Agenda

NHS Medway NHS Foundation Trust

Public Meeting of the Trust Board

Date: On 06 September 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 5 July 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	 Paper Paper	1320	 Note Discuss
10.	Organ Donation	Dr Gill Fargher	Presentation	1335	Note
11.	Quality a) IQPR b) Medical Appraisal & Revalidation Annual Report	 Director of Nursing & Medical Director Medical Director	 Paper Paper	1350	 Discuss Approve
12.	Performance a) Finance Report	 Director of Finance	 Paper	1410	 Discuss

	b) Standing Financial Instructions c) Communication Report	Director of Finance Director of Communications	Paper Paper		Approve Discuss
13.	People a) Workforce Report	Director of Operational HR	Paper	1430	Assurance
Reports from Board Committees					
14.	Quality Assurance Committee Report	QAC Chair	Paper	1450	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: 1st November 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 Deputy Chief Executive & 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.	David Sulch Acting 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 05/07/2018 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
	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
	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
	Dr D Sulch	Deputy Medical Director	DS
	Mr A Ward	Non-Executive Director	AW
Attendees:	Ms G Alexander	Director of Communications	GA
	Mr L Hinton	Director of Operational HR & OD	LH
	Ms C Hughes	Senior Matron, Emergency Department (item 1 only)	CHU
	Professor C Hughes	Quality Care Advisor	CH
	Ms D King	Governor Board Representative	DK
	Ms G Liston	Patient Story (item 1 only)	GLI
	Mr J Lowell	Director of Clinical Operations	JL
	Mr G Lupton	Director of Estates & Facilities	GL
	Ms G Mahil	Director of Clinical Operations	GM
	Ms H Puttock	Minute Taker	HP
Apologies:	Ms L Dwyer	Chief Executive	LD
	Mr J Billings	Non-Executive Director	JB
	Dr D Hamilton-Fairley	Medical Director	DHF
	Ms S Murphy	Trust Secretary: Director of Corporate Compliance and Legal Services	SMM

1. Patient Story

1.1 SC and KR welcomed GL and CHU to the meeting.

1.2 GL delivered a detailed presentation on her daughter's story in regards to her negative experience in the emergency department.

1.3 CHU advised after meeting with GL additional signage had been put in the new emergency department directing patients from the emergency department to MedOCC and the emergency department was working with the patient experience team to put up additional posters to show how patients can get in contact with the Trust to raise any issues.

1.4 The Board passed on their thanks to GL for her detailed presentation.

2. Welcome and Apologies for Absence

2.1 The Chairman welcomed everyone to the meeting.

2.2 SC introduced GM as the new Director of Clinical Operations for Planned Care.

2.3 SC welcomed CH to the meeting and thanked him for the seminars he had been holding across the Trust recently.

2.4 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 subject to two minor amendments.

6. Matters Arising and Action Log

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

6.2 It was noted action 0396 had been completed and closed.

6.3 Action 0399 was discussed. JD noted some initial work had been completed in regards to the correlation between complaints and the staff survey; however no immediate correlation had been identified. JD confirmed this would be picked up at the Quality Assurance Committee as one of the workforce and quality indicators. It was agreed that the action could be closed.

7. Chair's Report

7.1 SC advised it had been announced that LD would be leaving the Trust at the end of November to take up a new appointment in Australia and passed on the Trust's congratulations to LD.

7.2 SC reminded the members and attendees of the work completed under LD to ensure that the Trust improved and was removed from quality special measures.

7.3 SC noted the importance of continuity and succession planning and advised JD would be the interim Chief Executive for a 6 month period, after LD leaves in November 2018. The board agreed they were fully supportive of the succession plans in place and noted the importance of ensuring the progression of the transformation plan.

7.4 SC noted the CQC report had now been received by the Trust and was being checked for factual accuracy.

7.5 The members and attendees were informed that one of the Trust's longest serving governors, Renee Coussens, had passed away. SC advised Renee Coussens had shown great commitment to the hospital and the community, and this was greatly appreciated.

7.6 SC advised the results of the governor elections had now been published, and the next Council of Governors meeting with the new Governors would take place on 17th July 2018.

8. Chief Executive's Report

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

8.2 JD welcomed Gurjit Mahil to the Trust as the new Director of Clinical Operations for Planned Care and advised of the board's thanks to Benn Best who acted up as the interim in this role.

8.3 It was noted the Trust continued to face significant financial challenges, however at no point would quality be comprised in order to make cost savings.

8.4 JD noted the Trust continued to be nominated and win a number of awards, including the Trust being shortlisted in the 'Enhancing Patient Dignity' category for the Nursing Time awards.

8.5 The Board passed their thanks to Professor Cliff Hughes who had returned to the Trust to deliver a programme of seminars as the Trust's Quality and Safety expert in residence.

8.6 JD advised the stroke consultation for Kent and Medway had now closed, with a final decision now expected to be made in December 2018.

8.7 It was noted the Trust had begun to engage with the local universities in progressing its application to become a university teaching hospital.

8.8 JD reassured the Board the Trust had completed initial investigations in regards to the Gosport report and neonatal deaths that had both been published in the media recently.

8.9 JD advised a number of events had been held across the Trusts to celebrate the NHS 70th birthday.

9. Strategy

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

9.1 JD advised the main update from the STP was the stroke consultation, which was included in the Chief Executive report.

9b) Trust Improvement Plan

9.2 JD asked the members and attendees to take the report as read.

9.3 JD highlighted the transformation team recognised the importance of balancing the quality of care and the finances of the Trust.

9.4 It was noted the Trust had delivered 92% achievement for month 2 of the cost improvement plans.

9.5 JD noted the transformation team had being using the model hospital to review what services the Trust provides, and how services could be provided in a more efficient way.

9.6 It was noted the Transformation Assurance Group meets regularly to ensure the transformation plan is on target.

10. Quality

10a) IQPR

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

10.2 KR highlighted there had been an increase in the number of falls in May, however investigations had been undertaken into all of the falls and there were no emerging new themes identified.

10.3 It was noted the Trust had almost completed its look back investigation from October 2015 to December 2016 in regards to Duty of Candour, and 60 incidents were currently being investigated to ensure all the evidence required was available. KR advised there were no metrics for Duty of Candour included in the performance report as a review into how the Trust reports duty of Candour was being completed by NHSI and the Business Intelligence team. In April 2018 the Trust reported 72% compliance with duty of candour.

10.4 KR advised the Trust currently had 18 serious incidents with active investigations, with 2 of the incidents breaching the allocated timeframe due to being complex cases.

10.5 The Board recognised there had been an improvement in the number of mixed sex accommodation breaches.

10.6 KR noted the Trust was now meeting the national benchmark for safe staff working.

10.7 DS advised there had been a decrease in the HSMR from 111.9 to 111.1 and advised this continued to be reviewed at the Mortality and Morbidity meetings. DS recognised the Trust now had its own End of Life Care team, and patients were now being referred to the Trust instead of the Palliative Care team, which has caused an issue with coding and this may have contributed to the overall increase of the HSMR.

10.8 DS highlighted the Mortality and Morbidity meetings had a good attendance from both the Trust and recently the CCG, and it was felt the systems that had recently been put in place for HSMR were now more robust, however recognised there was still more work to do.

10.9 It was noted the Quality team, the CCG and NHSI would be meeting shortly to review the mortality data.

10.10 The Board recognised the importance of continuing to monitor the HSMR closely and ensuring data submitted was accurate.

10.11 GM advised the RRT performance had increased to 82.14%, which was a 1.2% increase from the previous month. This was still below the 92% expected standard, but was in line with the Trusts' trajectory that has been set as part of the Trust Improvement plan.

10.12 JL stated compliance with the 62 day cancer performance had increased to 86.42%, which was above the Trust Improvement Plan's trajectory.

10.13 It was noted there had been an issue with patient choice of the two week cancer wait, and more work was being done to understand why patients were choosing to delay their appointments.

10.14 JL advised there had been a deterioration of 3.2% in diagnostics, and this was partially due to capacity with the temporary and substantive sonography workforce. It was noted there was a national shortage of sonographers and the Trust would have to use agencies to meet the demand at the moment.

11 Performance

11a) Finance Report

11.1 TC asked the members and attendees to take the report as read.

11.2 TC advised in Month 2 the Trust was favourable to plan by £0.2m for the planned deficit of £9.8m pre PSF (provider suitability funding).

11.3 It was noted activity was being monitored against the block contract for 18/19 to ensure the Trust is managing its activity and is actively engaging with the CCG. TC highlighted the importance of holding the commissioners to account to ensure the Trust meets its trajectories.

11.4 TC noted the Cost Improvement Plans were behind plan by £0.1m for Month 2 and raised the importance of Directorates identifying any extra cost improvement plans to ensure the targets for quarters 3 and 4 are met.

11.5 TC advised the Trust Debtors continued to improve, with some very aged debt being collected.

11.6 The Board recognised the importance of the Trust staying on plan for Quarter 1.

11b) Annual report on Security Management

11.7 GL asked the members and attendees to take the report as read.

11.8 It was noted there were no non-compliant areas, 6 areas with partial compliance and 25 areas fully compliant.

11.9 GL highlighted reports on violence and aggression had reduced by 30%.

11c) Operational Plan 18/19

11.10 TC advised the draft operational plan for 18/19 was submitted in March 2018, however the Trust had been invited to re-submit the operational plan on 20th June 2018, to include a number of revised trajectories.

11.11 TC noted the Trust's revised control total for 18/19 had been accepted, which made the Trust eligible for Provider Sustainability Funding (PSF). The funding is £12.6m, which givens the Trust a revised control total of £34.2m post PSF.

11.12 It was noted the Board approved the submission of the revised operation plan on the 20th June.

11.13 It was recognised guidance on the way to earn PSF for 18/19 had not yet been published, however previously this has been linked to 70% financial delivery and 30% ED performance. It was if the same guidance applied this year, the Trust would not have earned its PSF for quarter 1.

11.14 JL advised work continued to improve the flow through the Emergency Department, to ensure patients are seen within the four hour time frame; however the Trust had seen a 7% increase of those attending the Emergency Department, in comparison to the 1% that was expected.

11.15 The Board recognised the challenges of the Provider Sustainability Funding and if the Trust did not meet the trajectories, the Trust would be in a more financially challenged position.

11.16 It was noted the Trust was working with the CCG to try and reduce attendance at the Emergency Department, in order to improve the flow through the Trust and ensure patients are treated in the correct place.

11.17 TC stated the Trust continued to work closely with the CCG and a joint system recovery approach was required.

11.18 JD advised the Executive Group and Transformation Assurance Group would be looking at the efficiency of services delivered at the Trust. It was recognised the cost improvement plans for quarter 2 would be challenging in regards to reducing the run rate on pay costs and further workforce schemes would be set up to assist with this.

11d) Communication Report

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

11.20 GA noted the communications team had been focusing on the communications regarding the transformation team, to ensure staff fully understand the workings of the transformation team.

11.21 It was noted there had been a lot of engagement around LD leaving the Trust and the Board recognised the importance of ensuring staff there will be continuity.

11.22 GA advised LD and SC continued to be in regular contact with the stakeholders and had provided them with updates, to engage their support of the Trust.

11.23 It was noted News@Medway had been relaunched in a new format, and now included more patient stories.

11.24 GA recognised the Trust had been going out into the community more and presenting on requested topics by groups.

11.25 GA advised the Trust continued to promote NHS70 and this had been a good opportunity to engage staff in a positive way.

11.26 JP suggested focusing some communications on cost improvement plans, and celebrating those that have made a positive difference.

11.27 DK noted the Salvation Army had raised concerns they have not been able to get involved with the Chapel at the Trust. It was agreed KR should review this.

Action: KR to investigate the Salvation Army's access to the Chapel at the Trust.

12 Governance

12a) Corporate Governance Report

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

12.2 JD highlighted the Trust was now compliant with GDPR and the EPRR team had now moved under the Estates directorate.

12.3 KR noted the compliance dashboard included was in draft format and continued to be updated.

12b) Board Assurance Framework & Risk Register Board Assurance

12.4 This paper was noted. JD advised the board assurance framework would be discussed again at a future board development session.

13 People

13a) Workforce Report

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

13.2 LH advised the Trust had increased the number of international recruitment companies it was working with, with a total of 565 applicants being processed and 174 anticipated starters.

13.3 It was noted there had been an increase in the number of starters for registered nurses; however there had been a large number of nurse leavers due to the Community Nursing service being transferred to Medway Community Healthcare.

13.4 LH stated there continued to be gaps in the junior medical rota, however this was reducing but remained an issue.

13.5 LH advised the sickness percentage of the Trust was 3.44%, compliance with statutory and mandatory training was 86.3% and compliance with appraisals was 85%.

13.6 It was noted in May 2018 19% of staff was made up of temporary staffing. LH advised the trust's annual agency ceiling had decreased to £16m in 2018/19 and the Trust was on plan to meet this.

13.7 A discussion took place around the Filipino Nurse Recruitment. LH advised the first recruitment session had a low number of starters; however the Trust now only approaches candidates who have passed the English test to avoid having a similar number of low starters.

13.8 KR noted the Trust was due to have the first 10 nurse associates begin in September, with a plan to take more nurse associates next year.

13b) WRES Report

13.9 LH advised the Workforce Race Equality Standard (WRES) report was a legal obligation under the NHS Standard Contract and had to be reported to the Board annually and published on the Trust website.

13.10 The key indicators within the WRES report were highlighted to the Board.

13.11 It was noted the Head of Equality and Inclusion would take forward the action plan included in the WRES report.

13.12 JD noted the equality objectives had been agreed earlier in the year, and a comparison of the actions from the WRES Reports and the equality objectives should take place.

13.13 TC stated one of the Trust's strategic objectives was people and it would be useful to include parts of the WRES report in the board assurance framework. JP noted this would also be helpful to have as a board development session.

13.14 The Board **APPROVED** the WRES reports.

13c) Freedom to Speak Up Self-Assessment

13.15 JD advised NHSI had requested all Trusts to complete a self-assessment on their Freedom to Speak Up arrangements. It was noted NSHI would be undertaking their own assessment later on in the year.

13.16 It was confirmed AW had reviewed the self-assessment as the Whistleblowing Non-Executive Director.

13.17 It was noted the self-assessment highlighted that all though the Freedom to Speak Up arrangements had been implemented well, more work needed to be done. JD advised there was now a clear structure of meetings for the Freedom to Speak Up Guardians to meet with the Chief Executive and this would also been reported to the Board twice a year.

13.18 It was noted the self-assessment was completed by the Freedom to Speak up Guardians and the Head of Culture and Engagement. TM highlighted the importance of the process being honest and transparent, as this would be fundamental to improving the culture within the organisation.

13.19 JD confirmed the Freedom to Speak Up Guardians receive training from the national guardian office.

13.20 The board noted the report.

15 Quality Assurance Committee (QAC) Report

15.1 EC asked the Members and Attendees to take the report as read.

15.2 EC advised the Quality Assurance Committee has been looking at best practice in regards to reporting on quality, and a new quality dashboard would be presented in September.

16 Integrated Audit Committee (IAC) Report

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

16.2 MS highlighted the Integrated Audit Committee had discussed how recommendations are audited once they are completed, and further discussion would take place at the next meeting.

17 Finance Committee Report

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

17.2 TM noted the Trust was going through a critical three month period in regards to Finance, however noted the importance that quality must not be comprised in order to achieve the control total.

18 Council of Governors' Update

18.1 DK as Governor Board Representative raised the following queries:

- Could it be made clear at the check in desk that you need your year of birth in order to check in for your appointment? GM advised she would take this forward.
- Was the Trust on track to open the emergency department? GL advised the Trust was due to open the new emergency department in August.

18.2 DK noted Governors continued to receive complaints in regards to the speed of patients receiving medication before being discharged.

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 6 September 2018 at 12pm.
Venue: Boardroom, Post Graduate Centre, Medway NHS Foundation Trust

The meeting closed at 3.30pm

Stephen Clark: Date:
Chair

Meeting Actions Log

NHS Medway NHS Foundation Trust

Public Board **Date: 06/09/2018**

Action Log Number	Agenda Item Description	Action Due Date	Outcome	Owner	Status
0400	KR to investigate the Salvation Army's difficulty locating patients for pastoral visits	06/09/2018	KR contacted Peter Willard, named liaison for MFT and agreed a meeting in October 2018.	Director of Nursing	Closed

Chief Executive's Report – August 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.

Board is asked to note the content of this report.

In and around Medway

Transformation

Work to transform our services to create a better patient experience, and to become more efficient and sustainable, continues at a pace.

We know we have a long way to go to ensure we are consistently delivering the best of care across all areas, and at the same time we need to reduce our significant financial deficit.

I am pleased to say that this work is now well underway. Under the umbrella of 'Better, Best, Brilliant' we have launched a number of targeted projects, including a trust-wide programme to address patient flow which includes length of stay. Members of our Transformation Team are working alongside directorate staff to drive these improvements.

We have a longer length of stay in some areas than other trusts, and while this is in part due to factors outside our control, there is much we can do to address the issue. In dealing with this, we aren't re-inventing the wheel; we are building on things we have done well in the past, looking at the bigger picture and making sure we are engaging with the right people to implement changes that will stick.

We are working with key members of staff, focusing on embedding criteria-led discharge, speeding up medicines to take home, and the consistent use of electronic systems like Extramed. Some of these changes are already being piloted on selected wards; these wards will serve as a gold standard for the Trust and support the wider roll-out.

Culture Programme

This year we have had a concerted effort to redefine the culture here at Medway, which is key to achieving the changes needed to truly make us the brilliant organisation we aspire to be. There have been multiple opportunities for staff to provide their feedback about working at Medway including the regular staff surveys and events such as the Unconference in January. It is now important that we listen to and act on this feedback if we are to truly create the best culture.

This is about working together to make the Trust more efficient, more capable of routinely meeting the operational and financial targets, and more able to meet the future needs of our patients. We can only create this new Medway by working together to change our culture, By ensuring that our staff feel supported and are able to be their best and experience joy at work, we will then be able to create a 'new Medway'.

As part of the work around culture, I'm pleased to say that we are about to launch a programme called "You are the Difference". This will be run by Alf Dunbar, an acclaimed motivational coach who has worked with big retail brands such as Tesco, Morrisons and H&M. The programme will seek to build upon the passion and commitment I know our staff have, as well as addressing the issues we know can hinder them.

Celebrating the best of Medway

The Executive Team and I were proud to attend the Best of People Awards. This was an opportunity to celebrate the very best of Medway, with staff and volunteers receiving well-deserved recognition for going the extra mile in their daily roles.

This year we awarded our first Brilliance award for exceptional contribution to the trust. Our inaugural recipient was Dr Gill Fargher who is the chair of the Organ Donation Committee.

We also had an opportunity to say thank you to our long servers who have devoted many years of service to Medway.

Chief Executive's Scholarship for Brilliance

We have launched a special scholarship, funded by The Medway Hospital Charity, aimed at supporting an exceptional candidate's learning and development. As an organisation it is vital that we support learning and encourage innovation and we will be considering all applications that focus on how we can sustain improvement, improve efficiency and/or developed our culture to make Medway brilliant.

The recipient/or recipients will be awarded at the Annual General Meeting on the 25th September.

Employer with Heart Charter

As an organisation, we know how important it is to care for those who are caring for others, so I am proud to announce that we have become the first NHS Trust in England to sign up to the Smallest Things 'Employer with Heart' Charter, pledging our commitment to support the needs of premature babies and their families.

Current NHS terms and conditions afford new mums whose baby has been born prematurely to split their maternity leave, allowing them to take two weeks' leave immediately after childbirth, and the rest following their baby's discharge from hospital. One in eight babies is born prematurely and subsequently parents have a reduced time to bond with their baby. The period from birth to discharge for babies born prematurely is typically several weeks, or even months.

The Trust has therefore taken the step to support new mums in this period by committing to ensure they receive their normal pay up until the point that their maternity pay commences.

We understand that it can be an extremely difficult and worrying time for those who experience premature labour and the last thing we want is for staff to feel they have to worry about work or whether they can afford to take time off to be with their baby.

Whilst I hope that this is something our staff will not need to take advantage of, I very much hope that it may provide some comfort to those going through a difficult time.

Kent and Medway Stroke Consultation

As you will know, the future of urgent stroke services in Kent and Medway is currently under consultation, with the Trust having submitted its formal response in April. As part of this process, we were requested to deliver a presentation to the Kent and Medway STP to assist with the development of a Decision Making Business Case. A panel was held on 4 September at the Mercure Hotel in Maidstone and, led by Dr David Sulch, we presented our plans for the delivery of a Hyper Acute Stroke Unit at Medway.

Following this session, the proposals from the different trusts around Kent and Medway will now be evaluated and considered, with the outcomes feeding into further analysis prior to a final decision being made. As this stage, we still expect this to be announced in December 2018.

Changes to the Executive Team

There have been some changes to the Executive Team. Firstly, Dr Diana Hamilton-Fairley has stepped away from her role as Medical Director to take up a new position at the Trust as the Director of Strategy. Thanks to Diana and her brilliant work as MD since she joined us from Guy's and St Thomas' NHS Foundation Trust, we have become a much safer organisation. This is in no small part down to her inspiring leadership and her unwavering commitment to improving quality and safety for our patients.

The Trust will now be able to benefit from Diana's substantial talents and experience: the strategy function is critical to the organisation if we are to serve the needs of our patients in the future.

Diana will work alongside James Lowell who has moved from his role as Director of Clinical Operations for Unplanned and Integrated Care, to become Director of Planning and Partnerships.

Dr David Sulch has stepped into the Medical Director role as an interim replacement for Diana while we seek to appoint a permanent Medical Director and I am in no doubt that David's extensive experience will provide the Trust with excellent support to this role over the coming months.

Additionally, our Director of Finance and Business Services, Tracey Cotterill, has decided to step down from her role and will leave the Trust in the autumn. We do have in place some transition arrangements and will commence recruitment to the role as soon as possible.

Beyond Medway

NHS England and NHS Improvement south east region event

I was invited to attend an event hosted by NHS England and NHS Improvement in London on 29 August, at which Chief Executives, Accountable Officers and local STP leads discussed the current position of NHS organisations within the region in terms of operational performance, financial position and preparation for winter.

In addition, STP leads were invited to share their views around the future financial support required from NHSE and NHSI to assist trusts in delivering against their targets. The event provided a great opportunity to talk through the current challenges facing our organisations as we head into the winter period, as well as looking back at what went well last year and what we will need to build on to ensure we are all in the best position possible as we approach what will undoubtedly be a period of significant pressure.

Community Services review

Medway CCG has announced a series of public engagement meetings as part of its review of Community Services. These will take place on 20 September, 8 October, and 19 October across Medway. More information on the review is available at www.medwayccg.nhs.uk

Organ and tissue donation

The government has outlined plans to implement a new opt-out system of consent for organ and tissue donation in order to tackle a shortage of donors. This will mean everyone is considered an organ donor unless they have explicitly recorded a wish not to be or they are from one of these excluded groups:

- children under 18
- individuals who lack the mental capacity to understand the changes
- people who have not lived in England for at least 12 months before their death.

The donor register will include an option for individuals to state important religious and cultural beliefs to ensure these are respected.

At Medway we are currently running a campaign to encourage people to join the register. Our organ donation lead, Dr Paul Hayden and organ donation committee chair Dr Gill Fargher have given talks to ethnic minority groups who are disproportionately represented on the organ waiting list, but under-represented on the donor register.

As both Paul and Gill are presenting the annual Organ Donation report to Board I am sure that they will cover some of the issues outlined.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 06/09/2018 Agenda item

9a

Title of Report	**Sustainability and Transformation Partnership update**
Prepared By:	Glynis Alexander
Lead Director	Lesley Dwyer, Chief Executive
Committees or Groups who have considered this report	NA
Executive Summary	This report provides an update on current activity in the STP in Medway and the rest of Kent.
Resource Implications	NA
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA
Improvement Plan Implication	Our transformation plan, *Better, Best, Brilliant*, is aligned with the STP
Quality Impact Assessment	NA
Recommendation	The Board is asked to note the report.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 Work under the umbrella of the Kent and Medway Sustainability and Transformation Partnership is progressing in a number of directions, including strategic projects such as the clinical vision, service improvements such as the stroke review, and specific workstreams, for example workforce, pathology and the electronic care record.

1.2 This report provides an update on activity since the last Board meeting.

1.3 Medway is involved in – and sometimes leading – a wide range of projects, and our transformation programme, Better, Best, Brilliant is within the context of the STP.

2 CLINICAL STRATEGY – QUALITY OF LIFE, QUALITY OF CARE

2.1 Having agreed a vision statement, the Clinical and Professional Board is continuing to develop the Clinical Strategy.

2.2 To bring the strategy to life a series of 'stories' is being created that will describe the services people at different stages of life, from different backgrounds, and with a range of health conditions, can expect.

2.3 The stories will include people who are mostly healthy and only rarely use health or social care services, through to patients with multiple complex health problems.

2.4 The idea is to exemplify patients with different health and social care support needs to guide plans for improving services.

2.5 The stories will be shared with patients and public as well as staff.

2.6 There has also been an initiative to work with members of the public to develop 'I' statements which identify what people regard as important to them in relation to quality of life and quality of care.

2.7 This is a well-recognised way of ensuring that service improvements are focused on patient priorities.

3 ACUTE STROKE SERVICES

3.1 Earlier this year a public consultation exercise took place on proposals to improve urgent stroke care across Kent and Medway.

3.2 People were asked for their views on proposals to create three new hyper acute stroke units. There are currently no HASUs in the county.

3.3 There was a good response to the consultation, with a large number of people in Medway and Swale attending public meetings and completing the survey.

3.4 During the early summer the responses were collated and analysed.

3.5 The results of the consultation have been shared with the Joint Health Oversight and Scrutiny Committee, who were supportive of the way the exercise was carried out.

3.6 They wanted to see more evidence of engagement with BAME communities, so additional work was carried out during the summer to provide this assurance.

3.7 On Tuesday (4 September) members of our Executive Team presented to a HASCU Deliverability Panel as part of the process of determining where the HASUs will be located.

3.8 A decision is expected before the end of the year.

4 PRODUCTIVITY BOARD

4.1 A Productivity Board has been established. It will work to ensure there is pace, commitment and engagement for the productivity workstream across all partners, with a focus on value.

4.2 The aim is to identify projects that will work well across the STP footprint. A principle has been agreed that when an organisation isn't involved for a particular reason, this shouldn't hold up progress for the rest.

4.3 Chief Executives have made a commitment to tackle temporary staffing rates.

4.4 Extra effort is being put into the medical bank to drive efficiencies in this area.

5 SYSTEM TRANSFORMATION

5.1 Discussions have been taking place over the summer about the role of a Kent and Medway strategic commissioner.

5.2 The strategic commissioning function would mean doing some things once across the eight clinical commissioning groups in the county, improving patient care and creating efficiencies by making best use of resources.

5.3 However, it is not intended to create a new organisation, and the CCGs are expected to remain as statutory NHS organisations responsible for commissioning care in their areas.

5.4 The strategic commissioner is expected to be in place by April 2019.

Performance Report to the Trust Board (public)

Committee Date: 06/09/2018 **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 M4) 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 M4 shows a 115% YTD achievement against plan. Against the £21m CIP target, we have now identified £18m (including the strategic workforce group schemes) with a PMO adjusted figure of £15.8m. Further schemes are currently being validated with the aim of further reducing the gap and these will be included in future updates to the transformation assurance group. As previously reported, the second half of the year will be challenging in CiP terms, with an increase in the savings required in Q3 and Q4 to meet the CiP target, and ultimately the 2018/19 control total. The work on using Model Hospital to better refine services defined as a specialist emergency centre continue with the Trust working closely with Medway CCG in reviewing alternative referral pathways, and/or service provision that is right for patients. Further work is ongoing within particular specialities to review areas such as service efficiency, workforce and reducing variation. The projects on reducing length of stay, and ED (emergency department) improvement have also commenced since the last report to the Board.
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.

Performance Report to the Trust Board

Legal Implications/Regulatory Requirements	Financial Special Measures (linked to non-delivery of CiP)
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 COST IMPROVEMENT (CIP)

1.1 The reported position for CiP delivery at M4 is115% to plan; with £3.89m achieved against a plan of £3.39m.

1.2 Against the CiP target of £21m, the Trust currently reporting a risk adjusted forecast delivery of £15.8m

Directorate Split	Unplanned Care (£'000)	Planned Care (£'000)	Corporate (£'000)	Estates (£'000)	Totals (£'000)
Target	(10,100)	(8,174)	(2,021)	(726)	(21,021)
CIP Budget as % of Expenditure Budget	7.0%	7.0%		3.1%	6.9%
Identified	(5,807)	(6,651)	(2,536)	(807)	(15,801)
Unidentified	(4,293)	(1,523)	515	81	(5,220)
% Identified to Target	57%	81%	125%	111%	75%
YTD Target	(1,797)	(1,453)	(8)	(132)	(3,390)
YTD Actuals	(1,346)	(1,979)	(423)	(146)	(3,894)
YTD Variance	(451)	526	415	14	504
YTD % Delivery	75%	136%	5288%	111%	115%

1.3 A large number of additional schemes are currently being validated which are not yet included in the adjusted forecast; therefore we expect the adjusted forecast to increase closer to the target; notwithstanding that second half of the year provides additional challenge, and the transformation team are continuing to work with the finance improvement director, and clinical directorates to generate additional schemes to bridge the current unidentified gap.

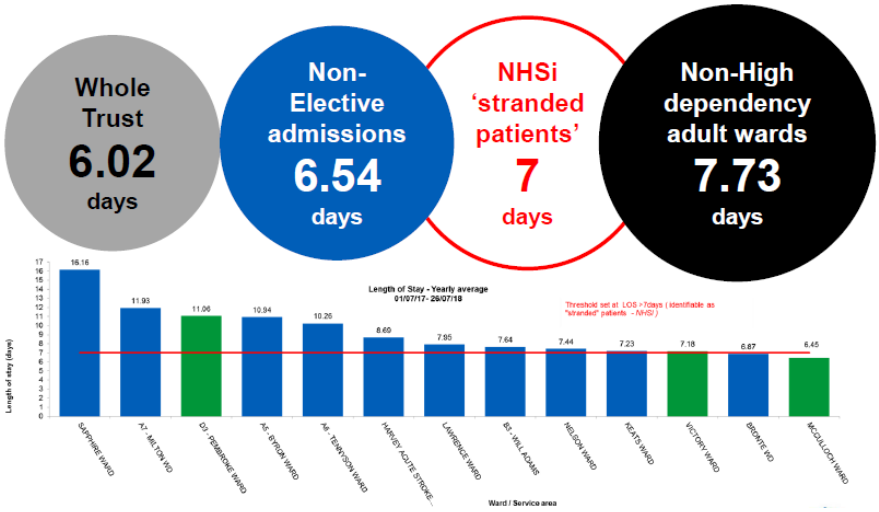
2 PROGRAMME STATUS UPDATES

2.1 Since the last report to the Trust Board, we have launched our work on improving length of stay, and emergency department improvement.

2.2 The project is aimed at reducing length of stay by 2 days, over the next 8 weeks. This will reduce the occupancy within the hospital, but also free up capacity to support flow in readiness for the winter period.

2.3 The table below shows the length of stay position for the Trust from Q1 of the current financial year. This shows that a number of wards, and particular specialities, have an above average length of stay – it is these areas which are the initial focus.

Performance Report to the Trust Board



2.3 The emergency department improvement plan is again focussed on improving performance against the 4 hour access standard – but is largely focussed on the root causes including ambulance handovers, ambulant patients, an escalation plan for dealing with a full ED, and specialty referrals. The table below summarises the objectives and KPIs for the group.

Working group	Objective	KPI(s)
Ambulance arrivals	1. Open RAA 2. To be compliant with the handover standard	1. Achieve trajectory 2. Reduction in HIU and primary care patients
Ambulant patients	1. Fully functioning Major Lite 2. Resilient Assessment Areas	1. Reduction in breaches 2. Reduced Blocks
Specialty referrals	1. Instigation of medical triage 2. Direct access model in place	1. Reduced time to SDM 2. No. patients RAPPed
Managing a full ED	Full Hospital Protocol in place	1. Reduction in ambulance breaches
Assessment areas	Fully functioning 24 hour speciality assessments areas	1. Increased flow to in-patient beds 2. Increased direct access
Site team and flow	Use of EDD for live correlation between MAU and in-patient discharges	1. Increased flow to in-patient beds 2. Reduction in patients discharged after EDD

2.4 The 'confirm & challenge' sessions on cost improvement, and budget management continued with both clinical directorates. These are aimed at improving control, and generating additional CiP schemes to bridge the unidentified gap.

2.5 Reviewed additional services to scope in respect of improving pathways in line with the hospital service portfolio; aimed at using the Model Hospital data to become the defined specialist emergency centre.

2.6 We have also worked with clinical teams to finalise the HASU deliverability model as part of the formal consultation process.

2.7 The Trusts new culture programme commences on 12 September 2018; the executive team went through the session on 30 August 2018.

3 NEXT STEPS

3.1 The areas of focus are as follows:

- Fully scope the cost improvement projects and agree the Transformation Team support to achieve the targets;
- Continue with the capability training programme to the trust via 'Mollie' with necessary communications.

---Ends---

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 06/09/2018

Agenda item 10

Title of Report	**Organ Donation Annual Report 2017-18 and Strategy for 2018-19**
Prepared By:	Dr Paul Hayden, Dr Gill Fargher and Mrs Alison Hill
Lead Director	David Sulch, Acting Medical Director
Committees or Groups who have considered this report	Organ Donation Committee
Executive Summary	The purpose of this report is to ensure the Trust Board is aware of the continuing work supporting organ donation at the Trust over the past financial year. Key points to note are: • 16 organs were transplanted in 17/18. • The Trust's metrics for the percentage of appropriate referrals and approaches to families remains positive and gives assurance that potential donors are not being missed. • The Trust had a referral rate of 98% for potential organ donors. • There had been a slight drop in the percentage of families approached to discuss organ donation with a SNOD. • The strategic objectives for 17/18 were largely met.
Resource Implications	Nil
Risk and Assurance	Not applicable
Legal Implications/Regulatory Requirements	Not applicable

Report to the Board of Directors

Improvement Plan Implication	Not applicable
Quality Impact Assessment	Not applicable
Recommendation	To accept the content of the report and continue to support organ donation as a Trust.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Medway NHS Foundation Trust Organ Donation Annual Report 2017 – 2018 & Strategy for 2018 - 2019

Dr Paul Hayden	*Clinical Lead Organ Donation*
Dr Gill Fargher	*Chairman Organ Donation Committee*
Mrs Alison Hill	*Specialist Nurse Organ Donation*

Contents

Glossary

- CLOD – Clinical Lead Organ Donation
- SNOD – Specialist Nurse Organ Donation
- NHSBT – NHS Blood and Transplant
- DBD – Donation after Brain Death
- DCD – Donation after Circulatory Death
- ODC – Organ Donation Committee
- PDA – Potential Donor Audit (national audit of activity by NHSBT)
- ICU/ITU – Intensive Care Unit
- ED/A&E – emergency department
- HDU – High Dependency Unit

Definitions

POTENTIAL DONOR AUDIT / REFERRAL RECORD	
Data excluded	Patients who did not die on a critical care unit or an emergency department and patients aged over 80 years are excluded.
Donors after brain death (DBD)	
Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates - less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SN-OD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's op-out decision via the Organ Donor Register
Consent / authorisation ascertained	Family supported expressed or deemed consent/authorisation, nominated/appointed representative gave consent, or where applicable the family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SN-OD
Approach rate	Percentage of eligible DBD families or nominated/appointed representatives approached for formal organ donation discussion
Consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
Expected consent / authorisation rate	Consent / authorisation rate adjusted for ethnicity case mix (white or BAME (black, asian and minority ethnic)), based on those patients whose family or nominated/appointed representative were approached to discuss organ donation where consent/authorisation was ascertained and patient ethnicity was known
SN-OD involvement rate	Percentage of family or nominated/appointed representative approaches where a SN-OD was involved
SN-OD consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion by a SN-OD where consented / authorisation for organ donation was ascertained

Donors after circulatory death (DCD)	
Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SN-OD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's op-out decision via the Organ Donor Register
Consent / authorisation ascertained	Family supported expressed or deemed consent/authorisation, nominated/appointed representative gave consent, or where applicable the family gave consent/authorisation
Actual DCD	DCD patients who became actual DCD as reported through the PDA
Referral rate	Percentage of patients for whom imminent death was anticipated who were discussed with the SN-OD
Approach rate	Percentage of eligible DCD families or nominated/appointed representatives approached for formal organ donation discussion
Consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
Expected consent / authorisation rate	Consent / authorisation rate adjusted for ethnicity case mix (white or BAME (black, asian and minority ethnic)), based on those patients whose family or nominated/appointed representative were approached to discuss organ donation where consent/authorisation was ascertained and patient ethnicity was known
SN-OD involvement rate	Percentage of family or nominated/appointed representative approaches where a SN-OD was involved
SN-OD consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion by a SN-OD where consented / authorisation for organ donation was ascertained
UK Transplant Registry (UKTR)	
Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by number of donors. The maximum number of solid organs that can be donated are 7 for a DBD and 6 for a DCD.
Number of organs transplanted	Total number of organs transplanted by organ type

1. Executive Summary

2017/18 was another year of high activity for the Trust compared to peer, with **11** consented potential donors resulting in **8** successful organ donations, which led to **16** organs being transplanted.

Overall the Trust's metrics for the percentage of appropriate referrals and approaches to families (measured using the National PDA – Potential Donor Audit, see appendix A), remain positive and give assurance that potential donors are not being missed. The data shows we are performing above national average in the majority of domains and are already achieving targets set for completion by 2020 as part of the national strategy (see appendix B).

The Trust's referral rate compares well with peer Trusts at 98% of potential organ donors compared with a national average of 92%.

A slight drop in percentage of approach to families to discuss organ donation where a SNOD is present (84% versus national average of 90%) was primarily due to out of hours approaches where a SNOD was not immediately available and families were not keen to delay conversations which is entirely understandable.

The Trust receives income for each patient that is consented for organ donation. For 2017-18, the Trust received £25,032 from donor reimbursements in addition to the money rolled over from 2016-17, leading to a cumulative balance of £45,770.09. Finances have been earmarked for 2018-19 including funding of improvements to the Trust's mortuary and provision of equipment for the operating theatres education room. It should be noted that the national mechanism for reimbursement has now changed and it is likely that future income will fall as a result.

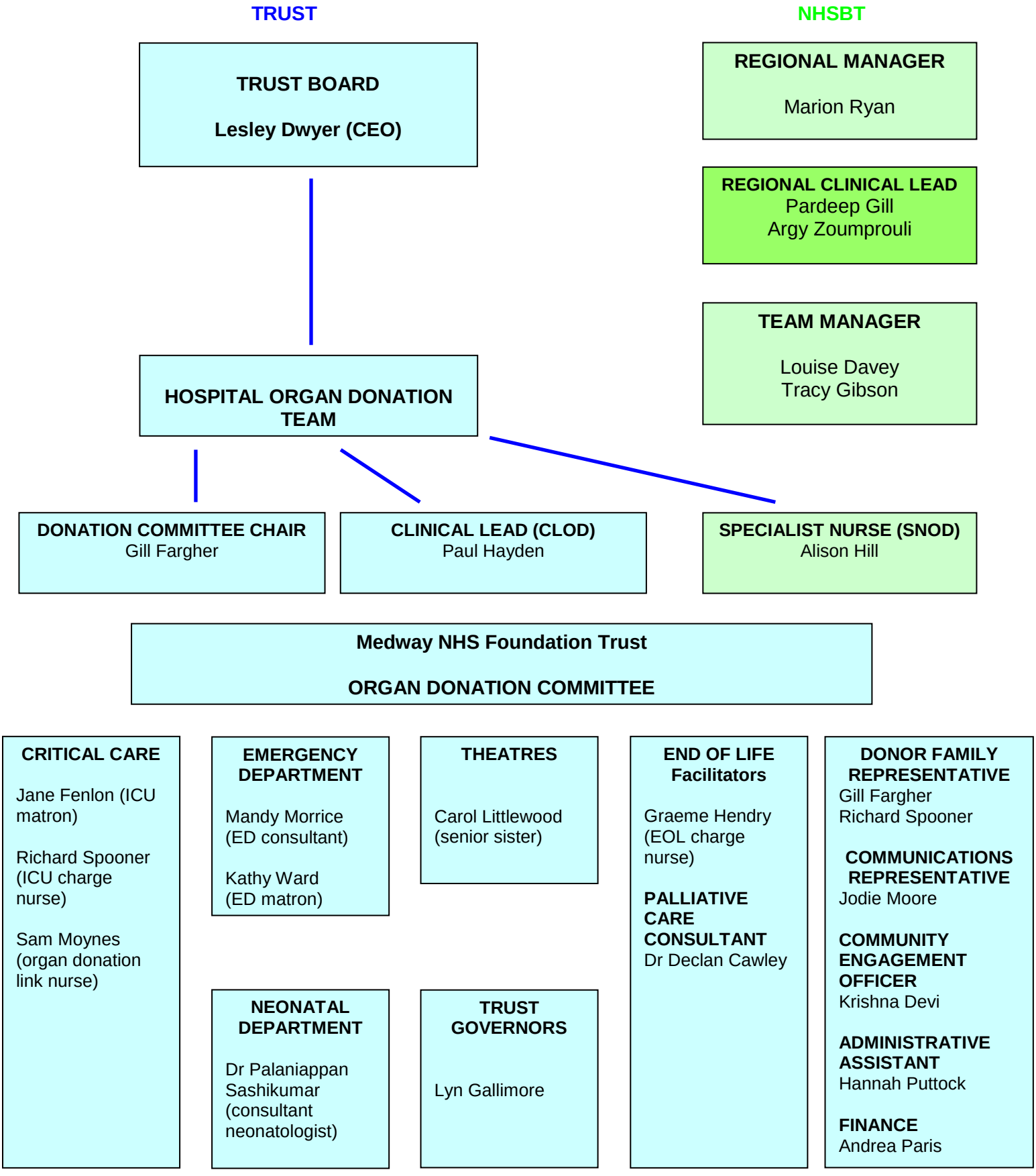
The committee is committed to improving organ donation rates with an on-going education and awareness strategy aimed at key stakeholders. Over the past year, the organ donation team has delivered simulation training on organ donation, met with local GPs and delivered lectures about organ donation and a successful educational session at the Medway Ethnic Minorities Forum to discuss the need to encourage people from Black and Asian Minority Ethnicity (BAME) to support organ donation. Members from the organ donation committee attended the Kent show in July which was very well attended and resulted in over 250 people signing up to the organ donor register over the weekend.

The strategic objectives for 2017-18 were largely met, with continued high organ donation referral rates, proactive educational sessions within and outside of the Trust, and an increase in tissue donation within the Trust. The aim to produce organ donation awareness using "lift wraps" was not deemed possible unfortunately due to ongoing issues with the Trust's lifts.

The strategic objectives for 2018-19 are:

1. To be the best performing Trust for organ donation in the region
2. To continue to provide educational sessions within and outside of the Trust to support and encourage membership of the Organ Donation Register
3. To work with BAME communities to improve support for the ODR
4. To provide information regarding the changes to national policy for “opt out”
5. To work towards a culture change within the Trust to strengthen tissue donation in all potential donors.

2. Trust Organ Donation Team Structure



3. Report from the Organ Donation Committee (ODC)

Medway Foundation Trust Organ Donation Committee (ODC) has clear purposes and objectives as set down by NHS Blood and Transplant (NHSBT) in influencing and monitoring all aspects of policy, practice, training and education relating to organ donation across the Trust. Robust scrutiny and challenge form an essential component of the function of the ODC. Recognition of the selfless generosity of our donors and their families is central and a significant element of the role of the committee.

The ODC reports to the Trust Board and our Annual Report is presented to the Board by the Clinical Lead for Organ Donation (CLOD) -Dr Paul Hayden and the ODC Chair.

Membership of the ODC has been further strengthened during the year as colleagues from communications and engagement, palliative medicine and a Trust Governor have joined the committee bringing additional invaluable expertise, experience and dedicated support.

The Trust has maintained its position as a Level 2 hospital (determined by the number of organ donors annually) with another year of high activity. 11 consented potential donors resulted in 8 successful organ donors leading to 16 transplanted organs.

The performance against the 2017/2018 strategic objectives were met with the exception of the installation of the lift wraps (due to the Trust lifts requiring essential maintenance in advance of lift wrap installation). Tissue donations have increased however the increase is small and further specific work is currently being planned in order to address this. Although the referral rate for potential donors was 98% and not 100%, this is an exceptional achievement. Any missed referral is however investigated and clear processes are in place to ensure that all potential referrals are made.

Promotion of organ donation within the community and within the Trust has been delivered in a number of ways and performance has exceeded the planned strategic objectives Interactive presentations have been delivered to the Swale GPs by the CLOD and to the Medway GPs by the CLOD and the ODC Chair. A further presentation from the CLOD and ODC Chair to Medway Ethnic Minorities Forum was well received. Collaborative working with Kent organ donation colleagues enabled a strong presence throughout the 3 days of the Kent County Show resulting in over 250 people being signed up to the Organ Donor Register (ODR) whilst delivering information and education to those coming to the stand.

Promotion of organ donation within the Trust has been significant and varied. A Grand Round on organ donation was held in September 2017 to coincide with Organ Donation Week. In October 2017 a highly successful simulation day followed which was planned and delivered by the CLOD supported by organ donation colleagues. A presentation by the CLOD and ODC Chair in July 2018 to the Trust Governors, Executives and Non-Executives completed a very active year.

Colleagues from communications and engagement have contributed very significantly to many aspects of the work in organ donation from facilitating the Medway Ethnic Minorities Forum presentation to consistently refreshing and ensuring availability of a variety of promotional material within the Trust working in collaboration with the ODC.

Regional organ donation meetings which are held biannually are attended by the Specialist Nurse in Organ Donation (SNOD), the CLOD and ODC Chair.

Annual meetings which include the Order Of St. John ceremony (posthumous donor awards made to families) are attended by organ donation colleagues which include the SNOD and ODC Chair.

"50 Years of Heart Transplantation" - a special and inspirational event at the Science Museum was attended by the ODC Chair.

During the last year a consultation period on an "opt-out" organ donation policy for England has been held. We will continue to support the need to provide education and information on this and organ donation in general in the year ahead both within the Trust and within the community.

Increasing tissue donation remains a strategic objective in addition to ensuring that 100% of potential organ donor referrals are made.

Working with our Black, Asian and Minority Ethnic Groups (BAME) will continue as a strategic objective during the next year and specific work is planned. We plan to approach our colleagues in education in order to introduce discussion of organ donation in schools.

Finally an immense debt of gratitude is owed to all those who have contributed to the achievements of the Trust in organ donation, most of all however to the donors and families for their selfless generosity and their gifts of life.

Dr Gill Fargher

ODC Chair

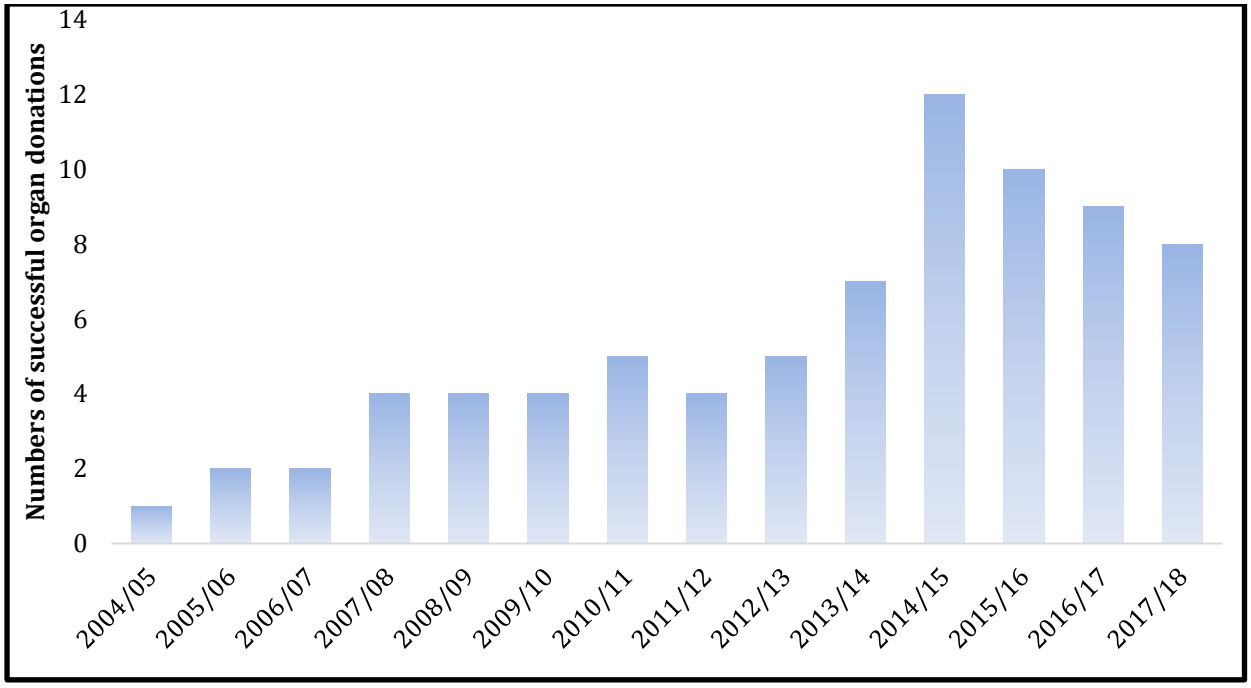
4. Organ Donation Rates / PDA Benchmarking 2017/18

4.1 Medway Trust overview of PDA metrics 2017-18 with 2016-17 data for comparison (see appendix A)

The table below shows the total numbers of organ donors based on the donor type (Donation after Brain Death: DBD versus Donation after Cardiac Death: DCD) with the previous year's data for comparison. There were a total of **11** consented donors but **8** proceeded to organ retrieval leading to **16** organ transplants.

Donor type	2017-18	2016-17
DBD	5	4
DCD	3	5
TOTAL	8	9

The bar chart below shows the numbers of DBD and DCD donors at Medway over the past 14 years.



The table below shows the number of individual organs transplanted (with previous year's data for comparison in brackets)

Donor type	Number of organs transplanted by type 2017-18 (2016-17)				
	Kidney	Pancreas	Liver	Heart	Lung
DBD	6 (8)	0 (1)	4 (3)	0 (0)	0 (0)
DCD	6 (8)	0 (0)	0 (2)	0 (0)	0 (0)
Totals	12 (16)	0 (1)	4 (5)	0 (0)	0 (0)

Overall the Trust's metrics for the percentage of appropriate referrals and approaches to families (measured using the National PDA – Potential Donor Audit, see appendix A), remain positive and give assurance that potential donors are not being missed. The data summarised below shows we are performing above national average in the majority of domains and are already achieving targets set for completion by 2020 as part of the national strategy (see appendix B). The drop in percentage of approach to families to discuss organ donation where a SNOD is present was primarily due to out of hours approaches where a SNOD was not immediately available and families were not keen to delay conversations which is entirely understandable.

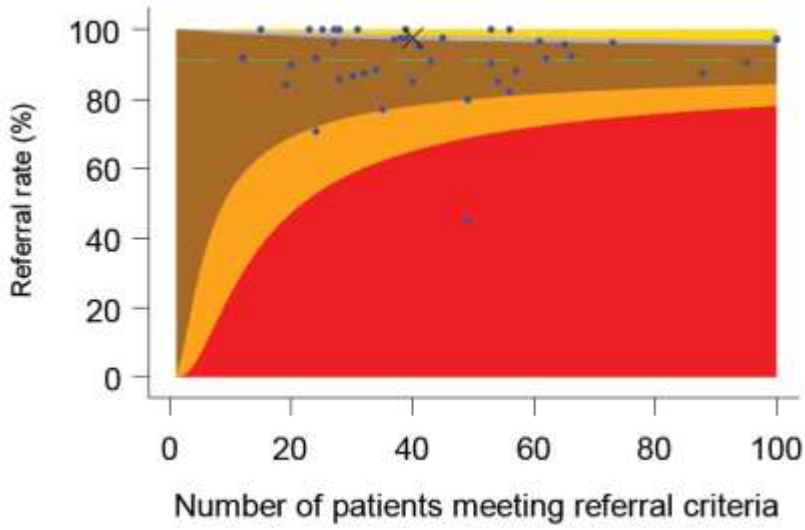
	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	14	1954	27	6281	40	7978
Referred to Organ Donation Service	14	1929	26	5615	39	7302
Referral rate %	G *100%*	*99%*	B *96%*	*89%*	S *98%*	*92%*
Neurological death tested	13	1676				
Testing rate %	B *93%*	*86%*				
Eligible donors[2]	12	1582	17	4456	29	6038
Family approached	11	1471	8	1858	19	3329
Family approached and SNOD present	9	1394	7	1591	16	2985
% of approaches where SNOD present	B *82%*	*95%*	B *88%*	*86%*	B *84%*	*90%*
Consent ascertained	6	1066	6	1115	12	2181
Consent rate %	B *55%*	*72%*	B *75%*	*60%*	B *63%*	*66%*
Actual donors (PDA data)	5	955	3	613	8	1568
% of consented donors that became actual donors	*83%*	*90%*	*50%*	*55%*	*67%*	*72%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

The graph below demonstrates that the Trust's referral rate compares well with peer Trusts. Furthermore, this "peer" group comprises predominantly large district general hospitals and teaching hospitals and reflects the high numbers of organ donation performed by the Trust.



Contra-indications to solid organ transplant

There were **9** patients with medical contraindications to solid organ donation for the period April 2017-18. The reasons listed were:

	DBD		DCD	
	Trust	UK	Trust	UK
Active (not in remission) haematological malignancy (myeloma, lymphoma, leukaemia)	-	15	1	212
All secondary intracerebral tumours	-	-	-	2
Any active cancer with evidence of spread outside affected organ within 3 years of donation	-	41	7	605
Choriocarcinoma	-	-	-	1
Definite, probable or possible case of human TSE, including CJD and vCJD	-	-	-	2
HIV disease (but not HIV infection)	-	2	-	14
Human TSE, CJD or vCJD; blood relatives with CJD; other infectious neurodegenerative diseases	-	-	-	6
Melanoma (except completely excised Stage 1 cancers)	-	4	-	9
No transplantable organ in accordance with organ specific contraindications	-	19	1	306
Other neurodegenerative diseases associated with infectious agents	-	-	-	1
Primary intra-cerebral lymphoma	-	-	-	3
TB: active and untreated	-	3	-	17
Total	**-**	**84**	**9**	**1178**

Reasons why families did not support organ donation

In the UK, organ donation is an “opt-in” process and where the patient’s wishes are unknown, the family is asked for their assent for organ donation. The Trust fully supports a collaborative process between ICU clinician and specialist nurse in organ donation, but even with their experience, some families do not support organ donation.

For 2017-18, there were **7** instances where families did not support organ donation. The reasons listed were:

	DBD		DCD	
	Trust	UK	Trust	UK
Families concerned about organ allocation	-	-	-	1
Family concerned donation may delay the funeral	-	2	-	1
Family concerned that organs may not be transplanted	-	2	-	11
Family did not believe in donation	-	13	-	29
Family did not want surgery to the body	1	52	-	72
Family felt it was against their religious/cultural beliefs	1	44	-	25
Family felt the body needs to be buried whole (unrelated to religious or cultural reasons)	-	39	-	24
Family felt the length of time for donation process was too long	-	23	-	128
Family felt the patient had suffered enough	-	15	-	57
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	-	-	9
Family were divided over the decision	2	21	-	26
Family were not sure whether the patient would have agreed to donation	-	65	1	103
Other	-	24	-	79
Patient previously expressed a wish not to donate	-	91	1	162
Strong refusal - probing not appropriate	1	11	-	16
Total	**5**	**405**	**2**	**743**

Reasons why solid organ donation did not occur

Despite our best efforts, some organs are not viable for transplantation. There were 4 instances documented for 2017-18, with reasons listed below:

	DBD		DCD	
	Trust	UK	Trust	UK
Cardiac Arrest	-	-	-	6
Coroner/Procurator Fiscal refusal	-	19	-	15
Family changed mind	-	4	-	25
Family placed conditions on donation	-	1	-	-
General instability	-	17	-	36
Logistic reasons	-	1	-	1
Organs deemed medically unsuitable by recipient centres	1	40	-	146
Organs deemed medically unsuitable on surgical inspection	-	17	-	8
Other	-	3	1	35
Positive virology	-	9	-	9
Prolonged time to asystole	-	-	2	221
Total	**1**	**111**	**3**	**502**

5. Performance against 2017/18 Objectives

Item	Objectives for 2017/18	Actions Required to Deliver Objective	Measurable Outcome / Milestones	Outcome
1	**0% missed opportunities for organ donation**	• Education for ICU team and feedback on missed cases	PDA data	**98% referral rate for potential DBD and DCD**
2	**Increase tissue donation referrals**	• Nurse education • PDSA cycles to improve referrals via iterative processes	Increased numbers of tissue donation referrals from Trust for 2017-18 compared with previous years	**Tissue donation numbers have increased but there has not been the required "culture change" to ensure this is sustained**
3	**Continue to promote organ donation and membership of the ODR to local community**	• Educational sessions to various stakeholders	Increased membership of PDR in local community	**Multiple lectures delivered:** • **Swale GPs** • **Medway GPs** • **Medway Ethnic Minorities Forum** **Organ donation stand at the Kent show**
4	**Promote organ donation within the hospital**	Lift wraps Organ Donor story boards		**Lift wraps are unable to proceed at this time due to significant problems with existing Trust lifts** **Continued Trust-wide dissemination of information and promotion of the Organ Donor Register** **Interview with ODC Chair in "News@Medway"** **Presentation to Trust Governors, Executives and Non-Executives** **Organ Donor story board produced and ready for unveiling in Organ Donation Week September 2018**

6. Strategic objectives for 2018/19 and Monitoring Arrangements

Objectives for 2018/ 19	Actions Required to Deliver Objective	Measurable Outcome / Milestones	Delivery Lead	Risks to completion
1. 0% missed opportunities for organ donation	Ensure 100% referral for potential DBD and DCD donors on ICU and ED Follow national best-practice for collaborative approach	PDA data	CLOD SNOD ED champion	Increased clinical workload may mean organ donation cannot proceed in suitable individuals at times of high clinical intensity
• **Increase tissue donation referrals**	Education for all ward nurses	Measure percentage referrals vs total number of deceased patients per ward. Overall target 100% but year on year targets need to be realistic.	CLOD SNOD EOL team Tissue donation link nurses	Failure to deliver education to ward staff
3. Continue to promote organ donation and membership of the ODR to local community	Consider potential to speak to schools Continue to work with ethnic minorities to improve ODR membership in BAME communities	Local ODR membership Family assent percentage for organ donation in ICU BAME-specific organ donation meeting	CLOD SNOD ODC	
4. Provide education regarding changes to national "opt out" policy for organ donation	Provide relevant education in accordance with national guidelines as details of "opt out" changes are disseminated from NHSBT	Educational sessions	CLOD SNOD ODC	Delays in relevant information being disseminated from government/ NHSBT

7. Critical Incidents

There were no critical incidents reported in 2017-18.

The critical incident from 2016-17 involving 2 recipients receiving organs from a donor with undiagnosed lymphoma was investigated fully and recently was the subject of a coronial case. Whilst the full report is awaited, the verbal commentary from the expert opinions present were that the teams could not have predicted the presence of the lymphoma prior to organ retrieval given the available information and the clinical presentation.

8. Appendices

A: National potential donor audit report 2017-18

Adobe Acrobat Document

B: “Taking Organ Transplant to 2020: A national strategy” document

Adobe Acrobat Document

C: Finance overview for 2017-18 Financial year

Financial Year	TOTAL 2016-17	2017 - 18 Q1	Q2	Q3	Q4	TOTAL 2017-18
Balance b/f	£0.00	£22,946.30	£31,341.44	£38,373.78	£42,046.96	£22,946.30
Income						
Lead clinician	£12,392.00	£3,098.00	£3,098.00	£3,098.00	£3,098.00	£12,392.00
Organ Donation Committee	£500.00	£500.00	£0.00	£0.00	£0.00	£500.00
Donor Reimbursement	£22,946.00	£8,344.00	£8,344.00	£4,172.00	£4,172.00	£25,032.00
TOTAL INCOME	**£35,838.00**	**£11,942.00**	**£11,442.00**	**£7,270.00**	**£7,270.00**	**£60,870.30**
Expenditure						
Lead clinician (1PA per week)	£12,392.00	£3,546.86	£3,546.86	£3,546.87	£3,546.87	£14,187.46
Organ Donation Committee expenses	£93.70	£0.00	£0.00	£0.00	£0.00	£0.00
Artwork unveiling expenses	£406.00	£0.00	£0.00	£0.00	£0.00	£0.00
Award Presentation for artwork in the atrium	£0.00	£0.00	£564.00	£0.00	£0.00	£564.00
Building Better Healthcare award entry for Collaborative Arts Project	£0.00	£0.00	£118.80	£0.00	£0.00	£118.80
Hotel Room at McDonald Burlington Hotel Birmingham	£0.00	£0.00	£180.00	£0.00	£0.00	£180.00
Lunch for candidates	£0.00	£0.00	£0.00	£49.95	£0.00	£49.95
TOTAL EXPENDITURE	**£12,891.70**	**£3,546.86**	**£4,409.66**	**£3,596.82**	**£3,546.87**	**£15,100.21**
NET (balance carried forward)	**£22,946.30**	**£31,341.44**	**£38,373.78**	**£42,046.96**	**£45,770.09**	**£45,770.09**

NHS
Blood and Transplant

Detailed Report

Actual and Potential Deceased Organ Donation

1 April 2017 - 31 March 2018

Medway NHS Foundation Trust

Table of Contents

Further Information

- Appendix A.1 contains definitions of terms and abbreviations used throughout this report and summarises the main changes made to the PDA over time.
- The latest Organ Donation and Transplantation Activity Report is available at https://www.organdonation.nhs.uk/supporting-my-decision/statistics-about-organ-donation/transplant-activity-report/
- The latest PDA Annual Report is available at http://www.odt.nhs.uk/statistics-and-reports/potential-donor-audit/
- Please refer any queries or requests for further information to your local Specialist Nurse - Organ Donation (SNOD)

Source

NHS Blood and Transplant: UK Transplant Registry (UKTR), Potential Donor Audit (PDA) and Referral Record.
Issued May 2018 based on data meeting PDA criteria reported at 9 May 2018.

1. Donor Outcomes

A summary of the number of donors, patients transplanted, average number of organs donated per donor and organs donated.

Data in this section is obtained from the UK Transplant Registry

Between 1 April 2017 and 31 March 2018, Medway NHS Foundation Trust had 8 deceased solid organ donors, resulting in 16 patients receiving a transplant. Additional information is shown in Tables 1.1 and 1.2, along with comparison data for 2016/17. Figure 1.1 shows the number of donors and patients transplanted for the previous ten periods for comparison.

Table 1.1 Donors, patients transplanted and organs per donor, 1 April 2017 - 31 March 2018 (1 April 2016 - 31 March 2017 for comparison)

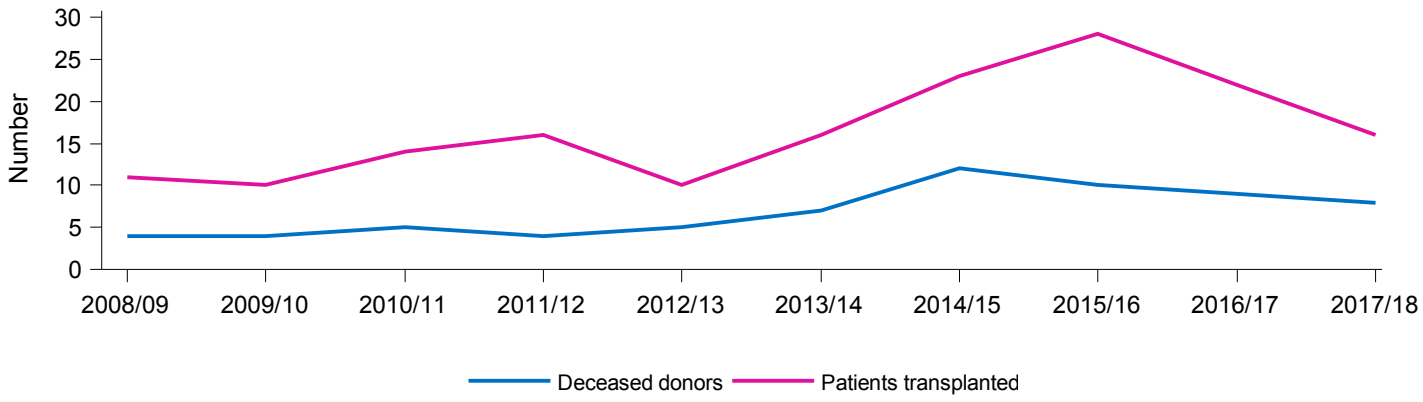
Donor type	Number of donors		Number of patients transplanted		Average number of organs donated per donor: Trust		Average number of organs donated per donor: UK	
DBD	5	(4)	10	(12)	2.8	(3.3)	3.7	(3.7)
DCD	3	(5)	6	(10)	2.0	(2.2)	2.8	(2.7)
DBD and DCD	8	(9)	16	(22)	2.5	(2.7)	3.3	(3.3)

In addition to the 8 proceeding donors there were 3 additional consented donors that did not proceed, all where DCD donation was being facilitated.

Table 1.2 Organs transplanted by type, 1 April 2017 - 31 March 2018 (1 April 2016 - 31 March 2017 for comparison)

Donor type	Number of organs transplanted by type: Kidney		Pancreas		Liver		Heart		Lung		Small bowel	
DBD	6	(8)	0	(1)	4	(3)	0	(0)	0	(0)	0	(0)
DCD	6	(8)	0	(0)	0	(2)	0	(0)	0	(0)	0	(0)
DBD and DCD	12	(16)	0	(1)	4	(5)	0	(0)	0	(0)	0	(0)

Figure 1.1 Number of donors and patients transplanted, 1 April 2008 - 31 March 2018



2. Key Rates in Potential for Organ Donation

A summary of the key rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section presents specific percentage measures of potential donation activity for Medway NHS Foundation Trust.

Performance in your Trust has been compared with UK performance in both Figure 2.1 and Table 2.1 using funnel plot boundaries and the Gold, Silver, Bronze, Amber, and Red (GoSBAR) colour scheme. When compared with UK performance, gold represents exceptional, silver represents good, bronze represents average, amber represents below average, and red represents poor performance. See Appendix A.3 for funnel plot ranges used.

It is acknowledged that the PDA does not capture all activity. In total there was 1 patient referred in 2017/18 who is not included in this section onwards because they were either over 80 years of age or did not die in a unit participating in the PDA. None of these are included in Section 1 because they did not become a solid organ donor.

Note that caution should be applied when interpreting percentages based on small numbers.

Goal: The agreed 2017/18 national targets for DBD and DCD consent rates are 73% and 67%, respectively.

Figure 2.1 Key rates on the potential for organ donation including UK comparison, 1 April 2017 - 31 March 2018

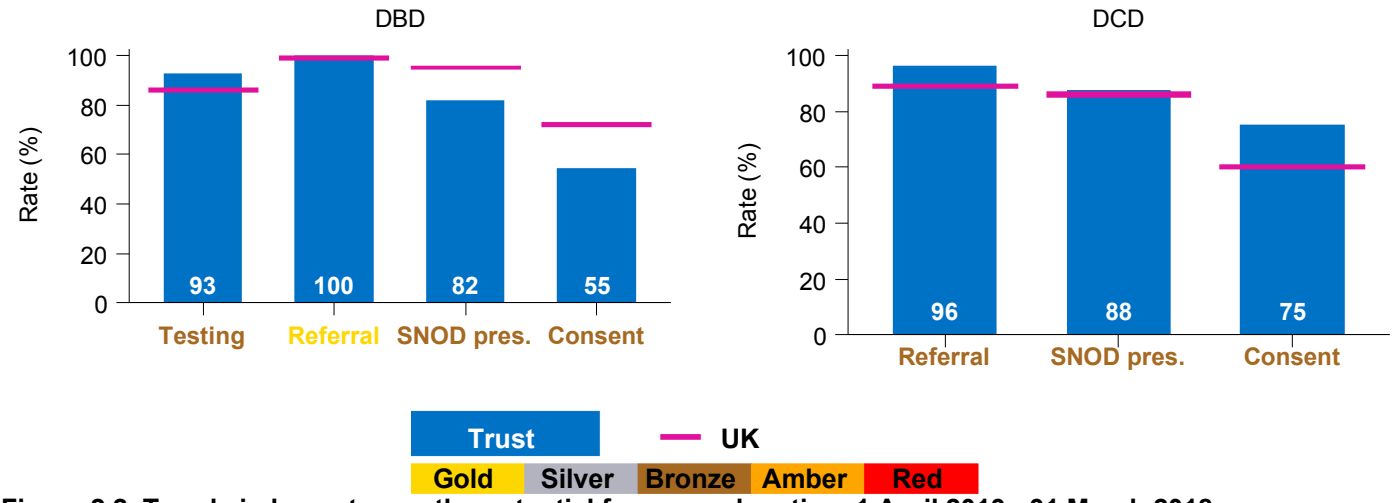


Figure 2.2 Trends in key rates on the potential for organ donation, 1 April 2013 - 31 March 2018

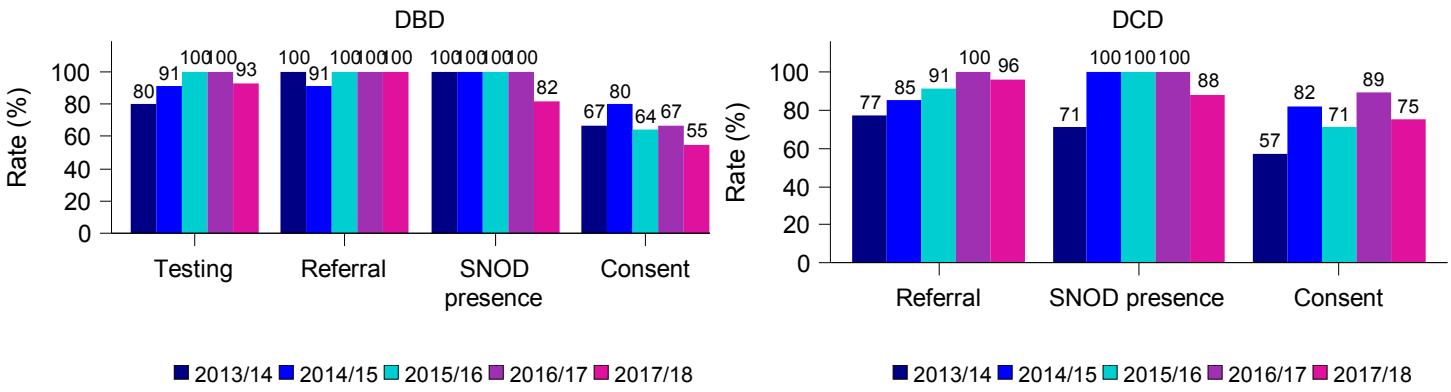


Table 2.1 Key numbers, rates and comparison with national rates, 1 April 2017 - 31 March 2018

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	14	1954	27	6281	40	7978
Referred to Organ Donation Service	14	1929	26	5615	39	7302
Referral rate %	G *100%*	*99%*	B *96%*	*89%*	S *98%*	*92%*
Neurological death tested	13	1676				
Testing rate %	B *93%*	*86%*				
Eligible donors[2]	12	1582	17	4456	29	6038
Family approached	11	1471	8	1858	19	3329
Family approached and SNOD present	9	1394	7	1591	16	2985
% of approaches where SNOD present	B *82%*	*95%*	B *88%*	*86%*	B *84%*	*90%*
Consent ascertained	6	1066	6	1115	12	2181
Consent rate %	B *55%*	*72%*	B *75%*	*60%*	B *63%*	*66%*
Actual donors (PDA data)	5	955	3	613	8	1568
% of consented donors that became actual donors	*83%*	*90%*	*50%*	*55%*	*67%*	*72%*

[1] DBD - A patient with suspected neurological death
DCD - A patient in whom imminent death is anticipated, ie a patient receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours

[2] DBD - Death confirmed by neurological tests and no absolute contraindications to solid organ donation
DCD - Imminent death anticipated and treatment withdrawn with no absolute contraindications to solid organ donation

Note that a patient that meets both the referral criteria for DBD and DCD organ donation is featured in both the DBD and DCD data but will only be counted once in the deceased donors total

Gold | Silver | Bronze | Amber | Red

From 1 April 2017 to 31 March 2018 there was one eligible DCD donor for whom consent for donation was ascertained who is not included in this section because they were facilitated in a neonatal ICU.

3. Best quality of care in organ donation

Key stages in best quality of care in organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section provides information on the quality of care in your Trust at the key stages of organ donation. The ambition is that your Trust misses no opportunity to make a transplant happen and that opportunities are maximised at every stage.

3.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 3.1 Number of patients with suspected neurological death, 1 April 2013 - 31 March 2018

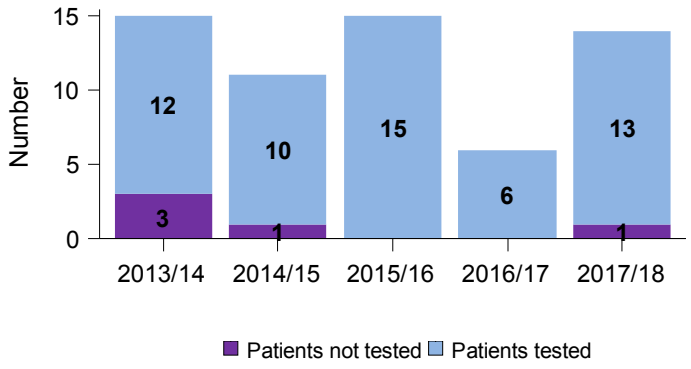


Table 3.1 Reasons given for neurological death tests not being performed, 1 April 2017 - 31 March 2018

	Trust	UK
Biochemical/endocrine abnormality	-	26
Clinical reason/Clinicians decision	-	64
Continuing effects of sedatives	-	17
Family declined donation	-	18
Family pressure not to test	-	21
Hypothermia	-	1
Inability to test all reflexes	-	12
Medical contraindication to donation	-	6
Other	-	18
Patient had previously expressed a wish not to donate	-	2
Patient haemodynamically unstable	1	69
Pressure on ICU beds	-	3
SN-OD advised that donor not suitable	-	9
Treatment withdrawn	-	9
Unknown	-	3
Total	**1**	**278**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to the Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Aim: There should be no purple on the following charts.

Note that patients who met the referral criteria for both DBD and DCD donation will appear in both bar charts and both columns of the reasons table.

Figure 3.2 Number of patients meeting referral criteria, 1 April 2013 - 31 March 2018

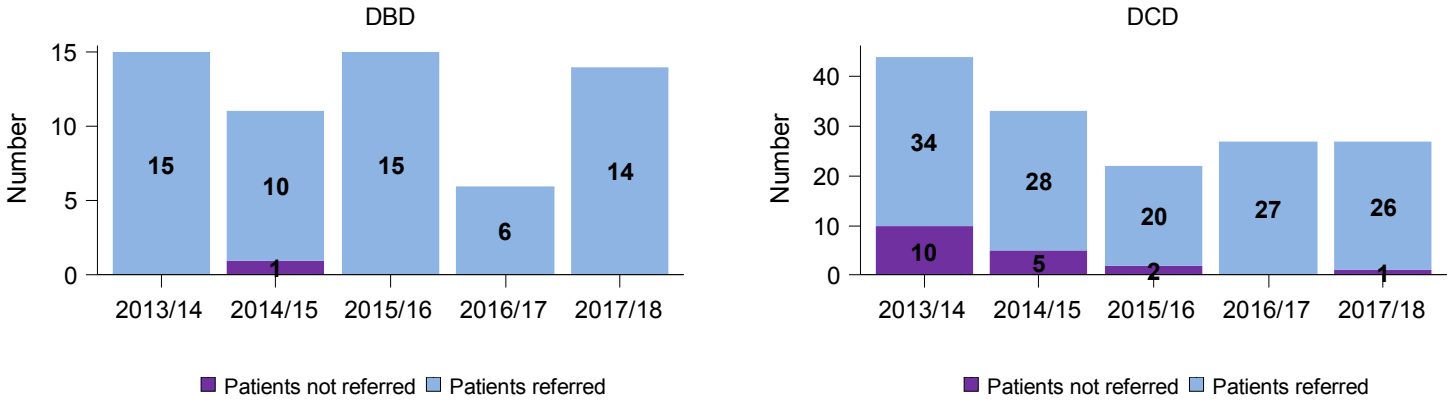


Table 3.2 Reasons given why patient not referred to SNOD, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Clinician assessed that patient was unlikely to become asystolic within 4 hours	-	-	-	7
Coroner/Procurator Fiscal Reason	-	1	-	3
Family declined donation after neurological testing	-	2	-	-
Family declined donation following decision to withdraw treatment	-	-	1	24
Family declined donation prior to neurological testing	-	2	-	3
Medical contraindications	-	1	-	110
Neurological death not confirmed	-	1	-	-
Not identified as a potential donor/organ donation not considered	-	10	-	320
Other	-	5	-	76
Patient had previously expressed a wish not to donate	-	-	-	2
Pressure on ICU beds	-	-	-	7
Reluctance to approach family	-	2	-	8
Thought to be medically unsuitable	-	1	-	106
Total	**-**	**25**	**1**	**666**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.3 Contraindications

Table 3.3 shows the primary absolute medical contraindications to solid organ donation, if applicable, for potential DBD donors confirmed dead by neurological death tests and potential DCD donors in your Trust.

Table 3.3 Primary absolute medical contraindications to solid organ donation, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Active (not in remission) haematological malignancy (myeloma, lymphoma, leukaemia)	-	15	1	212
All secondary intracerebral tumours	-	-	-	2
Any active cancer with evidence of spread outside affected organ within 3 years of donation	-	41	7	605
Choriocarcinoma	-	-	-	1
Definite, probable or possible case of human TSE, including CJD and vCJD	-	-	-	2
HIV disease (but not HIV infection)	-	2	-	14
Human TSE, CJD or vCJD; blood relatives with CJD; other infectious neurodegenerative diseases	-	-	-	6
Melanoma (except completely excised Stage 1 cancers)	-	4	-	9
No transplantable organ in accordance with organ specific contraindications	-	19	1	306
Other neurodegenerative diseases associated with infectious agents	-	-	-	1
Primary intra-cerebral lymphoma	-	-	-	3
TB: active and untreated	-	3	-	17
Total	**-**	**84**	**9**	**1178**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.4 SNOD presence

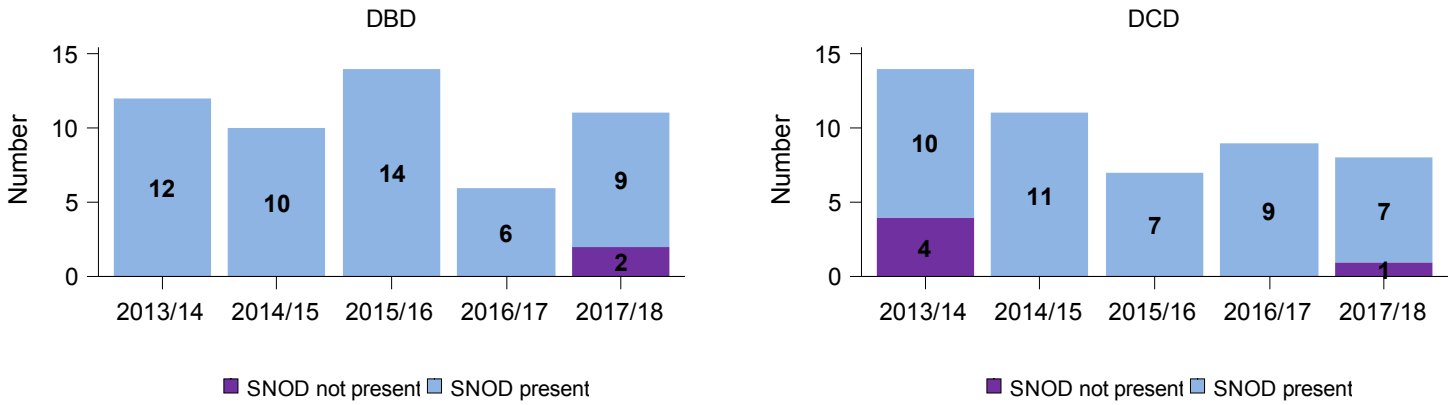
Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Aim: There should be no purple on the following charts.

In the UK, in 2017/18, when a SNOD was not present for the approach to the family to discuss organ donation, DBD and DCD consent/authorisation rates were 36% and 18%, respectively, compared with DBD and DCD consent/authorisation rates of 74% and 67%, respectively, when a SNOD was present.

Every approach to those close to the patient should be planned with the multidisciplinary team (MDT), should involve the SNOD and should be clearly planned taking into account the known wishes of the patient. The NHS Organ Donor Register (ODR) should be checked in all cases of potential donation and this information must be discussed with the family as it represents the eligible donor's legal consent to donation.

Figure 3.3 Number of families approached by SNOD presence, 1 April 2013 - 31 March 2018



[1] NICE, 2011.
NICE Clinical Guidelines - CG135
[accessed 9 May 2018]

[2] NHS Blood and Transplant, 2012.
Timely Identification and Referral of Potential Organ Donors - A Strategy for Implementation of Best Practice
[accessed 9 May 2018]

[3] NHS Blood and Transplant, 2013.
Approaching the Families of Potential Organ Donors – Best Practice Guidance
[accessed 9 May 2018]

3.5 Consent

Goal: The agreed 2017/18 national targets for DBD and DCD consent/authorisation rates are 73% and 67%, respectively.

In 2017/18 the DBD consent rate in your Trust was 55%, less than 10 families of eligible DCD donors were approached therefore this consent rate is not presented.

Figure 3.4 Number of families approached, 1 April 2013 - 31 March 2018

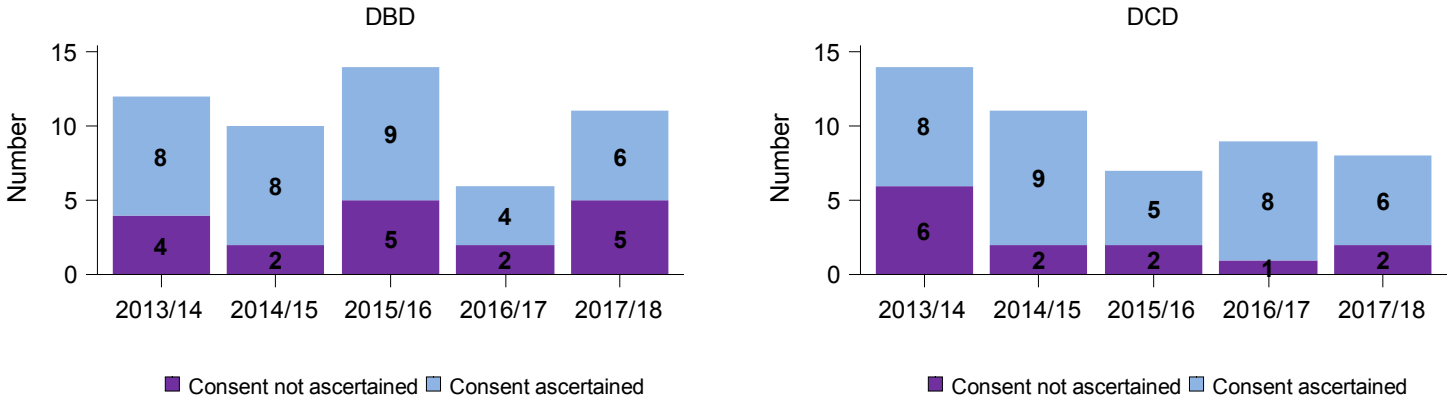


Table 3.4 Reasons given why consent was not ascertained, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Families concerned about organ allocation	-	-	-	1
Family concerned donation may delay the funeral	-	2	-	1
Family concerned that organs may not be transplanted	-	2	-	11
Family did not believe in donation	-	13	-	29
Family did not want surgery to the body	1	52	-	72
Family felt it was against their religious/cultural beliefs	1	44	-	25
Family felt the body needs to be buried whole (unrelated to religious or cultural reasons)	-	39	-	24
Family felt the length of time for donation process was too long	-	23	-	128
Family felt the patient had suffered enough	-	15	-	57
Family had difficulty understanding/accepting neurological testing	-	3	-	-
Family wanted to stay with the patient after death	-	-	-	9
Family were divided over the decision	2	21	-	26
Family were not sure whether the patient would have agreed to donation	-	65	1	103
Other	-	24	-	79
Patient previously expressed a wish not to donate	-	91	1	162
Strong refusal - probing not appropriate	1	11	-	16
Total	**5**	**405**	**2**	**743**

If 'other', please contact your local SNOD or CLOD for more information, if required.

3.6 Solid organ donation

Goal: NHSBT is committed to supporting transplant units to ensure as many organs as possible are safely transplanted. The strategy for achieving this, including steps to minimising warm ischaemic injury in proceeding DCD donors, is set out in NHSBT Taking Organ Utilisation to 2020 [4].

Table 3.5 Reasons why solid organ donation did not occur, 1 April 2017 - 31 March 2018

	DBD		DCD	
	Trust	**UK**	**Trust**	**UK**
Cardiac Arrest	-	-	-	6
Coroner/Procurator Fiscal refusal	-	19	-	15
Family changed mind	-	4	-	25
Family placed conditions on donation	-	1	-	-
General instability	-	17	-	36
Logistic reasons	-	1	-	1
Organs deemed medically unsuitable by recipient centres	1	40	-	146
Organs deemed medically unsuitable on surgical inspection	-	17	-	8
Other	-	3	1	35
Positive virology	-	9	-	9
Prolonged time to asystole	-	-	2	221
Total	**1**	**111**	**3**	**502**

If 'other', please contact your local SNOD or CLOD for more information, if required.

[4] NHS Blood and Transplant, 2017.

Taking Organ Utilisation to 2020
[accessed 9 May 2018]

4. Comparative Data

A comparison of performance in your Trust/Board with national data

Data in this section is obtained from the National Potential Donor Audit (PDA)

This section compares the quality of care in the key areas of organ donation in your Trust with the UK rate using funnel plots. The UK rate is shown as a green dashed line and the funnel shape is formed by the 95% and 99.8% confidence limits around the UK rate. The confidence limits reflect the level of precision of the UK rate relative to the number of observations. Performance in your Trust is indicated by a black cross. The Gold, Silver, Bronze, Amber, and Red colour scheme is used to indicate whether performance in your Trust, when compared to UK performance, is exceptional (gold), good (silver), average (bronze), below average (amber) or poor (red).

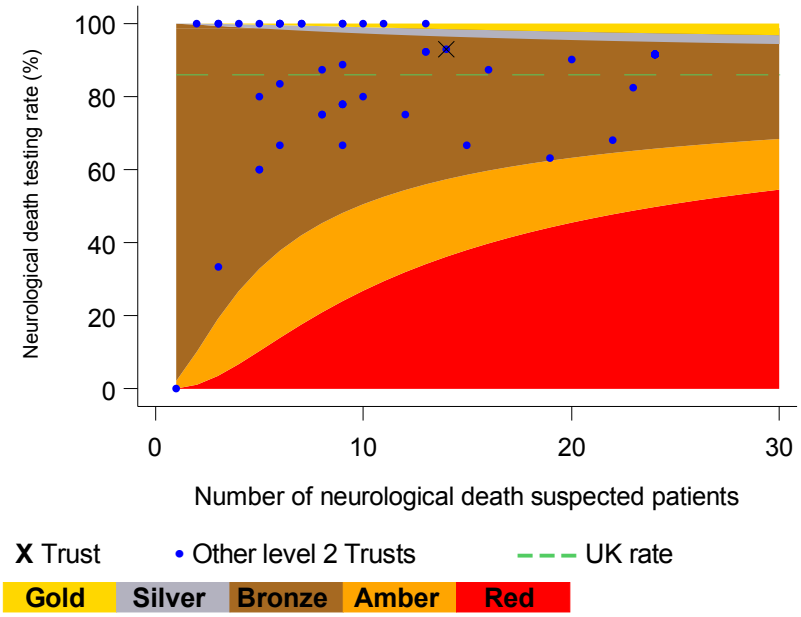
It is important to note that the differences in patient mix have not been accounted for in these plots. Further to these, separate funnel plots for DBD and DCD rates are presented in Section 7.

Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

4.1 Neurological death testing

Goal: neurological death tests are performed wherever possible.

Figure 4.1 Funnel plot of neurological death testing rate, 1 April 2017 - 31 March 2018

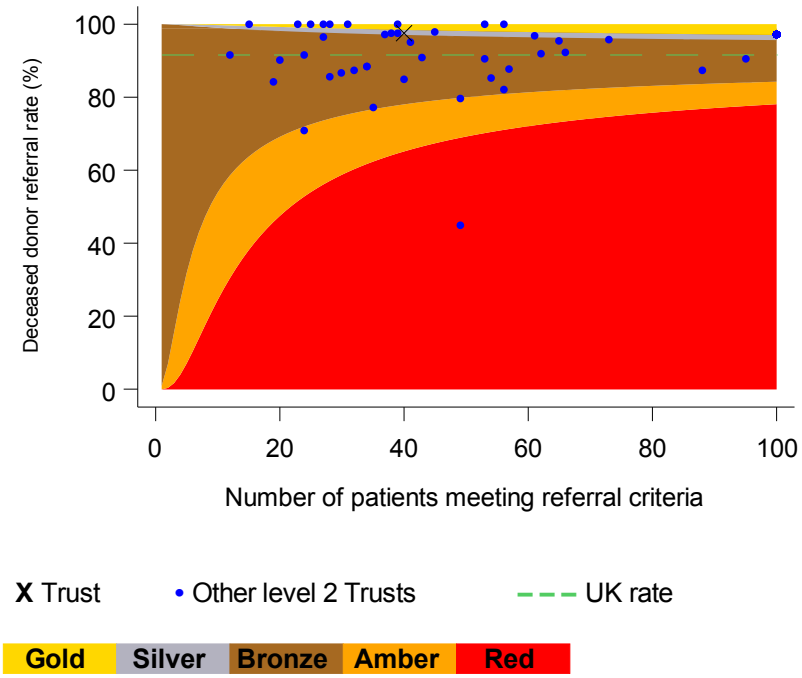


When compared with UK performance the neurological death testing rate in Medway NHS Foundation Trust was average (bronze).

4.2 Referral to Organ Donation Service

Goal: Every patient who meets the referral criteria should be identified and referred to NHSBT's Organ Donation Service, as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance on timely identification and referral of potential organ donors[2].

Figure 4.2 Funnel plot of deceased donor referral rate, 1 April 2017 - 31 March 2018

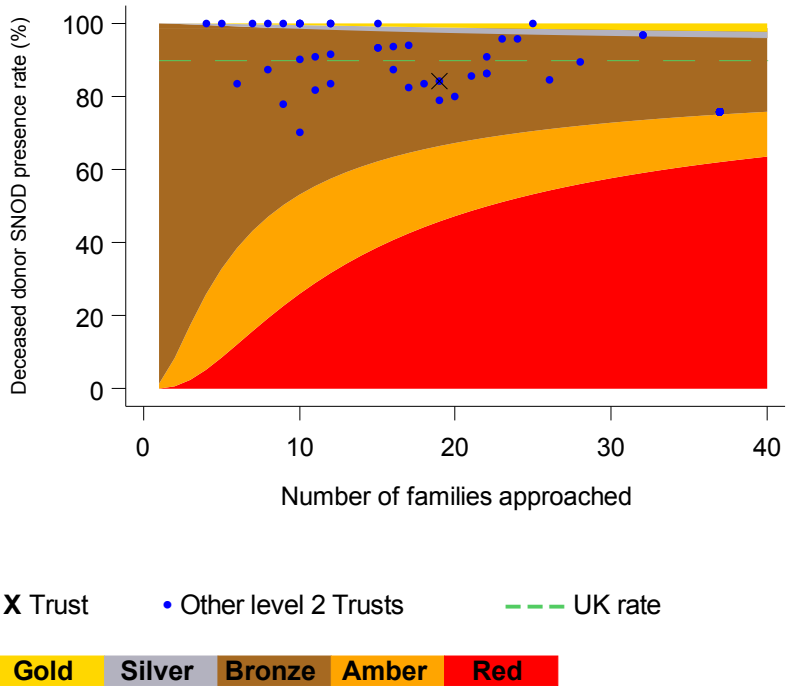


When compared with UK performance Medway NHS Foundation Trust was good (silver) for referral of potential organ donors to NHS Blood and Transplant's Organ Donation Service.

4.3 SNOD presence

Goal: A SNOD should be present during the formal family approach as per NICE CG135[1] and NHS Blood and Transplant (NHSBT) Best Practice Guidance.[3]

Figure 4.3 Funnel plot of SNOD presence rate, 1 April 2017 - 31 March 2018

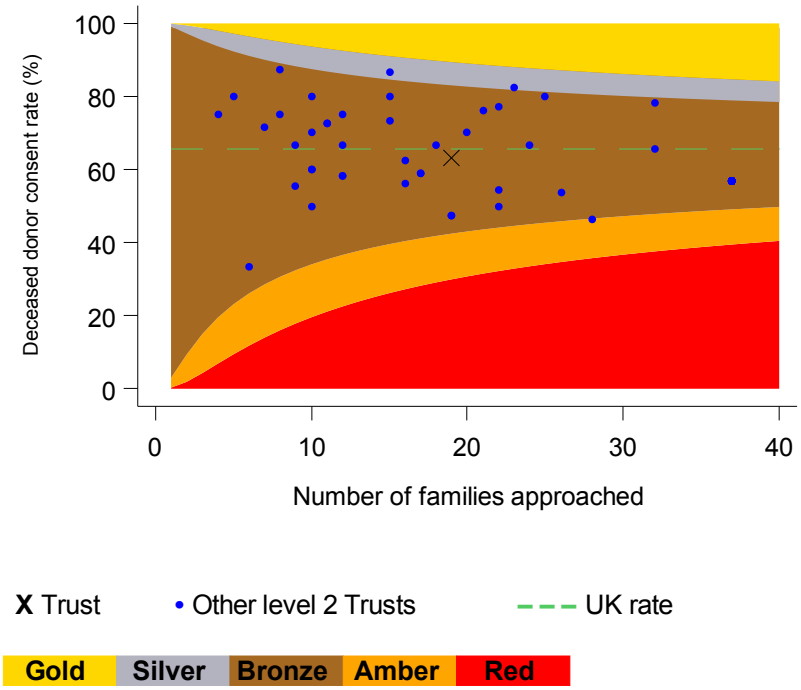


When compared with UK performance Medway NHS Foundation Trust was average (bronze) for Specialist Nurse presence when approaching families to discuss organ donation.

4.4 Consent

Goal: The agreed 2017/18 national targets for DBD and DCD consent/authorisation rates are 73% and 67%, respectively.

Figure 4.4 Funnel plot of consent rate, 1 April 2017 - 31 March 2018



When compared with UK performance the consent rate in Medway NHS Foundation Trust was average (bronze).

5. PDA data by hospital and unit

A summary of key numbers and rates from the PDA by hospital and unit where patient died

Data in this section is obtained from the National Potential Donor Audit (PDA)

Tables 5.1 and 5.2 show the key numbers and rates for patients who met the DBD and/or DCD referral criteria, respectively. Percentages have been excluded where numbers are less than 10.

Table 5.1 Patients who met the DBD referral criteria - key numbers and rates, 1 April 2017 - 31 March 2018

Unit where patient died	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Gillingham, Medway Hospital													
A&E	1	1	-	1	-	1	1	1	1	-	0	-	0
Gen. ICU/HDU	13	12	92	13	100	11	11	10	8	80	6	60	5

Table 5.2 Patients who met the DCD referral criteria - key numbers and rates, 1 April 2017 - 31 March 2018

Unit where patient died	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Gillingham, Medway Hospital											
A&E	0	0	-	0	0	0	0	-	0	-	0
Gen. ICU/HDU	27	26	96	26	17	8	7	-	6	-	3

Tables 5.1 and 5.2 show the unit where the patient died. However, it is acknowledged that there are some occasions where a patient is referred in an Emergency Department but moves to a critical care unit. In total for Medway NHS Foundation Trust in 2017/18 there were 2 such patients. For more information regarding the Emergency Department please see Section 6.

6. Emergency Department data

A summary of key numbers for Emergency Departments

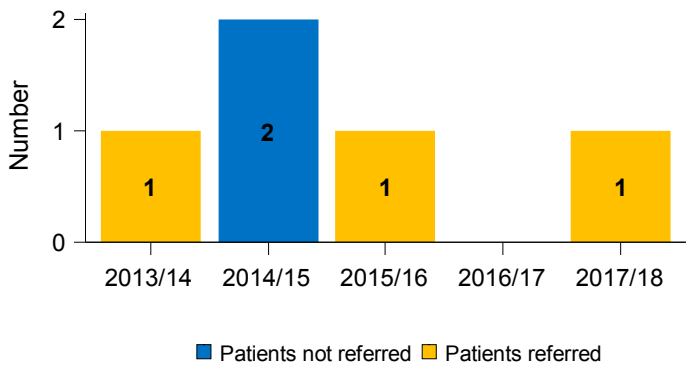
Data in this section is obtained from the National Potential Donor Audit (PDA)

Most patients who go on to become organ donors start their journey in the emergency department (ED). Deceased donation is important, not just for those people waiting on the transplant list, but also because many people in the UK have expressed a wish in life to become organ donors after their death. The overarching principle of the NHSBT Organ donation and Emergency Department strategy [5] is that best quality of care in organ donation should be followed irrespective of the location of the patient within the hospital at the time of death.

6.1 Referral to Organ Donation Service

Goal: No one dies in your ED meeting referral criteria and is not referred to NHSBT's Organ Donation Service.
Aim: There should be no blue on the following chart.

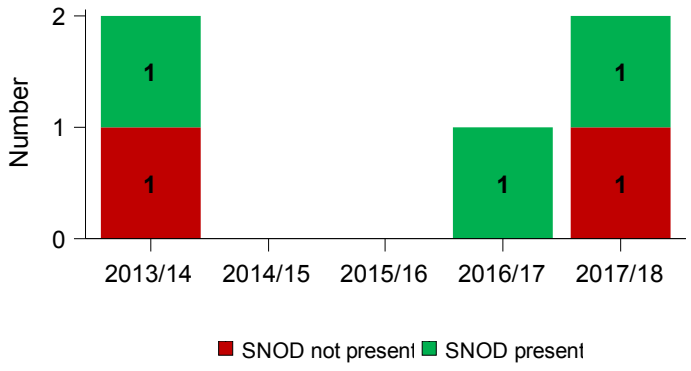
Figure 6.1 Number of patients meeting referral criteria that died in the ED, 1 April 2013 - 31 March 2018



6.2 Organ donation discussions

Goal: No family is approached in ED regarding organ donation without a SNOD present.
Aim: There should be no red on the following chart.

Figure 6.2 Number of families approached in ED by SNOD presence, 1 April 2013 - 31 March 2018



[5] NHS Blood and Transplant, 2016.

Organ Donation and the Emergency Department
[accessed 9 May 2018]

7. Additional data and figures

Regional donor, transplant, and transplant list numbers

Data in this section is obtained from the UK Transplant Registry

7.1 Supplementary Regional data

Table 7.1 Regional donors, transplants, waiting list, and NHS Organ Donor Register (ODR) data

	South East Coast*	UK
1 April 2017 - 31 March 2018		
Deceased donors	86	1,574
Transplants from deceased donors	224	4,012
Deaths on the transplant list	14	426
As at 31 March 2018		
Active transplant list	334	6,045
Number of NHS ODR opt-in registrations (% registered)**	1,993,087 (43%)	24,941,804 (38%)

*Regions have been defined as per former Strategic Health Authorities
** % registered based on population of 4.63 million, based on ONS 2011 census data

Key numbers and rates on the potential for organ donation

Data in this section is obtained from the National Potential Donor Audit (PDA)

7.2 Trust/Board Level Benchmarking

Medway NHS Foundation Trust has been categorised as a level 2 Trust. Levels were reallocated in July 2016 using the average number of donors in 2014/15 and 2015/16, Table 7.2 shows the criteria used and how many Trusts/Boards belong to each level.

Table 7.2 Trust/Board level categories

		Number of Trusts Boards in each level
Level 1	12 or more proceeding donors per year	33
Level 2	5-12 proceeding donors per year	45
Level 3	3-5 proceeding donors per year	47
Level 4	<3 proceeding donors per year	46

Tables 7.3 and 7.4 show the national DBD and DCD key numbers and rates for the UK by Trust/Board level, to aid in comparison with equivalent Trusts/Boards. Note that percentages have been excluded where numbers are less than 10.

Table 7.3 National DBD key numbers and rate by Trust/Board level, 1 April 2017 - 31 March 2018

	Patients where neurological death was suspected	Patients tested	Neurological death testing rate (%)	Patients referred	DBD referral rate (%)	Patients confirmed dead by neurological testing	Eligible DBD donors	Eligible DBD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DBD and DCD donors from eligible DBD donors
Your Trust	14	13	93	14	100	12	12	11	9	82	6	55	5
Level 1	1012	893	88	1002	99	878	843	791	753	95	560	71	510
Level 2	416	352	85	413	99	341	328	302	283	94	220	73	192
Level 3	322	272	84	320	99	265	255	240	230	96	184	77	165
Level 4	204	159	78	194	95	157	156	138	128	93	102	74	88

Table 7.4 National DCD key numbers and rate by Trust/Board level, 1 April 2017 - 31 March 2018

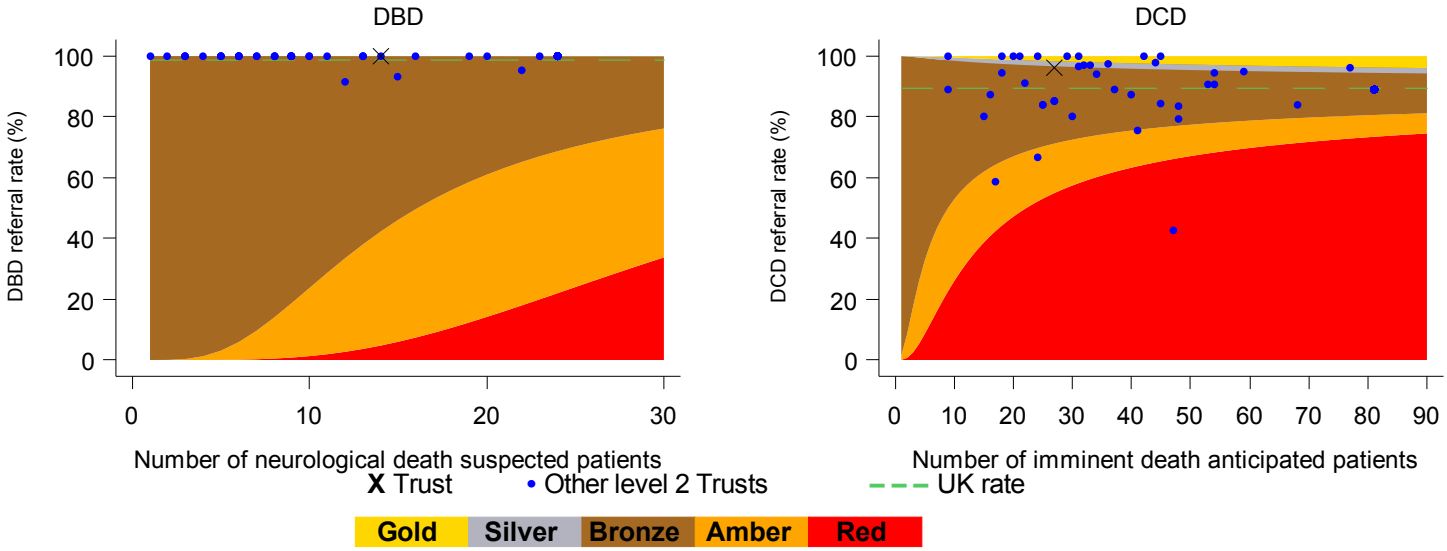
	Patients for whom imminent death was anticipated	Patients referred	DCD referral rate (%)	Patients for whom treatment was withdrawn	Eligible DCD donors	Eligible DCD donors whose family were approached	Approaches where SNOD present	SNOD presence rate (%)	Consent ascertained	Consent rate (%)	Actual DCD donors from eligible DBD donors
Your Trust	27	26	96	26	17	8	7	-	6	-	3
Level 1	2612	2372	91	2384	1906	978	841	86	596	61	349
Level 2	1510	1342	89	1355	1060	394	342	87	233	59	122
Level 3	1407	1253	89	1233	980	326	274	84	199	61	100
Level 4	752	648	86	668	510	160	134	84	87	54	42

7.3 Comparative data for DBD and DCD deceased donors

Funnel plots are presented in Section 4 showing performance in your Trust against the UK rate for deceased organ donation. The following funnel plots present data for DBD and DCD donors separately.

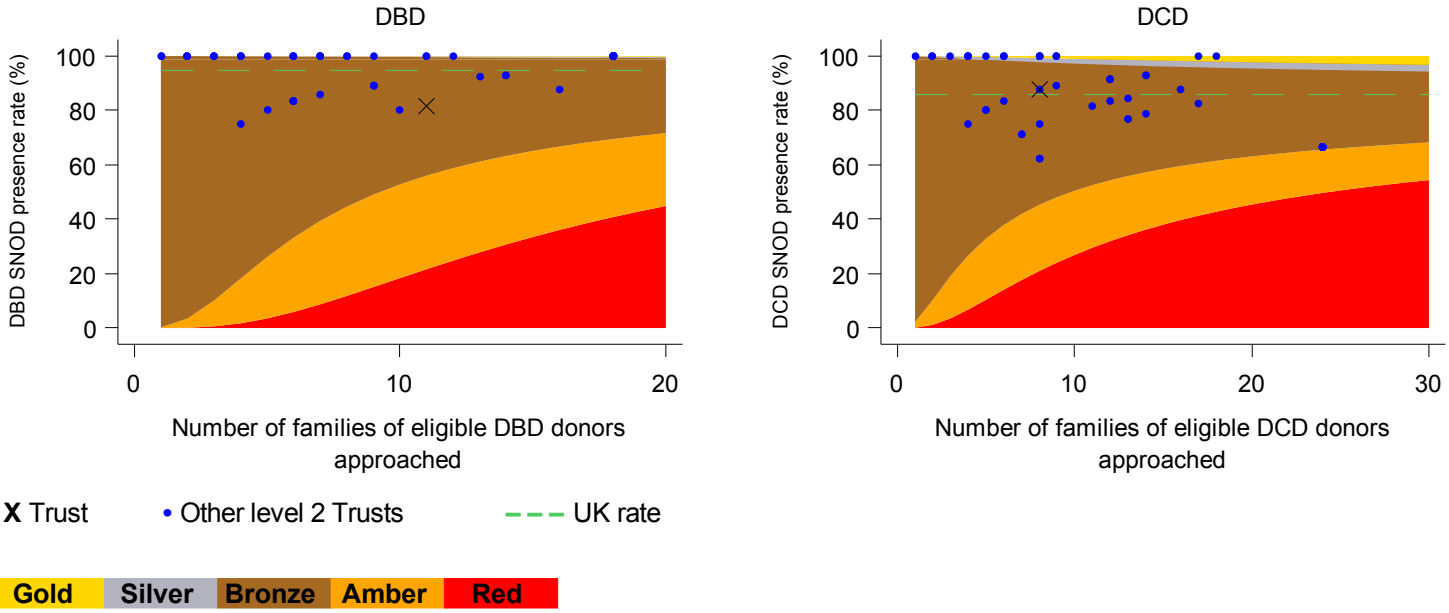
Note that caution should be applied when interpreting percentages calculated with numbers less than 10.

Figure 7.1 Funnel plots of referral rates, 1 April 2017 - 31 March 2018



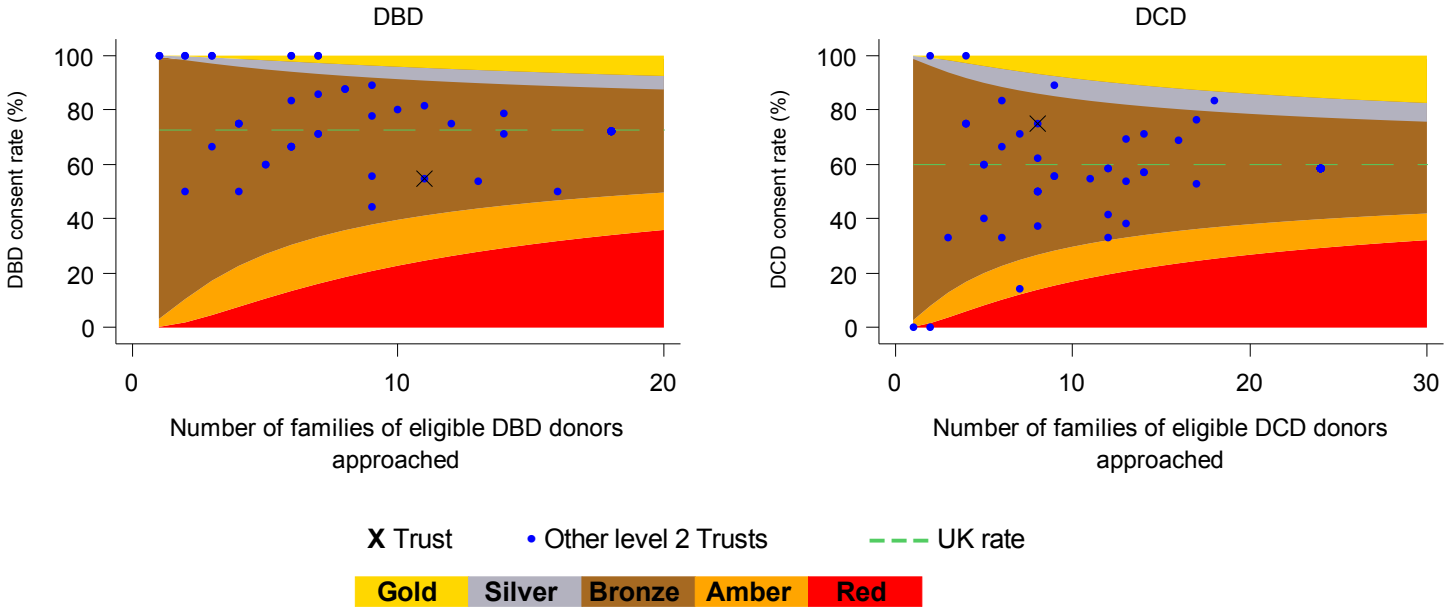
When compared with UK performance Medway NHS Foundation Trust was exceptional (gold) for referral of potential DBD organ donors and average (bronze) for referral of potential DCD organ donors to NHS Blood and Transplant's Organ Donation Service.

Figure 7.2 Funnel plots of SNOD presence rates, 1 April 2017 - 31 March 2018



When compared with UK performance Medway NHS Foundation Trust was average (bronze) and average (bronze) for Specialist Nurse presence in approaches to families of eligible DBD and DCD donors, respectively.

Figure 7.3 Funnel plots of consent rates, 1 April 2017 - 31 March 2018



When compared with UK performance the consent rate in Medway NHS Foundation Trust was average (bronze) and average (bronze) for DBD and DCD donors, respectively.

Appendices

Appendix A.1 Definitions

Potential Donor Audit Definitions

Potential Donor Audit inclusion criteria	1 October 2009 – 31 March 2010 All deaths in critical care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2010 – 31 March 2013 All deaths in critical and emergency care in patients aged 75 and under, excluding cardiothoracic intensive care units 1 April 2013 onwards All deaths in critical and emergency care in patients aged 80 and under

Donors after brain death (DBD) definitions

Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SNOD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to support patient's expressed or deemed consent/authorisation, informed of a nominated/appointed representative, asked to make a decision on donation on behalf of their relative, or informed of a patient's opt-out decision via the ODR.
Consent/authorisation ascertained	Family supported expressed or deemed consent/authorisation , nominated/appointed representative gave consent, or where applicable family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SNOD
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

Donors after circulatory death (DCD) definitions

Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within a time frame to allow donation to occur, as determined at time of assessment
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SNOD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: https://nhsbtdbe.blob.core.windows.net/umbraco-assets-corp/6455/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's opt-out decision via the Organ Donor Register
Consent/authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
SNOD presence rate	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present
Consent/authorisation rate where SNOD was present	Percentage of formal organ donation discussions with families or nominated/appointed representatives where a SNOD was present where consent/authorisation was ascertained

UK Transplant Registry (UKTR) definitions

Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by the number of donors.
Number of organs transplanted	Total number of organs transplanted by organ type

Appendix A.2 Data Description

This report provides a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit (PDA), the accompanying Referral Record, and the UK Transplant Registry (UKTR) for the specified Trust, Board, Organ Donation Services Team, or nation.

This report is provided for information and to facilitate case based discussion about organ donation by the Organ Donation Committee at your Trust/Board.

As part of the PDA, patients over 80 years of age and those who did not die on a critical care unit or emergency department are not audited nationally and are therefore excluded from the majority of this report. Data from neonatal intensive care units (ICU) have also been excluded from this report. In addition, some information may be outstanding due to late reporting and difficulties obtaining patient notes. Donations not captured by the PDA will still be included in the data supplied from the accompanying Referral Record or from the UKTR, as appropriate.

Percentages have not been calculated for level 3 or 4 Trust/Boards and where stated when numbers are less than 10.

Appendix A.3 Table and Figure Description

1 Donor outcomes	
Table 1.1	The number of actual donors, the resulting number of patients transplanted and the average number of organs donated per donor have been obtained from the UK Transplant Registry (UKTR) for your Trust/Board. Results have been displayed separately for donors after brain death (DBD) and donors after circulatory death (DCD).
Table 1.2	The number of organs transplanted by type from donors at your Trust/Board has been obtained from the UKTR. Further information can be obtained from your local Specialist Nurse – Organ Donation (SNOD), specifically regarding organs that were not transplanted. Results have been displayed separately for DBD and DCD.
Figure 1.1	The number of actual donors and the resulting number of patients transplanted obtained from the UKTR for your Trust/Board for the past 10 equivalent time periods are presented on a line chart.

2 Key rates in potential for organ donation	
Figure 2.1	Key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented in a bar chart, using data from the Potential Donor Audit (PDA). The comparative UK rate, for the same time period, is illustrated by the pink line. The key rates labels are coloured using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below.
Figure 2.2	Trends in the key percentage measures of DBD and DCD potential donation activity for your Trust/Board are presented for the past five equivalent time periods, using data from the PDA.
Table 2.1	A summary of DBD, DCD and deceased donor data and key numbers have been obtained from the PDA. A UK comparison is also provided. Note that caution should be applied when interpreting percentages based on small numbers. Appendix A.1 gives a fuller explanation of terms used. The key rates are highlighted using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme to show the performance of your Trust/Board, relative to the UK rate, as reflected in the funnel plots (see description for Figure 4.1 below).

3 Best quality of care in organ donation	
Figure 3.1	A stacked bar chart displays the number of patients with suspected neurological death who were tested and the number who were not tested in your Trust/Board for the past five equivalent time periods.
Table 3.1	The reasons given for neurological death tests not being performed in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.2	Stacked bar charts display the number of DBD and DCD patients meeting referral criteria who were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Table 3.2	The reasons given for not referring patients to the Organ Donation Service in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.3	The primary absolute medical contraindications to solid organ donation for DBD and DCD patients have been obtained from the PDA, if applicable. A UK comparison is also provided.
Figure 3.3	Stacked bar charts display the number of families of DBD and DCD patients approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.
Figure 3.4	Stacked bar charts display the number of families of DBD and DCD patients approached where consent/authorisation for organ donation was ascertained and the number approached where consent/authorisation was not ascertained in your Trust/Board for the past five equivalent time periods.

Table 3.4	The reasons why consent/authorisation was not ascertained for solid organ donation in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.
Table 3.5	The reasons why solid organ donation did not occur in your Trust/Board, have been obtained from the PDA, if applicable. A UK comparison is also provided.

4 Comparative data

Figure 4.1	A funnel plot of the neurological death testing rate is displayed using data obtained from the PDA. Each Trust/Board, of the same level, is represented on the plot as a blue dot, although one dot may represent more than one Trust/Board. The UK rate is shown on the plot as a green horizontal dashed line, together with 95% and 99.8% confidence limits for this rate. These limits form a 'funnel', which is shaded using the gold, silver, bronze, amber, and red (GoSBAR) colour scheme. Graphs obtained in this way are known as funnel plots. If a Trust/Board lies within the 95% limits, shaded bronze, then that Trust/Board has a rate that is statistically consistent with the UK rate (average performance). If a Trust/Board lies outside the 95% confidence limits, shaded silver (good performance) or amber (below average performance), this serves as an alert that the Trust/Board may have a rate that is significantly different from the UK rate. When a Trust/Board lies above the upper 99.8% limit, shaded gold, this indicates a rate that is significantly higher than the UK rate (exceptional performance), while a Trust/Board that lies below the lower limit, shaded red, has a rate that is significantly lower than the UK rate (poor performance). It is important to note that differences in patient mix have not been accounted for in these plots. Your Trust/Board is shown on the plot as the large black cross. If there is no large black cross on the plot, your Trust/Board did not report any patients of the type presented. The funnel plots can also be used to identify the maximum rates currently being achieved by Trusts/Boards with similar donor potential.
Figure 4.2	A funnel plot of the deceased donor referral rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.3	A funnel plot of the deceased donor SNOD presence rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 4.4	A funnel plot of the deceased donor consent/authorisation rate is displayed using data obtained from the PDA. See description for Figure 4.1 above.

5 PDA data by hospital and unit

Table 5.1	DBD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.
Table 5.2	DCD key numbers and rates by unit where the patient died have been obtained from the PDA. Percentages have been excluded where numbers are less than 10.

6 Emergency department data

Figure 6.1	Stacked bar charts display the number of patients that died in the emergency department (ED) who met the referral criteria and were referred to the Organ Donation Service and the number who were not referred in your Trust/Board for the past five equivalent time periods.
Figure 6.2	Stacked bar charts display the number of families of patients in ED approached where a SNOD was present and the number approached where a SNOD was not present in your Trust/Board for the past five equivalent time periods.

7 Additional data and figures

Table 7.1	A summary of deceased donor, transplant, transplant list and ODR opt-in registration data for your region have been obtained from the UKTR. Your region has been defined as per former Strategic Health Authority. A UK comparison is also provided.
Table 7.2	Trust/board level categories and the relevant expected number of proceeding donors per year are provided for information.
Table 7.3	National DBD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Table 7.4	National DCD key numbers and rates for level 1, 2, 3 and 4 Trusts/Boards are displayed alongside your local data to aid comparison with equivalent Trusts/Boards. Percentages have been excluded where numbers are less than 10.
Figure 7.1	A funnel plot of the DBD and DCD referral rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.2	A funnel plot of the DBD and DCD SNOD presence rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.
Figure 7.3	A funnel plot of the DBD and DCD consent/authorisation rates are displayed using data obtained from the PDA. See description for Figure 4.1 above.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 06/09/2018 Agenda item

11

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 Improvement Committee
Executive Summary	To inform Board Members in the form of a flash report of July's performance across all functions and key performance indicators. A full report will be presented to the next Board. Key points are: • The Trust did not achieve the **four hour ED target** for July but performance has improved from 80.62% in June to 85.53% in July. • There were four **12 hour breaches** in July. • **HSMR** data reported in this month's IQPR is for the period from April 2017 to March 2018. This is currently 111.9, which is within expected range. • This month saw a 19.13% decrease in the number of **Mixed Sex Accommodation** breaches, which totalled 186 in July. An IT system has been launched to support the wards in accurately recording and reviewing MSA breaches. • **RTT** performance has increased to 82.52% from 81.68%. This is below the national standard of 92%. • All 31-day **Cancer targets** and both the 62-day GP standard and 62-day screening have been achieved in June. The 2-week wait target has not been met. The 2-week wait symptomatic breast performance has decreased by 3.33% to 80.00%. The 62-day GP

Report to the Board of Directors

	performance was achieved in June, and performance has improved by 6.86% to 90.64%. The 62-day screening standard was also achieved in June, which has increased by 17.52% to 94.44%. • There was a 13.0% increase in the number of **falls** in July (78) compared to June (69). • 62 complaints were reported in the month, a decrease from June's 75. There were 5 complaint returners in July.
Resource Implications	N/A
Risk and Assurance	See report
Legal Implications/Regulatory Requirements	N/A
Improvement Plan Implication	Supports the Improvement Programme in the following areas: Workforce, Data Quality, Nursing, Finance
Quality Impact Assessment	See report 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

August 2018

Please note the data included in this report relates to **July** 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.

10867 Patients visited our ED , which is a **4.61% increase** on the previous month, with **85.53%** seen within 4 hours, compared to 80.62% . **1515** Patients were admitted, with an **increase** in conversion rate of **13.94%** compared to 13.86% in June.

There were **5559** total patient admissions in July, and **5519** patients were discharged.

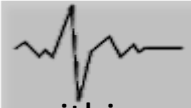
Bed Occupancy **decreased** by **1.94%** in July to **92.78%**.

3249 patients arrived at ED via ambulance which is a **4.84% increase** on last month.

28.8% Of ambulance patients were seen in under 15 minutes.

July's Story....

458 Babies were delivered in the month of July (66 more than June) with Emergency C-Section rate with an **increase** of **0.89%** from the previous month to **17.98%.**



HSMR is **111.9** and within expected parameters (106.0 – 118.1) compared to 110.5 as reported in June.

81% of staff have had an appraisal compared to **82%** in June.

37691 Patients attended an outpatient appointment with **8.75%** DNA rate which is an increase of **0.22%** on last month.

There were **78** total falls in July, compared to **69** in June.

RTT Overall Incomplete Pathways for July was **82.52%** which increased by **0.84%** on previous month. This is below the Trust improvement trajectory. The Trust also reported **2 x 52** week waiters which has increased compared to June.

31 day subsequent treatment surgery cancer target was achieved at **95.00%** in June (reported one month in arrears).

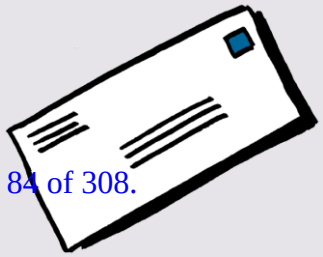
2 Week Wait symptomatic breast was below the target of **93%** in June with performance of **80.00%** - decreased by 3.33%.

2 Week Wait cancer performance for June was **92.76%** (reported one month in arrears) . This is a **0.29%** increase from May's performance.

July's Performance....

92.30% of patients waited under 6 weeks for diagnostic tests in the month of July, which has increased by **0.44%** since June's reported performance.

We received **62** complaints in July, decreasing from those received in June by **13**. The number of complaint returners has increased to **5** in July.



There were **186** Mixed Sex Accommodation breaches in July which is a **19.13%** decrease on June's performance.

Safe Page 10

Legend: Compliant with target; Breaching target

Serious Incidents

As at 31st July 2018 there are a total of:

- Open SIs within allocated timeframe – 20
- Open SIs breaching the allocated timeframe – 0
- New SIs reported on STEIS in July 2018 – 13

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 July is 43%.
- Submit a 72 hour report to the Clinical Commissioning Group (CCG) within 3 working days of the SI being reported. Trust wide compliance for July is 92%.
- Submit 100% of all serious incident final reports to the CCG within 60 working days. Trust wide compliance for July is 100%.

Infection Control

MRSA bacteraemia Trust-attributable

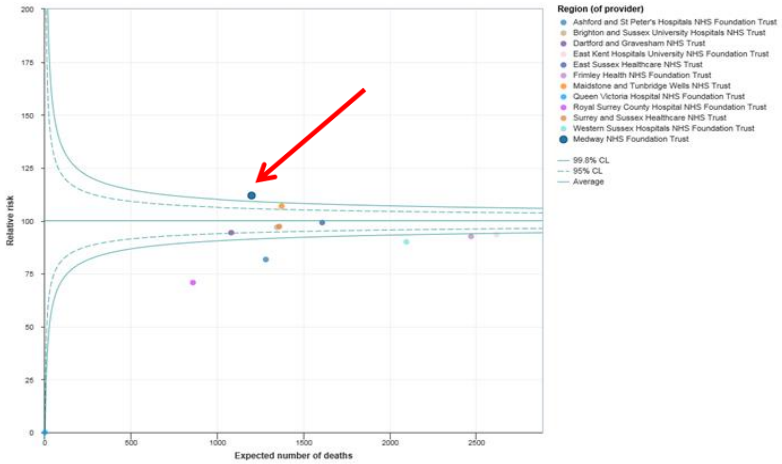
- There was one MRSA bacteraemia case for July, attributed to Nelson ward. Initial review has identified unnecessary blood culture sampling at two stages in the patient's admission. A full post-infection review is in progress.

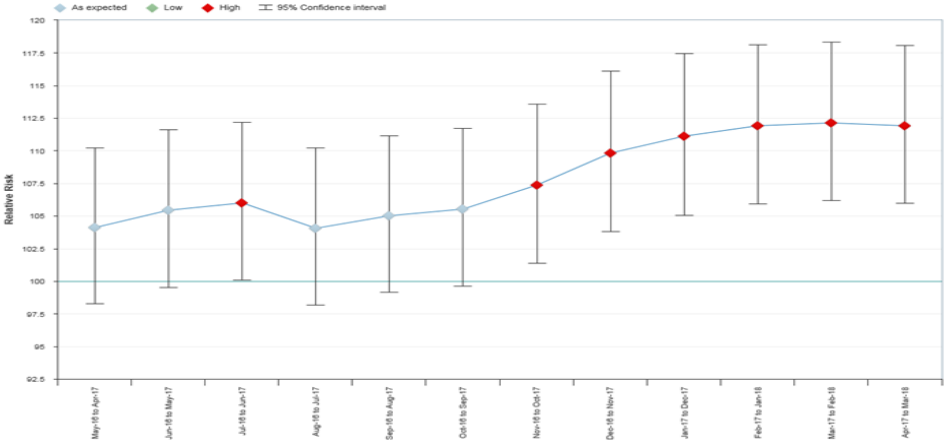
Pressure Injuries

We have reported a month on month increase of low harm pressure ulcer injuries with 20 incidences in July. There has been a change to the reporting methodology in line with recently launched national guidance. Prior to July 2018, Trusts did not internally report suspected deep tissue injury (SDTI) or unstageable pressure injury damage within local performance reports. The data previously reported reflected the monthly Safety Thermometer data which is used for national benchmarking. The IQPR data now includes all incidences of pressure injury, which explains the reported increase in incidents. The change in reporting has not required a new internal data collection process to be implemented. The Tissue Viability team have historically captured data for all incidents and used their internal data for reporting overall performance and improvement in 2017/2018.

Mortality

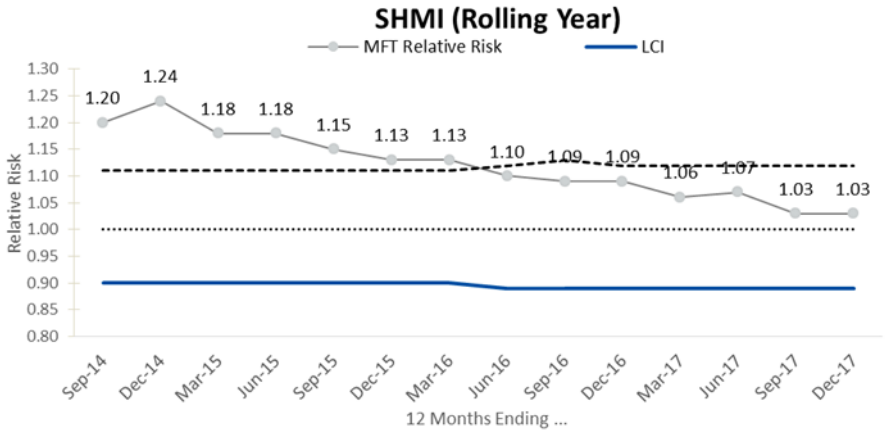
The Hospital Standardised Mortality Ratio (HSMR) for the period from April 2017 to March 2018 is 111.9 (95% confidence interval 106.0 – 118.1). This represents a decrease from the previous rolling 12 month value of 112.1 and is highlighted as high for the sixth consecutive month by Dr Foster. Peer comparison shows that the Trust currently has the highest relative risk in the area.



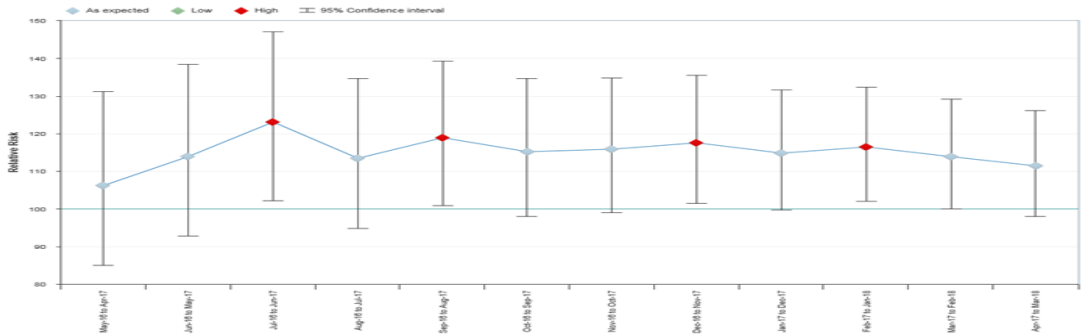


The latest SHMI value for the period January – December 2017 was published on 19 July 2018. This has not changed since the last publication in March 2018, and remains within the expected range.

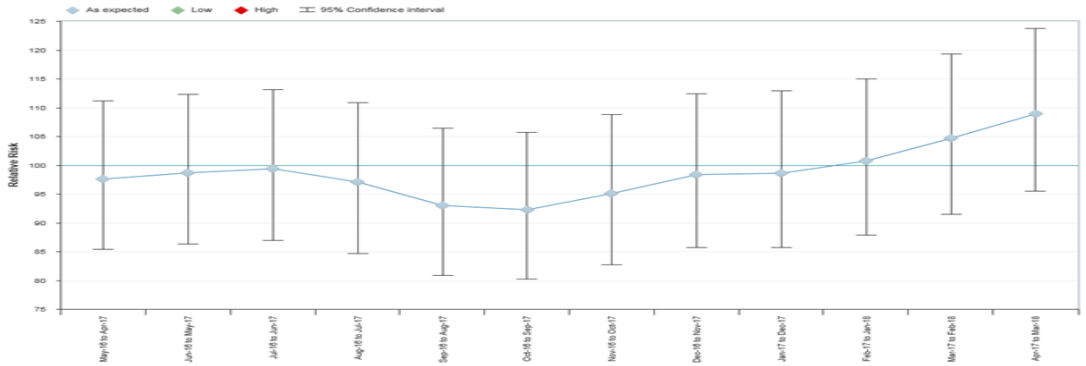
The rolling year trend is illustrated on the right.



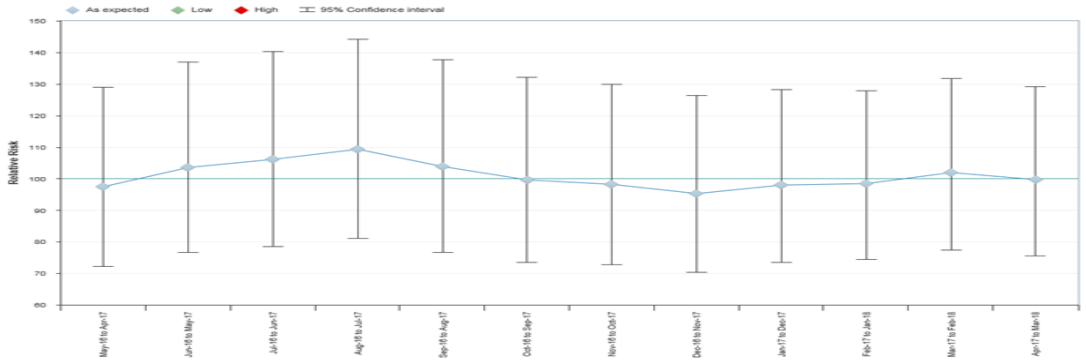
The HSMR for Septicaemia is currently **111.4** (95% confidence interval 98.0 – 126.1). This represents a decrease from 113.9 for the period March 2017 – February 2018, and is within the expected limits.



The HSMR for Pneumonia is currently **108.9** (95% confidence interval 95.4 – 123.7); this represents an increase compared to 104.8 for March 2017 – February 2018, but remains within the expected range.

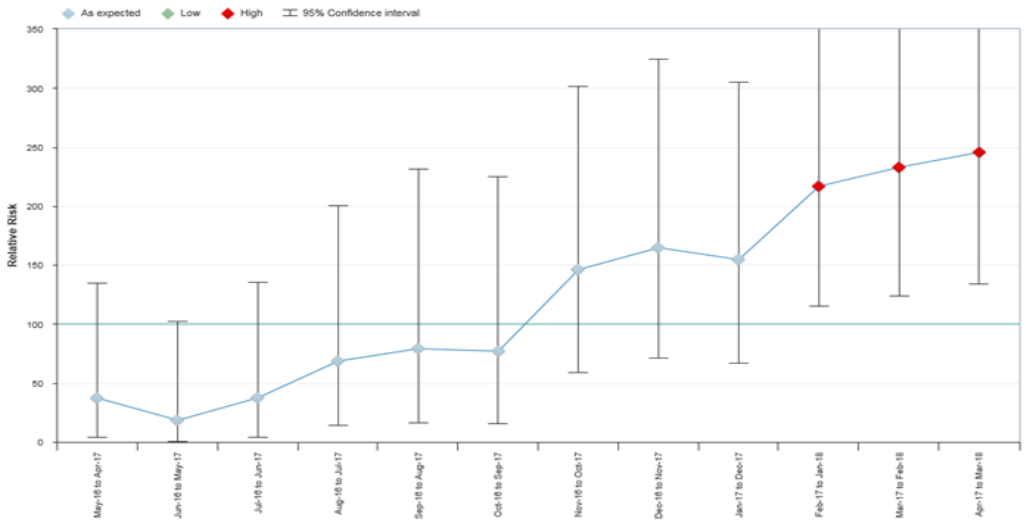


The HSMR for congestive heart failure is **99.7** (95% confidence interval 75.5 – 129.2) and is within expected limits.



The diagnosis group Complications of surgical procedures or medical care has flagged as having a high relative risk for three consecutive months; however, total numbers are low (only 14 deaths out of 616 patients in the period April 2017 to March 2018). Initial review of these cases does not show any obvious reason for concern.

The data is correct at the time of compilation – Thursday, 26th July 2018.



Caring Page 23

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

We have seen a decrease in MSA breaches this month as systemic changes are being further understood. Analysis is being undertaken of the MSA breach data to highlight key issues and working with the services to ensure data is being entered correctly on Extramed. On 15 August, the Trust hosted a visit from the NHSI MSA Improvement Collaborative leads. The visit provided the Trust MSA Improvement team an opportunity to discuss with NHSI the site-specific challenges of managing patient placement in accordance with MSA guidance. Three areas of particular challenge were visited; Bronte, ICU and Lister. Feedback on our improvement plan was positive and the discussion highlighted the critical success factor to achieving improvement in MSA compliance is a culture of zero tolerance of breaches.

Responsive Page 24

- **RTT**

18 week compliance has improved compared to the previous month. In July, the Trust achieved 82.52% against a trajectory of 81.70%.

Two 52-week breaches were declared, one in Colorectal and another in Neurology. Both pathways have had a clinical harm review completed.

Cancer

June performance against the cancer waiting time standards has improved on last month with compliant performance against all 31d targets and 62d GP referral and screening standards.

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

- There were 81 breaches in June across a number of tumour sites with Children, Lower GI, Lung, Skin, Thyroid and Upper GI being non-compliant.
- Breaches were predominantly as a result of patient choice, patient holidays, DNAs, lack of interpreter and rescheduled appointment due to patient medication.
- 8/21 of the 2 week wait breaches were booked within the target 48 hours from receipt of referral.
- There were 10 symptomatic breast breaches as a result of patient choice and patient holidays.

Cancer (cont'd)

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

- There were 2 reported breaches against the 31d first definitive standard.
- There was 1 reported breach against the 31 day subsequent treatment (Surgery).

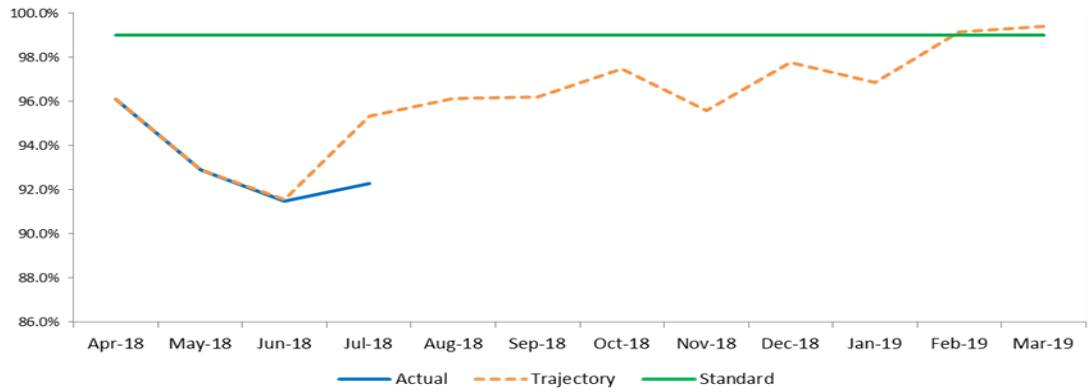
62D – The Trust is compliant against the GP 62 day standard and 62 day screening standard.

- The 62 GP standard performance is 90.64%, above the improvement trajectory.
- The shadow 38 day reporting performance improved the 62d standard to 93.33%
- There were 8 breaches against the GP 62 day referral standard. These are detailed as 1 Breast, 1 Gynaecology, 0.5 Haematology, 0.5 Head & Neck, 1 Lower GI, 1 Lung, 2 Upper GI and 1 Urology.
- Pathway breaches were as a result of late referral from tertiary trust, further diagnostic tests at tertiary trust, imaging delays, a complex pathway and patient holiday.
- There are 3 breaches over 104 days and 4 breaches between 62 and 76 days.

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual	86.4%	83.8%	90.6%									
Trajectory	86.4%	84.8%	84.0%	85.2%	85.1%	86.1%	86.1%	85.5%	85.7%	86.1%	85.9%	85.1%
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 an uplift of 0.8% in July 2018, due to significant issues with capacity .



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual	96.1	92.9	91.5	92.3								
Trajectory	96.1	92.9	91.6	95.3	96.2	96.2	97.5	95.6	97.8	96.8	99.1	99.4
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
Difference to Trajectory	0	0	0.1	3	96.2	96.2	97.5	95.6	97.8	96.8	99.1	99.4
Difference to Standard	-2.9	-6.1	-7.4	-3.7	-2.8	-2.8	-1.5	-3.4	-1.2	-2.2	0.1	0.4

Further actions:

- Performance has risen against the previous month (change of +0.44%), but remains behind trajectory
- Plan to clear backlog through additional capacity being brought in for NOUS – immediate and ongoing (increasing capacity by approx. 40%) + introduction of the BMUS vetting criteria 1st August, two months ahead of plan (reducing demand by approx. 30%).
- Additional capacity is being brought in for MRI (fortnightly van – marginal increase in capacity)
- Audiology have dated all backlog and performance improved by 5.9%; additional Data errors were discovered and removed from system, further clearing waiting list and reported breeches in error
- Data Quality validation is occurring in all diagnostic areas to clear old, duplicate and unrequired requests, with Exec sign off received to remove historic data
- 3rd Party providers to be managed on KPIs / TATs in line with national guidance
- Full and accurate D&C exercises being undertaken in all DM01 areas to identify gaps and opportunities

- **ED**

The Trust's performance against the national 4 hour standard for July was below trajectory at 87.06% for all types. This saw a 0.1% uplift on the prior months performance.

The total number of attendances for July is 10,867 in month. We observed a 2.7% increase above outturn for the same period last year. The type one attendances are 14.75% over the planned activity within the current agreed block contract. The Trust has therefore struggled to keep pace with this unplanned demand for non-elective services.

Admitted 4 hour performance was 17.69%, which is a reduction of 7.8% on June's position. The non-admitted pathway observed a slight improvement on the previous month and ended at 90.8%. Minors' performance was 99.23% and Children's ED ended on 100% for the month.

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

The Trust observed an average of 70 4-hour breaches each day. The majority of which are within Medicine and are 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. Total emergency admissions averaged 87 whilst total emergency discharges averaged at 80, which represents a widening gap when compared with last month's activity. The transformation team's work plan will have a focus on the organisational-wide length of stay reduction plan.

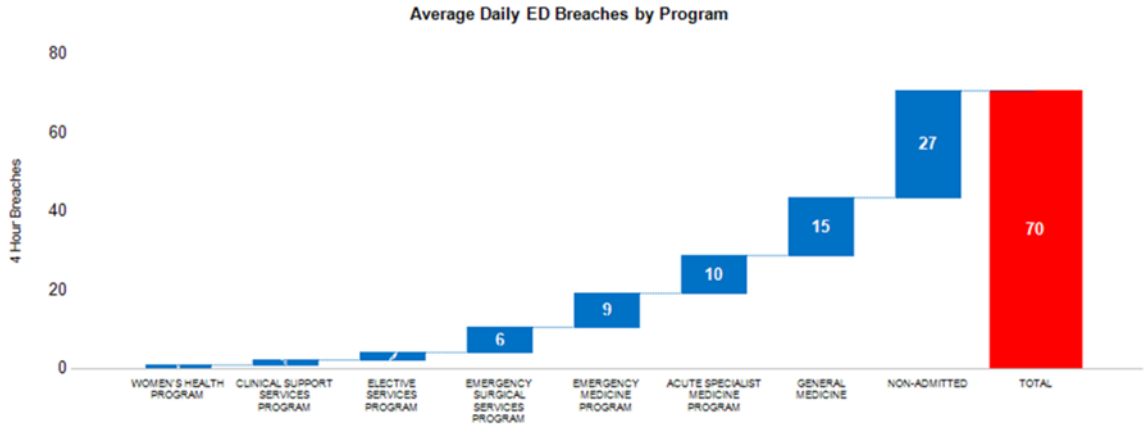


Fig 1

- **ED (cont'd)**

As a result the trust has been challenged with an ambulance handover performance and recorded compliance of 28.8% for transfers happening within 15 minutes.

The Trust continues to receive the largest number of conveyances in the region and recorded 3249 in the month.

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. The ED handover improvement plan has been completed and has shown an increase in compliance against the standard since the changes to the process were implemented in the latter part of the month.

Well Led Page 25

Voluntary Turnover at 11.9% is the same compared to June and remains above the tolerance level of 8%.

Overall Sickness absence rate at 3.99% has gone up by (+0.13) compared to June but remains below the tolerance level of 4%. Short term sickness absence at 1.95% is up by (+0.7) compared to June whilst long term sickness absence, at 2.04% is up by (+0.6) compared to June. The ratios of long-term sickness to short-term sickness remain broadly even.

Temporary staff (as a percentage of pay bill) at 21.30% is higher by (+4%) compared to the month of June and it is also higher than YTD average. This is due to slightly elevated costs for bank in the month of July and circa £1m, high accruals for bank made in the month of July. The Trust continues to meet its agency ceiling cap. Ongoing work to reduce use of agency workforce remains in place and focus on converting agency staff into substantive and or bank assignments continues.

The number of new starters at 74 is up by (+39), it is the expectation that this number will rise over the coming months, given the international nurses recruitment pipeline.

The number of leavers at 62 is higher by (+22) compared to June but remains lower than YTD average.

Data Quality Validation Update

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

Existing work projects:

- **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.
- **Inpatients Dataset** – DA Analysts are just beginning a deep dive project on the inpatient dataset, interviewing stakeholders and logging all issues, they will then use a rage of tools available to do some benchmarking for analysis. From this the HODA will be able to write a recommendation paper.
- **DM01** – Working with services to ensure the data on the new DM01 is clean and accurate, assisting with the data cleanse process.
- **Infusion Suite** – Working with transformational team process mapping the infusion suite to improve admin processes.

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. The team is also going to look at providing some training materials for cancer pathways.

Other DQ Validation Work:

The team continues to validate multiple data quality issues related to patient records, identified through the Data Quality dashboard. The DA 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 works 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 DA officers working within the services to offer support and be a visual presence.

3. Safe

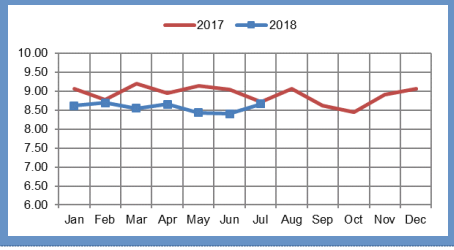
		Monthly Target	RAG Status	Trend May-18	Trend Jun-18	Trend Jul-18	Trend Movement	Trend YTD avg	Trend Data Quality	Alignment Carter	Alignment SOF	Alignment Quality Account / CQUIN
1.1.3.2	NRLS Organisational Reporting Rate (6 monthly)		G	46.74 (national median 40.14)								
1.1.4	Never events	0	G	0.00	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	4.00	2.00	2.00	⇔	4.1				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days)	0.30	G	0.40	0.21	0.20	⇩	0.31				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days)	2.20	G	1.61	0.69	0.94	⇧	1.4				✓
1.1.14	Pressure ulcers (low harm)	10	R	7.00	15.00	20.00	⇧	14.8				✓
1.1.15	Pressure ulcers (moderate, high level and SI)	0	R	2.00	0.00	2.00	⇧	1.1				✓
1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	0.2	G	0.20	0.07	0.00	⇩	0.1				
1.1.18	Falls per 1000 bed days	6.63	G	5.03	4.74	5.25	⇧	5.0				
1.1.19	Number of falls to fracture (per 1000 bed days)	0.2	G	0.20	0.07	0.00	⇩	0.1				
1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.00	0.00	0.00	⇔	0.0			✓	
1.2.2	New VTEs - point prevalence in month	0.36%	R	0.25%	0.24%	0.49%	⇧	0.7%			✓	
1.2.7	Emergency c-section rate	<15%	R	17.9%	17.1%	18.0%	⇧	18.8%				
1.3.1	MRSA screening of admissions	95%	G	99.7%	99.1%	99.1%	⇔	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	R	0.00	2.00	1.00	⇩	1			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	G	2.00	3.00	0.00	⇩	2			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	111.9 (106.0-118.1)							✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	114.0 (102.4-126.5)							✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	1	G	1.03 (0.89-1.12)							✓	✓

Commentary	Actions
See Executive Summary	See Executive Summary

Safe Staffing – Nursing Update - Highlights

Care Hours per Patient per Day

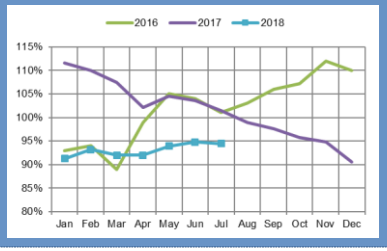
The Trust overall CHPPD is 8.67. Inpatient wards are delivering between 5.71 and 8.33 CHPPD. This is in line with Model Hospital benchmarking.



Daily huddles are being undertaken to make sure wards are staffed correctly for patient acuity and dependency.

Safe Staffing

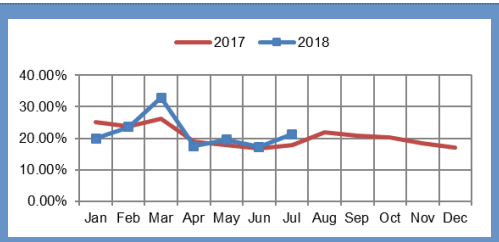
Actual v planned staffing has been stable over the past few months.



Staffing is risk assessed multiple time 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 on transfering 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	2003	1079	1225	1271	1364	1246	682	924	*54%*	*104%*	*91%*	*135%*
Bronte Ward	18	1160	936	774	844	1093	1094	729	753	*81%*	*109%*	*100%*	*103%*
Byron Ward	26	1575	1080	1104	1602	1046	1158	1046	1288	*69%*	*145%*	*111%*	*123%*
CCU	4	1075	709	23	40	713	701	23	23	*66%*	*174%*	*98%*	*100%*
Delivery Suite	15	2839	2850	708	708	2880	2898	348	348	*100%*	*100%*	*101%*	*100%*
Dickens Ward	25	1577	1041	1525	1710	1023	1101	1023	1104	*66%*	*112%*	*108%*	*108%*
Dolphin (Paeds)	34	3199	3091	1792	1383	2496	2553	357	265	*97%*	*77%*	*102%*	*74%*
Harvey Ward	24	1608	1171	1594	1711	1046	1249	1046	1103	*73%*	*107%*	*119%*	*105%*
ICU	9	3863	3004	0	0	3479	2942	0	0	*78%*		*85%*	
Keats Ward	27	1628	924	1148	1611	1023	1048	1023	1332	*57%*	*140%*	*102%*	*130%*
Kent Ward	24	1076	1071	606	607	756	756	684	685	*99%*	*100%*	*100%*	*100%*
Kingfisher SAU	14	1951	1610	1118	1447	1705	1639	682	913	*83%*	*130%*	*96%*	*134%*
Lawrence Ward	19	1127	1070	1152	1143	1046	1025	698	720	*95%*	*99%*	*98%*	*103%*
McCulloch Ward	29	2019	1448	1178	1449	1705	1563	682	958	*72%*	*123%*	*92%*	*140%*
Medical HDU	6	1469	1245	357	352	1415	1249	0	173	*85%*	*99%*	*88%*	
Milton Ward	27	1642	880	1464	2236	1046	949	1046	1571	*54%*	*153%*	*91%*	*150%*
Nelson Ward	24	1657	1067	1203	1233	1023	1059	682	671	*64%*	*102%*	*104%*	*98%*
NICU	25	4309	4036	921	610	4278	3986	357	345	*94%*	*66%*	*93%*	*97%*
Ocelot Ward	12	909	849	537	657	744	743	371	372	*93%*	*122%*	*100%*	*100%*
Pearl Ward	23	1121	1049	593	573	1116	1096	372	372	*94%*	*97%*	*98%*	*100%*
Pembroke Ward	27	1868	1569	1121	1453	1705	1683	682	946	*84%*	*130%*	*99%*	*139%*
Phoenix Ward	30	2038	1394	1235	1247	1364	1287	1034	1067	*68%*	*101%*	*94%*	*103%*
SDCC	26	2133	1315	1281	1029	682	506	242	263	*62%*	*80%*	*74%*	*108%*
Surgical HDU	10	2281	2146	388	383	2014	1896	0	22	*94%*	*99%*	*94%*	
Tennyson Ward	27	1652	1004	1166	1573	1023	971	1023	1067	*61%*	*135%*	*95%*	*104%*
The Birth Place	9	1117	1099	372	372	1092	1034	372	348	*98%*	*100%*	*95%*	*94%*
Victory Ward	18	1131	792	796	738	1023	836	682	615	*70%*	*93%*	*82%*	*90%*
Wakeley Ward	25	1585	1045	1562	1485	1046	1035	1046	1080	*66%*	*95%*	*99%*	*103%*
Will Adams Ward	26	1552	1020	1174	1382	1023	1056	1034	1296	*66%*	*118%*	*103%*	*125%*
Trust total	**610**	**53,162**	**41,590**	**28,112**	**30,847**	**41,968**	**40,359**	**17,965**	**20,620**	***78.2%***	***109.7%***	***96.2%***	***114.8%***

Staffing Levels – Nursing & Clinical Support Workers

	Quality Metrics / Actual Incidents								Internal KPIs	
WARD	Number of escalations of nurse staffing	Number of hospital acquired Pressure Ulcers grade 2 and above	Number of Falls with moderate to severe harm	Number of patient related medication errors - moderate to severe harm	Number of complaints relating to nursing care	Post 72 Hour CDIFF Acquisitions	MRSA Colonisations Post 48 hours	MRSA Bacteraemia Post 48 Hours	Overall fill rate	CHPPD Overall
Arethusa Ward	1	0	0	0	0	0	0	0	*86%*	5.75
Bronte Ward	3	1	0	0	0	0	0	0	*97%*	7.01
Byron Ward	0	1	0	0	1	0	1	0	*107%*	6.61
CCU	1	0	0	0	0	0	0	0	*80%*	12.28
Delivery Suite	0	0	0	0	2	0	0	0	*100%*	26.89
Dickens Ward	1	1	0	0	0	0	0	0	*96%*	7.15
Dolphin (Paeds)	0	0	0	0	0	0	0	0	*93%*	18.14
Harvey Ward	2	0	0	0	1	0	0	0	*99%*	7.16
ICU	0	1	0	0	0	0	1	0	*81%*	25.97
Keats Ward	5	2	0	0	0	0	0	0	*102%*	6.50
Kent Ward	0	0	0	0	0	0	0	0	*100%*	8.45
Kingfisher SAU	0	0	0	0	1	0	0	0	*103%*	20.25
Lawrence Ward	0	0	0	0	0	0	0	0	*98%*	7.38
McCulloch Ward	0	0	0	0	1	0	0	0	*97%*	6.86
Medical HDU	1	0	0	0	0	0	0	0	*93%*	17.97
Milton Ward	1	1	0	0	0	0	1	0	*108%*	7.18
Nelson Ward	0	1	0	0	0	0	0	1	*88%*	5.88
NICU	2	0	0	0	0	0	0	0	*91%*	11.87
Ocelot Ward	0	0	0	0	0	0	0	0	*102%*	7.68
Pearl Ward	2	0	0	0	0	0	0	0	*96%*	5.92
Pembroke Ward	0	0	0	0	0	0	0	0	*105%*	7.35
Phoenix Ward	1	0	0	0	0	0	0	0	*88%*	6.03
SDCC	0	0	0	0	1	0	0	0	*72%*	13.83
Surgical HDU	1	0	0	0	0	0	0	0	*95%*	15.44
Tennyson Ward	3	1	0	0	0	0	0	0	*95%*	5.71
The Birth Place	2	0	0	0	0	0	0	0	*97%*	21.28
Victory Ward	0	0	0	0	1	0	0	0	*82%*	8.33
Wakeley Ward	1	1	0	0	0	0	1	0	*89%*	6.36
Will Adams Ward	0	2	0	0	0	0	0	0	*99%*	6.26
Trust total	**27**	**12**	**0**	**0**	**8**	**0**	**4**	**1**	**94%**	8.67

Safe Staffing– Nursing Update KPIs

		Monthly Target	RAG Status	Trend May-18	Trend Jun-18	Trend Jul-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*		22	17	10	↓	16.0		
1.5.8	Nursing Leavers	*TBC*		34	14	13	↓	18.3		
1.5.9	CSW Starters	*TBC*		3	6	4	↓	6.8		
1.5.10	CSW Leavers	*TBC*		14	10	12	↑	10.5		
1.5.11	Rolling annual turnover rate	*8%*	R	11.54%	11.85%	11.92%	↑	11.32%		
1.5.16	Safe Staffing	*94.00%*	G	93.9%	94.8%	94.5%	↓	96.9%		
1.5.17	CHPPD	*8.00*	G	8.43	8.41	8.67	↑	8.67		

Commentary	Actions

4. Effective

		Monthly Target	Status	Trend						Alignment		
			Status	May-18	Jun-18	Jul-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
2.5.4	Emergency Readmissions within 30 days (1 month in arrears)	*10%*	R	11.70%	10.96%		↓	11%			✓	
2.5.4.1	Emergency Readmissions within 30 days Under 65 (1 month in arrears)	*10%*	G	9.63%	8.91%		↓	9%			✓	
2.5.4.2	Emergency Readmissions within 30 days 65 + (1 month in arrears)	*10%*	R	14.66%	13.68%		↓	14%			✓	
2.6	Discharges before noon	25%	R	21.81%	19.72%	19.52%	↓	19%			✓	✓

5. Caring

		Monthly Target	RAG Status	Trend May-18	Jun-18	Jul-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	87.0%	87.3%	87.1%	↓	88%			✓	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	*65%*	G	76.6%	78.9%	78.4%	↓	82%			✓	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	*79%*	G	97.8%	97.7%	100.0%	↑	99%			✓	
3.1.3	Mixed Sex Accommodation breaches	*15*	R	144	230	186	↓	48.1			✓	
3.4.1	Number of Complaints	*45*	R	83	75	62	↓	67			✓	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	*85%*	R	64.2%				49%			✓	
3.4.3	Number of complaint returners	↓	R	2	2	5	↑	3.1			✓	

Commentary	Actions
See Executive Summary	See Executive Summary

6. Responsive

		Monthly Target	Status	Trend						Alignment		
			Status	May-18	Jun-18	Jul-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CoQUIN
4.1.1	RTT – Incomplete pathways (overall)	92%	R	82.38%	81.68%	82.52%	↑	82.14%			✓	
4.1.2	RTT - Treatment Over 52 Weeks	0	R	1	0	2	↑	27				
4.2.3	A&E 4 hour target (all Types from Nov 2017)	95%	R	84.87%	80.62%	85.53%	↑	86.64%			✓	
4.3.1	Cancer – 2 week wait (1 month in arrears)	93%	R	92.47%	92.76%		↑	85.90%				
4.3.2	Cancer - 2 Week Wait Breast (1 month in arrears)	93%	R	83.33%	80.00%		↓	89.83%				
4.3.3	Cancer - 31 day first treatment (1 month in arrears)	96%	G	98.78%	97.84%		↓	97.01%				
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	94%	G	78.95%	95.00%		↑	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		75.00%	91.89%		↑	73.93%				
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	G	83.78%	90.64%		↑	78%			✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	90%	G	76.92%	94.44%		↑	86%			✓	
4.4.1	Diagnostic waits - under 6 weeks	99%	R	92.90%	91.86%	92.30%	↓	96%			✓	
4.5.8	Patients seen by a stroke consultant within 24 hours (Dec to Mar figures reported)	95%	R	37.70%	37.70%	37.70%	↔	56%				✓
4.6.1	Average elective Length of Stay	<5	G	2.43	2.45	3.44	↑	2.3				✓
4.6.2	Average non-elective Length of Stay	<5	R	6.51	6.47	6.12	↓	7.1				✓
4.6.6	Average occupancy	90%	R	94.11%	94.72%	92.78%	↓	95%				✓

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

Commentary	Actions
See Executive Summary	See Executive Summary

7. Well led

		Monthly Target	Status	Trend						Alignment		
			Status	May-18	Jun-18	Jul-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		51.2%		↓	58.0%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	*79%*	R		71.2%		↓	70.7%			✓	
5.3.7	Rolling annual turnover rate	*8%*	R	11.5%	11.9%	11.9%	↔				✓	
5.3.7.1	Executive Team Turnover Rate	*TBA*		0.0%	0.0%	7.7%	↑	3.8%			✓	
5.3.8	Overall Sickness rate	*4.0%*	G	3.44%	3.86%	3.99%	↑	3.8%				
5.3.9	Sickness rate – Short term	*3.0%*	G	1.85%	1.88%	1.95%	↑	1.9%			✓	
5.3.10	Sickness rate – Long term	*1.0%*	R	1.99%	1.98%	2.04%	↑	1.9%			✓	
5.3.11	Temporary staff % of pay bill	*15%*	R	19.6%	17.3%	21.30%	↑	19.3%			✓	
5.3.14	Starters	*N/A*		29	35	74	↑	85.1				
5.3.15	Leavers	*N/A*		100	40	62	↑	69.3				

Commentary	Actions
See Executive Summary	See Executive Summary

8. Enablers

		Monthly Target	Status	Trend						Alignment		
			Status	May-18	Jun-18	Jul-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
7.2.1	APC – NHS number completeness (2 month in arrears)	*99%*	G	99.3%				98.9%				✓
7.2.8	A&E – Attendance disposal (2 month in arrears)	*99%*	G	99.7%				93.4%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	*11*	R	140	98		↓	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	54	42		↓	102.0		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	*1%*	G	0.3%	0.2%		↓	0.5%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	*103.50*	G	14	6		↓	3.86				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	*0.00*	R	4.00	4.00		↔	2.14				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	*949*	R	2143	2010		↓	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*	G	0	0		↔	1.6		✓		✓
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	*13.25*	G	0	4		↑	0.7		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	*0.01*	G	0.04	0.05		↑	1%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	*2*	R	1	16		↑	3.0		✓		✓
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	*1.25*	R	0	2		↑	0.3		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	*1.25*	R	1	16		↑	2.9		✓		✓
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	*1*	R	0	3		↑	1.1		✓		✓

Commentary	Actions
See Executive Summary	See Executive Summary

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 06/09/2018

Agenda item 11c

Title of Report	**Medical Appraisal and Revalidation Annual Report 2017-18**
Prepared By:	Dr Kirti Mukherjee, Deputy Medical Director & Deputy Responsible Officer
Lead Director	Dr Diana Hamilton-Fairley
Committees or Groups who have considered this report	Not applicable
Executive Summary	The purpose of this report: • To provide assurance to the Board as part of the Responsible Officer's Regulations. • To seek approval of the statement of compliance confirming Medway NHS Foundation Trust is in compliance with the regulations. Key points are: • Arrangements for ensuring doctors are appraised to a standard that meets the requirements of the Responsible Officer Regulations and are revalidated in a timely manner are working effectively. In 2017/18, 97% of doctors with a prescribed connection to MFT had Completed appraisal. This compares favourably to national comparator data against a figure of 88.3% for the same sector designated bodies and 91.3% for all sectors designated bodies for 2017-18. This has maintained the performance since 2016-17 and confirms that the steps to improve compliance remain effective. • A total of 11 revalidation recommendations were made and 4 doctors were deferred due to lack of enough supporting evidence. Two doctors were referred to the GMC for non-engagement with the appraisal process. • Dr Diana Hamilton-Fairley will be stepping down as Medical Director and Responsible Officer and

Report to the Board of Directors

	recommendations are made below for managing the transition.
Resource Implications	To discharge statutory RO responsibilities, there will be ongoing resources required for training of new appraisers and yearly appraisal updates for the current appraisers and training of support staff. In addition the number of doctors with connections to Medway FT has increased by 15% in the last 12 months. This increase has implications for resources required to support the appraisal process, particularly in terms of medical appraisers. There will also need to be a review of the impact of the increase in numbers of doctors on the license fees for our revalidation software and provision of multi-source feedback.
Risk and Assurance	Not applicable
Legal Implications/Regulatory Requirements	Responsible Officer Regulations
Improvement Plan Implication	Not applicable
Quality Impact Assessment	Not applicable
Recommendation	The Board is asked to approve this report and for the Chairman/CEO to sign off the Statement of Compliance confirming that the Trust, as a Designated Body, is in compliance with the regulation. In addition the Board is advised that Dr Diana Hamilton-Fairley is stepping down as Medical Director with effect from 6 September 2018.

Report to the Board of Directors

	The Board is asked to approve the appointment of Dr David Sulch as Acting Medical Director with immediate effect. The Board is also asked to approve Dr Kirti Mukherjee as Responsible Officer with immediate effect until a permanent Medical Director is appointed. Dr Mukherjee meets the statutory requirements set out in the Medical Profession (Responsible Officer) Regulations 2010, namely she is a medical practitioners and have been continuously registered as medical practitioners for the previous 5 years. In addition Dr Mukherjee served previously as Responsible Officer from 1/8/2014 – 1/2/2016 and since 1/2/2016 she has acted as Deputy Responsible Officer. The appointment of Dr Mukherjee has been discussed with the General Medical Council and they have raised no objections to this approach as a temporary measure whilst a permanent Medical Director is appointed.
Purpose & Actions required by the Board :	**Approval** ☒ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

1. Executive Summary

For the appraisal year 1 April 2017 – 31 March 2018, there were 340 doctors who had a prescribed connection with Medway Foundation NHS Trust (MFT). For this reporting year, 331 doctors (97.4%) had a completed appraisal. These figures compare favourably to national comparator data (appendix 3) with 97.4% appraisal completion rate for MFT against a figure of 88.3% for the same sector designated bodies and 91.3% for all sectors designated bodies for 2017 - 2018. There were 2 doctors referred to GMC for non-engagement with the appraisal process. A total of 4 doctors had their revalidation recommendation deferred because of insufficient supporting evidence.

2. Purpose of the Report

This report is intended to provide assurance to the Board regarding compliance with its statutory duties and those of its nominated Responsible Officer as provided in the Medical Profession (Responsible Officer) Regulations 2010.

The report also provides assurance that appraisal systems are robust, support revalidation and are operating effectively. The report forms part of the Medical Director's duties as Responsible Officer (RO). This report gives the Trust Board an annual report on completion of the annual medical appraisals and the number of revalidation recommendations made for the year ending 31 March 2018.

A statement of compliance with Medical Profession (Responsible Officers) Regulations (Appendix 1) needs to be signed off by the chairman or CEO and submitted to NHS England.

3. Background

The Medical Profession (Responsible Officer) Regulations 2010 came into force in January 2011. The regulations designate the bodies to which they apply (including among others all NHS trusts, independent sector healthcare providers and most locum agencies) and create a 'prescribed connection' between a designated body and doctors contracted to it. Designated bodies are required to appoint or nominate a senior doctor - known as the Responsible Officer (RO), who in turn is given a range of statutory duties relating to the oversight of arrangements for assuring the fitness to practise of their doctors. The regulations place a duty on designated bodies to ensure they make sufficient resources available to their RO for the effective delivery of their responsibilities.

The aim of medical revalidation is to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system. Under this process, the RO must make a periodic recommendation to the General Medical Council – based on the outcomes of annual whole-practice appraisals and any other available information – that a doctor remains fit to practise and that their licence to practise should continue.

4. Designated Body

For the purpose of this report, the designated body is Medway NHS Foundation Trust.

5. Responsible Officer (RO)

The Trust Board has nominated Medical Director, Diana Hamilton-Fairley, as the Responsible Officer and she satisfies the condition for appointment to this role, namely she is a medical practitioner and at the time of the appointment had been continuously registered as a medical practitioner for the previous 5 years.

6. Statutory Responsibilities of Responsible Officer

This section explains how the RO is carrying out her responsibilities as per the Medical Professional (Responsible Officer) Regulations 2010, relating to the evaluation of the fitness to practise of every medical practitioner with a prescribed connection to MFT. It should be noted that this excludes doctors in training whose prescribed connection from FY2 onward is to their respective deanery or HEE Local Education and Training Board.

The following sections relate directly to the duties set out in the Responsible Officer Regulations 2010,

(a) Regular Appraisals;

All doctors who have a connection to MFT are given access to the Trust appraisal system (MyL2P) together with an appraiser and a date for completing their appraisal.

The appraisals are carried out using all available information relating to the medical practitioner's fitness to practise within their full scope of practice (MFT and any other organisations). All doctors who do work outside of MFT, are required to submit supporting information regarding their practice by the Responsible Officer (or delegate) of that organisation.

360 multi-source feedback (MSF) is a core component of appraisal for feedback on a doctor's performance which can help in effective development of personal, team and service practice; the Trust has a programme with an external provider to ensure that all non-training doctors undertake a 360 MSF with both patients and colleagues to support their appraisal and revalidation. This must be undertaken at least once on a 5 year revalidation cycle and must be within 3 years of the revalidation date. The Trust sets a minimum requirement of 15 responses for each MSF undertaken, which are anonymous and aggregated and any comments made are non-attributable to any individual. Colleague feedback reports are available for roles which include: Doctor as Clinician, Doctor as Educator, Doctor as appraiser and Doctor as Medical Manager. The responses are collated by our external provider and the 360 report is analysed against a national mean standard. Once received, the report is uploaded as supporting information on e-appraisal. The doctor is asked to reflect on the results and if necessary, have a Personal Development Plan

based on 360 multisource feedback. All MSF reports are reviewed, upon which the appraiser and/or RO can request MSF to be repeated if deemed necessary.

Appraisal and Revalidation Performance Data

(i) Appraisal and Revalidation Performance Data

- As on 31 March 2018 there were 340 non-training doctors who had a prescribed connection with the Trust. This was an increase of (15%) 42 on the previous year due to increased recruitment at the Trust as well as an increase in connected doctors due to development of the Staff Bank.
- 331 non-training doctors had completed their appraisal for the reporting period 1 April 2017 to 31 March 2018. This equates to an overall 97.4% compliance.

	No. of doctors with a prescribed connection with the Trust	Number and percentage of completed appraisals for MFT
Consultants	175	175 (100%)
Specialty Doctors	80	78 (97.5%)
Trust Doctors and Locums	73	67(92%)
Other doctors with a prescribed connection	12	11 (92%)
TOTAL	340	331 (97.4%)

Approved Missed or Incomplete Appraisals

9 doctors were reported as approved missed or incomplete appraisals out of which:

2 were Speciality Doctors:

- 1 appraisal relates to a doctor on maternity leave.
- 1 appraisal relates to a doctor on sick leave.

6 were Trust grade Doctors and Locums:

- 1 appraisal relates to a doctor on maternity leave
- 5 appraisees had an approved incomplete or missed appraisal with agreed reasons.

1 was Other doctors with a prescribed connection

- 1 appraisal relates to a doctor on sick leave.

Unapproved Missed or Incomplete Appraisals

0 doctors were reported as having unapproved or incomplete appraisals

(i) Clinical Governance

It is recognised that the Trust needs to improve the access of clinical data for individual doctors to support the appraisal process. The RO/Deputy RO and Senior Appraiser continue to liaise with our Governance Data Analyst, Complaints and Datix team to ensure that individual doctors have access to clinical incidents, complaints and their individual activity data to support the appraisal process.

Progress has been made on improving this process and an appropriate report is now available for the Planned Care Directorate identifying specific complaints from Datix naming individual doctors. That report will be available to individual Doctors for reflection in appraisals. The Unplanned Care Directorate are expected to have a similar process in place by September 2018.

b) Procedures to investigate concerns about a medical practitioner's fitness to practice raised by patients or staff of the designated body or arising from any other source;

The Trust has specific policies on Maintaining High Professional Practice and Remediation of Medical Staff.

The Trust has a Decision Making Group made up of Senior Decision makers including the RO, Deputy RO and HR Director (or delegate) to review and make decisions on investigations into concerns raised about individual practitioners and services. The group meets regularly and is supported by the Head of Medical Director Services.

Summary of issues managed within the Decision Making Group

- Conduct – there have been three specific conduct hearings held under the Trust Disciplinary Process.
- Capability Service Concerns – one case which required assistance via NCAS to resolve.

The Trust has been informally dealing with conduct related issues using an approach developed in the USA by Vanderbilt University. This focusses on managing conduct and capability concerns through initially more informal management processes. Medical staff have been trained as peer messengers to deliver messages causing concern with a view to managing issues at the lowest and earliest point. Research from the USA suggests this resolves 90% of issues without requiring formal action under MHPS.

(c) Referring concerns about the medical practitioner to the General Council;

The GMC provide advice and guidance for the RO on the threshold for raising concerns. Where there is doubt regarding the need for referral, a specified liaison officer from the GMC is consulted. The RO also has a regular quarterly meeting with the GMC liaison officer to discuss ongoing concerns and new concerns.

There were no formal concerns referred to the GMC by MFT during the reporting year. However, regular responses and support is giving to the GMC in any active investigations requiring MFT input.

(d) Monitoring conditions and undertakings imposed (or agreed) by the GMC on a medical practitioner

The Responsible Officer ensures that there is appropriate monitoring of conditions and undertakings through agreeing local action plans with Clinical Directors / Specialist Leads and the relevant doctor. This includes ensuring that there are appropriate qualified supervisors as per GMC guidance on level of supervision for medical practitioners and that those supervisors provide periodic reports as per the undertaking. The GMC is kept informed on progress.

(e) Make recommendations to the General Council about medical practitioners' fitness to practise (known as revalidation);

The RO, in conjunction with the Deputy RO and Senior Medical Appraiser, is responsible for reviewing all appraisals submitted by the appraisers for review and for making recommendations to the GMC for revalidation and renewal of a doctor's licence to practise.

The Medical Revalidation Governance Group was formed in December 2014. The main aim of this Group is to discuss all revalidation submissions to ensure that a consistent approach is taken in relation to all revalidation submissions made by the RO. This Group currently meets bi-monthly. A non-executive director is part of this Group to provide assurance on the process, however the RO will be reviewing this approach during 2018 – 2019 to improve assurance.

7. Revalidation Recommendations

For the year ending 31 March 2018 there were 24 doctors due to revalidate.
The recommendations made were as follows:-

	Recommendation Type	
20	Revalidate – positive recommendation	
4*	Defer – Insufficient evidence for a recommendation to revalidate **2* was *subsequently revalidated during the reporting year after submitting required evidence (included in 20 positive recommendations)*	
1	On Hold - pending an investigation by the GMC	
0	Missed or late recommendations	

(Please note: deferral is a neutral act (ie it does not imply an adverse judgement against a doctor) and their licence to practise continues unaffected in the meantime).

(f) maintain records of practitioners' fitness to practise evaluations, including appraisals and any other investigations or assessments.

All appraisal records are held electronically in the Medical Director's office by the Revalidation Manager and Head of Medical Director services maintain all the investigations and GMC correspondence for the doctors. The HR Department through the Directorate Business partners support the investigations and hold the personnel files of the Doctors.

8. Provision of Resources to RO

NHS England carried out an independent verification visit in October 2014. As part of this visit, they reviewed the resource available at MFT to support appraisal and revalidation. They advised on the need for a full time administrative post to support the Responsible Officer and for the appointment of two senior appraisers, and the provision of sufficient funds for appraiser refreshing training, training of new appraisers, training of case investigators and training of case managers. There are twenty trained case investigators and eleven case managers. The Trust intends to manage as many cases internally as possible and only use external support in exceptional situations. Best practice in safe revalidation has identified that it is essential to have these specific resources supporting the RO in the discharging of their statutory duties.

The Trust currently has 95 medical appraisers who have undertaken the approved appraisal training for enhanced medical appraisals. This number includes nineteen new doctors who were trained and appointed as appraisers in January 2018.

In 2017-18, there were sufficient staffing resources to discharge these responsibilities. However, we were unsuccessful in securing funding for Appraiser Refresher Sessions.

9. Monitoring Contracts of employment / provision of services with medical practitioners;

Established HR processes are in place which have been approved by the Responsible Officer to ensure
(a) that medical practitioners have qualifications and experience appropriate to the work to be performed;
(b) that appropriate references are obtained and checked;
(c) all steps necessary to verify the identity of medical practitioners are undertaken.

To ensure compliance with a-c above a Standing Operating Procedure (SOP) with the Human Resources Department is in place to ensure that all the necessary pre and post-employment checks have been undertaken for all doctors. This also applies to NHS locum appointments, Bank and temporary agency locum appointments. Where relevant, Medical Practice Information Transfer (MPIT) forms are used for all incoming non training doctors for RO to RO transfer of information. All new doctors are also required to submit a Transfer of Information form to Medical Staffing before the start of their employment in MFT.

9. Competence in English

Good medical practice (2013) states that doctors 'must have the necessary knowledge of the English language to provide a good standard of practice and care in the UK'.

To ensure this happens the GMC assess competency in English as part of their registration process for Doctors. In addition to the GMC standard the RO Regulations 2010 (amended 2013) brought in specific statutory duties for the Designated Body and Responsible Officer regarding competence in the English Language meaning the RO needs to ensure that

"medical practitioners have sufficient knowledge of the English language necessary for the work to be performed in a safe and competent manner;"

To ensure that medical practitioners have the necessary English Language skills MFT accepts the International English Language Testing System (IELTS) for all international doctor recruitment. MFT requires a score on the IELTS test of at least 7.5 which at the minimum level ensures that the doctor has operational command of English.

In addition an advanced action process during the interview has been developed, in which applicants are asked to write and speak English using case studies and assessed by an internal HR Assessor.

10. Monitoring medical practitioners' conduct and performance

The RO has put in place systems to monitor medical practitioners conduct and performance including
(a) general performance information held, including clinical indicators relating to outcomes for patients;
(b) Identifying any issues arising from that information relating to medical practitioners, such as
variations in individual performance; and
(c) ensuring she takes steps to address any such issues.

To ensure compliance with a-c there is an established Clinical Governance structure within the Trust which is overseen by the Medical Director / Responsible Officer.

- The Healthcare Evaluation Data (HED) system is used to provide an overview of individual consultant performance, the local specialty peer performance and the national specialty peer performance.

- Where appropriate, log books of procedures undertaken by individual doctors are uploaded and discussed within the appraisal process.

- National benchmarking data is uploaded to the appraisal and are discussed during the appraisal meeting.

- Issues that arise are managed by appropriately qualified case managers and case investigators and overseen by the Trust Decision Making Group.

11. Responding to concerns about medical practitioners' conduct or performance

The Responsible Officer chairs the Decision Making Group, which reviews all significant concerns and manages these under Maintaining High Professional Standards (MHPS) including liaising with National Clinical Assessment Service (NCAS) and the GMC as required in each case.

Maintaining High Professional Standards is a direction from the Department of Health, which sets out a detailed framework of how performance issues concerning medical staff must be managed by designated bodies such as MFT.

Where action is required the RO ensures that

(a) Investigations are managed by a Case Manager with qualified Case Investigators;

There are 20 trained Case Investigators and 11 trained Case Managers in MFT who manage cases when investigations are deemed necessary. From time to time, external investigators have been commissioned when specific expertise is needed.

(b) ensure that procedures are in place to address concerns raised by patients or staff of the designated body or arising from any other source;

Complaints procedures are in place to address concerns raised by patients and where clinical concerns are identified these are then managed under the appropriate Trust policy.

Complaints raised by staff indicating clinical concerns are investigated and action taken as appropriate in line with Trust policy.

(c) ensure that any investigation into the conduct or performance of a medical practitioner takes into account any other relevant matters within the designated body;

All Case Investigations follow NCAS best practice with terms of reference established to investigate the issues fully including where systems issues are affecting performance.

(d) consider the need for further monitoring of the practitioner's conduct and performance and ensure that this takes place where appropriate;

As part of the Case Management of each case, there are a range of options open to the case manager including considering the need for further monitoring of the practitioner's conduct and performance and ensure that this takes place where appropriate;

(e) ensure that a medical practitioner who is subject to procedures under this paragraph is kept informed about the progress of the investigation;

Case Managers are trained to ensure that medical practitioner under investigation are kept informed about the progress of the investigation;

(f) ensure that procedures under this paragraph include provision for the medical practitioner's comments to be sought and taken into account where appropriate;

Case Managers ensure that investigations include provision for the medical practitioner's comments to be sought and taken into account where appropriate;

(g) (i) take any steps necessary to protect patients;

Consideration regarding restrictions and exclusions of practitioners are made where there is any potential risk to patient safety.

(ii) recommend to the medical practitioner's employer that the practitioner should be suspended or have conditions or restrictions placed on their practice;

Appropriate recommendations are made as stipulated.

(h) identify concerns and ensure that appropriate measures are taken to address these, including but not limited to—

(i) requiring the medical practitioner to undergo training or retraining;

(ii) offering rehabilitation services;

(iii) providing opportunities to increase the medical practitioner's work experience;

The Case Manager and potentially Capability or Conduct hearings will determine appropriate measures to support the remediation of medical practitioners including addressing any systemic issues within the designated body which may have contributed to the concerns identified;

(I) maintain accurate records of all steps taken in accordance with this paragraph.

Management of all cases is in line with MHPS and the Trust Remediation of Medical Staff policies and accurate records are maintained of all actions taken.

12. Governance Arrangements

All Consultants, Specialty Doctors and doctors not in a formal training programme are required to use the e-appraisal system currently in operation in the Trust for completion of their annual appraisals. The e-appraisal system operates on a traffic light system in relation to both completion of the annual appraisal and the revalidation due date. This is monitored on a daily basis by the Medical Director's office to ensure that progress in meeting these deadlines is being maintained.

The Human Resources Department/Medical Staffing provides the Medical Director's office with a weekly list of all new non-training doctors together with a list of those non-training doctors who have left the Trust. Doctors are then added or deleted from the e-appraisal system and the GMC list as necessary to ensure the list of doctors with a prescribed connection to the Trust is as up to date as possible. All new doctors are given information on appointment explaining the requirements of appraisal and revalidation and are also contacted by the Medical Director's office and informed of the process for ensuring their annual appraisal (or before the end of their fixed term period with the Trust, whichever is the earlier) is completed.

13. Quality Assurance

- MFT's e-appraisal system incorporates an appraisee checklist of all supporting evidence covering the whole scope of practice. This must be completed before the appraisee can submit the appraisal to the Appraiser. In addition the Appraiser must complete the Appraiser checklist before submission to the RO for review. This reduces the occasions when the RO or Senior Medical Appraiser has to refer back an appraisal due to missing or incomplete supporting evidence.

- From July 2016, the GMC requires that all doctors who undertake a recognised educational role (educational supervisors and clinical supervisors), must provide evidence as part of the appraisal process, of their ongoing professional development against the seven domains agreed by the GMC and Academy of Medical Educators "Framework for Supervisors" (2010). This has now been incorporated into our e-appraisal system.

- Appraisers are required to check compliance against the previous year's PDP and agree a new PDP with the appraisee. The appraiser then completes the appraisal summary and appraisal output declarations before submitting the appraisal electronically to the RO for review.

- To provide assurance on the quality of the appraisals, the Deputy RO and Senior Appraiser review all appraisal forms with all supporting evidence and if any evidence is deemed missing or incomplete, the appraisal is referred back for correction and re-submission.

- To enhance the level of assurance and provide evidence which challenges the system or the decision-making, all designated bodies are required to undergo a process to validate the status of their revalidation systems at least once in every 5-year revalidation cycle. This may be carried out by audits commissioned by the designated body, their regulators, peers or higher-level RO. NHS England last undertook an audit of the Trust's appraisal and revalidation process with particular emphasis on the core standards of the Framework of Quality Assurance in October 2014.

- The RO, Deputy RO, Senior appraiser plus their administrative and management support have all ensured their CPD through appropriate RO training, RO network meetings and Great appraisal event.

- The Deputy RO is involved in peer review.

- The RO is appraised by the higher level RO as per guidance.

- The Revalidation Governance Group, chaired by the Responsible officer, continues to meet bi-monthly with a Non-executive Director as a member of the group. Work to ensure there is a robust incident reporting process to support the RO in making revalidation recommendations continues, although challenges around this process continue. However, this is an area of development that many other Trusts continue to experience.

- MFT has been subject to an independent review by NHS England for an independent verification visit in 2014.

- The Deputy RO and/or Senior Medical Appraiser provided a series of sessions (8 in 2017-18) to inform all new non-training doctors on the requirements for medical appraisal and revalidation. These sessions have been very well attended.

14. Policy and Guidance

The Trust has a Medical Appraisal and Revalidation Policy and a Remediation of Medical Staff Policy and Procedure. These are updated regularly to ensure all recent amendments to the RO regulations and guidance are included.

15. Access, security and confidentiality

All non-training doctors are required to use the e-appraisal system as their appraisal portfolio. All doctors have their individual login and password to access the system and only the appraiser and RO and Revalidation team can view the appraisal record and documents. The doctors are informed who can view the appraisal folders. The doctors themselves can then choose who else they may wish to share their appraisal folder with once this has been reviewed by the RO i.e. private organisations for which they undertake clinical work

17. Risk and Issues

The lack of a centralised reporting system around complaints within the Trust excludes the reporting of individual doctors to support the Revalidation and Appraisal process.

18. Improvements and Next Steps

10. Improvements and Next Steps

Improvements made since last annual report include:-

- E-appraisal software continues to develop to further improve the quality of appraisal evidence.
- Supporting documentation for doctors on Hospital Intranet regularly reviewed and updated – continues to be reviewed, amended and updated accordingly.
- A process to request a postponement of an appraisal has been established to support GMC guidance.
- External New Appraiser training sessions delivered to 19 newly appointed appraisers.
- Appraisal information workshops for non-training Trust Doctors scheduled regularly during the year.
- Coaching sessions continue for individual doctors regarding the appraisal process and system.
- Quarterly Workshops set up with the GMC for Doctors new to UK practice. All Doctors new to UK Practice must attend.
- E-learning for health for Internal Medical Graduates is promoted for Doctors New to UK practice. All Doctors new to UK Practice must complete within first two weeks of starting.
- Patient feedback confidentiality of patients protected by amending the way in which feedback forms are collected.

Next Steps

- Complete improvements in Clinical Governance reporting so that these can be fed into individual appraisals for reflection.
- Appraisals to be moved forward to ensure no appraisals are scheduled for August, February and March (unless there are exceptional circumstances), which improved compliance rates.
- Four Appraiser Refresher sessions have been arranged for all appraisers to be updated on recent updates from GMC and NHS England.
- Implementing the Promoting Professionalism model and ensure low level concerns are dealt with effectively at the point of issue by peer messengers.

The Board is asked to approve this report so that the CEO can sign the Statement of Compliance which is a statutory requirement.

Appendices

Appendix 1 - Designated Body Statement of Compliance – 2017-18

Appendix 2 - Appendix 2 – Appraisal Rates form MFT confirmed in AOA report for 2017 – 2018

Appendix 3 - Appendix 3 Comparator Reports – MFT against same and all sectors

Appendix 1. Compliance Statement

Designated Body Statement of Compliance – 2017 -18

The Trust Board management team of Medway NHS Foundation Trust has carried out and submitted an annual organisational audit (AOA) of its compliance with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013) and can confirm that:

1. A licensed medical practitioner with appropriate training and suitable capacity has been nominated or appointed as a responsible officer;

   CONFIRMED

2. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is maintained;

   CONFIRMED

3. There are sufficient numbers of trained appraisers to carry out annual medical appraisals for all licensed medical practitioners;

   CONFIRMED

4. Medical appraisers participate in ongoing performance review and training / development activities, to include peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers or equivalent);

   CONFIRMED

5. All licensed medical practitioners[1] either have an annual appraisal in keeping with GMC requirements (MAG or equivalent) or, where this does not occur, there is full understanding of the reasons why and suitable action taken;

   CONFIRMED

6. There are effective systems in place for monitoring the conduct and performance of all licensed medical practitioners[1], which includes [but is not limited to] monitoring: in-house training, clinical outcomes data, significant events, complaints, and feedback from patients and colleagues, ensuring that information about these is provided for doctors to include at their appraisal;

   CONFIRMED

7. There is a process established for responding to concerns about any licensed medical practitioners[1] fitness to practise;

   CONFIRMED

[1] Doctors with a prescribed connection to the designated body on the date of reporting.

8. There is a process for obtaining and sharing information of note about any licensed medical practitioners' fitness to practise between this organisation's responsible officer and other responsible officers (or persons with appropriate governance responsibility) in other places where licensed medical practitioners work;

CONFIRMED

9. The appropriate pre-employment background checks (including pre-engagement for Locums) are carried out to ensure that all licenced medical practitioners[2] have qualifications and experience appropriate to the work performed; and

CONFIRMED

10. A development plan is in place that addresses any identified weaknesses or gaps in compliance to the regulations.

CONFIRMED

Signed on behalf of the designated body (must be signed by the Chief Executive or Chair)

Name: Signed: _____

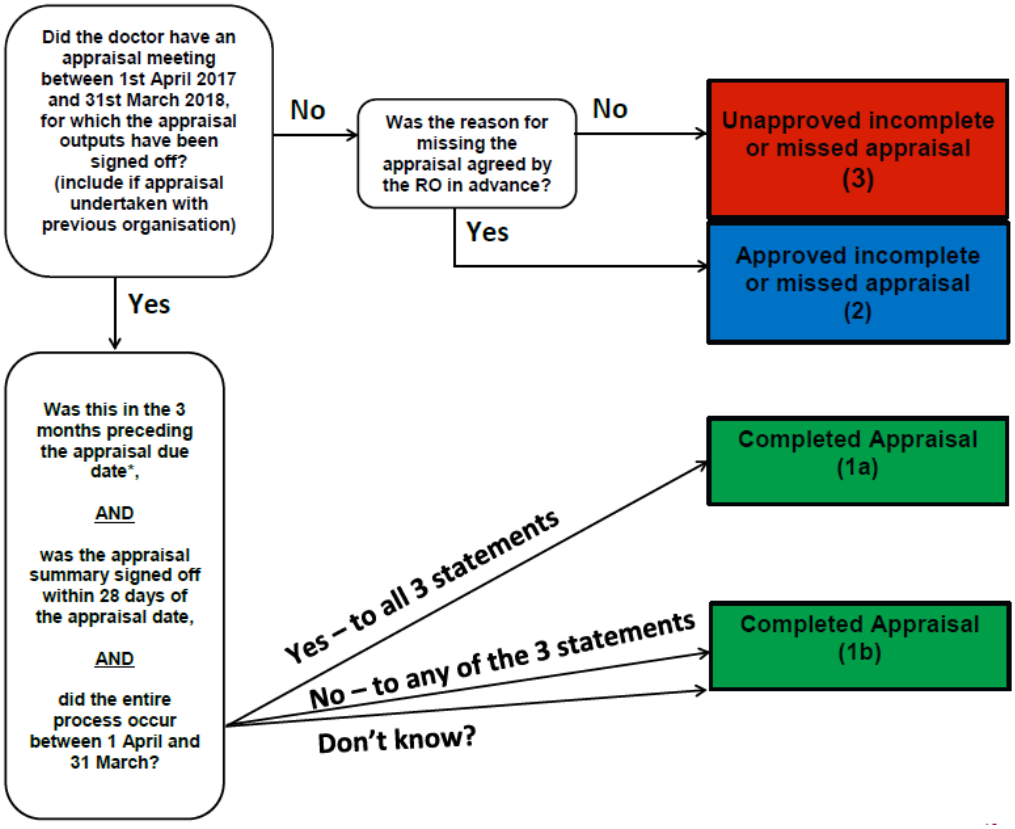
Medway NHS Foundation Trust

Date:

[2] Doctors with a prescribed connection to the designated body on the date of reporting.

Appendix 2 – Appraisal Rates form MFT confirmed in AOA report for 2017 - 2018

Section 2	Appraisal						
2.1	IMPORTANT: Only doctors with whom the designated body has a prescribed connection at 31 March 2018 should be included. Where the answer is 'nil' please enter '0'. See guidance notes on pages 16-18 for assistance completing this table		1a	1b	2	3	
		Number of Prescribed Connections	Completed Appraisal (1a)	Completed Appraisal (1b)	Approved incomplete or missed appraisal (2)	Unapproved incomplete or missed appraisal (3)	Total
2.1.1	**Consultants** (permanent employed consultant medical staff including honorary contract holders, NHS, hospices, and government /other public body staff. Academics with honorary clinical contracts will usually have their responsible officer in the NHS trust where they perform their clinical work).	175	74	101	0	0	175
2.1.2	**Staff grade, associate specialist, specialty doctor** (permanent employed staff including hospital practitioners, clinical assistants who do not have a prescribed connection elsewhere, NHS, hospices, and government/other public body staff).	80	32	46	2	0	80
2.1.3	**Doctors on Performers Lists** (for NHS England and the Armed Forces only; doctors on a medical or ophthalmic performers list. This includes all general practitioners (GPs) including principals, salaried and locum GPs).	0	0	0	0	0	0
2.1.4	**Doctors with practising privileges** (this is usually for independent healthcare providers, however practising privileges may also rarely be awarded by NHS organisations. All doctors with practising privileges who have a prescribed connection should be included in this section, irrespective of their grade).	0	0	0	0	0	0
2.1.5	**Temporary or short-term contract holders** (temporary employed staff including locums who are directly employed, trust doctors, locums for service, clinical research fellows, trainees not on national training schemes, doctors with fixed-term employment contracts, etc).	73	21	46	6	0	73
2.1.6	**Other doctors with a prescribed connection to this designated body** (depending on the type of designated body, this category may include responsible officers, locum doctors, and members of the faculties/professional bodies. It may also include some non-clinical management/leadership roles, research, civil service, doctors in wholly independent practice, other employed or contracted doctors not falling into the above categories, etc).	12	6	5	1	0	12
2.1.7	TOTAL (this cell will sum automatically 2.1.1 – 2.1.6).	340	133	198	9	0	340



Appendix 3 Comparator Reports – MFT against same and all sectors

a) Completed Appraisals

2017/18 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Completed appraisals (Measure 1a & 1b)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had a completed annual appraisal between 1 April 2017 – 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	175 (100%)	92.0%	92.7%
2.1.2	Staff grade, associate specialist, specialty doctor	78 (97.5%)	88.4%	88.9%
2.1.3	Doctors on Performers Lists	N/A	71.4%	94.7%
2.1.4	Doctors with practising privileges	N/A	66.7%	93.0%
2.1.5	Temporary or short-term contract holders	67 (91.8%)	77.2%	82.8%
2.1.6	Other doctors with a prescribed connection to this designated body	11 (91.7%)	63.9%	87.1%
2.1.7	**Total number of doctors who had a completed annual appraisal**	331 (97.4%)	88.3%	91.3%

b) Approved incomplete or missed appraisal

2017/18 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Approved incomplete or missed appraisal (Measure 2)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had an Approved incomplete or missed appraisal between 1 April 2017 – 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	0 (0%)	4.9%	4.3%
2.1.2	Staff grade, associate specialist, specialty doctor	2 (2.5%)	7.9%	7.5%
2.1.3	Doctors on Performers Lists	N/A	28.6%	4.8%
2.1.4	Doctors with practising privileges	N/A	33.3%	5.5%
2.1.5	Temporary or short-term contract holders	6 (8.2%)	17.2%	11.2%
2.1.6	Other doctors with a prescribed connection to this designated body	1 (8.3%)	18.5%	9.8%
2.1.7	**Total number of doctors who had an approved incomplete or missed appraisal**	9 (2.6%)	7.8%	6.1%

c) Unapproved incomplete or missed appraisal

2017/18 AOA indicator SECTION 2 (cont): Appraisal		Your organisation's response	Same sector: DBs in sector: 99	All sectors: Total DBs: 834
		Unapproved incomplete or missed appraisal (Measure 3)		
2.1	**Number of doctors with whom the designated body has a prescribed connection on 31 March 2018 who had an Unapproved incomplete or missed annual appraisal between 1 April 2017 – 31 March 2018**	Your organisation's response and (%) calculated appraisal rate	Same sector appraisal rate	ALL sectors appraisal rate
2.1.1	Consultants	0 (0%)	3.1%	3.0%
2.1.2	Staff grade, associate specialist, specialty doctor	0 (0%)	3.8%	3.6%
2.1.3	Doctors on Performers Lists	N/A	0.0%	0.6%
2.1.4	Doctors with practising privileges	N/A	0.0%	1.5%
2.1.5	Temporary or short-term contract holders	0 (0%)	5.6%	6.0%
2.1.6	Other doctors with a prescribed connection to this designated body	0 (0%)	17.5%	3.1%
2.1.7	**Total number of doctors who had an unapproved incomplete or missed annual appraisal**	0 (0%)	3.9%	2.7%

NHS
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Report to the Board

Committee Date: 06/09/2018 Item No. 12a

Title of Report	**Finance Report Month 4**
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 24th August 2018
Executive Summary	The purpose of this report is to summarise the M4 financial performance of the Trust against the agreed plan. Key points are : 1. Month 4 has been reported as a deficit of £17.33m year to date pre Provider Sustainability Funding (PSF). This is £1.3m favourable to the planned deficit of £18.60m pre PSF. The PSF was not achieved in full and therefore this element of funding is adverse to plan by £0.82m, bringing the overall performance to a favourable variance of £0.45m at month 4. 2. Income – Clinical income to date at month 4 is favourable by £1.9m. Of this £1.2m relates to High Cost Drugs and is offset by expenditure. 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. 3. Activity within the block contract is being monitored to inform future contracting rounds, and to enable a system approach to demand management. Based on the activity reported up to month 3 there are variances between services, but overall the financial value of services delivered is close to the block contract value. 4. Other income –Other income is favorable to plan by £0.3m year to date – in part driven by facilities income as well as the profile of educational income.

Report to the Board

	5. Expenditure – Month 4 expenditure is adverse to plan by £1.0m. Pay is adverse by £0.7m, non-pay adverse by £0.3m. Pay is due to increased spend on bank costs. Non pay is due to drugs expenditure (which is matched by corresponding income), and clinical supplies which are not procured evenly across the year. 6. The forecast position for the year is on plan pre PSF, with an adverse variance post PSF of £1.3m due to the loss of PSF with regard to the A&E target achievement. 7. The Trust has received an allocation from the Department of Health in relation to the costs of the pay awards for staff on Agenda for Change contracts. The allocation is slightly lower than the estimated cost of the awards based on current staffing levels, but as pay CIPs are delivered, there will be an incremental saving for those posts which will defray the impact of the funding shortfall. 8. At month 4 CIP delivery is slightly above plan by £0.5m. 9. 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 £11m. 10. The Trust has a Capital plan for the year of £31m. Year to date spend is £1.7m against a plan of £9m, with the programme being heavily weighted to the latter part of the year. 11. The balance sheet turned to a negative equity position during 2017/18 and this continues at Month 4, 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.**

Report to the Board

	• **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 is now fully resourced and has commenced a number of transformation projects to support the directorates as well as leading on organisation wide efficiency projects.** • **The Trust has appointed a Turnaround Director to support the financial recovery plan.** • **The Medway health partners are working on a system recovery plan that addresses financial and operational performance both in the current year and over the longer term.** • **The Trust is also undertaking a review of fragile services** 2. The acceptance of the control total has provided the Trust with £12.6m of PSF income. 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.** 3. 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.

Report to the Board

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

Finance Report

Month 04

2018/19

Best of care
Best of people

Medway NHS
NHS Foundation Trust

Finance Report for July 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

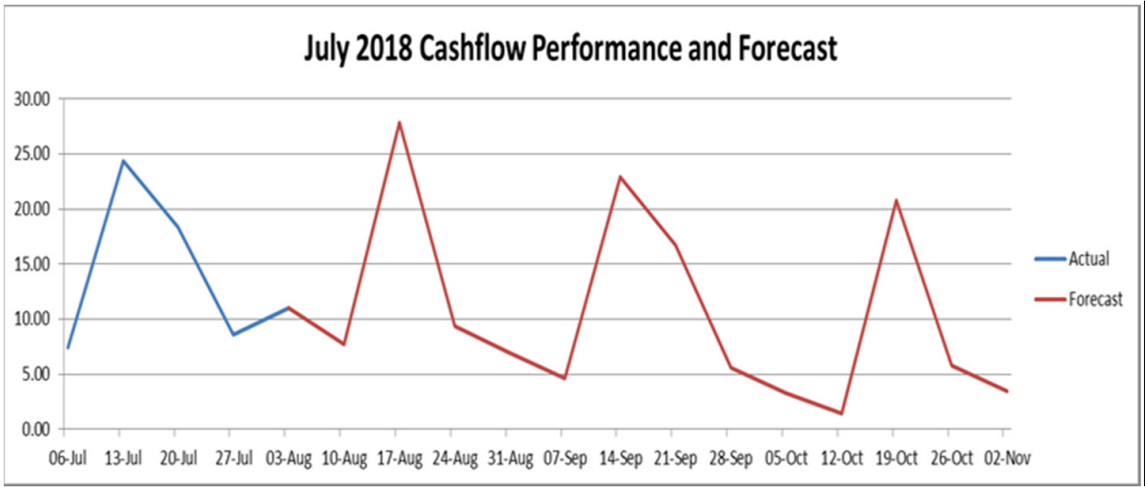
4. Capital
    a. Capital Summary

1. Liquidity

1a. Finance Report for Jul 2018- APPENDICES

13 Week Forecast **w/e**

	Actual					Forecast												
£m	06/07/18	13/07/18	20/07/18	27/07/18	03/08/18	10/08/18	17/08/18	24/08/18	31/08/18	07/09/18	14/09/18	21/09/18	28/09/18	05/10/18	12/10/18	19/10/18	26/10/18	02/11/18
BANK BALANCE B/FWD	**8.98**	**7.47**	**24.38**	**18.33**	**8.54**	**10.97**	**7.73**	**27.82**	**9.34**	**6.92**	**4.62**	**22.90**	**16.73**	**5.57**	**3.27**	**1.41**	**20.74**	**5.82**
Receipts																		
NHS Contract Income	0.24	19.37	0.40	0.00	0.78	0.80	21.29	0.00	0.00	0.00	20.25	0.26	0.00	0.00	0.00	20.51	0.00	0.00
Other	0.24	0.58	0.29	0.39	3.55	0.61	0.49	0.28	0.28	0.40	0.73	0.28	0.28	0.40	0.61	2.60	0.28	0.40
STF Funding	1.84	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	1.33	0.00
Total receipts	**2.32**	**19.94**	**0.68**	**0.39**	**4.33**	**1.40**	**21.77**	**0.28**	**0.28**	**0.40**	**20.98**	**0.53**	**0.28**	**0.40**	**0.61**	**23.11**	**1.60**	**0.40**
Payments																		
Pay Expenditure (excl. Agency)	(0.29)	(0.29)	(6.99)	(8.41)	(0.32)	(0.29)	(2.77)	(13.54)	(0.29)	(0.29)	(0.29)	(7.89)	(8.37)	(0.29)	(0.29)	(2.79)	(12.97)	(0.30)
Non Pay Expenditure	(3.53)	(2.75)	(3.55)	(1.77)	0.46	(4.36)	(4.57)	(4.92)	(0.39)	(2.41)	(2.41)	(4.75)	(1.21)	(2.41)	(2.18)	(4.25)	(3.56)	(0.05)
Capital Expenditure	0.00	0.00	0.00	0.00	(2.03)	0.00	0.00	0.00	(2.02)	0.00	0.00	0.00	(1.85)	0.00	0.00	0.00	0.00	(2.36)
Total payments	**(3.82)**	**(3.03)**	**(10.53)**	**(10.17)**	**(1.90)**	**(4.65)**	**(7.34)**	**(18.47)**	**(2.70)**	**(2.70)**	**(2.70)**	**(12.64)**	**(11.43)**	**(2.70)**	**(2.47)**	**(7.04)**	**(16.53)**	**(2.71)**
Net Receipts/ (Payments)	**(1.51)**	**16.91**	**(9.85)**	**(9.79)**	**2.43**	**(3.25)**	**14.43**	**(18.19)**	**(2.43)**	**(2.30)**	**18.28**	**(12.11)**	**(11.16)**	**(2.30)**	**(1.86)**	**16.07**	**(14.92)**	**(2.31)**
Funding Flows																		
FTFF/DOH - Revenue	0.00	0.00	4.05	0.00	0.00	0.00	5.53	0.00	0.00	0.00	0.00	3.25	0.00	0.00	0.00	1.71	0.00	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	0.73	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	4.05	0.00	0.00	0.00	1.00	0.00	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	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.13	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	(0.26)	0.00	0.00	0.00	0.00	(0.29)	0.00	0.00	0.00	(1.37)	0.00	0.00	0.00	(0.18)	0.00	0.00
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	**0.00**	**3.80**	**0.00**	**0.00**	**0.00**	**5.66**	**(0.29)**	**0.00**	**0.00**	**0.00**	**5.93**	**0.00**	**0.00**	**0.00**	**3.26**	**0.00**	**0.00**
BANK BALANCE C/FWD	**7.47**	**24.38**	**18.33**	**8.54**	**10.97**	**7.73**	**27.82**	**9.34**	**6.92**	**4.62**	**22.90**	**16.73**	**5.57**	**3.27**	**1.41**	**20.74**	**5.82**	**3.51**



Commentary

The above cash flow illustrates weekly cash inflows and outflows during July and provides a forecast for the subsequent 13 weeks as required by NHSI in order to access borrowings.

Whilst it cannot be seen in the above cash flow due to the 1st and 31st being mid-week dates it should be reported that the opening cash balance for July 2018 was £6.6m,closing balance £11m, representing a net increase of £4.4m cash in the month. This mainly relates to planned payments in relation to the ED project being withheld.

Receipts in the month were £27m, plus £4.1m loans & funding, therefore the total cash inflow for July was £31.1m. Payments, including capital, were £29.1m.Salary payments for the month were £16m with £9.3m in relation to direct salary costs and £6.7m employer costs.

The Trust has received £13.8m of deficit loan funding YTD in the form of uncommitted revenue loans.

Monthly payments for 2018/19 have so far averaged at £26.7m, with 57% relating to payroll costs. Monthly receipts (excluding loans) for 18/19 have so far averaged at £23.9m.

2. Financial Performance

2a. Finance Report for July 2018- APPENDICES

Consolidated I&E (July 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	20,598	19,046	1,552	76,407	75,581	827	226,095	225,459	636
High Cost Drugs	2,351	1,857	494	8,513	7,397	1,117	24,200	21,158	3,042
Other Operating Income	2,047	1,898	150	7,980	7,685	295	23,935	23,242	693
Total Revenue	**24,996**	**22,801**	**2,195**	**92,900**	**90,662**	**2,238**	**274,230**	**269,859**	**4,371**
Expenditure									
Substantive	-14,112	-16,935	2,823	-56,379	-68,526	12,148	-167,869	-197,967	30,098
Bank	-2,915	-69	-2,846	-8,895	-232	-8,663	-23,326	0	-23,326
Agency	-895	-32	-864	-4,345	-156	-4,189	-12,924	0	-12,924
Total Pay	**-17,923**	**-17,036**	**-887**	**-69,619**	**-68,915**	**-704**	**-204,119**	**-197,967**	**-6,152**
Clinical supplies	-2,900	-2,908	8	-10,750	-11,861	1,111	-27,054	-27,950	896
High Cost Drugs Expense	-3,303	-2,887	-415	-8,761	-7,284	-1,478	-23,323	-22,959	-364
Drugs	808	341	466	-1,850	-2,865	1,014	-3,731	-6,608	2,877
Consultancy	-136	-101	-35	-393	-380	-13	-1,027	-1,095	68
Other non pay	-3,558	-3,351	-207	-14,307	-13,420	-887	-48,872	-46,190	-2,682
Total Non Pay	**-9,089**	**-8,906**	**-183**	**-36,062**	**-35,809**	**-253**	**-104,007**	**-104,802**	**795**
Total Expenditure	**-27,012**	**-25,942**	**-1,070**	**-105,681**	**-104,724**	**-957**	**-308,126**	**-302,771**	**-5,357**
EBITDA	**-2,016**	**-3,142**	**1,125**	**-12,781**	**-14,062**	**1,281**	**-33,896**	**-32,912**	**-986**
Post EBITDA									
Depreciation	-1,060	-850	-210	-3,416	-3,320	-96	-9,699	-10,093	394
Interest	-304	-353	49	-1,135	-1,194	59	-3,352	-3,944	592
Dividend	0	-7	7	0	-27	27	0	0	0
Profit/(loss) on sale of asset	0	0	0	0	0	0	0	0	0
	-1,365	**-1,210**	**-155**	**-4,551**	**-4,541**	**-10**	**-13,051**	**-14,037**	**986**
Net (Surplus) / Deficit - Pre STF	**-3,381**	**-4,351**	**971**	**-17,332**	**-18,603**	**1,272**	**-46,947**	**-46,949**	**0**
PSF Income	591	844	-253	1,920	2,743	-823	11,333	12,663	-1,330
Net (Surplus) / Deficit - Post STF	**-2,790**	**-3,507**	**718**	**-15,412**	**-15,860**	**449**	**-35,614**	**-34,286**	**-1,330**

2b. Finance Report for July 2018- APPENDICES

Anaylsis of 15 monthly performance - Financials

	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	Jun-18	Jul-18
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue															
Clinical income	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	18.4	20.6
High Cost Drugs	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	2.1	2.4
PSF Income	0.9	0.5	0.6	0.4	0.6	0.4	0.9	-1.9	0.0	0.0	0.0	0.0	0.0	1.3	0.6
Other Operating Income	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	1.4	2.0
Total Revenue	**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**	**23.1**	**25.6**
Expenditure															
Substantive	-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	-14.0	-14.1
Bank	-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	-1.9	-2.9
Agency	-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	-1.0	-0.9
Total Pay	**-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**	**-17.0**	**-17.9**
Clinical supplies	-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	-2.5	-2.9
High Cost Drugs Expense	-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	-1.6	-3.3
Drugs	-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	-0.7	0.8
Consultancy	-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	-0.1	-0.1
Other non pay	-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	-3.1	-3.6
Total Non Pay	**-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**	**-8.0**	**-9.1**
Total Expenditure	**-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**	**-25.0**	**-27.0**
EBITDA	**-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**	**-1.9**	**-1.4**
Post EBITDA															
Depreciation	-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	-0.8	-1.1
Interest	-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	-0.4	-0.3
Dividend	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	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
Total Non-Operating Expense	**-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**	**-1.2**	**-1.4**
Net Surplus / (Deficit)	**-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**	**-3.0**	**-2.8**

2c. Finance Report for July 2018- APPENDICES

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
		WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Substantive	Consultants	195	230	-35	2.41	2.50	-0.09	2.52	9.86	10.19	-0.33	9.97
	Junior Medical	350	386	-36	1.95	2.42	-0.47	1.90	7.91	9.75	-1.84	7.69
	Nurses & Midwives	1126	1542	-417	4.17	5.79	-1.62	4.04	16.41	22.85	-6.45	16.36
	Scientific, Therapeutic & Technical	322	436	-114	1.07	1.45	-0.38	1.32	4.29	5.86	-1.57	5.46
	Healthcare Assts, etc.	481	583	-102	1.08	1.27	-0.19	1.03	4.23	5.00	-0.77	4.12
	Admin & Clerical	804	936	-132	2.18	2.58	-0.41	2.20	8.45	10.37	-1.91	8.59
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Executives	6	6	0	0.15	0.10	0.05	0.11	0.45	0.40	0.05	0.51
	Other Non Clinical	419	489	-70	0.92	1.06	-0.14	0.91	3.63	4.22	-0.59	3.72
	Pay Reserves	0	0	0	0.18	-0.23	0.42	0.00	1.15	-0.10	1.25	0.00
	Substantive Total	**3,703**	**4,608**	**-905**	**14.11**	**16.94**	**-2.82**	**14.02**	**56.38**	**68.53**	**-12.15**	**56.42**
Agency	Consultants	5	0	5	0.04	-0.05	0.08	2.52	0.27	-0.14	0.4	0.71
	Junior Medical	11	0	11	0.07	0.03	0.04	0.23	0.46	0.14	0.3	1.05
	Nurses & Midwives	123	0	123	0.68	0.00	0.68	0.61	2.44	0.00	2.4	2.41
	Scientific, Therapeutic & Technical	48	0	48	0.10	0.00	0.10	0.23	0.71	0.00	0.7	0.87
	Healthcare Assts, etc.	0	0	0	0.00	0.00	0.00	-0.02	0.00	0.00	0.0	0.14
	Admin & Clerical	7	0	7	-0.02	0.02	-0.04	0.03	0.27	0.04	0.2	0.22
	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	17	0	17	0.03	0.03	0.00	0.04	0.20	0.12	0.1	0.24
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Agency Total	**212**	**0**	**211**	**0.90**	**0.03**	**0.86**	**3.63**	**4.35**	**0.16**	**4.19**	**5.63**
Bank	Consultants	17	4.52	13	0.38	0.07	0.32	0.19	0.82	0.22	0.6	0.20
	Junior Medical	69	0	69	0.92	0.00	0.92	0.39	2.69	0.00	2.7	1.39
	Nurses & Midwives	155	0	155	0.75	0.00	0.75	0.44	2.31	0.00	2.3	2.20
	Scientific, Therapeutic & Technical	10	0	10	0.08	0.00	0.08	0.04	0.35	0.00	0.4	0.09
	Healthcare Assts, etc.	173	0	173	0.48	0.00	0.48	0.47	1.61	0.00	1.6	1.58
	Admin & Clerical	70	1	69	0.17	0.00	0.17	0.21	0.58	0.01	0.6	0.86
	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	71	1	70	0.14	0.00	0.14	0.09	0.53	0.01	0.5	0.45
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Bank Total	**565**	**6**	**559**	**2.91**	**0.07**	**2.85**	**1.83**	**8.90**	**0.23**	**8.66**	**6.77**
	Workforce Total	**4,480**	**4,615**	**-134**	**17.92**	**17.04**	**0.89**	**19.49**	**69.62**	**68.92**	**0.70**	**68.82**

	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	217	234	-18	2.83	2.52	0.31	5.22	10.95	10.27	0.68	10.88
Junior Medical	430	386	44	2.95	2.46	0.49	2.52	11.06	9.89	1.18	10.13
Nurses & Midwives	1,404	1,542	-138	5.59	5.79	-0.19	5.09	21.16	22.85	-1.70	20.98
Scientific, Therapeutic & Technical	381	436	-55	1.24	1.45	-0.21	1.60	5.36	5.86	-0.50	6.42
Healthcare Assts, etc.	653	583	71	1.55	1.27	0.28	1.49	5.84	5.00	0.85	5.83
Executives	881	937	0	2.33	2.60	-0.27	2.44	9.29	10.42	-1.12	9.66
Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Admin & Clerical	6	6	-56	0.15	0.10	0.05	0.11	0.45	0.40	0.05	0.51
Other Non Clinical	507	490	17	1.09	1.09	0.00	1.03	4.36	4.34	0.02	4.42
Pay Reserves	0	0	0	0.18	-0.23	0.42	0.00	1.15	-0.10	1.25	0.00
Workforce Total	**4,480**	**4,615**	**-134**	**17.92**	**17.04**	**0.89**	**19.49**	**69.62**	**68.92**	**0.70**	**68.82**

2d. Run rate analysis pay

		Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	189	189	192	190	193	192	192	191	196	197	190	195
	Junior Medical	348	346	354	339	359	356	352	357	358	351	353	350
	Nurses & Midwives	1152	1142	1161	1148	1128	1125	1138	1139	1121	1115	1132	1126
	Scientific, Therapeutic & Technical	429	442	446	438	433	425	419	342	340	339	316	322
	Healthcare Assts, etc	492	492	492	494	485	480	484	475	484	492	488	481
	Admin & Clerical	840	839	841	831	831	842	839	837	827	832	804	804
	Chair & NEDs	6	6	1	1	0	0	0	0	0	0	0	0
	Executives	7	6	6	6	6	6	6	6	7	7	7	6
	Other Non Clinical	449	442	441	436	437	435	440	429	425	428	424	419
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0
	Substantive Total	**3,912**	**3,904**	**3,935**	**3,883**	**3,872**	**3,861**	**3,871**	**3,776**	**3,758**	**3,761**	**3,715**	**3,703**
Agency	Consultants	14	10	11	12	4	3	8	6	6	7	6	5
	Junior Medical	24	24	12	23	20	17	14	13	13	12	11	11
	Nurses & Midwives	171	153	153	90	93	153	105	127	-20	19	127	123
	Scientific, Therapeutic & Technical	50	46	34	31	32	24	18	27	42	52	27	48
	Healthcare Assts, etc	0	0	0	0	0	0	0	0	0	0	0	0
	Admin & Clerical	4	4	3	3	3	5	4	8	7	8	9	7
	Chair & NEDs	0	0	0	0	0	0	0	0	0	0	0	0
	Executives	0	0	0	0	0	0	0	0	0	0	0	0
	Other Non Clinical	28	21	26	20	19	18	19	19	16	18	20	17
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0
	Agency Total	**291**	**258**	**238**	**179**	**171**	**220**	**168**	**201**	**65**	**117**	**199**	**212**
Bank	Consultants	10	13	14	15	14	15	12	12	12	14	8	17
	Junior Medical	45	41	48	39	32	41	35	42	43	47	48	69
	Nurses & Midwives	137	126	125	124	105	195	167	158	118	111	132	155
	Scientific, Therapeutic & Technical	11	12	12	16	17	22	22	23	19	34	16	10
	Healthcare Assts, etc	249	207	203	195	182	208	191	222	161	142	156	173
	Admin & Clerical	114	74	91	75	58	59	55	60	52	53	57	70
	Chair & NEDs	0	0	0	0	0	0	0	0	0	0	0	0
	Executives	0	0	0	0	0	0	0	0	0	0	0	0
	Other Non Clinical	71	59	65	56	59	66	62	74	59	63	63	71
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0
	Bank Total	**637**	**532**	**558**	**518**	**467**	**606**	**544**	**591**	**464**	**465**	**480**	**565**
	Workforce Total	**4,840**	**4,694**	**4,730**	**4,580**	**4,510**	**4,687**	**4,583**	**4,567**	**4,287**	**4,342**	**4,395**	**4,480**

Analysis of 12 monthly performance - £

		Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.47	2.37	2.54	2.41	2.40	2.39	2.48	2.48	2.52	2.46	2.47	2.41
	Junior Medical	2.09	1.81	2.22	2.01	2.05	2.08	1.96	1.88	1.99	1.99	1.97	1.95
	Nurses & Midwives	4.13	4.05	4.08	4.07	3.88	4.06	4.05	4.03	4.11	4.01	4.11	4.17
	Scientific, Therapeutic & Technical	1.33	1.37	1.38	1.36	1.36	1.27	1.31	1.12	1.11	1.10	1.02	1.07
	Healthcare Assts, etc	1.03	1.04	1.02	1.05	1.04	1.05	1.04	1.01	1.03	1.06	1.07	1.08
	Admin & Clerical	2.20	2.20	2.15	2.20	2.27	2.22	2.10	2.01	2.11	2.12	2.04	2.18
	Chair & NEDs	0.01	0.01	0.01	0.01	0.01	0.02	0.00	0.00	0.00	0.00	0.00	0.00
	Executives	0.10	0.09	0.09	0.09	0.09	0.14	0.18	-0.02	0.10	0.10	0.10	0.15
	Other Non Clinical	0.91	0.92	0.91	0.90	0.90	0.94	0.93	0.90	0.90	0.91	0.90	0.92
	Pay Reserves	0.07	0.07	0.07	0.07	0.07	0.66	-0.52	1.52	0.03	0.58	0.35	0.18
	Substantive Total	**14.34**	**13.93**	**14.48**	**14.17**	**14.07**	**14.83**	**13.53**	**14.93**	**13.90**	**14.33**	**14.03**	**14.11**
Agency	Consultants	0.25	0.15	0.18	0.09	0.02	0.08	0.08	0.10	0.06	0.07	0.10	0.04
	Junior Medical	0.21	0.12	0.12	0.21	0.12	0.26	0.14	-0.01	0.15	0.16	0.08	0.07
	Nurses & Midwives	0.76	0.69	0.75	0.43	0.44	0.72	0.49	2.46	0.32	0.87	0.58	0.68
	Scientific, Therapeutic & Technical	0.26	0.32	0.20	0.18	0.22	0.02	0.23	0.64	0.27	0.24	0.11	0.10
	Healthcare Assts, etc	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.00
	Admin & Clerical	0.01	0.04	0.00	0.12	0.04	0.03	0.10	0.13	0.09	0.11	0.09	-0.02
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Other Non Clinical	0.08	0.06	0.06	0.05	0.05	0.06	0.05	0.03	0.06	0.05	0.06	0.03
	Agency Total	**1.57**	**1.38**	**1.31**	**1.08**	**0.89**	**1.17**	**1.09**	**3.37**	**0.95**	**1.50**	**1.02**	**0.90**
Bank	Consultants	0.21	0.25	0.26	0.22	0.21	0.24	0.20	0.12	0.17	0.19	0.08	0.38
	Junior Medical	0.59	0.48	0.58	0.47	0.50	0.58	0.43	0.52	0.59	0.56	0.62	0.92
	Nurses & Midwives	0.53	0.61	0.56	0.51	0.44	0.81	0.83	0.69	0.52	0.51	0.53	0.75
	Scientific, Therapeutic & Technical	0.03	0.05	0.05	0.12	0.08	0.10	0.10	0.03	0.09	0.12	0.07	0.08
	Healthcare Assts, etc	0.54	0.57	0.51	0.49	0.48	0.52	0.47	0.66	0.40	0.37	0.37	0.48
	Admin & Clerical	0.39	0.23	0.28	0.21	0.18	0.18	0.16	0.11	0.14	0.12	0.14	0.17
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Other Non Clinical	0.16	0.11	0.14	0.12	0.13	0.14	0.14	0.19	0.13	0.13	0.13	0.14
	Bank Total	**2.45**	**2.30**	**2.38**	**2.15**	**2.02**	**2.58**	**2.34**	**2.33**	**2.04**	**2.00**	**1.94**	**2.92**
	Workforce Total	**18.36**	**17.61**	**18.17**	**17.40**	**16.98**	**18.57**	**16.96**	**20.63**	**16.89**	**17.83**	**16.99**	**17.93**

2d. Run rate analysis pay continued

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Summary by Staff Group												
Consultants	2.93	2.77	2.98	2.72	2.63	2.72	2.76	2.70	2.75	2.72	2.65	2.83
Junior Medical	2.89	2.41	2.92	2.69	2.67	2.92	2.53	2.39	2.73	2.71	2.67	2.94
Nurses & Midwives	5.42	5.35	5.39	5.01	4.76	5.59	5.37	7.18	4.95	5.39	5.22	5.60
Scientific, Therapeutic & Technical	1.62	1.74	1.63	1.66	1.66	1.39	1.64	1.79	1.47	1.46	1.20	1.25
Healthcare Assts, etc	1.57	1.61	1.53	1.54	1.52	1.57	1.51	1.69	1.43	1.43	1.44	1.56
Admin & Clerical	2.60	2.47	2.43	2.53	2.49	2.42	2.36	2.25	2.34	2.35	2.27	2.33
Chair & NEDs	0.01	0.01	0.01	0.01	0.01	0.02	0.00	0.00	0.00	0.00	0.00	0.00
Executives	0.10	0.09	0.09	0.09	0.09	0.14	0.18	-0.02	0.10	0.10	0.10	0.15
Other Non Clinical	1.15	1.09	1.11	1.07	1.08	1.14	1.12	1.12	1.09	1.09	1.09	1.09
Pay Reserves	0.07	0.07	0.07	0.07	0.07	0.66	-0.52	1.52	0.03	0.58	0.35	0.18
Total InclSubstantive and Temp	**18.36**	**17.61**	**18.17**	**17.40**	**16.98**	**18.57**	**16.95**	**20.62**	**16.89**	**17.83**	**16.99**	**17.93**

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Summary by Staff Group												
Consultants	213	212	217	217	211	210	212	210	213	218	204	217
Junior Medical	417	411	414	401	411	414	401	413	414	411	412	430
Nurses & Midwives	1460	1421	1438	1362	1326	1473	1410	1424	1219	1245	1392	1404
Scientific, Therapeutic & Technical	490	500	492	485	482	471	459	392	401	425	359	381
Healthcare Assts, etc	741	699	695	689	667	688	675	697	646	634	644	653
Admin & Clerical	958	917	935	909	892	906	898	906	886	894	870	881
Chair & NEDs	6	6	1	1	0	0	0	0	0	0	0	0
Executives	7	6	6	6	6	6	6	6	7	7	7	6
Other Non Clinical	548	522	532	512	515	519	521	521	500	509	506	507
Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0
Total InclSubstantive and Temp	**4,840**	**4,694**	**4,730**	**4,580**	**4,510**	**4,687**	**4,583**	**4,567**	**4,287**	**4,342**	**4,395**	**4,480**

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	195.5	193.3	202.1	-8.8
Trade and Other Receivables: Other	0.3	0.4	0.0	0.4
Total Non current Assets	**195.9**	**193.6**	**202.1**	**-8.5**
Current Assets				
Inventories	7.5	7.5	7.4	0.1
Trade and Other Receivables: Trade	17.6	18.5	12.7	5.8
Trade and Other Receivables: Accruals	15.8	16.3	14.7	1.6
Trade and Other Receivables: Prepayments	4.0	4.5	3.6	0.9
Trade and Other Receivables: Other	2.8	2.8	2.5	0.3
Cash and Cash Equivalents	6.6	11.0	6.1	4.9
Total Current Assets	**54.3**	**60.6**	**47.0**	**13.6**
Current Liabilities				
Borrowings	-58.0	-58.0	-58.2	0.2
Trade and Other Payables: Trade	-13.2	-15.3	-16.1	0.8
Trade and other payables: Accruals	-21.5	-19.9	-13.5	-6.4
Trade and other payables: Other	-7.8	-8.6	-5.0	-3.6
Other liabilities: Deferred Income	-2.9	-4.5	-4.3	-0.2
Provisions	-0.3	-0.2	-0.6	0.4
Total Current Liabilities	**-103.7**	**-106.5**	**-97.7**	**-8.8**
Total Assets Less Current Liabilities	**146.5**	**147.7**	**151.4**	**-3.7**
Non Current Liabilities				
Borrowings	-168.4	-172.5	-172.7	0.2
Provisions	-0.9	-1.0	-0.9	-0.1
Total Non Current Liabilities	**-169.4**	**-173.4**	**-173.6**	**0.1**
Net Assets Employed	**-22.9**	**-25.8**	**-22.2**	**-3.6**
Taxpayers Equity				
Public Dividend Capital	137.7	137.7	137.7	0.0
Retained Earnings	-207.0	-209.7	-207.2	-2.5
Revaluation Reserve	46.4	46.1	47.3	-1.2
Total taxpayers' equity	**-22.9**	**-25.9**	**-22.2**	**-3.7**

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.

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 estimated balances owed to The Trust which are yet to be invoiced.

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 July 2018 was £11m. 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. This balance is expected to steadily and slightly decrease each month as old queried supplier balances are cleared.

Other, mainly relates to payovers such as Pensions and HMRC costs. Payment to these bodies is required a month in arrears.

Deferred Income, This mainly relates to Maternity Pathway income from Medway and Swale CCG's in respect of the agreed accounting treatment for Maternity Income billed at the start of the Clinical Pathway. This balance also includes deferred income for Research & Development Funds and organ donation 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 in retained earningsare because the plan is the expected cumulative positive at the year end. There are minimal expected changes in other areas of taxpayers equity.

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

3b. Trade Receivables

Aged Debtors in Sales ledger

	Total	Current	31 to 60 Days	61 to 90 Days	91 to 180 Days	6 Months +
	£m	£m	£m	£m	£m	£m
NHS FTs	2.36	0.28	0.29	0.04	0.68	1.07
NHS Trusts	3.13	0.92	0.22	0.56	0.74	0.70
DH	0.00	0.00	0.00	0.00	0.00	0.00
Public Health England	0.00	0.00	0.00	0.00	0.00	0.00
Health Education England	0.00	0.00	0.00	0.00	0.00	0.00
CCGs and NHS England	12.01	0.45	1.49	0.89	4.11	5.06
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 Debtors	**17.55**	**1.65**	**2.00**	**1.49**	**5.53**	**6.88**
other WGA bodies	0.01	0.00	0.00	0.00	0.00	0.01
Local Authorities	0.04	0.00	0.00	0.00	-0.05	0.09
Bodies external to Government	2.67	0.25	0.18	0.13	0.47	1.64
Total Non NHS Debtors	**2.72**	**0.25**	**0.18**	**0.13**	**0.42**	**1.74**
Total Debtors	**20.27**	**1.90**	**2.18**	**1.62**	**5.95**	**8.62**

Commentary

Total outstanding Trade Receivables as at the 31st July 2018 are £20.27m , for which there is a doubtful debt provision of £1.83m .

NHS Debt is £17.55m , £8.85m of this relates to the debt with the Trust's three main Commissioners, much of this is due to be paid in August. There is a further £4m of Debt with local trusts mainly for provider to provider and dispensing services. Some of these payments are being witheld until like for like payments can be arranged.

Non NHS Debt is £2.72m, 39%,£1.08m with Medway Community Healthcare CIC(MCH), for which there are some ongoing disputes. The Trust owes MCH £0.9m also with disputes so payments to MFT are on hold until these are resolved and like for like payments can be made.

Figs 1 to 4 provide further debtor analysis by age, trend and value.

Fig.1 - Aged Debtor Analysis by financial year

	2018/19	2017/18	2016/17	2015/16 and before	Total
NHS	6.62	6.03	2.92	1.07	16.64
NON NHS	0.65	0.92	0.87	0.38	2.82
Total	7.27	6.94	3.79	1.45	19.46

Fig.2 - Aged Debtor Analysis by ageing category

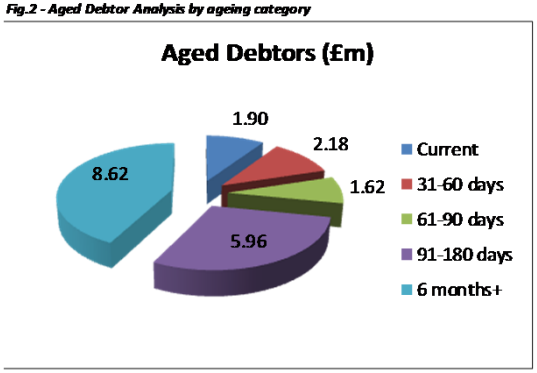


Fig.3 - Aged Debtor Analysis

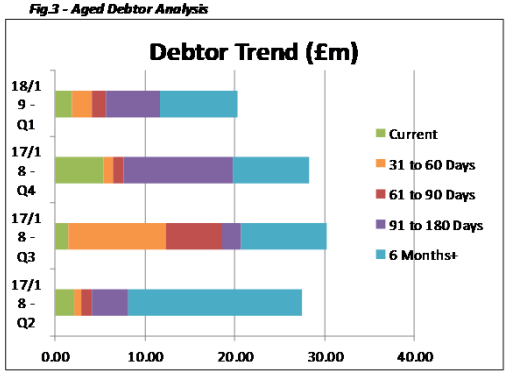


Fig.4 - Aged Debtor Analysis

Top 10 Debtors (£m)

		£m
1	NHS Medway CCG	3.47
2	NHS Swale CCG	2.73
3	NHS Dartford Gravesham & Swal	2.65
4	DARTFORD & GRAVESHAM NHS TRUST	1.88
5	NHS West Kent CCG	1.22
6	E.K.HOSP.UNIV.NHS.FOUNDA.TRUST	1.15
7	MEDWAY COMM HEALTHCARE CIC	1.08
8	QUEEN VICTORIA HOSP. NHS TRUST	0.97
9	MAIDSTONE AND TUNBRIDGE WELLS	0.82
10	NHS ENGLAND	0.34

3c. Trade Payables

Aged Trade Creditors in Purchase Ledger

	Total £m	Current £m	31 to 60 Days £m	61 to 90 Days £m	91 to 180 Days £m	6 Months + £m
NHS FTs	1.84	0.11	0.14	0.17	0.43	0.99
NHS Trusts	2.81	1.45	0.61	0.19	0.09	0.47
DH	0.00	0.00	0.00	0.00	0.00	0.00
Public Health England	0.00	0.00	0.00	0.00	0.00	0.00
Health Education England	0.00	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	0.15	0.00	0.06	0.01	0.05	0.02
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.21	0.01	0.01	0.02	0.00	0.17
Total NHS Creditors	**5.01**	**1.57**	**0.82**	**0.39**	**0.57**	**1.65**
other WGA bodies	0.11	0.11	0.00	0.00	0.00	0.00
Local Authorities	1.12	0.00	0.00	1.10	0.02	0.00
Bodies external to Government	9.09	3.65	1.63	0.81	1.81	1.20
Total Non NHS Creditors	**10.32**	**3.76**	**1.63**	**1.91**	**1.83**	**1.20**
Total Trade Creditors	**15.33**	**5.33**	**2.45**	**2.30**	**2.40**	**2.85**

Commentary

Total outstanding creditors in the purchase ledger as at 31st July 2018 were £15.33m of which 65% (10m) 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.

Of the £10m Overdue Creditors, there are £7.5m of unapproved invoices that are more than 60 days old, unpproval relates to issues with Purchase Orders and an nability to validate historical NO PO invoices. Finance and Procurement continue to work with operational teams to gain approval for these invoices.

The Trust has £2.85m creditors over 6 months, Finance is rctively invesitgating these ibalances by reconciling statements, where invoices are no longer due they will be removed or approval chased with operational teams.

Fig.1 shows aged creditors analysed by ageing category; Fig.2 shows the rolling creditor trend; & Fig.3 provides a list of thre top 10 Creditors by value

Fig.1 - Aged Payables Analysis

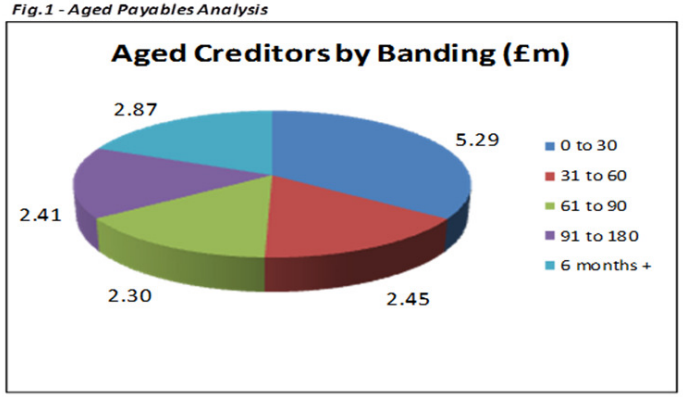


Fig.2 - Creditor Trend

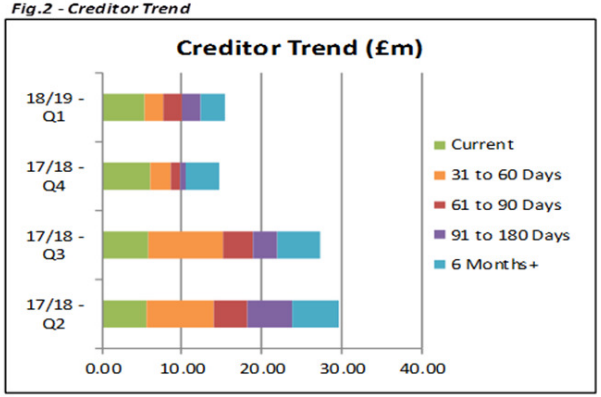


Fig.3 - Top 10 Creditors

Top 10 Creditors

		£m
1	DARTFORD & GRAVESHAM NHS TRUST (RN7)	1.92
2	MEDWAY COUNCIL	1.12
3	MAIDSTONE TUNBRIDGE WELLS NHST (RWF)	0.88
4	MEDWAY COMMUNITY HEALTHCARE CIC	0.81
5	KINGS COLLEGE HOSPITAL NHS TRUST (RJZ)	0.61
6	EAST KENT HOSPITALS NHS TRUST (RVV)	0.57
7	KENT COMMUNITY HEALTH NHS FT (RYY)	0.49
8	NHS SUPPLY CHAIN	0.48
9	MEDTRONIC LIMITED	0.42
10	GENEPOOL PERSONNEL LTD	0.38

4. Capital

4a. Capital

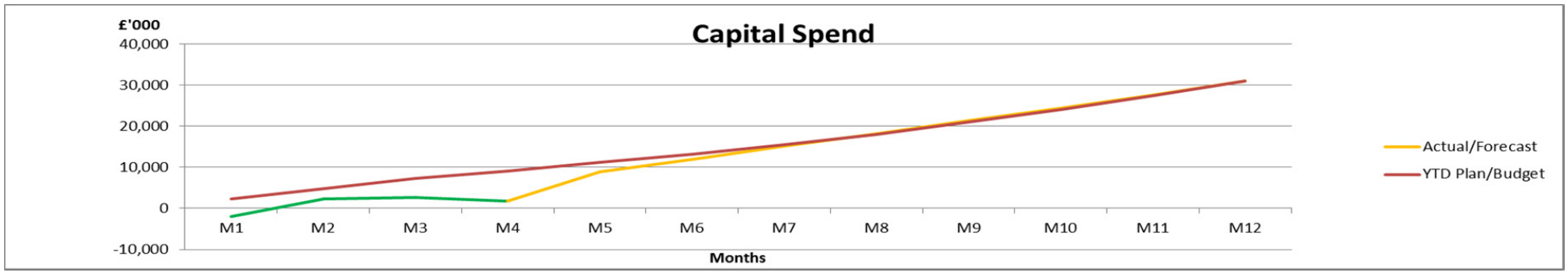
Capital Programme Summary

	Current Month			Year to Date			Forecast year end Outturn		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Original Plan £m	Forecast Outturn £m	Forecast Variance £m
Expenditure									
Recurrent Estates & Site Infrastructure	1.51	1.09	0.42	2.45	4.18	-1.73	19.50	19.50	0.00
IM&T	0.02	0.13	-0.11	0.19	0.50	-0.31	2.20	2.20	0.00
Medical & Surgical Equipment	0.03	0.08	-0.05	-0.07	0.30	-0.37	1.30	1.30	0.00
Specific Business Cases	0.10	0.06	0.04	0.22	0.25	-0.03	0.60	0.60	0.00
Transform Projects (ED/AAU)	-2.68	0.37	-3.05	-1.08	3.55	-4.63	6.48	6.48	0.00
Medical Asssessment Unit (MAU)	0.15	0.08	0.07	0.02	0.33	-0.31	1.00	1.00	0.00
Total	**-0.87**	**1.81**	**-2.68**	**1.72**	**9.11**	**-7.39**	**31.08**	**31.08**	**0.00**

The total capital spend for the period ending 31st July 2018 was £1.7m against a plan of £9.1m, £7.4m underspent.

All capital areas are underspent against plan as at month 4. £4.6m (62%) of the underperformance relates to phase 1 of the Emergency Department(ED) project. A credit for £0.8m recognised in month from the main contractor in relation to performance/quality issues has increased the value of this underspend.

Estates backlog maintenance is underspent by £1.7m ytd. There are however plans to phase in considerable fire urgency expenditure in October 2018 and there is a review of backlog maintenance plans across the Trust's site infrastructure.



Note: The green line represents the actual to July 2018 while the rest of the amber line represents the forecast to the end of March 2019

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 06/09/2018

Agenda item 12b

Title of Report	**Amendments to the standing financial instructions (SFIs)**
Prepared By:	Richard Boyce – Deputy Director of Finance
Lead Director	Tracey Cotterill – Director of Finance
Committees or Groups who have considered this report	Executive Group – 15th August 2018 Integrated Audit Committee – 23rd August 2018
Executive Summary	The SFIs are recommended to be amended: • To update the scheme of delegation to reflect the current controls and executive portfolios. • To update the limits on petty cash payments and establish separate control of this for trust and charitable funds. • To fully align with Medway NHS Foundation Trust's constitution. • To incorporate elements of standard NHS SFIs, principally regarding insurance policy, that were previously excluded. • To generalise references to specific procurement frameworks. • To reflect the regulatory control in place regarding consultancy spend. Changes to the SFIs need to be approved by the board.
Resource Implications	None
Risk and Assurance	SFIs are part of the trust's controls environment. These changes are intended to ensure the balance between risk and efficiency is appropriate.
Legal Implications/Regulatory Requirements	SFIs and Scheme of Delegation are constitutional requirements

Report to the Board of Directors

Improvement Plan Implication	None
Quality Impact Assessment	None
Recommendation	To approve the changes to the SFIs and the proposed scheme of delegation
Purpose and Actions required by the Board :	**Approval** ☒ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

Corporate Policy – Standing Financial Instructions

Author:	Isla Fraser, Financial Controller Richard Boyce, Deputy director of finance
Document Owner:	Tracey Cotterill, Director of Finance
Revision No:	2
Document ID Number	
Approved By:	Trust Board
Implementation Date:	
Date of Next Review:	One year from approval


Best of care
Best of people

Corporate Policy – Standing Financial Instructions

Document Control / History	
Revision No	**Reason for change**
1	Annual SFIs review and update
2	Update procurement frameworks Adjust petty cash limits Make SoD changes to • facilitate transaction aspect of pharmacy transformation project • reflect creation of trust capital group • ensure consistency of levels across directors

Consultation
Deputy Director of Finance
Head of Procurement
Director of Estates and Facilities

Corporate Policy – Standing Financial Instructions

Table of Contents

Corporate Policy – Standing Financial Instructions

To be read in conjunction with any policies and Standing Operating Procedures listed in Trust Associated Documents.

1 Introduction

1.1 General

1.1.1 Medway NHS Foundation Trust (the "Trust") became a Public Benefit Corporation on 1st April 2008 following authorisation by the Independent Regulator pursuant to the 2006 Act.

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Matters reserved to the Board and the Scheme of Delegation approved by the Board of Directors.

1.1.3 These Standing Financial Instructions identify the financial responsibilities, which apply to everyone working for the Trust and its constituent organisations including Trading Units. The financial responsibilities also apply to service organisations providing financial services on behalf of the Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. The Director of Finance (DoF) must approve all financial procedures.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting.

1.1.5 **Failure to comply with Standing Financial Instructions can be regarded as a disciplinary matter that could result in dismissal.**

1.1.6 All members of the Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible

1.1.7 Overriding of Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance including justification and circumstances around which non-compliance arose shall be reported to the next formal meeting of the Integrated Audit Committee for referring action or ratification.

1.2 Terminology

1.2.1 Any expression, to which a meaning is given in Acts of Parliament, or in the Financial Directions made under such Acts, shall have the same meaning in these instructions.

(a) "Trust" means Medway NHS Foundation Trust.

(b) "Board of Directors" means the Board of Directors as constituted in accordance with the constitution of the Trust.

(c) "Assembly of Governors" means the Assembly of Governors as constituted in accordance with the constitution of the Trust.

(d) "Budget" means a resource, expressed in financial terms, proposed by the Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

(e) "Budget Holder/Manager" means the director or employee with delegated authority to manage finances (Income and Expenditure, or capital where applicable) for a specific area of the organisation.

(f) "Chief Executive" (CE) and "Accounting Officer" means the Chief Executive Officer of the Trust.

(g) "Director of Finance" (DoF) means the chief financial officer of the Trust.

(h) "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

(i) "NHS Improvement" means the sector regulator for health service providers in England.

(j) "The Chair" is the Chair of the Trust.

(k) "Funds held on trust" shall mean those funds which the Trust holds at its date of Authorisation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.47(2)(c) of the NHS Act 2006, as amended. Such funds may or may not be charitable.

(l) 'Virements' means an administrative transfer of funds from one part of a budget to another.

1.3 Responsibilities and Delegation

1.3.1 **The Board** exercises financial supervision and control by:

(a) formulating the financial strategy;

(b) requiring the submission and approval of budgets within approved allocations/overall income;

(c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation (SD); and

(e) ensuring that the duties of the Chief Executive as Accounting Officer are performed.

1.3.2 **The Board** has resolved that certain powers and decisions may only be exercised by the Board in formal sessions. These are set out in the 'Schedule of Matters Reserved for the Board' document. All other powers have been delegated to such other committees as the Trust has established.

1.3.3 **The Board** will delegate responsibility for the performance of its functions in accordance with its constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of the delegation shall be kept under review by the Board.

1.3.4 Within the SFIs it is acknowledged that the Chief Executive is accountable to the Board, and to Parliament as Accounting Officer.

1.3.5 The Chief Executive Officer is the Accounting Officer of the Trust and as such has the following principal responsibilities:

(a) To ensure there is a high standard of financial management within the Trust;

(b) To ensure financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Trust; and

(c) To ensure financial considerations are fully taken into account in decisions on Trust policy proposals.

1.3.6 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.7 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.8 The Director of Finance is responsible for:

(a) implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and

(c) ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

1.3.9 Without prejudice to any other functions of directors and employees to the Trust, the duties of the Director of Finance include:

(a) the provision of financial advice to other members of the Board of Directors, the Assembly of Governors and Trust employees;

(b) the design, implementation and supervision of systems of financial control to provide reasonable assurance as to the probity and regularity of transactions;

(c) the preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties; and

(d) deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.

1.3.10 All directors and employees, severally and collectively, are responsible for:

(a) the security of Trust property;

(b) avoiding loss;

(c) exercising economy and efficiency in the use of resources; and

(d) conforming with the requirements of the Constitution, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.11 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

1.3.12 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of their duties under these SFIs.

2 Audit

2.1 Integrated Audit Committee

2.1.1 In accordance with the Constitution of the Trust, the Board of Directors shall formally establish an Audit Committee, with clearly defined and approved terms of reference which includes approving the appointment of the internal auditors. This Committee will, amongst other things:

(a) provide an independent and objective view of integrated governance, risk management and internal control systems across the whole of the Trust's activities (both clinical and non-clinical);

(b) monitor and review the effectiveness of Internal and External Audit services;

(c) review financial and information systems and monitor the integrity and quality of the financial statements and review significant financial reporting judgments;

(d) ratify schedules of losses, compensations, and settlements with staff, as approved through sub-committee; review and monitor the effectiveness of the Local Counter Fraud Service; and

(e) review the arrangements in place to support the Board Assurance Framework process prepared on behalf of the Board and advising the Board accordingly.

2.1.2 Where the Integrated Audit Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Integrated Audit Committee should immediately inform the Chief Executive and raise the matter at the next meeting of the Board. Exceptionally, the

matter may need to be referred to NHS Improvement after seeking the advice of Chair/Company Secretary/DoF.

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Integrated Audit Committee shall be involved in the selection process when an internal audit service provider is changed. It must ensure a cost-effective service is provided, in compliance with the contracting procedures herein.

2.2 Countering Fraud, Bribery and Corruption

2.2.1 The Board recognises that fraud and bribery is a hugely damaging practice that undermines competition and the reputation of public and private bodies involved. It is the Board's policy to act with integrity, and bribery and corruption will not be tolerated in any form.

2.2.2 An Anti-Fraud and Bribery Policy is in place that sets out procedures designed to prevent everyone associated with the Trust from undertaking acts of fraud, bribery or corruption.

2.2.3 'Fraud' - any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006.

2.2.4 'Bribery' - Inducement for an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards or other advantages.

This can be broadly defined as the offering or acceptance of inducements, gifts, favours, payment or benefit-in-kind which may influence the action of any person. Bribery does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

It is the criminal offence of bribery to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.

2.2.5 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the NHS Standards for Providers on Fraud, Bribery and Corruption issued by the NHS Counter Fraud Authority (NHSCFA).

2.2.6 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Standards for Providers on fraud, bribery and corruption. The Director of Finance is responsible for ensuring that the Police are notified at an appropriate stage in any investigation. This shall be following advice from the NHS Counter Fraud Authority.

2.2.7 If any employee suspects or discovers any act of fraud or bribery, they must inform the Local Counter Fraud Specialist or the Director of Finance immediately. Employees can also call the NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60 or fill in an online form at www.reportnhsfraud.nhs.uk.

2.2.8 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in the NHS Counter Fraud Authority in accordance with the NHS Standards for Providers and NHS Anti-Fraud Manual.

2.2.9 The Local Counter Fraud Specialist will provide a written report to the Integrated Audit Committee, as required by the Committee, on counter fraud work within the Trust.

2.2.10 The Trust will ensure that policies and procedures for all work related to fraud are implemented. The Trust will consider the major findings of investigations and respond accordingly.

2.2.11 The Trust will enable the Local Counter Fraud Specialist to attend the Integrated Audit Committee meetings. The Trust shall receive Local Counter Fraud Specialist reports at these meetings.

2.3 Director of Finance responsibilities with regard to audit

2.3.1 The Director of Finance is responsible for:

(a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an internal audit function.

(b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards.

(c) In conjunction with the Local Counter Fraud Specialist (LCFS), Local Security Management Specialist (LSMS) and/or the NHS Counter Fraud Authority, as appropriate, deciding at what stage to involve the Police in cases of misappropriation and other irregularities.

(d) ensuring that an annual internal audit report is prepared for the consideration of the Integrated Audit Committee and the Board in line with relevant guidance. The report must cover:

(ii) a clear opinion on the effectiveness of internal control in accordance with current and relevant assurance framework guidance issued;

(iii) major internal financial control weaknesses discovered;

(iv) progress on the implementation of internal audit recommendations;

(v) progress against plan over the previous year;

(vi) strategic audit plan covering the coming three years; and

(vii) a detailed plan for the coming year.

2.3.2 The Director of Finance and/or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) access at all reasonable times to any land, premises or employees of the Trust;

(c) the production of any cash, stores or other property of the Trust under an employee's control; and

(d) explanations concerning any matter under investigation.

2.4 Role of Internal Audit

2.4.1 Internal Audit, as an independent and objective appraisal service commissioned by the Trust, will review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant, established policies, plans and procedures;

(b) The adequacy and application of financial and other related management controls;

(c) The suitability of financial and other related management data;

(d) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) Fraud and other offences;

(ii) Waste, extravagance, inefficient administration;

(iii) Poor value for money or other causes.

(e) Internal Audit shall also independently provide assurance on the Assurance Statements.

2.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.4.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.4.4 The Head of Internal Audit will normally attend Integrated Audit Committee meetings and has a right of access to all Integrated Audit Committee members, the Chairman, Chief Executive, and all non-executive directors of the Trust.

2.4.5 The Head of Internal Audit shall be accountable to the Chairman of the Integrated Audit Committee. The reporting system for internal audit shall be agreed between the Director of Finance, the Integrated Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

2.5 External Audit

2.5.1 The external auditor is appointed and removed by the Council of Governors at a general meeting of the Council of Governors in accordance with the appointment process set out in the Audit Code for NHS Foundation Trusts as issued by the Independent Regulator from time to time.

2.5.2 The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria included by the Independent Regulator within the Audit Code for NHS Foundation Trusts at the date of appointment, and on an on-going basis throughout the term of their appointment.

2.5.3 The Trust will provide the external auditor with every facility and all information which he may require for the purposes of his functions under the 2006 Act.

2.6 Security Management

2.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the LSMS.

2.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Director of Estates and Facilities as the Security Management Director (SMD) and the appointed LSMS.

2.6.4 The Chief Executive and the Executive Director with designated responsibility for Security Management matters will ensure that the Local Security Management Specialist:

(a) keeps full and accurate records of any breaches, or suspected breaches, of security:

(b) reports to the Integrated Audit Committee, any weaknesses in security-related systems or any other matters which may have implications for security management for the Trust;

(c) has all necessary support to enable them to efficiently, effectively and promptly carry out their functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of the work;

(d) receives appropriate training and support, and

(e) participates in activities which NHS Improvement directs, relating to national security management measures

3 Business Planning, Budgets, Budgetary Control and Monitoring

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Chief Executive will compile and submit to the Board an operational plan, a strategic plan, and an annual revenue and capital operating plan, together forming the Trust's Business Plan which will take into account financial targets, forecast limits of available resources and clinical governance requirements. The Business Plan will be developed in line with guidance issued by NHS Improvement and will contain:

(a) the key objectives of the Trust;

(b) a statement of the significant assumptions on which the plan is based;

(c) details of major changes in clinical activity, delivery of services or resources required to achieve the plan, including any impact on the Trust's continuity of services risk rating;

(d) an annual revenue plan which the Director of Finance shall prepare. This shall detail expected income by main purchaser and the main expenditure headings; and

(e) an annual capital plan which should:

(ii) identify all sources of funding, including charitable, for both capital and revenue,

(iii) the allocation of this funding to major capital schemes, rolling replacement and individual schemes and budgets where appropriate.

3.1.2 Prior to the start of each new financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board.

Such budgets will:

(a) be in accordance with the aims and objectives set out in the annual Business Plan;

(b) accord with activity and workforce plans;

(c) be produced following discussion with appropriate budget holders;

(d) be prepared within the limits of available funds; and

(e) identify potential risks;

3.1.3 The Board shall monitor performance against the budget and the business plan.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled. All budget holders will sign up to their allocated budgets at the commencement of each financial year.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;

(b) The purpose of each budget heading;

(c) Individual and group responsibilities;

(d) Authorities to exercise virement;

(e) Achievement of planned levels of service; and

(f) Provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

3.3 Budgetary Control and Reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) Monthly financial reports to the Board in an approved form containing:

(ii) income and expenditure to date showing trends and forecast year-end position;

(iii) performance on cash, accounts receivable, capital expenditure against plan, and accounts payable payment performance;

(iv) a statement of financial position and investment information;

(v) actual and forecast financial risk ratings as required by NHS Improvement's Risk Assessment Framework;

(vi) capital project spend and projected out-turn against plan;

(vii) explanations of any material variances from plan;

(viii) details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation; and

(ix) identify potential risks.

(b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

(c) investigation and reporting of variances from financial, activity and manpower budgets.

(d) monitoring of management action to correct variances.

(e) arrangements for the authorisation of budget transfers within the limits set out in the scheme of delegation.

3.3.2 Each budget holder is responsible for ensuring that:

(a) they deliver their budgets as agreed in the Business Plan;

(b) any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board;

(c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(d) no employees are appointed without the approval of the Chief Executive or delegated officer other than those provided for in the budgeted establishment as approved by the Board, and that all recruitment is approved through the Trust's vacancy control process; and

(e) cost improvements, cost savings and income generation initiatives are identified and implemented.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (The particular applications relating to capital are contained in Section 11).

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that appropriate systems are in place in order for the Trust to meet its licence conditions and any other compliance requirements as issued by NHS Improvement, any other legal or other mandated obligations and any contractual obligations of the Trust.

3.5.2 The Chief Executive, or delegated officer, shall ensure appropriate information is submitted to the Board of Directors, in a format agreed by the Board of Directors, to enable the Board to monitor compliance against its obligations and to enable the Board to certify that appropriate and adequate performance management systems are, and will remain in place to meet its obligations.

4 Annual Accounts and Reports

4.1 Annual Financial Accounts

4.1.1 The Accounting Officer is responsible for the preparation and submission of annual accounts in respect of each financial year in such form as NHS Improvement may require. The annual accounts are approved prior to submission to NHS Improvement by those deemed by the Board to be 'charged with governance'

4.1.2 The Director of Finance, on behalf of the Trust, will:

(a) prepare financial returns in accordance with the accounting policies and guidance given by NHS Improvement, the Trust's accounting policies, and International Financial Reporting Standards; and

(b) submit financial returns to Parliament and NHS Improvement for each financial year in accordance with the timetable prescribed by NHS Improvement.

4.2 Annual Quality Accounts and Report

4.2.1 The Chief Executive, as Accounting Officer, shall ensure that the Trust prepares, in respect of each financial year, annual quality accounts and report in such form as NHS Improvement, and the Department of Health direct.

4.2.2 In preparing its annual quality accounts and report, the Trust shall comply with any directions given by NHS Improvement and the Department of Health as to the presentation and content to be included.

4.3 Annual Report

4.3.1 The Trust will publish an annual report, in accordance with guidelines issued by NHS Improvement and present it to a public general meeting of the Assembly of Governors.

4.4 General

4.4.1 The Chief Executive, as Accounting Officer, shall ensure that the Annual Accounts, the Annual Quality Accounts and Report, the Annual Report and any report of the Auditor are submitted to the Board of Directors for its adoption and thereafter, together with any report of the Auditor on these are laid before Parliament and submitted to NHS Improvement on dates prescribed by NHS Improvement and, in respect of Quality Accounts, the Department of Health.

4.4.2 The Board of Directors will present the adopted Annual Accounts and Reports, and shall arrange for the Auditor to present his/her report on said statements to a general meeting of the Assembly of Governors by no later than 30th September of the financial year end to which the accounts and report relate.

4.4.3 The Company Secretary shall ensure that the Annual Accounts and Reports are made available to the membership of the Trust and to the wider public

4.5 Annual Plans

4.5.1 The Chief Executive shall ensure that the Trust prepares an annual plan for each financial year, the form and minimum contents of which are to be consistent with those prescribed by NHS Improvement.

4.5.2 In preparing the Annual Plan, the Board of Directors shall have regard to the views of the Assembly of Governors.

4.5.3 The Board of Directors shall submit the Annual Plan together with its agreed self certification statements of compliance as required by NHS Improvement, to NHS Improvement at a time specified by NHS Improvement.

5 Bank and Government Banking Service (GBS) Accounts

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by NHS Improvement.

5.1.2 The Boards shall approve the banking arrangements.

5.2 Commercial Bank and GBS Accounts

5.2.1 The Director of Finance is responsible for:

(a) commercial bank accounts and GBS accounts;

(b) establishing separate bank accounts for the Trust's non-exchequer funds;

(c) reporting to the Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

(d) ensuring payments made from bank or Government Banking Service accounts do not exceed the amount credited to the account except where arrangements have been made.

5.3 Banking Procedures

5.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) the conditions under which each bank and GBS account is to be operated.

(b) those authorised to sign cheques or other orders drawn on the Trust's accounts;

(c) those authorised to use any credit facility ie credit cards associated with Trust accounts.

(d) the limit to apply to any overdraft

5.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

(a) the names of all officers and directors authorised to release money from and draw cheques on and payable orders on, each bank account of the Trust and shall notify promptly the cancellation of any such authorisation

(b) cheques drawn on a named payee over the value of £25,000 shall require two authorised signatories

(c) cheques over the value of £1,500 drawn as cash shall require two authorised signatories

5.3.3 All cheques are to be treated as Controlled Stationery, in the charge of the Director of Finance or designated officer controlling their issue

5.3.4 All funds shall be held in accounts in the name of the Trust. No officer other than the Director of Finance shall open any bank account in the name of the Trust or relating to the activities of the Trust. The Director of finance will inform the Board at the earliest opportunity of details of such accounts.

5.3.5 No officer or Director may open a bank account bearing a name or description that includes the name or description of any of the Trust's hospitals, wards or departments, or in any way that may indicate the bank account is an official account of the Trust without prior written approval of the Director of Finance.

5.4 Tendering and Review

5.4.1 The Board will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to the Board.

5.5 Public Dividend Capital

5.5.1 The amount that was the Public Dividend Capital (PDC) immediately prior to becoming an NHS Foundation Trust continues as the PDC of the Trust.

5.5.2 The dividend paid by the Trust is to be the same as that payable by NHS Trusts in England in pursuance of section 9(7) of the 1990 Act (dividend on public dividend capital) and must be authorised by the Director of Finance.

5.5.3 Any amount paid to the Secretary of State by the Trust by way of repayment of public dividend capital is to be paid into the Consolidated Fund.

5.6 External Borrowing

5.6.1 The Director of Finance will advise the Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing.

5.6.2 The Director of Finance is also responsible for reporting periodically to the Board concerning the originating debt and all loans and overdrafts.

5.6.3 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and the Director of Finance.

5.6.4 Any short-term borrowing must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

5.6.5 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position.

5.6.6 All long-term borrowing must be consistent with the plans outlined in the current Business Plan.

5.6.7 The Trust also has freedom to access short-term working capital facilities, subject to an overall limit agreed with NHS Improvement. All such short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position.

5.7 Investments

5.7.1 The Trust will comply with any relevant guidance and best practice advice issued by NHS Improvement regarding the management of cash surpluses and the making of investments including for the avoidance of doubt, Managing Operating Cash in NHS Foundation Trusts and Risk Evaluation for Investment Decisions by NHS Foundation Trusts.

5.7.2 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held.

5.7.3 An Investment policy will be formulated by the Director of Finance in conjunction with Investment Committee and approved by the Board of Directors. The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

6 Income and Security of Cash and Cheques and Other Negotiable Instruments

6.1 Income Systems

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.2 Fees and Charges

6.2.1 The Trust shall follow the relevant guidance in setting prices for services or the equivalent regime for Foundation Trusts.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the NHS or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the DH's "Commercial Sponsorship – Ethical standards in the NHS" shall be followed.

6.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate and/or deal with, including all contracts, leases, tenancy agreements, research income, private patient undertakings and other transactions.

6.2.4 Approval to enter into Non-NHS contracts may be delegated in accordance with the scheme of delegation.

6.3 Debt Recovery

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.3.3 The Director of Finance shall establish procedures for the write off of debts after all reasonable steps have been taken to secure payment.

6.3.4 Income not received should be dealt with in accordance with the losses procedures.

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The Director of Finance shall be responsible for:

(a) approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) ensuring arrangements are in place for the ordering and secure control and storage of any such stationery;

(c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) prescribing systems and procedures for handling cash, cheques and negotiable securities on behalf of the Trust.

6.4.2 Money owned by the Trust and kept at any of its premises shall not under any circumstances be used for the encashment of private cheques or "IOUs".

6.4.3 All cheques, postal orders, cash, etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.5 Money Laundering Regulations

6.5.1 Under no circumstances will the Trust accept cash payments in excess of 15,000 Euros (converted to sterling at the prevailing rate at the time) in respect of any single transaction. Any attempts by an individual officer to effect payment above this amount shall be notified immediately to the Director of Finance.

7 Tendering and Contracting Procedures

7.1 Duty to comply with Standing Orders and Standing Financial Instructions

The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied)

7.2 EU Directives Governing Public Procurement

Directives by the Council of the European Union prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

7.3 Reverse eAuctions

The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk

7.4 Capital Investment Guidance

7.4.1 The Trust shall consider the guidance "Risk Evaluation for Investment Decisions by NHS Foundation Trusts" and such other guidance as may be issued by the Independent Regulator from time to time in respect of capital investment and estate and property transactions.

7.5 Formal Competitive Tendering

7.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- the supply of goods, materials and manufactured articles;
- the rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals

7.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 8.

7.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures **need not be applied** where:

(a) the estimated expenditure or income does not, or is not reasonably expected during the total period of the contract to exceed **£ 24,999**; Where expenditure throughout the period of the contract is likely to be between £5,000 and £24,999 a minimum of 3 written quotations will be required. SFI 7.7 refers.

(b) Where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with. This includes the use of DH procurement frameworks for the construction of healthcare facilities;

(c) in transactions involving the disposal of assets Standing Financial Instructions No. 14 does not require formal competitive tendering;

Formal tendering procedures **may be waived** in the following circumstances:

(d) in very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) where the requirement is covered by an existing contract;

(f) where national framework agreements are in place.

(g) where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) where specialist expertise is required and is available from only one source;

(j) when the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) there is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must

outweigh any potential financial advantage to be gained by competitive tendering;

(l) for the provision of legal advice and services providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The Director of Finance will ensure that any fees paid are reasonable and within commonly accepted rates for the costing of such work.

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Integrated Audit Committee at each meeting.

7.5.4 Fair and Adequate Competition

Where the exceptions set out in these standing financial instructions do not apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.5.5 List of Approved Firms

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists or approved by pre-qualification, unless through open invitation to tender consistent with EU directives. Where in the opinion of the Director of Finance it is desirable to seek tenders from firms not approved, the reason shall be recorded.

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

For building and engineering construction works and consultancy costs, invitations to tender shall be made only to firms included on the approved list of tenders compiled in accordance with this instruction or on the separate maintenance lists compiled and who

are listed on the Constructionline Supplier List for the relevant scope and value of works/services being procured.

Firms included on the approved list of tenders shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equality Act 2010 and any amending and /or related legislation.

Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and /or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. For building and engineering construction works, firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

7.5.6 Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries he/she deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

7.5.7 Exceptions to using Approved Contractors

If in the opinion of the Chief Executive and the Director of Finance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.5.8 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

7.6 **Contracting/Tendering Procedure**

7.6.1 Invitation to tender

(a) All invitations to tender shall state the date and time as being the latest time for the receipt of tenders.

(b) All invitations to tender shall state that no tender will be accepted unless:

(ii) submitted in a plain sealed package or envelope bearing a pre-printed label supplied by the Trust (or the word "tender" followed by the subject to which it relates) and the latest date and time for the receipt of such tender addressed to the Chief Executive or nominated Manager;

(iii) that tender envelopes/ packages shall not bear any names or marks indicating the sender. The use of courier/postal services must not identify the sender on the envelope or on any receipt so required by the deliverer.

(c) Every tender for goods, materials, services or disposals shall embody such of the NHS Standard Contract Conditions as are applicable.

(d) Every tender for building or engineering works (except for maintenance work, when Estate code guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors, or in the case of contracts entered into using DH frameworks the rules and regulations regarding this procurement route. If the Trust deems appropriate these documents shall be modified and/or amplified to accord with Independent Regulator guidance and, in minor respects, to cover special features of individual projects.

7.6.2 Receipt and safe custody of tenders

The Chief Executive or his nominated representative will be responsible for the receipt, endorsement and safe custody of tenders received until the time appointed for their opening.

The date and time of receipt of each tender shall be endorsed on the tender envelope/package.

7.6.3 Opening tenders and Register of tenders

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened by two senior officers/managers designated by the Chief Executive and not from the originating department.

(b) The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

(c) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(d) The involvement of Finance Directorate staff in the preparation of a tender proposal will not preclude the Director of Finance or any approved Senior Manager from the Finance Directorate from serving as one of the two senior managers to open tenders.

(e) All Executive Directors/members will be authorised to open tenders regardless of whether they are from the originating department provided that the other authorised person opening the tenders with them is not from the originating department.

The Trust's Company Secretary will count as a Director for the purposes of opening tenders.

(f) Every tender received shall be marked with the date of opening and initialled by those present at the opening.

(g) A register shall be maintained by the Chief Executive, or a person authorised by them, to show for each set of competitive tender invitations despatched:

i) the name of all firms or individuals invited;

ii) the names of firms individuals from which tenders have been received;

iii) the date the tenders were opened;

iv) the persons present at the opening;

v) the price shown on each tender;

Each entry to this register shall be signed by those present.

A note shall be made in the register if any one tender price has had so many alterations that it cannot be readily read or understood.

(h) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

7.6.4 Admissibility

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(b) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust

7.6.5 Late tenders

(a) Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

(b) Only in the most exceptional circumstances will a tender be considered which is received after the opening of the other tenders and only then if the tenders that have been duly opened have not left the custody of the Chief Executive or his nominated officer or if the process of evaluation and adjudication has not started.

(c) While decisions as to the admissibility of late, incomplete or amended tenders are under consideration, the tender documents shall be kept strictly confidential, recorded, and held in safe custody by the Chief Executive or his nominated officer.

7.6.6 Acceptance of formal tenders

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

(b) The lowest tender, if payment is to be made by the Trust, or the highest

(c) value, if payment is to be received by the Trust, shall ordinarily be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. The process of determining the lowest net cost, or the highest net value, should ensure that optimum value for money is achieved and should therefore assess the factors of

economy, effectiveness and efficiency of the tendered goods or services. Other qualitative factors affecting the success of specific projects should also be assessed and include the:

i) experience and qualifications of the supplier team member;

ii) understanding of client's needs;

iii) feasibility and credibility of proposed approach;

iv) ability to complete the project or deliver the service within the required timescale

(d) Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(e) If only one tender is received and this is in the range of the initial estimate then the contract can be awarded to that tenderer.

(f)

(g) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(h) The use of these procedures must demonstrate that the award of the contract was:

i) not in excess of the going market rate / price current at the time the contract was awarded;

ii) that best value for money was achieved.

(i) All tenders should be treated as confidential and should be retained for inspection.

7.6.7 Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

7.7 **Quotations: Competitive and non-competitive**

7.7.1 General Position on quotations

Competitive quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income during the total period of the contract exceeds or is reasonably expected to exceed £5,000 but not exceed £24,999.

7.7.2 Competitive Quotations

(a) Quotations or Tenders as appropriate should be obtained from at least 3 suppliers up to £49,999, 4 from £50,000 to £249,999 and a minimum of 5 over £250,000, based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(b) Quotations should be in writing unless the Chief Executive or his nominated officer determines that it is impractical to do so in which case quotations may be obtained by telephone. Confirmation of telephone quotations should be obtained as soon as possible and the reasons why the telephone quotation was obtained should be set out in a permanent record.

(c) All quotations should be treated as confidential and should be retained for inspection.

(d) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.7.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances

(a) the supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) the supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) miscellaneous services, supplies and disposals;

(d) where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (a) and (b) of this SFI) apply.

7.7.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

7.8 **Authorisation of Tenders and Competitive Quotations**

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by those with delegated authority.

The total value of the contract should be determined by reference to the total period to which the contract relates

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

7.9 **Instances where formal competitive tendering or competitive quotation is not required**

Where competitive tenders or competitive quotations are not required because the amounts are less than those specified in 7.7 the Trust should adopt one of the following alternatives:

(a) the Trust shall use NHS Supply Chain or other national collaborative agreement for the procurement of goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the NHS Supply Chain or other national collaborative agreement - the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

(c) Where a schedule of rates for work has already been approved via a minor / major construction framework agreement.

7.10 **Private Finance for capital procurement**

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Independent Regulator for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by the Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.11 **Compliance requirements for all contracts**

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Constitution, Terms of Authorisation, Standing

(b) Orders and Standing Financial Instructions;

(c) EU Directives and other statutory provisions;

(d) any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;

(e) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(f) In all contracts made by the Trust, the Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.12 **Personnel and Agency or Temporary Staff Contracts**

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.13 **Disposals**

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) obsolete or condemned articles and stores, which may be disposed of in accordance with the supplies policy of the Trust;

(c) items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

(d) items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

7.14 **In-house Services**

7.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust should ensure from time to time that benchmarking takes place.

7.14.2 In all cases where the Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £500,000, a non-officer member should be a member of the evaluation team.

7.14.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.14.4 The evaluation team shall make recommendations to the Board.

7.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.15 **Applicability of SFIs on Tendering and Contracting to funds held in Trust**

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's trust funds and private sources

8 NHS Contracts for the Provision of Healthcare Services

8.1 Commissioning

8.1.1 Contracts with NHS providers for the supply of healthcare services shall be drawn up in accordance with the latest guidance available from the Department of Health and administered by the Trust.

8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services. This responsibility has been delegated to the Director of Finance who is responsible for commissioning NHS service agreements for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for non-contracted activity. In carrying out these functions, the Director of Finance will pay due regards to:

(a) costing and pricing of services;

(b) payment terms and conditions;

(c) amendments to NHS contracts and contracted activity; and

(d) Licence conditions and any other guidance issued by NHS Improvement and or NHS England.

8.2 Contract Pricing and Reporting

8.2.1 NHS contracts should comply with the most recent guidance from the DH and be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. NHS contract prices should comply with Costing and Payment by Results guidelines and the latest guidance published by NHS England and conform with any licence conditions and other guidance issued by NHS Improvement.

8.2.2 The Director of Finance will need to ensure that regular reports are provided to the Board detailing actual and forecast income from the contract. This will include information on costing arrangements; any pricing of NHS contracts at marginal/subsidised cost must be undertaken by the Director of Finance and reported to the Board.

8.3 Content of Contracts

8.3.1 All contracts should aim to implement the agreed priorities contained within the Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account the latest relevant guidance available from NHS Improvement and NHS England, including:

(a) the standards of service quality expected;

(b) the relevant national service framework (if any);

(c) the provision of reliable information on cost and volume of services; and

(d) the NHS National Performance Assessment Framework.

8.3.2 Approval of contracts must be in accordance with the scheme of delegation.

9 Employment and Terms of Service including staff expenses

9.1 Remuneration and Terms of Service

9.1.1 In accordance with the trust constitution, the Board shall establish a Non-Executive led nomination and remuneration committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See guidance contained in the Higgs report.)

9.1.2 The Remuneration Committee is a committee of the Board and fulfils the role of the Personnel and Remuneration and Terms of Service Committee described in the NHS 2006 Act.

9.1.3 The Remuneration Committee reviews and makes recommendations to the Board of Directors (BoD) on the composition, balance, skill mix and succession planning of the Board. It recommends to the BoD the appointment of Executive Directors. It is responsible for setting the overall remuneration and benefits for the Chief Executive, the Executive Directors and other senior managers reporting directly to the Chief Executive. In carrying out this role it has the specific duty to:

(a) Regularly review the composition and effectiveness of the BoD and to make recommendations to the Board to improve its own governance and effectiveness.

(b) Ensure that appraisals are undertaken for all members of the BoD

(c) Regularly review the structure, size and composition (including the skills, knowledge and experience of the Board of Directors) and make recommendations to the Board with regard to any changes and appropriate process.

(d) To ensure a succession plan is in place and appropriate actions are taken to ensure the continued leadership of the Trust for the most senior leaders (including consultants) of the Trust.

(e) To ensure an appropriate process is in place for the appointment of the Chief Executive, Executive Directors, senior managers and consultants to and recommend the appointment of Executive Directors to the BoD and the Chief Executive to the Council of Governors (CoG).

(f) In conjunction with the CoG Appointment committee and the Council of Governors, ensure that the process for appointing the Trust Chair and Non-Executive Directors, and the process for appointing the Chair, Executive, Executive Directors, senior managers and consultants are aligned.

(g) to advise and make recommendations to the BoD about appropriate remuneration and terms of service for the Chief Executive, the Executive, senior managers reporting directly the Chief Executive and consultants which will include:

- all aspects of salary (including any performance related element/bonuses)
- provision for other benefits, including pensions and cars
- agreement of contracts of employment and if applicable terms of office
- arrangements for termination of employment and other contractual terms, including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.
- Clinical Excellence Awards

(h) To consider a report annually from the Chair on the performance of the Chief Executive and from the Chief Executive on the performance of Executive Directors and consultants and determine any adjustment to salary and PRP.

(i) To agree the policy and strategy for remuneration for all staff.

9.1.4 The minutes of the Remuneration Committee shall be submitted to the Board or, where this is not appropriate due to a confidentiality issue, a report or extract from the minutes will be submitted to the Board. The Chair of the Committee shall draw the attention of the Board to any issues that require disclosure to the full board, or require executive action.

9.1.5 The Board will be required to consider and to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

9.2 Funded Establishment

9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment, as approved by the Board.

9.2.2 The funded establishment of any department can only be varied if its cost remains within the approved run-rate budget for pay and changes are within approved virement levels. Any amendment to establishments must obtain prior approval from the Vacancy Control Panel.

9.3 Staff Appointments

9.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a) they are duly authorised to do so by the Chief Executive; and

(b) and the changes are within the limit of their approved budget and funded establishment;

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc, for employees.

9.4 Agency Nurses

9.4.1 Agency nursing staff will only be appointed to fill gaps in the funded establishment up to safe minimum operating levels. The appointment of agency nursing staff will only be approved by officers who have been delegated the authority to do so, and in accordance with the Trust's mandatory processes for recruiting temporary staff.

9.5 Processing Payroll

9.5.1 The Director of Finance and the Director of HR, OD and development are jointly responsible for arranging the provision of an appropriate payroll service. Together with the service provider, The Director is responsible for:

(a) specifying timetables for submission of properly authorised time record

(b) and other notifications;

(c) the final determination of pay and allowances including the verification that rates of pay and other relevant conditions of service are in accordance with the current agreements as approved by the Board;

(d) making payment on agreed dates;

(e) agreeing method of payment.

(f) determining the correct tax status of any payment made

9.5.2 Together with the payroll service provider, the Director of Finance and the Director of HR, OD and Development will issue instructions in compliance with the standard operation of the national NHS Electronic Staff Record System and in compliance with the procedures of the relevant payroll service provider regarding:

(a) verification and documentation of data;

(b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) maintenance of subsidiary records for superannuation, income tax, national insurance and other authorised deductions from pay;

(d) security and confidentiality of payroll information;

(e) checks to be applied to completed payroll before and after payment;

(f) authority to release payroll data under the provisions of the Data Protection Act;

(g) methods of payment available to various categories of employee and officers;

(h) procedures for payment by cheque, bank credit, or cash to employees and officers;

(i) procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) maintenance of regular and independent reconciliation of pay control accounts;

(l) separation of duties of preparing records and handling cash;

(m) a system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

9.5.3 Managers authorised under the Scheme of Delegation have delegated responsibility for:

(a) submitting time records, and other notifications, in accordance with agreed timetables;

(b) completing time records and other notifications in accordance with the Director of HR, OD and Developments instructions and in the form prescribed by the Director of HR, OD and Developments;

(c) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of HR, OD and Developments must be informed immediately;

(d) Submitting change of detail forms regarding both employment and personal data as soon as information is available.

9.5.4 Regardless of the arrangements for providing the payroll service, the Director of Finance and the Director of HR, OD and Developments shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.6 Contracts of Employment

9.6.1 The Board shall delegate responsibility to the Director of HR,OD and Developments for:

(a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation;

(b) dealing with variations to, or termination of, contracts of employment.

9.7 Staff Expenses

9.7.1 The Director of Finance and Director of HR, OD & Developments are jointly responsible for establishing procedures for the management of expense claims submitted by Trust employees.
They shall arrange for duly approved expense claims, which are in accordance with the Trust's expense policy, to be processed through the Trust's payroll system Expense claims shall be authorised in accordance with the Scheme of Delegation.

9.7.2 The Director of Finance and Director of HR, OD & Developments shall refer to the Trust's general policies on staff expenses and may reject expense claims where there are material breaches of Trust policies. In this regard the Director of Finance shall liaise with the Chief Executive where appropriate.

10 Non Pay Expenditure

10.1 General

The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.1 The Chief Executive will set out:

(a) the list of managers who are authorised to place requisitions for the supply of goods and services;

(b) the maximum level of each requisition and the system for authorisation above that level.

10.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.1.3 Where appropriate the Director of Finance will ensure that relevant statutory and guidance notes are followed. This will include the requirements in relation to the construction industry certificates.

10.1.4 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 7)

10.2 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

10.3 System of Payment and Payment Verification

The Director of Finance shall be responsible for ensuring there is a system and associated procedures in place for the prompt payment of supplier invoices and charges. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with **national guidance.**

10.3.1 The Director of Finance will:

(a) advise the Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once

approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) be responsible for the prompt payment of all properly authorised accounts and claims;

(d) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(ii) A list of employees (including specimens of their signatures) authorised to certify invoices.

(iii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;
- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment.

(iv) A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

(v) Instructions to employees regarding the handling and payment of accounts within the Finance Department.

10.3.2 Prepayments

Prepayments are only permitted where exceptional circumstances apply. In such instances:

(a) Prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flows must be discounted to Net Present Value (NPV) using the National Loans Fund (NLF) rate plus 2%).

(b) The appropriate Director must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments:

(c) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold):

(d) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

(e) Payment in respect of training courses and book purchases where appropriate may be paid in advance of the receipt of the goods or services.

10.4 **Official orders**

10.4.1 Official Orders must:

(a) be consecutively numbered;

(b) be in a form approved by the Director of Finance;

(c) state the Trust's terms and conditions of trade;

(d) only be issued to, and used by, those duly authorised by the Chief Executive.

10.4.2 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) all goods, services, or works must be ordered on an official order. Staff will be liable for expenditure committed on behalf of the Trust without a purchase order;

(b) all contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(c) contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(d) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by the Independent Regulator;

(e) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

- isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

- conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction the principles outlined in the national guidance contained in HSG 93(5) "Standards of Business Conduct for NHS Staff", Specifically all orders shall be issued in compliance with the Trust's standards of business conduct policy, ensuring that no director or employees benefit from contracts with the Trusts suppliers or obtain private use of the Trust's assets, goods or services

(f) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(g) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(h) where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHS Improvement;

(i) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(j) goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(k) changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(l) purchases from trust petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; No single petty cash payment may exceed £50 without finance department approval.

(m) purchases from charitable funds petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Charitable funds committee; No single petty cash payment may exceed £100 and be in accordance with the delegations agreed the the Trustees.

(n) The trust will not reimburse personal expenses or petty cash payments for items that have a formal contract and should have been ordered through an official purchase order.

(o) petty cash records are maintained in a form as determined by the Director of Finance.

(p) The Director of Finance or designated officer may authorise advances on the Imprest system for petty cash and other purposes as required. He/she may make supplementary advances in excess of the Imprest where, through special circumstances, the amount of an officer's Imprest is temporarily insufficient to meet outgoings.

(q) It is the responsibility of budget holders to ensure that accruals of expenditure are notified to Finance and that they are fully and accurately reflected within monthly financial reports and records.

10.4.3 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.5 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

10.5.1 Payments to local authorities and voluntary organisations made under the powers of section 256 of the NHS Act 2006 shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

11 External Borrowing

11.1 External Borrowing and Public Dividend Capital

11.1.1 The Director of Finance will advise the Board concerning the Trust's ability to pay dividends and repay Public Dividend Capital together with any proposed new borrowing, within the limits set by the Terms of the Authorisation and reviewed annually by the Independent Regulator (the "Prudential Borrowing Code"). The Director of Finance is also

responsible for reporting periodically to the Board concerning Public Dividend Capital debt and all loans, overdrafts and associated interest.

11.1.2 Any application for new borrowings will only be made by the Director of Finance or by an employee acting on their his behalf and in accordance with the Scheme of Delegation as appropriate.

11.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for new borrowings which comply with the instructions issued by the Independent Regulator from time to time.

11.1.4 Assets protected under the Terms of Authorisation shall not be used or allocated for borrowing. Non-protected assets will be eligible as security for loans.

11.1.5 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and the Director of Finance.

11.1.6 Any short-term borrowing must be with the authority of two Directors of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

11.1.7 The Director of Finance will produce an investment policy in accordance with any guidance issued by the Independent Regulator from time to time, for approval by the Board.

11.1.8 The Board will report to the Independent Regulator on any proposed major investments that could affect their financial risk rating, as part of the annual planning process or in year, prior to financial closure. In determining whether any investment decision is to be reported to the Independent Regulator the Trust will take into account guidance issued by the Independent Regulator "Risk Evaluation for Investment Decisions by NHS Foundation Trusts" as amended from time to time. Temporary cash surpluses must be held only in such investments as authorised by the Board and within the terms of guidance as may be issued by the Independent Regulator from time to time.

11.1.9 The Director of Finance is responsible for advising the Board on investments and shall report periodically to the Board concerning the performance of investments held. The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

12.1 Capital Investment

12.1.1 The Chief Executive shall:

(a) ensure that there is an adequate appraisal and approval process in place for determining capital expenditure, including leasing, priorities and the effect of each proposal upon Business Plans;

(b) be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) ensure that the capital investment is not undertaken without appropriate authorisation and confirmation of purchaser(s) support, and resources to finance all revenue consequences, including depreciation and interest payable.

For every significant capital expenditure proposal the Chief Executive shall ensure:

(a) that a business case, prepared to a standard format as determined by the Board of Directors, is produced setting out:

(ii) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(iii) the involvement of appropriate Trust personnel and external agencies;

(iv) appropriate project management and control arrangements;

(b) that the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of “Estate code”.

12.2 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

12.2.1 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.2.2 The approval of the annual capital plan shall not constitute approval for expenditure on any scheme within that plan.

12.2.3 The approval of annual programmes of maintenance, renewal or similar works shall constitute approval for schemes within that programme under the responsible supervision of the trust capital group.

12.2.4 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estate code" guidance, the Trust’s Standing Orders and any guidance issued by the Independent Regulator.

12.2.5 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. Escalation thresholds for approving variations to authorised capital programmes are set out in the Scheme of Delegation.

12.3 Private Finance

12.3.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its internally generated funds or formal borrowing, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Independent Regulator or in line with any current guidelines.

(c) The proposal must be specifically agreed by the Board.

12.4 Asset Registers

12.4.1 The Chief Executive is responsible for ensuring procedures are in place for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

12.4.2 The Trust shall maintain a publicly available property asset register recording protected property in accordance with the guidance issued by the Independent Regulator.

12.4.3 The Trust may not dispose of any protected property assets without the approval of the Independent Regulator. This includes the disposal of part of the property or granting an interest in it.

12.4.4 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on protected property asset registers.

12.4.5 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) lease agreements in respect of assets held under a finance lease and capitalised.

12.4.6 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4.7 The Director of Finance of the Trust shall calculate and pay capital charges.

12.5 Security of Assets

12.5.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.5.2 Asset control procedures (including fixed assets, cash, cheques, negotiable instruments and donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) recording managerial responsibility for each asset;

(b) identification of additions and disposals;

(c) identification of all repairs and maintenance expenses;

(d) physical security of assets;

(e) periodic verification of the existence of, condition of, and title to, assets recorded;

(f) identification and reporting of all costs associated with the retention of an asset;

(g) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.5.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

12.5.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

12.5.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.5.6 Where practical, assets should be marked as Trust property.

13 Stores and Receipt of Goods

13.1 General

13.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) kept to a minimum practical level;

(b) subjected to regular stock take –perpetual and/or annual;

(c) valued at the lower of cost and net realisable value; and

(d) be kept as secure as practically possible.

13.2 Control

13.2.1 Subject to the responsibility of the Director of Finance for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day to day responsibility may be delegated by them to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; and the control of fuel oil and coal to a designated estates manager.

13.2.2 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/pharmaceutical officer. Wherever practicable, stocks should be marked as Trust property.

13.2.3 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, stocktaking and losses.

13.2.4 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

13.2.5 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

13.2.6 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.3 Goods supplied to the Trust

13.3.1 For all goods supplied to the Trust, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance, or delegated representative, who shall satisfy himself that the goods have been received before accepting the recharge.

14 Bankruptcy, Liquidations and Receiverships

14.1 Responsibility of The Finance Director

14.1.1 **The Director** of Finance should make every effort to become aware, at the earliest point possible, of the bankruptcy, liquidation or receivership of any supplier.

14.1.2 When a bankruptcy, liquidation or receivership is discovered, all payments should be ceased pending confirmation of the bankruptcy, etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

14.1.3 The Director of Finance must ensure that:

Any payments due to the Trust are made to the correct person;

Any claim by the Trust is properly lodged with the correct party and without delay.

15 Disposals and Condemnations, Losses and Special Payments

15.1 Disposals and Condemnations

15.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

(a) condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance; and

(b) recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

15.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

15.2 Losses and Special Payments

15.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. In cases involving suspected fraud, the Director of Finance must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

15.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their head of department, who must immediately inform the Chief Executive and the Director of Finance or inform an officer charged with responsibility for responding to concerns involving loss. This officer will then appropriately inform the Director of Finance and/or Chief Executive. Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of anomalies which may indicate fraud or corruption, the Director of Finance must inform the Trust's LCFS and the NHS Counter Fraud Authority in accordance with the NHS Standards for providers.

15.2.3 The Director of Finance must notify the Counter Fraud and Security Management Services (CFSMS) and the External Auditor of all frauds.

15.2.4 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) the Board, and

(b) the External Auditor.

15.2.5 The Director of Finance shall present a report to the Board of Directors seeking its approval to write off losses and make payments.

15.2.6 The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in personal and company insolvencies.

15.2.7 For any loss, the Director of Finance in conjunction with the Company Secretary should consider whether any insurance claim can be made.

15.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write off action is recorded, including bad debt written off. The register should show:

(a) The nature, gross amount (or estimate where an accurate value is unavailable), and cause of each loss;

(b) The action taken, total recoveries and date of write-off where appropriate; and

(c) The category in which each loss is to be noted.

15.2.9 All Losses and special payments must be reported to the Integrated Audit Committee on a regular basis; at least annually.

16 Information Technology

16.1 Controls

16.1.1 The Chief Executive will nominate a Senior Information Risk Owner (SIRO) who is responsible for the accuracy and security of the computerised data of the Trust, shall;

(a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Act, Human Rights Act and Freedom of Information Act;

(b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as may be considered necessary are being carried out;

16.1.2 The Director of IT Transformation shall:

(a) prepare and maintain an IT strategy for regular approval by the Board; and

(b) ensure that all purchases of hardware/software are in compliance with the Trust's IT strategy.

16.1.3 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.1.4 The Chief Executive shall ensure that the Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Freedom of Information Publication Scheme approved by the information Commissioner.

16.2 System Development

16.2.1 The Chief Executive Officer shall satisfy themselves that new computer systems and amendments to current systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

16.2.2 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Authorities/Trusts in the cluster or nationally wish to sponsor jointly) all responsible Directors and employees will send to the Director of Finance:

(a) details of the outline design of the system; and

(b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.2.3 Contracts for Computer Services with other health bodies or outside agencies

16.2.4 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency/party shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness,

and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.2.5 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.3 Risk Assessment

16.3.1 The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

16.4 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) staff as delegated by the Director of Finance have access to such data; and

(d) such computer audit reviews as are considered necessary are being carried out.

16.5 Data Security and Integrity as it relates to Financial Systems

16.5.1 The Director of Finance shall ensure that appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

16.5.2 Where another health organisation or any other agency provides a computer service for financial applications, the nominated Executive Director shall periodically seek assurances that adequate controls are in operation

17 Patients Property

17.1 Responsibilities

17.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as “property”) handed in by patients, in the possession of

unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.1.2 The Chief Executive is responsible for ensuring:

(a) that patients or their carers, as appropriate, are informed before or at admission by:

(ii) notices and information booklets; (notices are subject to sensitivity guidance);

(iii) hospital admission documentation and property records; and

(iv) the oral advice of administration and nursing staff responsible for admissions.

(b) that the Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.1.3 The Director of Finance must provide detailed written instructions on the collection, custody, investment, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. Due care should be exercised in the management of patients' money in order to avoid loss.

17.1.4 Where current guidance requires the opening of separate accounts for patients' monies, these shall be opened and operated under arrangements agreed by the Director of Finance.

17.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965) the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of indemnity shall be obtained, and the authority of the Director of Finance received to release the property.

17.1.6 Staff should be informed, on appointment, by appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients, detailed in the patient's property policy and procedure.

17.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18 Funds Held on Trust – Charitable Funds

"Charitable Funds" are those gifts, donations and endowments held on trust for purposes relating to services provided by the Trust.

18.1 Corporate Trustee

18.1.1 The Trust has responsibilities as a corporate trustee for the management of funds it holds on trust and will comply with the Charities Commission latest guidance and best practice.

18.1.2 The responsibilities of the Trust acting as corporate trustee are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

18.1.3 The Charitable funds manager on authority from the Trustees of the Charitable Funds shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

18.2 Accountability to Charity Commission and Secretary of State for Health

18.2.1 The Trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

18.2.2 The Schedule of Matters Reserved to the Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Trust officers must take account of that guidance before taking action.

18.3 Applicability of Standing Financial Instructions to funds held on Trust

18.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

18.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

18.3.3 Specific differences in SFIs or their application are explicitly set out in the relevant section.

19 Acceptance of Gifts by Staff and Link to Standards of Business Conduct

19.1 The Trust's policy on acceptance of gifts and other benefits in kind by staff is embodied in the Trust's Policies on Anti-Fraud and Bribery and Standards of Business Conduct Policy. The Standards of Business Conduct policy follows the guidance from DH, in particular Health Circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' which is deemed to be an integral part of these SFIs.

19.2 The Company Secretary shall ensure that a Code of Conduct and arrangements and procedures for the declaration and registering of interests of members of both the Board of Directors and the Assembly of Governors and other senior management as determined by the Board of Directors are in place.

20 Retention of Records

20.1 The Chief Executive shall be responsible for the management of all NHS records by the Trust, regardless of the media on which they are held.

20.2 The Chief Executive shall be responsible for ensuring that all records required to be retained in accordance with the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 and taking into account the guidance contained in Records Management: NHS Code of Practice (2010).

20.3 The records held in archives shall be capable of retrieval by authorised persons in accordance with the provisions of the Records Management Code.

20.4 Records held shall only be destroyed at the express instigation of the Chief Executive and details shall be maintained of records so destroyed.

21 Risk Management and Insurance

21.1 Programme of Risk Management

The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Independent Regulator requirements (if any), which must be approved and monitored by the Board.

The programme of risk management shall include:

(a) a process for identifying and quantifying risks and potential liabilities;

(b) engendering among all levels of staff a positive attitude towards the control of risk;

(c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) contingency plans to offset the impact of adverse events;

(e) audit arrangements including; Internal Audit, clinical audit, health and safety review;

(f) a clear indication of which risks shall be insured;

(g) arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to create the Annual Governance Statement (AGS) within the Annual Report and Accounts.

Insurance brokers may be appointed if required in accordance with the Trust's SFIs governing tendering and contracting procedures, to effect such insurance cover.

19.1 Insurance: Risk Pooling Schemes administered by NHS RESOLUTION

19.1.1 The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution, commercial insurers or self-insure for some or all of the risks covered by the risk pooling schemes. Any decision not to use the risk pooling scheme administered by the NHS RESOLUTION for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme should be reviewed annually.

19.2 Insurance arrangements with commercial insurers

19.2.1 Insurance cover for the Trust's assets (except income generation activities and motor vehicles) shall as a minimum be provided through the Property Expenses Scheme (PES) operated by the National Health Service Litigation Authority.

19.2.2 The Trust is free to enter into appropriate insurance arrangements with commercial insurers. Insurance to cover the risk of legal action against the Trust's directors shall be arranged in line with guidance set out in the NHS Foundation Trust Code of Governance.

21.2 **Arrangements to be followed by the Board in agreeing Insurance cover**

21.2.1 Where the Board decides to use the risk pooling schemes administered by the NHS Resolution the Company Secretary shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Company Secretary shall ensure that documented procedures cover these arrangements.

21.2.2 Where the Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, or to source commercial insurance for those risks, the Company Secretary shall ensure that the Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. It shall be for the Board of Directors to decide if the cost of insuring assets to a greater extent than the PES is warranted.

21.2.3 The Trust's nominated Claims Manager will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.2.4 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case

22 Credit Finance Arrangements Including Leasing Commitments

22.1 There are no grounds where any employee of the Trust can approve any contract or transaction which binds the Trust to credit finance commitments without the clear prior authority of the Director of Finance. This includes all Executive Directors of the Trust as well as all officers. The Board has provided the Director of Finance with sole authority to enter into such commitments, although these powers can be delegated by him/her to appropriate officers under his/her organisational control.

22.2 This instruction applies to leasing agreements and Hire Purchase undertaking which must be sent to the Director of Finance for prior approval. No officer of the Trust outside the organisational control of the Director of Finance has any powers to approve such commitments.

23 Delegated Matters

24.1 Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive.

24.2 All items concerning Finance must be carried out in accordance with Standing Financial Instructions.

24.3 The Scheme of Delegation can be amended by the Chief Executive at any time providing there is no change to the Standing Financial Instructions.

24.4 The level of authority to authorise delegated matters is contained within the Scheme of Delegation – Financial Authorities document.

24.5 The table of delegated matters below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate.

24 Scheme of Delegation – Financial Authorities

Medway foundation trust	Expenditure		Tender Waivers	Disposal/ Write off of assets	Write off of Debt	Losses & Special Payments
	General	Capital				
Trust Board	£500k+	£1m+	£300k+	£500k+	£500k+	£500k+
Chief Executive	£500k	£1m	£300k	£500k	£500k	£500k
Director of Finance	£150k		£200k	£150k	£150k	£150k
Director of Estates and Facilities	£100k[1]	£100k				
Directors of Clinical Operations	£50k					£10k
Medical Director	£25k					
Director of Nursing	£25k					
Director of HR, OD & Development	£25k					
Chief Pharmacist[2]	£25k					
Director of Planning & Partnerships	£10k					
Director of Strategy	£10k					
Director Of Communications	£10k					
Deputy Director of Finance	£10k		£50k			
Deputy Director of HR	£10k					
Company Secretary	£10k					
Head of Temporary Staffing[3]	£5K					
Director of Procurement / Qualified pharmacy buyers[3]	£5K					
Heads of Service / General Manager	£5K			£5k		£5k
Financial Controller				£5k	£5k	
Service Managers	£3K			£3k		£3k

Notes:

[1] Rates and utilities expenditure for Medway Maritime Hospital site. £25k for general expenditure.

[2] Drugs & pharmaceuticals expenditure being allocated to prescribing service line budgets

[3] Specific items

Charitable funds	All spend
Charitable funds committee	£15k+
Chief Executive	£15k[4]
Financial Controller	£5k[5]
Charity & Fundraising Manager	£2k

Notes:

[4] Countersigned by Committee Chair

[5] In conjunction with Fund Manager

End of document

NHS Medway NHS Foundation Trust

Report to the Board

Board Date: 06/09/2018 Agenda item 12c

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	Our communications and engagement with staff centres on our transformation programme, Better, Best, Brilliant, to ensure our services focus on the needs of our community now and in the future. We always stress that our improvements need to improve patient experience through being as efficient as we can be, which in turn will create services that are sustainable for the future. Externally we seek to engage our community in the improvements we are making, raising awareness of our services and creating opportunities for stakeholders, patients, carers and members of the public to have their say. We use a wide range of communications channels and engagement methods to reach staff across the Trust, and to build networks and relationships around Medway and Swale.
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 transformation plan.			
Quality Impact Assessment	NA			
Recommendation	The Board is asked to note the report.			
Purpose and Actions required by the Board :	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 Our communications and engagement with staff centres on our transformation programme, Better, Best, Brilliant, to ensure our services focus on the needs of our community now and in the future.

1.2 We always stress that our improvements need to improve patient experience through being as efficient as we can be, which in turn will create services that are sustainable for the future.

1.3 Externally we seek to engage our community in the improvements we are making, raising awareness of our services and creating opportunities for stakeholders, patients, carers and members of the public to have their say.

1.4 We use a wide range of communications channels and engagement methods to reach staff across the Trust, and to build networks and relationships around Medway and Swale.

2 ENGAGING COLLEAGUES

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

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

2.3 Communications to promote awareness of the 'You are the Difference' culture programme include video and messaging in the run-up to the launch.

Report to the Board of Directors

2.4 In July we communicated the publication of the CQC's report into services at the Trust. This included a well-attended senior managers' meeting and staff briefing (with more than 300 staff in attendance).

2.5 An internal communications campaign has supported the launch of the Promoting Professionalism initiative.

2.6 The highly successful summer fair and other celebrations held at the hospital to celebrate NHS 70 in July provided opportunities for staff to express a sense of pride and team spirit, and communications and photography of the events help spread the positive atmosphere generated.

2.7 The Best of People Awards created another chance to celebrate all that is good about our staff and teams. The awards were well-celebrated and communicated extensively.

2.8 The Communications and Organisational Development teams have worked together to promote actions taken to improve the working environment for staff following feedback from the last NHS Staff Survey.

2.9 Staff have been encouraged to enter the new Chief Executive's Scholarship for Brilliance funded through the Medway Hospital Charity.

3 MEDIA

3.1 Since the last board meeting the communications team handled to 21 media releases and enquiries, generating significant local, regional and national media coverage.

3.2 There was extensive coverage of the release of our CQC report, including on BBC South East, BBC News, BBC Radio Kent, ITV Meridian, Medway Messenger, the Kent Messenger's various Swale publications and other, smaller local titles. The coverage was mostly balanced in tone and acknowledged that Medway had maintained improvements, while acknowledging that there is more to do.

3.3 Also covered extensively was the Trust's decision to sign up to the 'Employer with Heart' charter, pledging to provide additional maternity and paternity leave for parents whose children are born prematurely.

3.4 The Trust communications team facilitated interviews with the Health Service Journal, BBC South East, BBC Radio Kent and local TV station KMTV and there was additional positive coverage in the Nursing Times, Medway Messenger and on the Kent Online website.

3.5 Other positive stories about the Trust in local media include further coverage of our summer fair, a write-up of our activities to celebrate World Hepatitis Day, a mention of the Trust's low absence rates in a piece on NHS staff sickness levels in the Medway Messenger, which also carried a brief item about a donation of new wheelchairs to the Trust by the League of Friends.

3.6 Less positively, there has been coverage of the delays to the opening of our new Emergency Department. The Trust has explained the cause of the delay and is looking forward to an official opening later in the year.

4 SOCIAL MEDIA

4.1 Since the last update Medway has maintained its position as Kent's most-followed acute Trust on Twitter.

4.2 Several key announcements were shared across our social media accounts in this period, which resulted in more than 100,000 people viewing our posts (42,074 on Facebook and 62,500 on Twitter, as of 24 August 2018).

4.3 Our social media channels were used to raise awareness of the Trust's 'Employer with Heart' Charter pledge. This announcement was seen by more than 20,000 social media users and helped to generate more than 3,000 visits to the Trust's official website.

4.4 Medway's social media account followers now total 4,189 on Twitter (up from 4,033 at the last update), 5,910 on Facebook (up from 5,729) and 900 on Instagram (up from 734).

4.5 Elsewhere, our social media accounts raise awareness of the release of the Trust's CQC report; the staging of our NHS 70 Summer Fair; alternative treatment options for those considering visiting our Emergency Department during periods of increased pressure; the continued support of the Medway League of Friends, following their donation of 30 brand new wheelchairs; our regular members' and governor events; and advice on how stay safe in the sun during the summer heatwave.

5 COMMUNITY ENGAGEMENT

5.1 Governors

5.1.1 We were delighted to welcome our newly elected governors at their governor induction.

5.1.2 We provided a presentation on Trust engagement activities and how governors are supported to get involved with these efforts.

5.1.3 We will be supporting our governors to attend the Kent and Medway Regional Governors network meeting in October.

5.1.4 This meeting will focus on the role of governors and look at other examples of good practice.

5.2 Members

5.2.1 Our Annual Members' Meeting will take place in the hospital restaurant at 6pm on 25 September, when the Chief Executive will give a presentation on the year's achievements.

5.2.2 Other speakers and information stands will ensure an interesting evening. Members and stakeholders have been invited to attend.

5.2.3 Our governors held a very engaging and productive membership recruitment stand in the hospital in August.

5.2.4 Two of our new governors, David Nehra and Richard Shannon, were proactive in reaching out to those using our services on the day, alongside more experienced governors, Doreen King and Vivien Bouttell.

5.3 Supporting services to engage with patients and public

5.3.1 Accompanied by our Community Engagement Officer, our Breast Screening Lead, Dr Asma Javed, was able to give a breast awareness presentation to parents of students at Brompton Academy.

5.3.2 This presentation was well received and the school has asked for further presentations from other clinicians for their students.

5.3.3 We supported the Trust's Macmillan Recovery Package Facilitator in a patient co-production event.

5.3.4 Cancer patients spoke about what would have helped when they received their diagnosis, identifying their three priority improvements.

5.4 Reaching out to less engaged audiences

5.4.1 Our community engagement officer is working with the simulation team and local primary schools to create a 'teddy bear hospital' to reduce fear and anxiety in children coming into hospital.

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Report to the Board of Directors

Board Date: 06/09/2018

Agenda item 13

Title of Report	**Workforce Report**
Prepared By:	Elizabeth Nyawade, Deputy Director of HR & OD
Lead Director	Leon Hinton, Director of Operational HR
Committees or Groups who have considered this report	Senior HR Team
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The Trust's nursing recruitment campaigns, including national, local and international have delivered a total of 383 candidates to date – 53 candidates supplied to us by Cpl Healthcare and 171 candidates provided by HCL. The initial Philippines recruitment plan for nursing continues with a total of 59 candidates being processed for posts at MFT. Trust turnover has increased to 12% (+0.15% from 11.85%), sickness absence at 4% (+0.06% from 3.94%) is at the Trust's tolerance level of 4%, compliance with mandatory training at 86% has slightly deteriorated (-1.17% from 87.17%) against target of 85%, appraisal compliance deteriorated to 81% (-1.12% from 82.12%) against target of 85%. Due to a significant bank accrual, there was a decrease in the percentage of pay bill spent on substantive staff in July at (78.74%) compared to 83% in the month of June. There was a decrease (of 1%) in agency usage in July to the Trust's lowest monthly spend on agency staff in over four years.
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	To approve 5.3, the content of the Trust annual statement – Modern Slavery and to delegate the annual approval to a Board committee.
Purpose & Actions required by the Board :	**Approval** ☒ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

Report to the Board of Directors

1 INTRODUCTION

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

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During July 2018, 13 FTE nurses and midwives joined the Trust on a substantive basis, alongside 4 FTE substantive clinical support workers.

2.2 The international campaign in the Philippines continues. Harvey Nash our international recruitment partner agency working on Filipino nurse recruitment campaign is continuing to process 59 of the Filipino nurses that remain engaged in the process. A further 19 candidates recently passed their International English language Test (IELTS). It is anticipated that the 19 nurses who have successfully passed the IELTS will commence in post in the next 3 - 4 months.

2.3 An additional 14 international nurses successfully undertook their objective structured clinical examination (OSCE) in July 2018 and are now working as registered staff nurses in the Trust. A further 16 international nurses are booked to undertake their OSCE exam in Belfast in August 2018.

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 registered Cpl international neonatal nurse arrived in March 2018. 18 nurses provided by HCL have also commenced in post with a further 171 candidates with offers being processed.

2.5 The Trust is also working with eight additional permanent recruitment agency providers: Blue Thistle, EPSN Workforce, Ascend, We Solutions, Person Anderson; Imperial, MSI Group and Xander Hendrix. These agency partners are working with the Trust on developing a pipeline of nurses.

The table below summarises the Trust's recruitment pipeline via some of our partner agency providers.

Agency Provider	Commenced in post	Pipeline	Agency total	Anticipated starters over the next 12 months from pipeline
Harvey Nash	6	***59***	65	(32%) **19**
Cpl Healthcare	1	***53***	54	(20%) **11**
HCL	18	***171***	189	(40%) **69**
Person Anderson	18	***5***	23	(100%) **5**
Imperial MS	9	***47***	56	(40%) **19**
MSI Group	2	***7***	9	(42%) **3**
Xander Hendrix	3	***11***	14	(63%) **7**
We Solutions	1	***22***	23	(63%) **14**
Blue Thistle	0	***8***	8	(47%) **3**
Total	58	***383***	441	**150**

(Table 1: Nurse recruitment pipeline July 2018)

2.6 To increase reach the Trust has commissioned the services of Medical Careers Global, a careers adverting platform for a period of 12 months on a fixed fee. All clinical posts will be advertised on this platform with a view to attracting more applicants. To date 23,977 individuals have viewed MFT clinical vacancies posted on this platform and 43 applications have been received including five for a clinical attachment role and 4 for LAS (locum appointment for service) ST3+ post. The applications received through Medical Careers Global platform from candidates who are yet to undertake the required IELTS examination will be stored to create a local talent pool.

2.7 Four FTE Trust junior doctors commenced in post in July. The ten Certificates of Sponsorship (CoS) applications previously declined by the UKVI have now been approved following the new ruling from the Government. It is anticipated that the ten doctors allocated these certificates of sponsorship will be in post by the end of September 2018.

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

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses & midwives	**33** (28 NHS Jobs/open days & 5 international)	**13** (12 RNs and 1 midwife)	**14 (11RNs and 3 midwives)**
Clinical support workers	**0**	**4**	**10**

(Table 2: Monthly starters and leavers July 2018)

2.9 Four Physician Associates commenced in post in July 2018.

3 DIRECTORATE METRICS

3.1 The table below (table 3) shows performance across five key performance indicators by directorate. Turnover, at 12% (+0.15% from 11.85% in June), remains above the tolerance level of 8%. Sickness absence at 4% (+0.06% from 3.94%) is at the Trust 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 with to implement service-specific retention plans.

3.2 The Trust appraisal rate stands at 81% (-1.12%), below the Trust target of 85%, Mandatory training remains above target at (86%, slight deterioration by 1.17%) – three directorates are meeting the mandatory training target (Corporate, Planned Care and Unplanned Care) and one directorate (Corporate) is meeting appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings are included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics.

Report to the Board of Directors

	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%	▲		14%	▼		13%	▼		6%	▲		12%	▲	
Vacancy rate (12%)	16%	▼		22%	▼		11%	▼		16%	▲		18%	▼	
Sickness rate (4%)	4%	▼		4%	▲		3%	▲		5%	▲		4%	▲	
StatMan (85%)	87%	▼		86%	▼		97%	▲		82%	▼		86%	▼	
Appraisal (85%)	83%	▼		78%	▼		95%	▲		83%	▲		81%	▼	

(Table 3: Key workforce metrics)

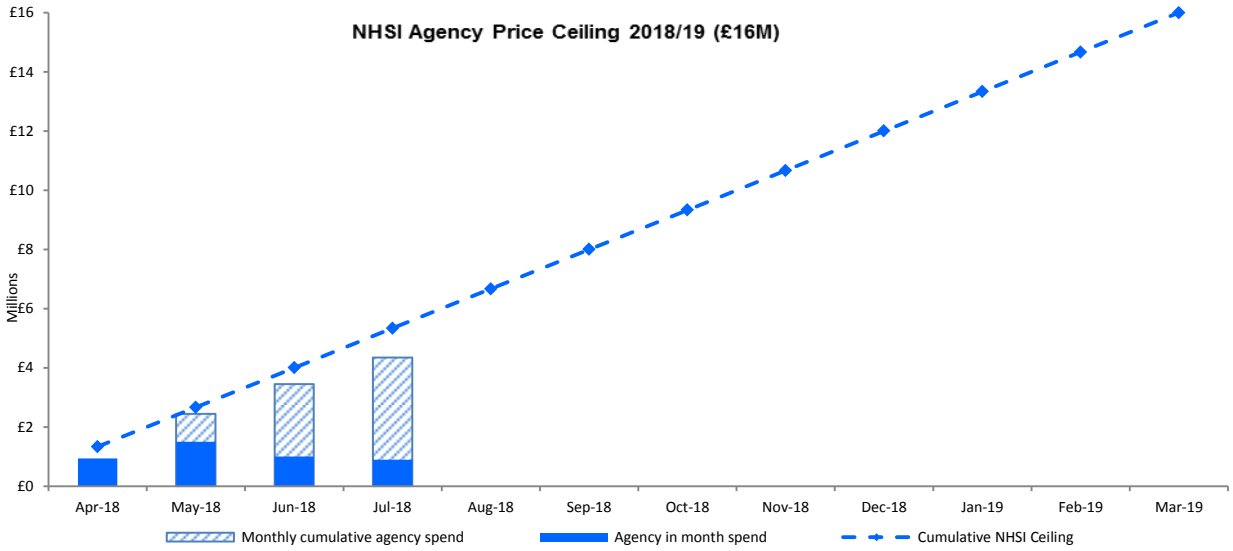
4 TEMPORARY STAFFING

4.1 Table 4 below demonstrates that temporary staffing expenditure increased in July 2018 compared to June 2018. The significant increase in bank spend is due to an accruals process. July's agency spend has reduced to its lowest level in over four years.

		Mar-17	Mar 18	Apr 18	May 18	June 18	**July**
Spend	Agency	3,890,198	2,597,697	943,419	1,502,866	1,003,597	895,452
	Bank	920,473	2,329,768	2,307,191	2,003,992	1,939,086	2,914,664
	Substantive	13,611,458	13,542,990	13,904,703	14,328,856	14,032,556	14,112,476
% Pay bill	Agency	21%	14%	5.5%	8%	6%	5%
	Bank	5%	12%	13.5%	11%	11%	16.26%
	Substantive	74%	74%	81%	81%	83%	78.74%

(Table 4: Workforce profile based on contractual arrangement)

4.2 The agency cap breaches across all staff groups have decreased with approximately 35 price cap breaches per week. The Trust's NHSi annual agency spend celing has decreased from £21.6m in 2017/18 to £16m in 2018/19. Based on cumulative agency spend YTD, the Trust is £988K below the NHSi agency ceiling cap target.



4.3 Temporary nursing demand in July 2018 was comparable to June 2018 (8,689 shifts requested in July 2018 compared to 8,674 shifts requested in June 2018). The fill rate in July 2018 increased to 77% (+1.5%). Medical locum demand decreased in July 2018 compared to June 2018 (1,527 shifts requested in July 2018 compared to 1,821 shifts requested in June 2018). The fill rate for medical locum demand also decreased by 6% to 80.5%.

5 MODERN SLAVERY ANNUAL TRUST STATEMENT 2018/19

5.1 Modern slavery encompasses slavery, servitude, human trafficking and forced labour. The Trust has a zero tolerance approach to any form of modern slavery. We are committed to acting ethically and with integrity and transparency in all business dealings and to putting effective systems and controls in place to safeguard against any form of modern slavery taking place within the organisation or our supply chain.

5.2 The Trust is required to provide an annual statement of commitment as made pursuant to s54 of the Modern Slavery Act 2015 and sets out the steps the Trust has taken, and is continuing to take, to make sure that modern slavery or human trafficking is not taking place within our organisation or supply chain. The proposed Trust statement is provided as appendix I and will be made available through the Trust's publication scheme (internet) and registered with the Modern Slavery Registry (https://www.modernslaveryregistry.org/) and TISC report (https://tiscreport.org/).

Report to the Board of Directors

5.3 It is recommended that the Board approve the statement (appendix I) in full. It is also recommended that the Board delegate the future approval of the annual statement to a Board committee.

-End

Report to the Board of Directors

APPENDIX I: TRUST ANNUAL STATEMENT – MODERN SLAVERY

Our policies on slavery and human trafficking

The Trust is aware of our responsibilities towards patients, service users, employees and the local community and expects all suppliers to the Trust to adhere to the same ethical principles. We are committed to ensuring that there is no modern slavery or human trafficking in our supply chains or in any part of our business. Our internal policies replicate our commitment to acting ethically and with integrity in all our business relationships.

Currently, all awarded suppliers sign up to our terms and conditions of contract which contain a provision around Good Industry Practice to ensure each supplier's commitment to anti-slavery and human trafficking in their supply chains; and that they conduct their businesses in a manner that is consistent with the Trust's stance on anti-slavery. In addition, an increasing number of suppliers are implementing the Labour Standards Assurance System (LSAS) as a condition of contract for tenders within high risk sectors and product categories and indeed this has been referenced in the Government's Modern Slavery Strategy. Many aspects of the LSAS align to the seven reporting areas that the Government has outlined and should appear within any slavery and human trafficking statement.

We operate a number of internal policies to ensure that we are conducting business in an ethical and transparent manner. These include:

- Recruitment policy. We operate a robust recruitment policy, including conducting eligibility to work in the UK checks for all directly employed staff, and agencies on approved frameworks are audited to provide assurance that pre-employment clearance has been obtained for agency staff, to safeguard against human trafficking or individuals being forced to work against their will;
- Equal Opportunities. We have a range of controls to protect staff from poor treatment and/or exploitation, which comply with all respective laws and regulations. These include provision of fair pay rates, fair terms and conditions of employment, and access to training and development opportunities;
- Safeguarding policies. We adhere to the principles inherent within both our safeguarding children and adults policies. These are compliant with Medway multiagency agreements and provide clear guidance so that our employees are clear on how to raise safeguarding concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain;
- Whistleblowing policy. We operate a Freedom to Speak Up, Raising Concerns at Work and Whistleblowing Policy so that all employees know that they can raise concerns about how colleagues or people receiving our services are being treated, or about practices within our business or supply chain, without fear of reprisals;
- Standards of business conduct. This code explains the manner in which we behave as an organisation and how we expect our employees and suppliers to act.

Our approach to procurement and our supply chain includes:

- Ensuring that our suppliers are carefully selected through our robust supplier selection criteria/processes;
- Requiring that the main contractor provides details of its sub-contractor(s) to enable the Trust to check their credentials;
- Random requests that the main contractor provides details of its supply chain;
- Ensuring invitation to tender documents contain a clause on human rights issues;
- Ensuring invitation to tender documents also contain clauses giving the Trust the right to terminate a contract for failure to comply with labour laws;
- Using the standard Supplier Selection Questionnaire (SQ) that has been introduced (which includes a section on Modern Day Slavery).

Trust staff must contact and work with the Procurement department when looking to work with new suppliers so appropriate checks can be undertaken.

Supplier adherence to our values: we are zero tolerant to slavery and human trafficking and thereby expect all our direct and indirect suppliers/contractors to follow suit.

Where it is verified that a subcontractor has breached the child labour laws or human trafficking, then this subcontractor will be excluded in accordance with Regulation 57 of the Public Contracts Regulations 2015. The Trust will require that the main contractor substitute a new subcontractor.

Training

Advice and training about modern slavery and human trafficking is available to staff through our mandatory safeguarding children and adults training programmes, our safeguarding policies and procedures, and our safeguarding leads. It is also discussed at our compulsory staff induction training.

We are looking at ways to continuously increase awareness within our organisation, and to ensure a high level of understanding of the risks involved with modern slavery and human trafficking in our supply chains and in our business.

Our performance indicators

We will know the effectiveness of the steps that we are taking to ensure that slavery and/or human trafficking is not taking place within our organisation or supply chain if no reports are received from our staff, the public, or law enforcement agencies to indicate that modern slavery practices have been identified.

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Quality Assurance Committee held on 24/08/2018

Report to:	**Trust Board**	**Date of meeting: 6 September 2018**		**1**
Presented by:	**Jon Billings** **Chair, Quality Assurance Committee**	**Prepared by:**	**Jon Billings** **Chair, Quality Assurance Committee**	
	The papers and full minutes will be available for Board members to review on BoardPad			

Matters for escalation or highlighting	• The QAC considered the Director of Infection Prevention and Control's (DIPC) Annual Report (attached as an appendix to this paper). This highlights some real successes and good work undertaken during the year, but also emphasises the need for constant trust-wide vigilance to ensure consistently good clinical practice and mitigation of risks – for example in relation to older parts of the estate. • QAC received an oral update on work being done to ensure we understand fully the factors behind recent rises in reported HSMR. The Committee was reassured that the crude mortality (numbers of deaths) remains unchanged and the HSMR rise appears to be linked to desirable (in terms of appropriate care) referrals to the end of life team as an alternative to palliative care, with attendant differences in coding. Work continues with NHSI, the CCG and Dr Foster to agree the most appropriate handling and reporting of this issue.
Other matters considered by the committee:	• Progress with the new quality dashboard • Oral update on the process for Quality Impact Assessment (QIA) of service change • Directorate assurance report • CQUIN programme 2018/19
Key decisions made/ actions identified:	• Interim Medical Director will discuss DIPC Annual Report with consultants • QIA to be a standing item with regular case examples presented to QAC

Risks:	• Key area discussed was the DIPC report and follow up steps agreed.
Assurance:	• A regular focus on QIA of service change will provide assurance as the Transformation Programme progresses.

Key Issues Report

NHS Medway NHS Foundation Trust

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

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

Best of care Best of people

NHS
Medway
NHS Foundation Trust

Infection Prevention and Control

Annual Report

2017 – 2018

NHS Medway NHS Foundation Trust

CONTENTS

Graphs:

Tables:

Charts:

FOREWORD

I am delighted to introduce Medway NHS Foundation Trust's Annual Infection Prevention and Control Report for the period 2017 to 2018.

The report outlines our continued commitment to promoting best practice in Infection Prevention and Control and demonstrates that the Trust has continued to make progress towards achieving key infection and Prevention priorities.

The Infection Prevention and Control practitioners work together to provide an effective infection prevention and control service to ensure the Trust complies with the requirements of the Health and Social Care Act (2008). They provide strong leadership, both challenging and supporting the clinical teams to deliver best infection prevention and control practice and supporting learning across the Trust through training and education.

However, Infection Prevention and Control is everyone's responsibility and this report acknowledges the work and diligence of all grades of clinical and non-clinical staff that play a vital role in reducing the risk of healthcare associated infections.

Producing an annual report is required under the Health and Social Care Act 2008: Code of Practice. As in previous years, the report follows the format of the Code of Practice 10 criteria for Infection Prevention Control to demonstrate the Trust's compliance with the requirements of the Act.

Karen Rule

Karen Rule
Executive Director of Nursing
August 2018

INTRODUCTION

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

The IPC Annual Report, together with the Annual IPC Plan and the Assurance Framework are the means by which the Trust Board assures itself that prevention and control of infection risks is being managed effectively and that the Trust remains registered with the CQC without conditions.

In addition, the Annual Report seeks to assure the Trust Board that progress has been made against the Annual Plan. It demonstrates that priorities identified in the Annual Plan last year have been addressed by employing a robust programme of work that enabled some notable successes on which to build.

However, every year brings with it its share of challenges in infection prevention and control and the past year was no exception.

We breached agreed trajectories for MRSA (zero) and Clostridium *difficile* (20) with incidences of 7 and 26 respectively. Since both healthcare infections have diminished over the years, it is possible their presence as disease entities in their own right is not always recognised immediately by clinicians, resulting in sporadic avoidable cases. This indicates the need for continued vigilance by all in the clinical team.

We did well however for the Gram negative bacteraemia target where we achieved the required 10 percent reduction. Future reductions will be more challenging to achieve because the majority of the E coli bacteraemia were related to endogenous urinary tract and intraabdominal infections. Only a small proportion of these were due to catheters which qualify as healthcare associated, and will be the focus of target reduction in the years to come. There is a national requirement to reduce the number of gram negative bacteraemia by 50% by 2021.

Of the E.coli bacteraemia, the multi resistant extended spectrum beta lactamase E coli are rising nationally but the Trust performance is above the national average, a testament to the good antimicrobial controls practiced by the consultant microbiologists. Good antibiotic stewardship is one of the key issues in helping reduce the vulnerability of patients to developing Clostridium *difficile* infection. Antimicrobial stewardship CQUIN targets were achieved by interventions such as stewardship ward rounds introduced by microbiologists and improvement work undertaken by the antimicrobial pharmacist.

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

Victory ward which was a MRSA cohort ward in Surgery had to close, having fulfilled its purpose. As a control strategy in the previous ten years, this cohort ward was responsible for a dramatic reduction in cases and was successful in achieving our targets year on year.

The report gives a full and robust consideration to the ten criteria which are set out in the table below along with our self-assessment of compliance for 2017/2018.

	Compliance criterion *What the registered provider will need to demonstrate*	Trust rating
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.	Compliant
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	Compliant
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.	Compliant
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.	Compliant
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.	Compliant
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	Compliant
7	Provide or secure adequate isolation facilities.	Partial compliance
8	Secure adequate access to laboratory support as appropriate.	Compliant
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.	Compliant
10	Providers have a system in place to manage the occupational health needs	Compliant

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

- Dr Rella Workman, Director of Infection Prevention and Control (DIPC)
- Kathryn Lawson-Hughes, Head of Infection Control, Deputy DIPC
- Dr Vasile Laza–Stanca – Consultant Microbiologist
- Dr Dimitrios Mermerelis – Locum Consultant Microbiologist
- Sheila Gogah – Infection Control Matron
- Clair Taylor – Infection Control Nurse
- Caroline Cook – Infection Control Nurse (joined the team in March 2016)
- Robert Saloka – Lead Antimicrobial Pharmacist (joined the team in January 2018)
- Syed Gilani – Lead Antimicrobial Pharmacist (left the team in December 2017)
- Lorraine Shephard, PA to Head of Infection Control (joined the team in October 2017)

Dr Rella Workman
Consultant Microbiologist / Director of Infection Prevention and Control
August 2018

COMPLIANCE WITH THE HEALTH AND SOCIAL CARE ACT

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

Roles and responsibilities

IPC is the responsibility of everyone in the organisation. Key roles and arrangements are detailed below:

1.1 Board to Ward Commitment

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

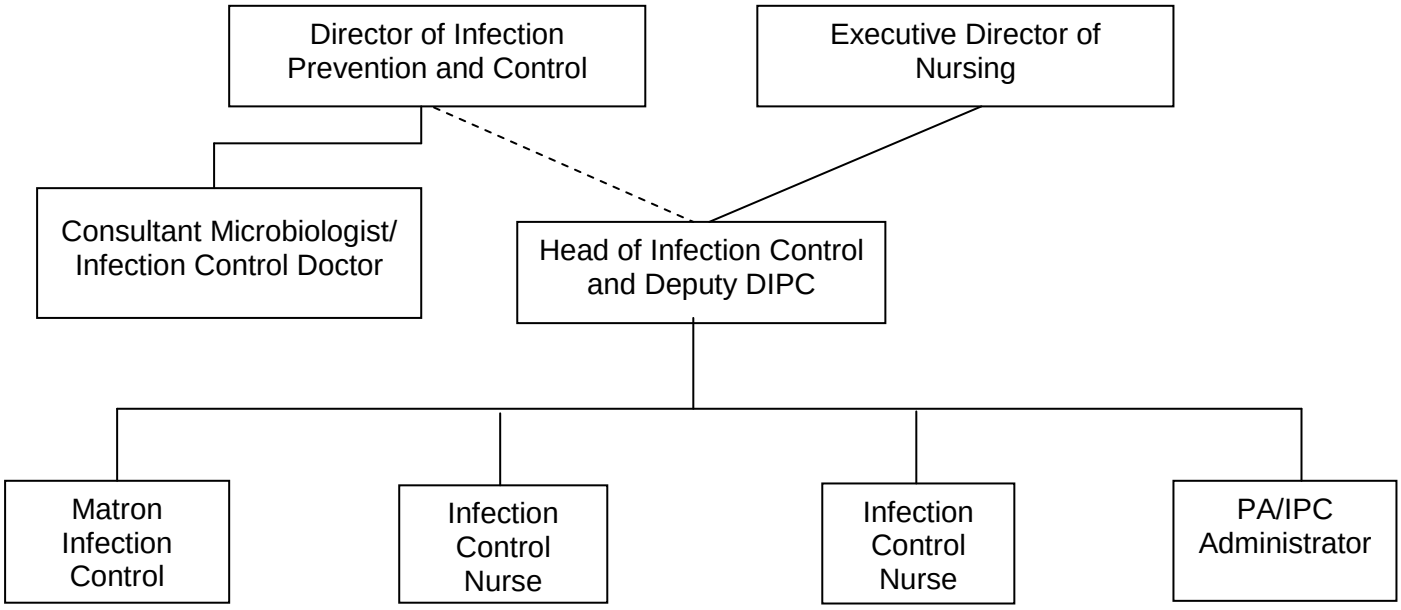
1.2 Director of Infection Prevention and Control

Dr Rella Workman, a Consultant Microbiologist, remains Director of Infection Prevention and Control (DIPC). The DIPC reports to the Trust Board Chief Executive via the Executive Director of Nursing.

1.3 Infection Prevention and Control Nursing Team (IPCT)

The IPC nursing team report to the Executive Director of Nursing. The team is up to full establishment. They continue to have a high visibility and strong ward presence throughout the Trust and are represented on the Nursing and Midwifery Advisory Group. The team achieved all the objectives on the annual work plan.

Infection Prevention and Control Team Structure



1.4 Infection Prevention and Control Link Practitioner Network

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

1.5 Assurance Framework

The Clinical Directorates have responsibility for reporting and assessing infection control risks assisted by the Infection Prevention and Control Team. IPC performance is reported via Directorate and Trust quality and performance scorecards. IPC action plans are monitored at monthly Directorate Governance and Performance Review meetings with exception reporting to the quarterly Infection Control and Antimicrobial Stewardship Group (ICAS). Risks are fed into the Trust's Risk Register for review at the Quality Steering Group (QSG).

This robust assurance framework ensures the Board is fully informed of all Infection Prevention and Control issues and risks. The DIPC reports to the QSG monthly and the Quality Assurance Committee (QAC) quarterly. The QAC is a sub-committee of the Trust Board and is chaired by a Non Executive Director.

1.6 Monthly Statistics

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

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

1.7 Infection Control and Antimicrobial Stewardship Group (ICAS)

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

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

The ICAS group oversees the work plan/programme and audit of the IPCT; it is responsible for ratifying all IPCT policies.

Appendix 2 – IPC Work Programme 2017-18
Appendix 3 – IPC Audit Programme 2017-18

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

1.8 Commissioner Reporting

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

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

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

1.9 Monthly Targets

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

Gap analysis against criteria: Compliant

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

2.1 Environmental Audits

The IPCT complete their comprehensive environmental audit programme in all acute areas and non-acute areas. Enhanced audits were undertaken where cases of health care associated infections were identified and following outbreaks. Verbal and written feedback was provided in real time to the Directorates for action in areas of non-compliance.

Exception reporting and assurance is fed back at the ICAS meeting.

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

The areas listed below have all been audited during the year using adapted Infection Prevention Society audit tools:

Unplanned and Integrated Care		
Acute Medicine	**Acute Specialist Medicine**	**Cancer and Clinical Support**
ED Ambulatory Care / Lister Byron Dickens Discharge Lounge Harvey Milton Sapphire Tennyson Wakeley	Bronte Cardiac Catheter Suite Cardio Angio / resp function room CCU Dermatology Diabetic Centre Endoscopy Keats Nelson Will Adams	CT Galton Day Unit Imaging Interventional Radiology Lawrence Medical Infusion Suite/neuroscience MRI Nuclear Medicine Osteoporosis Phlebotomy Physio Gym Ultrasound

Planned Care Directorate		
Surgical Services	**Critical Care and Perioperative**	**Women and Children**
Arethusa Audiology Breast Care Unit ENT OPD Kingfisher / SAU Max Fax (Orthodontics) McCulloch Pembroke Phoenix Victory	Day Surgery Procedure Suite ICU Main Theatre Main Theatre Recovery MHDU POCU Pre-Assessment Clinic Sunderland Day Case Sunderland Theatre Trafalgar(SHDU)	Antenatal Colposcopy Delivery Dolphin Kent Maternity Care Unit Obstetrics Theatre Ocelot Oliver Fisher Neonatal Unit (NICU) Outpatients Pearl Penguin Swale Nursery The Birth Place

2.2 Challenges

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

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

A bedside locker replacement programme commenced in April 2018.

Appendix 4 – Bed Spacing

2.3 Cleaning Standards

Cleaning Audits

Due to the challenges of maintaining agreed staffing levels in the housekeeping service the 2017-18 cleaning audit programme has been inconsistently applied and monitored. The team focussed on covering the Very High and High Risk areas, but have struggled to maintain the programme on the Significant and Low Risk areas.

Following each audit the inspected areas are issued with a copy of the audit, including a scorecard and task list. The task lists are issued to the Team Leaders who address any performance issues with their staff and work to bring areas back up to standard.

AREA	% SCORE
ASEPTIC SUITE	92%
BRONTE HDU	97%
CARDIAC CATHETER SUITE	91%
DELIVERY SUITE	97%
ENDOSCOPY	97%
GALTON DAY UNIT	91%
ICU / CCU	99%
LAWRENCE WARD	97%
MAIN THEATRES	99%
OBSETRIC THEATRES	100%
OLIVER FISHER NEONATAL UNIT	97%
RENAL UNIT	94%
SUNDERLAND THEATRES	98%
TRAFALGAR WARD	97%
VICTORY WARD	97%
TOTAL ANNUAL SCORE	**96%**

Table No 1: *Very High Risk Areas Annual Average Scores*

AREA	% SCORE
A&E MAJORS	98%
A&E MINORS	98%
A&E PEADS	99%
ARETHUSA WARD	95%
BRONTE WARD	97%
BYRON WARD	95%
DICKENS WARD	93%
DOLPHIN WARD	96%
ELIOT WARD	80%
HARVEY WARD	91%
KEATS WARD	96%
KENT WARD	93%
KINGFISHER WARD	91%
LISTER WARD / AMU	97%
McCULLOCH WARD	96%
MEDOCC	96%
MILTON WARD	96%
NELSON WARD	86%
OBSERVATION WARD	90%
OCELOT WARD	95%
PEARL WARD	94%

PEMBROKE WARD	95%
PENGUIN ASSESSMENT UNIT	95%
PHOENIX WARD	88%
SAPPHIRE WARD	80%
SUNDERLAND DAY UNIT	95%
SURGICAL ADDMISSION UNIT	84%
TENNYSON WARD	95%
THE BIRTH PLACE	99%
WAKELEY WARD	95%
WILL ADAMS WARD	95%
TOTAL ANNUAL SCORE	**93%**

Table No 2: *High Risk Areas Annual Average Score*

The audit processes and programme have been reviewed. In 2018/2019 a new audit process will be implemented with the inclusion of previously unaudited (mainly low risk) areas and the frequency of others realigned to meet the requirements of the National Cleaning Standards. It is expected that the levels of compliance with timescales will improve significantly as the team and processes are strengthened.

Infected Discharge Cleans

Response to requests for infected discharge cleans made via the helpdesk has significantly increased further this year (12% on last year) as we have introduced the use of Hydrogen Peroxide Vapor (HPV) and Ultraviolet Light cleaning (UVC) machines to further strengthen the cleaning regime and reduce the bacterial load in the patient environment post infection. The requirement for a discharge clean is RAG rated according to the infection that was present with the most serious infections taking up to 5 hours to run the full cleaning cycle.

Response staff have attended training and been certified to use this specialist machinery. This has however, impacted on the cleaning time for a room and the turnaround time for beds.

	2016-2017	**2017-2018**
April	464	489
May	454	527
June	506	550
July	420	539
August	453	469
September	430	469
October	456	608
November	443	536
December	506	453
January	428	533
February	430	433
March	509	508
Totals	**5499**	**6114**

Table No 3: *Number of Discharge Cleans*

Management and Supervision

In 2017 a service wide review of the Housekeeping Department was commissioned with the Birch Foundation. The review considered the tasks, frequency, hours and productivity alongside the needs of the hospital and compliance with the National Cleaning Standards.

The review identified a number of proposals with regards to the structure of the Managers, Team Leaders and Leading Hands going forward. In August 2018, management responsibility for the housekeeping service will transfer to a newly appointed Head of Hotel Services who will have a remit for cleaning, catering and portering services. The review will be completed with the implementation of a new housekeeping services structure, processes and monitoring regimes. The service redesign will be focussed on meeting the National Cleaning Standards and reducing the reliance on bank staff.

A revised staff training programme will be implemented to include 'Back to Basic' training for both the Housekeeper and Hostess roles and a renewed focus on mandatory training compliance.

PLACE (Patient Led Assessment of the Care Environment)

The PLACE assessment was completed on the 10th and 11th May 2017 with a team of staff and volunteers. We achieved a lower percentage score in the cleanliness domain in the 2017 programme than our previous year and lower against the national average.

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

Table No 4: *Cleanliness domain*

Significant work has been undertaken throughout the year to improve the cleaning standards and increase the monitoring and we are anticipating an improvement for the outcome of the 2018 assessment.

Gap analysis against criteria: Compliant

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

3.1 Antimicrobial prescribing.

The past year has brought about significant achievements through the contributions of the pharmacy antimicrobial team irrespective of the challenges. Our focus being supporting and educating all staff on the rudiments of 'Antimicrobial Stewardship' emphasising on the impact of overprescribing, under prescribing and inappropriate durations of antimicrobial therapy. The team have maintained a high vigilance to encourage prudent antimicrobial prescribing habits through the initiatives described below.

3.2 Antimicrobial Guidelines

- Continued revision and update of the Adult Antimicrobial guidelines in accordance with both national and local guidelines on the 'Antimicrobial Guideline APP' ('Microguide').
- Update and revision of pharmacist's, doctors and nursing roles within the 'Antimicrobial Stewardship Policy' to help optimise prudent antimicrobial prescribing and ensure prompt review of antimicrobial therapy at 48 hours after initiation. This is in line with the Governments 'Start Smart- Then Focus' initiative to help combat inappropriate prescribing and minimise the rise of antimicrobial resistance.

3.3 Restricted Antibiotics

- 'Actual' antimicrobial prescribing practice via antibiotic transcription sheets are reviewed regularly.
- Monitoring of 'restricted antibiotics', carbapenem, cephalosporins, quinolones and piperacillin/tazobactam. This has been achieved via monthly issue reports and Pharmacy 'real time' surveillance, issues are addressed as appropriate.
- Reinforcement of a maximum of a 3 day supply of restricted antibiotics to wards to ensure antimicrobial therapy is regularly reviewed where possible by pharmacy, before further supplies are given. This has helped to minimise unnecessary durations of therapy.

3.4 Antibiotic Awareness

- Successfully initiated 'World Antibiotic Awareness week' in November 2017. During this week we were able to raise awareness through posters, staff interaction and Trust wide computer screen savers. The week helped raise both public and staff awareness regarding safe and appropriate use of antibiotics.

3.5 Training

- An antimicrobial teaching programme has again been successfully maintained throughout the past year to improve prescribing behaviour in treatment regimens, prophylaxis and therapeutic drug monitoring to all Foundation Year Doctors, Pharmacists, Clinical Technicians and Nurses.
- The antimicrobial team are also teaching 'prudent antimicrobial prescribing and administration' to Nurses via their IV Study Days to address the problem of omission and delays in administration of antimicrobial drugs.
- Bi weekly antimicrobial teaching sessions are given to all Nurses new to The Trust to help enhance antimicrobial awareness and encourage prudent antimicrobial prescribing.
- 'Micro' teaching sessions have been given to individual wards where therapeutic drug monitoring has been required for high risk antimicrobials, vancomycin and gentamicin. The teaching sessions were identified through daily vancomycin and gentamicin reports and where extra pharmacy support was needed with dosing and monitoring.

3.6 DATIX and Incident Logs

- All incident reports via the 'DATIX' reporting system involving antimicrobials are regularly monitored, reviewed and actioned as appropriate.

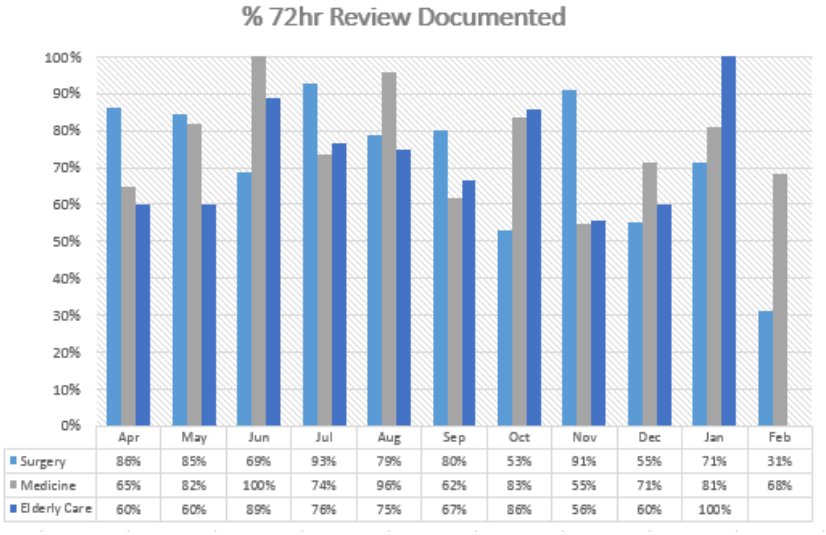
3.7 Audits

72 hour Review Audit

A monthly 72 hour review audit was undertaken across a number of wards to ensure antimicrobials are appropriately initiated and reviewed in line with the Government's 'Start Smart- Then Focus' initiative and the Trusts 'Antimicrobial Stewardship Policy'. Monthly audit results were compared against previous months to determine progress and consistency in adherence.

Five main areas were audited;

- Antimicrobials are prescribed in line with guidelines or appropriateness with clinical need.
- A clear antimicrobial indication is documented on the prescription chart
- A 48 hour antimicrobial review is documented in the clinical notes in relation to the **FIVE** antimicrobial decisions (**Modify, IV to oral switch, Stop, Continue or Outpatient treatment**) points
- To assess whether the 48 hour review decision has been supported by any clinical, pathology or microbiology results
- To assess whether any subsequent 48 hour reviews have been undertaken.



Graph No. 1: *Monthly 72 hour Antimicrobial Review Audit*

3.8 Monitoring

Pharmacist participation in Clostridium *difficile* post infection review meetings to help identify themes related to antimicrobial prescribing and pharmaceutical review of the patient. Good and poor prescribing is determined and fed back to clinical pharmacy teams for learning and action via Pharmacy Clinical Group meetings.

Daily list of patients on vancomycin and gentamicin and the levels obtained from Pathology. All sub-therapeutic and toxic levels were followed up by the Antimicrobial Pharmacist and ward team advised appropriately.

3.9 Antimicrobial consumption and CQUIN

Reduction in antibiotic consumption is one of a four part CQUIN, relating to infections and antimicrobial resistance. It is a 2 year CQUIN programme for the financial years 2017 to 2019. For the first year, the target was a 1% reduction in total antibiotics usage, carbapenem and piperacillin-tazobactam per 1,000 admissions respectively, benchmarked against 2016/2017 antimicrobial usage. At the end of year one (2017/2018), we achieved a 48% reduction in piperacillin-tazobactam usage and 40% reduction in carbapenem usage.

Total DDDs	Q1	Q2	Q3	Q4	Total
Piperacillin/tazobactam Usage 2016/2017	1762.86	2026.86	2323.71	2261.57	8375
Piperacillin/tazobactam Usage 2017/2018	1089	1319.43	1062	923.14	4393.57
Reduction	673.85	707.43	1261.71	1338.43	3981.43
% reduction	38	35	54	59	48
RAG					

Carbapenem Usage 2016/2017	1484.5	1576	1612.25	1441.5	6114.25
Carbapenem Usage 2017/2018	1138.5	1137.75	821.75	587.25	3685.25
Reduction	346	438.25	790.5	854.25	2429
% reduction	23	28	49	59	40
RAG					

Table 5 : *Carbapenem and Piperacillin usage and reduction 2016/2017 v 2017/2018*

What was done to achieve improvement:

- All patients initiated on Carbapenem and Piperacillin/tazobactam were identified by the antimicrobial pharmacist from inpatient transcription sheets. These were reviewed based on the Trust antimicrobial policy and national antimicrobial stewardship recommendations.
- All non-compliant prescriptions and restricted antibiotics without a microbiologist approval were highlighted to the Microbiologist via email by the Antimicrobial Pharmacist. These patients were followed up during the daily antimicrobial stewardship ward round by the Consultant Microbiologist(s) and Antimicrobial Pharmacist.
- Patients on prolonged antimicrobial regime and restricted antibiotics were discussed during the daily Infection Control and Antimicrobial Stewardship MDT meeting. This was attended by all Microbiologists, Infection Control Nurses and the Antimicrobial Pharmacist.
- Following identified gap in knowledge, target teachings were carried out at ward level by Consultant Microbiologist and Antimicrobial Pharmacist. Response to antimicrobial queries by Junior Doctors was used as an opportunity to educate the Doctors on prudent antimicrobial prescribing.
  The use of Piperacillin/tazobactam for neutropenic sepsis was replaced with ceftazidime in the Trust antimicrobial policy. This change in policy was a contributory factor to the significant reduction in Piperacillin/tazobactam usage

Appendix 5 – Antimicrobial Pharmacist Programme 2017-2018

Gap analysis against criteria: Compliant

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

4.1 Admissions and transfers into the Trust

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

4.2 Transfers out of the Trust

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

4.3 Collaboration

The Trust's IPCT work in close collaboration not only with the Microbiology department staff to ensure that microbiology results are fed back in real time to wards and departments, but also with our Primary Care providers, including Kent Community Healthcare, Medway Community Healthcare and Public Health England (PHE) Kent and the North Kent Clinical Commissioning Group (CCG). This ensures a two way flow of information and has demonstrated some significant improvements. There has been close collaboration with the CCG Infection Prevention Specialists to look at issues and trends as they occur. In the new financial year the microbiology laboratory will be moving to Darent Valley Hospital, so close collaboration will be even more important.

4.4 Leaflets

The Infection Prevention and Control Team patient information leaflets are available in hard copies and on the intranet. Moving forward, these will be electronic only.

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

4.5 Information

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

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

The information is being reviewed and will be standardised throughout the Trust in 2018-2019.

Gap analysis against criteria: Compliant

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

5.1 Reducing Risk of Transmission

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

Disappointingly we breached our C.diff target of 20 by six. However, post infection reviews concluded that many of them were unavoidable. Any non-compliance issues are addressed via directorate action plans.

Very disappointingly the Trust had seven trust apportioned cases of MRSA bacteraemia this year.

5.2 Outbreaks

Two wards had increased incidence of MRSA colonisation and as a result an outbreak was declared in each area. Enhanced cleaning and increased input from the IPCT in collaboration with the ward teams ensured that these were dealt with successfully to reduce the risk of further transmissions.

The Trust only closed three bays for a short period of time due to norovirus this year. The key to this success was the early recognition and prompt isolation of potential and actual cases, especially in the emergency admission areas.

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

Quarter	Date Started/ Completed	Ward	Total No. of Patients Affected	Bay Closed/ Date	Ward Closed/ Date	Estimated Bed Days Lost	Nature of Outbreak/ incident (Include Organism)
1	05/05/2017 – 06/05/2017	Nelson	2	06/05/2017	NA	6	Cdt identical ribotypes (O)
	20/04/2017- 29/05/2017	Tennyson	6	04/05/5017	NA	4	MRSA colonisation – identical SPA types(O)
	19/05/2017.	Dickens	8	na	na	na	Pulmonary TB (I) no follow up required.
2	15/09/2017	Main Theatre	1	na	na	na	Sporadic CJD(I) No follow up

							required
3	22/09/17	Keats	5	03/10/17	na	16	MRSA colonisation (O)
4	12/10/17	Tennyson	1	na	na	na	Suspected CPE (urine), known CPE
	21/12/17 – 27/12/17	Tennyson	9	21/12/17 /	na	16	Gastroenteritis, confirmed Norovirus 21/12/17

Table No 6: *Quarterly Outbreaks / Incidents 2017 to 2018*

Gap analysis against criteria: Compliant

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

6.1 Essential Training Infection Prevention and Control

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

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

6.2 Induction

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

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

6.3 Other Infection Control Training

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

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

6.4 Contractors/Estates

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

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

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

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

6.5 Group and Committee Membership

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

Internal:

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

External:

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

Gap analysis against criteria: Compliant

Compliance Criterion 7: Provide or secure adequate isolation facilities.

7.1 Isolation Rooms

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

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

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

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

Gap analysis against criteria: Partial compliance as not all side rooms have en-suite facilities. Risk assessments carried out on all patients requiring isolation.

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

8.1 Microbiology Department

The Microbiology Department has full CPA accreditation. The IPCT work alongside the Microbiology team. The Infection Control Nurses meet with the Consultant Microbiologists on a daily basis, promoting excellent collaboration which expedites timely interventions in patient management and ensures a consistent approach to enhance patient safety. The microbiology service is available seven days a week. In 2018 the department will be merging with Darent Valley Hospital. The IPCT on both sites will work collaboratively to standardise processes and protocols as much as possible.

Gap analysis against criteria: Compliant

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

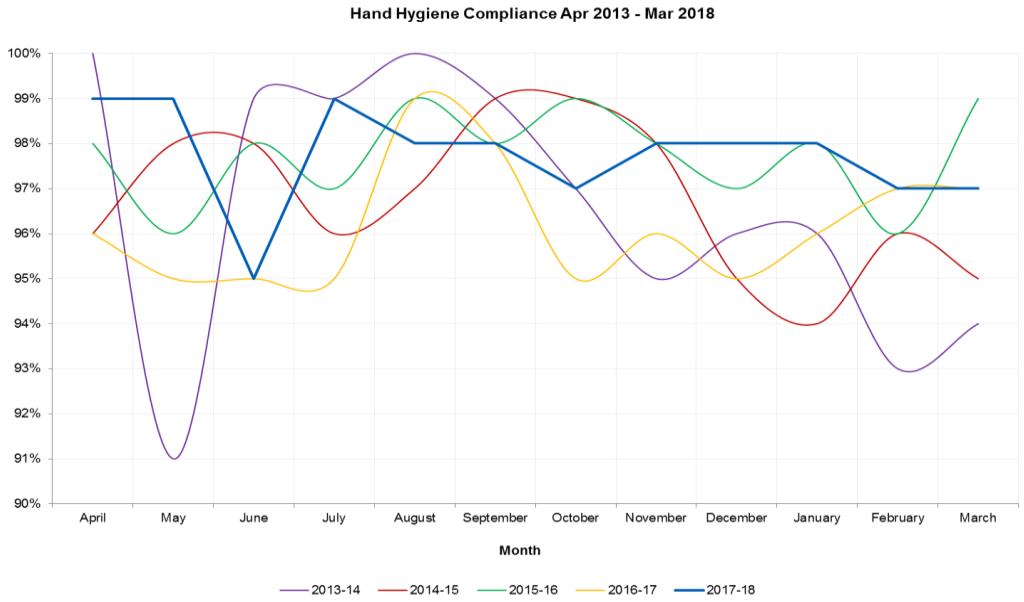
9.1 Policies

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

Appendix 5 – IPC Policies

Adherence to policy is assured via a number of IPCT audits.

9.2 Hand Hygiene



Graph No. 2: *Monthly Trust Hand Hygiene Compliance 2013 to 2018*

9.3 Commodes

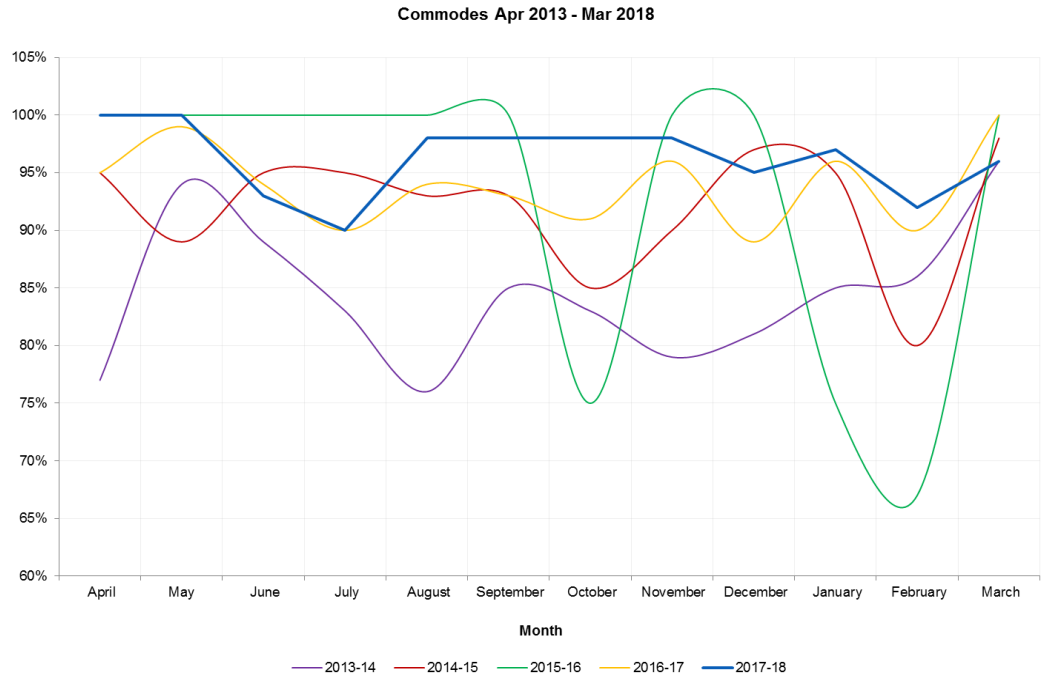
The IPCT undertake monthly unannounced commode audits and have been trained in the process. Any area not achieving 100% is re-audited daily until the target is met. The Senior Sister/Charge Nurse is responsible for completing an action plan to address any issues identified.

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

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

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

The overall score for 2017–18 is 94%



Graph No. 3: *Monthly Trust Commode Scores 2013 to 2017*

9.4 Isolation

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

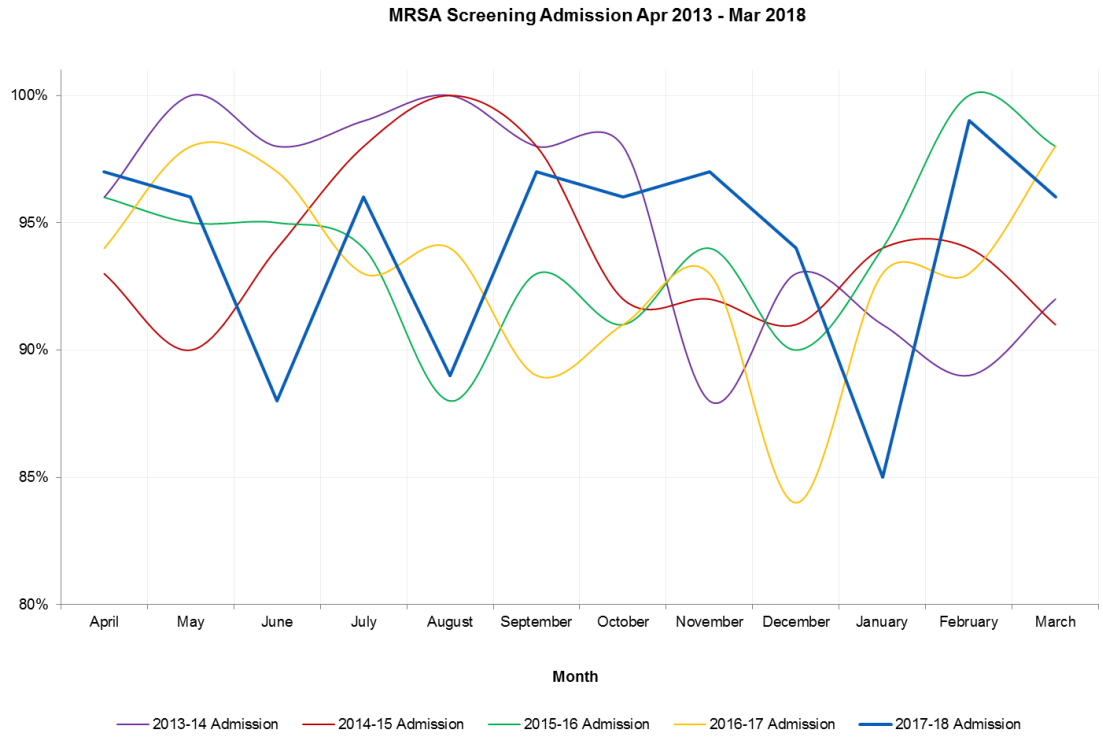
9.5 MRSA Screening

MRSA screening is undertaken as per national guidelines to:

a. Reduce the risk of transmission to other patients
b. Reduce the risk of infection on the individual

9.5.1 Admission Screening

Admission screening is mandatory for all admissions and transfers into the Trust with the exception of Paediatrics and Maternity, where only high risk patient categories are screened. The IPCT undertake monthly audit of compliance. The standard set is a minimum of 95%. This year we scored 96%. Staff who undertakes screening must complete screening competencies.

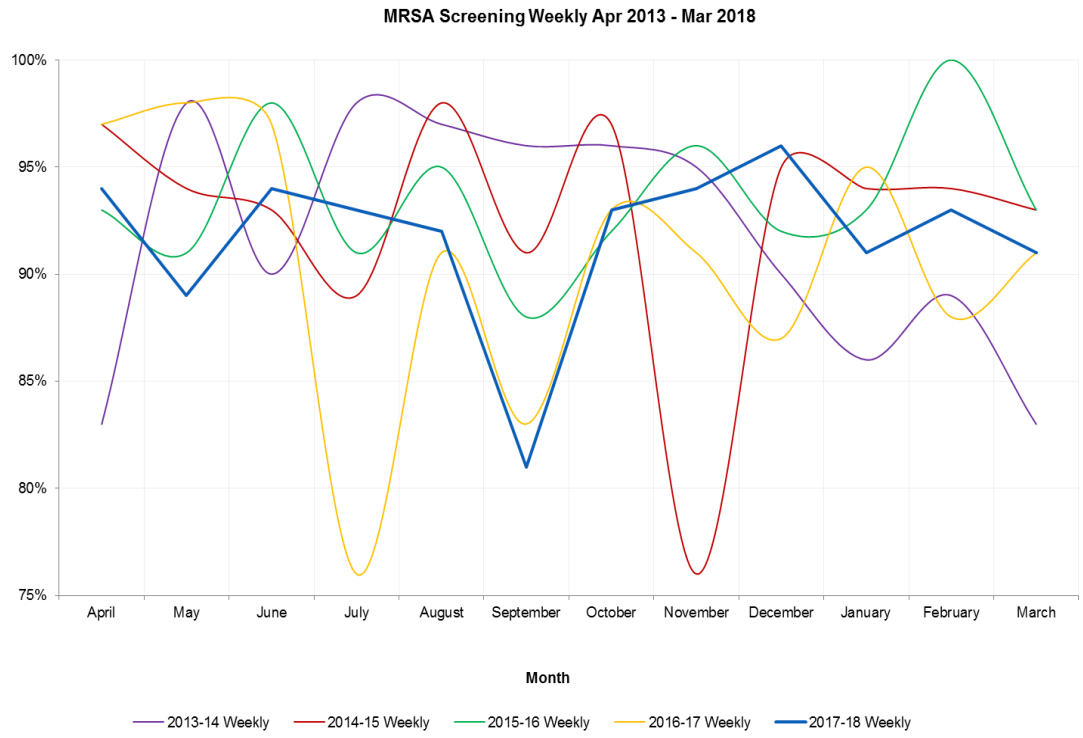


Graph No. 4: *Monthly Average MRSA Admission Screening Scores 2013 to 2018*

9.5.2 Weekly Screening

Screening for MRSA colonisation is carried out as per national guidelines. All adult patients that remain in hospital for more than one week are screened for MRSA colonisation. Paediatric and Maternity patients are only screened if they fall into a high risk category, circulated monthly as part of the data set.

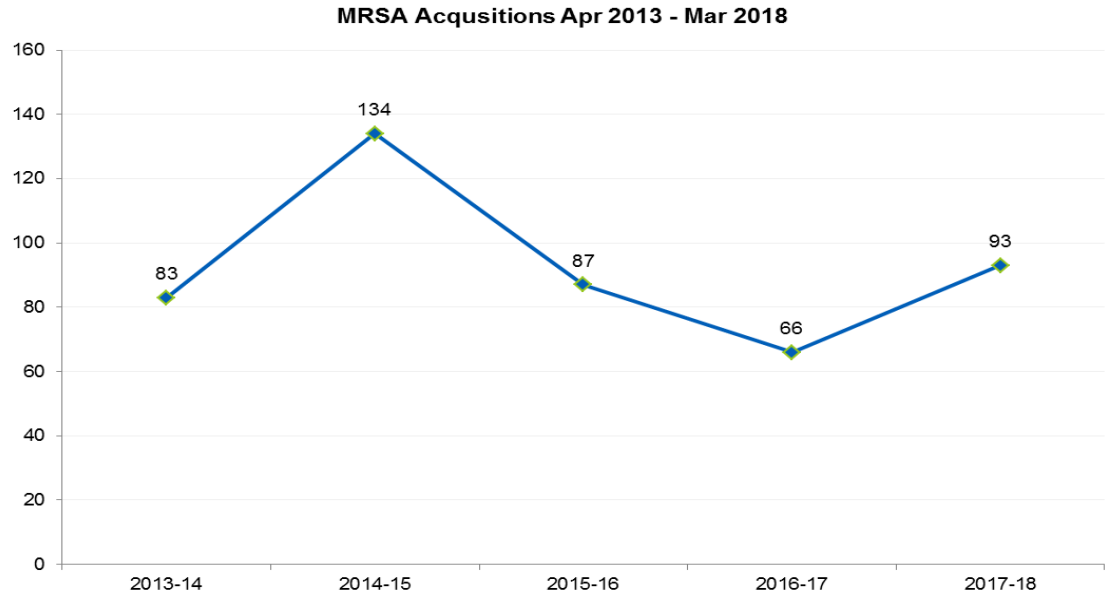
Any exception to the screening is fed back in writing with the rationale to the Ward Manager, Matron and Deputy Director of Nursing for action.



Graph No. 5: *Monthly Average MRSA Weekly Screening Scores 2013 to 2018*

9.5.3 Post 48 Hour MRSA acquisitions

The majority of these cases were in the Unplanned and integrated care directorate.



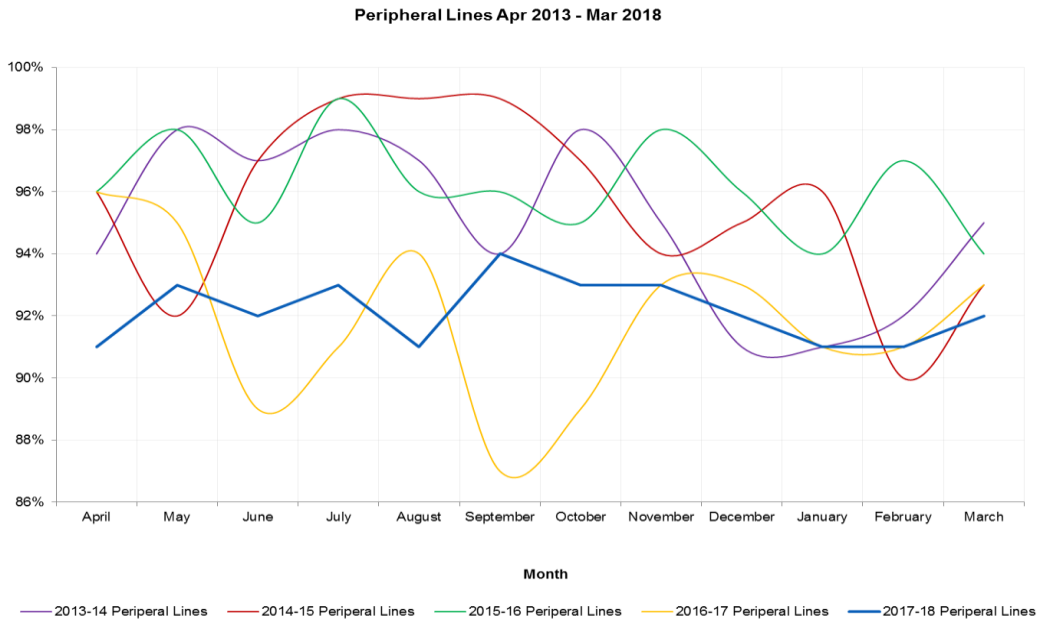
Graph No. 6: *Post 48 hour MRSA Acquisitions 2013 to 2018*

9.6 Saving Lives High Impact Interventions

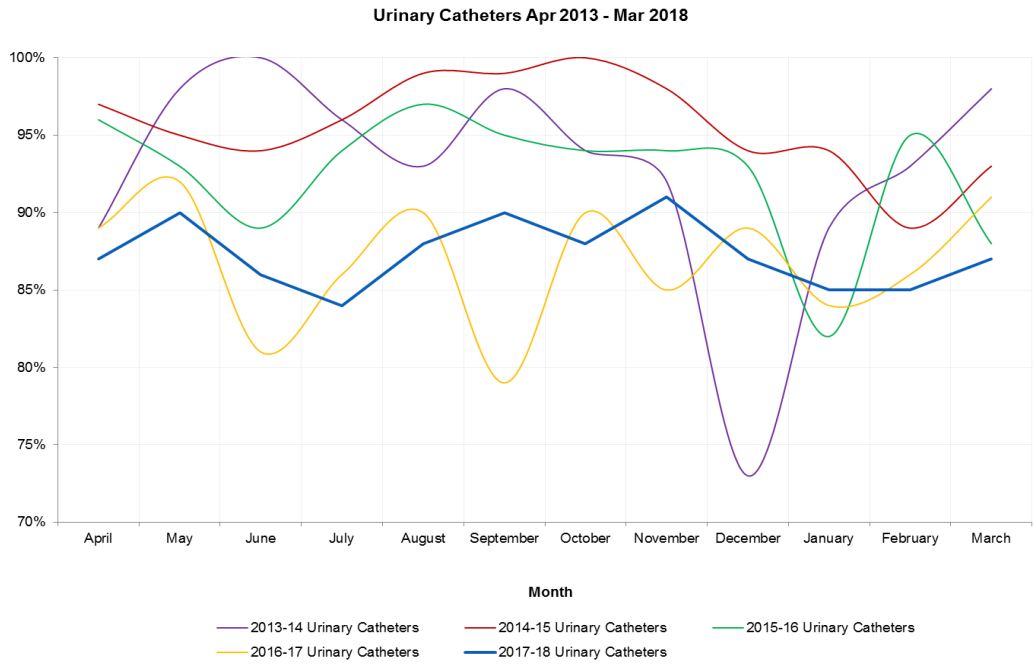
The Trust continues to utilise the Saving Lives High Impact Interventions (HII) or care bundles as an important element of its Health Care Associated Infection reduction strategy. The HII's are undertaken for all patients with peripheral vascular devices, central venous devices and urinary catheters.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

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

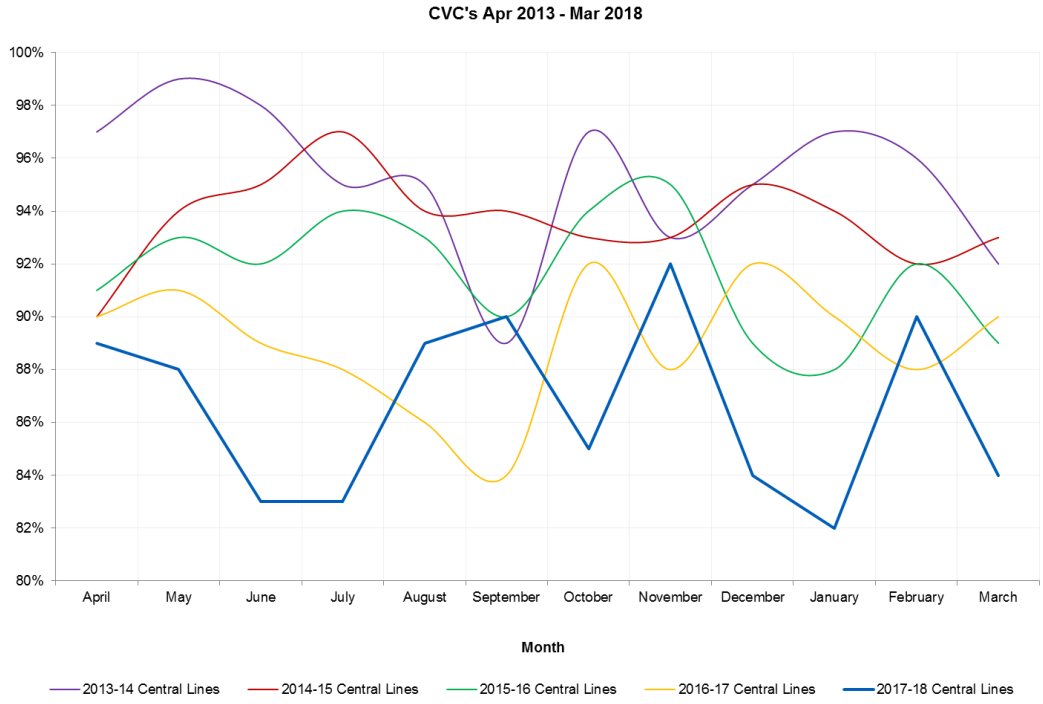
- The trust overall score for urinary catheters was 87%
- The trust overall score for peripheral venous catheters was 92%
- The trust overall score for central venous catheters was 84%



Graph No. 7: *Saving Lives Compliance - Peripheral Lines Ongoing Care 2013 to 2018*



Graph No. 8: *Saving Lives Compliance - Urinary Catheters Ongoing Care 2013 to 2018*



Graph No. 9: *Saving Lives Compliance - Central Venous Catheters Ongoing Care 2013 to 2018*

9.7 Safety Thermometer

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

In April last year, the HOUDINI protocol was introduced into the Trust. This is a nurse led program to ensure the appropriate insertion, timely removal and appropriate use of urinary catheters. The name is an acronym to help staff remember the indications for insertion and removal of catheters. If no indications are identified, consideration should be given to catheter removal, or alternative management. The evidence suggests that use of this protocol by nursing staff in the UK reduces catheter usage and CAUTI, with usage falling by 17% in one study. However, we have not yet seen a reduction in the number of urinary catheters inserted in the Trust and the incidence of new onset catheter associated urinary tract infection has remained relatively unchanged. This will be an area of focussed work in 2018-2019.

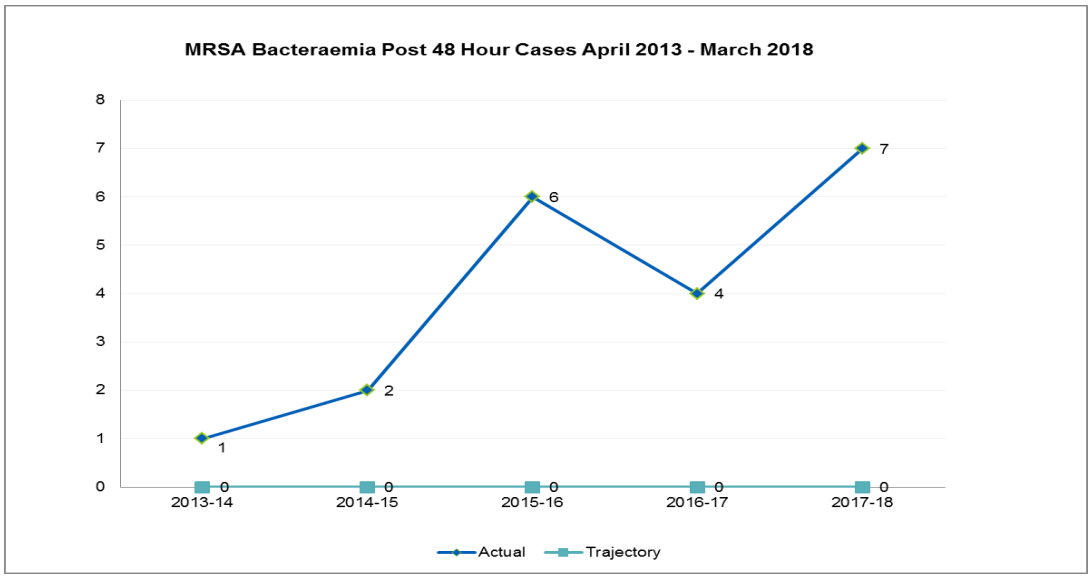
9.8 National Targets/Monitor targets

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

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

9.8.1 MRSA Bacteraemia

This year there were seven trust apportioned MRSA cases



Graph No. 10: *MRSA Bacteraemia Post 48 Hour Cases 2013 to 2018*

9.8.2 MRSA Bacteraemia Post 48 Hour Reduction Trajectory

Zero Tolerance

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Trust attributed	0	0	0	0	1	1	3	1	0	0	1	0	**7**
CCG attributed	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Third party attributed	1	0	0	0	0	1	1 (P)	0	0	0	0	0	**2 + 1 (P)**

(P) = provisional assignment

9.8.3 Clostridium *difficile* Associated Diarrhoea (CDAD)

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

Mandatory reporting of cases of C.diff are classified as pre or post 72 hours depending on the date of the sample. Therefore any sample taken after 72 hours of admission is assigned to the Trust trajectory. The Trust had 26 cases against a trajectory of 20 for this year.

All post 72 hour cases are reviewed by the IPCT and the clinical team ream responsible for the patient to determine if there have been any lapses of care. External assurance is provided when these cases are discussed at the North Kent Health Care Associated Infection (HCAI) assurance meetings that are held monthly. Of the 26 cases, many were considered to be unavoidable

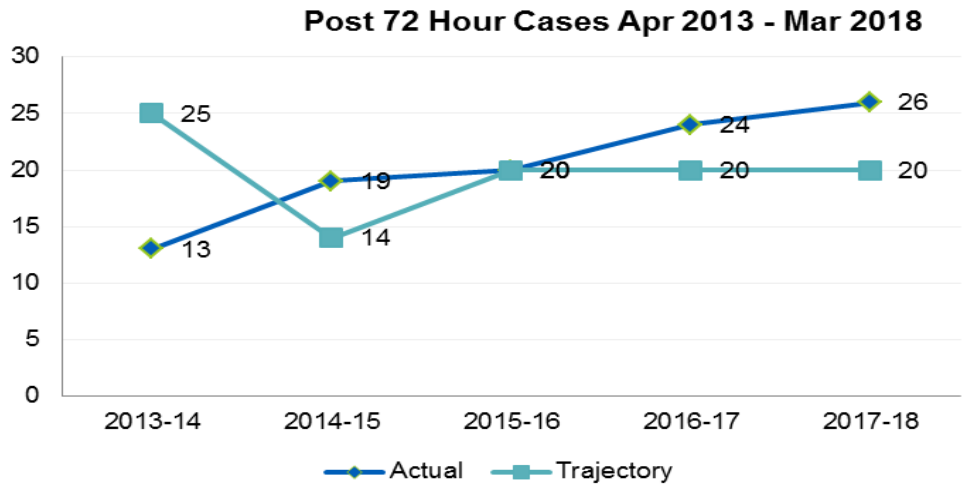
We take level 1 and 2 lapses of care seriously as we believe these would prevent progression to level 3. The main issues arising and lapses of care (LOC) identified from the Post Infection Reviews (PIRs) are summarised below.

	Date	Attributed to	Ribo type	Avoidable / Unavoidable	Lapses of care consideration	LOC level
1	01.05.17	Nelson	T070	Unavoidable		
2	03.05.17	Nelson	T070	Avoidable	Cross transmission	3
3	08.05.17	Ambulatory Care	T087	Avoidable	Inappropriate antibiotic	2
4	08.06.17	ICU	T002	Unavoidable		
5	12.06.17	Will Adams		Unavoidable		
6	13.06.17	Byron	T014	Unavoidable		
7	14.06.17	Keats	T023	Unavoidable		
8	15.06.17	Nelson	T216	Unavoidable		
9	17.06.17	Arethusa	T078	Avoidable	Irrational antimicrobial prescribing & poor stewardship	3
10	16.07.17	Arethusa	T023	Unavoidable		
11	29.08.17	Milton	Spor	Avoidable	Antimicrobial stewardship	2
12	05.09.17	Tennyson	Spor	Avoidable	Antimicrobial stewardship	2
13	11.09.17	Bronte	T023	Avoidable	Antimicrobial stewardship	2
14	26.09.17	Ambulatory Care	T056	Unavoidable		
15	19.10.17	Arethusa	Not sent	Unavoidable		
16	14.11.17	Will Adams	T023	Avoidable	Antimicrobial stewardship	3
17	06.12.17	Wakeley	T014	Avoidable	Missed opportunity to discontinue antimicrobial therapy earlier	2

18	16.12.17	Milton	T023	Avoidable	Secondary diagnosis	1
19	24.12.17	Harvey	T005	Unavoidable		
20	26.12.17	Lawrence	T023	Avoidable	Missed opportunity to discontinue antimicrobial therapy earlier	2
21	05.1.18	Victory	T002	Unavoidable		
22	21.01.18	Milton	T078	Unavoidable		
23	21.01.18	Milton	T002	Avoidable	Antimicrobial stewardship and sepsis protocol remiss	2
24	07.02.18	Byron	T014	Unavoidable		
25	17.02.18	McCulloch	T014	Unavoidable		
26	26.03.18	Phoenix		Unavoidable		

Table No 7: *Post 72 hour Cdt cases 2017–2018*

Wards that have cases of post 72 hour C.diff are placed into enhanced measures where patient care, infection control precautions and environmental issues are reviewed. Directorates are responsible for putting actions in place to address any issues uncovered at post infection review as well as sharing best practice.



Graph No. 11: *Post 72 hour Clostridium difficile cases 2013 to 2018*

9.8.4 CDT trajectory

The trust target of CDAD cases for 2017-18 was no more than 20 cases. The Trust reported 26 cases. 13 out of 24 cases to date are considered unavoidable.

	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Pre 72 Hour	2	9	6	5	9	7	8	6	6	4	2	9	74
Post 72 Hour	0	3	6	1	1	3	1	1	4	3	2	1	26
Trajectory	**1**	**2**	**2**	**2**	**1**	**2**	**1**	**2**	**2**	**2**	**1**	**2**	**20**

There have been 24 post infection reviews undertaken so far, with 3 cases level 3 lapses of care. These cases will incur a £10,000 fine per case.

The trends and themes identified:

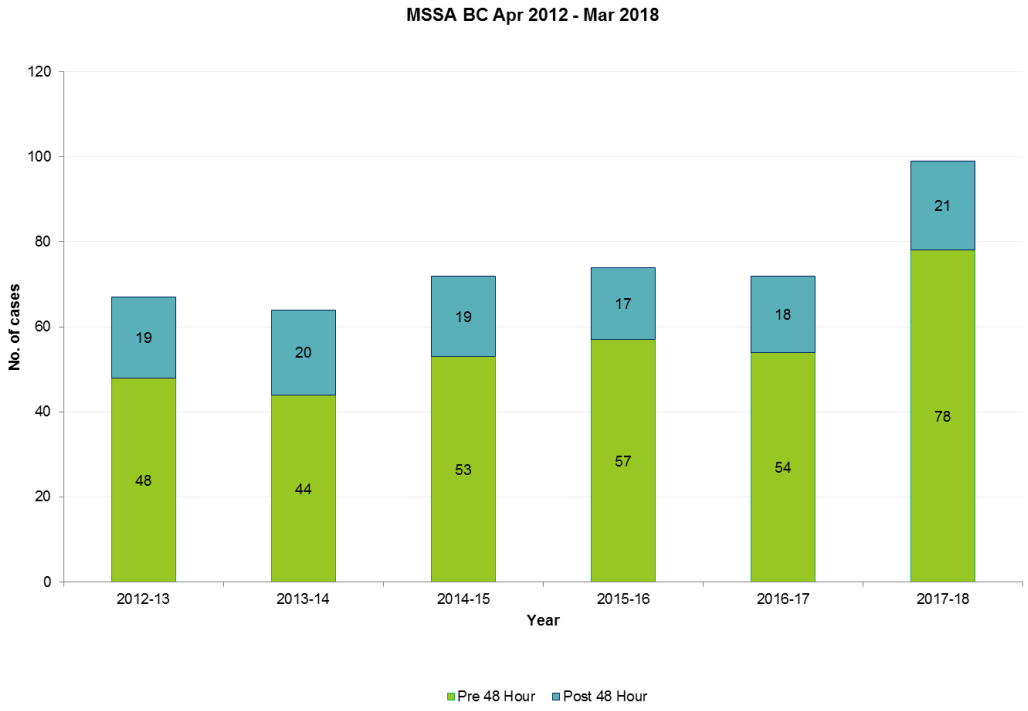
- Irrational antimicrobial prescribing / poor antimicrobial stewardship
- Timeliness of stool samples and incomplete risk assessment / time to isolation.
- Delay in empirical treatment with metronidazole.
- Poor diagnoses with subsequent inappropriate antimicrobial therapy.

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

9.8.5 Methicillin Sensitive *Staphylococcus aureus* (MSSA)

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

There were a total of 21 post 48 hour MSSA bacteraemia cases in the year.



Graph No. 12: *MSSA Bacteraemia Pre v Post 48 Hour 2012 to 2018*

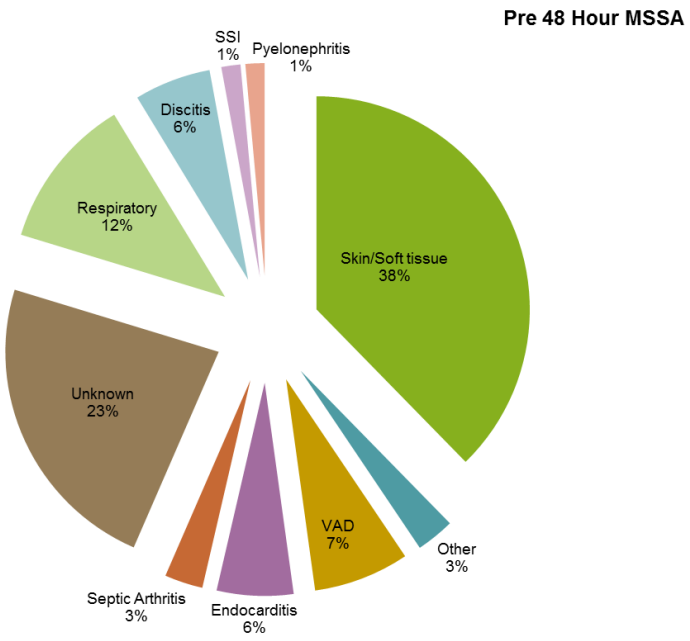


Chart No. 1: *MSSA Bacteraemia Pre 48 Hour Sources 2017 to 2018*

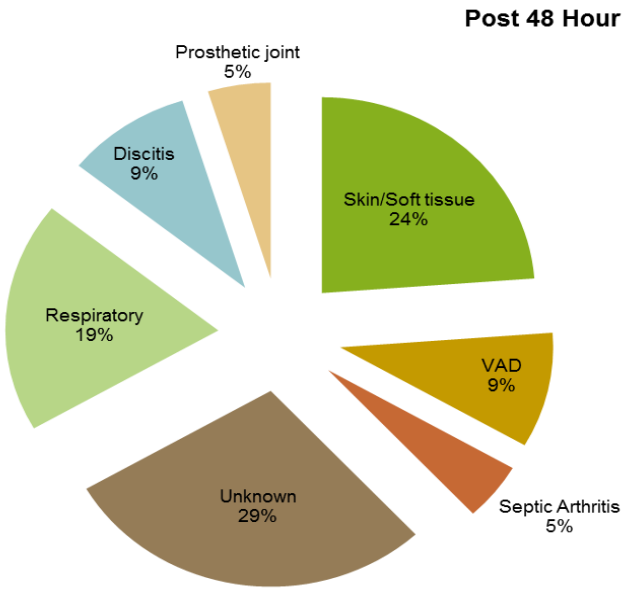
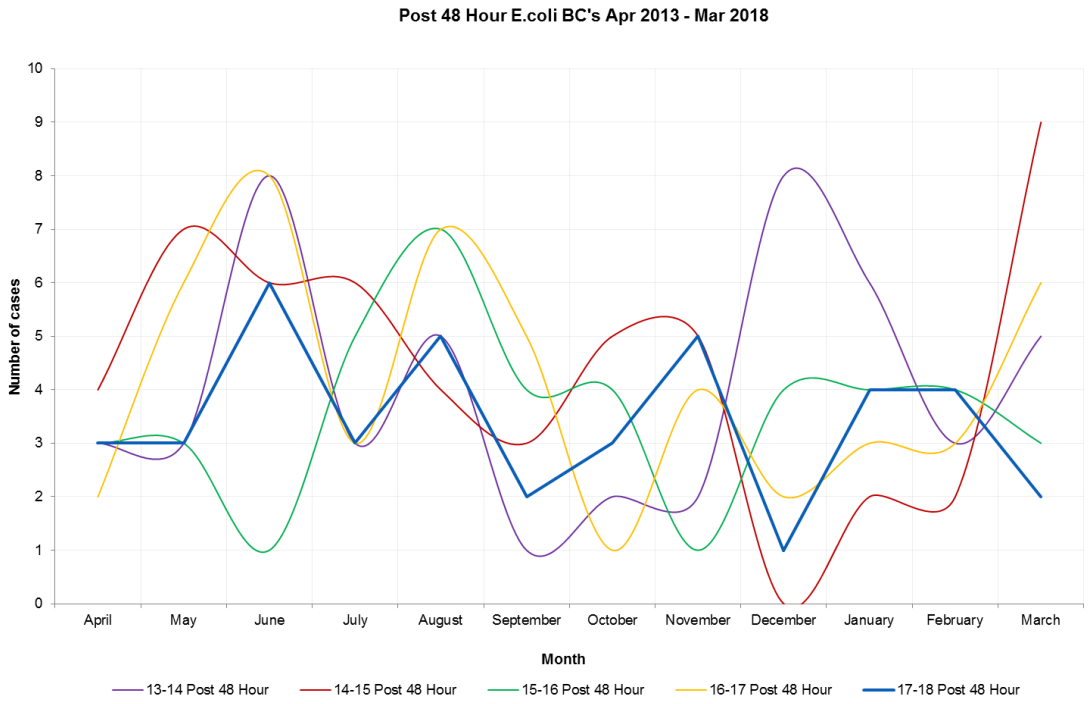


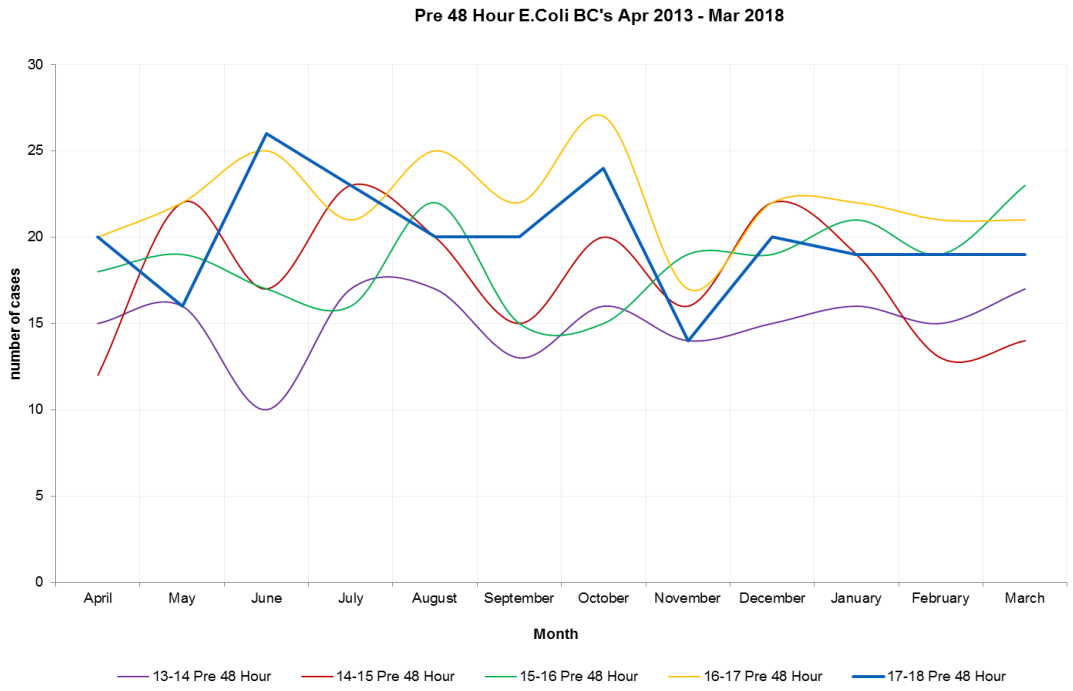
Chart No. 2: *MSSA Bacteraemia Post 48 Hour Sources 2017 to 2018*

9.8.6 *Gram Negative* Blood Cultures

There is a national requirement to reduce the number of gram negative bacteraemia by 50% by 2021.There was a total of 71 post 48 hour bacteraemia cases this year. The IPCT scrutinise each case to ascertain the likely source, with particular interest in any catheter related urinary tract infection (CAUTI) which would then require a post infection review. The majority of all cases are related to endogenous urinary tract/intra-abdominal infections. A small proportion of these are catheter associated and would qualify as healthcare associated, which will be the focus of target reduction in the years to come. IPCT teams across Kent and Medway from acute care are working alongside their community colleagues to look at strategies to reduce these, in particular the management of patients with urinary catheters.



Graph No. 13: *Post 48 hour Escherichia Coli (E-Coli) Blood Cultures 2013 to 2018*



Graph No. 14: *Pre 48 hour Escherichia Coli (E-Coli) Blood Cultures 2013 to 2018*

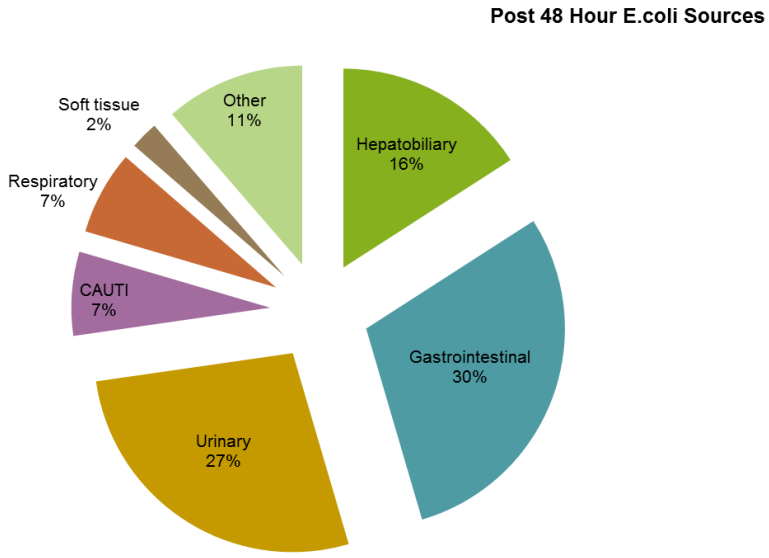


Chart No. 3: *Post 48 hour Escherichia Coli (E-Coli) Sources 2017 to 2018*

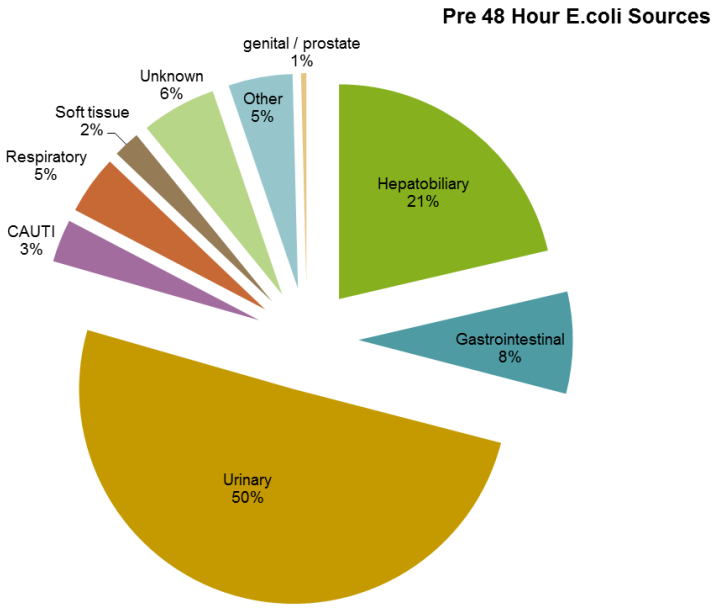


Chart No. 4: *Pre 48 Hour Escherichia Coli (E-Coli) Sources 2017 to 2018*

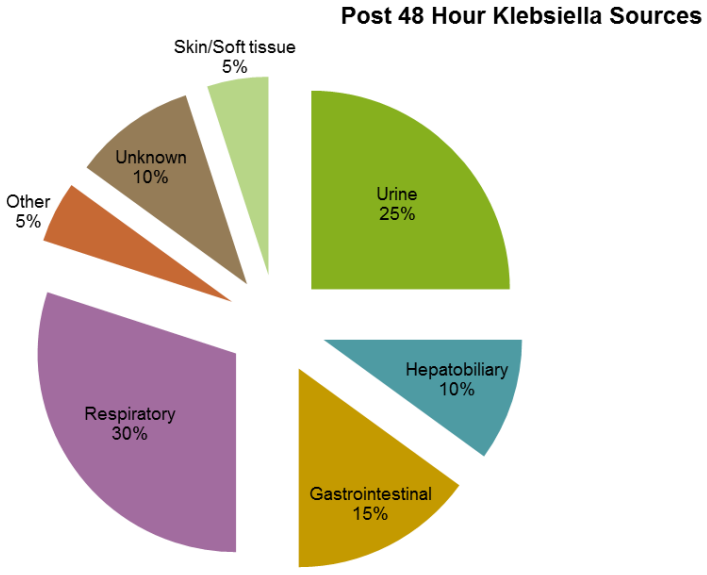


Chart No. 5: *Post 48 Hour Klebsiella Bacteraemia Sources 2017 to 2018*

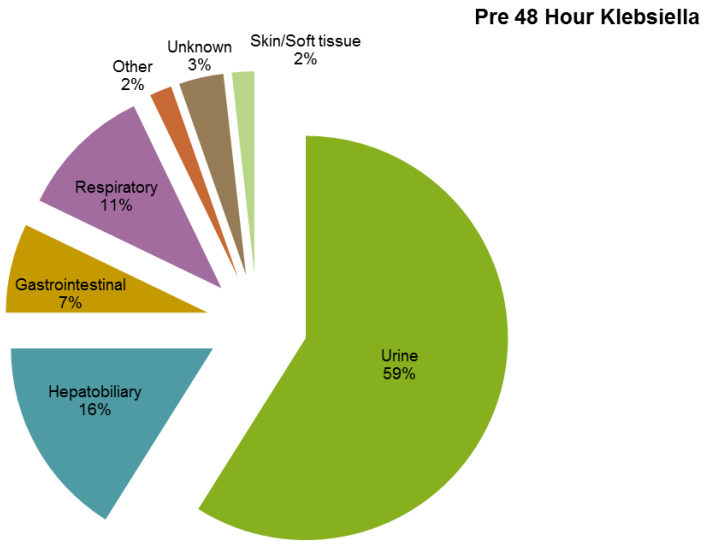


Chart No. 6: *Pre 48 Hour Klebsiella Bacteraemia Sources 2017 to 2018*

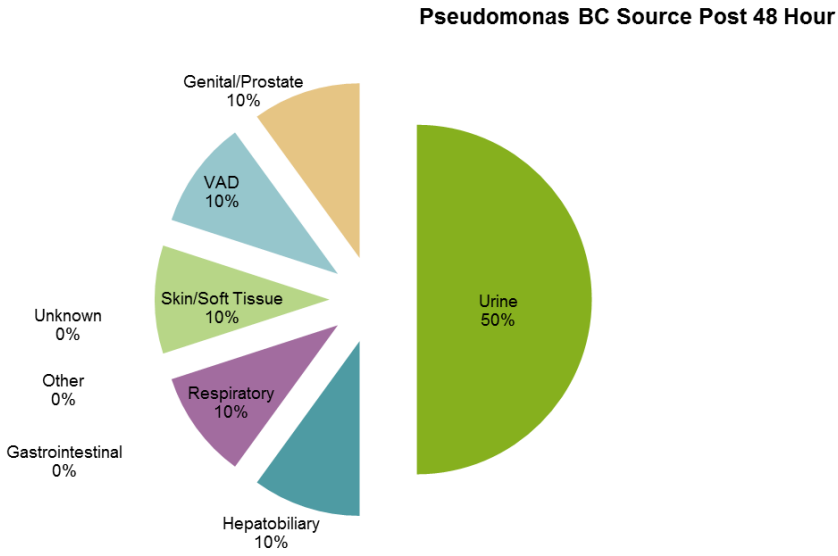


Chart No. 7: *Post 48 Hour Pseudomonas Bacteraemia Sources 2017 to 2018*

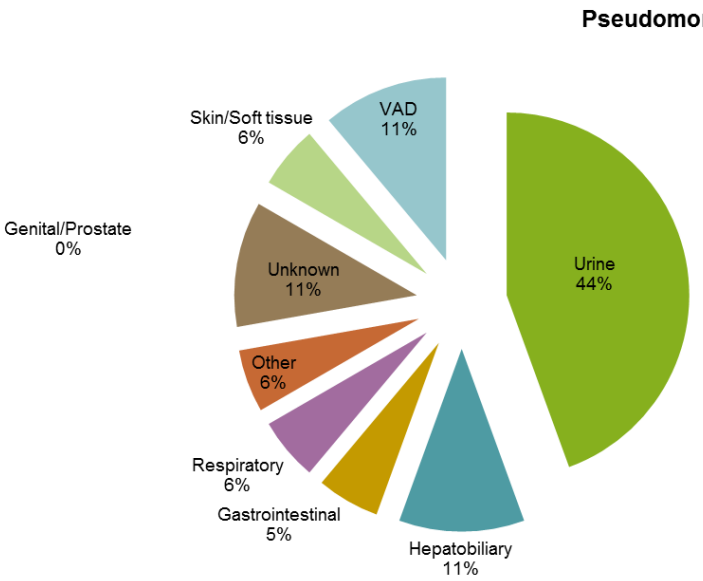


Chart No. 8: *Pre 48 Hour Pseudomonas Bacteraemia Sources 2017 to 2018*

9.8.7 Glycopeptide Resistant Enterococci (GRE)

The Trust continues to screen admissions to Lawrence Ward for GRE colonisation as a marker of good infection control precautions on the unit;

9.8.8 Meningitis

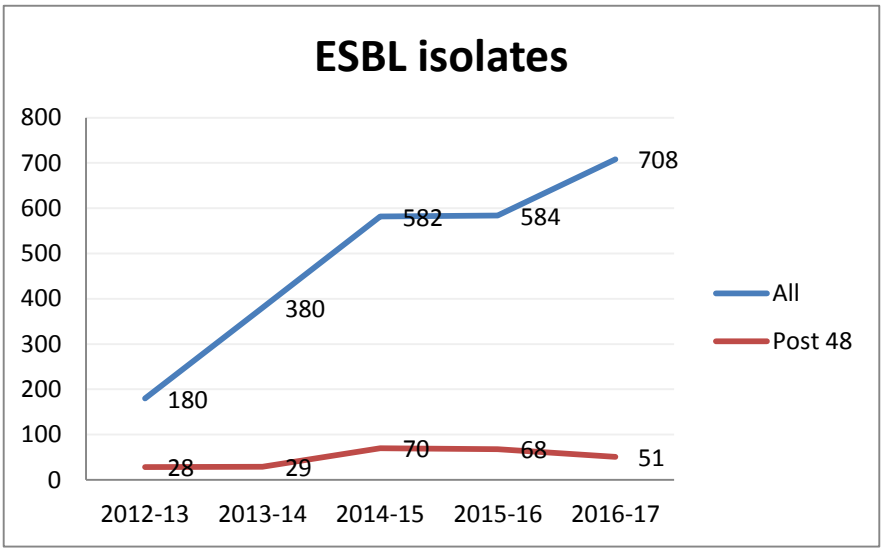
All meningitis cases are notified to the Health Protection Unit in addition to the Infection Control precautions that are instigated.

9.8.9 Tuberculosis (TB)

The IPCT work closely with the Chest Clinic team to ensure correct management of all TB cases. The Team review all inpatients with confirmed/suspected PTB. Numbers have remained steady.

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

The Trust continues to see an increase in the incidence of ESBL cases across the whole health economy in urinary isolates and this is anticipated to become an increasing concern over the next few years. Cases in hospital are followed by the IPCT and isolation precautions taken as per Trust policy. This is a significant risk in the elderly population in patients with urinary catheters. Although the number of urinary isolates is steadily increasing our blood culture isolates remain lower than the PHE published national average of 10%.



Graph No. 15: *All ESBL Isolates 2012 to 2018*

9.8.11 Carbapenemase producing enterobacteriaceae (CPE).

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

Gap analysis against criteria: Compliant

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

10.1 Occupational Health Department

The Trust has an Occupational Health Service and undertakes a comprehensive staff health screening programme including vaccinations and health surveillance The IPCT work in close collaboration with the Occupational Health Team.

A flu immunisation programme was delivered in 2017-2018 and the Trust achieved a 71% uptake of the vaccination.

Gap analysis against criteria: Compliant

SUMMARY

This report demonstrates the continued commitment of the Trust and evidences the successes and service improvements achieved through the leadership of a proactive and dedicated IPC team. It is also a testament to the commitment of a Trust workforce dedicated to keeping IPC high on everyone's agenda. A key priority for the IPC team is to work to a Trust wide approach for all IPC activity as recommended in the internal audit.

The Trust remains committed to preventing and reducing the incidence and risks associated with HCAIs and recognises that we can do even more by continually working with colleagues across the wider health system, patients, service users and carers to develop and implement a wide range of IPC strategies and initiatives to deliver clean, safe care in our ambition to have no avoidable infections.

Our priorities for 2018-2019 include

- Response to CQC inspection findings
- Response to PLACE and internal audit findings
- Antimicrobial stewardship
- Identification and management of sepsis
- Staff flu vaccination programme
- Catheter practice

Looking forward to 2018-19, Medway NHS Trust staff will continue to work hard to embed a robust governance approach to IPC across the whole organisation and the IPC team and all staff will continue to work hard to improve and focus on the prevention of all healthcare associated infections.

Appendix 1

Terms of Reference

Infection Control & Antimicrobial Stewardship Group

1. Purpose

1.1 The purpose of this group is to maintain an overview of infection prevention and control / Antimicrobial prescribing priorities within the Trust, and to link this into the clinical governance structures of directorates in order to meet the regulatory and legislative requirements associated with this area of work.

2. Constitution

2.1 The Infection Control & Antimicrobial Stewardship Group is established on the authority of the Quality Improvement Group which reports to the Executive Group.

3. Authority

3.1 The group is authorised by the Quality Improvement Group (QIG) to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Infection Control & Antimicrobial Stewardship Group

3.2 The Infection Control & Antimicrobial Stewardship Group is also authorised to implement any activities which are in line with the terms of reference, as part of the Patient Experience Strategy work programme.

4. Accountability

4.1 The Group will report to the Quality Improvement Group which in turn reports to the Executive Group.

4.2 Any matters requiring Board approval under the Trust's Scheme of Delegation and Reservation will be submitted to the Board via the Executive Group

4.3 The Chair of the Infection Control & Antimicrobial Stewardship Group will provide a quarterly report to the Quality Improvement Group on issues and progress through the production of a Key Issues Report following each Infection Control & Antimicrobial Stewardship Group meeting.

5. Chairperson

5.1 The Chair of the Group will be the Director of Infection Prevention and Control and Antimicrobial Stewardship.

5.2 The Deputy Director of Infection Prevention and Control will be the Deputy Chair.

6. Membership

6.1 The membership of the Infection Control & Antimicrobial Stewardship Group will consist of the following:

Director of Infection Control and Antimicrobial Stewardship*
Head of Infection Control/Deputy Director of Infection Prevention and Control *
Consultant Microbiologist *
Specialist Antimicrobial Pharmacists*/Head of Pharmacy
Director of Nursing – Executive Lead
Programme Infection Control / Antimicrobial Stewardship Consultant lead
Head of Occupational Health
Head of Estates
Head of facilities
Directorate Deputy Directors of Nursing,
Chair of decontamination Group
Chair of Water safety group.

7. Attendance is expected from:

7.1 There is a requirement for members to attend all meetings and a minimum 75%. A designated deputy must attend on behalf of a member. They must come prepared and have sufficient authority to make decisions on behalf of the group member.

7.2 Other attendees from relevant directorates/ services may be invited to attend as and when appropriate.

7.3 Depending on agenda items others representatives from CCG and Kent, Surrey & Sussex, Health Protection, Public Health England Centre may be invited to attend as and when appropriate.

8. Quorum

8.1 The meeting will be quorate provided that five members are present (the Infection Prevention and Control Team* count as one member). The Clinical Directorates must be adequately represented.

9. Frequency

9.1 Meetings will be held every quarter

9.2 The Group will be convened in an emergency as required.

10. Key responsibilities

10.1 To provide assurance to the QIG that the Trust is compliant with mandatory reporting of HCAI's and statutory regulations, eg Health and Social Care Act 2008, Care Quality Commission, CQUIN targets etc.

10.2 Review and monitor Trust performance against national and local targets via the HCAI Key Performance Indicators (KPI) including MRSA blood stream infections and *Clostridium difficile* reduction.

10.3 To receive and approve the Infection Control and Antibiotic Stewardship work and audit programmes.

10.4 To escalate risks associated with Infection Prevention Control and Antimicrobial Stewardship issues, ensuring that there are appropriate plans in place to mitigate those risks and to ensure that these are recorded on the appropriate risk register.

10.5 Promote responsible prescribing across the Trust and receive reports on antimicrobial stewardship programme of audit, feedback, surveillance and education.

10.6 Maintain and monitor the Antimicrobial Stewardship Policy. Advise, as required, the Medicines Management Group on restricted antimicrobial consumption. Review the release of new antimicrobials and monitor its use.

10.7 To receive assurance from the Directorates that Infection Prevention and Control/antimicrobial stewardships risks are identified, discussed at their respective governance meetings and plans drawn up to mitigate the risks. This will be presented in the form of exception reports from each of the Directorates and specialist support services on a designated template report. This report should be sent to the secretary of the IPC/ AMS group one week before the meeting.

10.8 To monitor the establishment and performance of surgical site infection surveillance programme (mandatory and non-mandatory) across Surgical specialities and Obstetrics and Gynaecology.

10.9 To review and monitor the activities (including the attendance register and minutes) from the following sub-groups: the Water Safety Group and the Decontamination Group by means of receipt of a Key Issues Report following each meeting

10.10 To ratify infection control and antimicrobial policies, procedures and guidelines and maintain a rolling programme of updates

10.11 To receive and approve the Infection Control Team's Annual Report before it is presented to the QIG.

10.12 Deliver a robust assurance programme that holds directorates and support specialties to account and provide feedback to the QIG.

10.13 To work collaboratively with our CCG's on both Infection Control and Antibiotic Stewardship in the community

11. Process for Monitoring compliance with Terms of Reference

11.1 Compliance will be monitored by reports on progress, regular agenda items covering the assurance plan for the Group and by producing quarterly Key Issues Reports to the Quality Improvement Group.

12. Links to other meetings

12.1 Water Safety Group

12.2 Decontamination Group

12.3 Quality Improvement Group

13. Review Date

13.1 All Terms of Reference will be reviewed annually.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Terms of Reference	Reviewed by way of an annual report	Chair	Quality Improvement Group	Where gaps are recognised, action plans will be put into place; key issues will be escalated to the Quality Improvement Group
Programme of Work	Via Key Issues Report quarterly	Chair	Quality Improvement Group	Where gaps are recognised, action plans will be put into place; key issues will be escalated to the Quality Improvement Group
To review and monitor the activities (including the attendance register and minutes) from the following sub-groups: the Water Safety Group and the Decontamination Group	By means of receipt of Key Issues Reports following each meeting	Chair	Quality Improvement Group	Where gaps are recognised, action plans will be put into place; key issues will be escalated to the Quality Improvement Group

Appendix 2

Infection Prevention and Control Work Programme 2017 - 18

Introduction: This work programme is a requirement under the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance. Produced for the Chief executive and trust board it describes the programme of work planned for 2017 – 18.

Priority	Action	Responsible Person	Frequency /review	Reporting/Assurance
1	To undertake mandatory reporting of all relevant organisms: C.diff; MRSA, MSSA, Gram negatives - E-Coli, Pseudomonas Klebsiella.	Head of Infection Control/ Deputy DIPC	Monthly	National HCAI Data capture system monthly. Monthly via monthly stats. Quarterly to Infection control and antimicrobial stewardship group (ICAS) and QIG
1	Review the effectiveness of the MRSA bacteraemia, Clostridium *difficile* and Gram negative bacteraemia reduction strategies to meet and exceed national targets. Zero tolerance for MRSA bacteraemia No more than 20 cases of C.diff toxin	Head of Infection Control/ Deputy DIPC	Monthly	Quarterly report to ICAS and QIG
1	To provide an efficient, proactive Infection Prevention and Control service to meet the Trust's requirements.	Head of Infection Control/ Deputy DIPC	Quarterly	ICAS
1	To undertake surveillance of alert organisms (Resistant Organisms, Tuberculosis and Norovirus) and provide accurate timely data to the Directorates.	Head of Infection Control/ Deputy DIPC	Monthly	Monthly Stats Reported to ICAS quarterly
1	To undertake a comprehensive audit programme to meet the requirements of regulations and to identify areas of potential risk for the Trust (attached).	Head of Infection Control/ Deputy DIPC	Quarterly	ICAS
1	To provide Infection Prevention and Control training programme to ensure all staff receive appropriate training from induction and annual updates (including hand hygiene) and support new Trust training days.	Head of Infection Control/ Deputy DIPC	Monthly	Learning and Development report via MOLLIE. Directorate reporting of training uptake quarterly at ICAS
1	Support the Directorates in undertaking PIR's/RCA's for all hospital acquired Clostridium *difficile*, MRSA Bacteraemias, SUI's and outbreaks.	Head of Infection Control/ Deputy DIPC & IPC Team	As required	Completed PIR's Directorate action plans reported to ICAS, Performance review meetings (PRM's) and QIG
1	Clinical review by IPCT of every inpatient with MRSA / Clostridium *difficile* / GRE / CPE / GDH/ any other alert organisms colonisation or infection. Any key no compliance issues identified, IPCT will liaise with the directorates to address this	Head of Infection Control/ Deputy DIPC	Daily	Medical Notes completed in real time. Real time Verbal feedback and Written feedback to directorates Directorate action plans monitored at PRM's and exception reporting to ICAS
1	To identify and lead the management of	Head of Infection Control/ Deputy	As they occur	Outbreak meeting minutes. ICAS.

	outbreaks.	DIPC		
1	Provide specialist advice on decontamination issues.	Decontamination Lead	As required	Quarterly decontamination committee
1	Ensure the Trust is compliant with the CQC Registration, NHSLA compliance and provide assurance to the Trust Board	DIPC	As required	
1	Provide the strategy for antimicrobial stewardship.	DIPC	Annually	ICAS
1	Provide policy, training and education for new and emerging threats	Head of Infection Control/ Deputy DIPC	As required	New policies ICAS
1	Maintain the HCAI Data Capture System data base for the Trust ensuring timely updated and enhanced fields are all entered.	Head of Infection Control/ Deputy DIPC and PA to Head of IPC	Per case	Monthly lock down of HCAI data by IPCT on behalf of Chief Executive monthly
1	In partnership with housekeeping introduce RAG rated decontamination protocol with new vaporised hydrogen peroxide and ultra violet light technology for specific organisms and report usage	Head of facilities	Monthly	Quarterly decontamination committee
1	Review and sustain hand hygiene campaign to raise further awareness throughout the trust	Head of Infection Control/ Deputy DIPC	Monthly	
1	Undertake RCA on all: Gram negative Blood Cultures with E.coli, Pseudomonas and Klebsiella. (if Catheter / invasive procedure related then PIR), liaising with CCG and community Infection control leads with the aim of reducing community acquired bacteraemia by 10% MSSA blood cultures (if SSI or CVC related then PIR)	IPCT with Directorate Leads, Community infection control leads and CCG	As required	Completed RCA's Directorate action plans at ICAS. Presentation of issues by CCG / Community infection control at Healthcare associated infection assurance panel, fed back to ICAS
1	Review the effectiveness of antimicrobial stewardship specifically 72 hour review, to reduce antimicrobial resistance through Antimicrobial stewardship ward rounds, point prevalence audits and audit report of antibiotic usage within each directorate. Results fed back to directorates for action	DIPC, Lead antimicrobial pharmacist	As required	ICAS PRM's
1	To ensure that surgical site surveillance results are utilised to the maximum benefit with regard to service improvement	Deputy Director of Nursing Coordinated Surgical Directorate	Quarterly	PRM,s Exception reports to ICAS
2	Provide reports to Clinical Commissioning Group, Primary Care Organisation on IPC issues, as requested and other reports as required.	Head of Infection Control/ Deputy DIPC	weekly, monthly, quarterly	ICAS quarterly HCAI assurance group monthly
2	Provide specialist Infection Prevention and	Head of Infection Control/ Deputy	As required	Minutes of meetings

	Control advice Trust wide and attend appropriate Committees and Groups.	DIPC		
2	Continue to develop Infection control link practitioners network	Infection Control Matron	Quarterly	Quarterly meetings/minutes
2	To maintain evidenced based policies that are based on national guidance ensuring these are updated and reviewed by the ICAS on a rolling basis.	Head of Infection Control/ Deputy DIPC	As required	Updated policies ratified at ICC and placed on intranet
2	Provide Infection Control input/liaison on all environmental, estates and housekeeping projects, policies and reviews of service as per HTM infection control in the built environment and Health and Social Care Act.	Head of Infection Control/ Deputy DIPC	As required	ICAS
3	Support the production of the annual Infection Prevention and Control Report 2017 -18	Head of Infection Control/ Deputy DIPC	Annually	ICAS and QIG
3	Infection Control Competencies: Hand Hygiene Commodes ANTT FFP3 mask fit testing MRSA Screening	Deputy Director of Nursing 1. Acute Continuing Care 2. Coordinated Surgical 3. Critical Care 4. Women and Children	Annually	ICAS

Key – Priority: **1 = Top** **2 = Medium** **3 = Lowest Priority**

Infection Prevention and Control Team:
Dr. Rella Workman, Director of Infection Prevention and Control (DIPC)
Kath Lawson-Hughes, Head of Infection Prevention and Control / Deputy DIPC
Droomila (Sheila) Gogah, Matron of Infection Prevention and Control
Clair Taylor, Infection Control Nurse
Caroline Cook, Infection Control Nurse
Dr Vasile Laza-Stanca, Consultant Microbiologist
Dr Dimitrios Mermerelis, Consultant microbiologist
Syed Gilani, Chief Antimicrobial Pharmacist
Mandy Fassum, PA to Head of Infection Prevention and Control

Appendix 3

Infection Prevention and Control Audit Programme
April 2017 – March 2018

The Code of practice (2008) requires that there is a programme of audit to ensure key policies are being implemented appropriately.

Audit	By Whom	Target Compliance	Frequency	Results To	Monitoring of Action Plans	Review
Hand hygiene	IPCT, matrons, departmental leads	95%	Monthly or weekly of compliance less than minimum	IPCT fed back as part of monthly stats	Directorate governance groups. Infection Control and antimicrobial stewardship Committee (ICAS) Exception Reporting	Monthly
Environmental	IPCT in conjunction with ward / department managers	Minimum 90%	• All inpatient areas annually • Post HCAI / Outbreak/ Period of increased incidence • Mini audit as part of enhanced measures weekly for minimum 4 weeks post HCAI if considered avoidable	Senior Sisters Department Managers Line Manager Deputy Directors of Nursing Director of Nursing Clinical Director	Directorate Governance Group ICAS Exception Reporting	Quarterly
Compliance with Infection Control Policies (this includes isolation and Personal protective equipment)	IPCT	100%	Monthly: • Clostridium *difficile* • MRSA • Other alert organisms as required • All cases nursed in side rooms with potential infections	Senior Sisters Deputy Directors of Nursing	Directorate Governance Groups ICAS Exception Reporting	Quarterly
Saving Lives Compliance	IPCT	100%	Monthly: Peripheral lines Central lines Urinary catheters More frequently if scores <80%. Weekly: if ward in enhanced measures All patients with HCAI's weekly as part of patient review	Feedback In real time to clinical nurse in charge of shift. Written feedback weekly to: Senior Sisters Deputy Directors of Nursing Scores disseminated as part of monthly stats	Directorate Governance Groups ICAS Exception Reporting	Monthly Quarterly
Decontamination of Medical Devices: Endoscopes	IPCT	100%	Quarterly	Department Managers Decon Lead Director of Nursing	Decontamination Committee ICAS	Quarterly

Patient Reviews (alert organisms)	IPCT	100%	Weekly	Feedback in real time to clinical nurse in charge of shift. Written feedback weekly to Senior sisters Deputy Directors of Nursing Scores disseminated as part of monthly stats	Directorate Governance Groups	Monthly
MRSA Screening Compliance • Admission • Weekly	IPCT	100%	Monthly Weekly all inpatients with MRSA	Scores disseminated as part of monthly stats fed back to all directorates and senior managers. Nursing and midwifery strategy forum.	Directorate Governance Groups ICAS Exception Reporting	Monthly Quarterly
Commode Audits	IPCT	100%	Monthly (minimum) Weekly as part of enhanced measures	Senior Sisters Deputy Directors of Nursing. Part of monthly stats	Directorate Governance Groups ICAS Exception Reporting	Monthly Quarterly
Audit Following HCAI: Clostridium *difficile*, MRSA Bacteraemia Acquisitions/ Periods of increased incidence /Outbreak	IPCT	100%	Response to incident / case (as required)	Senior Sisters Deputy Directors of Nursing Director of Nursing Director Clinical Ops	Directorate Governance Groups	Monthly as required
Clostridium *difficile* Patient Reviews	IPCT	100%	X2-3 Weekly each case dependent on severity of case	Senior Sister Deputy Directors of Nursing Director of Nursing	Directorate Governance	Monthly
Clostridium *difficile* Enhanced Measures	IPCT	95%	Weekly until audit result 95% or above –	Senior Sister Deputy Directors of Nursing GM CD Director of Nursing	Directorate Governance	Monthly
Other Infectious Organisms Patient reviews / enhanced measures	IPCT	100%	As required –	Senior Sister Deputy Directors of Nursing GM CD Director of Nursing	Directorate Governance meetings	Monthly
Admission infection status	IPCT	100%	Quarterly –	Senior Sister Deputy Directors of Nursing GM Governance Leads CD's; GM's, DCO's, MD, CQO Director of Nursing Part of monthly stats	Directorate Governance, ICAS Exception Reporting	Monthly Quarterly

EDN infection status	IPCT	100%	Quarterly	Ward and departmental managers. CD's; GM's, DCO's, MD,	Directorate Governance,	Quarterly
Compliance with local antibiotic prescribing and stewardship policies	IPCT Chief Antimicrobial Pharmacist Directorate antimicrobial champions	100% See antimicrobial audit plan	Part of patient reviews As per antimicrobial audit plan	Fed back in real time to clinical sister in charge of shift.	ICAS exception reporting.	
Blood culture contaminants Emergency Department	IPCT	3-4%	Monthly	DDoN; Consultant Nurse ED	Directorate Governance. Exception reporting to ICAS	Quarterly
Management of sharps	IPCT	95%	Annually(by sharps box provider)		Directorate governance	May 2017
Static / dynamic Mattresses	IPCT / Tissue viability and equipment services	Mattresses are fit for purpose	Annually	Medical devices and equipment group	Medical devices and equipment group	Quarterly as required

Key:

IPCT	Infection Prevention & Control Team
SS	Senior Sisters
GM	General Managers
DDN	Deputy Directors of Nursing
DN	Director of Nursing
CD	Clinical Director
MD	Medical Director
NMSF	Nursing & Midwifery Strategy Forum
OH	Occupational Health
HK	Housekeeping
ICC	Infection Control Committee
NSPEG	Near Side Patient Equipment Group

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Appendix 4

Bed Spacing

Ward Name	4 Bedded Bays (cm)	6 Bedded Bays (cm)	Other
A Block			
Milton	240	230	3 Bedded Bay 240cm
Tennyson	240	230	3 Bedded Bay 240cm
Byron	240	230	2 Bedded Bay N/A
Lawrence	247		3 bedded bays 350
Sapphire			
Harvey		BO25 230 BO 19, 16 220	
B+C Blocks		Main Ward Area	
Keats		240	2 Bedded Bay 160cm
Wakeley		240	2 Bedded Bay 250cm
Will Adams		220	3 Bedded Bay 200cm
Nelson	250	280	7 bedded area 200-280
New Build			
McCulloch		240	
Phoenix		240	
Victory		240	
Pearl		240	
Kent		240	
Ocelot		240	
Dolphin		240	one bay 3 bedded 220
KFW	220		200
D. Block			
Arethusa	200		8 Bedded bays
Pembroke	200		240cm 240cm

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Appendix 5

Infection Prevention and Control Policies

Policy Code	Policy Title	Dated	Review Date
POLCGR37	Isolation Policy for Patients	May 2016	May 2018
POLCGR38	Mattress Policy	February 2015	February 2018
POLCGR39	Arrangements for the Control of an Outbreak of Infection (including Norovirus) in Medway NHS Trust	December 2015	December 2018
POLCGR41	Policy for the Management of Suspected or Confirmed Tuberculosis (including MDR TB)	March 2016	March 2019
POLCGR42	Management of MRSA (Meticillin Resistant Staphylococcus aureus)	August 2015	August 2018
POLCGR43	Guidelines for the Management of Clostridium *difficile*	September 2015	September 2018
POLCGR45	Varicella Zoster Virus (VZV) Chickenpox and Shingles	December 2015	December 2018
POLCGR46	Viral Haemorrhagic Fever (VHF) Ebola	November 2014	November 2017
POLCGR47	Policy for Investigating Hospital- Acquired Legionellosis (now incorporated in the Water Policy)	September 2013	September 2015
POLCGR50	Guidelines for Laundry	October 2015	October 2018
POLCGR51	Hand Hygiene Guidelines	October 2015	October 2018
POLCGR52	Cleaning/Disinfection Policy	February 2015	February 2018
POLCGR53	Guidelines for the Management of Transmissible Spongiform Encephalopathy (TSE) including Creutzfeldt-Jakob Disease (CJD)	December 2015	December 2018
POLCGR54	Policy for the Prevention of Blood Borne Viruses	December 2015	December 2018
GUCPCM011	Preventing Infections Associated with Indwelling Urinary Catheters	March 2016	March 2018
POLCGR063	Meningococcal Meningitis/Septicaemia	March 2016	March 2018
POLCGR066	Control of Glycopeptide Resistant Enterococci (GRE)	March 2016	March 2019
POLCGR067	Policy for the Management of Risks Associated with Infection Prevention and Control	April 2015	April 2018
POLCGR068	Control of Multi-Resistant Gram Negative Bacilli	February 2015	February 2018
POLCGR069	Blood Culture Policy	September 2015	September 2018
POLCGR070	Principles of Asepsis and Aseptic Non Touch Technique (ANTT)	March 2016	March 2019
POLCPCM026	Policy for the Prevention of Infections Associated with Vascular Access Devices	June 2015	June 2017
GUCPCM006	Guidelines for the Prevention of Infections Associated with the Insertion and Maintenance of Central Venous Devices	March 2016	March 2019
GUCPCM007	Guidelines for the Prevention of Infections Associated with Peripheral Venous Catheters	March 2016	March 2019
GUGR017	Guidelines for the Use of Faecal Management System	December 2015	December 2018
POLL0M017	Clinical Workwear Policy	February 2015	February 2018
POLLOM015	Victory Ward Operational Policy (Surgery's policy)	September 2013	September 2015
POLCPCM075	Adult Valved Peripherally Inserted Central Catheters (PICCs) Placement and Management Policy	March 2016	March 2018
POLCGR121	Management and Control of Carbapenemase Producing Enterobacteriaceae (new)	October 2015	October 2018
PROLPCM021	Ebola – Patient at Risk Procedure	January 2015	January 2016
POLCOM002	Decontamination Policy (now incorporated in the Cleaning/Disinfection Policy)	March 2014	March 2016
GUCGR018	Admission Guidelines for Suspected A/H1N1V Influenza (Swine Flu) – Adults	March 2015	March 2018
POLCGR125	Respiratory Viruses Policy	March 2016	March 2019

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Appendix 6

Antimicrobial Pharmacist Programmes 2017– 2018

Audit	Objectives	By Whom	Target Compliance	Frequency	Results To	Monitoring of Action Plans
Prudent Antimicrobial Prescribing Audit across all 25-27 Adult Wards over 12 month period. Wards will be divided in to groups. Each group audited per quarter.	All prescription charts are reviewed; - to assess legibility - documentation of clinical indication for antimicrobial use - documentation of stop/ review date - allergy documentation - Compliance to Adult Antibiotic Guidelines - Clinical appropriateness	Antimicrobial Pharmacists/ ward pharmacists	100% 90% 80% 100% >85% 90%	Every 3 months	Antibiotic Stewardship Group and Directorates Governance Leads	DTC MMC CCG
IV to Oral Switch	To assess appropriate change from IV to oral therapy in accordance with Trust Antimicrobial Guidelines	Antimicrobial Pharmacists/ ward pharmacists	TBC Ideally >90%	As part of other audits	Antibiotic Stewardship Group and Directorates Governance Leads	DTC MMC CCG
72 Hour Review	To assess appropriate clinical review of AB therapy 72 hours after initiation	Antimicrobial Pharmacists	Variable (agreed with CCG) but our aim is >90%	Every months Data sent to CCG (till July) will discuss in July about future agreement	Antibiotic Stewardship Group and Directorates Governance Leads	DTC MMC CCG
Ad-hoc Audits to support RCA's and Outbreaks	As appropriate	Antimicrobial Pharmacists/ward pharmacists		Response to incident (Ongoing)	Relevant clinical leads concerned with areas of audit	As appropriate
Specific audits on treatment regimens	As required	Antimicrobial Pharmacists				As appropriate

Key:
DTC – Drugs and Therapeutics Committee
MMC – Medicines Management Committee
RCA – Root Cause Analysis

Antimicrobial education programme 2017- 2018

Education	To whom	By whom	Frequency	Comments
Pharmacy antimicrobial educational sessions	Pharmacists, Pharmacy technicians and dispensary assistants	Antimicrobial pharmacists	Every 4 months	In place
Antimicrobial teaching sessions	All Foundation doctors	Antimicrobial pharmacists	6 monthly	In place
Therapeutic drug monitoring and prudent antimicrobial prescribing Safe Prescribing – Antimicrobial Therapy	Nursing staff Induction for all new joined nurses to the Trust	Antimicrobial pharmacists	Every 2 months via nurse IV study days. Plus induction sessions for new nurses done by Junior Pharmacists. Mini tutorials to be arranged as and when required at ward level	In place Ongoing – as required

Reduction in antibiotic consumption as agreed by CCG

Key Task Area	Action Required	Action Taken
Submission of monthly consumption data to CCG Medicines Management leads to identify trends and set baseline	Manually calculate monthly DDD data for carbapenems and piperacillin-tazobactam Calculate monthly DDD data for carbapenems and piperacillin-tazobactam from 'Define' Submit data monthly to CCGs by end of the second week of each month Review data monthly in line with expenditure to match changes in consumption with usage and activity	Daily Antimicrobial ward round; All patients on restricted antibiotics identified by antimicrobial pharmacist and emailed to microbiologist on daily basis. Patients reviewed during ward round and antibiotics reviewed in line with Trust policy and sensitivities as appropriate.

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Integrated Audit Committee held on 24/08/2018

Report to:	**Board of Directors**	**Date of meeting:**	**06/09/2018**
Presented by:	**Mark Spragg. Chair Integrated Audit Committee**	**Prepared by:**	**Tracey Cotterill. Director of Finance & Bus Svcs**

1

Matters for escalation

1. The Exec to review the findings of the Homecare Services Report and to ensure that remedial actions are sufficient.
2. The Exec to review handover arrangements when staff leave the Trust.
3. Board are recommended to approve the updated Standing Financial Instructions and Scheme of Delegation.

Other matters considered by the group:

1. The Committee had a private meeting to consider the performance of the Internal and External Auditors.
2. The Internal Audit and Counter Fraud Progress Report was presented. It was noted that fraud investigations must retain an element of independence and objectivity and that internal departmental investigations were not ordinarily supported, but balancing the cost of external support with use of Trust resources as appropriate.
3. On Counter Fraud – 3 new referrals had been received by LCFS with 4 being closed in the period.
4. It was noted that a number of Internal Audit Recommendations had been closed, and that there were none overdue, however, it was also noted that the implementation date had been revised for 5 items. These were considered by the committee and it was noted that progress had been made towards implementation but that more time was required to complete them.
5. Internal Audit reports were presented on Guardian of Safe Working Hours, Nurse Revalidation and Biologics Homecare Services.

   There was lengthy discussion regarding the recommendations from the Biologics Homecare audit, and the Exec Committee are to be asked to review further.
6. The LCFS benchmarking report was presented, and there was discussion around communication to staff on Fraud awareness.
7. There was an update on the register of interests, gifts and

	hospitality, and it was agreed that the new company secretary would be asked to review the reporting process. 8. A paper was presented on the buildings insurance policy 9. The updated standing financial instructions and scheme of delegation were reviewed and are recommended to Board for approval subject to some minor changes. 10. The committee received an update on the utilisation of the Da Vinci Robot 11. Losses and special payments in the period were presented. 12. The volume and value of waivers of standing financial instructions were presented. 13. The committee was asked to complete a Self-Assessment form and return to the Company Secretary to consolidate responses for the next meeting.
Key decisions made/ actions identified:	1. The committee agreed the SFIs and SDs subject to some minor changes
Risks:	1. The BAF – it was noted that the updated BAF had been presented to Board, and that the strategic risks would be reviewed and updated by the Exec ahead of the November meeting.
Assurance:	Assurance was provided on; 1. Progress with the recommendations from audit reports 2. Control of adherence to the delegations within the SFIs are is managed via the electronic ordering and payment systems. 3. 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 24/08/2018

Report to:	**Board of Directors**	**Date of meeting:**	**06/09/2018**	**1**
Presented by:	**Tony Moore Chair Finance Committee**	**Prepared by:**	**Tracey Cotterill, Director of Finance**	

Matters for escalation

1. Month 4 was submitted favourable to plan before and after Provider Sustainability Funding (PSF). The trust is anticipating a further loss of PSF income relating to ED performance for Q2. Whilst the loss of PSF does not affect delivery of the agreed financial position, it does increase the reported deficit.

Matters considered by the group:

2. The standard reporting pack was discussed.

   Key items brought to the committees attention included:

   - The year to date position and forecast outturn particularly with regard to PSF. It was noted that the Unplanned Care directorate was adverse to plan, whilst the other directorates were favourable.
   - The Exec had held a meeting with all the programmes to consider forecasts, CIP plans, cost pressures and mitigations to ensure that all risks were being captured and managed.
   - Activity volumes and values vs plan was considered, and the impact of a block v. variable contract is being monitored. To date the variable value of activity is close to the block value.
   - Cash balance was noted at £11m, with cash being held against some large payments expected in the early part of the next month.
   - Capital is currently behind plan. It was noted that the capital allocation is not transferrable to other schemes, and any slippage will need to be captured in the next financial year.
   - The committee was advised that the pay award for month 4 had been processed.

3. The CIP progress was discussed, with the committee being advised of a number of new schemes which had been identified and were currently being scoped.
4. Contract update - It was noted that the Concordat had been signed and the Trust has now formally committed to the Block agreement. The committee were also updated on the timelines for issuing provider intentions and preparing for the contracting round 2019/20.

	5. An update was received on the Sustainability and Transformation Partnership and it was noted that there has been a request for data relating to service level performance. 6. The committee had an update on the Emergency Department build. 7. Board Assurance Framework was taken as read – noting that there were no changes to the risks scores this month. 8. The committee completed a self-assessment questionnaire. There was discussion regarding the governance report published on another challenged Trust, and the committee considered the adequacy of the information provided - particularly in relation to cash.
Risks:	9. Risk register relating to 2018/19 are unchanged from last month. 10. The capital plan is significant but funding is available. Currently behind plan which will mean more work in the latter part of the year, and potential slippage on schemes that are centrally funded. 11. PSF relating to operational performance is a risk to the overall financial position, but NHSI have confirmed that the financial control total is measured pre PSF. 12. CIPs are noted as a risk to delivery of the control total.