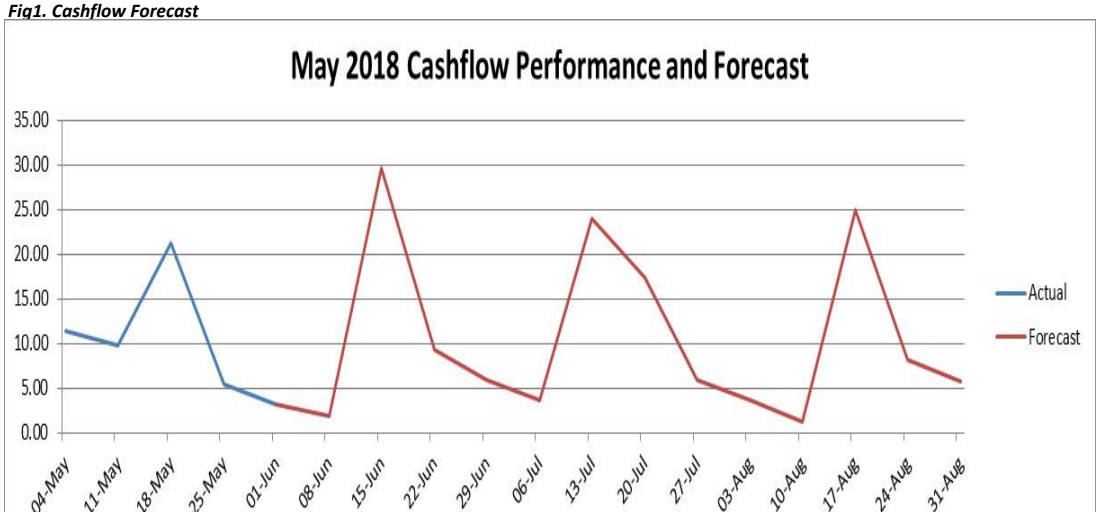
1. Liquidity

1a Cashflow

13 Week Forecast

	Actual				Forecast												
Week Ending	04/05/18	11/05/18	18/05/18	25/05/18	01/06/18	08/06/18	15/06/18	22/06/18	29/06/18	06/07/18	13/07/18	20/07/18	27/07/18	03/08/18	10/08/18	17/08/18	24/08/18
BANK BALANCE B/FWD	**14.83**	**11.37**	**9.90**	**21.31**	**5.55**	**3.25**	**1.88**	**29.63**	**9.38**	**6.00**	**3.69**	**24.06**	**17.48**	**5.97**	**3.66**	**1.31**	**24.94**
Receipts																	
NHS Contract Income	0.71	0.01	17.01	0.08	0.07	0.00	25.19	0.00	0.00	0.00	20.32	0.00	0.00	0.00	0.00	20.30	0.00
Other	0.41	0.76	0.29	0.15	0.41	0.12	0.58	0.28	0.28	0.40	3.03	0.28	0.28	0.40	0.61	0.40	0.28
STF Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total receipts	**1.12**	**0.77**	**17.30**	**0.22**	**0.48**	**0.12**	**25.77**	**0.28**	**0.28**	**0.40**	**23.35**	**0.28**	**0.28**	**0.40**	**0.61**	**20.70**	**0.28**
Payments																	
Pay Expenditure (excl. Agency)	(0.32)	(0.30)	(2.74)	(12.97)	(0.31)	(0.28)	(0.30)	(15.22)	(0.31)	(0.30)	(0.30)	(7.20)	(8.72)	(0.30)	(0.30)	(2.85)	(13.22)
Non Pay Expenditure	(3.66)	(1.94)	(2.96)	(3.01)	(1.87)	(1.22)	(3.03)	(5.19)	(2.75)	(2.41)	(2.68)	(4.45)	(3.06)	(1.06)	(2.66)	(4.01)	(3.51)
Capital Expenditure	(0.60)	0.00	0.00	0.00	(0.60)	0.00	0.00	0.00	(0.60)	0.00	0.00	0.00	0.00	(1.35)	0.00	0.00	0.00
Total payments	**(4.58)**	**(2.24)**	**(5.70)**	**(15.98)**	**(2.78)**	**(1.50)**	**(3.33)**	**(20.41)**	**(3.66)**	**(2.71)**	**(2.98)**	**(11.65)**	**(11.78)**	**(2.71)**	**(2.96)**	**(6.86)**	**(16.73)**
Net Receipts/ (Payments)	**(3.46)**	**(1.47)**	**11.60**	**(15.76)**	**(2.30)**	**(1.37)**	**22.44**	**(20.14)**	**(3.38)**	**(2.31)**	**20.37**	**(11.38)**	**(11.51)**	**(2.31)**	**(2.35)**	**13.85**	**(16.45)**
Funding Flows																	
FTFF/DOH - Revenue	0.00	0.00	0.00	0.00	0.00	0.00	5.31	0.00	0.00	0.00	0.00	4.05	0.00	0.00	0.00	7.04	0.00
STF Advance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
FTFF/DOH - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	0.00	0.00	0.00	2.75	0.00
Incentive Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	(0.19)	0.00	0.00	0.00	0.00	(0.12)	0.00	0.00	0.00	(0.26)	0.00	0.00	0.00	0.00	(0.29)
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	0.00	**0.00**	**(0.19)**	**0.00**	**0.00**	**0.00**	**5.31**	**(0.12)**	**0.00**	**0.00**	**0.00**	**4.80**	**0.00**	**0.00**	**0.00**	**9.79**	**(0.29)**
BANK BALANCE C/FWD	**11.37**	**9.90**	**21.31**	**5.55**	**3.25**	**1.88**	**29.63**	**9.38**	**6.00**	**3.69**	**24.06**	**17.48**	**5.97**	**3.66**	**1.31**	**24.94**	**8.21**

Fig1. Cashflow Forecast



Commentary

The opening cash balance for May 2018 was £14.8m, with a closing balance of £5.6m. The Trust is now required to retain sufficient month balances following the CCG's decision to delay settlement of monthly contract invoices to the 15th of the month from the new financial ye

The graph shows the actual cashflow for May and the projected weekly cashflow up to and including w/e 31 August 2018.

Receipts in the month were £19.4m, with no Loan Funding in May, therefore the total cash inflow for April was £19.4m.
Payments, including capital & financing costs in the month were £27.5m.

The Trust has received £4.4m of deficit loan funding YTD in the form of an uncommitted revenue loan.

Salary payments for the month were £16.3m with £9.5m in relation to direct salary costs and £6.8m employer costs.
As we commence the start of the new financial year, the availability of additional revenue cash support during March has enabled both NH NHS creditor balances to be reduced significantly with all approved invoices continuing to be paid to term. It is expected that this will grea pressure from suppliers during the first quarter of the new year.

2. Financial Performance

2a Consolidated I&E

Consolidated I&E (May 2018)

	Current Month			Year to Date (YTD)			Annual		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Forecast*	*Plan*	*Variance*
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical income	18,751	18,735	16	37,459	37,404	55	224,047	224,047	0
High Cost Drugs	2,207	1,895	311	4,096	3,787	309	22,699	22,699	0
Other Operating Income	2,140	1,921	219	4,516	3,842	674	23,153	23,153	0
Total Revenue	**23,098**	**22,551**	**547**	**46,071**	**45,033**	**1,038**	**269,898**	**269,898**	**0**
Expenditure									
Substantive	-14,329	-17,240	2,911	-28,234	-34,481	6,247	-196,692	-196,692	0
Bank	-2,004	-54	-1,950	-4,041	-109	-3,932	-654	-654	0
Agency	-1,503	-37	-1,466	-2,446	-75	-2,372	-448	-448	0
Total Pay	**-17,836**	**-17,332**	**-504**	**-34,721**	**-34,664**	**-57**	**-197,794**	**-197,794**	**0**
Clinical supplies	-2,771	-3,014	242	-5,341	-6,027	686	-36,093	-36,093	0
High Cost Drugs Expense	-1,961	-1,466	-496	-3,884	-2,931	-953	-17,586	-17,586	0
Drugs	-842	-1,071	229	-1,919	-2,141	222	-12,789	-12,789	0
Consultancy	-120	-93	-28	-191	-186	-5	-1,114	-1,114	0
Other non pay	-3,620	-3,318	-302	-7,619	-6,636	-984	-36,524	-36,524	0
Total Non Pay	**-9,315**	**-8,960**	**-354**	**-18,954**	**-17,921**	**-1,033**	**-104,106**	**-104,106**	**0**
Total Expenditure	**-27,150**	**-26,292**	**-858**	**-53,675**	**-52,585**	**-1,090**	**-301,899**	**-301,899**	**0**
EBITDA	**-4,053**	**-3,741**	**-311**	**-7,604**	**-7,552**	**-52**	**-32,001**	**-32,001**	**0**
Post EBITDA									
Depreciation	-786	-823	37	-1,573	-1,647	74	-10,293	-10,293	0
Interest	-284	-330	46	-444	-640	196	-4,456	-4,456	0
Dividend	0	-7	7	0	-14	14	-81	-81	0
Profit/(loss) on sale of asset	0	0	0	0	0	0	0	0	0
Net (Surplus) / Deficit - Pre STF	**-5,123**	**-4,901**	**-221**	**-9,621**	**-9,852**	**231**	**-46,832**	**-46,832**	**0**
STF Income	0	0	0	0	0	0	12,663	12,663	0
Net (Surplus) / Deficit - Post STF	**-5,123**	**-4,901**	**-221**	**-9,621**	**-9,852**	**231**	**-34,169**	**-34,169**	**0**

2b Run Rate Analysis

Anaylsis of 15 monthly performance - Financials

	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue															
Clinical income	22.6	18.5	19.1	19.8	20.0	20.7	19.8	15.6	19.2	13.7	20.0	16.4	16.8	18.7	18.8
High Cost Drugs	1.6	1.7	1.9	1.9	1.8	1.8	1.7	2.2	1.9	1.6	1.5	2.0	2.0	1.9	2.2
STF Income	2.4	0.1	0.9	0.5	0.6	0.4	0.6	0.4	0.9	- 1.9	-		-	-	-
Other Operating Income	3.0	2.0	1.6	2.1	2.0	2.0	1.9	1.7	1.9	1.9	1.9	1.9	3.4	2.4	2.1
Total Revenue	**29.5**	**22.3**	**23.6**	**24.3**	**24.4**	**24.9**	**24.0**	**19.8**	**23.9**	**15.3**	**23.4**	**20.4**	**22.2**	**23.0**	**23.1**
Expenditure															
Substantive	-13.6	-14.0	-14.3	-14.3	-14.1	-14.3	-13.9	-14.5	-14.2	-14.1	-14.8	-13.5	-15.0	-13.9	-14.3
Bank	-0.9	-1.1	-1.2	-2.7	-1.8	-2.4	-2.3	-2.4	-2.2	-2.0	-2.6	-2.3	-2.3	-2.0	-2.0
Agency	-3.9	-2.2	-1.9	-0.2	-1.3	-1.6	-1.4	-1.3	-1.1	-0.9	-1.1	-1.9	-2.6	-0.9	-1.5
Total Pay	**-18.4**	**-17.3**	**-17.4**	**-17.2**	**-17.2**	**-18.3**	**-17.6**	**-18.2**	**-17.4**	**-17.0**	**-18.5**	**-17.7**	**-19.9**	**-16.9**	**-17.8**
Clinical supplies	-3.0	-2.7	-3.8	-2.8	-3.1	-3.3	-3.3	-3.2	-3.0	-2.9	-2.9	-2.4	-3.0	-2.6	-2.8
High Cost Drugs Expense	0.0	-1.5	-1.5	-1.5	-1.5	-1.5	-9.2	-2.0	-1.9	-1.5	-1.7	-1.7	-1.5	-1.9	-2.0
Drugs	-2.4	-1.0	-1.2	-1.1	-1.1	-1.4	6.3	-2.0	-1.7	1.0	-1.3	-0.8	-1.1	-1.1	-0.8
Consultancy	0.0	-0.2	-0.1	-0.2	-0.2	-0.3	-0.1	0.0	-0.1	-0.1	-0.1	-0.1	0.0	-0.1	-0.1
Other non pay	-7.0	-3.1	-3.3	-2.0	-4.3	-1.4	-2.6	-3.2	-2.3	0.3	-3.0	-3.2	-8.1	-4.0	-3.6
Total Non Pay	**-12.4**	**-8.5**	**-9.9**	**-7.6**	**-10.2**	**-7.9**	**-8.9**	**-10.4**	**-8.9**	**-3.2**	**-9.0**	**-8.2**	**-13.8**	**-9.6**	**-9.3**
Total Expenditure	**-30.8**	**-25.9**	**-27.3**	**-24.8**	**-27.4**	**-26.2**	**-26.5**	**-28.6**	**-26.3**	**-20.1**	**-27.5**	**-26.0**	**-33.8**	**-26.5**	**-27.2**
EBITDA	**-1.3**	**-3.6**	**-3.8**	**-0.5**	**-3.0**	**-1.3**	**-2.5**	**-8.8**	**-2.4**	**-4.8**	**-4.1**	**-5.6**	**-11.6**	**-3.6**	**-4.1**
Post EBITDA															
Depreciation	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.9	-0.8	-0.8
Interest	-0.2	-0.3	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.2	-0.3
Dividend	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0
Fixed Asset Impairment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Profit on sale of asset	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	-1.0	**-1.1**	**-0.9**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.2**	**-0.9**	**-1.1**
Net Surplus / (Deficit)	**-2.2**	**-4.7**	**-4.7**	**-1.5**	**-4.0**	**-2.3**	**-3.5**	**-9.8**	**-3.5**	**-5.9**	**-5.1**	**-6.5**	**-12.8**	**-4.5**	**-5.1**

2C Workforce

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual WTE	*Plan* WTE	*Variance* WTE	*Actual* £m	*Plan* £m	*Variance* £m	*Actual* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Actual* £m
Substantive	Consultants	197	235	-37	2.46	2.60	-0.14	2.36	4.98	5.22	-0.24	4.91
	Junior Medical	351	389	-38	1.99	2.45	-0.46	1.95	3.98	4.90	-0.92	3.79
	Nurses & Midwives	1115	1542	-427	4.01	5.70	-1.69	4.03	8.12	11.41	-3.29	7.97
	Scientific, Therapeutic & Technical	339	463	-124	1.10	1.51	-0.41	1.36	2.20	3.01	-0.81	2.69
	Healthcare Assts, etc.	492	585	-94	1.06	1.24	-0.19	1.05	2.09	2.49	-0.40	2.05
	Admin & Clerical	832	953	-121	2.12	2.61	-0.49	2.43	4.23	5.22	-0.99	4.69
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.03
	Executives	7	6	1	0.10	0.10	0.00	0.16	0.20	0.20	0.00	0.33
	Other Non Clinical	428	496	-68	0.91	1.05	-0.14	0.94	1.81	2.05	-0.24	1.84
	Pay Reserves	0	0	0	0.56	0.00	0.56	0.00	0.61	0.00	0.61	0.00
	Substantive Total	**3,761**	**4,669**	**-908**	**14.30**	**17.27**	**-2.97**	**14.30**	**28.23**	**34.50**	**-6.27**	**28.29**
Agency	Consultants	7	0	6	0.07	-0.03	0.10	0.18	0.14	-0.06	0.2	0.55
	Junior Medical	12	0	12	0.16	0.03	0.12	0.24	0.31	0.06	0.3	0.63
	Nurses & Midwives	19	0	19	0.87	0.00	0.87	1.25	1.19	0.00	1.2	1.44
	Scientific, Therapeutic & Technical	52	0	52	0.24	0.00	0.24	0.19	0.50	0.00	0.5	0.48
	Healthcare Assts, etc.	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.01
	Admin & Clerical	8	0	8	0.11	0.00	0.11	0.01	0.20	0.00	0.2	0.14
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	18	0	18	0.05	0.03	0.02	0.07	0.11	0.07	0.0	0.28
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Agency Total	**117**	**1**	**116**	**1.50**	**0.04**	**1.47**	**1.94**	**2.44**	**0.07**	**2.37**	**3.53**
Bank	Consultants	14	4.32	10	0.19	0.05	0.14	0.00	0.36	0.10	0.3	0.00
	Junior Medical	47	0	47	0.56	0.00	0.56	0.23	1.15	0.00	1.2	0.32
	Nurses & Midwives	111	0	111	0.51	0.00	0.51	0.03	1.03	0.00	1.0	0.22
	Scientific, Therapeutic & Technical	34	0	34	0.12	0.00	0.12	0.01	0.21	0.00	0.2	0.01
	Healthcare Assts, etc.	142	0	142	0.37	0.00	0.37	0.35	0.77	0.00	0.8	0.67
	Admin & Clerical	53	1	53	0.12	0.00	0.12	0.58	0.27	0.00	0.3	1.55
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	63	1	61	0.13	0.00	0.13	0.08	0.26	0.00	0.3	0.15
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Bank Total	**465**	**6**	**459**	**2.00**	**0.05**	**1.95**	**1.27**	**4.05**	**0.10**	**3.95**	**2.92**
	Workforce Total	**4,342**	**4,676**	**-334**	**17.81**	**17.36**	**0.45**	**17.51**	**34.72**	**34.67**	**0.05**	**34.74**

2c. Continued

	Current Month						Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
Staff Group:	WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Consultants	218	239	-21	2.72	2.62	0.10	2.54	5.48	5.26	0.22	5.46
Junior Medical	411	389	21	2.70	2.49	0.22	2.42	5.44	4.96	0.48	4.74
Nurses & Midwives	1,245	1,542	-297	5.39	5.70	-0.31	5.31	10.34	11.41	-1.07	9.63
Scientific, Therapeutic & Technical	425	463	-38	1.46	1.51	-0.05	1.56	2.92	3.01	-0.09	3.18
Healthcare Assts, etc.	634	585	49	1.42	1.24	0.18	1.40	2.86	2.49	0.37	2.73
Executives	894	954	1	2.35	2.62	-0.26	3.02	4.69	5.22	-0.52	6.38
Chair & NEDs	0	0	0	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.03
Admin & Clerical	7	6	-60	0.10	0.10	-0.00	0.16	0.20	0.20	-0.00	0.33
Other Non Clinical	509	497	12	1.10	1.08	0.02	1.08	2.18	2.12	0.06	2.27
Pay Reserves	0	0	0	0.56	0.00	0.56	0.00	0.61	0.00	0.61	0.00
Workforce Total	**4,342**	**4,676**	**-334**	**17.81**	**17.36**	**0.45**	**17.51**	**34.72**	**34.67**	**0.05**	**34.74**

2d. Run rate analysis pay

		Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.55	2.36	2.55	2.52	2.47	2.37	2.54	2.41	2.40	2.39	2.48	2.48
	Junior Medical	1.84	1.95	2.00	1.90	2.09	1.81	2.22	2.01	2.05	2.08	1.96	1.88
	Nurses & Midwives	3.94	4.03	4.12	4.04	4.13	4.05	4.08	4.07	3.88	4.06	4.05	4.03
	Scientific, Therapeutic & Technical	1.33	1.36	1.34	1.32	1.33	1.37	1.38	1.36	1.36	1.27	1.31	1.12
	Healthcare Assts, etc	1.00	1.05	1.04	1.03	1.03	1.04	1.02	1.05	1.04	1.05	1.04	1.01
	Admin & Clerical	2.26	2.43	2.14	2.20	2.20	2.20	2.15	2.20	2.27	2.22	2.10	2.01
	Chair & NEDs	0.01	0.02	0.02	0.01	0.01	0.01	0.01	0.01	0.01	0.02	0.01	0.01
	Executives	0.17	0.16	0.12	0.11	0.10	0.09	0.09	0.09	0.09	0.14	0.18	- 0.02
	Other Non Clinical	0.90	0.94	0.93	0.90	0.91	0.92	0.91	0.90	0.90	0.94	0.93	0.90
	Pay Reserves	0.02	0.02	0.07	0.06	0.07	0.07	0.07	0.07	0.07	0.66		
	Substantive Total	**14.01**	**14.32**	**14.32**	**14.09**	**14.34**	**13.93**	**14.48**	**14.17**	**14.07**	**14.83**	**14.06**	**13.42**
Agency	Consultants	0.37	0.18	0.03	0.14	0.25	0.15	0.18	0.09	0.02	0.08	0.08	0.10
	Junior Medical	0.39	0.24	0.18	0.23	0.21	0.12	0.12	0.21	0.12	0.26	0.14	- 0.01
	Nurses & Midwives	0.19	1.25	0.37	0.61	0.76	0.69	0.75	0.43	0.44	0.72	0.49	2.46
	Scientific, Therapeutic & Technical	0.29	0.19	0.16	0.23	0.26	0.32	0.20	0.18	0.22	0.02	0.23	0.64
	Healthcare Assts, etc	0.01	0.00	0.00	- 0.02	-	-	-	-	-	- 0.03	-	0.02
	Admin & Clerical	0.13	0.01	0.06	0.04	0.01	0.04	-	0.12	0.04	0.03	0.10	0.13
	Chair & NEDs	0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-
	Executives	0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-
	Other Non Clinical	0.21	0.07	0.07	0.04	0.08	0.06	0.06	0.05	0.05	0.06	0.05	0.03
	Agency Total	**1.58**	**1.94**	**0.87**	**1.27**	**1.57**	**1.38**	**1.31**	**1.08**	**0.89**	**1.14**	**1.09**	**3.37**
Bank	Consultants	0.00	0.00	0.21	0.19	0.21	0.25	0.26	0.22	0.21	0.24	0.20	0.12
	Junior Medical	0.25	- 0.03	1.16	0.45	0.59	0.48	0.58	0.47	0.50	0.58	0.43	0.52
	Nurses & Midwives	0.09	0.23	0.50	0.39	0.53	0.61	0.56	0.51	0.44	0.81	0.83	0.69
	Scientific, Therapeutic & Technical	0.00	0.01	0.04	0.04	0.03	0.05	0.05	0.12	0.08	0.10	0.10	0.03
	Healthcare Assts, etc	0.33	0.35	0.81	0.47	0.54	0.57	0.51	0.49	0.48	0.52	0.47	0.66
	Admin & Clerical	0.97	0.58	- 0.89	0.21	0.39	0.23	0.28	0.21	0.18	0.18	0.16	0.11
	Chair & NEDs	0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-
	Executives	0.00	0.00	0.00	0.00	-	-	-	-	-	-	-	-
	Other Non Clinical	0.07	0.08	0.23	0.09	0.16	0.11	0.14	0.12	0.13	0.14	0.14	0.19
	Bank Total	**1.70**	**1.21**	**2.05**	**1.84**	**2.45**	**2.30**	**2.38**	**2.15**	**2.02**	**2.58**	**2.33**	**2.32**
	Workforce Total	**17.29**	**17.47**	**17.23**	**17.20**	**18.36**	**17.61**	**18.17**	**17.40**	**16.98**	**18.54**	**17.48**	**19.11**

2d. Run rate analysis pay continued

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Summary by Staff Group														
Consultants	2.92	2.54	2.78	2.85	2.93	2.77	2.98	2.72	2.63	2.72	2.76	2.70	2.75	2.72
Junior Medical	2.48	2.16	3.34	2.58	2.89	2.41	2.92	2.69	2.67	2.92	2.53	2.39	2.73	2.71
Nurses & Midwives	4.22	5.51	4.99	5.04	5.42	5.35	5.39	5.01	4.76	5.59	5.37	7.18	4.95	5.39
Scientific, Therapeutic & Technical	1.62	1.56	1.54	1.59	1.62	1.74	1.63	1.66	1.66	1.39	1.64	1.79	1.47	1.46
Healthcare Assts, etc	1.34	1.40	1.85	1.48	1.57	1.61	1.53	1.54	1.52	1.57	1.51	1.69	1.43	1.43
Admin & Clerical	3.36	3.02	1.31	2.45	2.60	2.47	2.43	2.53	2.49	2.42	2.36	2.25	2.34	2.35
Chair & NEDs	0.01	0.02	0.02	0.01	0.01	0.01	0.01	0.01	0.01	0.02	0.01	0.01	0.01	0.01
Executives	0.17	0.16	0.12	0.11	0.10	0.09	0.09	0.09	0.09	0.14	0.18	- 0.02	0.10	0.10
Other Non Clinical	1.17	1.09	1.22	1.03	1.15	1.09	1.11	1.07	1.08	1.14	1.12	1.12	1.09	1.09
Pay Reserves	0.02	0.02	0.07	0.06	0.07	0.07	0.07	0.07	0.07	0.66	-	-	-	0.56
Total InclSubstantive and Temp	**17.29**	**17.47**	**17.23**	**17.20**	**18.36**	**17.61**	**18.17**	**17.40**	**16.98**	**18.57**	**17.48**	**19.11**	**16.87**	**17.81**

	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Summary by Staff Group														
Consultants	180	184	187	186	189	189	192	190	193	192	192	191	196	197
Junior Medical	315	320	320	320	348	346	354	339	359	356	352	357	358	351
Nurses & Midwives	1,087	1,096	1,148	1,148	1,152	1,142	1,161	1,148	1,128	1,125	1,138	1,139	1,121	1,115
Scientific, Therapeutic & Technical	437	437	426	425	429	442	446	438	433	425	419	342	340	339
Healthcare Assts, etc	470	478	491	489	492	492	492	494	485	480	484	475	484	492
Admin & Clerical	894	889	825	835	840	839	841	831	831	842	839	837	827	832
Chair & NEDs	3	11	7	- 2	6	6	1	1	1	1	1	1	1	1
Executives	7	8	8	7	7	6	6	6	6	6	6	6	7	7
Other Non Clinical	440	445	446	445	449	442	441	436	437	435	440	429	425	428
Pay Reserves	-	-	-	-	-	-	-	-	-		-	-	-	-
Total InclSubstantive and Temp	**3,833**	**3,868**	**3,857**	**3,853**	**3,912**	**3,904**	**3,935**	**3,883**	**3,873**	**3,862**	**3,872**	**3,777**	**3,759**	**3,762**

3. Balance Sheet

3a. Statement of Financial Position

	Last Month Actual £m	Current Month Actual £m	Plan £m	Variance £m
Non current Assets				
Property, Plant and Equipment	193.6	197.0	195.0	2.1
Trade and Other Receivables: Other	0.3	0.3	0.5	-0.2
Total Non current Assets	**194.0**	**197.4**	**195.5**	**1.9**
Current Assets				
Inventories	7.4	7.7	6.4	1.3
Trade and Other Receivables: Trade	27.8	16.4	9.2	7.2
Trade and Other Receivables: Accruals	4.2	17.3	9.7	7.6
Trade and Other Receivables: Prepayments	4.7	4.3	2.4	1.9
Trade and Other Receivables: Other	2.3	2.0	1.1	0.9
Cash and Cash Equivalents	15.0	4.5	1.0	3.5
Total Current Assets	**61.2**	**52.1**	**29.7**	**22.4**
Current Liabilities				
Borrowings	-58.1	-58.0	-1.3	-56.8
Trade and Other Payables: Trade	-22.3	-22.3	-17.7	-4.6
Trade and other payables: Accruals	-14.3	-14.7	-11.6	-3.0
Trade and other payables: Other	-5.3	-5.5	-4.4	-1.1
Other liabilities: Deferred Income	-4.4	-3.7	-4.2	0.5
Provisions	-0.6	-0.2	0.0	-0.2
Total Current Liabilities	**-105.0**	**-104.4**	**-39.2**	**-65.3**
Total Assets Less Current Liabilities	**150.2**	**145.1**	**186.0**	**-41.0**
Non Current Liabilities				
Borrowings	-163.0	-163.0	-182.1	19.1
Provisions	-0.9	-0.9	-0.9	-0.1
Total Non Current Liabilities	**-164.0**	**-164.0**	**-183.0**	**19.0**
Net Assets Employed	**-13.8**	**-18.9**	**3.0**	**-21.9**
Taxpayers Equity				
Public Dividend Capital	137.7	137.7	138.8	-1.1
Retained Earnings	-198.9	-204.0	-168.0	-35.9
Revaluation Reserve	47.3	47.3	32.3	15.1
Total taxpayers' equity	**-13.8**	**-18.9**	**3.0**	**-21.9**

Commentary

Non Current Assets

Trade and Other Receivables balances relate to Road Traffic Accident (RTA) outstanding receivables as advised by NHS England.
These debts are managed externally by NHBSA who advises The Trust on balances outstanding and the Current/Non Current Classification.

Current Assets

Trade and Other Receivables have been reported over four separate headings to provide further detail:
Trade, these are balances owed to the Trust for trading activities for which sales invoices have been raised and are yet to be paid.
Accruals, these relate to balances owed to The Trust which are yet to be invoiced for.
Prepayments, payments made in advance for purchases such as equipment, software, maintenance. Payments for some of these services are paid annually in advance which is the reason for the current variance on plan. This balance should reduce each month unless additional prepayments are made in the month.
Other, included in other are further RTA debts and VAT Contracted Out Services refunds.

Cash and Cash Equivalents

A condition of the deficit loans is for The Trust to hold a balance of £1.4m to ensure there is always an adequate balance from which to make emergency payments. The balance as at 31st of May 2018 was £4.5m. Please see 1a Cashflow for further detail.

Current Liabilities

Borrowings, this balance relates to both capital and deficit loans due in this financial year. £56.8 being the deficit support loan and the balance being the capital loan.

Trade and Other Payables

Trade, please see note 4c for further information. These balances remain at a fairly constant level due to the Trusts inability to improve working balances without the injection of additional cash. The 2018/19 plan assumes a slight increased in the levels of income which should allow for an an improvement in this area at the year end.
Other, mainly relates to payovers such as Pensions and HMRC costs. Payment to these bodies is required a month in arrears.

Deferred Income, This relates to Maternity Pathway receipts mainly from Medway CCG and Swale CCG in re4spect of agreed accounting treatment for Maternity income billed at the start fo Clinical Pathway, Research & Development Funds and some private patients fees.

Non Current Liabilities

Borrowings, this balance relates to both capital and deficit loans repayments due in future financial years. £68.2m 2014/15 and 2015/16 deficit support loans are repayable in 2019/20, £41.5m 2017/18 deficit support loans are repayables in 2020/21. The remaining balance relates to capital repayments which are repayable over a much longer term, some of which do not start until 2035/36.

Taxpayers Equity

Variances relate to the phasing of the PDC drawdown (-£1.1m) and the year end upwards revaluation of the hospital site and associated residences and dwellings.

Please see additional notes as specified in the table for further analysis and commentary for Capital, Cash and Trade Payables/Receivables.

3b Debtors

Aged Debtors

	Total	Current	31 to 60 Days	61 to 90 Days	91 to 180 Days	6 Months +
NHS						
CCGs and NHS England	10.88	0.74	2.30	1.69	1.32	4.82
NHS FTs	2.10	0.27	0.31	0.11	0.47	0.94
NHS Trusts	2.49	0.67	0.56	0.07	0.23	0.96
Health Education England	0.00	0.00	0.00	0.00	0.00	0.00
Special Health Authorities	0.05	0.00	0.00	0.00	0.00	0.05
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.00	0.00	0.00	0.00	0.00	0.00
Total NHS	**15.52**	**1.68**	**3.17**	**1.86**	**2.03**	**6.77**
Non NHS						
Bodies external to Government	2.63	0.27	0.16	0.29	0.24	1.67
other WGA bodies	0.01	0.00	0.00	0.00	0.00	0.01
Local Authorities	0.04	0.00	(0.01)	(0.05)	0.00	0.09
Total Non NHS	**2.68**	**0.27**	**0.15**	**0.23**	**0.25**	**1.78**
Bad Debt Provision	(1.83)	0.00	0.00	0.00	0.00	(1.83)
Other Receivables	0.00	0.00	0.00	0.00	0.00	0.00
Total Receivables	**16.37**	**1.95**	**3.32**	**2.10**	**2.28**	**6.72**

Commentary

Total outstanding Trade Receivables as at the 31 May 2018 are £16.37m. This includes a £1.83m bad debt provision.

NHS Debt is £15.52m, £8.02m of this relates to debt with the Trust's three main CCG's. There is a further 1.57m of Debt with Dartford Hospital - and both Trusts are allocating resource to resolve their Aged debt.

Non NHS Debt is £2.68m, with £1.13m owing from Medway Community Healthcare.

Fig.1 shows aged debt analysed by Ageing Category; Fig.2 shows the rolling receivables trend; & Fig.3 provides a list of the top ten debtors by value.

Fig 1 Aged Receivables Analysis

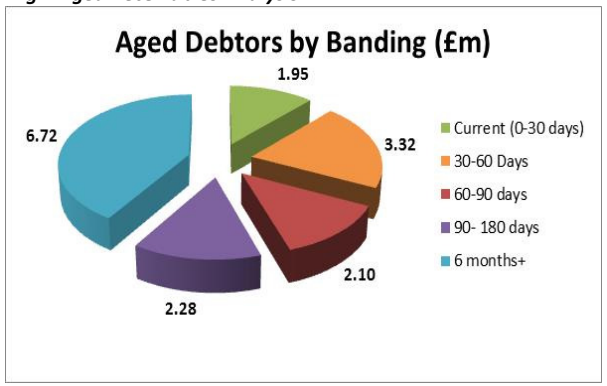


Fig 2 - Debtor Trends

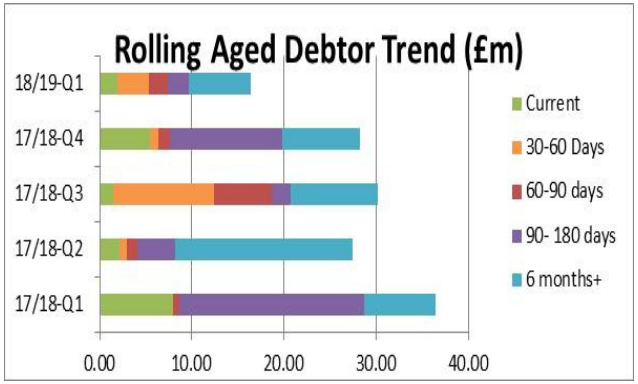


Fig.3 Top Ten Debtors

Top 10 Debtors

		£m
1	NHS Dartford Gravesham & Swal	2.84
2	NHS Medway CCG	2.70
3	NHS Swale CCG	2.49
4	DARTFORD & GRAVESHAM NHS TRUST	1.57
5	MEDWAY COMM HEALTHCARE CIC	1.13
6	NHS West Kent CCG	1.13
7	E.K.HOSP.UNIV.NHS.FOUNDA.TRUST	1.03
8	QUEEN VICTORIA HOSP. NHS TRUST	0.81
9	MAIDSTONE AND TUNBRIDGE WELLS	0.68
10	NHS ENGLAND	0.38

3c. Creditors

Aged Creditors

	Total	Current	31 to 60 Days	61 to 90 Days	91 - 180 Days	6 months +
	£m	£m	£m	£m	£m	£m
NHS FTs	1.83	0.15	0.14	0.37	0.14	1.03
NHS Trusts	2.93	0.87	0.32	0.41	0.30	1.02
Public Health England	0.01	0.00	0.00	0.00	0.00	0.00
CCGs and NHS England	0.00	0.00	0.00	0.00	0.00	0.00
Special Health Authorities	(0.83)	(0.98)	0.05	0.08	0.00	0.02
Other DH bodies	0.23	0.02	0.01	0.01	0.01	0.18
Total NHS Payables	**4.36**	**0.06**	**0.72**	**0.87**	**0.45**	**2.25**
Other WGA bodies	0.12	0.12	0.00	0.00	0.00	0.00
Local Authorities	1.54	1.50	0.03	0.00	0.00	0.00
Bodies external to Government	8.37	3.14	1.55	1.36	0.60	1.73
Total Non NHS Payables	**10.03**	**4.76**	**1.58**	**1.36**	**0.60**	**1.73**
Capital	3.95	3.95	0.00	0.00	0.00	0.00
Payroll	2.92	2.92	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00
Total Other Trade Payables	**6.87**	**6.87**	**0.00**	**0.00**	**0.00**	**0.00**
Total Trade Payables	**21.26**	**11.69**	**2.30**	**2.23**	**1.05**	**3.99**

Commentary

Total outstanding creditors as at 31st May were £21.26m of which 45% (£9.57m) were overdue based on 30 day payment terms.

Following receipt of a Working Capital Loan from the DoH in Mid March, the Trust has began to pay approved invoices in approx 30 days from the invoice date. However prior to receipt of this Loan, payment days were between 60 and 90 Days.

Average payment days for 17/18 were 78.14 days.

Of the £9.57m Overdue Creditors, there are £6.43m of unapproved invoices that are more than 60 days old, unapproval relates to issues with Purchase Orders and inability to validate historical NO PO invoices. The Finance team is working to reconcile these balances with suppliers and with Procurement and Operational Teams to clear the balance down as quickly as possible. Enforcement of NO PO/NO PAY should ensure that such significant balances of aged unapproved invoices do not accumulate in the future.

The Trust has £3.99m creditors over 6 months; Fig. 1 shows aged creditors analysed by ageing category; Fig.2 shows the rolling creditor trend; & Fig.3 provides a list of the top 10 creditors by value.

Fig.1 - Aged Payables Analysis

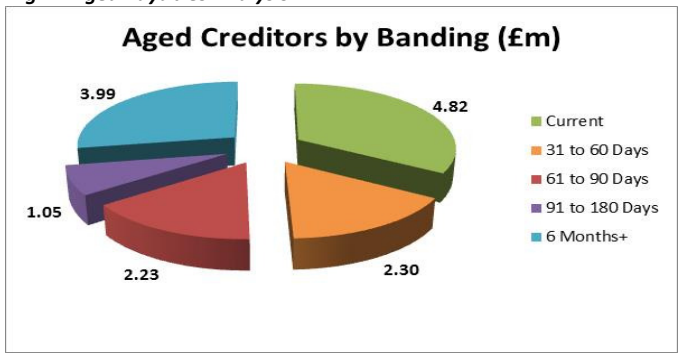


Fig.2 - Creditor Trends

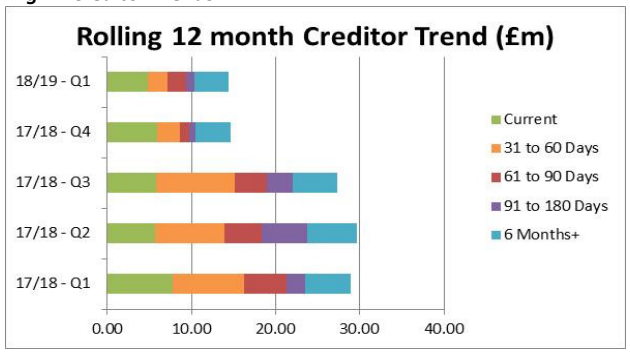


Fig.3 - Top 10 Creditors

Top 10 Creditors	£m
1 MEDWAY COUNCIL	1.53
2 MAIDSTONE TUNBRIDGE WELLS NHST (RWF)	1.49
3 DARTFORD & GRAVESHAM NHS TRUST (RN7)	1.43
4 MEDWAY COMMUNITY HEALTHCARE CIC	0.83
5 NHS SUPPLY CHAIN	0.64
6 KINGS COLLEGE HOSPITAL NHS TRUST (RJZ)	0.64
7 EAST KENT HOSPITALS NHS TRUST (RVV)	0.54
8 KENT COMMUNITY HEALTH NHS FT (RYY)	0.50
9 KENT INST OF MEDICINE & SURGEY (KIMS)	0.37
10 CARDIAC SERVICES LTD	0.35

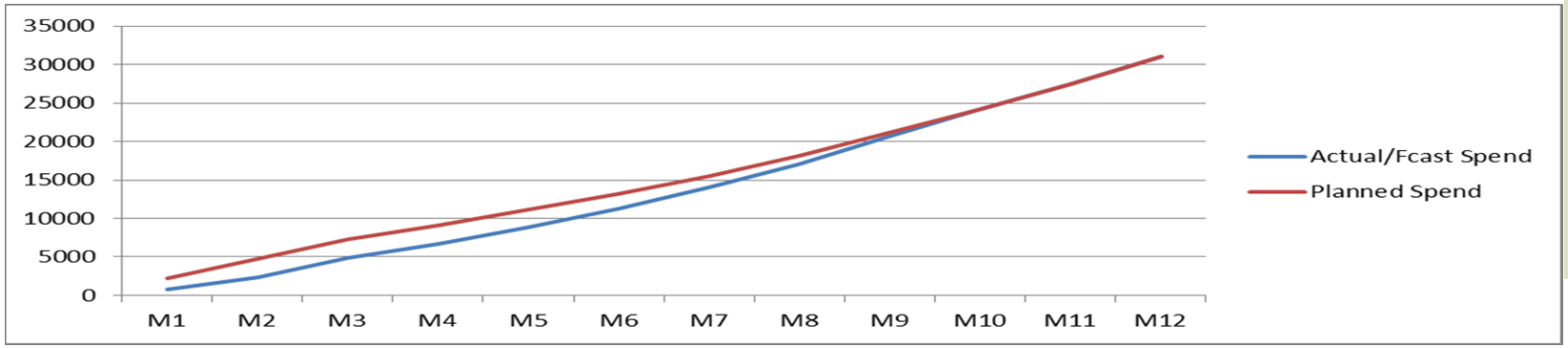
4. Capital

4a. Capital

Capital Programme Summary

	Current Month			Year to Date			Forecast year end Outturn		
	Actual	Plan	Variance	Actual	Plan	Variance	Original Plan	Forecast Outturn	Forecast Variance
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Expenditure									
Recurrent Estates & Site Infrastructure	0.44	1.17	-0.73	0.46	2.15	-1.68	19.50	19.50	0.00
IM&T	0.10	0.13	-0.03	0.13	0.24	-0.12	2.20	2.20	0.00
Medical & Surgical Equipment	0.00	0.08	-0.08	-0.06	0.14	-0.20	1.30	1.30	0.00
Specific Business Cases	0.10	0.08	0.02	0.05	0.01	0.04	0.60	0.60	0.00
Transform Projects (ED/AAU)	0.90	0.82	0.08	1.72	0.82	0.90	6.48	6.48	0.00
Medical Asssessment Unit (MAU)	0.00	0.02	-0.02	0.00	0.17	-0.16	1.00	1.00	0.00
Total	**1.54**	**2.30**	**-0.76**	**2.31**	**3.53**	**-1.22**	**31.08**	**31.08**	**0.00**

The total capital spend for the period to May 2018 amounted to £2.31 giving an underspend of £1.22 for the first 2 months of the new financial year. The achievement of the current year capital programme(£31.081m) will be subject to review as the year progresses with the forecast and the original plan equal to each other at this point in time. Estates Infrastrucuture has already identified changing priorities within backlog maintenance around realistic achievement within this financial year and will re-forecast a revised position end as soon as is practicable



Report to the Board of Directors

Board Date: 05/07/2018 Agenda item 11b

Title of Report	**Annual Report to the Board – Security Management**
Prepared By:	Ariel Kowalaszek - Local Security Management Specialist
Lead Director	Gary Lupton, Director of Estates and Facilities.
Committees or Groups who have considered this report	Executive Group – 20th June 2018
Executive Summary	Security Management Standards for Providers (NHS Protect 2013), and the Department of Health require that a report is submitted annually to the Trust board communicating Security Management issues, assurances and compliance. This report provides the Board with that update and the self-assessment of compliance against the 4 domains for security management standards for providers. The Security Management Standards have been updated since the last Board Report and this report details the new requirements and our level of compliance. The report shows that there are no non-compliance issues, there are 25 standards which are fully met, only 6 are partially met. There are no standards showing non-compliance. Compliance is continually reviewed. The review of incident data shows a decrease in serious incidents reported: Violence and Aggression incidents decreased by around 30% and thefts remained low in the period of the report. The report details improvements to CCTV, Lockdown and door entry, and the introduction of Digital Radios, which contribute to improvements to security on site. Trust policies are updated and changes in legislation have been reflected into policy and practice. Missing Patient enquiries have been enhanced by close Police liaison including police training for the Security Team. Counter Terrorism Training is being integrated within the Trust learning

Report to the Board of Directors

	management system. The Report highlights issues with lockdown and door entry systems where a clear strategy is required. The report assures the Trust Board that Security at the Trust is compliant with relevant guidance and legislation and that regular reviews are undertaken and that areas of concern are being addressed.
Resource Implications	
Risk and Assurance	Board assurance on compliance with security management standards. A risk register is maintained for security services.
Legal Implications/Regulatory Requirements	The submission of the annual report to the board is a requirement under the Security Management Standards for Providers (Standard 1.4) (2013 and relevant updates).
Improvement Plan Implication	
Quality Impact Assessment	
Recommendation	To note the contents of this report.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

NHS
Medway
NHS Foundation Trust

Annual Board Report – Security Management

Ariel Kowalaszek

26 APRIL 2018

Best of care
Best of people

Contents

1 EXECUTIVE SUMMARY

1.1 This report is compiled to inform the Trust Board on security management arrangements in line with the requirements from Security Management Standards for Providers and the Department of Health.

1.2 The security management standards document came into effect on the 31st March 2013. For the first time security arrangements were identified within a robust framework where quality of Security Management can be measured.

1.3 The Secretary of State Directions 2004 for security management and the Security Management Standards for security management arrangements apply Trust wide.

1.4 The submission of the annual report to the board is a requirement under the Security Management Standards for Providers (Standard 1.4).

2 NHS PROTECT UPDATE

2.1 NHS Protect led on work to identify and tackle crime across the health service. The aim is to protect NHS staff and resources from activities that would otherwise undermine their effectiveness and their ability to meet the needs of patients and professionals. Ultimately, this helps to ensure the proper use of valuable NHS resources and a safer, more secure environment in which to deliver and receive care.

2.2 The NHS Protect standards have been developed to support NHS providers in ensuring they have appropriate security management arrangements in place within their organisation, to protect staff and patients and to ensure NHS assets are kept safe and secure.

2.3 The Security Management Standards for Providers aim to assist providers in implementing key aspects of security management, identifying areas requiring improvement and developing their own plans for improvements. It is the responsibility of the organisation as a whole to ensure it meets the required standards, though one or more departments, business units or individuals may be responsible for implementing a specific standard.

2.4 NHS Protect ceased to exist in July 2017 and all security management components of this organisation have also stopped. The new organisation, replacing NHS Protect's counter fraud activities is called the NHS Counter Fraud Authority (NHSCFA).

2.5 Any security management and anti-crime work carried out by the Trust is still governed by the Security Management Standards for Providers, which are enforceable and have to be complied with at least until 2019. There is, however, no external support function and each NHS organisation needs to be self-sufficient in the provision the security management aspect. At this stage there is no further information if, and who, will be taking the ownership of these standards and associated compliance aspects in the future.

2.6 NHS Protect revised the security standards for providers in 2016/2017 and the summary of changes is below:

Standard	Changes
1.1	The standard has been amended to include the requirement that the person responsible is nominated to NHS Protect. The rating descriptors have been amended slightly.
1.2	No change.
1.3	The amber rating descriptor has been slightly amended.
1.4	No change.
1.5	The standard has been amended to include a specific requirement for organisations to align with NHS Protect's anti-crime strategy. The rationale has been slightly amended.
2.1	Previously standard 2.2, otherwise no change.
2.2	Previously standard 2.3, otherwise no change.
2.3	Previously standard 2.4, otherwise no change.
2.4	Previously standard 2.5, otherwise no change.
2.5	Previously standard 2.6, otherwise no change.
2.6	(Pilot, second year) Previously standard 2.7, otherwise no change.
3.1	The standard has been amended slightly. The rating descriptors have all been slightly amended.
3.2	The standard (including the rationale and rating descriptors) is new.
3.3	Previously standard 3.2, otherwise no change.
3.4	Previously standard 3.3, otherwise no change.
3.5	Previously standard 3.4, otherwise no change.
3.6	Previously standard 3.5, otherwise no change.
3.7	Previously standard 3.6.

	The amber rating has been amended slightly.
3.8	Previously standard 3.7, otherwise no change.
3.9	Previously standard 3.8. The amber and green ratings have been amended slightly.
3.10	The standard (including the rationale and rating descriptors) is new.
3.11	Previously standard 3.9, otherwise no change.
3.12	Previously standard 3.10, otherwise no change.
3.13	Previously standard 3.11, otherwise no change.
3.14	Previously standard 3.12. The amber rating has been amended slightly.
3.15	Previously standard 3.13, otherwise no change.
3.16	Previously standard 3.14, otherwise no change.
4.1	Previously standard 4.2. The amber rating has been amended slightly.
4.2	Previously standard 4.1, otherwise no change.
4.3	The wording of the standard has been amended slightly, otherwise no change.
4.4	No change.

There are four key sections that follow NHS Protect's strategy:

- **Strategic Governance -** This section sets out the standards in relation to the organisation's strategic governance arrangements. The aim is to ensure that anti-crime measures are embedded at all levels across the organisation.

- **Inform and Involve -** This section sets out the requirements in relation to raising awareness of crime risks against the NHS and working with NHS staff, stakeholders and the public to highlight the risks and consequences of crime against the NHS. A new pilot standard has been introduced last year (2.7 now 2.6) pertaining to Security

Incident Reporting System (SIRS), which is currently not mandatory. Considering the changes to NHS Protect and the demise of SIRS this is no longer required.

- **Prevent and Deter -** This section sets out the requirements in relation to discouraging individuals who may be tempted to commit crimes against the NHS and ensuring that opportunities for crime to occur are minimised.
- **Hold to Account -** This section sets out the requirements in relation to detecting and investigating crime, prosecuting those who have committed crimes and seeking redress.

3 SECURITY SERVICE

3.1 In general, the team performs well and the individuals are quite enthusiastic and committed. There were few incidents recently that the security team was praised for by ward staff. There is a need for some additional training and staff development, mainly around legal issues, customer care and counter terrorism awareness, but this can be delivered in-house. Additional physical intervention training is also required for the security team to allow them to carry out their duties safely – this has been booked.

3.2 The security fire safety review took place in October. Additional cameras have been put in place to mitigate blind spots and assist with fire detection. A new video management system (VMS) has also been deployed and the ageing DM infrastructure replaced.

3.3 Additional physical intervention training for the security team was sourced to ensure the team can carry out their duties effectively and safely.

4 COMPLIANCE WITH SECURITY MANAGEMENT STANDARDS FOR PROVIDERS

No.	Standard	Rating	Comments
STRATEGIC GOVERNANCE			
1.1	A member of the executive board or equivalent body is responsible for overseeing and providing strategic management and support for all security management work within the organisation.		• Director of Finance is a nominated Security Management Director (SMD). Liaison with LSMS directly in relation to sanctions for violent and

			aggressive behaviour, and via Director of Estates and Facilities.
1.2	The organisation employs or contracts a qualified, accredited and nominated security specialist(s) to oversee and undertake the delivery of the full range of security management work.		• Full time LSMS in post.
1.3	The organisation allocates resources and investment to security management in line with its identified risks.		• A number of security related projects have been funded. This includes CCTV system improvements and the replacement of the access control system across the Trust. • Security Risk Register has been populated and is monitored. Risk Assure to be updated with security risks. • Full security review has been completed. • Backlog maintenance and capital funding also include security related projects/systems. • A new digital radio system has been deployed with additional functionality (man down function, panic alarms, internal and external (GPS) tracking. • Further improvements to the

			CCTV system have been recommended to aid fire detection. Additional cameras have been purchased to increase coverage. • There is also a proposal to redesigning or move the current Security Control Room to allow 24/7 monitoring of CCTV and various alarms in an ergonomic environment.
1.4	The organisation reports annually to its executive board, or equivalent body, on how it has met the standards set by NHS Protect in relation to security management, and its local priorities as identified in its work plan.		• 2015/16 report presented by TIIA. • 2017/18 report presented by LSMS.
1.5	The organisation has a security management strategy aligned to NHS Protect's strategy. The strategy has been approved by the executive board or equivalent body and is reviewed, evaluated and updated as required.		• Security Management Policy is ratified. To be reviewed and amended as and when necessary.
INFORM AND INVOLVE			
2.1	The organisation develops and maintains effective relationships and partnerships with local and regional anti-crime groups and agencies to help protect NHS staff, premises, property and assets.		• PCSO on site part-funded by the Trust. • Regular meetings with the Kent Police Chief Inspector. • Regular contact with the Kent Police Missing Adult Liaison Officer (MALO) – additional training for the security team has been delivered by Kent Police – a live exercise is planned

			to test the response to a missing patient incident. The aim is to test the search aspect of the response. • A further training to ED and ward staff is planned to raise awareness and importance of detailed and timely reporting of missing patients. • Regular liaison with Counter Terrorism Security Advisor (CTSA)
2.2	The organisation has an ongoing programme of work to raise awareness of security measures and security management in order to create a pro-security culture among all staff. As part of this, the organisation participates in all national and local publicity initiatives, as required by NHS Protect, to improve security awareness. This programme of work will be reviewed, evaluated and updated as appropriate to ensure that it is effective.		• Some posters on site. • Limited information about security provided with the induction pack. • Leaflets to be provided to all new starters and distributed to all wards/departments. • A joint awareness stand is planned with the local Police force in the near future.
2.3	The organisation ensures that security is a key criterion in any new build projects, or in the modification and alteration (e.g. refurbishment or refitting) of existing premises. The organisation demonstrates effective communication between risk management, capital projects management, estates, security management and external stakeholders to discuss security weaknesses and to agree a response.		• LSMS attends Health and Safety and a number of Estates meetings. • Regular meetings with Director of Estates and Facilities. • Regular liaison with

			ED and ward staff. • Weekly incidents review. • Security Review was conducted and a local Risk Register populated – to feed into Risk Assure.
2.4	All staff know how to report a violent incident, theft, criminal damage or security breach. Their knowledge and understanding in this area is regularly checked and improvements in staff training are made where necessary.		• Online incident Reporting system, part of local induction training. • Incidents are reviewed and followed up by line management. • Weekly reviews of V&A incidents. Sanctions issued as and when required. • Staff know how to contact security – security numbers on ID badges.
2.5	All staff who have been a victim of a violent incident have access to support services if required.		• Incident investigations conducted by line manager or most appropriate person. • Referral made to OH or HR where deemed appropriate. • Support services are available – external counselling.
2.6	The organisation uses the Security Incident Reporting System (SIRS) to record details of physical assaults against staff in a systematic and comprehensive manner. This process is reviewed, evaluated and improvements are made where necessary.		• SIRS has been discontinued so the standard no longer applies.

PREVENT AND DETER			
3.1	The organisation risk assesses job roles and undertakes training needs analyses for all employees, contractors and volunteers whose work brings them into contact with NHS patients and members of the public. As a result, the appropriate level of training on prevention of violence and aggression is delivered to them in accordance with NHS Protect's guidance on conflict resolution training and the prevention and management of clinically related challenging behaviour. The training is monitored, reviewed and evaluated for effectiveness.		• Managing Medically Challenging Behaviour training to replace face to face CRT. It will be delivered to certain staff groups (A&E, Maternity, staff working with dementia patients). • The Security Team was trained in restraint techniques. • Conflict Resolution Training available to all staff as an E-learning package.
3.2	The organisation ensures that staff whose work brings them into contact with NHS patients are trained in the prevention and management of clinically related challenging behaviour, in accordance with NHS Protect's guidance. Training is monitored, reviewed and evaluated for effectiveness.		• Conflict Resolution E-learning for all staff. A booklet is available for staff who cannot access or use a PC. • Managing Medically Challenging Behaviour/Breakaway Techniques training to be introduced to replace face to face CRT.
3.3	The organisation assesses the risks to its lone workers, including the risk of violence. It takes steps to avoid or control the risks and these measures are regularly and soundly monitored, reviewed and evaluated for their effectiveness.		• Some local lone worker risk assessments are in place. • Lone Worker Policy is in place. • H&S department conducting further work around lone working assessment.

3.4	The organisation distributes national and regional NHS Protect alerts to relevant staff and action is taken to raise awareness of security risks and incidents. The process is controlled, monitored, reviewed and evaluated.		• NHS protect no longer disseminates these alerts. • Local arrangements are in place to share information between local trusts. • A close local LSMS liaison is on-going. • Close liaison with the Police.
3.5	The organisation has arrangements in place to manage access and control the movement of people within its premises, buildings and any associated grounds.		• Two access control systems are in place at present. A migration to a new system has already started. Further work will be done around access groups and authorisations once the system is fully deployed. • New ID badges will also be required and a Holocote coating will be incorporated to increase the security of staff ID badges.
3.6	The organisation has systems in place to protect all its assets from the point of procurement to the point of decommissioning or disposal.		• Asset register, including Central Medical Equipment Asset Register in place. • Equipment marked with an asset number, a barcode and owner information to indicate a discipline(i.e. general, mechanical)

3.7	The organisation operates a corporate asset register for assets worth £5,000 or more.		• Asset register, including Central Medical Equipment Asset Register in place. • Equipment marked with an asset number, a barcode and owner information to indicate a discipline (i.e. general, mechanical)
3.8	The organisation has departmental asset registers and records for business critical assets worth less than £5,000.		• Asset register, including Central Medical Equipment Asset Register in place. • Equipment marked with an asset number, a barcode and owner information to indicate a discipline(i.e. general, mechanical)
3.9	The organisation has clear policies and procedures in place for the security of all medicines and controlled drugs.		• Medicines Management Policy. • Medicines Management Sub-Policy 1 – Safe and Secure Handling of Medicines. • Medicines Management Sub-Policy 2 – Prescription Writing. • Medicines Management Sub-Policy 3 - Controlled Drugs Procedure.

3.10	The organisation has policies and procedures in place to ensure prescription forms are protected against theft and misuse. These policies and procedures are reviewed, evaluated and updated as required.		• Medicines Management Policy. • Medicines Management Sub-Policy 2 – Prescription Writing. • Process for lost prescriptions is in place.
3.11	Staff and patients have access to safe and secure facilities for the storage of their personal property.		• Some staff lockers are available in different departments • Bedside lockers available to patients. • Patients Property Policy in place. • Denture Marking Procedure. • New patients' lockers have been ordered.
3.12	The organisation records all security related incidents affecting staff, property and assets in a comprehensive and systematic manner. Records made inform security management priorities and the development of security policies.		• Datix is used across the trust. • Patient safety team reviews all incidents on a daily basis. • LSMS and Health and safety assist line managers as and when required. • LSMS applies administrative sanctions and liaises with the Police when required.
3.13	The organisation takes a risk-based approach to identifying and protecting its critical assets and infrastructure. This is included in the organisation's policies and procedures.		• The full Security Review was completed with a number of recommendations. All findings fed into to the Security Risk Register which was shared with Estates

			team. • Incident reports reviewed regularly.
3.14	In the event of increased security threats, the organisation is able to increase its security resources and responses.		• In house staff can be called to assist and cover any gaps in the roster. • Premiere Work Support agency is also used for the same purpose – PWS has limited to no available staff with an SIA license. • It would be more beneficial to engage with a dedicated security company to ensure that appropriate calibre of staff is available at short notice.
3.15	The organisation has suitable lockdown arrangements for each of its sites, or for specific buildings or areas.		• Lockdown Plan is in place. • It was recently tested during the Infant Abduction live exercise. • New access control system to be deployed to all external access points to reinstate remote lockdown capability.
3.16	Where applicable, the organisation has clear policies and procedures to prevent a potential child or infant abduction, and they are regularly tested, monitored and reviewed.		• Infant Abduction policy is in place. • An infant abduction live exercise was conducted in June 2017.

HOLD TO ACCOUNT			
4.1	The organisation is committed to applying all appropriate sanctions against those responsible for security related incidents.		• Sanctions and Redress Policy has been ratified. • Incidents reported to the Police as and when required. • Application of administrative sanctions (yellow and red cards).
4.2	The organisation is committed to applying all appropriate sanctions against those responsible for security related incidents.		• Amber and Red alerts are issued as and when required. • A number of racially aggravated assaults on the security team were reported to the Police and successful prosecution was secured in two cases. • The most recent case of multiple staff assaults (09/03/2018) has also resulted in criminal sanctions.
4.3	Where appropriate, the organisation publicises sanctions successfully applied following security related incidents.		• A number of criminal sanctions were secured. • A significant number of administrative sanctions were applied.
4.4	The organisation has a clear policy on the recovery of financial losses incurred due to security related incidents, and can demonstrate its effectiveness.		• Sanctions and Redress Policy has been ratified.

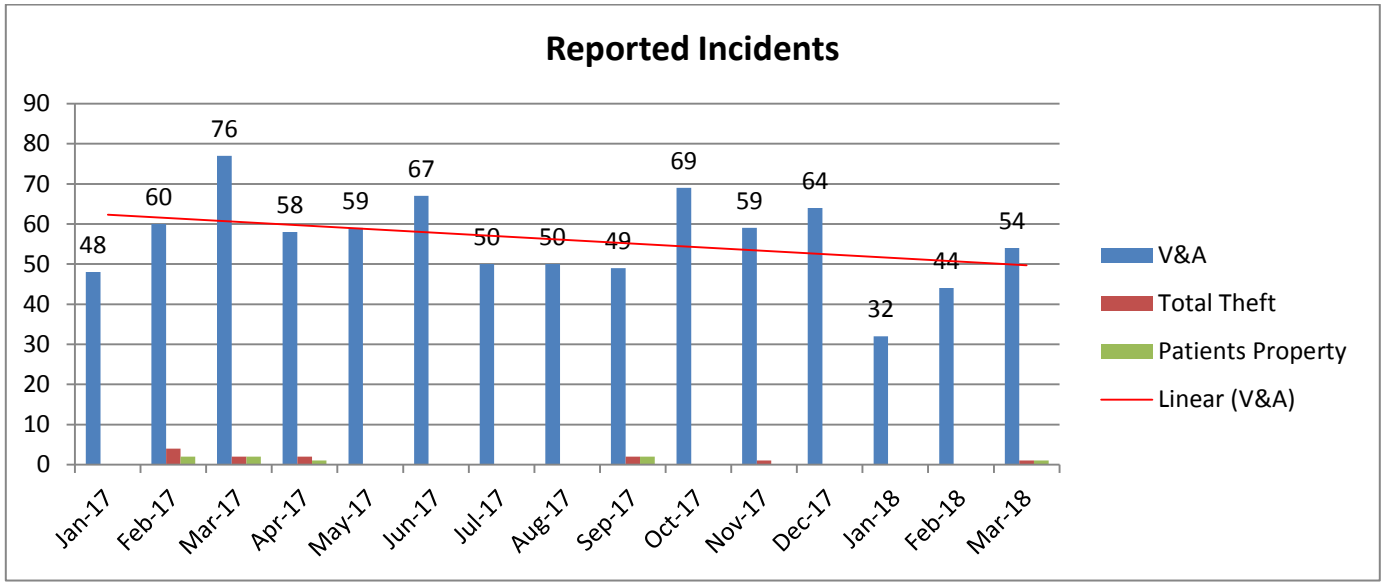
4.1 Due to the demise of NHS Protect and a current lack of external oversight and compliance assurance regarding Security Management Standards for Providers, the Trust should consider obtaining ISO 9001:2015 certification for Security Management. As an external certification this would provide additional level of assurance to the board.

5 REPORTED SECURITY INCIDENTS

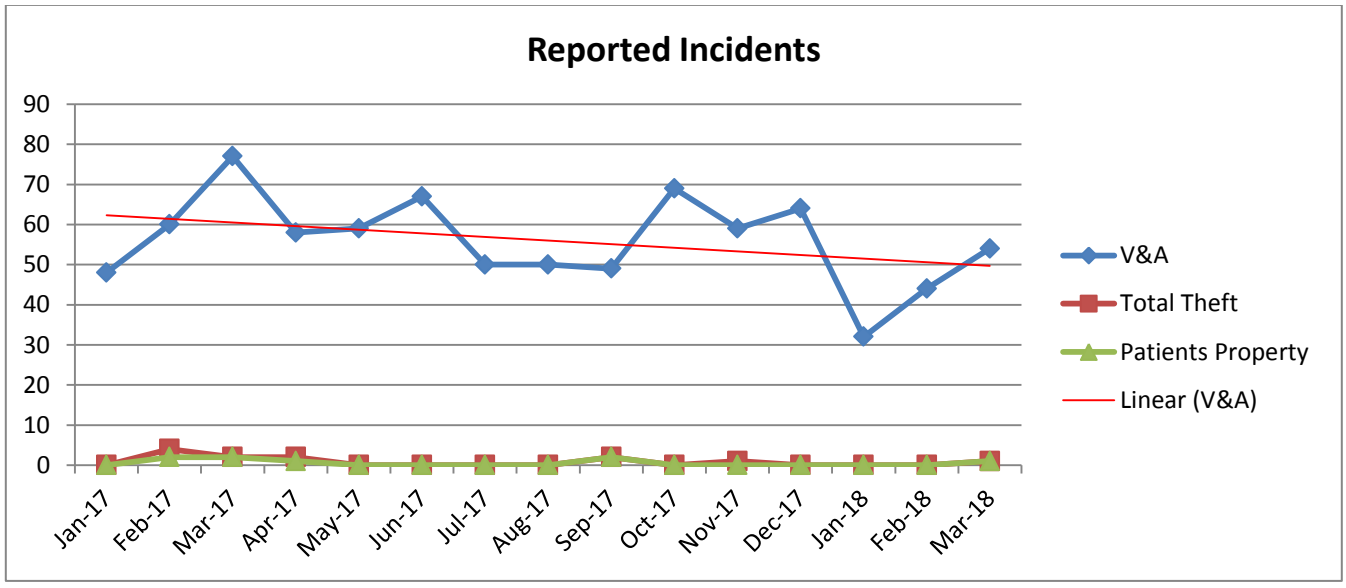
5.1 Table 1: Reported Incidents by Month

Reported Security (V&A and Theft) Incidents by Month - 2017												
	January	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
V&A	47	60	76	58	59	67	50	50	49	69	59	64
Total Theft	0	4	2	2	0	0	0	0	2	0	1	0
Patients property	0	2	2	1	0	0	0	0	2	0	0	0
Reported Security (V&A and Theft) Incidents by Month - 2018												
	January	**February**	**March**	**April**	**May**	**June**	**July**	**August**	**September**	**October**	**November**	**December**
V&A	31	45	54									
Total Theft	0	0	1									
Patients property	0	0	1									

5.2 Graph 1



5.3 Graph 2



5.4 There appears to be a slight decline in number of reported V&A incidents in the first three months of 2018 compared to the same period in 2017. It is hard to pin point the exact reason for the decline but it is a positive trend so far. The presence of the security team on site and the regular application of sanctions would have contributed to the decrease.

5.5 In January 2018 31 V&A incidents were reported – a 34% reduction compared to January 2017.

5.6 In February 2018 45 V&A incidents were reported – a 25% reduction compared to February 2017.

5.7 In March 2018 54 V&A incidents were reported – a 29% reduction compared to March 2017.

5.8 The LSMS and SMD link is working well and authorisations for red card sanctions can usually be finalised the same day.

5.9 The Trust has a Violence and Aggression Policy in place and Amber and Red cards are issued to visitors or patients whose behaviour is not acceptable. There are currently 72 active Amber and Red cards on record – 31 Amber alerts have now expired. A red card excludes a patient from receiving non-emergency care at our hospital and all visiting rights are withdrawn.

5.10 A recent example of a red carded patient, who was admitted on to a ward, demonstrates the level of disruption such patients can cause. This individual was a subject to 4 incident reports in a 4 day period (24/28-03-2018). He was evicted and escorted of the premises once medically cleared.

5.11 There are some significant issues with mental health patients and patients dealing with substance dependence who are admitted to the hospital and are treated on open wards. This causes significant problems around violent and aggressive behaviour and creates disruption and distress to other patients and their relatives.

5.12 There is a proposal to introduce an additional training pertaining to managing challenging behaviour, including breakaway techniques. This is also part of the compliance requirement in amended Security Management Standards for providers (Standard 3.2).

6 REPORTED PHYSICAL ASSAULTS - ANNUAL FIGURES AS PER PREVIOUS NHS PROTECT REQUIREMENT

6.1 The common definition of physical assault against staff for recording and reporting purposes, is shown below, and replaces any definitions of a physical assault previously in use across the NHS:

- ‘The intentional application of force against the person of another without lawful justification, resulting in physical injury or personal discomfort.’

6.2 Definition of NHS staff:

- NHS staff means directly employed staff and contracted staff and professionals providing services or goods to the health body. For the purposes of RPA returns assaults on volunteers and students providing services to the health body, and for whom the health body have a duty of care, should be included.

6.3 In general, the following categories fall under the definition of 'NHS staff' for the purposes of dealing with physical assaults:

- directly employed staff and professionals, contractors, students or volunteers, including those involved in shared-care provision of NHS services
- those providing services or goods to the NHS
- during the course of their work on site or off site, or if they can clearly be identified as and targeted as an NHS employee, for example, by their uniform or other indication

6.4 Table 2: RPA Figures

	2010/2011	2011/2012	2012/2013	2013/2014	2014/2015	2015/2016	2016/2017	2017/2018
Number of Physical Assaults	81	62	68	116	93	70	93	72

6.5 The national physical assaults for acute sector have been increasing year on year (no official data available past 2015), as per the table below, and the MFT figures are fairly constant. Due to the demise of NHS Protect the submission of physical assault figures has also ceased. Data for 2015/16 was published but has not been archived on any government website and could not be located online.

6.6 Table 3: National reported physical assaults for acute sector.

	2010/11	2011/12	2012/13	2013/14	2014/15
Number of Incidents	13436	15536	16356	17900	19167
Increase Compared to a Previous Year	N/A	2100	820	1544	1267

7 SECURITY SYSTEMS

7.1 Closed Circuit Television (CCTV)

7.1.1 The new video management system was deployed and the new hardware infrastructure is now in place to support the new system.

7.1.2 The new cameras have been deployed to minimise external and internal blind spots and to support the fire strategy.

7.1.3 The CCTV system is currently used forensically as the control room is not manned 24/7. This is one of the proposals worked on at present as the 24/7 control room would allow introduction of additional safety and security systems, i.e. panic alarms, man down function on the new radio system, as these would require constant monitoring to ensure appropriate response.

7.1.4 The retention period has been extended to 56 days to ensure evidence can be disclosed to the police as some crimes may not surface or be reported in a timely manner.

7.1.5 The new system is capable of facial recognition, which would aid an early detection of known perpetrators of violence and enhance access control arrangements. This function is currently being tested.

7.2 Digital Radio System

7.2.1 The new digital radio system is being deployed; the planned switchover to digital is planned for 24th April 2018.

7.2.2 The new system offers some additional safety features such as a panic alarm and a man down function. These aspect, however, require 24/7 monitoring in order to be effective tools.

7.2.3 There is an active GPS tracking and indoor tracking is possible with Bluetooth beacons. This radio function will replace current security patrol monitoring tool and provide a more robust assurance of security visibility across the site.

7.2.4 The new digital system is also capable of geo-fencing; for example a radio can automatically switch to a lone working mode when entering a certain area i.e. under croft.

7.3 Paxton Access Control System

7.3.1 The new access control system is currently being deployed to replace the ageing and unreliable ADT system.

7.3.2 The new system is capable of being integrated with the CCTV system.

7.3.3 There is a need for a tighter control of the deployment process and a clear strategy; currently pursued by the Head of Clinical Engineering.

7.3.4 The target deployment should include drug rooms, fridges and other high risk locations to allow for a robust control of access and an audit trail.

8 LEGISLATION CHANGES

8.1 Amendments to the Mental health Act 1983, pertaining to sections 135 and 136, came into effect on 11th December 2017.

8.2 The percentage of section 136 detainees taken to an NHS health-based place of safety for assessment appears to continue to rise. This is mainly due to an ongoing attempt to reduce the use of police custody as a place of safety. There may be some additional pressure arising from more admissions for assessment to our ED department.

8.3 The amendments to the Mental Health Act mean that:

- it is unlawful to use a police station as a place of safety for anyone under the age of 18 in any circumstances;
- a police station can only be used as a place of safety for adults in specific circumstances, which are set out in regulations;
- the previous maximum detention period under s136 of up to 72 hours was reduced to 24 hours (unless medically advised otherwise - it can be extended for further 12 hours).

9 POLICE LIAISON

9.1 There is an ongoing liaison with the Kent Police. Bi-monthly meetings with the Chief Inspector, LSMS and the Director of Estates and Facilities take place.

9.2 Regular liaison with the Kent Missing Adult Liaising Officer (MALO) also takes place. The MALO has recently delivered additional training to our security team around searching for missing patients and documenting carried out searches. The training enhances our practice and the policy currently in place.

9.3 Additional awareness sessions will be delivered to the medical staff, mainly to highlight the importance of rapid escalation of missing patients and providing accurate details and descriptions.

9.4 A live exercise involving a missing patient is planned and will be delivered in conjunction with the Kent Police and Kent Search and Rescue.

9.5 Police Community Support Officer (PCSO) is part funded by the Trust and provides a regular presence on our premises. Low level and non-urgent crime can also be reported to the PCSO when on site.

9.6 **Project Griffin Industry Self-Delivery** was launched in 2016. This scheme offered a modular package of professional and authoritative guidance for corporate use, enabling company trainers to deliver a CT Awareness package to their own staff at a time that suits them best.

9.6.1 The MFT joined the Industry Self-delivery scheme in 2017 but the National Counter Terrorism Security Office has changed its approach to the delivery of the counter terrorism training. This will be launched in April 2018.

9.6.2 This initiative though initially aimed at larger companies, soon welcomed other organisations operating in our crowded places to join the scheme. Today over 400 companies, Local Authorities, NHS Trusts, Universities, with a combined UK workforce in excess of 2,000,000 have joined this initiative.

9.6.3 Industry Self-Delivery relied on a front facing PowerPoint method of delivery which was becoming increasingly anachronistic for many companies and its reliance on a USB/DVD format to distribute the product has presented challenges to 21st century firewall technology. The registration process will be simplified for new users and existing users, like MFT, will be automatically accepted onto the eLearning scheme.

9.6.4 In April 2018 CTP will launch its new ACT CT Awareness eLearning. The eLearning will provide nationally accredited CT guidance, helping industry to better understand and mitigate against current terrorist methodology and the modules will include:

- Introduction to Terrorism
- Identifying Security Vulnerabilities
- How to identify and respond to Suspicious Behaviour
- What to do in the event of a Bomb Threat
- How to identify and deal with a Suspicious Item
- How to react to a Firearms or Weapons attack

Report to the Board

Board Date: 05/07/2018 Agenda item 11c

Title of Report	**Planning Update**
Prepared By:	Tracey Cotterill – Director of Finance & Business Services
Lead Director	Executive Team
Committees or Groups who have considered this report	Circulated via email – 19th June 2018 Executive Committee – 20th June 2018Finance Committee – 28th June 2018
Executive Summary	As circulated for approval on 19th June, prior to submitting the revised annual plan and supporting templates on 20th June, this report outlines the changes to the 2018/19 annual plan. Documentation in support is also attached including correspondence between NHSI and the Trust. The plan reflects changes made as a result of feedback from NHSI on the annual plan submitted 30th April with regard to: • Confirmation of the deficit at £46.8m • The award of Provider Sustainability Funding in the amount of £12.6m leading to a control total of £34.2m • Re-profiling of pay costs to better reflect CIP delivery plans • Update of CIP plans to reflect progress in scheme developments and identification. • Update of the trajectories for the constitutional targets • Review of narrative to draw out the operational interventions planned in year to support delivery of the control total and trajectories.
Resource Implications	
Risk and Assurance	
Legal	Regulatory requirement to re-submit the annual plan reflecting

Report to the Board

Implications/Regulatory Requirements	feedback on the previous version.			
Improvement Plan Implication	The revised trajectories are designed to move the Trust toward constitutional targets. The agreed financial control total is in line with the financial recovery plan.			
Quality Impact Assessment	The plan includes a section on quality and performance.			
Recommendation	To formally approve the revised plan in session			
Purpose and Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☒	☐	☐	☐

NHS
Medway
NHS Foundation Trust

Operating Plan Refresh 2018/19

June 2018

Best of care
Best of people

Foreword

In common with NHS services across the country, Medway NHS Foundation Trust is planning changes over the next two years that will ensure our services are sustainable from both a clinical and a financial perspective.

We are developing our plans as part of the wider NHS 'health economy' in Kent, recognising that we treat both local people and patients who travel to our hospitals from further afield. Our plans form part of the Kent & Medway Sustainability and Transformation Plan (K&M STP) and we also play an important role in a number of clinical networks that join up services provided across several NHS Trusts including clinical care, and research. Given the increasing demand and the major constraints on NHS, social care and public health funding, there are undoubtedly risks to the Trust achieving this plan. Our plan for 2018/19 requires true partnership working from our partners across Kent & Medway, both operationally, and financially.

This year, we have entered in to a block contract. Whilst this has many benefits both financially and in drawing a line under long standing disputes on demand, counting and activity; there are risks with the demand picture at Medway being an outlier against various national growth positions. If demand exceeds our planned activity this year (2018/19), this will delay our ability to achieve national access standards, such as overall waiting times for treatment and specific targets in A&E or for cancer treatment to begin. This is particularly the case where we have capacity constraints, such as the availability of beds, operating theatre time or the right clinical staff to deliver services. Without question, we will work as part of the local healthcare system to manage demand and provide alternatives to hospital care, but other options may be required to deliver a challenging financial target, and at pace

Identifying and delivering the cost improvement savings required to achieve our financial plan is critical. This includes being transformational in the way, and where we deliver care. We have identified schemes to deliver the challenging control total; and we will do this with the principle of *the best of care* at the forefront of our decision making.

As a Board and executive team, we acknowledge the challenges we face and believe that we have good, robust plans in place to address them. For our staff and the people of Medway & Swale, we must truly live our values and be bold as we continue to improve, and put the best of care with the best of people in to a genuine reality.

Stephen Clark

Chair

Lesley Dwyer

Chief Executive

Contents

1. EXECUTIVE SUMMARY

As part of the original 2017-19 Planning process the Trust submitted plans with agreed control totals of £37.9m deficit (2017-18) and £29.1m deficit (2018-19). The Trust has reported an adverse financial position to the total plan for 2017-18 of £26m post STF, and has therefore undertaken a revision to the 2018-19 financial plan.

The original 2 year plan agreed in December 2016, which was set to meet the £29m control total in 2018-19, included an optimistic presentation of income. This continued from the optimistic income assumptions within the 2017-18 plan which have contributed to the adverse variance. In 2017-18 the Trust was unable to meet the planned control total and had a deficit of £66.43m, which is a £19.6m variance against the pre STF control total. The deficit position for 2017-18 included the outcome of the expert determination process. The Trust agreed a year end position with the North Kent CCGs which reflected the impact of the expert determination decisions and was a reasonable settlement for all organisations.

The Trust has agreed a block contract for 2018-19 with the 3 North Kent CCGs which will enable the focus to be on care pathways, application of Right Care and GIRFT, and financial efficiencies, particularly as evidenced by Model Hospital over the year. The contract value was based on a planned activity schedule uplifted for national growth, which also ensures that the system is aligned in terms of both planned activity and financial position. We will continue to work with our CCG partners on demand strategies over the course of the year.

The revision to the original plan reflects a challenging position for 2018-19 with a deficit of £46.8m, based on £21m of cost improvement savings. Following submission of the plan at the end of April 18, the Trust has been offered a revised control total based on the planned deficit of £46.8m, which will enable the Trust to access Provider Sustainability Funding (PSF) of £12.6m giving a control total post PSF of £34.2m. The Trust has accepted the revised control total and this forms the basis for the 2018/19 plan. The planned deficit shows an improvement of £19.6m on the 2017-18 outturn deficit of £66.43m, but reflects that the transformational change required to reach financial sustainability will require investment in the year and will take longer to deliver.

	2018-19 Original CT £000's	2018-19 Revised CT £000's
Deficit Pre STF	**(38,155)**	**(46,832)**
STF	9,006	
PSF		12,663
Deficit	**(29,149)**	**(34,169)**

The Trust has developed an initial Financial Recovery Plan and is working closely with NHSI and system partners to ensure financial stability for the Trust is achieved at the earliest opportunity without compromising safety and quality. The Trust will be working with CCG colleagues over the next few months to develop a system recovery plan with the aim of bringing the system into balance over a 3 year period.

2. FINANCIAL PLANNING

Financial Forecasts and modelling

We fully recognise that the long-standing and underlying financial position at Medway is a challenge, and one that must now truly be addressed. Our regulator, NHS Improvement and the CQC have both acknowledged that we have improved quality indicators, and performance against constitutional targets over the past 2 years, however, we equally recognise that there is much more to do, and particularly with finance, which is an area that we must cast a different lens over in order to deliver the efficiencies & transformation required.

As a Board, we are committed to achieving the financial recovery plan, and have detailed efficiency and transformation schemes to deliver the control total for 2018-19. That said, in order to reduce the deficit, we must reduce our cost base, and to achieve this, we acknowledge, and remain committed to working as a system partner to provide the best care for our patients of Medway and Swale; and provide that care within the financial envelope so that MFT remains sustainable as a healthcare provider, and employer.

It is fair to say that in recent years the Trust has operated at significant financial deficits. The table below details the year on year position and incremental change:

Year On Year Movement £							
							Submitted Plan
£m	**2012-13**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**
Clinical Income	212.1	221.5	223.2	231.8	247.5	242.1	246.6
Other Income	25.3	30.6	32.1	23.2	25.3	24.3	23.2
Total	**237.4**	**252.1**	**255.3**	**255**	**272.8**	**266.4**	**269.8**
Pay	-152.2	-166.3	-182.7	-197.5	-211.8	-213.9	-198.1
Non Pay	-73.8	-82.9	-89.9	-95.6	-101.9	-106.6	-104.5
Total	**-226**	**-249.2**	**-272.6**	**-293.1**	**-313.7**	**-320.5**	**-302.6**
ITDA	-13.2	-12.9	-13.3	-14.2	-12.7	-12.3	-14
Deficit	**-1.8**	**-10**	**-30.6**	**-52.3**	**-53.6**	**-66.4**	**-46.8**
Year on Year Movement £							
		2013-14	**2014-15**	**2015-16**	**2016-17**	**2017-18**	**2018-19**
£m							
Clinical Income		9.4	1.7	8.6	15.7	-5.4	4.5
Other Income		5.3	1.5	-8.9	2.1	-1	-1.1
Total		**14.7**	**3.2**	**-0.3**	**17.8**	**-6.4**	**3.4**
Pay		-14.1	-16.4	-14.8	-14.3	-2.1	15.8
Non Pay		-9.1	-7	-5.7	-6.3	-4.7	2.1
Total		**-23.2**	**-23.4**	**-20.5**	**-20.6**	**-6.8**	**17.9**
ITDA		0.3	-0.4	-0.9	1.5	0.4	-1.7
Deficit		**-8.2**	**-20.6**	**-21.7**	**-1.3**	**-12.8**	**19.6**

We believe that the plan submitted is sufficiently stretching, and there is confidence in delivery, recognising that difficult solutions will need to be implemented. The focus for the year is on transformation across Medway health economy to facilitate lasting benefits, and the block contract

arrangement ensures that the contractual issues are not a blocker to the necessary change. The aim for the Trust is to move to a system control total and to utilise resources in a way that reduces the overall financial burden for Medway. Work is underway with GE Finnamore to gain greater insight into the system capacity and demand to support this aim.

The Trust plan being submitted for 2018-19 is for a deficit of £46.8m, pre PSF of £12,6m. The tables below detail the summary bridge and the high level income and expenditure analysis underpinning this position.

Summary Bridge	**£m**
Forecast Outturn Deficit 2017/18	58.1
Income Risk Adjustment	8.3
Adjusted Deficit 2017/18	**66.4**
Activity Income Growth	(5.0)
Other Income Changes	(2.3)
Pay Inflation	4.0
CNST	2.7
Other Non-Pay Inflation	1.6
NR adjustment - PY	(2.5)
FYE of CIP 17/18	(1.5)
Invest to save costs	3.0
ITDA Increases	1.4
Position before applying savings	**67.8**
Savings	(21.0)
Proposed Deficit Plan	**46.8**

	2018-19 Plan £m
Clinical Income	225.4
HCD	21.2
Other Income	23.2
	269.8
Pay	(198.1)
Non Pay	(104.5)
Total Expenditure	**(302.6)**
Post EBITDA	(14.0)
Total Surplus (Deficit) Pre STF	**(46.8)**

As can be seen from the bridge above, the Trust has included £4m of pay inflation in its plan. This reflects the 1% pay award and cost of increments based on the substantive workforce. Non pay inflation has been included for drugs, but the Trust has a particular focus on improved use of biosimilars which will offset some of the inflationary pressure that may otherwise have been anticipated. There will be an increase in interest costs associated with the additional borrowing, and depreciation will increase in year as a result of revaluation and capital expenditure in 2017-18. Much of the capital programme for 2017-18 remains as work in progress so will not affect 2018-19 depreciation plans. £3m has been set aside for investment in efficiency schemes that may need up front funding, as well as to secure external support as and when required to deliver change at pace, and bring additional capability to specific projects.

The Trust has not set budgets for agency or bank expenditure. In order to maintain focus on managing staff to the agreed establishments all budgets have been set on substantive staff. Internal reporting on agency and bank expenditure is in place to ensure that agency is managed within the required agency ceiling of £16m and that all temporary expenditure is managed within the overall pay budget.

The following table identifies how the revised plan differs from the 2018-19 plan submitted in December 2016:

	2018-19 Revised Plan £m	2018-19 Original Plan £m	Change to Plan
Clinical Income	225.4	228.2	(2.8)
HCD	21.2	22.4	(1.2)
Other Income	23.2	23.0	0.2
	269.8	**273.6**	**(3.8)**
Pay	(198.1)	(193.0)	(5.1)
Non Pay	(104.5)	(106.9)	2.4
Total Expenditure	**(302.6)**	**(299.9)**	**(2.7)**
Post EBITDA	(14.0)	(13.3)	(0.7)
Total Surplus (Deficit) Pre STF	**(46.8)**	**(39.6)**	**(7.2)**

Efficiency Savings for 2018-19

The Trust has set a challenging CIP plan of £21m for 2018-19. £6m of this was added to the target for which a number of plans are now being evaluated. It is likely to be largely non-recurrent in nature and will be predominantly workforce related; many of these workforce schemes have been scoped and implemented (e.g. policy changes), with additional workforce schemes being implemented within the first half of the year. The majority of schemes from the original £15m plan are already in development, with the additional £6m CIP currently being held centrally until suitable schemes (as mentioned above) are approved, acknowledging that some are likely, and rightly, to be system driven. Whilst the workforce has been triangulated for the main £15m CIP programme, no adjustments to workforce have yet been made relating to the £6m element of the programme.

The Trust believes the programme is deliverable and will not negatively impact on patient care; with full quality impact assessments (QIA) a pre-requisite for all schemes.

The detailed cost improvement plans are being further developed and scrutinised, with the aim of ensuring delivery. In addition, a continuing cycle of identifying new schemes is in place to ensure that the Trust meets the £21m target for 2018-19.

To date, the Trust has identified £13.37m of schemes, with the current gap at £7.64m (excluding additional workforce schemes currently being scoped). The combined value of savings and productivity in 2018-19 is £21m which represents 8.5% of the 2018-19 turnover.

The table below details the current plans and the phasing of savings throughout 2018-19. It should be noted that in order to return the Trust to balance, we must also seek schemes that may be developed in the current year, but will deliver in future years (e.g. digital transformation).

		Phasing Months												
Scheme	**Core BBB Domain**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**Saving**
Bank and Agency Spend Reduction	Workforce			100	100	100	100	100	100	100	100	100	100	1,000
Nursing Skill Mix (Safe Staffing)	Workforce	250	250	250	250	250	250	250	250	250	250	250	250	3,000
Early Retirements	Workforce				22	22	22	22	22	22	22	23	23	200
Best Choices Initiative	Workforce	30	30	30	45	45	45	45	46	46	46	46	25	500
VSM Pay Freeze	Workforce	2	2	2	2	2	2	2	2	2	2	2	2	21
Removal of vacant posts below 0.5FTE	Workforce	42	42	42	42	42	42	42	42	41	41	41	41	500
Workforce Initiatives	Workforce	20	20	20	45	45	50	50	50	50	50	50	50	479
Radiology Digitalisation	Digital				10	10	10	28	28	28	28	29	29	200
Drug Spend Initiatives	Service Redesign	125	125	125	125	125	125	125	125	125	125	125	125	1,500
Support Services rota changes	Workforce				22	22	22	22	22	22	22	23	23	200
Implementation of Order Comms	Digital			5	5	5	5	5	5	5	5	5	5	50
Digital Dictation Project	Digital			5	5	5	5	5	5	5	5	5	5	50
Cessation of non-profitable service areas	Financial Recovery							83	83	83	83	83	84	500
Model Hospital (pay)	Care Redesign	150	150	200	200	250	300	350	400	500	500	600	600	4,200
Model Hospital (Non-Pay)	Care Redesign	25	25	25	25	150	150	233	233	233	233	233	233	1,800
Paediatrics Critical Care	Care Redesign	67	67	67	67	67	67	67	67	66	66	66	66	800
Unidentified Stretch Target	Unidentified							1,000	1,000	1,000	1,000	1,000	1,000	6,000
Total		711	711	871	965	1,140	1,195	2,429	2,480	2,578	2,578	2,681	2,661	21,000

Scope	**Q1 2,293**	**Q2 3,300**	**Q3 7,487**	**Q4 7,920**
Deliver				

Statement of Financial Position

The Trust had a challenging year managing cash and secured additional working capital at the end of 2017-18 to support the increased deficit position. The cash at the start of 2018-19 is higher than the minimum balance required, reflecting the capital loans drawn for the emergency department project which has slipped to early 2018-19 and the need to keep a cash balance as the CCG moves to a payment date of 15th of the month from the previous 1st of the month.

The Trust balance sheet shows negative net assets throughout the year.

Capital

The proposed Capital Programme for 2018-19 is derived from the existing long term financial plan. This reflects not only the investment necessary to maintain the estate but also addresses the essential replacement of aged medical equipment, improvement to IM&T infrastructure and systems and includes the completion of Medway's major project to substantially improve the Emergency Department facilities and the emergency care pathway. The coming year will also see the continuation of a programme of works to improve the fire safety position within the hospital.

The table below provides summary information relating to the proposed capital programme and shows a total forecast requirement of £31.1m for 2018-19.

The summary also provides information relating to the agreed sources of funding which consist both of internal funding amounting to £13.6m and external funding amounting to a total of £17.5m. The internal funding is comprised principally of the annual provision for depreciation, currently forecast at £10.1m and a further £3.5m relating to loans drawn in 2017-18 but that were unspent as at the year

end. The external funding for the coming year consists firstly of the remainder of the undrawn loans, previously agreed for the completion of the ED project, which now amount to £3.3m. Secondly a further sum of £14.2m loan funding relates to a loan recently agreed with the DH for the implementation of the Fire Safety programme. Given the fact that the external loan funding included within this plan has already been fully agreed, the overall programme for Capital investment 2018-19 is considered to be affordable.

Proposed Capital Programme 2018-19	**2018-19 £000's**
Estates and Site Infrastructure General	700
Health and Safety Fire and Security	550
Backlog Maintenance Mechanical Works	1,600
Backlog Maintenance Electrical Works	1,200
Backlog Maintenance Building Works	650
Accommodation Maintenance	500
Bed Replacement Programme	100
Information Technology	2,200
Medical and Surgical Equipment Programme	1,300
Imaging Digitisation MRI	500
Pathology	100
Fire Urgency Works	14,200
Programme Contingency	500
Planning Provision for specific business cases pending (Theatre Equipment/ Cardiac Suite Equipment/ Breast Screening)	500
Emergency Department	6,481
	31,081
Sources of Finance	**£000's**
Internal Funding	
Depreciation	10,093
Unspent Capital Loan monies drawn in 17/18	3,488
External Funding	
ED remainder of available funding to draw	3,300
Fire Urgency Monies	14,200
	31,081

3. ACTIVITY PLANNING

Methodology

Prior to the start of 2018/19, the Trust and Medway CCG completed an expert determination process to finalise the position on long standing disputes in relation to demand and capacity. Since that time, the Trust has worked closely with local commissioners to ensure that the year to date activity is aligned with the CCG submission. As a result, a block contract has been agreed for 2018/19. Within the block contract, activity (for the purposes of income) has been uplifted by national assumptions – The Trust has worked closely with the Commissioners to ensure that the 2018-19 activity within the contract is able to meet demand. In addition to this work, the local system is being reviewed externally by GE Finnamore to analyse demand and capacity issues. This work should be available at the end of Quarter One, with any variations to existing contractual terms being reviewed at that point.

The table below details the national growth uplifts applied:

Growth Uplifts	
Elective	3.60%
Non Elective	2.30%
Outpatient	4.90%
A&E	1.10%
Other	1.00%

Performance

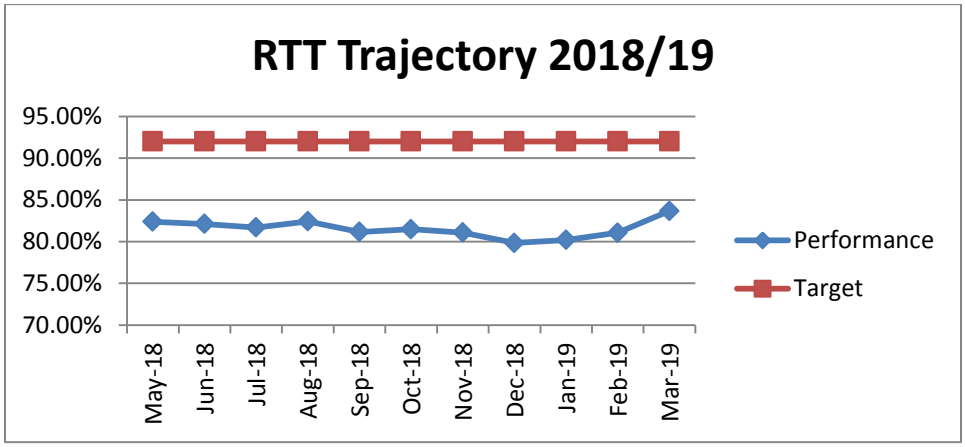
On 18 Weeks (RTT); The Trust continues to work in partnership with our commissioners and our regulators to improve our constitutional RTT 18 week target. Each failing speciality has submitted a trajectory and an action plan which is being monitored on a weekly basis. At the review meetings, we investigate how each individual programme is managing their patients; we discuss long waiters, number of referrals, polling times, trajectories and corrective actions.

All trajectories have been reviewed in light of the current activity planning assumptions (national growth); acknowledging that these will need to be regularly reviewed.

For every speciality there has been an individual action plan set against performance which is managed weekly with Service Leads. We are working well with our commissioners to reduce referrals and this is shown in the trajectory particularly in Dermatology which shows a steady decrease in referrals towards the end of the year.

We have identified seven specific specialities which cause particular concern in relation to the ability to meet the RTT 18 week standard; these include dermatology, bone, cardiology, respiratory, general surgery, T&O and ENT. For each of these specialties, we are working with our CCG partners to discuss and agree demand management initiatives, and admission avoidance plans. These include in-sourcing theatre solutions (which will move the service to a 7 day model), e-referral including advice & guidance, centralising of services (to improve efficiency), reduction of variation and improved

validation. We have also been actively using the Model Hospital data and GIRFT to progress these changes.

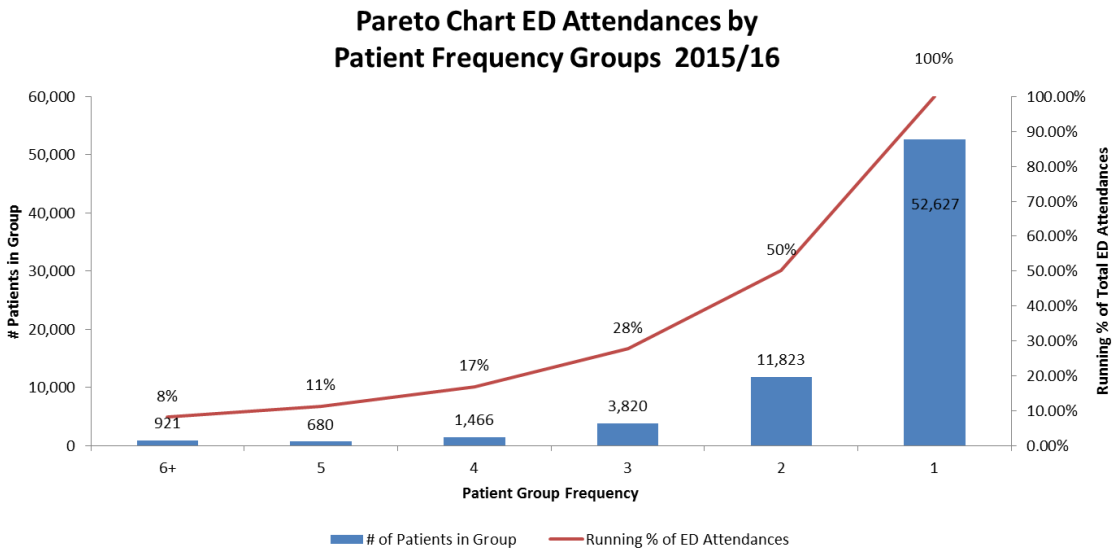


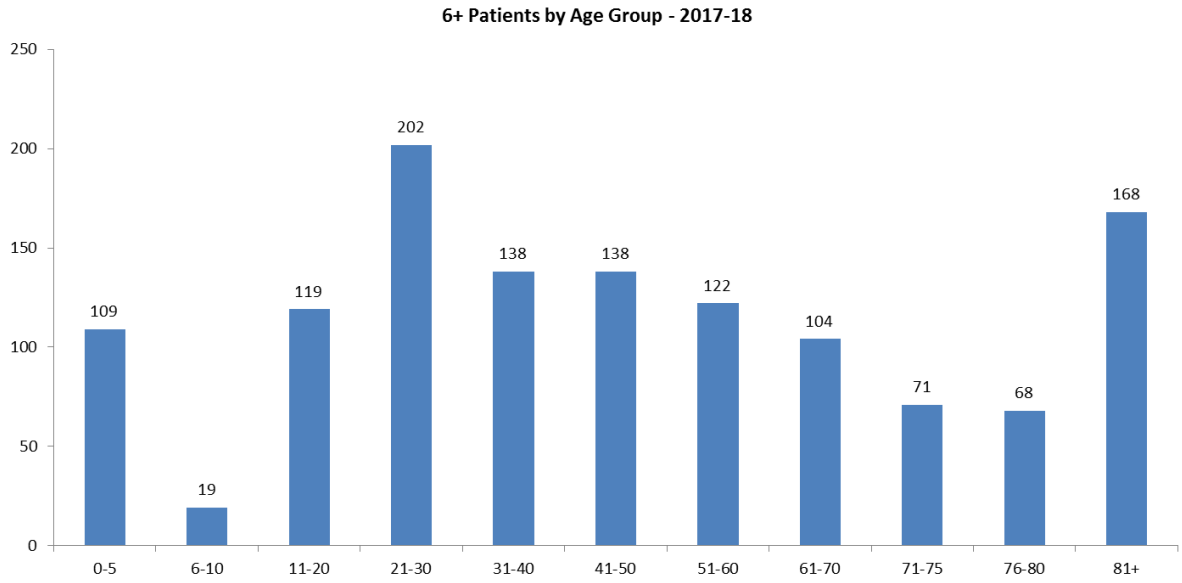
Referral to Treatment	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Number of incomplete RTT pathways <=18 weeks	17637	17143.83	16892.14	16866.78	16018.38	15772.7	15281.7	15060.17	15186.74	15873.15	16396.14
Number of incomplete RTT pathways >18 weeks	3773	3732.649	3783.496	3595.185	3718.608	3585.401	3564.131	3803.353	3748.818	3707.744	3200.953
Total	**21410**	**20876.48**	**20675.64**	**20461.96**	**19736.99**	**19358.1**	**18845.84**	**18863.53**	**18935.56**	**19580.89**	**19597.09**
Performance	**82.38%**	**82.12%**	**81.70%**	**82.43%**	**81.16%**	**81.48%**	**81.09%**	**79.84%**	**80.20%**	**81.06%**	**83.67%**

On Cancer; The Trust has delivered the Constitutional Cancer Standard over the first 4 months of 2018. To support this, it reviewed its Cancer Strategy, with collaboration and engagement of all stakeholders. A new dashboard was designed, which supports daily focus and escalation in all areas. Review of the support hierarchy identified gaps at the patient navigator level and the service is looking to recruit into these roles, aware that these are essential to support continued delivery in coming months. Diagnostic TAT was improved and these need to be sustained, in order to reduce timelines, particularly in the complex tumour groups.

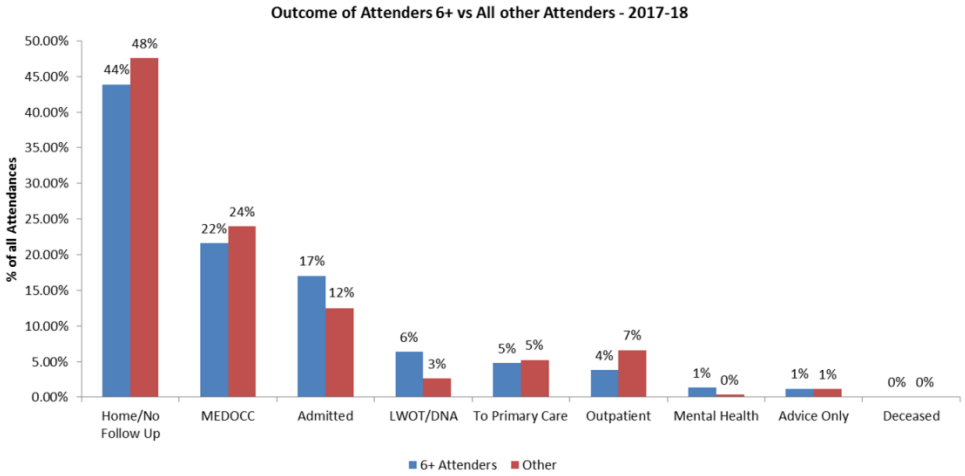
On 4 hour (ED): The Trust is continuing to develop its relationships with our system partners and is implementing multiple work streams as part of the agreed a Local A&E Delivery Board (LAEDB) wide 4 hour trajectory which aims to meet the national planning guidance. Although the MFT on site 4 hour performance in 2017/18 saw a 6% improvement (85.03%) on the previous year, it fell short of the constitutional standard. There are significant community and primary care developments required to certain pathways in Q1&2 in order for the LAEDB to meet the sector trajectory. Primary care led Urgent Care, a reduction in readmissions and services being delivered closer to patients homes are all key elements of the 2018/19 Urgent and Emergency Care Strategy.

LAEDB partners, though work led by the Urgent Care Operational Group (UCOG), has set an ambitious target to reduce activity at the ED front door by up to 10%, which has been supported by the following analysis.





Analysis shows that there are significant opportunities with regards to reducing bed days and attendances in ED when we consider the patients who attend ED more than 6 times in a year, this cohort is growing faster than overall ED attendances as demonstrated by the below:



Subsequently the following planned performance trajectory has been underpinned by a number of further internal interventions.

Performance	Apr 18 (%)	May 18 (%)	Jun 18 (%)	Jul 18 (%)	Aug 18 (%)	Sep 18 (%)	Oct 18 (%)	Nov 18 (%)	Dec 18 (%)	Jan 19 (%)	Feb 19 (%)	Mar 19 (%)
Type 1	71.18	74.49	79.51	83.37	82.91	83.22	83.06	83.20	82.84	82.68	83.25	92.51
MedOcc Streamed Type 3	100.00	100.00	95.02	95.01	95.01	95.00	95.01	95.00	95.02	95.01	95.01	95.03
Type 1 + MedOcc	**78.12**	**80.39**	**82.87**	**85.96**	**85.65**	**85.89**	**85.91**	**85.98**	**85.96**	**85.81**	**86.13**	**93.14**

There is a greater focus on reducing Ambulance handover delays in the 2018/19 plan and the Trust is working with the SECAmb project team to ensure an effective performance and improvement plan is in place.

The Trust has implemented several major interventions to support the improvement in patient flow through the organisation.

The introduction of a refreshed medical model which improves patient continuity and supports better bed management according to length of stay will assist in reducing admissions and improvement in short stay discharges.

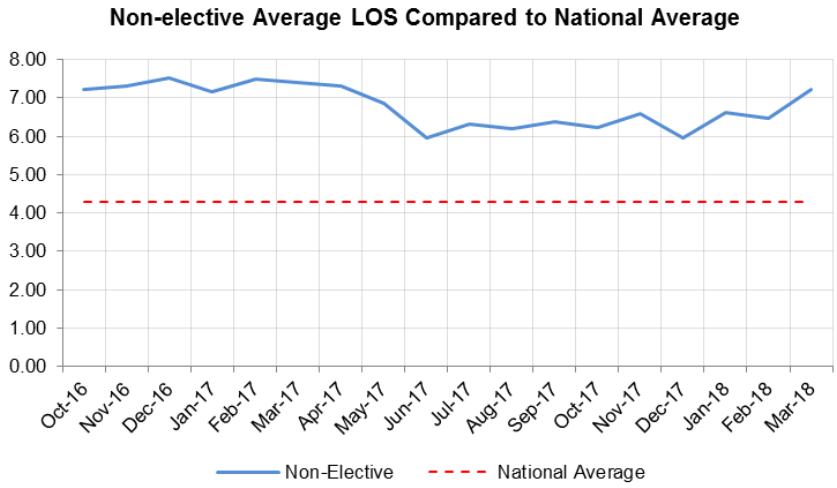
The development of length of stay reduction plans from sub specialities with focused attention on the stranded and super stranded rates will assist in ensuring our assessment areas have the capacity to receive patients from the emergency department to undergo specialist assessments.

A new rapid assessment process is being rolled out to include ambulance patients which will assist in the early referral and formation of management plans for our more complex patients. This process will further be improved once the handover of the new ED build is completed giving the team a new dedicated 4 bay space in which to undertake this function more appropriately and efficiently.

Therefore the planned interventions have been applied to the breach profile of the organisation for the past 3 months and the expected improvements, with sensitivity for over and under-performances, have been set accordingly to give the anticipated phased front door impact as below:

	Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Annual Position
	2017/18 Type 1	7366	7796	7649	8207	7574	7809	8054	7834	8100	7503	6830	7885	**92607**
	2017/18 MedOcc	2279	2368	2339	2387	2241	2208	2272	2372	2709	2718	2292	2748	**28933**
Type 1	Expected Type 1attendances pre interventions (pop growth)	7796	8399	7759	8385	7747	7920	8119	8002	8026	7762	7673	8521	**96109**
	Increase Streaming Rate to 30% to MedOcc (50% sensitivity)	0	0	-164	-396	-352	-399	-413	-345	-267	-174	-222	-221	**-2952**
	MHI Frequent Flyer Reductions (70% sensitivity)	0	0	0	0	-40	-40	-40	-40	-40	-40	-40	-40	**-318**
	<5 yrs old Frequent Flyer Reductions (50% sensitivity)	0	0	0	0	-32	-32	-32	-32	-32	-32	-32	-32	**-258**
	Frailty Frequent Flyer Reductions (70% sensitivity)	0	0	0	0	-26	-26	-26	-26	-26	-26	-26	-26	**-211**
	Alcohol Related Frequent Flyer Reductions(70% sensitivity)	0	0	0	0	-47	-47	-47	-47	-47	-47	-47	-47	**-374**
	Type 1 Expected Attendances	**7796**	**8399**	**7595**	**7989**	**7250**	**7376**	**7561**	**7512**	**7614**	**7443**	**7306**	**8155**	**91995**
MedOcc	Expected attendances pre interventions (pop growth)	2474	2528	2148	2405	2262	2319	2547	2461	2769	2644	2484	2818	**29859**
	Increase Streaming Rate to 30% to MedOcc (50% sensitivity)	0	0	164	396	352	399	413	345	267	174	222	221	**2952**
	MedOcc Expected Attendances	**2474**	**2528**	**2312**	**2801**	**2614**	**2718**	**2960**	**2806**	**3036**	**2818**	**2706**	**3039**	**32811**
	Total Expected Attendances	**10270**	**10927**	**9907**	**10790**	**9864**	**10094**	**10521**	**10318**	**10650**	**10261**	**10012**	**11194**	**124807**

Analysis demonstrates that MFT has a 2 day LOS reduction opportunity.



Initiatives which underpin the trajectory include the development of the Length of Stay reduction plans, for non-elective cases that will release capacity and has been calculated over a phased period, beginning Q2 with 478 saved bed days for July, increasing to 962 in August. This equates to 0.5 day in speciality wards and 1 day reduction in elderly care wards. Further planned interventions will have an effect on the bed occupancy via length of stay and have been quantified within the below run rate:

Metric	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Annual position
18/19 performance	2.0	1.9	2.0	2.1	2.1	1.9	2.5	1.8	2.1	2.2	2.2	2.5	2.1
17/18 performance	1.9	1.9	2.0	2.1	2.1	1.9	2.5	1.8	2.1	2.2	2.2	2.7	2.1
Average number of beds required for 18/19	49.0	46.8	54.2	56.6	51.4	57.8	63.7	51.6	57.5	53.9	62.3	64.4	64.4
17/18 Average number of beds	57.1	50.9	55.7	58.4	54.0	56.3	66.1	53.3	52.1	33.0	54.9	67.1	67.1

This equates to 0.5 day in speciality wards and 1 day reduction in elderly care wards which is demonstrated below:

Metric	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Annual Position
2018/19 > 3 Day LOS Performance	7.7	9.2	8.4	7.9	7.4	7.7	7.6	7.4	6.2	7.3	7.7	6.9	7.6
2017/18 > 3 Day LOS Performance	9.7	9.2	8.5	8.7	8.6	8.8	8.9	8.6	7.5	8.7	8.6	8.2	8.7

By further concentrating on SAFER and the stranded patient reduction work this will also provide a benefit of 80 bed days per month from September and the planned reduction of super stranded to 5 patients within the Trust, which will provide a max benefit of 550 bed days per month from July. These assumptions allow us to plan for winter pressures with a small increase in capacity; 1 ward from December to February which equates to additional around 30 beds. In addition there is a plan to increase MAU capacity by 9 beds in September 2018.

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In addition there is a plan to increase MAU capacity by 9 beds in September 2018.

Expected Occupied Bed Days	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Proposed Bed Numbers	467	467	467	467	467	476	476	476	476	506	506	506

Further work is ongoing to plan for the national requirement to achieve 95% in ED performance at year end and the trajectory demonstrates the level of Type 1 and onsite Type 3 required in order for the LAEDB to do so.

On DM01; diagnostic waiting times have improved by 4% in 2017/18 (96.39%) and the Trust has now introduced a similar way of working for 2018/19 as with RTT where diagnostic modality leads meet on a weekly basis to review the diagnostic PTL and monitor performance and required actions. Diagnostic modality level action plans have been developed to address particular areas of challenge. The Trust is working closely with our commissioners and our regulators to improve our performance against all constitutional targets.

Metric	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Total PTL/ Treatments	6248	6506	5745	7143	6834	7028	6548	7394	7891	8927	9011	9773
Total Breaches/ Backlog	254	175	152	57	65	150	90	286	238	435	103	96
Performance (%)	95.9	97.3	97.4	99.2	99.0	97.9	98.6	96.1	97.0	95.1	98.9	99.0

Workforce planning and new models of service delivery are key for realising operational performance trajectories in 2018/19. The model hospital opportunities will be, in part, leveraged by utilising a more agile approach to workforce redesign and new models of care being implemented at scale and pace.

A more cohesive and integrated workforce across Primary, Secondary and Tertiary care with voluntary sector input is vital over this next year.

4. WORKFORCE PLANNING

Workforce and Clinical Leadership are key programmes to support the delivery of the Trust's Strategic Objectives. The Workforce Plan has been developed to provide a Trust approach to workforce challenges faced by the organisation and has been refreshed to triangulate the delivery of the clinical directorate's key priorities for the forthcoming year, service changes, transformative changes and workforce plans. The Workforce Plan has the following objectives:

- Establishing a sustainable workforce through a focussed and targeted recruitment plan to address vacancy levels through proactive UK and international recruitment and through consideration of attraction and retention initiatives;
- Continue the successful recruitment campaigns to address nursing vacancies;
- Continue to align clinical staff to ensure safe staffing and quality outcomes;
- Build plans and strategies for the Trust services to transform to Model Hospital and best practice clinical pathways and profile;
- Building on our apprenticeship strategy to further embed apprentices across clinical and non-clinical areas;
- Continue to actively pursue new roles integration into the Trust following our appointments to Physicians' Associates, Doctors' Assistant, Medical Training Initiative (MTI) doctors and plans for future Nursing Associates;
- Continue trajectory of reducing agency usage and cost in the Trust through conversion to in-house bank workers or substantive appointments and continue the success of compliance with agency cap;
- Working with Kent STP colleagues to harmonise bank and agency rates following implementation of harmonised break-glass procedures;
- Embedding our values in everything we do to ensure ongoing culture change within the organisation;
- Ensure that all staff have the training and the skills to do their job well and are provided with feedback about their performance;
- Continued development of leadership skills and in house management programmes to ensure consistent, high standards of leadership performance;
- Embrace and enable technology to deliver process improvement, streamline workforce process and produce effective workforce KPIs working within the Kent and Medway region to share learning and best practice.

The Strategic Workforce Group and Directorate Performance reviews will play a key part in the governance and assurance regarding the delivery and performance against these objectives.

We are now in the second year of our Workforce Strategy. We have seen significant shifts within the Trust workforce profile moving from c. 19% agency to c.8% of paybill and an increase substantive workforce base of c. +3% of paybill. Following the successes of our recruitment strategies over the

past 12-months, greater focus is now on the retention strategies of the Trust and building a better Medway through our culture programme (under the Better, Best Brilliant improvement programme).

The Trust is an active member of the STP agenda, both as a pathfinder for the consolidated back office review, and representation on the clinical pathways workstream. This work will include dialogue with our external partners about the provision of healthcare across Kent & Medway and is underway. There has been much work to improve the recruitment marketing of the hospital, and this work will continue over the next 12 months, with more bespoke initiatives targeted at business critical roles; supported by succession planning and talent management strategies.

Specific operating plan template highlights

Nursing & Support to Nursing Staff:

- Following a safe staffing review and benchmarking of CHPPD information, the Nursing Directorate have reviewed each ward area in turn to establish a revised workforce. These changes have been enacted in this plan for Month 1 onwards (101 FTE, of which 29 FTE registered nursing, 72 FTE nursing support);
- A TUPE out of community paediatric services in July 2018 is included;
- Changes phased through year based on outliers to Model Hospital nursing efficiencies where nursing staff are considerably different to peer Trusts (based on Trust size and clinical output).

Scientific, Technical & Therapeutic Staff (including support to STT & HCS staff):

- Changes include workforce changes following the radiology review to the workforce model and order comms implementation.

NHS Infrastructure support:

- The Trust remains an outlier for administrative and clerical infrastructure support, with a significant number of posts to be removed across corporate areas and clinical areas (some mapped as support to nursing staff) including managers and senior managers following review of Model Hospital;

Medical & Dental staff:

- The Trust is currently working through detailed planning workshops, as clinically-led events, to understand their model hospital information, to rationalise loss-making services, to collaboratively compare patient pathways and obstacles with leader peer organisations (based on Trust size and clinical output). As a Trust we have also been directly involved with development sessions with the model hospital to improve the product and usability. Model hospital information currently shows disproportionate levels of medical staff (and costs) against

each clinical service WAU. The plans included for 18/19 are based on the reduction, by service, for additional sessions which do not directly affect the substantive FTE.

Workforce KPIs:

- [Turnover] The Trust will be implementing through quarter 1 (18/19) the Trust's retention strategy. This will initially focus on the registered nursing workforce, based on the scale of vacancies. The Trust's vacancy rate (12-month rolling) is readily extrapolated based on known leavers over the last 12-months. The Trust's retention strategy is based on international evidence-based research for healthcare providers and will centred around responding differently to generational needs, focusing on skill development, development of residency approach and nurse career planning;
- [Sickness] The Trust has already seen a reduction in sickness following a significant change to our Employee Relations case function – and we expect the trend to continue below the Trust's cap of 4% (combined);
- [Vacancy] The Trust has demonstrated a significant shift over the last twelve months from 19% agency as percentage of paybill to 8%, an increase to bank staff and an increase to the substantive staffing as percentage of paybill (from 77% 2016/17). The Trust's current recruitment pipeline (local, national and international) has been used to reflect the expected reduction in vacancy rate – also, the safe staffing review will directly affect the vacancy rate;
- [Appraisal] The Trust has subsequently increased to 85.5% in March 2018. The new appraisal mechanism, which addresses a number of gaps in business intelligence (performance, values , talent and education provision) went live on 01 April 2018;
- [StatMan] The Trust has subsequently increased to 85.1% in March 2018. Capacity planning and training needs analysis is being undertaken to move the Trust to Best (90%) within the financial year.

WTE Summary for bank and agency staff:

The Trust has written its plan based on the full demand for substantive staff and therefore not included figures for bank and agency to avoid double counting of FTE. The organisation has significantly changed its workforce profile with a significant increase to substantive staff over the last 12-months, and a significant change from agency to bank spend. Following achieving the stretching NHSI agency ceiling for 2017/18 target, the Trust is aiming to continue aggressively reducing agency even further this year beneath the NHSI ceiling 2018/19.

		2016/17	2017/18
Spend (£)	Agency	40,530,735	17,444,863
	Bank	8,438,690	25,329,117
	Substantive	164,147,453	171,098,554
% Pay bill	Agency	19%	8%
	Bank	4%	12%
	Substantive	77%	80%

NHS Medway NHS Foundation Trust

Temporary staffing FTE conversion plan

(In order to provide clarity regarding expected temporary staffing, the list below (which mirrors the main operational plan return) is provided and should be considered as included with the planned FTE numbers from the submitted plan, not in addition to. Note: nursing support is included in the registered nursing lines)

	01WTEM01	01WTEM02	01WTEM03	01WTEM04	01WTEM05	01WTEM06	01WTEM07	01WTEM08	01WTEM09	01WTEM10	01WTEM11	01WTEM12
	30/04/2018	31/05/2018	30/06/2018	31/07/2018	31/08/2018	30/09/2018	31/10/2018	30/11/2018	31/12/2018	31/01/2019	28/02/2019	31/03/2019
Bank												
Total Non Medical -Clinical Staff	476	476	476	471	471	471	466	466	466	462	462	462
Registered Nurses	453	453	453	449	449	449	444	444	444	440	440	440
Qualified Scientific, Therapeutic and Technical	23	23	23	22	22	22	22	22	22	22	22	22
Qualified Ambulance Staff												
Support to clinical staff												
of which Support to nursing staff												
of which Support to AHP												
Total Non Medical- Non-Clinical Staff	60	60	60	60	60	60	59	59	59	58	58	58
Total Medical and Dental Staff	55	55	55	54	54	54	53	53	53	53	53	53
Career/Staff Grades												
Trainee Grades	42	42	42	42	42	42	41	41	41	41	41	41
Consultants	12	12	12	12	12	12	12	12	12	12	12	12
Agency staff (including, Agency, Contract												
Total Non Medical -Clinical Staff	173	163	154	144	134	115	96	96	134	125	106	96
Registered Nurses	146	138	130	121	113	97	81	81	113	105	89	81
Qualified Scientific, Therapeutic and Technical	27	26	24	23	21	18	15	15	21	20	17	15
Qualified Ambulance Staff												
Support to clinical staff												
of which Support to nursing staff												
of which Support to AHPs												
Total Non Medical- Non-Clinical Staff	8	8	7	7	7	6	5	5	7	6	5	5
Total Medical and Dental Staff	19	18	17	16	15	13	11	11	15	14	12	11
Career/Staff Grades												
Trainee Grades	13	13	12	11	10	9	7	7	10	10	8	7
Consultants	6	6	5	5	5	4	3	3	5	4	4	3

5. QUALITY PLANNING

Approach to Quality Improvement

Exiting special measures in March 2017 was significant for the Trust and our main focus in 2017/18 was to maintain the momentum. During the past year quality and patient safety has continued to be a focus, with a wide range of changes implemented to make sure patients receive safe and compassionate treatment and we look forward to delivering sustainable and continuously improving care in 2018/19.

This section outlines our approach to quality planning 2018/2019.

Our Approach

Our Executive Director of Nursing and Executive Medical Director are executive leads for quality and patient safety. Quality improvement is integral to all the work we do and delivery of safe, effective and compassionate care is achieved alongside delivery of operational and financial objectives.

Our Trust wide Better, Best, Brilliant Improvement Programme is built around our four strategic objectives – integrated healthcare, innovation, people and financial stability –and sets out our bold and ambitious plans to build on the progress already made and provide brilliant care for our community. This programme shows we are restless to improve when it comes to quality. We want to challenge ourselves to keep improving, to strive to be become better still, to become brilliant.

We have a newly established transformation team who will be supporting improvement projects within and across specialities using a consistent improvement method. The transformation team will not be 'doing the doing', they will be working alongside staff to deliver improvement. We are building capability for improvement transformation within our workforce through the delivery of training in improvement methodology and providing coaching for staff leading improvement projects. To date we have trained over 250 staff in white belt* change management methodology and all junior medical staff undertaking our Medilead programme receive white belt training. We have trained 17 staff to green belt* level. In addition to this we are undertaking a programme of work that will deliver a better culture and engagement.

We have commenced work to refresh our Quality Strategy for 2018/2021. It is not easy to balance the need to deliver quality care in the context of operational priorities and the challenges of workforce availability. With this in mind our approach is to design quality into every aspect of our services to support achievement of our quality goals. By using a framework that will help us look at services as a series of 'design features' that need to be effectively organised to deliver desired outcomes for patients we will be able to look objectively at how best we can improve quality and how best to use our finite resources. The strategy also supports a 'ground up' approach to quality improvement that our staff can use every day to think about their service and how it might be better.

We cannot work alone to achieve our quality goals and we will continue to work closely with our Clinical Commissioning Group colleagues and partners across Kent to identify and deliver joint quality

initiatives. We will continue to participate in regional and national quality improvement collaborative to support the delivery of quality improvement, such as the NHSI led Mixed Sex Accommodation intensive improvement programme commencing June 2018.

We will also maintain our relationship with Professor Cliff Hughes, an international expert in quality and safety and President of the International Society for Quality in Healthcare (ISQua) who is providing support to deliver our quality improvement and cultural change.

Quality Improvement plan

We have demonstrated achievement against local 2017/2018 quality priorities but remain committed to achieving more. Our ambition is to provide the best of care and the best patient experience. We have considered carefully which quality priorities we should adopt in 2018/2019 and which will support this ambition. Our local priorities have been developed in collaboration with Trust governors, staff, members and patient group representatives.

The local quality priorities we are taking forward for 2018/2019 span all three domains of healthcare quality

- Patient safety – keeping patients safe from harm
  - We will ensure all patients with sepsis are identified and treated in accordance with national recommendations
  - We will reduce the number of incidents where delay in reporting or reviewing of test results may have contributed to a delay in diagnosis or treatment for a patient regardless of level of harm
  - We will ensure that patients whose condition deteriorates are recognised, reported and responded to in a timely and appropriate way

- Clinical effectiveness – how successful is the care provided?
  - We will comply with the national standards for Learning from Deaths and use the learning to improve patient care
  - We will meet our regulatory duties in relation to Duty of Candour legislation
  - We will improve the timeliness of our communications with GPs

- Patient experience – how patients experience the care they receive
  - We will ensure our staff consistently behave in accordance with the Trust's values as described in the clinical compact*
  - We will improve patient satisfaction with waiting times for discharge and outpatient medicines
  - We will improve patients experience of care by reducing the number of mixed sex accommodation breaches

On development of the quality account priorities for 2017/18, it was recognised that some priorities would form part of our longer term strategy and would extend into our priorities for 2018/2019.

In addition to our local quality priorities we will continue to deliver improvements against the 2017/2019 national quality priorities.

National priorities	Progress / Plan
National Audits	The Trust takes part in all national audits annually and they are all currently in date. The results are presented with recommendations.
Seven day services	The plans for achieving the four priority standards for seven-day hospital services are embedded in all improvement plans for the trust. We have an ongoing recruitment programme for consultants which includes 7-day working. Our medical model has been reviewed and a refreshed model was implemented in June 2018 that increases consultant reviews particularly at weekends.
Safe staffing	Having the right staffing levels is important, and during the past year we have continued to work hard to recruit substantive staff and reduce our reliance on agency staff. We have had a good deal of success in this area, with a significant reduction in the number of agency staff we employ. Staffing levels are monitored in our safety huddles and at our site meetings in the Clinical Coordination Centre. A safe staffing review for inpatient wards has been undertaken and recommended changes to establishments were implemented in April 2018.
Care Hours per patient day (CHPPD)	CHPPD data was used to inform the safe staffing review and is monitored at least once per day.
Mental Health Standards	Kent and Medway NHS and Social Care Partnership provide a 24 hour Mental Health Liaison Service on site and we work closely with them to achieve IAPT (Improving Access to Psychological Therapies).
Actions from Better Births review	Our Maternity Safety Strategy to achieve the recommendations of the Better Births review has been presented and approved by the Trust Board. We have a perinatal mortality and stillbirth rate which is below the national average as many of the recommendations are already in place.
Improving the quality of mortality and SI reviews	We have fully implemented the new mortality reviews and are reporting using the national dashboard monthly to the Mortality and Morbidity meeting and quarterly to the Trust Board. Each specialty reviews all of the deaths on a regular basis. We have fully implemented the LeDER recommendations.

National priorities	Progress / Plan
Anti-Microbial resistance	We have implemented a MicroApp so that all staff can easily access best practice for prescribing of antibiotics. Antibiotic usage is reviewed in all areas on the daily board rounds. Our Infection Control and Anti-microbial Stewardship Group meets monthly and monitors performance data and improvement actions.
Infection Prevention and Control (IPC)	We have a dedicated IPC team and a Director of Infection Control. There is a continuous programme of training, monitoring and reporting to Trust Board.
Falls	We have a well embedded falls assessment toolkit. Falls prevention equipment has been reviewed in the last year and new equipment is in place. Our falls per 1000 patient days is consistently below the national average.
Sepsis	We use the Sepsis 6 tool and have a higher than the national average rate of screening and treatment in our ED. We continue to audit this on a regular basis and are now focussing on improving our rates for in-patients.
Pressure Ulcers	We have implemented the ASSKIN toolkit for pressure ulcer prevention and trained all nursing staff in its use. We have a tissue viability team who provide support and training to ward staff. Our pressure ulcer acquisitions have reduced over the last year.
End of Life Care	We have an End of Life care team and specialist palliative care is provided by Medway Community Health. Our End of Life Care policies and procedures are now embedded across the Trust. Our current focus is the implementation of advance care planning. We are members of the Kent & Medway End of Life Care Programme Board that has responsibility for delivering the Kent & Medway End of Life Care strategy.
Patient experience	We are developing a patient experience strategy which will form part of a suite of documents under the Quality Strategy.
National CQUINS	National schemes have been agreed on: • Improving health and wellbeing of staff • Healthy food for NHSE staff, visitors and patients • Improving the update of flu vaccinations for front line staff within providers • Timely identification of sepsis in ED and acute inpatient settings • Timely treatment for sepsis in ED and acute inpatient settings • Antibiotic review • Reduction in antibiotic consumption per 1,000 admissions • Improving services for people with mental health needs who

present to A&E
- Offering advice and guidance (non-emergency A&G)
- NHS e-referrals
- Supporting proactive and safe discharge
- Hospital medicines optimisation
- School age immunisations.

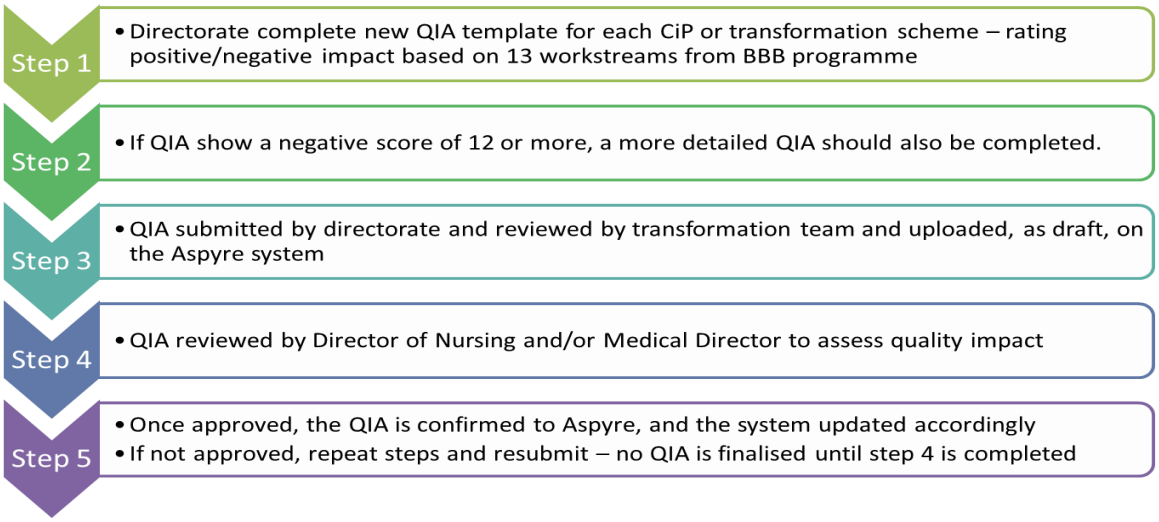
Details of the agreed goals for 2017/18 and for the following 12 months are available electronically at https://www.medway.nhs.uk/about-us/publications/board-papers.htm

Quality Impact Assessments

All service development, efficiency, improvement and transformation plans are assessed to ensure they will not adversely affect quality of care. Our approach is to improve quality, safety and efficiency in parallel.

Directorates through their Directorate Programme Boards propose projects for quality or service improvements. The projects are aligned to local and national priorities. All projects are monitored using standard project management tools including an agreed set of KPIs with a bi-weekly check and challenge meeting. All projects are assessed against a Quality Impact Assessment grid. This is completed by the project lead. If the QIA score is 12 or more a detailed QIA is completed for review and approval or not by the executive Director of Nursing and / or the Executive Medical Director. The full QIA process is shown below.

QIA Approval Process – 5 steps



Monitoring Quality

Monitoring of quality takes place through an established performance and quality governance framework. The Trust has a devolved leadership model with a clear thread of accountability permeating through the organisation from frontline staff to senior management and the Board. The directorate structures for governing quality run from wards up to directorate board which in turn reports into the monthly executive led performance review meetings.

The Executive Group receives reports from the Quality Steering Group and other quality groups. The Board monitors quality primarily through the work of the Quality Assurance Committee (QAC), a sub-committee of the board, and the Executive Integrated Quality & Performance Report, supplemented by reports taken directly to Board. The QAC receives regular monitoring information from its sub groups covering all principle strands of quality assurance as well as receives reports directly on matters where further assurance is required.

Scorecards are used at every level of performance management and quality governance, presenting outcome measures relating to patient safety, effectiveness and experience. Data is presented in a non-aggregated way to ensure variation is easily identifiable and supports benchmarking.

A programme of activities enables the Board and senior managers to test the assurances provided via reports. These activities include Executive 'GEMBA' walkabouts, a programme of unannounced out of hour visits by senior nurses and Non-Executive Director visits to wards and departments. Our approach to quality monitoring is a means to ensure quality is owned by front line staff and therefore embedded in daily practice and provides a seamless approach to quality monitoring from Ward to Board.

We are supported by the CCG in undertaking quality reviews and deep dives and the bi monthly Quality Monitoring Group provides a forum for shared learning, problem solving and joint assurance on quality.

We are committed to using learning to improve. Learning informs many of our quality improvement programmes and we have a number of initiatives in place to share learning. Examples include the weekly message from the Executive Director of Nursing and Executive Medical Director, learning events within directorates and safety alerts.

Summary of Triangulation of Quality with Workforce and Finance

The integrated Quality and Performance Report which goes to Trust Board contains all the metrics for the five domains, key metrics for workforce together with a monthly finance report. There is a bi-weekly executive review of all QI and CIP projects which brings together quality, finance and workforce indicators for each project and their progress. The Quality and Performance Report is undergoing a review of the metrics provided to Board, and a comparative analysis has been completed with other Trusts.

The directorate monthly performance reviews also brings together five domains of permance review. These include workforce, financial performance, complaints & SI, operational performance and risk.
- End

Report to the Board of Directors

Board Date: 05/07/2018 Agenda item

11d

Title of Report	**Communications and Engagement report**
Prepared By:	Glynis Alexander
Lead Director	Glynis Alexander, Director of Communications and Engagement
Committees or Groups who have considered this report	NA
Executive Summary	We continue to inform and engage staff in the Better, Best, Brilliant improvement plan, our financial position and the need for transformation. Our engagement work continues to develop, ensuring that the people in our community feel connected and involved with ongoing developments in the Trust. Many staff have been involved in celebrations to mark the 70th anniversary of the NHS, and this in itself has generated a lot of positive interest in the Trust. We were delighted to launch our "new look" News@Medway. The magazine-style publication is full of patient stories and news from the Trust and has been very well received. We have communicated with a wide range of people about the departure at the end of November of Lesley Dwyer, who is returning home to Australia to take up a new appointment and be close to her family.
Resource Implications	NA
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA

Report to the Board of Directors

Improvement Plan Implication	Communications and engagement activity is aligned with the Better, Best, Brilliant improvement plan
Quality Impact Assessment	NA
Recommendation	The Board is asked to note the report.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

Our engagement work continues to develop, ensuring that the people in our community feel connected and involved with ongoing developments in the Trust.

Many staff have been involved in celebrations to mark the 70th anniversary of the NHS, and this in itself has generated a lot of positive interest in the Trust.

1.1 We continue to inform and engage staff in the Better, Best, Brilliant improvement plan, our financial position and the need for transformation.

1.2 Our engagement work continues to develop, ensuring that the people in our community feel connected and involved with ongoing developments in the Trust.

1.3 Many staff have been involved in celebrations to mark the 70th anniversary of the NHS, and this in itself has generated a lot of positive interest in the Trust.

1.4 We were delighted to launch our “new look” News@Medway. The magazine-style publication is full of patient stories and news from the Trust and has been very well received.

1.5 We have communicated with a wide range of people about the departure at the end of November of Lesley Dwyer, who is returning home to Australia to take up a new appointment and be close to her family.

2 ENGAGING COLLEAGUES

2.1 In the last week we have communicated with staff about the announcement that Lesley Dwyer is to leave the Trust. We held a briefing for staff, attended by around 500.

2.2 Lesley recorded a video message and wrote to staff to explain that we will remain totally committed to improvement and transformation, and our plans will not be affected by her departure.

2.3 We have continued to communicate our financial position, and to develop understanding about the challenges we face, as well as explain actions being taken as part of our Better, Best, Brilliant improvement plan and financial recovery.

2.4 We are currently updating our Better, Best, Brilliant Communications Plan to reflect the priorities of the organisation for the next six months as work gets underway on our transformation programme.

2.5 A very successful senior managers’ meeting was held in June. The main topics of the meeting were our current financial position and how we can work together to enable transformation. The meeting also served to introduce our new Transformation Team to the senior leadership in the Trust.

2.6 We widely promoted the Best of People Awards 2018 nomination process, encouraging members of staff to nominate their colleagues who had gone above and beyond the call of duty.

2.7 Our NHS70 communications campaign has continued to encourage staff to take part in the NHS 70 Summer Fair and other celebrations. The team produced videos of our staff governor Chris Harvey and a former midwife talking about their memories of Medway over the years.

2.8 We have supported our colleagues in HR with the promotion of the Best Choices scheme.

2.9 We have continued to work with our colleagues in organisational and professional development to communicate actions that have been taken to improve the working environment for staff following feedback from the last NHS staff survey.

3 MEDIA

3.1 We have responded to 29 separate media enquiries since the last board report. The majority of these were from regional and local press and online, although there were a number of enquiries from national publications as well as regional TV and radio.

3.2 A number of news outlets have reported on the announcement about Lesley's departure from the Trust, with many complimentary comments.

3.3 Our plans for celebrating the NHS's 70th birthday have been promoted in the media, including a specific campaign with the Medway Messenger that we pitched to the

paper, including coverage of our 'Bake Off' competition and an art competition with local schools.

3.4 We have also received several requests from regional TV and radio stations to film at the hospital for their NHS70 programming, and an interview with Lesley Dwyer.

3.5 We have received media coverage on our volunteers, our financial deficit, nurse recruitment and the date that the new emergency department is set to open.

3.6 Local MP Rehman Chishti addressed attendees at the launch of our surgical education programme which generated a lot of positive media interest.

3.7 On a negative note, we responded to a number of media queries into challenging Trust issues, including an inquest into the death of a baby who was born prematurely at Medway, the case of a patient with cancer who received compensation from the Trust for failure to offer a mastectomy, a follow-up story on the storage of a body in the Trust morgue and the Trust's deficit. In each case we provided responses to the media.

3.8 Our "new look" News@Medway was launched in June. The magazine-style publication is full of patient stories and news from the Trust and includes the great work done by the Medway Hospital Charity, the hospital's history and plans for celebrating the NHS' 70th birthday. Feedback on the magazine's new look has been extremely positive.

Report to the Board of Directors

4 SOCIAL MEDIA

4.1 During the past month Medway maintained its position as Kent's most-followed acute trust on Twitter, breaking the 4,000 follower mark in the process.

4.2 Our engaging and regular content has focused heavily on NHS70, including the promotion of our Summer Fair on 7 July and the release of our 'Medway Memories' video series with former members of staff. This has led to an increased overall following across all of our channels.

4.3 Trust social media account followers now total 4,393 on Twitter (up from 3,833 at the last update), 5,729 on Facebook (up from 5,517) and 734 on Instagram (up from 552).

4.4 In addition to promoting key news updates, our social media accounts distributed news of the recent awards won by our employees; the Trust's involvement in key awareness events, such as the #EndPJParalysis campaign, International Nurses Day and Volunteers Week; our Governor Election campaign; the availability of alternative healthcare options, such as 111 and pharmacies, during the bank holiday periods; and our regular members' and governor events.

5 COMMUNITY ENGAGEMENT

5.1 Governors

5.1.1 Since the last report our governors have had a number of opportunities to engage with our local population.

5.1.2 Alongside our Community Engagement Officer, Krishna Devi, Trust Governor, Doreen King met members of the public at the Pentagon Shopping Centre. Feedback received about the Trust was very positive.

5.1.3 Trust Governor, Doreen King with our community engagement officer met with Major Ian Payne of the Salvation Army in Chatham. Major Payne spoke about the services they provided. We are pleased to say that the Salvation Army is very keen to work with the Trust to reach out to the local community.

5.1.4 Our extensive campaign to encourage community members to stand for governor elections has been very successful, with a good number of applications being received.

5.1.5 Our patients, their relatives and the public were able to meet with our governors in the main entrance of the hospital at their membership recruitment stand.

5.1.6 In addition to recruiting members, governors promoted our NHS70 summer fair.

5.2 Members

5.2.1 We had a very successful members' meeting in May. More than 30 attendees listened to presentations about innovation at the Trust from Prof Matin Sheriff Consultant Urological Surgeon and Dr Rahul Kanegaonkar.

5.3 Supporting services to engage with patients and public

5.3.1 Our Community Engagement Officer supported the Trust's Macmillan Recovery Package Facilitator in a co-production event to plan for a series of health and wellbeing sessions.

5.3.2 People with experience of cancer were asked to identify and prioritise what should be included in these sessions.

5.3.3 The organ donation committee was able to present to the Medway Ethnic Minority Forum to talk about the importance of organ donation. There is a

low number of registrations for organ donation from the BAME community, so this is a really important topic.

5.3.4 This presentation was well received with the forum members commenting that the presentation was delivered in a very ‘compassionate and culturally appropriate way’.

5.3.5 They are very keen to do a joint event later in the year to raise further awareness.

5.3.6 Research and development team, the Recruitment Team, the Simulation Team, and Trust Governor, Doreen King joined our community engagement officer at the River Festival at the Chatham Historic Dockyard.

5.3.7 This was an excellent opportunity to engage and promote trust services to 7,000 people from the local area who attended the event.

Report to the Board of Directors

5.3.8 Medway African and Caribbean, (MACA) pensioners were very pleased to hear from the Trust's senior physiotherapist Lorna Flisher at a community event.

5.3.9 Lorna's wellbeing presentation focused on what measures this group of individuals could take to keep well and active.

5.4 Reaching out to less engaged audiences

5.4.1 Glynis Alexander, The Trust's Director of Communications and Engagement, Dr Richard Patey, Paediatric Consultant, and our community engagement officer met young people at the Medway Youth Council.

5.4.2 Updates from the hospital were shared with the group, along with recent success stories.

5.4.3 This was an excellent engagement opportunity with members asking questions about Trust services and how they can access work experience opportunities.

5.4.4 We continued to strengthen our engagement with young people, and our Community Engagement Officer recently gave a presentation to the Gillingham and Twydall Area Youth Centre Network.

5.5 Engagement for NHS 70

5.5.1 We engaged and involved staff and local community in our NHS70 summer fair and July open day.

5.5.2 We have had a very positive response to our school arts competition. Four primary schools engaged well with this activity. The Trust received hundreds of pieces of art work from them which were then displayed in the hospital.

5.5.3 One teacher thanked us for involving them by saying: ‘Your competition has really made the children think and appreciate all you do at Medway hospital’.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/05/2018 Item No. 12a

Title of Report	Corporate Governance Report
Presented By:	Sheila M Murphy: Trust Secretary: Director of Corporate Compliance and Legal Services
Lead Director	Sheila M Murphy: Trust Secretary: Director of Corporate Compliance and Legal Services
Committees or Groups who have considered this report	Not Applicable (N/A)
Executive Summary	The report outlines current activity and issues in corporate governance.
Resource Implications	N/A
Risk and Assurance	The report outlines the progress of a number of Trust wide initiatives designed to improve corporate governance arrangements.
Legal Implications/Regulatory Requirements	Yes
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	The Board is requested to note the report.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE SUMMARY

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

2 CARE QUALITY COMMISSION

2.1 The Trust underwent a Core Service inspection on the 10 & 11 April 2018 and a Well Led inspection on the 2 & 3 May 2018. NHS Improvement carried out a Use of Resources assessment on 30 April 2018.

2.2 The Trust has now received the draft report and is checking for factual accuracy. The report is due to be publicly released at the beginning of August 2018.

3 GENERAL DATA PROTECTION REGULATION (GDPR) UPDATE

3.1 Hill Dickson, our external legal advisor on the implementation of GDPR has confirmed that the Trust is compliant.

3.2 The Trust will continue to work with Hill Dickson to ensure Trust contracts are GDPR compliant.

4 RISK AND REGULATION ASSURANCE

4.1 The Designated Individual for the Human Tissue Authority has now left the Trust. This position is now being held by David Sulch on an interim basis, until the position is recruited to.

5 DOCUMENTATION MANAGEMENT

5.1 The table below shows the status of the corporate policies, all have been approved and are available on the intranet and internet.

Corporate Policy	Document Owner	Status
Conflicts of Interest	Company Secretary	Approved; Available on intranet and website
Consent	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Duty of Candour	Medical Director	Requires review
Complaints	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Emergency Preparedness, Resilience and Response	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Estates and Facilities	Director of Finance	Approved; Available on intranet and website

Fire Safety	Director of Finance	Approved; Available on intranet and website
Health and Safety	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Human Resources and Organisational Development	Director of Workforce and OD	Approved; Available on intranet and website
Information Governance	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Medicines Management	Medical Director	Requires Review
Risk Management Strategy	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Safeguarding	Director of Nursing	Approved; Available on intranet and website
Serious Incidents	Medical Director	Requires review
Standing Financial Instructions	Director of Finance	Approved; Available on intranet and website
Violence, Aggression and Disruptive Behaviour	Security Director (currently Director of Finance)	Approved; Available on intranet and website

6 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

6.1 The EPRR service moved under the Estates & Facilities Directorate on 1st June 2018.

6.2 On the 7th June 2018 the Trust attended a Multi-Agency Exercise alongside Swale Clinical Commission Group and other NHS Providers to test the North Kent Flooding Plan for Swale in relation to the Isle of Sheppey. The outcome from this exercise is to further develop the operational detail within the Flood Plan retained by Swale Borough Council. This plan links back to the Command and Control arrangements within the Trist Significant Incident Plan for our commissioned services on Sheppey and their related Service Business Continuity Plans.

6.3 The Trusts EPRR Group have raised a risk that the EPRR Manager is leaving the Trust, as compliance with the Civil Contingencies Act requires the Trust to have an appropriately qualified EPRR Manger for the size and scope of the organisation as detailed by NHS England The Trust is audited annually by NHS EPRR Assurance Programme which is due in September 2018.

7 COMPLAINTS AND COMPLIANCE DASHBOARD

7.1 The compliance dashboard gives an overview of performance across a range of corporate governance key performance indicators and is monitored at the monthly

Report to the Board of Directors

Directorate Performance Review Meetings. There is an overarching Trust level dashboard (attached at appendix 1) and each directorate (clinical and corporate) has a dashboard tailored to the relevant KPIs of that service.

COMPLIANCE DASHBOARD 18/19 - TRUSTWIDE

NHS Medway NHS Foundation Trust

Complaints		Target	Apr-18	May-18
1.1	Number of complaints received	N/A	78	83
1.2	Number of complaints under investigation	N/A	116	188
1.3	Number of complaints breached response deadline	N/A	53	79
1.4	% of red assessed complaints with final response within 60 working days	85%	25%	50%
1.5	% of amber assessed complaints with final response within 30 working days	85%	67%	60%
1.6	% of green assessed complaints with final response within 10 working days	85%	25%	47%
1.7	% complaints acknowledged within 3 working days	100%	100%	100%
1.8	Number of referred complaints taken up by the Ombudsman	N/A	0	0
1.9	Ombudsman Outcomes - upheld	N/A	0	0
1.10	Ombudsman Outcomes - partially upheld	N/A	0	0
1.11	Ombudsman Outcomes - not upheld	N/A	1	0

Serious Incident Reporting		Target	Apr-18	May-18
2.1	No. of Serious Incidents reported on STEIS in month	N/A	5	12
2.2	No. of Serious Incidents reported on STEIS within 48 hours of incident date	N/A	1	5
2.3	48 hour compliance rate	100%	20%	42%
2.4	No. of Serious Incident 72 hour reports due for submission in month	N/A	11	6
2.5	No. of Serious Incident 72 hour reports submitted in month	N/A	11	6
2.6	72 hour report compliance rate	100%	100%	100%
2.7	Number of Serious Incident Reports due for Submission (60 Working Day)	N/A	10	11
2.8	Number of Serious Incidents Reports submitted within 60 working days	N/A	5	11
2.9	60 Day Report Submission Compliance Rate	100%	50%	100%

Incident Reporting		Target	Apr-18	May-18
3.1	Number of incidents awaiting review and being reviewed	N/A	N/A	3127
3.2	Number of incidents awaiting review and being reviewed that are overdue	N/A	N/A	2926
3.3	Awaiting final approval and overdue	N/A	N/A	2358

Duty of Candour		Target	Apr-18	May-18
4.1	Number of incidents triggering Duty of Candour	N/A	13	34
4.2	Total number of first letter sent	N/A	4	12
4.3	Compliance rate - first letter	100%	31%	35%
4.4	Number of second letter	N/A	0	0
4.5	Compliance rate - second letter	100%	0%	0%

		Q1 (Apr-Jun 18)		
Care Quality Commission		UPIC	PC	Trustwide
5.1	Compliance against Safe domain (as per CQC Assure)	Process under review - information to follow		
5.2	Compliance against Effective domain (as per CQC Assure)			
5.3	Compliance against Caring domain (as per CQC Assure)			
5.4	Compliance against Responsive domain (as per CQC Assure)			
5.5	Compliance against Well led domain (as per CQC Assure)			

Mortality		Target	Apr-18	May-18
6.1	Deaths in month	N/A	0	0
6.2	SJR requested in month	N/A	0	0
6.3	Total SJR requested (From April 2018)	N/A	0	0
6.4	Total SJR completion (From April 2018)	N/A	0	0
6.5	Total SJR completion (% From April 2018)	100%	0%	0%
6.6	Total Stage 2 required (From April 2018)	N/A	0	0

NICE - (all guidelines assessed)		Target	Apr-18	May-18
7.1	NICE guidelines published	NA	0	0
7.2	NICE guidelines due for assessment	NA	0	0
7.3	% assessed within 90 days	100%	0%	0%
7.4	% implemented (fully/partially)	100%	0%	0%
7.5	% overdue	0%	0%	0%

National Audit Projects		Target	Apr-18	May-18
8.1	Projects open -- participation	NA	0	0
8.2	Participation rate (%) -participation	100%	0%	0%
8.3	Reports published	NA	0	0
8.4	Feedback received within 28days	100%	0%	0%
8.5	Number of open actions	NA	0	0
8.6	% actions overdue	0%	0%	0%
LocalAudit Projects		Target	Apr-18	May-18
9.1	Total Local projects on 2018-18 plan	NA	0	0
9.2	Planned local projects registered	NA	0	0
9.3	Additional local projects registered	NA	0	0
9.4	Total due for completion in month	NA	0	0
9.5	% of projects due for completion overdue	0%	0%	0%
9.6	Total actions due for completion in month	NA	0	0
9.7	% of actions due for completion overdue	0%	0%	0%
9.8	Total number of open actions	NA	0	0

Report to the Board

Meeting Date: 05/07/2018 Agenda item 12b & c

Title of Report	**Corporate Risk Register**
Prepared By:	Sheila Murphy – Trust Secretary: Director of Corporate Compliance & Legal Services
Lead Director	Sheila Murphy – Trust Secretary: Director of Corporate Compliance & Legal Services
Committees or Groups who have considered this report	Executive Group – 20th June 2018
Executive Summary	At the Private Board Meeting on 3rd May 2018, it was agreed the Trust should move towards a strategic Risk Register based on a threshold score of 15 and where a risk consequence a maximum score of 5 but the total score was less than 15. The Executive review the strategic and high scoring operational risks at the 90 day forum. In addition the Finance Committee reviews their high scoring risks and other Board committees should follow this approach.
Resource Implications	N/A
Risk and Assurance	Within report
Legal Implications/Regulatory Requirements	The Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver its strategic and operational objectives and comply with the registration requirements of the quality regulator. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks. For Foundation Trusts, this also includes risks to compliance with the terms of authorisation. The Trust Board is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives.

Report to the Board

Improvement Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	To provide assurance to the Board that the significant risks to the Trust achieving its operational objectives are being appropriately managed.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

Report to the Board

1 EXECUTIVE OVERVIEW

1.1 The Board Assurance Framework is presented at appendix 1, with updates on strategic risks to Strategic Objective 2 – Innovation and Strategic Objective 3 – Financial Stability, from Tracey Cotterill, Director of Finance & Business Services, following discussions at the 90 day forum 30.05.2018.

1.2 Appendix 2 is the Trust Risk Rating Guidance.

1.3 It was agreed that this strategic Risk Register format would replace the former Corporate Risk Register format i.e. that of themed significant risks, with links to Trust wide risks scoring 12 or above, as discussed by the Private Board 03.05.2018.

2 STRATEGIC RISK REGISTER

2.1 The Strategic Risk Register comprises those Trust wide risk scoring 15 and above and hence significant operational risks to the Trust and as such requiring Executive oversight and assurance to the Trust Board that the risks are being managed and mitigated appropriately.

2.2 The Executive Group reviewed the risks in terms of appropriateness of risk articulation, scoring and mitigation.

Risk Response	Description/example
Avoid	The risk is avoided by changing the project in some way to bypass the risk.
Accept	The risk may be accepted perhaps because there is a low impact or likelihood.
Reduce	Action is taken to reduce the likelihood of the risk occurring and / or the impact that it will have if it did happen
Transfer	Some or all of the risk is transferred to a third party, for example by purchasing an insurance policy.
Contingency	Here a plan is put in place to respond if the risk is realised.

Report to the Board

2.3 The Trust Risk Rating Guidance is presented at Appendix 2.

2.4 There are a number of Information Governance Risks on the Strategic risk register which have been reviewed by the Information Governance Group. The electronic platform RiskAssure will be updated with any changes as soon as possible.

3 BOARD ASSURANCE FRAMEWORK (BAF)

3.1 The role and purpose of the Board Assurance Framework (BAF) is to clearly identify the principle risks which may prevent the organisation from achieving its strategic objectives.

3.2 The Trust has identified its four Strategic Objectives for 2018 and the Principle Risks to the organisation which may prevent the Trust from achieving these objectives, i.e. the Strategic Risks.

3.3 The BAF was discussed at the 90 day forum on 30.05.2018 and subsequently those risks to the trust achievement of Strategic Objectives 2 - Innovation and 3 - Financial stability and been updated by Tracey Cotterill, Director of Finance & Business Services.

3.4 The revised BAF is presented Appendix 2.

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

Strategic Aim

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

Board / Board Committee for review - Trust Board

Strategic Risks	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Assurance
Failure of partnership and integration There is a risk that the Trust may not be seen as an organisation to partner with.	**12** (4x3)	**9** (3x3)	**6** (2x3)	The Trust is working closely with the STP and is the leader of the STP clinical strategy and participating in shaping local care delivery for Medway and Swale. The Trust is fully engaged with et system Transformation Board work and an active participant in developing new integrate services via the planned and local care work streams. As part of this partnership work the Trust has developed a frailty pathway including community programme for elderly (PACE), community geriatrician clinics and nursing home attendance and buddying systems to support complex case management. Monthly monitoring has shown a reduction in falls in the community; the Trust is developing a similar model for Chronic Obstructive Pulmonary Disease (COPD). Consultation on stroke services is now underway across the county following a long period of review and engagement.
Brand failure – The Trust may have a brand failure in that confidence may be lost in the Trust.	**12** (4x3)	**9** (3x3)	**6** (2x3)	
Collaborating with partners There may be a lack of confidence in the Trust by fellow STP partners and the STP may fail.	**16** (4x4)	**9** (3x3)	**6** (2x3)	

				The trust is actively reviewing all services provided with other organisations with a view to foster better integrated partnership working. Strategic commissioner arrangements have been put in place and the organisations are working on an aligned incentive contract to better facilitate an ICS in the future. The Trust is engaged with delivery of the new Urgent treatment centre clinical model design and is leading on the development of the awarded £1m DH fund to deliver a remodelled Urgent Treatment Centre on the MFT site as part of the Medway Model, which was taken to public consultation by Medway sector Partners in 2017 .
Gaps in control and Actions to address				
The Trust Improvement Plan is aligned with the STP and will take account of STP strategy. On-going work regarding Accountable Care Partnerships (ACP) and engagement with GPs. Strategic commissioner arrangements have been put in place and will operate in shadow form from April 2018.				

Strategic Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care.

Strategic Aim

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

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

Board / Board Committee for review - Finance Committee

Strategic Risks	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Assurance
Innovation Strategy There may be difficulty in making appropriate decisions with imperfect information on the future clinical and IT strategy of the STP and the organisation's role therein.	**16** (4x4)	**12** (4x3)	**9** (3x3)	Organisational structure devised to ensure services aligned and encourage innovation. Further work in progress on colocation of services to assist best working practices. Working with Getting it Right First Time (GIRFT) to improve efficiency and effectiveness of surgical pathways. Innovative front door model streaming to Primary Care (MEDOCC), ambulatory emergency centre and assessment areas. £1m capital Investment received for Urgent Care Front Door. Trust investment in the R&D department which has shown success attracting NHS and private funding for trials. Ensuring communication and engagement with patients eligible for trials so they are aware of opportunities to join trials. Partnering arrangements being secured for managed services in a number of areas to enable cost of innovation to be spread over the
Capability There is a risk that the Trust does not have sufficient capacity and capability to implement the required technology	**9** (3x3)	**9** (3x3)	**4** (2x2)	
Funding There is a risk that the Trust will be unable to secure sufficient funding for investment in clinical research.	**9** (3x3)	**9** (3x3)	**4** (2x2)	

There is a risk that the Trust will be unable to secure sufficient capital to invest in the desired new technologies				life, as well as ensuring there is sufficient expertise for optimum implementation and adoption. IT project office has a programme for delivering a number of digital solutions in the year. Working across the STP on digital plan for interoperability between partners.
Gaps in control and Actions to address				
Better, Best, Brilliant improvement programmes looking at ways to improve use of digital technology, such as Extramed, to provide the best of care for patients. Development of Digital Strategy within Trust and across STP footprint.				

Strategic Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do.				
Strategic Aim				
We will maximise efficiency in service delivery and operational management. We will regain and retain financial control. We will be outward looking, actively working in partnership with the wider health economy through the Kent and Medway Sustainability and Transformation Partnership to maximise transformation opportunities in service delivery workforce, back-office functions, digital strategy and estates utilisation.				
Board / Board Committee for review - Finance Committee				
Strategic Risks	**Initial Risk (CxL)**	**Current Risk (CxL)**	**Target Risk (CxL)**	**Assurance**
Going Concern The Trust's Going Concern assessment is at risk given the proportionality of the continued and sustained deficit, which could lead to further licence conditions and potential regulatory action.	**16** (4x4)	**16** (4x4)	**6** (2x3)	Recovery programmes with monthly Cost Improvement Programmes (CIP) sprints, keeping focus on achieving CIPs and efficiencies; improvements in procurement, grip and control, vacancy control measures. Recovery programmes with monthly Cost Improvement Programmes (CIP) sprints, keeping focus on achieving CIPs and efficiencies; improvements in procurement, grip and control, vacancy control measures. Agency usage has reduced, bank usage increased – continue to focus on this, and to address bank rate differentials. Carter Model Hospital has identified a potential £30m opportunity that is being analysed at specialty level and actions developed to achieve. Implementing patient level costing for reference costs submission to provide granularity of Carter opportunity. Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board. Weekly
Risk that central funding is not made available as required to support the deficit, capital investment, and loan repayments that fall due. Risks to the Trust's Viability / Sustainability. May be unable to field adequate resources to maintain high quality, safe services. There is also a risk to the transformation plan if there is insufficient cash to invest in new technologies.	**16** (4x4)	**8** (4x2)	**6** (2x3)	
Unable to deliver our financial control total The Trust may be unable to establish financial sustainability within the required timeframe. The Trust may not be able to realise efficiencies necessary to return to balance or receive payment for all activity.	**16** (4x4)	**16** (4x4)	**6** (2x3)	

				performance overview meetings. Internal accountability framework at programme level. Capacity and capability: Appointment of financial improvement director. Recruitment to PMO/transformation team to support the CIP and transformation programme. External support from KPMG on key projects. Fortnightly system transformation meetings to look at efficiency across the care pathway. Monthly Integrated Assurance Meetings with regulators. Developing planning tools to better triangulate resources with activity. Operational plan has been submitted which should assure central funding to support cash needs.
Gaps in control and Actions to address				
BBB improvement programme supporting the Financial Recovery of the Trust. Entered block contract for 2018/19 to focus on system change instead of inter-organisational flows, but need to ensure demand is managed. Further engagement at senior level to ensure that CIP schemes are identified and implemented. Controls to capture and validate CIP and budget delivery.				

Strategic Objective Four - Our People: We will enable our people to give their best and achieve their best.				
Strategic Aim				
We will have effective and appreciative leadership throughout the organisation, creating a high performance environment where staff have clarity about what is expected of them, receive regular feedback and understand that poor performance will be addressed. Our employees will be engaged, committed to continuous improvement and embrace change. We will be an employer of choice.				
Board / Board Committee for review - Quality Committee				
Strategic Risks	**Initial Risk (CxL)**	**Current Risk (CxL)**	**Target Risk (CxL)**	**Assurance**
Recruit / Retain sufficient qualified staff The Trust may be unable to attract, recruit and retain high quality staff impacting on a continued dependency on temporary staff and safe staffing levels, affecting quality of care, and financial costs.	**16** (4x4)	**12** (4x3)	**4** (2x2)	The Trust has undertaken a huge recruitment drive locally, nationally and internationally, introducing recruitment and retention incentives. For the first time in late 2017 the Trust had more starters than leavers and this has been maintained. A pipeline of new recruits is regularly reviewed, showing the nursing new starters over the next 12 months is The directorates undertake reviews of roles, particularly in high vacancy areas to assess role redesign (including roles such as physicians associate and nurse associate) We are reviewing usage of the apprentice levy to support retention of staff (career development) and new opportunities with Henley Business School Shifts are reviewed on a daily basis and usage of the same temporary workers where possible to maintain continuity of care Retention group launched to share best practice and consider retention initiatives for nursing roles particular The Trust has developed a clinical compact for all senior clinicians of all professions - forming the basis of the promoting professionalism

				programme. The Trust has undertaken a review of our governance structures and processes. The Quality Assurance Committee is developing a Quality and Safety framework that will be used from the wards to the board. Medical Model and patient surveillance e.g. NEWS, Physician associate posts developed.

Gaps in control and Actions to address

Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).

We will continue to consider role redesign in hard to recruit areas (using case studies) or work from other NHS Trusts.

Risk Rating Guidance

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on Safety of Patients, Staff, Visitors	Minimal injury requiring no / minimal intervention or treatment. No time off work	Minor injury/illness requiring minor intervention Time off work <3 days Increase in LOS by 1-3 days Affects 1-2 people	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay 4-14 days RIDDOR/agency reportable incident An event which impacts on a small number of patients Affects (3-15) people	Major injury leading to long-term incapacity/disability >14 days off work Increase in LOS by >15 days Mismanagement of patient care with long term effects An event which impacts on moderate numbers (16-50)	Death Multiple permanent injuries or irreversible health effects An event which impacts on large numbers (>50)
Business objectives / projects	Insignificant cost increase / schedule slippage.	<5% over project budget	5-10% over budget	10-25% over budget	>25% over budget
Finance	Small loss <£1000	Loss of 0.1 -0.25 % of budget	Loss of 0.26-0.5% of budget	Loss of 0.51-1.0% of budget Uncertain delivery of key objectives Purchasers failing to pay on time	Loss of >1% of budget Non-delivery of key objectives Failure to meet specification/ slippage Loss of contract/service/payment by results

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality/Audit	Peripheral element or treatment or service suboptimal	Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Noncompliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
Complaints / Claims	Locally resolved complaint Potential for settlement /litigation <£500	Overall treatment /service substandard Formal justified complaint (stage 1) Claim <£10K	Justified complaint (stage 2, with potential to go to independent review) involving lack of appropriate care Claims between £10k - £100K	Multiple justified complaints Independent review Claim(s) between £100k - £1m	Multiple justified complaints Inquest (involving legal representation) ombudsman inquiry Multiple claims or single major claim Claim(s) >£1 million
Human resources	Low staff morale affecting one person	Low staff morale (1%-25% of staff)	Low staff morale (26%-50% of staff)	Very low staff morale (51%-75% of staff)	Very low staff morale >75%

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Organisational development /	Minor competency related failure reduces service quality <1 day	75% - 95% staff completing mandatory/key training	50% - 74% staff completing mandatory/key training	25% - 49% staff completing mandatory/key training	<25% of staff completing mandatory/key training
Staffing competence	Short term low staffing level temporarily reduces service quality (<1 day), Minor competency related failure reduces service quality <1 day	On-going low staffing level resulting in minor reduction in the quality of patient care, Unresolved trend relating to competency reducing service quality	Late delivery of key objective/service due to lack of staff, Unsafe staffing level > 1 day, Minor error due to ineffective training	Uncertain delivery of key objective/service due to lack of staff, Unsafe staffing level or competence (>5 days), Serious error due to ineffective training, Loss of key staff	Non-delivery of key objectives/service due to lack of staff, Ongoing unsafe staffing levels/competence, Loss of several key staff, Critical error due to insufficient training/competency
Compliance / Audit / Governance	Minor lapse in governance or process; affects one person; single instance of failure relating to human error with no patient harm; policy is out of date by < 1 month, minor non-compliance with standards/guidance	Non-compliance with policy or process in a single department; policy is out of date by < 2 months; affects up to 5 people but causes no patient harm; policy is out of date by < 2 months, Non-compliance with standards/guidance	Failure of governance/process impacting beyond a single department; policy out of date by 2-6 months; affects 5-20 people or results in patient harm; improvement or non-compliance notice received	Trust wide governance failure/multiple breaches; policy out of date > 6mths/non-existent; failure affects 20-50 people; Major non-compliance with core standards	Governance failure resulting in prosecution; gross failure in governance; significant patient harm and/or death, Prosecution, severely critical report, overall rating of inadequate against any of the CQC 5 questions

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public expectation not being met	Local media coverage Long term reduction in public confidence	National media coverage < than 3 days Confidence on organisation undermined Use of services affected	National media coverage with > 3 days service well below reasonable public expectation MP concern (questions in house) Total loss of public confidence
Service / business interruption	Loss/interruption of >1 hour, no impact on delivery of patient care/ability to provide services	Loss/interruption of >8 hours	Loss/Interruption of > 1 day Disruption causes unacceptable impact on patient care	Loss/interruption of > 1 week Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked Temporary service closure	Permanent loss of core service or facility Disruption to facility leading to significant knock-on effect across the local health economy
Environmental Impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
Agreed Targets	Not Applicable for this Risk Type	1% off planned Fail to meet National target 1 quarter	2%-4% off planned Fail to meet National target 2 qtrs. Amber light	5%-10% off planned. Fail to meet National target > 2 quarters Red light	>10% off planned Failure to meet National target > 2 quarters, by more than 20%

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Fire Safety/General Security	Minor short term (<1day) shortfall in fire safety system Security incident no adverse outcome	Temporary (<1 month) shortfall in fire safety system / single detector etc. (non-patient area) Security incident managed locally Controlled drug discrepancy accounted for	Fire code non-compliance / lack of single detector – patient area etc. Security incident leading to compromised staff / patient safety. Controlled drug discrepancy – not accounted for	Significant failure of critical component of fire safety system (patient area) Serious compromise of staff / patient safety	Failure of multiple critical components of fire safety system (high risk patient area) Infant / young person abduction
Information Governance / IT	Breach of confidentiality – no adverse outcome. Unplanned loss of IT facilities < half a day Health records / documentation incident – no adverse outcome	Minor breach of confidentiality – readily Resolvable Unplanned loss of IT facilities < 1 day Health records incident / documentation incident – readily resolvable	Moderate breach of confidentiality – complaint initiated Health records documentation incident – patient care affected with short term consequence	Serious breach of confidentiality – more than one person Unplanned loss of IT facilities >1 day but less than one week Health records / documentation incident – patient care affected with major consequence	Serious breach of confidentiality – large Numbers Unplanned loss of IT facilities >1 week Health records / documentation incident – catastrophic consequence

Table 2	Likelihood score
Level	**Description**
1 Rare	<3% probability. **Not expected to occur for years**, but may occur, but only in exceptional circumstances. • Loss, accident or illness could only occur under freak conditions • The situation is well managed and all reasonable precautions have been taken Ideally, this should be the normal state of the workplace
2 Unlikely	3%-10% probability. **Expected to occur at least annually**. The situation is generally well managed. However occasional lapses could occur. • This also applies to situations where people are required to behave safely in order to protect themselves but are well trained
3 Possible	11%-30% probability. **Expected to occur at least monthly**. • Insufficient or substandard controls in place • Loss is unlikely during normal operation, however, may occur in emergencies or non – routine conditions.
4 Likely	31%-90% probability. **Expected to occur at least weekly.** • Serious failures in management controls • The effects of human behaviour or other factors could cause an accident but is unlikely without this additional factor.
5 Almost Certain	>90% probability. **Expected to occur at least daily.** • Absence of any management controls • If conditions remain unchanged there is almost a 100% certainty that the hazard will be realised

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

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 05/07/2018

Agenda item 13a

Title of Report	**Workforce Report**
Prepared By:	Leon Hinton, Director of Operational HR
Lead Director	Leon Hinton, Director of Operational HR
Committees or Groups who have considered this report	Executive Team
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the hospital. The Trust's recruitment campaigns, including national, local and international have delivered 64 candidates to-date via Cpl, 177 candidates to-date via HCL. The initial Philippines recruitment plan for nursing continues with a total of 193 nurses being processed for posts at MFT. Trust turnover has increased to 11.97% (+0.08% from 11.89%), sickness remains under 4% at 3.44% (-0.35% from 3.83%), compliance with mandatory training compliance has improved to 86.6% (+0.23% from 86.4%) against target of 85%, appraisal compliance deteriorated to 82.2% (-5.1% from 87.3%) against target of 85%. There is no change to the percentage of pay bill spent on substantive staff between May and April (at 81%) but remains higher than 2017/18 average of 80% with an increase (of 2.5%) in agency usage and an decrease (of 2.5%) to bank usage. The profile of the organisation remains lower than average temporary staffing spend for 2017/18.
Resource Implications	None
Risk and Assurance	• Nurse Recruitment • Temporary Staffing Spend

Report to the Board of Directors

	The following activities are in place to mitigate this through: 1. Targeted campaign to attract local and national nurses 2. Update on overseas campaign 3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway 5. Agency/Temporary Staffing Workstream as part of the 2018/19 cost improvement programme
Legal Implications/Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators.
Improvement Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).
Quality Impact Assessment	Not applicable
Recommendation	Not applicable
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

Report to the Board of Directors

1 INTRODUCTION

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

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During May 2018, 20 FTE nurses joined the Trust on a substantive basis, alongside two FTE clinical support workers.

2.2 The international campaign in the Philippines continues. Harvey Nash, our international partner agency working on our Filipino nurse recruitment campaign, is continuing to process 193 of the Filipino nurses that remain engaged in the process (47 individuals have withdrawn or have failed to follow-up on the offer). One nurse joined the new six-week objective structured clinical examination (OSCE) training programme in February and successfully obtained her NMC registration in May.

2.3 An additional 12 international nurses undertook their OSCE exam in May and June. Of these, five passed the OSCE exam and the remainder will retake the exam in the coming weeks. A further 16 international nurses joined the OSCE programme in May and June.

2.4 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. One NMC pinned Cpl international neonatal nurse arrived in March, and a further 63 offers in process. Seven HCL nurses have commenced in post with a further 170 offers are in process (including 129 offers made during the recent Philippines Campaign trip).

2.5 The Trust is also working with six additional permanent recruitment agency providers: Person Anderson; Imperial MS, MSI Group, Xander Hendrix, We Solution, Blue Thistle. agency partners are working with the Trust on developing a pipeline of nurses with start dates from March 2018 onwards. The table below summarises the Trust's recruitment pipeline via all our partner agency providers:

Agency Provider	Commenced in post	Pipeline	Agency total	Anticipated starters over the next 12 months from pipeline
Harvey Nash	1	***193***	194	(5%) **10**
Cpl	1	***63***	64	(40%) **25**

Healthcare				
HCL	7	***170***	177	(40%) **68**
Person Anderson	17	***37***	54	(90%) **33**
Imperial MS	3	***31***	34	(40%) **12**
MSI Group	2	***7***	9	(40%) **3**
Xander Hendrix	1	***11***	12	(60%) **7**
We Solutions	0	***13***	13	(90%) **11**
Blue Thistle	0	***8***	8	(70%) **5**
Total	32	**533**	565	**174**

(Table 1: Nurse recruitment pipeline)

2.6 The Trust has commissioned the services of HealthSectorJobs (HSJ), a specialist health sector advertising company to undertake a four-week targeted nurse recruitment advertising campaign on behalf of the Trust, two nurses have been offered following this campaign. HSJ agreed a shared risk approach to this campaign. The Trust was also granted access to a Nursing CV database on a 12 week free trial (ended May 2018). This proactive recruitment approach has resulted in two band 7 nurses and one matron being shortlisted and booked for interview. A further 84 CVs have been download with 60 shortlisted by the clinical senior management team and contacted by the Resourcing Team to discuss working at the Trust.

2.7 The table below summarises offers made, starters and leavers for May 2018.

Role	Offers made in month	Actual Starters	Actual Leavers
Registered Nurses	29	20 (inc 13 pre-reg international)	12 (+23 TUPE out)
Clinical Support Workers	9	2	4

(Table 2: Monthly starters and leavers)

2.8 Two FTE consultants commenced in post in May: one oncoplastic breast surgeon and one consultant in respiratory medicine. Seven physician associates (masters training posts) are commencing in post on 24 June and a further physician associate is commencing in post in July.

2.9 The Trust has received confirmation of their allocation of training doctors for the August 2018 rotations across all specialties. The Trust anticipates that a number of any rotational gaps will be filled by Health Education Kent Surrey and Sussex (HEKSS) via their round two recruitment process. HEKSS will inform the Trust of final allocated numbers by end of June. As a precaution, vacant slots have been advertised in anticipation that HEKSS will not fill all vacant rotational slots.

3 DIRECTORATE METRICS

3.1 The table below (table 3) shows performance across five core indicators by directorate. Turnover, at 11.97% (+0.08% from April), remains above the tolerance level of 8%. Sickness absence (-0.39% at 3.44%) remains below the tolerance level of 4%. HR Business Partners will work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let's work together commissioned by Health Education England) and staff survey results.

3.2 Trust achievement review rate stands at 82.22% (-5.07%), below the Trust target of 85%, Mandatory training remains above target (at 86.63%, improvement by 0.23%) four successive months of improvement – three directorates are meeting the mandatory training target (Corporate, Planned Care and Estates & Facilities) and three directorates are meeting the achievement review target (Corporate, Planned Care and Estates & Facilities). A revised achievement review (AR) system was implemented across the Trust on 01 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 are included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics.

	Planned Care			Unplanned & Integrated Care			Corporate			Estates & Facilities			Trust		
	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend
Turnover rate (8%)	12%	▲		13%	▼		13%	▲		6%	▲		12%	▲	
Vacancy rate (12%)	17%	▼		23%	▲		12%	▼		14%	▲		19%	▲	
Sickness rate (4%)	4%	▼		3%	▼		3%	▲		4%	▼		3%	▼	
StatMan (85%)	87%	▲		84%	▲		96%	▲		85%	▲		87%	▲	
Appraisal (85%)	87%	▼		83%	▼		92%	▼		91%	▲		82%	▼	

(Table 3: Key workforce metrics)

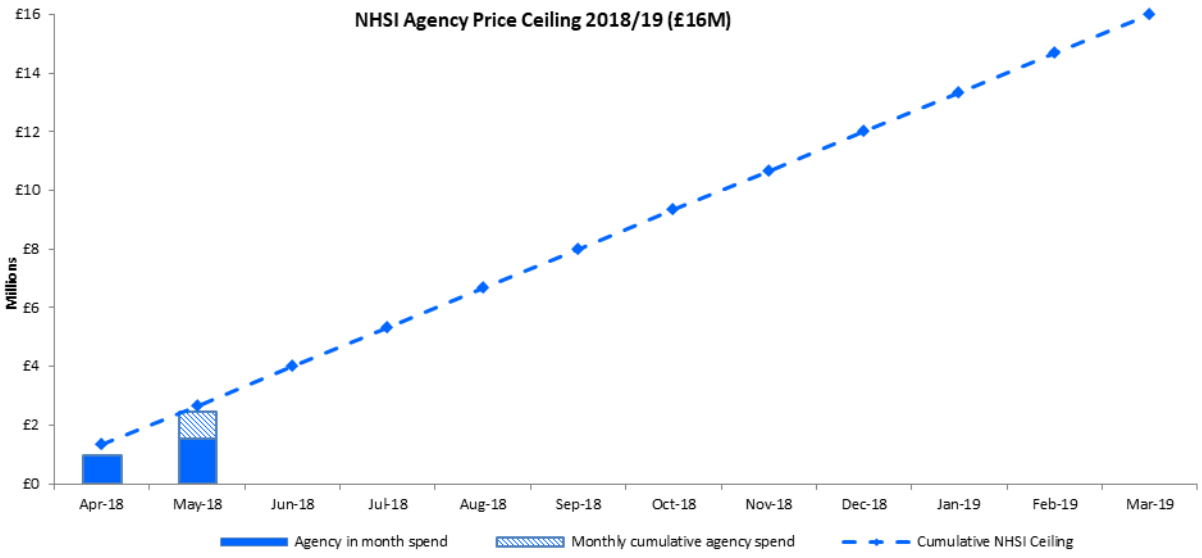
4 TEMPORARY STAFFING

4.1 Table 4 below demonstrates that temporary staffing expenditure increased in May compared to April.

		2016/17	2017/18	Apr-18	May-18
Spend	Agency	40,530,735	17,444,863	943,419	1,502,866
	Bank	8,438,690	25,329,117	2,307,191	2,003,992
	Substantive	164,147,453	171,098,554	13,904,703	14,328,856
% Pay bill	Agency	19%	8%	5.5%	8%
	Bank	4%	12%	13.5%	11%
	Substantive	77%	80%	81%	81%

(Table 4: Workforce profile based on contractual arrangement)

4.2 The agency cap breaches across all staff groups unchanged with approximately 80 price cap breaches per week. The Trust's NHSi annual agency celing has decreased from £21.6m in 2017/18 to £16m in 2018/19. Based on April and May's cumulative agency spend, the Trust is £226k below the NHSi agency ceiling cap target (on target).



(Chart 1: NHSI cumulative agency spend against cap)

4.3 Temporary nursing demand decreased in May compared to April (8,747 shifts requests in May compared to 9,824 shifts requests in April). The fill rate in May increased to 76% (+4%). Medical locum demand increased significant in April and May compared to previous months. The average requests for the first two months' of 2018/19 was 1,542 compared to a monthly average of 810 in 2017/18. Conversely the average fill rate increased to 58% in April and May compared to an average fill rate of 74% in 2017/18.

-End

Report to the Board of Directors

Board Date: 05/07/2018 Item No: 13b

Title of Report	**Workforce Race Equality Standard (WRES) Report 2018**
Presented By:	Leon Hinton, Director of HR Operations
Lead Director	Leon Hinton, Director of HR Operations
Committees or Groups who have considered this report	Executive Group Senior HR & OD team
Executive Summary	This report provides the annual Workforce Race Equality Standard summary (WRES) for 2018. This is an obligation under the NHS Standard Contract, and also provides the Trust with information to help achieve greater racial equality, as required by the Equality Act 2010. Indicator 2 (likelihood of BME candidates being appointed from shortlist, compared to White candidates), shows a deterioration compared to 2017 (1.33 to 1.2), but is an improvement since 2016. Medway performs better than average compared to other Acute Trusts and was one of only 26 Trusts performing better than the national position for England in 2017. Performance on Indicator 3 (relative likelihood of staff being in formal procedures) shows that White staff continue to be more likely than BME staff to be in formal procedures. The national picture is the reverse, with BME staff being more likely to be in formal procedures. Performance on Indicator 4 (access to non-mandatory training and continued professional development) shows continued improvement, whilst indicators 5-8 (measured through the 2017 Staff Survey) have deteriorated compared to the previous year (2016 Staff Survey). The deterioration in performance on indicators 5-8 is broadly similar to those of other Acute Trusts. The indicators from the Staff Survey are: • Indicator 5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months • Indicator 6 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months • Indicator 7 – Percentage believing that the trust provides

Report to the Board of Directors

	equal opportunities for career progression or promotion • Indicator 8 – In the last 12 months have you personally experienced discrimination at work form … manager/team leader or other colleagues? An action plan to address concerns and improve performance is set out in section 5 of this report.
Resource Implications	None identified at this stage. Any actions should be achieved within existing resources.
Risk and Assurance	Actions within the plan are designed to improve the Trust's performance on race equality, and maintain its reputation.
Legal Implications/Regulatory Requirements	The Equality Act 2010 requires all employers to demonstrate equality of opportunity for staff, as measured against nine Protected Characteristics, including Race. The Public Sector Equality Duty, contained within the Equality Act 2010, requires all public sector organisations to publish equality performance data on an annual basis; and the NHS Standard Contract requires all provider organisations to publish information on race equality in the form of the WRES summary.
Improvement Plan Implication	Aligns to Better, Best, Brilliant improvement programmes 8 – Building a sustainable workforce and 9 – Culture and engagement. Managing workforce equality is an essential element of making the Trust an employer of choice, and an enabler for organisational delivery.
Quality Impact Assessment	Not applicable.
Recommendation	To approve the publication of the Trust's Workforce Race Equality Standard Report (appended to this report).
Purpose & Actions required by the Board :	**Approval** ☒ **Assurance** ☐ **Discussion** ☒ **Noting** ☐

Report to the Board of Directors

1 EXECUTIVE SUMMARY

1.1 The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- to improve BME representation at the Board level of the organisation.

1.2 The WRES assessment has been prepared following revised technical guidance published by NHS England in March 2017. There are 9 performance indicators. Not included as an indicator, but essential to the quality of reporting, is the percentage of staff who have self-declared their ethnic origin. The Trust's performance on self-declaration is excellent, at 96.5%.

[For Indicators 2, 3 and 4, a score of 1.00 equals equity. A score of greater than 1.00 shows an advantage to White staff; a score of less than 1.00 shows an advantage to BME staff.]

1.3 Indicator 2 (likelihood of BME candidates being appointed from shortlist, compared to White candidates), for example, shows a deterioration compared to 2017 (1.33 from 1.2), but still an improvement since 2016. It is also worth noting that for that indicator, Medway performs better than average compared to other acute Trusts and was one of only 26 Trusts performing better than the national position for England (2017).

1.4 Performance on Indicator 3 (relative likelihood of staff being in formal procedures) shows that White staff continue to be more likely than BME staff to be in formal procedures. The national picture is the reverse, with BME staff being more likely to be in formal procedures.

1.5 Performance on Indicator 4 (access to non-mandatory training and continued professional development) shows continued improvement, whilst indicators 5-8 (measured through the 2017 Staff Survey) have deteriorated compared to the previous year. The deterioration in performance on indicators 5-8 is broadly similar to those of other acute trusts.

1.6 An action plan to address concerns and improve performance is set out in section 5.

2 BACKGROUND

2.1 The Five Year Forward View sets out a direction of travel for the NHS which depends on ensuring the NHS is innovative, engages and respects staff, and draws on the immense talent in our workforce. The evidence of the link between the treatment of staff and patient care is particularly well evidenced for Black and Minority Ethnic (BME) staff in the NHS, so this is an issue for patient care, not just for staff. The Equality and Diversity Council - representing the major national organisations in the NHS, proposed the Workforce Race Equality Standard, which supports and requires organisations to make these changes.

2.2 The NHS Workforce Race Equality Standard (WRES) was made available to the NHS from April 2015, following sustained engagement and consultation with key stakeholders including a widespread of NHS organisations across England. The WRES is included in the NHS standard contract, and since July 2015, NHS trusts have been producing and publishing their WRES data on an annual basis. Medway NHS Foundation Trust produced its first WRES report in 2016, which formed the baseline against future years' assessments can be compared.

2.3 The main purpose of the WRES is:

- to help local, and national, NHS organisations (and other organisations providing NHS services) to review their data against the nine WRES indicators,
- to produce action plans to close the gaps in workplace experience between white and Black and Ethnic Minority (BME) staff, and,
- to improve BME representation at the Board level of the organisation.

2.4 It is now a mandatory requirement in NHS standard contracts (Schedule 6a) to report on the WRES, including sign-off at Board level, before 31 July each year. The Trust must, therefore, publish its WRES following the Trust Board meeting on 5 July 2018.

2.5 The WRES Summary assessment is attached with this paper, and the key findings are set out below. The summary shows a mixture of positive and negative changes compared to 2017, but still an overall improvement compared to 2016. However, the assessment in 2018 also has more statistical accuracy than previous years, so effectively forms a new and improved baseline assessment.

3 KEY FINDINGS

3.1 The WRES assessment has been prepared following revised technical guidance published by NHS England in March 2017. There are 9 performance indicators. Not included as an indicator, but essential to the quality of reporting, is the percentage of staff who have self-declared their ethnic origin. The Trust's performance on self-declaration is excellent, at 96.5%.

[For indicators 2, 3 and 4, a score of 1.00 equals equity. A score of greater than 1.00 shows an advantage to White staff; a score of less than 1.00 shows an advantage to BME staff.]

Report to the Board of Directors

3.2 Indicator 1 – Workforce profile

Staff in each of the Agenda for Change (AfC) Bands 1-9 and VSM (including executive Board members) compared with staff in the overall workforce.

This information was required to be broken down not only by band, but also separating clinical, medical and dental and non-clinical staff. The data shows that there is an over representation of White staff at Band 2 (non-clinical), although it is likely to be due to staff at lower pay bands being recruited more from the local community than higher bands. The Trust's workforce is considerably more diverse than the local population. Additionally, the data shows that people from BME backgrounds are under-represented in all non-clinical roles from AfC Band 8b upwards, and in clinical roles from AfC Band 8c upwards (with the exception of Band 9).

There is significantly higher representation of people from BME backgrounds in medical and dental roles, which is reflective of the profile of their professions.

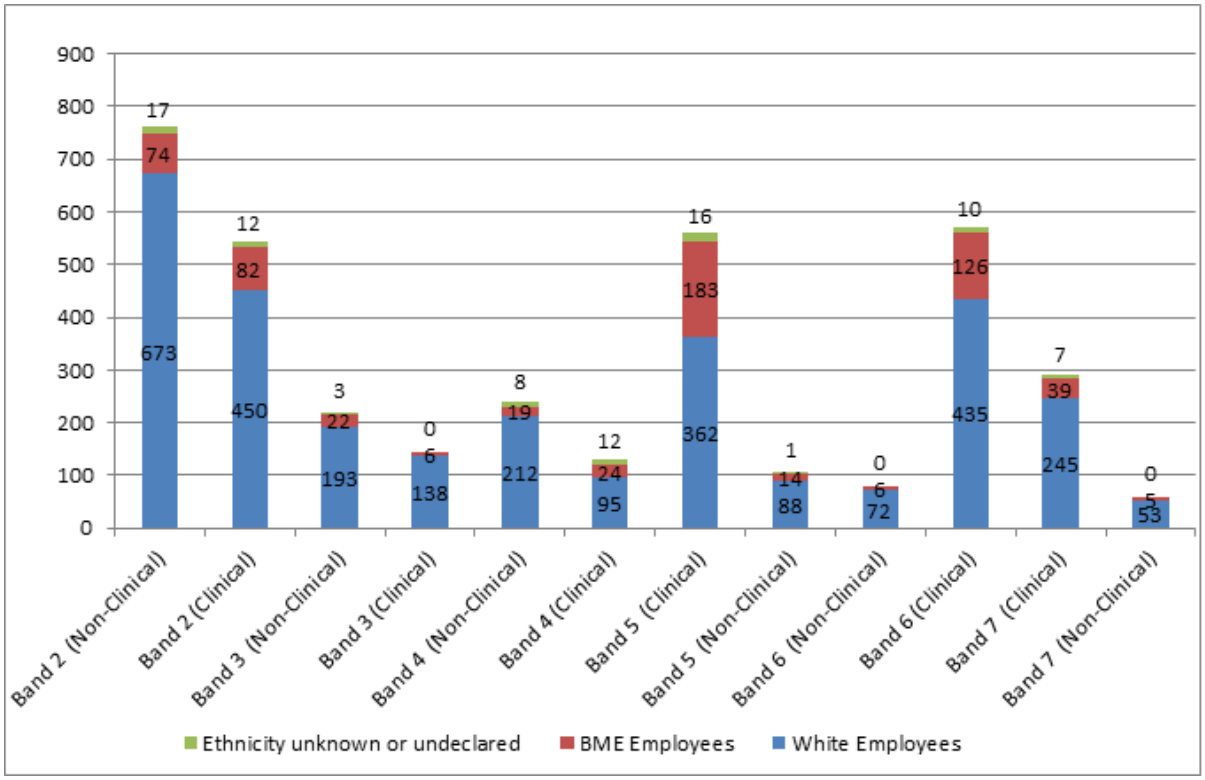


Table 1: Ethnicity (AfC Bands 2 to 7)

Report to the Board of Directors

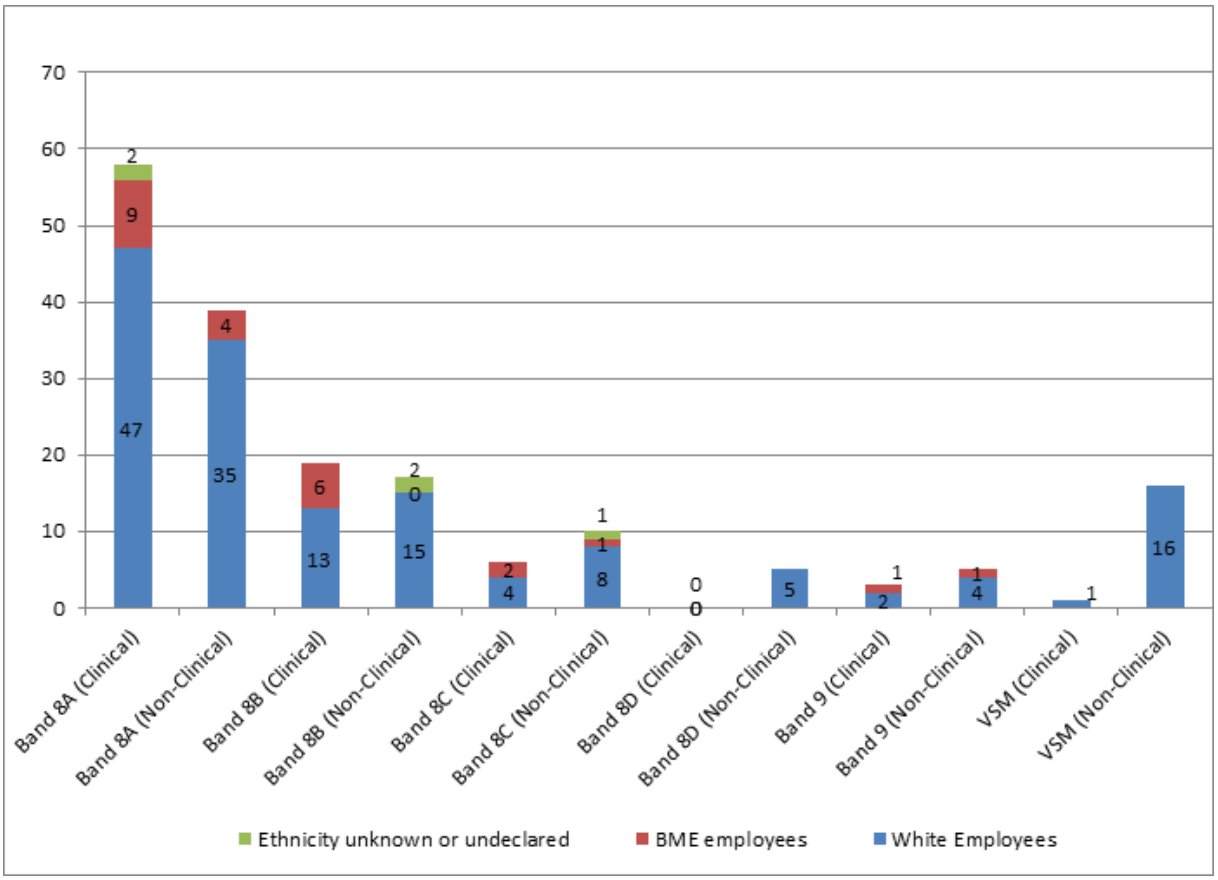


Table 2: Ethnicity (AfC Bands 8a to VSM)

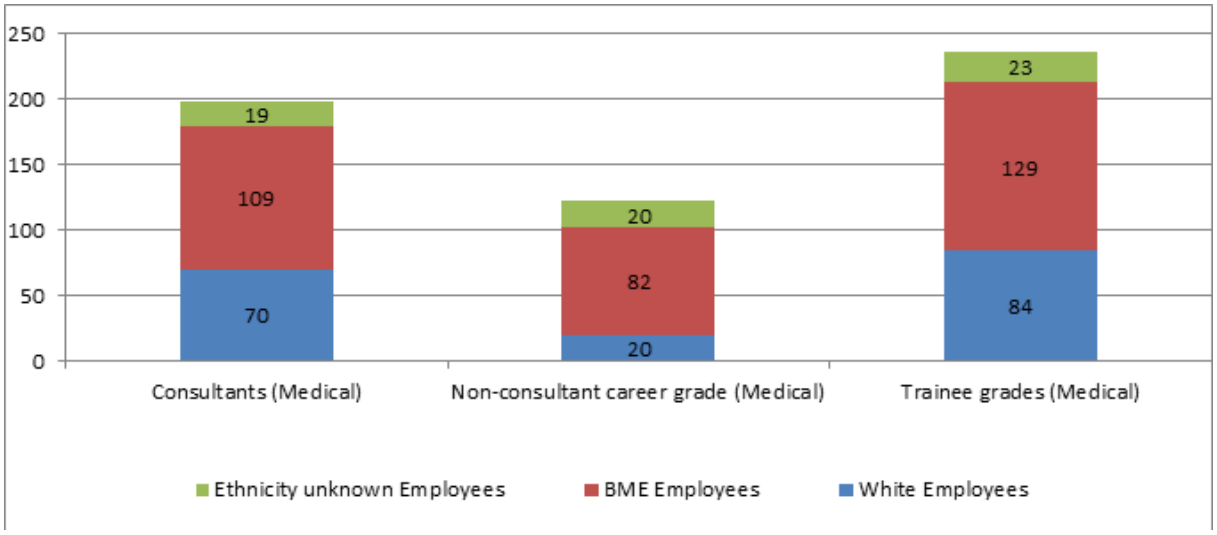


Table 3: Ethnicity (Medical and Dental)

3.3 **Indicator 2** - Relative likelihood of staff being appointed from shortlisting across all posts.

In 2015/16, White people shortlisted for interview were 2.58 times more likely than BME people to be appointed. In 2016/17 this gap narrowed to 1.20 times, but rose slightly in 2017/18 to 1.33 times. National benchmarking for 2018 is not yet available, but, for comparison the national benchmark for this indicator in 2017 was 1.6, and the benchmark for acute trusts was 1.58; so this Trust is performing better than average on this indicator. Whilst this is still an improvement on the situation in 2015/16, the reality is that White candidates still have a greater likelihood of being appointed than candidates from BME backgrounds. The increase in the gap between White and BME candidates from last year's report to this years' will need further investigation, including benchmarking with similar Trusts, and an internal assessment of unconscious bias of appointing panels. These will be conducted by September 2018.

Nevertheless, the Trust still aims for equality of opportunity in the appointments process, and will continue to include training on unconscious bias and affinity bias. From summer 2018, this is to be incorporated in a programme of recruitment training, which appointing managers will be required to complete.

3.4 **Indicator 3** - Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

A statistically small number of individuals (2.97% of the whole workforce) have entered formal disciplinary procedures in the past year. White staff continue to be more likely to enter formal procedures than those from BME backgrounds. The proportion of BME staff in formal procedures is falling, whilst the proportion of White staff in formal procedures is increasing. More work is needed to understand why this is, and an equality impact assessment of employee relations will be conducted in 2018/19.

Likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation			
WRES year	White employees	BME employees	**Relative likelihood (ratio)** (1.00 = equality)
2018	3.58%	1.61%	0.45
2017	1.22%	0.86%	0.71

3.5 **Indicator 4** - Relative likelihood of staff accessing non-mandatory training and CPD.

From this year onwards, NHS England's WRES team have asked all NHS organisations to explain their definition of non-mandatory training. As with previous years, this Trust defines access to non-mandatory training as being all training available via MOLLIE (the training management platform) with the exception of the 11 Statutory and Mandatory training courses under the Core Training Standards Framework. Continued Professional Development (CPD) is defined as courses provided by Universities and other external providers. In house professional development specific to individual clinical disciplines and medical education are not included.

The data for this indicator shows that there has been a performance improvement in the take-up of non-mandatory training and CPD in both 2016/17 and 2017/18. Staff from BME backgrounds are still marginally more likely to access non-mandatory, although White staff and BME staff are almost equally likely to access CPD. The indicator combines both scores, and the net effect is that staff from BME backgrounds are more likely to access training.

Likelihood of staff accessing non-mandatory training and CPD			
	White employees	BME employees	**Relative likelihood (ratio)** (1.00 = equality)
Overall	58.31%	68.68%	0.85
Non-Mandatory Training	51.03%	69.62%	0.73
CPD	4.92%	4.97%	0.99

3.6 **Indicators 5-8** – National NHS Staff Survey indicators

The Trust is clear that harassment, bullying and abuse is not acceptable as it impacts on wellbeing, productivity, turnover and patient care. Whilst actions have been taken to address this, the indicators 5, 6 and 8 show deterioration from the previous year, and the Trust is performing at or below national average.

The indicators from the Staff Survey are:

- Indicator 5 – Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months;
- Indicator 6 – Percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months;
- Indicator 7 – Percentage believing that the trust provides equal opportunities for career progression or promotion;
- Indicator 8 – In the last 12 months have you personally experienced discrimination at work form … manager/team leader or other colleagues?.

For indicator 7 (Percentage believing that trust provides equal opportunities for career progression or promotion), the percentage of staff giving a positive answer has fallen, particularly amongst BME staff.

Percentage believing that trust provides equal opportunities for career progression or promotion		
WRES year (staff survey year)	White employees	BME employees
2018 (2017)	79.76%	67.32%
2017 (2016)	87.10%	76.29%

There is now greater awareness in the Trust of equality and diversity (evidenced by increased compliance with mandatory training on equality and human rights and attendance at non-mandatory equality training), which may be contributing to greater awareness of potentially discriminatory practice.

Further investigation is needed, and is progressing, into the reasons why performance on these indicators has fallen. However, initial analysis indicates that the pattern is not consistent across the Trust.

3.7 **Indicator 9** - Percentage difference between the organisations' Board voting membership and its overall workforce

A marginal shift in this indicator is due only to a change in the size of the workforce. The Board had no voting or executive members from a BME background, although this will change in 2018/19 following a recent appointment. Given the low number of people involved, it is not appropriate to identify target dates for change, but the Trust will continue to identify action to encourage a wide range of suitable candidates at senior levels.

3.8 **Summary**

Performance against the WRES indicators 1, 2 and 9 in 2018 is broadly similar to 2017, and it is a significant improvement since 2016. Performance against indicator 3 shows year on year improvement, as does the Trust's performance on the proportion of staff who declare their ethnicity (now at 96.5%). For Indicator 4, performance appears to be worse in 2018, but it needs to be recognised that records on staff entering formal procedures are now significantly more accurate and consistent than previous years.

The most concerning indicators are those relating to the staff survey (Indicators 5 to 8), which have been the subject of a previous report. Performance on those indicators is poorer in 2017 staff survey than the previous year, but broadly similar to the year before (2015). Additionally, a more detailed analysis of the staff survey indicates that performance against these indicators varies across the Trust.

4 NEXT STEPS

4.1 The next steps fall into two categories: actions for the Trust to implement to improve on the WRES indicators in future years; and ensuring the publication of the WRES summary by 8 August 2018.

4.2 Actions to improve performance must be published on the Trust website. A summary of proposed actions is set out below (section 4). These actions will be incorporated in the Trust's EDS2 (equality delivery system) action plan, which is published annually as a part of the Trust's management information on equality, diversity and inclusion.

4.3 Publication of the WRES

The WRES summary will be published in July 2018, subject to approval by the Trust Board. This must be on the NHS England WRES portal and the Trust's website.

Report to the Board of Directors

5 ACTION PLAN

Indicator	Direction of Travel compared to:		Action	Timeframe	Responsibility
	2017	2016			
1 – Workforce Diversity	↔	↔	Continue to promote ESR self-service	Current and ongoing	Workforce Intelligence
2 - Recruitment	↓	↑	New Recruitment Training for appointing managers	September 2018 onwards	Resourcing Services and Organisational & Professional Development
3 – Formal Procedures	↔	↑	Equality analysis of reasons for White staff being more likely to be in formal procedures	September 2018	Employee Relations
4 – Training	↑	↑	Introduction of new IT platform to access training Equality Impact Assessment of Access to Non-mandatory training	August 2018 July 2018	Organisational and Professional Development
5-8 – Staff Survey	↓	↔	Programme of staff engagement activity	Current and ongoing to October 2018	Staff survey task group
9 – Board Membership	↑	↑	Review of methods and media for future recruitment of Non-Executive Directors and Senior managers.	September 2018	HR&OD Senior Team

6 RECOMMENDATIONS

6.1 It is recommended that the Workforce Race Equality Summary be received and approved for submission to The Trust Board, and then uploaded to The NHS England WRES Portal and the Trust's website.

Report to the Board of Directors

Appendix

WORKFORCE RACE EQUALITY STANDARD, SUMMARY REPORT, 2018

Board Report - Workforce WRES Rep

Workforce Race Equality Standards annual collection

as at March-2017

For any techincal queries or additional clarification relating to the collection please contact:

For any queries or additional clarification relating to submissions please contact: data.collections@nhs.net

Workforce Race Equality Standards

Validations
Please correct all issues listed within the table below. If the issues are not corrected then the pro forma will fail the validation stage in SDCS.

Trust - Frontsheet
Please complete all yellow answer cells on the 'Data for submission' tab. The 'Validation and Data Checks' tab can be used to identify which cells still need to be answered.

SubmissionTemplate
Workforce Race Equality Standards 2017/18 template

Answer Required
Auto Populated
N/A

INDICATOR		DATA ITEM		MEASURE	31st MARCH 2017						31st MARCH 2018						Notes
					WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
					Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce		**1a) Non Clinical workforce**														
		1	Under Band 1	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
		2	Band 1	Headcount	4	4	0	0	0	0	0	0	0	0	0	0	
		3	Band 2	Headcount	614	614	68	68	10	10	638	638	73	73	12	12	
		4	Band 3	Headcount	182	182	21	21	3	3	191	191	22	22	3	3	
		5	Band 4	Headcount	216	216	15	15	7	7	209	209	20	20	6	6	
		6	Band 5	Headcount	94	94	12	12	0	0	99	99	15	15	0	0	
		7	Band 6	Headcount	70	70	5	5	0	0	72	72	5	5	0	0	
		8	Band 7	Headcount	47	47	6	6	2	2	51	51	5	5	0	0	
		9	Band 8A	Headcount	25	25	5	5	0	0	33	33	4	4	0	0	
		10	Band 8B	Headcount	25	25	2	2	0	0	14	14	0	0	2	2	
		11	Band 8C	Headcount	9	9	1	1	1	1	8	8	1	1	1	1	
		12	Band 8D	Headcount	7	7	1	1	0	0	5	5	0	0	0	0	
		13	Band 9	Headcount	2	2	0	0	0	0	4	4	0	0	0	0	
		14	VSM	Headcount	5	5	0	0	0	0	5	5	0	0	0	0	
			1b) Clinical workforce of which Non Medical														
		15	Under Band 1	Headcount	0	0	0	0	0	0	0	0	0	0	0	0	
		16	Band 1	Headcount	14	14	3	3	0	0	0	0	0	0	0	0	
		17	Band 2	Headcount	537	537	85	85	9	9	464	464	89	89	8	8	
		18	Band 3	Headcount	141	141	9	9	1	1	135	135	4	4	0	0	
		19	Band 4	Headcount	79	79	13	13	4	4	97	97	27	27	10	10	
		20	Band 5	Headcount	398	398	186	186	18	18	350	350	185	185	15	15	
		21	Band 6	Headcount	454	454	126	126	11	11	432	432	127	127	7	7	
		22	Band 7	Headcount	254	254	35	35	5	5	242	242	39	39	7	7	
		23	Band 8A	Headcount	60	60	9	9	0	0	49	49	11	11	0	0	
		24	Band 8B	Headcount	9	9	3	3	0	0	13	13	6	6	0	0	
		25	Band 8C	Headcount	3	3	2	2	0	0	4	4	2	2	0	0	
		26	Band 8D	Headcount	1	1	1	1	0	0	0	0	0	0	0	0	
		27	Band 9	Headcount	0	0	0	0	0	0	0	0	1	1	0	0	
		28	VSM	Headcount	4	4	2	2	1	1	6	6	2	2	0	0	
			Of which Medical & Dental														
		29	Consultants	Headcount	67	67	110	110	8	8	68	68	119	119	6	6	
		30	*of which Senior medical manager*	Headcount													
		31	Non-consultant career grade	Headcount	28	28	82	82	8	8	22	22	102	102	12	12	
		32	Trainee grades	Headcount	89	89	119	119	0	0	23	23	66	66	6	6	
		33	Other	Headcount	1	1	4	4	15	15	60	60	68	68	7	7	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants	Headcount								1667		902		89	
		35	Number appointed from shortlisting	Headcount								439		178		35	
		36	Relative likelihood of shortlisting/appointed	Auto calculated		0.3372461929		0.2805860806		0.0000000000		0.2633473305		0.1973392461		0.3932584270	
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated		1.20						1.33					
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce	Auto calculated							3294	3294	993	993	102	102	
		39	Number of staff entering the formal disciplinary process	Headcount								118		16		0	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated		0.0122341975		0.0086486486		0.0000000000		0.0358227080		0.0161127895		0.0000000000	
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated				0.71						0.45			

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Answer Required
Auto Populated
N/A

INDICATOR		DATA ITEM		MEASURE	31st MARCH 2017						31st MARCH 2018						Notes
					WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
4	**Relative likelihood of staff accessing non-mandatory training and CPD**	42	Number of staff in workforce (White)	Auto calculated								3294		993		102	
		43	Number of staff accessing non-mandatory training and CPD (White):	Headcount								1921		682		92	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated		0.6090882610		0.7427027027		0.0000000000		0.5831815422		0.6868076536		0.9019607843	
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated		0.82						0.85					
5	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**	46	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage	27.91%		25.99%				27.14%		29.08%				
6	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**	47	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage	27.13%		27.74%				28.40%		31.80%				
7	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**	48	% staff believing that trust provides equal opportunities for career progression or promotion	Percentage	87.10%		76.29%				79.76%		67.32%				
8	**Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**	49	% staff personally experienced discrimination at work from Manager/team leader or other colleague	Percentage	6.94%		13.00%				8.27%		16.17%				
9	**Percentage difference between the organisations' Board voting membership and its overall workforce** **Note: Only voting members of the Board should be included when considering this indicator**	50	Total Board members	Headcount		18		0		0		18		0		0	
		51	*of which: Voting Board members*	Headcount		13		0		0		13		0		0	
		52	*: Non Voting Board members*	Auto calculated		5		0		0		5		0		0	
		53	Total Board members	Auto calculated		18		0		0		18		0		0	
		54	*of which: Exec Board members*	Headcount		6		0		0		6		0		0	
		55	*: Non Executive Board members*	Auto calculated		12		0		0		12		0		0	
		56	Number of staff in overall workforce	Auto calculated		3439		925		103		3294		993		102	
		57	Total Board members - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		58	Voting Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		59	Non Voting Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		60	Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		61	Non Executive Board Member - % by Ethnicity	Auto calculated		100.0%		0.0%		0.0%		100.0%		0.0%		0.0%	
		62	Overall workforce - % by Ethnicity	Auto calculated	0.00%	77.0%	0.00%	20.7%	0.00%	2.3%	0.00%	75.1%		22.6%		2.3%	
		63	Difference (Total Board -Overall workforce)	Auto calculated		23.0%		-20.7%		-2.3%		24.9%		-22.6%		-2.3%	

SubmissionTemplate
Workforce Race Equality Standards 2017/18 template

INDICATOR		DATA ITEM		MEASURE	31st MARCH 2017						31st MARCH 2018						Notes
					WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
			1a) Non Clinical workforce		Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures		Verified figures	Prepopulated figures	Verified figures	Prepopulated figures	Verified figures	
		1	Under Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		2	Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		3	Band 2	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		4	Band 3	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		5	Band 4	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		6	Band 5	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		7	Band 6	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		8	Band 7	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		9	Band 8A	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		10	Band 8B	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		11	Band 8C	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		12	Band 8D	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		13	Band 9	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		14	VSM	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
1	Percentage of staff in each of the AfC Bands 1-9 OR Medical and Dental subgroups and VSM (including executive Board members) compared with the percentage of staff in the overall workforce		1b) Clinical workforce of which Non Medical														
		15	Under Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		16	Band 1	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		17	Band 2	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		18	Band 3	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		19	Band 4	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		20	Band 5	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		21	Band 6	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		22	Band 7	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		23	Band 8A	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		24	Band 8B	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		25	Band 8C	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		26	Band 8D	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		27	Band 9	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		28	VSM	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
			Of which Medical & Dental														
		29	Consultants	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		30	*of which Senior medical manager*	Headcount		No Data		No Data		No Data		No Data		No Data		No Data	
		31	Non-consultant career grade	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		32	Trainee grades	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
		33	Other	Headcount	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	OK	
2	Relative likelihood of staff being appointed from shortlisting across all posts	34	Number of shortlisted applicants	Headcount				OK		OK		Good		Good		OK	
		35	Number appointed from shortlisting	Headcount				OK		OK		Good		Good		OK	
		36	Relative likelihood of shortlisting/appointed	Auto calculated													
		37	Relative likelihood of White staff being appointed from shortlisting compared to BME staff	Auto calculated													
3	Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation Note: This indicator will be based on data from a two year rolling average of the current year and the previous year	38	Number of staff in workforce	Auto calculated													
		39	Number of staff entering the formal disciplinary process	Headcount								Good		Good		Good	
		40	Likelihood of staff entering the formal disciplinary process	Auto calculated													
		41	Relative likelihood of BME staff entering the formal disciplinary process compared to White staff	Auto calculated													

SubmissionTemplate
Workforce Race Equality Standards 2017/18 template

	INDICATOR	DATA ITEM		MEASURE	31st MARCH 2017						31st MARCH 2018						Notes
					WHITE		BME		ETHNICITY UNKNOWN/NULL		WHITE		BME		ETHNICITY UNKNOWN/NULL		
4	**Relative likelihood of staff accessing non-mandatory training and CPD**	42	Number of staff in workforce (White)	Auto calculated													
		43	Number of staff accessing non-mandatory training and CPD (White):	Headcount								Good		Good		Good	
		44	Likelihood of staff accessing non-mandatory training and CPD	Auto calculated													
		45	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	Auto calculated													
5	**KF 25. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months**	46	% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months	Percentage													
6	**KF 26. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months**	47	% of staff experiencing harassment, bullying or abuse from staff in last 12 months	Percentage													
7	**KF 21. Percentage believing that trust provides equal opportunities for career progression or promotion**	48	% staff believing that trust provides equal opportunities for career progression or promotion	Percentage													
8	**Q17. In the last 12 months have you personally experienced discrimination at work from any of the following? b) Manager/team leader or other colleagues**	49	% staff personally experienced discrimination at work from Manager/team leader or other colleague	Percentage													
9	**Percentage difference between the organisations' Board voting membership and its overall workforce** **Note: Only voting members of the Board should be included when considering this indicator**	50	Total Board members	Headcount		Good		Good		Good		Good		Good		Good	
		51	*of which: Voting Board members*	Headcount		Good		Good		Good		Good		Good		Good	
		52	*: Non Voting Board members*	Auto calculated													
		53	Total Board members	Auto calculated													
		54	*of which: Exec Board members*	Headcount		Good		Good		Good		Good		Good		Good	
		55	*: Non Executive Board members*	Auto calculated													
		56	Number of staff in overall workforce	Auto calculated													
		57	Total Board members - % by Ethnicity	Auto calculated													
		58	Voting Board Member - % by Ethnicity	Auto calculated													
		59	Non Voting Board Member - % by Ethnicity	Auto calculated													
		60	Executive Board Member - % by Ethnicity	Auto calculated													
		61	Non Executive Board Member - % by Ethnicity	Auto calculated													
		62	Overall workforce - % by Ethnicity	Auto calculated													
		63	Difference (Total Board -Overall workforce)	Auto calculated													

Report to the Board of Directors

Board Date: 05/07/2018

Agenda item 13c

Title of Report	**Freedom to Speak Up (FTSU) Self-Assessment**
Prepared By:	Rita Lawrence, Head of Culture & Engagement
Lead Director	James Devine, Deputy Chief Executive and Executive Director of HR & OD
Committees or Groups who have considered this report	Executive Team
Executive Summary	In May 2018, NHS Improvement (NHSI) Freedom to Speak Up (FTSU) self-assessment toolkit was issued to Trusts. Following a self-assessment an action plan has been written to address newly-clarified requirements as part of the FTSU duties and Board assurances and requirements. A total of 23 criteria are currently fully-met, 33 partially met and 11 are not met. An action plan with associated leads, actions, timescales and an audit cycle is provided.
Resource Implications	None identified at this stage
Risk and Assurance	Development of an action plan will enable the Trust to mitigate the duty gaps associated with the clarifications of FTSU processes, governance, support and assurances.
Legal Implications/Regulatory Requirements	To provide assurances in meeting Freedom to Speak Up and associated legal frameworks and policy (Freedom to Speak Up review; NHS Constitution; Public Interest Disclosure Act 1998; Enterprise and Regulatory Reform Act 2013; The Bribery Act; Whistleblowing Arrangements Code of Practice)
Improvement Plan Implication	Freedom to speak up crosses all Better, Best, Brilliant programmes.
Quality Impact Assessment	Not applicable
Recommendation	To note the actions associated with the self-assessment.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

Report to the Board of Directors

1 EXECUTIVE SUMMARY

1.1 In May 2018, NHS Improvement (NHSI) Freedom to Speak Up (FTSU) self-assessment toolkit was issued to Trusts. Following a self-assessment an action plan has been written to address newly-clarified requirements as part of the FTSU duties and Board assurances and requirements.

1.2 A total of 23 criteria are currently fully-met, 33 partially met and 11 are not met. An action plan with associated leads, actions, timescales and an audit cycle is provided.

2 INTRODUCTION

2.1 The NHS Improvement (NHSI) Freedom to Speak Up (FTSU) self-assessment toolkit was issued to NHS Trusts in May 2018. The toolkit provides guidance and sets expectations of Boards in relation to FTSU with the expected outcome of a Board with a cultural responsiveness to feedback and focused on learning and continual improvement. The toolkit specifically identifies areas of development and improvement across FTSU strategy, policy, Board interaction, FTSU Guardian role clarity and embedding culture throughout organisation.

2.2 The self-assessment toolkit and guidance provides a new, granular level of detail for organisations to further embed FTSU; this includes specific, new requirements. The output of the self-assessment forms the basis for this report and the associated action plan.

3 SELF ASSESSMENT RESULTS

3.1 Chart 1 below denotes the results of the June 2018 self-assessment.

3.2 A total of 23 criteria are currently fully-met, 33 partially met and 11 are not met.

3.3 A full list of each criteria, actions to remedy, lead and timescales is highlighted as per appendix I.

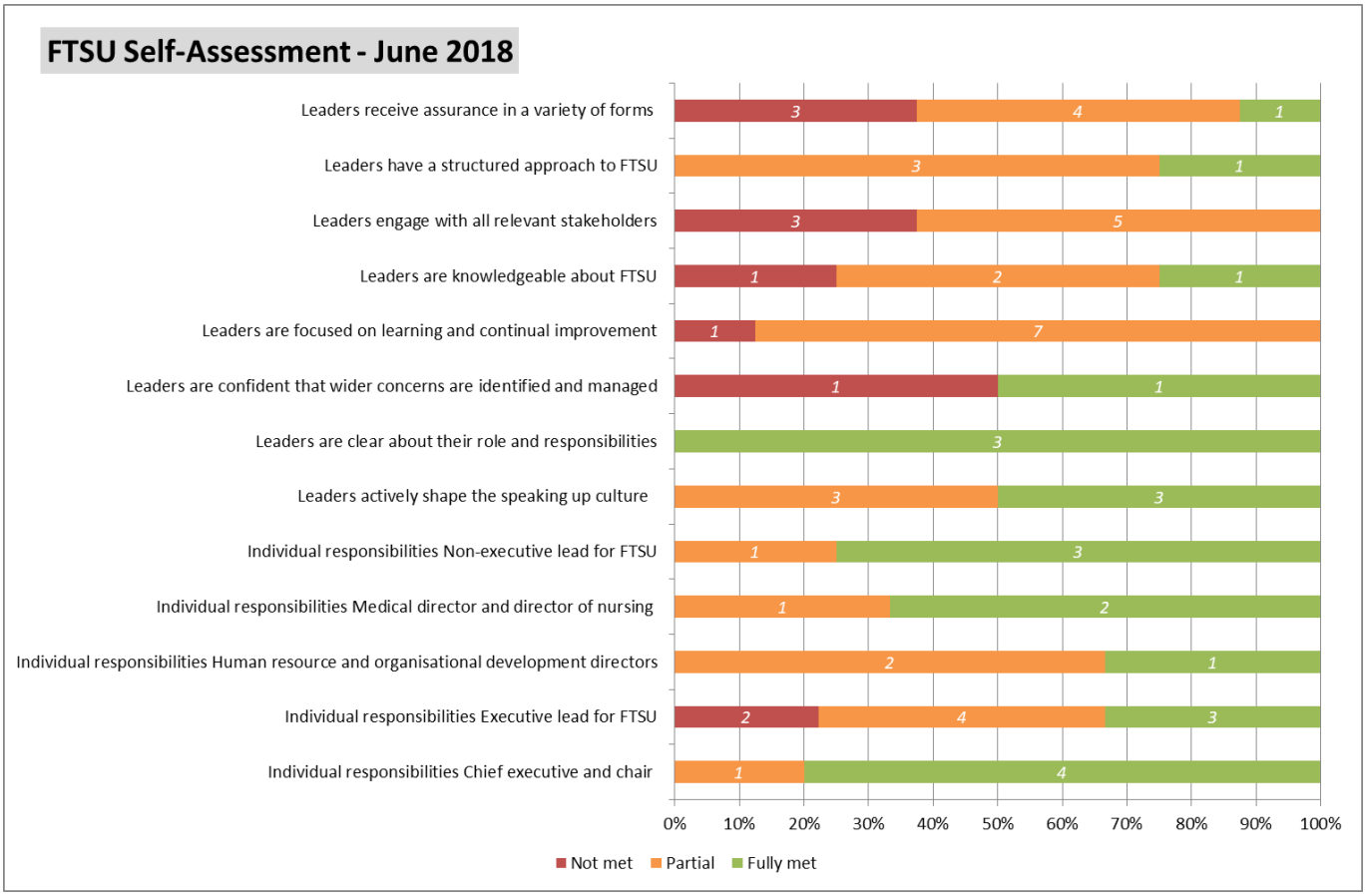


Chart 1: Self-Assessment June 2018

4 ACTION PLAN

4.1 As a result of the new granular-level of expectations of the FTSU Guardian and Board, appendix I highlights the remedial actions, leads and timescales. This can largely be sectioned into three main actions:

4.1.1 Create the FTSU outline and plan, to address and confirm each criteria building upon the existing FTSU guidelines, this will include confirming the model job description, confirming the structures, agreeing content of Board reports and assurance. August 2018, Head of Culture & Engagement;

4.1.2 Hold a FTSU reflection session, annual review with stakeholders and scene-setting for forthcoming year. September 2018, Head of Culture & Engagement;

4.1.3 Determine FTSU communications plan, refresh of messaging and engagement models across organisation. October 2018, Head of Culture & Engagement;

4.1.4 Introduce FTSU annual auditing by Deputy Director of HR & OD against FTSU processes, plan and criteria. The self-assessment will then be carried out annually in September.

4.2 Appendix II highlights the annual reporting cycles and review meetings between FTSU guardians and Chief Executive.

- End

Report to the Board of Directors

APPENDIX I: SELF-ASSESSMENT (FULL)

Self review indicator **(Aligned to well-led KLOEs)**	**To what extent is this expectation being met?**	**What are the principal actions required for development?**	**How is the board assured it is meeting the expectation?** Evidence
Our expectations			
Leaders are knowledgeable about FTSU			
Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office.	Fully met through the variety of comms since the inception of FTSU Guardians	Implementation of the model job description for new reporting structure. Model JD Relaunch of the Guardian role following appointment of new NED (previous one left), and introduction of peer messengers following implementation of behavioural reporting tool	Twice yearly report to the Trust Board with CEO/Guardian meets once per quarter.
Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up.	Partial	A relaunch of the Guardian role will enable us to better promote the FTSU vision – we have held reflection events with the FTSU Guardians, where we shared what has gone well, and what can be improved. *[FTSU Outline & Plan – (Meeting with CEO) August 18, Head of Culture & Engagement (HoC&E)]*	Twice yearly report to the Trust Board plus feedback from the nominated non-executive director
They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up.	Not met	The reflection session mentioned above raised the gaps in relation to ongoing support for the Guardians, and a clear vision/strategy. These will be in place and reported via the twice yearly Board papers. *[FTSU reflection session – September 18, HoC&E]*	Twice yearly Board paper Feedback from CEO from 4 times yearly meetings Anecdotal feedback from nominated non-executive director Trust reports to national guardians

			office, 4 times per year
Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.	Partial	Focussed reflection session for Board members on FTSU *[FTSU reflection session – September 18, HoC&E]*	Every Person Counts campaign (part of the values)
Leaders have a structured approach to FTSU			
There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement.	Partial	A clear vision / strategy needs to be developed in conjunction with leaders, guardians and with NED support – the 'Every Person Counts' campaign talks to the role of the FTSU guardians, and questions regarding speaking up feature within the staff survey *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	Trust Board staff survey presentation Twice yearly FTSU Board papers
There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement.	Fully met	Ongoing review	Noting by the non-executive director
The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian) and it aligns with existing guidance from the National Guardian.	Partial	The Trust policy is lifted by the national raising concerns policy Further work is required on a local strategy *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	Twice yearly Board papers Evidence of a FTSU strategy
Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative	Partial	Whilst a clearer set of measures need to be defined, agreed and regularly reviewed, the Board papers do provide information on number of cases received, and themes. These have been discussed in meetings with the	Twice yearly Board papers Evidence of FTSU strategy

measures.		FTSU Guardians, along with the CEO and HR Director. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	Theme analysis of reporting by area
Leaders actively shape the speaking up culture			
All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up.	Fully met	Messaging, nudge etc. need to be included in all appropriate channels so that leaders can actively shape the way this type of culture can be lived in the Trust.	Trust Board discussion/minutes evidence robust discussion on developing a culture of safety, improvement etc. Staff survey presentation (results) Twice yearly Board paper
They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty.	Fully met	Need to join up / lessons learnt from FTSU and other associated processes. To be included in clinical board/ nursing board meetings on a regular basis.	Trust Board discussion/minutes evidence robust discussion on developing a culture of safety, improvement etc. Board sub-groups (quality assurance committee) Staff survey presentation (results) Twice yearly Board paper
Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers.	Fully met	Relaunch Guardian role along with the Promoting Professionalism Pyramid (PPP) model to ensure all staff are aware of how to report concerns.	GEMBA Executive footprints DATIX Walkarounds Staff survey Twice yearly Board paper

			Annual reflection session with FTSU Guardians
Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian.	Partial	The FTSU role at MFT is relatively new – the reflection session with the guardians showed areas that we can improve, which we are all committed to achieving. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
Senior leaders model speaking up by acknowledging mistakes and making improvements.	Partial	Open and transparent communication and behaviours need to be role modelled by all leaders. Further embedding of culture programme and 'every person counts' domain *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	Staff survey presentation (results)
1. The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.	Partial	*[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	Staff survey presentation (results) Twice yearly Board presentation Feedback from non-executive director
Leaders are clear about their role and responsibilities			
The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility.	Fully met	Newly appointed NED has asked for suitable training/ awareness.	Confirmation of named non-executive director
They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support.	Fully met	Review current reporting framework for efficiency at annual reflection session in September	4 times yearly meet with CEO Annual reflection session with CEO, NED

			and HR Director 4 times yearly reporting to national guardians office Ad hoc meetings with CEO and HR Director
Other senior leaders support the FTSU Guardian as required.	Fully met	Leadership teams support Guardians with reasonable time off	FTSU strategy FTSU reporting structure FTSU (Raising concerns) policy
Leaders are confident that wider concerns are identified and managed			
Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns.	Not met	Need to agree a robust reporting system and links with DATIX. Guardians to lead and theme as appropriate as well as knowing who to raise with when issues occur. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
2. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.	Fully met	Yes and needs to be formally agreed through new reporting structure.	FTSU guardians have access to the CEO and Deputy CEO/HR Director and frequently contact them
Leaders receive assurance in a variety of forms			
Workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process.	Not met	Need to be more proactive in how we communicate (trust wide and via usual directorate methods. Leaders need to openly talk about this day to day. *[FTSU Communication Plan – October 18, HoC&E]*	

Steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers	Not met	Align the work of the FTSU guardians and the Head of Equality and Inclusion *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
Speak up issues that raise immediate patient safety concerns are quickly escalated	Fully met	Ongoing review	Twice yearly Board paper Annual reflection session
Action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority	Partial	No current issues but commitment to deal with such an issue *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
Lessons learnt are shared widely both within relevant service areas and across the trust	Not met	Need to include a proactive method of lessons learnt as part of new structure led by guardians. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
The handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented	Partial	*[FTSU Audit – September 18, Deputy Director of HR & OD]*	Annual audit report by Deputy Director of HR & OD to Board.
FTSU policies and procedures are reviewed and improved using feedback from workers	Partial	Guardians to help to test with staff through their interactions. Policy is reviewed as part of the policy approval group *[FTSU Audit – September 18, Deputy Director of HR & OD]*	Policy approval group minutes
The board receives a report, at least every six months, from the FTSU Guardian.	Partial	Confirmed structure now in place for this to occur *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	Copy of reporting structure

Report to the Board of Directors

Leaders engage with all relevant stakeholders			
3. A diverse range of workers' views are sought, heard and acted upon to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.	Not met	Guardians to identify ways in which this could be built into the future. *[FTSU reflection session – September 18, HoC&E]*	Reflection session
Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement.	Partial. Discussed during last CQC inspection	Currently awaiting results and actions as appropriate. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals).	Not met	Reporting structure now has this on the Board agenda twice per year *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	Twice yearly Board paper
The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture.	Partial	Reporting structure now has this on the Board agenda twice per year *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	Twice yearly Board paper
4. Reviews and audits are shared externally to support improvement elsewhere.	Not met	Reviews and audits are discussed externally at the CQC inspection under KLOE *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the	Partial	Ongoing – the Trust engages with the national guardians office, the FTSU attend events/training at the national office	

trust's speaking up culture		[*FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
5. Senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians	Partly – able to attend regional guardians meetings	Annual reflection session FTSU guardians meet with CQC inspectors *[FTSU Communication Plan – October 18, HoC&E]*	
6. Senior leaders request external improvement support when required.	Partial	Hasn't been required to date, but commitment to do so if required	
Leaders are focused on learning and continual improvement			
Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience.	Partial	*[FTSU Communication Plan – October 18, HoC&E]*	Twice yearly Board paper
Senior leaders and the FTSU Guardian engage with other trusts to identify best practice.	Partial	Embed a way of working to enable senior leaders to do this without permission to learn from best practice elsewhere e.g. Trust values. *[FTSU Communication Plan – October 18, HoC&E]*	Twice yearly Board paper
Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities.	Partial	Will be discussed at annual reflection session, and the 4 times yearly meetings with CEO *[FTSU Communication Plan – October 18, HoC&E]*	
7. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.	Partial	Will be discussed at annual reflection session, and the 4 times yearly meetings with CEO *[FTSU Communication Plan – October 18, HoC&E]*	

8. The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.	Partial	Review data from Board papers and agree action with FTSU guardians at 4 times yearly meeting Meetings have occurred with Guardians to review what has gone well, and what can be improved *[FTSU Communication Plan – October 18, HoC&E]*	
The FTSU policy and process is reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them.	Partial	The policy is reviewed as part of the Trusts policy review group – further work is required to include feedback, analysis and inclusion data *[FTSU Communication Plan – October 18, HoC&E]*	
A sample of cases is quality assured to ensure: • the investigation process is of high quality; that outcomes and recommendations are reasonable and that the impact of change is being measured • workers are thanked for speaking up, are kept up to date though out the investigation and are told of the outcome • Investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored	Partial	Whilst the review meetings that have taken place have discussed these issues (as will the annual reflection session), a further review should be undertaken using current cases and agree how often this will be completed going forward. Lead guardian is responsible and working with colleagues. Process for going back to the individual need to be refined and must be from the guardian who issue was raised with. Work with HR team and other appropriate leads on a case/ by case basis. Need to agree a process for investigations and review to ensure fit for purpose. *[FTSU Communication Plan – October 18, HoC&E]*	

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up.	Not met	The relaunch of the FTSU guardian role will include cases and impact [*FTSU Communication Plan – October 18, HoC&E]*	
Individual responsibilities			
Chief executive and chair			
The chief executive is responsible for appointing the FTSU Guardian.	Fully met	Trust currently has 5.	
The chief executive is accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust.	Fully met	Yes	
The chief executive and chair are responsible for ensuring the annual report contains information about FTSU.	Fully met	Yes	
9. The chief executive and chair are responsible for ensuring the trust is engaged with both the regional Guardian network and the National Guardian's Office.	Fully met	Yes	
10. Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.	Partial	Structured meetings are in place with the CEO, but not yet the Chair. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	

Report to the Board of Directors

Executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Fully met	Yes	
Overseeing the creation of the FTSU vision and strategy.	Fully met		
11. Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian.	Fully met	Yes	
12. Ensuring that the FTSU Guardian has a suitable amount of ring fenced time and other resources and there is cover for planned and unplanned absence.	Partial	Same principles applied as those afforded to trade union representatives *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	

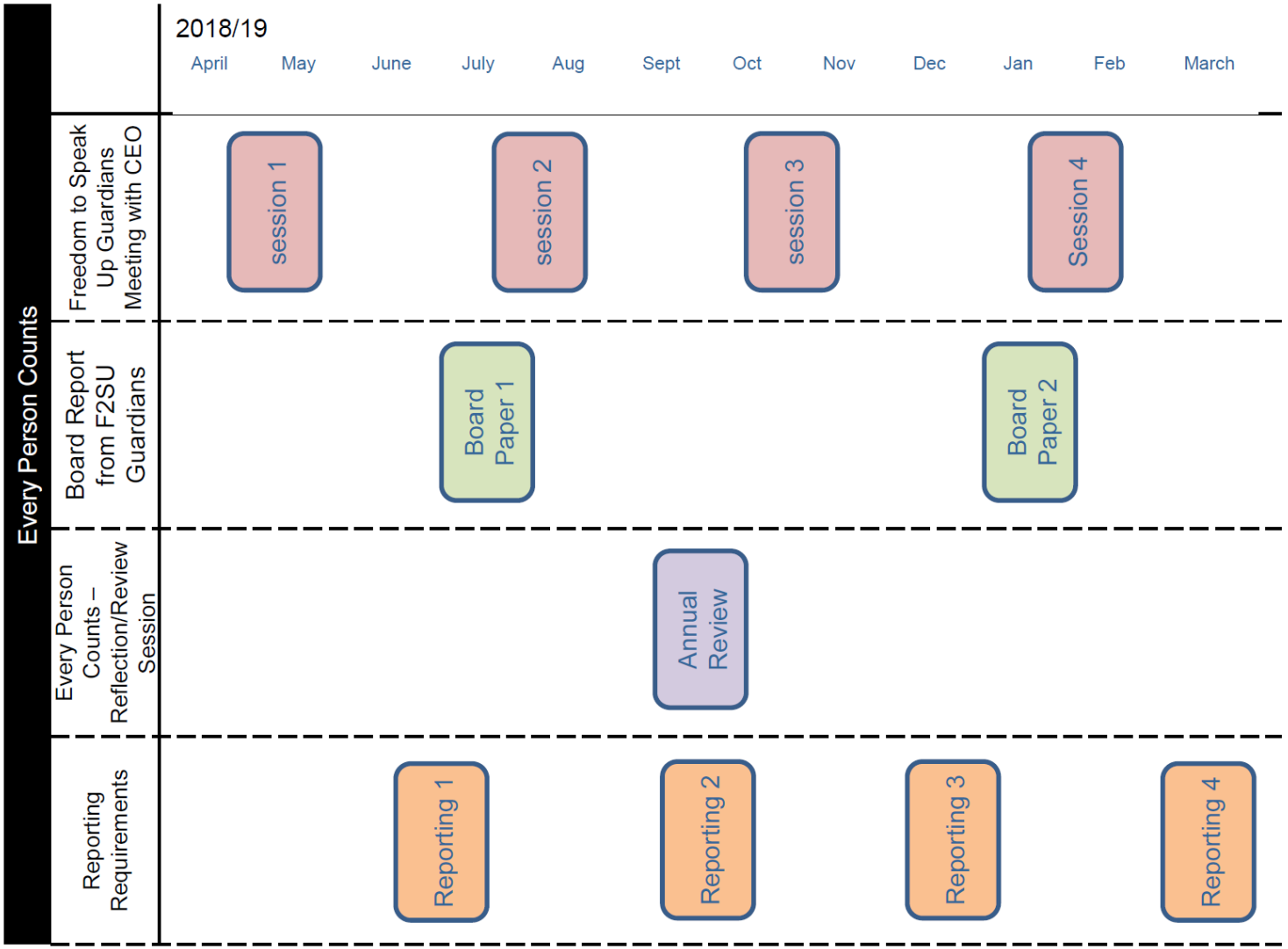
Ensuring that a sample of speaking up cases have been quality assured.	Not met	Lead guardian to oversee cases once a quarter / utilising other guardians to ensure all cases are uploaded on system – need to agree quality measures for cases to be reviewed against [*FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
Conducting an annual review of the strategy, policy and process.	Partial	*[FTSU Audit – September 18, Deputy Director of HR & OD]*	
Operationalising the learning derived from speaking up issues.	Partial	Need to look into themes and where appropriate design some short bite size training sessions. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
Ensuring allegations of detriment are promptly and fairly investigated and acted on.	Partial	Need to agree on a case by case basis (no such cases to date)	
Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.	Not met	New Board paper will come to Board later in 2018. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
Non-executive lead for FTSU			
Ensuring they are aware of latest guidance from National Guardian's Office.	Partial	New NED appointed and undertaking training *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
13. Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy.	Newly appointed NED is supportive and	To agree process, controls and measures. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	

	wants to support the Trust in this way.		
Robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement.	Newly appointed NED.	To be agreed with NED and interactions with Board. NED to discuss with Head of Culture & Engagement. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
14. Role-modelling high standards of conduct around FTSU.	Fully met	Yes.	
15. Acting as an alternative source of advice and support for the FTSU Guardian.	Fully met	Taken as read. This and above point to be re communicated to guardians/ messaging through existing channels.	
16. Overseeing speaking up concerns regarding board members.	Fully met	Yes.	
Human resource and organisational development directors			
17. Ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up.	Fully met	Need to agree who is responsible/ accountable within the HR/OD team.	
18. Ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is	Partial	Policies in place are aligned to the commitment of FTSU; evidence of every person counts' route map is in place *[FTSU Outline & Plan – (Meeting with CEO) August 18,*	

disseminated across the trust.		*HoC&E]*	
19. Ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.	Partial	Being included within the ongoing "key messages" framework development. Signposting during induction. Included in appraisal training. Referenced in management training. *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	
Medical director and director of nursing			
20. Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues.	Fully met	To take personal responsibility.	
21. Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up.	Fully met	Yes and on a case by case basis – needs a collaborative approach between MD & DoN	
22. Ensuring learning is operationalised within the teams and departments that they oversee.	Partial	Speak to MD and DoN to establish how this will work in future, how often and which channels – e.g. part of medilead? Part of nurse's development programme? *[FTSU Outline & Plan – (Meeting with CEO) August 18, HoC&E]*	

Report to the Board of Directors

APPENDIX II: FTSU ANNUAL SCHEDULE



Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Quality Assurance Committee held on 22/06/2018

Report to:	**Trust Board**	**Date of meeting: 5 July 2018**		**1**
Presented by:	**Ewan Carmichael Non-executive Director**	**Prepared by:**	**Jon Billings Chair, Quality Assurance Committee**	
	The papers and full minutes will be available to review on BoardPad			

Matters for escalation or highlighting	• QAC considered a range of quality report formats from various trusts and agreed the suite of metrics and a preferred approach to build into the revised IQPR or quality dashboard. This will be introduced from September. • QAC has asked the executive to consider launching a concerted campaign to drive consistent compliance with the 'basics' of good care such as infection control, medicines management, antimicrobial stewardship.
Other matters considered by the committee:	• CQUIN performance for 2017/18 • Quality Steering Group report – including oral update on Duty of Candour performance and the handling of FP10 prescription forms. • Directorate assurance report - surgery
Key decisions made/ actions identified:	• The preferred format and metrics suite for a revised quality dashboard were agreed (as above). • The format and attendance for directorate assurance reports are to be standardised. • The executive group will consider options for a concerted campaign to drive consistent performance on core quality areas such as infection control and medicines management (as above). • QAC commissioned a briefing on good practice in relation to public involvement within quality governance.
Risks:	• The key quality and safety risks on the risk register mainly relate to workforce challenges – we discussed at length the challenge of ensuring consistent implementation of good practice and further work on this has been commissioned.

Assurance:	The revised quality dashboard with provide clearer presentation of issues and allow us to pick up on trends more easily

Key Issues Report

NHS Medway NHS Foundation Trust

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

Name and Job Title of Member	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Insert name and job title												
Ewan Carmichael, NED			✓									
Diana Hamilton-Fairley, Medical Director			✓									
Karen Rule, Director of Nursing			✓									
Jon Billings, NED & chair			✓									
Adrian Ward, NED			x									

Best of care Best of people

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Integrated Audit Committee held on 27/06/2018

Report to:	**Board of Directors**	**Date of meeting:**	**04/07/2018**
Presented by:	**Mark Spragg. Chair Integrated Audit Committee**	**Prepared by:**	**Tracey Cotterill. Director of Finance & Bus Svcs**

1

Matters for escalation

1. Quality committee to review the internal audit report on complaints in conjunction with the chair of Audit Committee.
2. The Committee would like to discuss the ownership and accountability of the audit recommendations to gain assurance that appropriate follow up actions are taken.

Other matters considered by the group:

1. The external auditor updated on the final submission and sign off of the annual report and accounts and noted that this was all completed on time.
2. The Internal Audit Plan was discussed at length – consideration given to the adequacy of the number of days available and the appropriateness of the allocation of days to the planned audits. Assurance was provided that the plan had been considered in consultation with the full executive.

   It was noted that the governance review forms part of the plan and committee members will contribute to terms of reference for this work.

   There was discussion around the timing of audits within the plan, noting that the governance review will now be Q2 rather than Q1.
3. The Internal Audit and counter fraud progress report was presented. A number of referrals had been received to LCFS with 10 being closed in the period.
4. Final Head of Internal Audit Opinion was presented.
5. Internal Audit reports were presented on Complaints and Data Quality Assurance, and a counter fraud report was presented on sickness management.

   There was lengthy discussion regarding the recommendations from the complaints audit, and the Quality Committee are to be asked to review further and work with chair of Audit Committee
6. The LCFS annual report was presented
7. The LCFS plan for 2018/19 was presented
8. It was noted that the LCFS self-review toolkit had been

	completed. 9. The annual report and accounts consolidation process was discussed, and the external auditor agreed to provide exemplars of how other audit committees oversee the process. It was also recorded, that whilst there is still room for improvement, the process has improved over the last 2 years, and the content is also of a higher standard. 10. There was an update on the register of interests, gifts and hospitality. 11. The committee received an update on the actions from the health and safety report. 12. Losses and special payments in the period were presented. 13. The volume and value of waivers of standing financial instructions were presented.
Key decisions made/ actions identified:	1. The committee approved the proposed internal audit plan subject to minor changes to timings of the audits and sharing the scope of the governance review. 2. The committee approved the proposed LCFS plan
Risks:	1. The risks associated with all items on the agenda were considered 2. The BAF – it was noted that the executive had reviewed the strategic risks at the executive committee.
Assurance:	Assurance was provided on; 1. The committee discussed responsibility and accountability for various areas to ensure that this was embedded through the organization. 2. The self-assessment for LCFS gave assurance that all measures had either stayed the same as prior year or improved. 3. Expenditure on waivers and framework awards is being appropriately managed and controlled to minimise risk of fraud. 4. There was an update on progress against the Health and Safety report action plan. 5. The waivers of SFIs report provided assurance that the controls were being adhered to, and exceptions were authorized at CEO and FD level.

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Finance Committee held on 27/06/2018

Report to:	**Board of Directors**	**Date of meeting:**	**05/07/2018**	**1**
Presented by:	**Tony Moore Chair Finance Committee**	**Prepared by:**	**Tracey Cotterill, Director of Finance**	

Matters for escalation

1. Month 2 was submitted slightly favourable to plan, but noting that the plan for the profile of pay has been resubmitted to reflect the CIP profile.
2. The committee supported the revised laundry business case.

Matters considered by the group:

3. The standard reporting pack was not discussed.

   Key items brought to the committees attention included:

   - The Control Total has been approved by NHSI at £46,8m pre PSF of £12.6m to give a net planned deficit of £34.2m.
   - Outturn was favourable to the approved plan in respect of income, particularly for high cost drugs which is offset by adverse variances in non-pay. It was noted that given the block contract the variability for income was reduced.
   - Cash balance was noted.
   - It was noted that the debtor balances had improved.
   - The creditors position was noted as well as the performance against the better payment practice code.
4. The CIP element of the agenda was used to consider the longer term savings plans as well as the in year progress. Funding non recurrent investment costs as enablers was discussed.
5. Contract update - focus is on the contract workplan, delivery of Quality Innovation plans and Best practice tariff as the variable element of the contract and working on system recovery plan. Starting to gather the data for provider intentions letter and thinking about next year's contract now.
6. Progress against the capital budget was considered, and discussion ensued on the options to vary the plan to support investment in transformation.
7. An update was received on the Sustainability and Transformation Partnership and it was noted that current focus is Stroke services, local care and wave 4 capital bids.
8. The committee was updated on the Emergency Department build.
9. Procurement performance report was taken as read with no further

	questions. 10. The board received an update on 2 projects that are in the pre-business case phase: Telephony and Ledger system update. 11. The committee considered the a revised business case for laundry services. 12. Board Assurance Framework was taken as read – noting that the strategic risks have been updated at the executive committee ready for the next Board meeting. 13. In private session the committee formally considered and approved the annual operating plan update.
Risks:	14. Risks relating to 2018/19 are unchanged from last month. 15. The capital plan is significant but funding is available. 16. CIPs are noted as a risk to delivery of the control total.