NHS Medway NHS Foundation Trust

Agenda

Public Meeting of the Trust Board

Date: On 01 June 2017 at 12.30pm – 3pm

Location: Boardroom, Postgraduate Centre, Medway Maritime Hospital

Item	Subject	Presenter	Time	Action
1.	Presentation - "Medilead & Human Factors"	Rhydian Harris	12.30pm	Note
	Opening of the Meeting			
2.	Chair's Welcome	Chairman	1.00pm	Note
3.	Quorum	Chairman		Note
4.	Register of Interests	Chairman		Note
	Meeting Administration			
5.	Minutes of the previous meeting held on 4 May 2017	Chairman	1.05pm	Approve
6.	Matters Arising Action Log	Chairman		Note
	Main Business			
7.	Chair's Report	Chairman	1.10pm	Note
8.	Chief Executive's Report	Chief Executive	1.15pm	Note
9.	Strategy a) STP Update b) Trust Improvement Plan	Chief Executive Ben Stevens/20-20	1.25pm	Note Discussion
10.	Quality a) IQPD	Executive	1.40pm	Discussion
11.	Performance a) Finance Report b) Communications Report	Director of Finance Director of Communication	1.50pm	Discussion Discussion
12.	Governance			

NHS Medway NHS Foundation Trust

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	a) Corporate Governance	Director of Corporate Governance, Compliance, Legal & Risk	2.05pm	Assurance
13.	Emergency Planning, Resilience and Response – Trust preparedness in relation to recent events in Manchester	Director of Corporate Governance, Compliance, Legal & Risk	2.15pm	Assurance
14.	People a) Workforce Report	Director of HR & OD	2.20pm	Discussion
15.	Research Annual Board Report	Medical Director/ Edyta McCallum	2.25pm	Note
For Approval				
16.	Medicines Management Policy	Medical Director	2.45pm	Approve
17.	NHSI Self-Assessment (Licence Conditions)	Director of Corporate Governance, Compliance, Legal & Risk /Director of Finance	2.50pm	Approve
Reports from Board Committees				
18.	Quality Assurance Committee Report	QAC Chair	2.55pm	Note
19.	Finance Committee Report	Finance Chair		Note
20.	Audit Committee Report	Audit Chair		Verbal
AOB				
21.	Council of Governors' Update	Governor Representative	3.00pm	Discussion
22.	Any other business	Chairman		Note
23.	Questions from members of the public relating to the Agenda	Chairman		Discussion
Close of Meeting				
24.	Date and time of next meeting: 6th July 2017			

Agenda

	Boardroom, Post Graduate Centre, Medway Maritime Hospital

NHS Medway NHS Foundation Trust

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
2.	Ewan Carmichael Non-Executive Director	• Timepathfinders Ltd • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
3.	Darren Cattell Interim Director of Finance	• Director and shareholder of Mill Street Consultancy Limited • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
4.	Stephen Clark Chair	• Pro-Chancellor and chair of Governors Canterbury Christ Church University • Deputy Chairman Marshalls Charity • Chairman 3H Fund Charity • Non-Executive Director Nutmeg Savings and Investments • Member Strategy Board Henley Business School • Business mentor Leadership Exchange Scheme with Metropolitan Police • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Access Bank UK Limited – Non Executive Director
5.	James Devine Director of HR & OD	• Member of the London Board for the Healthcare People Management Association
6.	Lesley Dwyer Chief Executive	• Member of the Corporate Trustees of Medway NHS Foundation Trust Charitable Funds
7.	Diana Hamilton-Fairley Medical Director	• Director of Education Transformation at Guy's and St. Thomas' Hospitals NHS FT • Member of London Clinical Senate Council • Elected Fellows Representative for London South for RCOG • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
8.	Anthony Moore Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
9.	Joanne Palmer Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Lloyds Bank (Fountainbridge 1) Limited • Lloyds Bank (Fountainbridge 2) Limited • Halifax Premises Limited • Gresham Nominee1 Limited • Gresham Nominee 2 Limited

		• Lloyds Commercial Properties Limited • Lloyds Bank Properties Limited • Lloyds Commercial Property Investments Limited • Target Corporate Services Limited
10.	Karen Rule Director of Nursing	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
11.	Mark Spragg Non-Executive Director	• Trustee for the Marcela Trust • Trustee of the Sisi & Savita Chartiable Trust • Director of Mark Spragg Limited
12.	Jan Stephens Non Executive Director	• Trustee of Medway Youth Trust • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds. • Trustee of The Foord Almshouses
13.	David Rice Company Secretary	• Director and shareholder of Shooters Hill Management Co Limited

Meeting in Public

Medway NHS
NHS Foundation Trust

Board of Directors Meeting in Public on 04/05/2017 held Trust Boardroom, Postgraduate Centre, Medway Maritime Hospital

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Mrs L Dwyer	Chief Executive (items 1 to 8)	LD
	Mr J Billings	Non-Executive Director	JB
	Mr E Carmichael	Non-Executive Director	EC
	Mr D Cattell	Interim Finance Director	DC
	Mrs T Cotterill	Finance Director	TC
	Mr J Devine	Director of Workforce	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
	Mrs J Stephens	Non-Executive Director	JS
Attendees:	Ms G Alexander	Director of Communications	GA
	Mr C Bradley	(item 8.2 only)	CB
	Ms C Cake	(item 8.2 only)	CC
	Mrs I Gowan	Foresight Centre for Governance @ GE Healthcare Finnamore (Observer)	IG
	Mr J Lowell	Director of Clinical Operations, Women and Children's Directorate	JL
	Ms N Meadows	Assistant Company Secretary	AM
	Mrs S Murphy	Trust Secretary	SM
	Mr R Nicholls	Deputy Director of Nursing, Acute & Continuing Care Directorate	RN
	Mr B Stevens	Director of Clinical Operations, Co-Ordinated Surgical Care	BS

	Mrs L Stuart	Director of Corporate Governance, Risk, Compliance & Legal	LS
	Paul Riley	Presenter of Patient Story	PR
	Ben Green	Healthwatch Medway	BG
	Mr D Rice	Trust Secretary	DR
Observers:	Mrs D King	Governor Board Representative	DK
Apologies:	Dr D Hamilton-Fairley	Medical Director	DHF
	Members of the public/staff/Governors (7)		

PATIENT STORY

The Chairman welcomed Paul Riley, the patient's relative and Ben Green from Healthwatch Medway.

PR gave a presentation regarding the treatment of 97 year old Marjorie who had been on Will Adams ward in December 2016. The treatment Marjorie received fell short of the expected standards of the Trust and the following areas were highlighted:

- a failure to understand the patient's dependence on the use of a hearing aid
- poor communication with the family and in particular the inability of the ward sister to discuss the patient for 48 hours after admission
- inability to respond to the patient's hygiene requirements
- lack of dignity and respect for the patient
- disregard to the patient's needs regarding helping her to eat and drink
- the fact that agency nurses did not provide the same level of care as substantive staff members

PR stressed that the case was brought to the Trust Board's attention to as constructive criticism to ensure awareness of the issues encountered rather than to apportion blame to specific members of staff.

RN apologised for the treatment and explained that since the end of 2016 a number of changes had been introduced in terms of management and practical matters which had significantly improved the level of care and issues such as communication.

1. Welcome and Apologies for Absence

1.1 The Chairman welcomed everyone to the meeting and in particular Tracey Cotterill, the new Finance Director and Sheila Murphy, the new Trust Secretary. Apologies were noted as above.

2. Quorum

2.1 The Chairman confirmed that a quorum was present.

3. Register of Interests

3.1 The Chairman noted that the register of interests had been included in the board pack and if there were any changes required to be made they should be passed to the Trust Secretary.

4. Minutes of the Previous Meeting

4.1 The minutes of the meeting held on 6 April 2017 were **APPROVED** for signature as a true and accurate account of the meeting subject to minor amendments.

5. Matters Arising – Action Log

5.1 The Board of Directors **RECEIVED** the Action Log which was noted and updated accordingly.

6. Chair's Report

6.1 The Chairman commented that the Trust had met with the League of Friends regarding the introduction of additional catering provision at the Trust. A detailed review of services at the Trust would be carried out and, following this, there would be a process of consultation with the League of Friends before a final decision was made.

6.2 The Chairman explained that a "Well Led" review had been started and was scheduled to be completed by July 2017. All NHSI Trust Boards were required to undertake a Board Governance Review every two years and, following NHSI's agreement to an extension, it was being effected this year. The review was led by GE Healthcare Finnamore and covered the following areas:

- Strategy and planning
- Capability and culture
- Process and structure
- Measurement and reliability of data

The review would involve interviewing the board and stakeholders, observing board meetings, discussing the findings and a final report would be prepared for the Board in July 2017.

7. Chief Executive's Report

7.1 The Chief Executive presented her report which was taken as read and it was noted that:

- The Trust had submitted its improvement plan to the CQC detailing the further improvements it intended to make in order to achieve the "Must do" and "Should do" actions from the report and the CQC had no concerns.
- The Trust's buddying agreement with GSTT was officially completed at an event held on 25 April which recognised the impact of the support the Trust had received.
- The Trust's Staff Excellence Awards were taking place on 26 May which would be an opportunity to demonstrate the achievements by the staff.
- Charlie Massey, the Chief Executive Officer of the GMC was visiting the Trust that day and including the maternity services where we were showcasing "Abigail's Place" of which he was impressed.

8. Strategy

8.1 STP Update

8.1.1 GA noted that the Medway and Swale CCGs had been in talks with "semi-informed" audiences regarding the Sustainability & Transformation Partnership ("STP"). The Trust will be creating opportunities from June for patients and the public from a range of different user groups across to hear about and have input into the STP.

8.2 Trust Improvement Plan

8.2.1 The Chairman welcomed CC and CB from 2020 to the meeting. LD explained that following the closure of the PMO with effect from 31 March 2017 and the Trust would be heading into Phase 3 of its improvement plan. There was a presentation of the plan and it was explained that this would be owned by the Trust with managers being fully accountable with support from consultants 2020. There would be a financial commitment to progress the plan as swiftly as possible in the next six months.

8.2.3 There was a discussion about the size of the 2020 team and it was confirmed that four people had been assigned to work at the Trust and embed improvement. It was noted that this was not a replacement for the PMO which had employed more staff.

8.2.4 It was noted that 2020 would focus on a short-term strategy for improvement rather than a longer-term recovery programme.

8.2.5 Following a question from JB there was a discussion about whether improving the quality of care should be specifically referred to or whether it was inherent within the improvements that the Trust was introducing.

8.2.6 JP noted that the importance of ensuring that the improvement plan took account of the health trends within the wider community in order that the Trust was ahead of any increase in demand before the problems manifested themselves.

8.2.7 There was a discussion regarding the risks to the success of the Improvement Plan. CB noted that one of the major risks was embedding change with appropriate governance so that it became "business as usual" and the key to this was the obtaining staff engagement.

8.2.8 The Executive's approach to the improvement plan and the involvement of 2020 was endorsed by the Board.

9.0 **Quality**

9.1 **IQPD**

9.1.1 Members of the Executive team were invited to talk to the Integrated Quality Performance Dashboard relating to the period to 31 March 2017.

9.1.2 KR explained the current position for Serious Incidents (SIs) noting that as at 31 March 2017 there were a total of 39 open SIs. There had been 33 SIs submitted for closure at the April 2017 CCG SI Closure Panel and 21 SIs had been closed by the panel during March 2017.

9.1.3 KR commented that in March there had been one Grade 3 pressure ulcer. In Q4 the importance of Tissue Viability had been noted as a potential risk area in the context of required fundamental standards with seven grade 3 pressure ulcers having been reported in the financial year 2015-16 although there had been none at Grade 4.

9.1.4 KR noted that in the year 2015-16 there had been 38 falls and there had been a significant reduction to 21 in 2016-17.

9.1.5 There was a rise in VTE's with 16 recorded between January and April 2017 and this had led to some focussed actions including the flagging of cases on Hospedia and a safety message of the day.

9.1.6 The emergency c-section rate had increased over a 3 month period and this had led to some analysis of the issues and whilst this area was under close scrutiny it had not raised any immediate concerns.

9.1.7 One MRSA attributed to the Trust had due to non-compliance with the protocols had led to reinforcing of the issues with staff at a Midwifery forum.

9.1.8 CDiff cases had totaled 24 at the end of 2016-17 and there would be resulting fines for the Trust.

9.1.9 The Hospital Standardised Mortality Ratio (HMSR) remained static and stood at 102.0 (it was noted that this result was two months in arrears).

KM had noted that there had been 26 cardiovascular cases in the three month period to December. KM noted that all mortality cases were reviewed in detail and that the Trust's performance was comparable to the majority of other trusts.

9.1.10 JS queried what initiatives the Trust was intending to use to recruit more stroke consultants. KR explained that there was a continuing recruitment porgramme in this area and JL added that the Trust was engaging with national stroke services and that this was being followed up at both a local and STP level.

9.1.11 JS commented that the Friends and Family results in ED were low and queried whether staff were as engaged as they could be in terms of encouraging visitors to complete the necessary forms. KR noted the concern but added that the response rate at the Trust was around the national average.

9.1.12 LS noted that under the "Safe" section of the IQPD the incidents resulting in death or harm all had a "red" status and queried whether there were trends or themes which could be analysed in greater depth. KR noted that the Trust undertakes regular monitoring of trends and themes and there has been an increased level of reporting of incidents.

Action: KR to provide additional information to the next meeting on SI's resulting in death.

9.1.13 TM queried the level of re-admissions which had not improved in recent times and queried whether there was a specific theme. DC explained that this was an area that was being reviewed with the CCG. Following a query raised by JS it was confirmed that the data was broken down into shorter periods to analyse it in greater detail.

9.1.14 BS explained that whilst the Trust had not achieved the four hour ED target performance had increased from 76% in February to 77% in March. The percentages of discharges taking place before noon had risen from 13.7% in January to 16.7% in March.

9.1.15 The Clinical Co-ordination Centre had been launched on 14 March to oversee and solve problems and to ensure the sustainability of improvements.

9.1.16 The performance of the 18 week trajectory of RTT had fallen but it remained 2% above the trajectory and the two week wait for symptomatic breast examinations remained above the target.

9.1.17 There was an initiative to recruit staff in Dermatology and it was therefore expected that performance would improve.

9.1.18 Following a question from TM regarding data quality DC confirmed that there was a six point data quality improvement plan and that there would be improvements in information following the introduction of the bed management system.

9.1.19 JS queried the level of communications with RTT patients and in particular those who had paused treatment for personal reasons and BS confirmed that such patients received regular communications.

10.0 Performance

10.1 Finance Report

10.1.1 DC explained that the report summarised the M12 unaudited end of year financial performance against the plan. The year-end position was a £42.9m deficit which was an improvement on the "stretch" plan of £43.8m deficit and the control total of £46.6m deficit. In addition the £12.6m CIP target had been achieved and delivered the revised Capital Plan.

10.1.2 The Board agreed that this was a significant achievement given that the Trust had also exited Special Measures due to improved quality and the staff should be congratulated for this performance.

10.1.3. The Trust still had much to do to build upon this performance and whilst the trading performance was a deficit of £45.4m as forecast, however, two tranches of STF funding had been received (one matched funding of £1.25m and a "bonus" of £1.25m for performance).

10.1.4 KM noted that the general morale within the Trust had improved with the resumption of elective work and that the backlog was being eroded.

10.2 Communications Report

10.2.1. GA explained that following the agreement of the House of Commons to hold a general election on 8 June, a pre-election period of "purdah" had begun on 22 April. During this period, there are restrictions placed on the communications activity of public bodies and this prevented the release of announcements which could be seen to influence the election.

10.2.2 There were communications initiatives in connection with the Trust's Improvement Plan and this was being cascaded throughout the various staff groups.

10.2.3 There was engagement with local stakeholders, for example at Kent's Active Roadshow, regarding initiatives to improve care for patients, as well as ensuring that the Trust's own staff were able to influence the development of plans.

10.2.4 The Trust had a refreshed Internal Communications Strategy which would include updating the News at Medway and views would be sought in the next edition.

10.2.5 The Trust had received favourable press coverage regarding the award-winning STOMP initiative which was featured in the press including the Mail on Sunday and the Daily Mail On-Line.

10.2.6 SC queried whether the Trust picked up on comments made about the Trust on social media and GA confirmed that this was constantly monitored and action taken particularly where misrepresentations about the Trust were being made.

11 Governance

Corporate Governance Report

11.1 The paper was taken as read. LD highlighted that a corporate governance dashboard had been developed and disseminated to all clinical directorates and corporate functions. The dashboard gave an overview of performance across a range of corporate governance indicators.

11.2 Following a query from JS regarding the Marsden Model, KR confirmed that the Trust had purchased the on-line resource of nationally approved nursing guidelines and this will replace many of the Trust's procedural SOPs for nursing.

Emergency Preparedness, Resilience and Response (EPRR) Annual Report

11.3 The paper was taken as read. The EPRR provides assurance to the Board that it is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response. The EPRR is a statutory responsibility and the Annual Report is the conclusion of the Work Plan agreed by the Trust Board in May 2016.

11.4 LS noted that the EPRR training had been reviewed and that new packages would be rolled out in 2017. Internal Audit would be carrying out an audit of Business Continuity plans.

11.5 The 2017/18 EPRR Work Plan was reviewed and endorsed by the Board.

Board Assurance Framework

11.6 LS explained that the BAF pulled together the strategic risks (with the aligned corporate risks drawn from the Trust registers) and set out the gaps in assurance and controls and the actions being taken to address them. The

Executive were invited, prior to the Board meeting, to review and update them. The Board's role was to consider the adequacy of the assurance and the mitigating actions and to consider whether they were sufficient in reducing the risk to a manageable level. LS advised that the target risk column represented the Board's previously agreed risk appetite across the different risk areas.

11.7 There was discussion on one particular risk by way of an example and clarification was sought as to the apparent different scores on the BAF and Corporate Risk Register. LS explained that the BAF set out the strategic risks which were risks to delivery of the Trust's strategic objectives whereas the Corporate Risk Register was based on an analysis of all the Trust's registers and a scoring was applied based on the thematic analysis and agreed by the Executive Group.

11.8 It was noted that there were sometimes time lags between mitigating actions impacting, for example, in the case of the Philippine recruitment, which had been considered by KR and JD, the corporate risk scoring had remained at 16 as the impact had not yet manifested itself into tangible improvements.

11.9 JP suggested that the assessment of risk should be reviewed by the Board sub-committees and JS added that the consideration of risk and any mitigations should be reflected in reports submitted to Board.

11.10 SC emphasised that the format for reviewing risks needed to be in a format that was easy to understand and it was concluded that the BAF should be included at each meeting of the Board and, that if mitigations to reduce risk were not working, these should be discussed by Board to consider where any necessary adjustments were required.

Action: BAF to be included on each monthly Board agenda.

Action: Provide assurance to the Board where mitigating actions to reduce risk are not working.

12 People

Workforce Report

12.1 The Board took the paper as read. JD highlighted the following from the report:

- The international campaigns in both Europe and the Philippines were on track. Twelve European nurses had commenced in April with a further cohort arriving in July. Some 241 Filipino nurses were offered employment in March and would arrive by the end of the calendar year. Recruitment within the UK between March and April had generated more than 40 offers.

- On temporary staffing agency breaches had fallen from around 1000 per week in December 2016 to less than 400 with latest figures showing 285 breaches per week. The highest level of shift breaches is within the medical and dental workforce (67%), followed by admin & estates (13%), healthcare science (12%) and the lowest was nursing and midwifery (8%).
- On Equality and Inclusion the Equality Diversity System (EDS2) aimed to help local NHS organisations, following discussions with local partners including members of the public, improve their performance for individuals protected by the Equality Act 2010. Work was also being carried out on the Gender Pay Audit.
- It was noted that mandatory training remained below the target at 72%.

12.2 Following the Patient Story presented earlier at the meeting there was a discussion about how the patient's appointment for surgery had been cancelled as they were unable to hear but this was because they had been instructed by theatre staff to remove their hearing aid. KR commented that this had presented a learning opportunity and would be followed up.

ACTION: Follow up on how patients with hearing aids were consulted ahead of surgery.

13 Membership Strategy

The Board noted the Membership Strategy and DR explained that was reviewed by the Governor Membership Engagement Group on an annual basis. The strategy aimed to recruit new members and engage with existing ones across the community in terms of age, gender, disability, sexuality and ethnicity. The Board **APPROVED** the Membership Strategy for 2017-18.

14 Quality Assurance Committee Report

14.1 The Quality Assurance Committee had met on 20 April and EC noted the following:

- there was concern regarding the steady build-up of complaints; and
- there could be a change to the sequencing of meetings of the Quality Improvement Group and therefore the Quality Assurance Group.

15 Finance Committee Report

15.1 The Finance Committee had met on 27 April and TM summarised the following matters which had been discussed:

- financial performance was better than the control total and the income and expenditure plan;

- the CIP target had been achieved;
- the Capital Plan had been delivered.

17. Council of Governors' Update

17.1 DK as Governor Board Representative noted the following:

- A Governor's Coffee morning had been held on 22 April which was well attended.
- DK was concerned about the impact on the Trust dealing with cases of use of the drug known as "Spice". DK would pass on information for the Board to consider.

ACTION: DR to circulate information about the drug Spice to the Trust Board.

ACTION: DHF/KR to consider the clinical implications of patients using the drug Spice.

18 Any other business

18.1 JS noted that there would be a launch of a Whistleblowing initiative on 15 May 2017 when the policy and processes would be explained.

19 Questions from the members of the public

19.1 Mr Stephens asked if there would be any public, patient or staff consultation about any proposals to bring additional vendors onto the Trust site. The Chair noted that there would be consultation and detailed business case reviews before any future decisions were taken. LS noted that this would not be formal consultation in the legal sense.

19.2 Mr Stephens noted that Southern Water were carrying out major works to improve the mains water supply and whether this could affect the main entrance. DR noted that he spoken to Claire Lowe, the Director of Estates who had been in discussions with Southern Water to ensure that disruption would be kept to a minimum and that any essential work was carried out at evenings or weekends.

20.0 Date of next meeting

The next meeting of the Trust Board will be held on Thursday 1 June 2017 in the Boardroom, Postgraduate Centre, Medway Maritime Hospital.

The meeting closed at 4.45 pm.

Stephen Clark:
Chair

Date:

PUBLIC BOARD ACTION LOG
ITEM 06

NHS Medway NHS Foundation Trust

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB - 0369	02/02/17	15.4	DC and GA agreed to investigate if drilled down information could be provided on the infographics in the IQPR.	Director of Finance & Director of Communications	02/03/17 – There will be development work to link reporting once the Trust website is set up.	Open (red)
PUB - 0376	04/05/17	9.1.2	IQPR data quality assurance required for SI's resulting in death.	Director of Nursing	01/06/17 – Director of Nursing to provide a verbal update.	Open (red)
PUB - 0377	04/05/17	11.10	BAF to be included on each monthly agenda.	Director of Corporate Governance	01/06/17 – To be discussed.	Open (red)
PUB - 0378	04/05/17	11.10	Assurance required where mitigating actions to reduce risks are not working.	Director of Corporate Governance	01/06/17 – To be discussed.	Open (red)
PUB - 0379	04/05/17	12.2	Follow up on how patients with hearing aids are consulted prior to surgery.	Director of Nursing	01/06/17 – Verbal update.	Open (red)
PUB - 0380	04/05/17	17.1	Circulate "Spice" Drug information to Board	Trust Secretary	01/06/17 – circulated after meeting.	Closed (green)
PUB - 0381	04/05/17	17.1	Clinical implications of "Spice" drug.	Medical Director & Director of Nursing	01/06/17 – Verbal update.	Open (red)

NHS Medway NHS Foundation Trust

Chief Executive's Report – June 2017

This report provides the Trust Board with an overview of matters to bring to the Board's attention on a range of strategic and operational issues, some of which are not covered elsewhere on the agenda for this meeting

The Board is asked to note the content of this report.

1. Opening summary

On 9 May Stephen Clark and I attended a meeting with Simon Stevens, Chief Executive of NHS England, and other senior figures from NHS England and other organisations. We had been invited to the meeting, along with colleagues from Medway and Swale CCGs, to explain the actions we were taking to improve our performance against the four-hour target for the Emergency Department – in other words, to increase the number of people waiting less than four hours to be seen. Due to various factors, we had not been as successful as we would have liked at achieving this since the winter when we faced unprecedented pressure.

I am pleased to say that since that meeting, our improvement plan – Better, Best, Brilliant – has been launched, concentrating first on flow, and we have seen a marked increase in the number of people waiting less than four hours. On some days our figure has been at or close to 100 per cent.

We had already established a Clinical Co-Ordination Centre, which oversees the patient journey through the hospital, targeting any potential delays. Over the past three weeks we have analysed the causes of potential delays and changed our processes where necessary, for example making sure we identify at an early stage patients who are ready for discharge the next day, getting their medications ready so this doesn't hold them up, booking patient transport where necessary. We have also focused on presentations at the Emergency Department so that we are triaging people more quickly. This way only those who really need to be seen in ED follow that route, while others might be directed to MedOCC, for example.

We have made great progress in this area, however there are still some challenges to overcome and we now need to ensure we maintain the same high standards.

Meanwhile, our improvement plan covers a number of other workstreams, for example quality, workforce, finance and digital, which will also lead to better services for our patients. We will provide further updates on these areas as they evolve.

On 19 May, the Trust also received a visit from Pauline Philip, National Urgent and Emergency Care Director for NHS England. She is also the Chief Executive of Luton and Dunstable University Hospital NHS Foundation Trust who developed the recommended model for 'Front Door' streaming to better navigate patients to be seen quickly, which trusts are expected to implement by September 2017. She was accompanied by

Anne Eden, Executive Regional Managing Director for NHS Improvement and James Thallon, NHS England South East Medical Director. They were able to observe the processes that we have implemented through the Better, Best, Brilliant improvements. Feedback from the visit was positive, however we are aware that we still have a way to go to ensure that the improvements can be sustained and we are working hard with our partner organisations to make it happen.

As I am sure you are all aware the NHS was the subject of a global Cyber Attack. Medway NHS Foundation Trust was not affected as our IT team had been proactive in carrying out security and anti-virus updates and routine maintenance. They continue to be vigilant to ensure that the Trust remains protected for any future attempted attacks.

Following the saddening events in Manchester last week, and in response to the government raising the UK threat level to Critical, which is the highest threat level and indicates that terrorist attacks are believed to be imminent, the Trust has been co-ordinating with NHS England to ensure preparedness in the event of an incident. We are keeping in close contact with our colleagues at other NHS organisations, the police and other government agencies as well as evaluating and, where appropriate, enhancing the security we have on our site. This is important to keep our patients, staff and public as safe as we can from possible threats. Staff have been communicated with to provide them with information about how to respond if they see or hear anything suspicious.

2. At and around Medway NHS Foundation Trust

Bank Holiday Preparedness

- In order to ensure that the momentum for improving patient flow was kept up over the bank holiday, we co-ordinated with other health and social care providers in the local area to identify where there were challenges to capacity that may impact the Trust. Internally, we continued to evaluate patient flow through the Clinical Co-ordination Centre and ensure that staffing was sufficient throughout all of our departments. Our communications team used social media channels to ensure that the public were aware of the options available to them if they required medical advice or help over the Bank Holiday weekend. This included promoting pharmacy opening times and the Health Help Now app.

Workforce and Recruitment

Darzi Fellow

- We are fortunate to have in the Trust Coral Akenzua, who has been selected as one of the first Darzi Fellows outside London. She is one of three in the county, and has chosen to come to Medway to undertake a respiratory pathway project. Coral is a junior doctor selected to be part of the prestigious Darzi Fellowship programme. In fact she is a paediatrician, but she has chosen adult medicine for her project.
- Over the past eight years, Darzi Fellows in London have led major service improvements, implemented safety and quality initiatives, and achieved financial savings for trusts. The programme has been shown to have a profoundly positive impact on participants and on the organisations they

choose to work in, so I would like to welcome Coral and thank her for choosing to come to Medway. We wish her well as she embarks on her year-long project.

Nursing Update

The international recruitment plan for nursing continues with a total of 240 nurses being processed for posts at Medway NHS Foundation Trust. A further 14 nurses will join us in July from successful EU recruitment. Furthermore, the Trust is taking part in a collaborative regional procurement approach for international recruitment as part of the Sustainability and Transformation Partnership.

Director recruitment update

- I am pleased to announce that since the successful appointment of Tracey Cotterill as the new Director of Finance, Darren Cattell has now transitioned into the position of Director of Improvement to support the Trust with the ongoing journey from Better into Best and then onto Brilliant.
- There have also been changes to our Directors of Clinical Operations. Therefore, James Lowell is now the Director of Clinical Operations for Acute and Continuing Care following the departure of Margaret Dalziel who has taken up another role in another Trust. Alistair Lindsay and Karen Mcintyre have become Co-Directors of Operations for Families and Clinical Support Services, while Ben Stevens remains the Director of Clinical Operations for Co-ordinated Surgical Care.

Recognition for service excellence

Medway NHS Foundation Trust Staff Excellence Awards

- I was delighted to attend our staff awards – Celebrating Excellence – at Priestfield Stadium last Friday. I was proud to present awards to staff who had been singled out for really making a difference to patients in their care, or for providing support behind the scenes to ensure the way we care for patients is really special. I was also very pleased to hand out long service awards to staff who have shown dedication over 20, 30 and 40 years. It was a lovely occasion, and a reminder of the fabulous staff we have at Medway and another great opportunity to showcase the great work our staff are doing in providing the best of care.

International Nurses' Day

- On 12 May we marked International Nurses' Day, celebrating the amazing work of our nurses and midwives. The event is held every year to commemorate the birth of Florence Nightingale, who is hailed as the founder of modern nursing, and celebrates the important contribution that nurses make to healthcare. It is a great opportunity for us to recognise the

dedication and hard work of nurses and midwives at Medway Maritime Hospital and to say thank you. They work around the clock, to provide care of the highest quality and we are incredibly proud of the difference they make to our patients' lives.

Foetal Anomaly Screening

- The Trust received a quality assurance visit for the foetal anomaly screening programme on 18 May from Public Health England. Initial feedback provided on the day was extremely positive and we look forward to receiving their report.

General Medical Council visit

- As you are aware, we received a visit from Charlie Massey, the Chief Executive and Registrar of the GMC on 4 May. Following the visit he sent a note of thanks where he particularly mentioned how privileged he felt being invited to observe a Caesarean section. He also expressed how he hopes that the GMC will be able to work more proactively with providers in future to improve medical practice and use its data more effectively.

Service changes

Surgical ward reconfiguration

- As part of the Trust's continued efforts to take our care from better to best and on to brilliant, the surgical directorate has made changes to how the surgical wards are organised at Medway Maritime Hospital. The team put together an ambitious programme, changing the way that surgical wards work individually and together to get the most out of the available resources. The changes have included increasing the number of patients that can be cared for in the Surgical Assessment Unit, creating a new 'short stay' acute surgery ward, and ring fencing elective orthopaedic surgery beds to ensure that patients having planned surgery will continue to be treated during busy periods. This was one of the changes that took place sooner than originally planned in line with the Better, Best, Brilliant flow month.

Regulatory update

- On 23 May, the Trust met the CQC to discuss our plan for continuing improvement, and the CQC was happy with the progress that has been made. We acknowledge that there is still work to do, however the improvements are being made at pace and staff are engaged with keeping up the momentum to reach our target of 'outstanding'.

Sustainability and Transformation Partnership update

- The Trust continues to support the Kent and Medway STP across a number of workstreams including the hospital care programme, workforce and finance. The Medway, North and West Kent Delivery Board is now taking shape and the first meeting is planned for 16 June.

3. Away from MFT

National NHS priorities

Pre-election period

- As you are aware we are still in purdah in the lead up to the general election on 8 June. This means that as an NHS Trust there are certain restrictions on announcements and communications in the NHS to avoid influencing, or appearing to influence, the outcome of the election. We will remain in this period until the election has passed and a new government has formed.

Kent and Medway NHS and Social Care Partnership Trust

- The Director of Corporate Governance, Risk, Compliance and Legal attended KMPT's Quality Summit on 17 May. This follows their comprehensive inspection in January 2017 leading to an overall rating of Good for services and Outstanding for being caring. The event was well attended by stakeholders with KMPT sharing details of their Improvement Plan.

Medway NHS
NHS Foundation Trust

Board Report

Report date: 1st June 2017

Agenda Item: 9b

Title of Report	Better, Best, Brilliant – Our Trust Improvement Programme
Presented by	Lesley Dwyer, CEO. Chris Bradley, Director 2020 Delivery
Lead Director	Lesley Dwyer, CEO
Committees or Groups who have considered this report	Executive Group
Executive Summary	The Board approved the Business case for the appointment of 202 Delivery to support the Trust in the Better, Best, Brilliant Improvement Plan. 2020 Delivery have been working to the Trust Executive and importantly with Trust staff and Stakeholders to identify and support improvement initiatives. The Executive Group has focused all Trust and 2020 effort on improving Patient Flow which is number 1 in our list of 13 improvement work streams. In practical terms, 4 hour ED performance has improved with less Patients waiting more than 4 hours for treatment. During the first ten days, the seven day rolling average has hit an absolute high of 95% level from a fairly static position of around 80% prior to the improvements. There remains more work to do but so far progress has been good and results encouraging. During the first week of our rapid improvement, the Trust received a visit from the National ED Czar who fed back initial progress was encouraging. The Board is asked to note progress, endorse the approach so far, consider next steps and agree how the Board receives regular updates on progress given the intensive activity in a relatively short timescale.
Resource Implications	As outlined in the presentation.

Risk and Assurance	The risk is continued non delivery of the 4 hour ED standard. Risk mitigation and assurance is attached in the presentation. Sustainability of this improvement is clearly a risk and all actions contain elements for medium to long term sustainability for example revising Patient pathways or increasing Assessment area space.
Legal Implications/Regulatory Requirements	None at this point. There is the clear expectation that further improvement in services standards and ratings in made. This programme will enable us to do that. If we do not then further regulatory action will follow.
Recovery Plan Implication	As above.
Quality Impact Assessment	All actions continue to follow an appropriate QIA process
Recommendation	**The Board is asked to note the progress made in the report.**
Purpose & Actions required by the Board :	Approval ☐ Assurance ☒ Discussion ☐ Noting ☐

Better, Best, Brilliant

Our improvement programme

Board Update

Thursday 1st June 2017

Best of care
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In the last month, the programme has been focusing on Flow to improve ED performance

Integrated health care

1. **Patient flow,** including: A&E, DTOCs
2. **STP** & working with our communities and out of hospital, especially planned care
3. **Quality**, including CQC improvement plan

Innovation

4. **Care redesign and networks**, including clinical and non-clinical functions and pathways, and Getting it right first time
5. **Digital**
6. **Development** programme & Continuous Improvement
7. **Informatics & analytics**

People

8. **Building a sustainable workforce**, including recruitment, retention and 7-day working
9. **Culture & engagement**
10. **Governance and standards** including streamlined processes and assurance

Financial stability

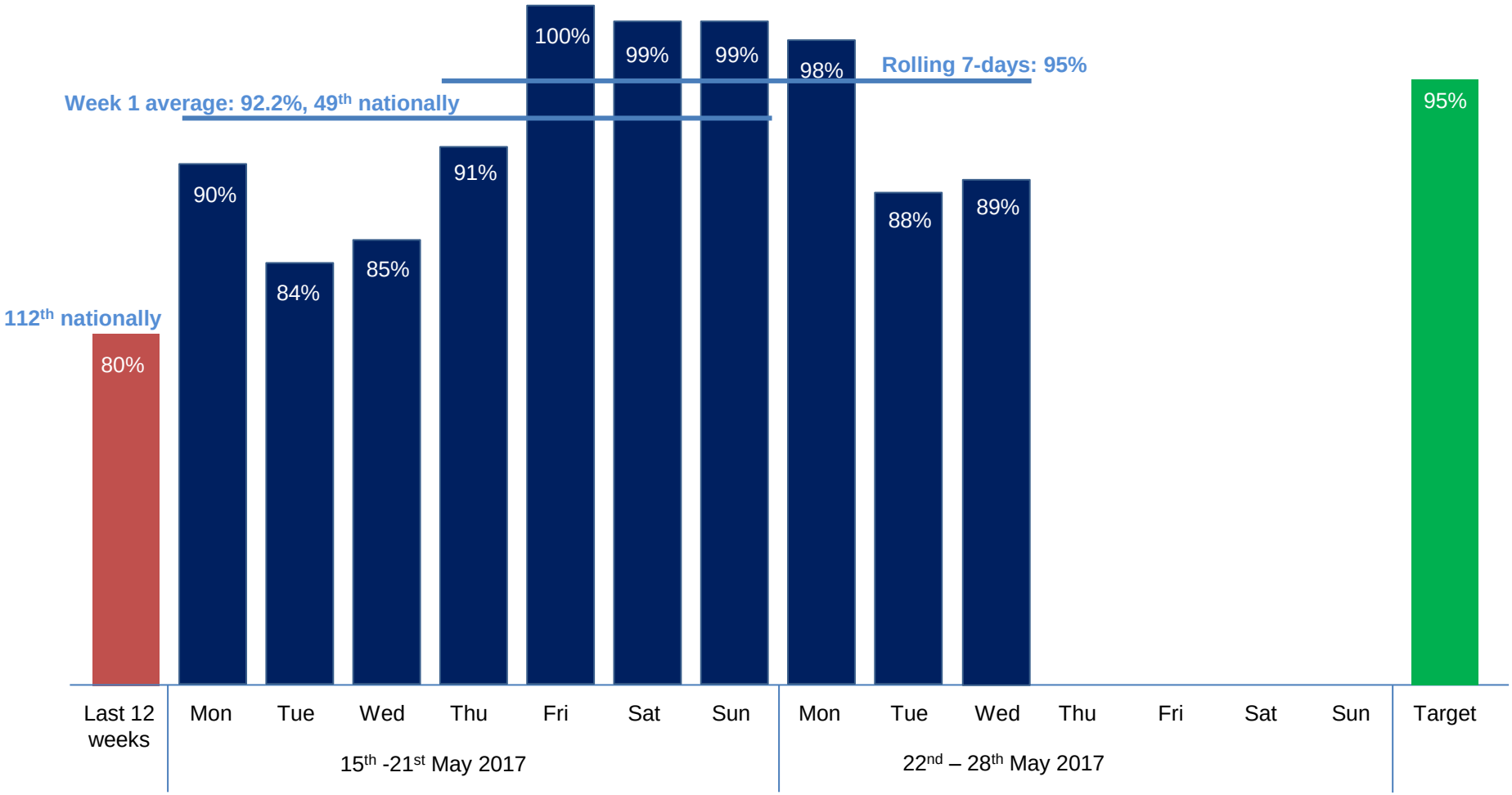
11. **Financial recovery**
12. **Commercial Efficiency** including: Pharmacy, procurement and tendering
13. **Estates**, including new ways of working

Our directorate and corporate strategies

The Better, Best, Brilliant Flow Team has been working at pace to deliver improvement

A few members of the BBB Flow Team on Friday 19th May

4-hour Performance has improved immediately as a result of the 'Flow Month' improvement work. 7-day rolling average has hit 95%



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Individual key performance indicators are looking better. However, flow of medical patients out of ED is the biggest opportunity

Metric	Last 12 weeks	18th May – 24th May
4hr performance	80.76%	95%
4hr performance - admitted	30.21%	81%
4hr performance - non-admitted	92.96%	98%
Median time in department	128.00	109.00
Average time to Triage	16.00	10.00
Average time by AE doctor	70.00	61.00
Avg time between ED Dr & DTA	62.00	85.00
Avg time between specialty referral & being seen (minutes)	118.00	106.00
Time between DTA and leaving ED	312.00	197.00
% Patients with an EDD	30%	58%

Now a significantly lower time in ED

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The team have implemented five major changes to improve flow and confirmed the effectiveness using first-hand evidence

Front Door	• **Front-door streaming** to ensure patients receive treatment in the appropriate setting. Patients are streamed to MedOCC. Previously, 25-30% of patients would access the MedOCC service. Now, our studies show that **40% access MedOCC or their GP** from the front door
ED	• Moved **clerking for medical/surgical patients** to Lister to reduce crowding in ED.
Short-Stay	• Lister ward allocated as a **24hr acute medical unit** to increase flow in the evening. Medical admission 4-hour performance has gone up from **27% to 81%**
Ward discharge	• Increased use, resourcing and opening hours of the **Discharge Lounge** so that it becomes the default option for patient discharges.
Culture change	• Changed the **3 daily huddles** in CCC to generate actions to remove delays and identify sustainable changes, including introducing a 48hr+ staffing confirmation process

Performance has improved in the short-term and focus is now on sustaining the changes

Based on the data provided by the new ED dashboard, medical admissions are still causing the greatest number of delays in ED, so the focus for the coming weeks is to sustain changes and identify further opportunities

25/5/17	– Finalise **Bank Holiday staffing** for all critical areas – Agree and sign-off protocols and **standard operating procedures** / standard work for: • Streaming and MedOCC • Admissions from ED to wards • Discharge lounge • Board rounds including golden patient and EDD • Short stay wards < 48hrs LoS and Lister 2-4hrs turnaround – Review **medical staffing rotas** against admissions to de-bottleneck evening surge in demand
26/5/17	
Week commencing 29/5/17	– Agree **plan to expand capacity of Lister** – Understand **medical workload** and how we could make tasks easier – Downstream focus on **discharge procedures** (TTOs, EDNs) and **board rounds** in specialty wards – **Communication of new procedures** and engagement of key stakeholders in agreed and future changes

The trust has invested in improving ED performance but has learned a lot about how to run successful improvement teams in the future

- Investments
  - Dedicated time from key members of the trust
  - 4 weeks of 2020 Delivery's resources, diverted from the overall transformation programme, and equivalent to c£70,000 + VAT

- Lessons learnt
  - The flow team has been able to implement immediate changes by using a rapid improvement approach, meeting in 'huddles' three-times-a-day
  - We have embodied the *Better, Best, Brilliant* principles and worked in an inclusive, evidence-based and accountable manner
  - This has had a big impact on the culture of the ED and supporting teams, allowing people with ideas to come forward and try new things. The changes in streaming came from a member of the ED team
  - This rapid improvement approach will work with other improvement teams
  - The team has also learned that using an iterative (plan-do-check-act) approach helps develop solutions quickly and allows us to evaluate the success in a controlled manner

- Evaluation
  - The leadership team are meeting once a week to review changes and will wrap-up the 4-week project with an evaluation of key changes and a plan to embed continuous improvement of the Trust's 4-hour performance

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date: 31st May 2017

Agenda item 10a

Title of Report	Integrated Quality Performance Dashboard - Update
Presented by	N/A
Lead Reporting Director	Tracey Cotterill Director of Finance, however **Executive Team accountability**
Committees or Groups who have considered this report	Quality Assurance Committee Quality Improvement Committee
Executive Summary	To inform Board Members in the form of a flash report of March'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 April. Performance has increased from 77.51% in March to 80.77% in April. The main reasons for this as outlined by the Operational Teams are; o Flow issues caused by a deficit between demand and capacity o The whole system of Medway and Swale indicated a high level of pressure o Bed occupancy was 96.67% • The Trust has reported a total of 0 **12 hour breaches** in April compared to 3 reported in March. • **HSMR** has decreased slightly to 100.8 when compared to the previous rolling 12 month period. We remain within benchmarked limits when compared with other Trust's nationally. • This month saw a 19.5% decrease in the number of **Mixed Sex Accommodation** breaches, these totalled 33 in April. • **RTT** performance has seen a small increase in performance at 76.97% from 76.24%, slightly under the revised trajectory of 78.5% following the elective pause.

	• **Cancer targets** have not all been achieved. The 2 week wait performance decreased 19.41% to 71.82%. This is due to an ongoing consultant vacancy which has now been filled. Performance improvement plans are in place for 62D GP Referrals for Urology and Lower GI. • There was a small increase number of **falls** in April (65) when compared to March (64) • 53 complaints were reported in month, an small decrease on February's 56.
Resource Implications	N/A
Risk and Assurance	See report
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	Supports the Recovery Plan in the following areas: Workforce, Data Quality, Nursing, Finance
Quality Impact Assessment	See report as appropriate
Recommendation	N/A
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

NHS Medway NHS Foundation Trust

Integrated Quality and Performance Report

May 2017

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

Best of care
Best of people

Contents

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

Best of care
Best of people

9654 Patients visited our ED , which is a **7.63% decrease** on the previous month, with **80.77%** seen within 4 hours, compared to 77.51% . **2081** Patients were admitted, with a slight **decrease** in conversion rate of **21.55%** compared to 21.65% in March

There were **4969** total patient admissions April, and **4998** patients were discharged.

Bed Occupancy **increased** by **1.97%** in April to **96.67%**.

3116 patients arrived at ED via ambulance which is a **6.90% decrease** on last month

42.4% Of ambulance patients were seen in under 15 minutes

April's Story....

413 Babies were delivered in the month of April (**10** less than March) with Emergency C-Section rate **decreasing** by **4.33%** from the previous month to **16.95%**

HSMR is 100.8 and within expected parameters (95.18 – 106.65)

74% of staff have had completed mandatory training which is a **2% increase** on the previous month

20007 Patients attended an outpatient appointment with **9.88%** DNA rate which is a decrease of **0.41%** on last month

There were **65** total falls in April, compared to **64** in March

RTT Overall Incomplete Pathways for April was **76.97%** which increased by **0.73%** on previous month. We remain on our improvement trajectory. The trust also reported 33 x 52 week waiters which increased by 2 from March

31 day subsequent treatment surgery cancer target remains above target at **96.55%** in March (reported one month in arrears)

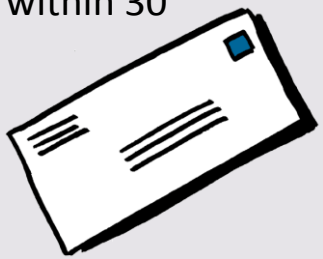
2 Week Wait symptomatic breast dropped below the target of **93%** in March with performance of **92.97%** - down by 4.40%

2 Week Wait cancer performance for March was **71.82%** (reported one month in arrears) . This is a **19.41%** decrease on February's performance

April's Performance....

95.16% of Patients waited under 6 weeks for diagnostic tests in the month of April, this has decreased by **0.87%** since March's reported performance

We received **53** complaints in April, decreased from those received in March by **5.4%**. In February, **36%** of complaints previously received were responded to within 30 working days



There were 33 Mixed Sex Accommodation breaches in April which was a **19.51%** improvement on March's performance

Safe Page 11

Legend
- Compliant with target
- Breaching target

Infection Control

CDiff – no cases for April 2017

MRSA – no post 48 hour cases for April 2017

Serious Incidents

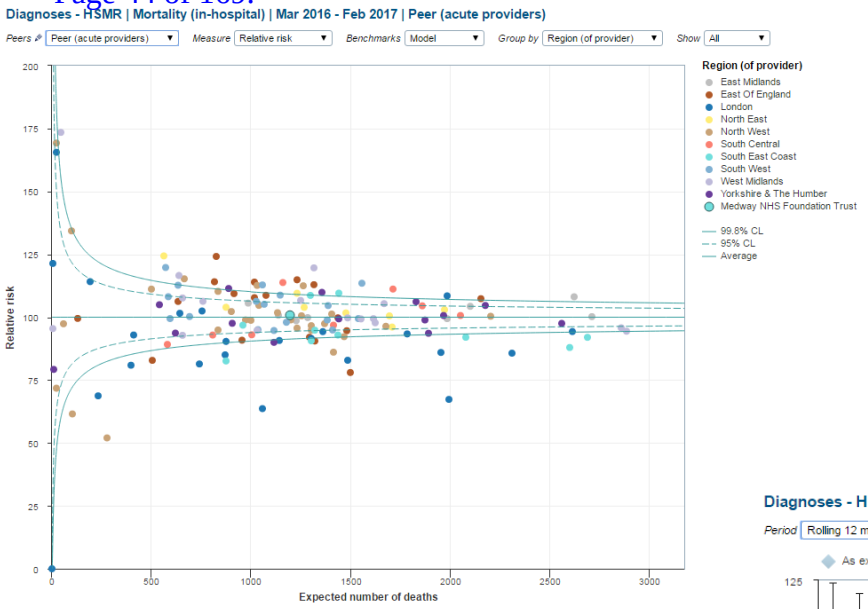
The key issues of note are as follows:
The Trust received a Contract Performance Notice (CPN) in relation to SI performance, learning and key themes in March 2017. The Trust has been liaising with the CCG on an ongoing basis to review and update a draft remedial action plan (RAP) to address the points raised. This risk has also been added to the Risk Register as there are financial implications if the Trust fails to address the concerns raised
As at 30 April 2017 there are a total of 92 open Serious Incidents (SIs)

Open SIs within allocated timeframe - 41
Open SIs breaching the allocated timeframe – 51
Of the 51 breaching 37 SIs have been presented to the CCG (represented in 7 final reports). Additional information has been requested in relation to these 7 final reports prior to closure of the 37 SIs; this is currently being progressed

New SIs reported on STEIS in April – 9
16 SIs were presented at the CCG Closure panel on the 7 April 2017 – of these 4 were closed, 5 were virtual closure (requiring minor adjustments) and 7 reports require additional information prior to closure. Key themes around the required additional information relate to the deteriorating patient, nutrition and hydration.

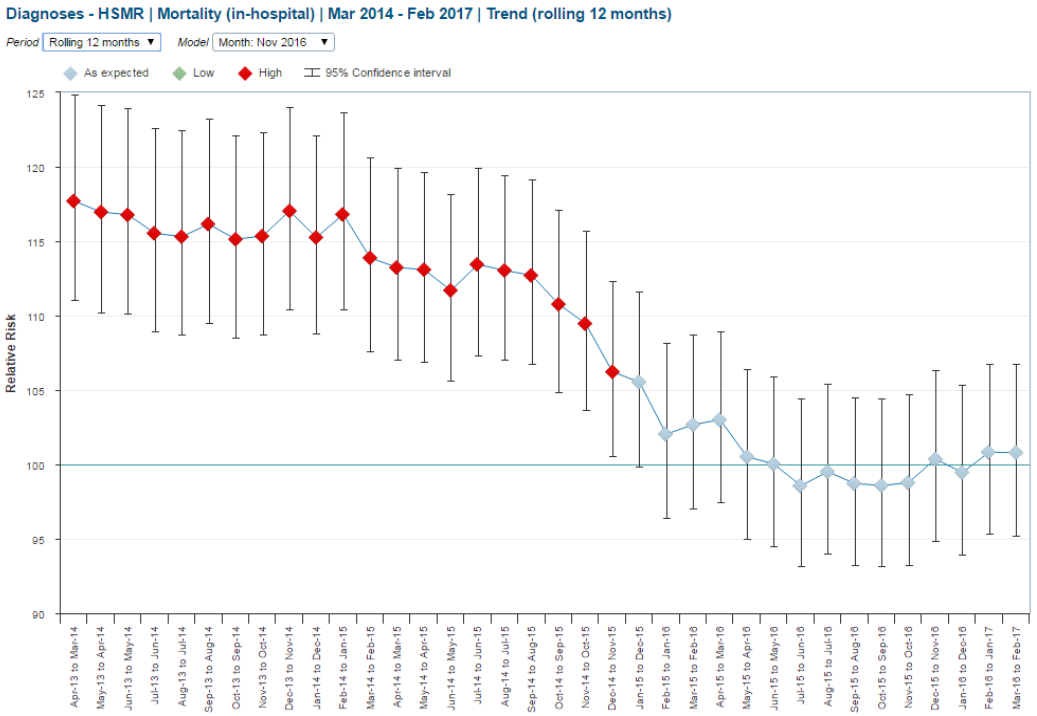
Mortality

The Hospital Standardised Mortality Ratio (HSMR) is currently 100.8 for period from March 2016 to February 2017 (latest available data) and remains within the expected range of 95.18 – 106.65. The latest data and rolling HSMR trend is demonstrated by the funnel plot and graph on the following slide:



The most recently published SHMI value, for the period October 2015 – September 2016, is 1.09. This shows a further reduction on previous periods and is the lowest value for the Trust in this indicator for over two years. The Trust aimed to be within benchmarked limits by the end of 2016/17 and this has now been achieved. The Trust is optimistic that the SHMI will continue to demonstrate a reduction moving forward. The next SHMI value for the period January 2016 – December 2016 will be published on 22nd June 2017.

The SMR for Pneumonia has reduced further to 94.51, whilst the Acute & Unspecified Renal Failure SMR has now dropped below the benchmark to 90.60. Acute Cerebrovascular Disease has recently increased and is now statistically significantly high at 126.66.



Effective Page 15

Please see CQUIN update under Effective

Caring Page 16

Friends and Family

Emergency department – 82.8%
Inpatient – 88.8%
Maternity – 99.0%

The Emergency department response rate continues to be challenging, however in April we have seen an improvement of 3.5%. A number of options to improve the response rate such as using a tablet to undertake survey are being considered including placing the FFT questions on a tablet and the use of a wall mounted option to enable patients and carer to participate in a more timely manner. There is the expectation that the improved response rate will increase the % likely to recommend the Trust to others. The Patient Experience Manager will help embed the benefits of FFT and staff will see the value of patient feedback.

Responsive Page 17

- **ED –**

April saw 9654 total attenders in the ED, down on March's 10450 and an increase of 8.8% on April 16. Ambulance attendances were 3115, slightly down on March's 3347. MFT remains consistently one of the top performer's in the region and saw 42.4% of handovers within 15 minutes. This is despite seeing over 1100 more ambulances than the top performer for April. Performance against the 4 hour standard was 80.77% for April, almost 3% up on April 16 and a reflection on improving flow which has also seen an improvement in the ED length of stay at the 80th and 95th percentile.

Clinical markers are still performing well with 95-100% NEWS compliance. This is recorded through random, snapshot audits covering the 24 hour period.

Emergency flow remains challenged with a deficit between demand and capacity resulting in significant delays. Almost all alternate pathways have had periods of closure with the exception of Ambulatory and Medocc.

The Clinical Coordination Centre has focused attention on the functionality of all pathways. This has allowed the reduction of medical outliers to below 25 and has seen up to 35 patients per day managed through the still unbedded discharge lounge. Progress continues to be made in the closure of Victory as an MRSA ward and priority is being placed on managing patients through the correct pathways.
A Rapid Assessment Process (RAP) was instigated, at the end of October, at the ED front door, providing a combined senior nurse and Associate Practitioner allowing much earlier interventions and streaming. This continues to be closely monitored with expectations it will continue to improve the time to be seen by an ED clinician significantly as well as the number of patients streamed to alternate pathways.

- **RTT**

RTT performance is 76.97%, an increase of 0.73% on the previous month. In total compared to March there are less patients waiting over 18 weeks, (5323 compared to 5585) The management of elective activity is being supported through further use of the independent sector.
There has been a small increase in 52 week waiters from 14 to 3, and work is continuing to ensure patients are seen in a safe and timely fashion.

Cancer

- **2WW** - The Trust failed to achieve the GP 2 week wait predominantly due to clinic capacity in Skin as a result of ongoing Consultant vacancy. Dermatology have filled an outstanding vacancy and introducing a new clinic structure from mid-May to increase the 2ww capacity to achieve a compliant position

- Compliance with the 2 week wait symptomatic breast standard failed to be maintained. Nine breaches for symptomatic breast were as a result of patient choice

- **31D – The Trust failed to achieve the first definitive treatment standard and subsequent drug treatment**
  - Four breaches in breast were due to reduced elective surgery due to site pressures
  - Two breaches in skin were as a result of patient choice and a planned surgery cancelled by the patient
  - One Medway Urology patient failed to attend planned surgery
  - Two MTW Urology patients had an agreed treatment dates with the Consultant prior to referral onto treating Trust
  - One Haematology patient breach was as a result of the patient requiring medical treatment for another medical condition before haematology treatment could commence

- **31D – Sub –** The Trust achieved the 31D first definitive treatment for subsequent surgical standards.

- **62D** - The Trust failed to achieve compliance with the GP 62 day referral standard
  - There were 18 breaches against the GP 62 day referral standard with 7.5 Urology breaches with the remaining spread across several tumour sites
  - There were six 104 day breaches which was higher than February's five 104 day breaches
  - Performance improvement plans remain in place for Urology & Lower GI which are consistently the most challenged tumour sites

- **62D Screening –** The Trust achieved the 62D Screening target.

Well Led Page 18

There has been a slight increase (0.6%) in the long term absence rate, although this is linked to the change in trigger system following the introduction of a new sickness absence policy. In turn, the short term absence level has reduced to 2.1% - absence generally remains slightly below the threshold of 4%.

Turnover remains relatively static at 10.1% (a 0.1% increase on the previous month)

Whilst the number of starters outweighs the number of leavers in month, this should be read in conjunction with the workforce Board paper, which shows number of offers made, particularly within the nursing staff group.

The results of the quarterly Friends and Family Test are relatively static when compared to the previous quarter.

Enablers Page 19

Data Quality Validation Update

The data quality team are continuing to work through the follow up review lists specialty by specialty.

The validation of the review lists is now complete for Trauma and Orthopaedics. Rheumatology is almost complete, with Paediatrics and the Paediatric sub-specialties to commence once agreed with the Service Manager.

The Data Quality Team has delivered review list refresher training to the ENT admin team.

The Data Quality Team has now introduced an ongoing audit process, enabling us to assess and record the audit outcomes of the validation work. The continuing audits will ensure that the validation work is completed with maximum accuracy.

The Data Quality meetings have now been arranged to run bi-monthly, with the first meeting scheduled for 24th May 2017.

3. Safe

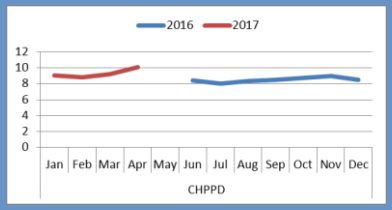
		Monthly Target	RAG Status	Trend Feb-17	Mar-17	Apr-17	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
1.1.3.2	Potential under-reporting of patient safety incidents (Quarterly)	Information on NRLS under review from DOH.										
1.1.4	Never events	0	G	0.00	0.00	0.00	⇔	0.2				✓
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	7.00	-	4.00	↓	4.2				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days)	0.11	R	0.29	-	0.60	↑	0.24				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days)	1.87	G	2.30	-	1.81	⇓	1.7				✓
1.1.10	Incidents with moderate or severe harm with duty of candour response	100%	G	71.7%	-	32.0%	↓	13.6				✓
1.1.14	Pressure ulcers (grade 2) attributable to trust	10	G	11.00	9.00	10.00	↑	10.8				✓
1.1.15	Pressure ulcers (grade 3&4)	0	R	0.00	1.00	1.00	⇔	1.2				✓
1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	0.2	G	0.07	0.06	0.07	↑	0.1				
1.1.18	Falls per 1000 bed days	6.63	G	4.23	4.15	4.90	↑	5.2				
1.1.19	Number of falls to fracture (per 1000 bed days)	0.2	G	0.07	0.00	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			✓	
1.1.21	% Duty of Candour with first letter	Datix system being reconfigured to allow accurate data capture.										
1.2.2	New VTEs - point prevalence in month	0.36%	R	1.0%	1.21%	0.41%	⇓	0.6%			✓	
1.2.7	Emergency c-section rate	<15%	R	18.1%	21.3%	17.0%	⇓	17.6%				
1.3.1	MRSA screening of admissions	95%	G	92.9%	97.0%	97.4%	⇑	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	G	1.00	0.00	0.00	⇔	0			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	G	2.00	0.00	0.00	⇔	2			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	R	100.8			⇓	102.4			✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	R	108.8			⇓	106.5			✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	100	R	108.66			⇔	112			✓	✓

Commentary	Actions
Please see Executive summary	Please see Executive summary

Safe Staffing – Nursing Update - Highlights

Care Hours per Patient per Day

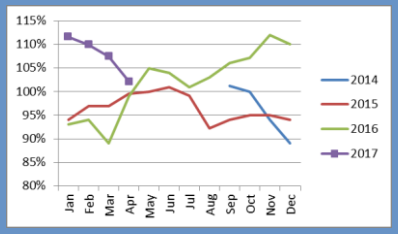
We have continued to see good performance remaining over the target of 8 for April.



Further work is being undertaken to ensure wards are adequately staffed for their activity, and patients remain safe.

Safe Staffing

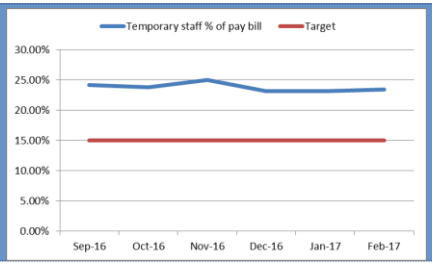
There has been a small decrease in the amount of actual hours worked vs plan, however we remain above 100%.



Staffing issues are being risk assessed daily, with staff being deployed from other areas where appropriate.

Temporary Staffing

The Trust remains below target for Temporary Staffing.



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

Best of care
Best of people

Staffing Levels – Nursing & Clinical Support Workers

			Day				Night				Day		Night		Associate Chief Nurse (Divisonal) review		
			Registered Staff		Care Staff		Registered Staff		Care Staff								
Directorate	WARD	Bed	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 (%)	ACND rag rating	Assurance statement	ACND signoff
Acute & Continuing Care	Bronte Ward	18	1468	1178	1098	1106	1058	986	705	716	*80%*	*101%*	*93%*	*102%*			
Acute & Continuing Care	Byron Ward	26	1388	1247	989	1661	788	1035	1001	1447	*90%*	*168%*	*131%*	*144%*			
Acute & Continuing Care	CCU	4	683	683	0	0	679	678	0	0	*100%*		*100%*				
Acute & Continuing Care	Gundulph	25	1935	1314	1542	1372	1309	1236	1320	1365	*68%*	*89%*	*94%*	*103%*			
Acute & Continuing Care	Harvey Ward	24	1215	1086	1595	1337	934	1104	990	1032	*89%*	*84%*	*118%*	*104%*			
Acute & Continuing Care	Keats Ward	27	1607	1225	1223	1214	946	992	990	946	*76%*	*99%*	*105%*	*96%*			
Acute & Continuing Care	Lawrence Ward	19	1093	1042	830	895	675	733	675	709	*95%*	*108%*	*109%*	*105%*			
Acute & Continuing Care	Milton Ward	27	1561	1452	1109	1977	1013	1373	1023	1615	*93%*	*178%*	*136%*	*158%*			
Acute & Continuing Care	Nelson Ward	24	1492	1230	1177	1303	957	935	660	869	*82%*	*111%*	*98%*	*132%*			
Acute & Continuing Care	Sapphire Ward	28	1799	997	2242	2033	978	978	1320	1321	*55%*	*91%*	*100%*	*100%*			
Acute & Continuing Care	Tennyson Ward	27	1748	1125	1176	1294	1013	1015	1013	1293	*64%*	*110%*	*100%*	*128%*			
Acute & Continuing Care	Wakeley Ward	25	1927	1398	1491	1398	1339	1260	1350	1350	*73%*	*94%*	*94%*	*100%*			
Acute & Continuing Care	Will Adams Ward	26	1584	1124	1148	1112	979	948	990	1196	*71%*	*97%*	*97%*	*121%*			
Co-ordinated Surgical	Arethusa Ward	27	1713	1564	1026	1580	1265	1496	964	1453	*91%*	*154%*	*118%*	*151%*		Arethusa and Pembroke wards work flexibly and share specialist orthopaedic staff across the two wards, moving	
Co-ordinated Surgical	ICU	9	3622	3332	0	0	3341	3063	0	0	*92%*		*92%*			The nursing team work flexibly across all critical care areas to ensure cover and mainatin safe staffing levels. When	
Co-ordinated Surgical	Kingfisher SAU	14	1891	1592	1509	1435	1276	1310	660	704	*84%*	*95%*	*103%*	*107%*		When the ward staffing numbers are lower than planned nurses are moved fromother wards or the Matron and Senior	
Co-ordinated Surgical	McCulloch Ward	24	1469	1733	1061	1556	968	1310	979	1452	*118%*	*147%*	*135%*	*148%*		When the ward staffing numbers are lower than planned nurses are moved fromother wards or the Matron and Senior	
Co-ordinated Surgical	Medical HDU	6	1342	1301	345	341	1035	1036	345	334	*97%*	*99%*	*100%*	*97%*		The nursing team work flexibly across all critical care areas to ensure cover and mainatin safe staffing levels. When	
Co-ordinated Surgical	Pembroke Ward	27	1446	1254	1108	1455	990	1265	990	1254	*87%*	*131%*	*128%*	*127%*		Arethusa and Pembroke wards work flexibly and share specialist orthopaedic staff across the two wards, moving	
Co-ordinated Surgical	Phoenix Ward	30	1765	1758	1542	1699	1232	1350	1309	1640	*100%*	*110%*	*110%*	*125%*		There are a number of new staff nurses on the ward working in a supernumerary capacity whilst waiting for their	
Co-ordinated Surgical	SDCC	26	1670	1373	1446	568	484	440	627	363	*82%*	*39%*	*91%*	*58%*		Sunderland Day care unit have closed the open esccalation beds and returned to the function of day surgery and 23hr	
Co-ordinated Surgical	Surgical HDU	10	2189	2148	375	340	1639	1760	0	11	*98%*	*91%*	*107%*			The nursing team work flexibly across all critical care areas to ensure cover and mainatin safe staffing levels. When	
Co-ordinated Surgical	Victory Ward	18	1111	864	694	1602	968	947	660	1265	*78%*	*231%*	*98%*	*192%*		When the ward staffing numbers are lower than planned nurses are moved fromother wards or the Matron and Senior	
Women & Childrens	Delivery Suite	15	2713	2713	498	585	2832	2846	468	468	*100%*	*117%*	*101%*	*100%*		safe staffing maintained	
Women & Childrens	Dolphin (Paeds)	34	3009	3194	672	986	2415	2552	345	403	*106%*	*147%*	*106%*	*117%*		safe staffing maintained	
Women & Childrens	Kent Ward	24	1097	1120	470	470	708	709	636	635	*102%*	*100%*	*100%*	*100%*		safe staffing maintained	
Women & Childrens	NICU	25	3441	3514	168	138	3409	3469	0	0	*102%*	*82%*	*102%*			safe staffing maintained	
Women & Childrens	Ocelot Ward	12	855	827	495	499	708	695	360	360	*97%*	*101%*	*98%*	*100%*		safe staffing maintained	
Women & Childrens	Pearl Ward	23	1075	1282	666	642	1068	1068	360	360	*119%*	*96%*	*100%*	*100%*		safe staffing maintained	
Women & Childrens	The Birth Place	9	1081	1081	359	341	1080	1014	348	318	*100%*	*95%*	*94%*	*91%*		safe staffing maintained	
	Trust total	**633**	**50,985**	**45,748**	**28,052**	**30,935**	**38,083**	**39,600**	**21,088**	**24,875**	***89.7%***	***110.3%***	***104.0%***	***118.0%***			

Commentary

On-going daily assessments are in place to ensure safe staffing across acute and surgical care to ensure all areas are covered appropriately.

Actions

Recruitment plan in place to increase staffing.
Ward sisters are working clinically when staffing requires them to do so.
Work is ongoing to look at the role of the CSW for 1:1 when required.

Safe Staffing– Nursing Update KPIs

		Monthly Target	RAG Status	Trend Feb-17	Mar-17	Apr-17	Movement	YTD avg	Trend	Data Quality
1.5.2	Vacancy Rate (Overall)	8%	G	23.67%	24.70%			0.2		
1.5.3	Total Vacancies (WTE)	TBC		352.00	367.00	471.24	↑	396.7		
1.5.4	Vacancy Rate (Band 5)	TBC		46.23%		53.70%	↑	0.5		
1.5.5	Vacancy Rate (Band 6)	TBC		35.70%		61.42%	↑	0.49		
1.5.6	Vacancy Rate (CSW)	TBC		16.33%		17.91%	↑	0.2		
1.5.7	Nursing Starters	TBC		10.00	23	14	↓	15.7		
1.5.8	Nursing Leavers	TBC		7.00	31	18	↓	18.7		
1.5.9	CWS Starters	TBC		23.00	39	16	↓	26.0		
1.5.10	CWS Leavers	TBC		3.00	31	12	↓	15.3		
1.5.11	Rolling annual turnover rate	8%	R	9.67%	9.97%	10.00%	↑	0.1		
1.5.12	Total WTE % Substantive	85.00%	R	82.22%			↑	0.8		
1.5.13	Total WTE % Bank	TBC		6.65%			↑	0.1		
1.5.15	Total WTE % Agency	15.00%	G	11.14%			↓	0.11		
1.5.16	Safe Staffing	94.00%	G	110.0%	107.5%	102.1%	→	106.5%		
1.5.17	CHPPD	8.00	G	8.78	9.21	10.09	↓	936%		

Please note all indicators with a TBC target will be developed with a calculated baseline once 6 months of data is available.

Commentary	Actions
The current budgeted FTE shown above is currently based on outturn from 2016/17 and is subject to review, in consideration of both safe establishments, and the cost improvement requirements. These do not represent true vacancy rates We have attended several recruitment fairs with more planned throughout the year. We have almost recruited to estbalishment for CSWs.	To continue to recruit, we are exploring further internatinal recruitment and have planned to recruit a further 60 EU nurses over the coming months.

4. Effective

		Monthly Target	Status	Trend						Alignment		
			Status	Feb-17	Mar-17	Apr-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
2.5.4	Emergency Readmissions within 28 days	5%	R	11.9%	13.3%	14.4%	↑	12%			✓	
2.5.4.1	Emergency Readmissions within 28 days Under 65	5%	R	10%	12%	12.9%	↑	11%				
2.5.4.2	Emergency Readmissions within 28 days 65 +	5%	R	14%	15%	16.3%	↑	15%				
2.6	Discharges before noon	25%	R	14.30%	16.66%	13.78%	↓	14%			✓	✓

CQUIN Ref.	Q1	Q2	Q3	Q4	YTD(£)	Comments
NHS Staff and Wellbeing option B	£85,680	n/a	n/a		£85,680	Forecasting Q4 full achievement
NHS Staff and Wellbeing food	£0	n/a	n/a		£0	Did not achieve Q1. Expecting to achieve Q4
NHS Staff and Wellbeing flu	n/a	n/a	n/a		£0	Forecasting Q4 full achievement
Sepsis 2a - Emergency Department	£10,710	£0	£26,775		£37,485	Partial achievement
Sepsis 2b	£53,550	£0	£53,550		£107,100	
Antimicrobial Resistance 5a - reduction	£0	£0	£0		£0	In dispute with CCG regarding publishing of PHE data
Antimicrobial Resistance 5b - review	£0	£0	£0		£0	
National CQUIN Total Indicative Value	**£149,940**	**£0**	**£80,325**		**£230,265**	

CQUIN Ref.	Q1	Q2	Q3	Q4	YTD(£)	Comments
Joint Formulary	£0	£0	£0		£0	In dispute with CCG
Medicines Reconcilliation	£0	£0	£10,025		£10,025	
SIP Feed Review	£66,830	£66,830	£0		£133,661	
Pressure Ulcer Collaborative	£53,464	£53,464	£53,464		£160,393	
Discharge Before Midday	£53,464	£0	£0		£53,464	
Community Paediatric Paperless Referral	£53,464	n/a	n/a		£53,464	Forecasting Q4 full achievement
Improved EDN Information	£53,464	£80,196	£80,196		£213,857	
Children Asthma pathway	£53,464	n/a	n/a		£53,464	Forecasting Q4 full achievement
Local CQUIN Total Indicative Value	**£334,152**	**£200,491**	**£143,685**		**£678,329**	
Optimal Device						
Adult Critical Care Timely Discharge						
Increase take up of School Immunisation						

5. Caring

		Monthly Target	RAG Status	Trend Feb-17	Mar-17	Apr-17	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	87.2%	89.2%	88.8%	↓	86%			✓	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	*65%*	G	78.5%	79.3%	82.8%	↑	77%			✓	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	*79%*	G	98.5%	99.2%	99.0%	↓	99%			✓	
3.1.3	Mixed Sex Accommodation breaches	*15*	R	45.00	41.00	33.00	↓	28.3			✓	
3.4.1	Number of Complaints	*45*	R	46.00	56.00	53.00	↓	49			✓	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	*85%*	R	36.0%				42%			✓	
3.4.3	Number of complaint returners	↓	G	4.00	1.00	0.00	↓	6.3			✓	

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

6. Responsive

		Monthly Target	Status	Trend: Feb-17	Mar-17	Apr-17	Movement	YTD avg	Data Quality	Alignment: Carter	SDF	Quality Account / CQUIN
4.1.1	RTT – Incomplete pathways (overall)	92%	R	76.45%	76.24%	76.97%	↑	76.87%			✓	
4.1.2	RTT - Treatment Over 52 Weeks	0	R	34	31	33	↑	20				
4.2.3	A&E 4 hour target	95%	R	76.17%	77.51%	80.77%	↑	78.50%			✓	
4.3.1	Cancer – 2 week wait (1 month in arrears)	93%	R	91.23%	71.82%		↓	83.89%				
4.3.2	Cancer - 2 Week Wait Breast (1 month in arrears)	93%	R	97.37%	92.97%		↓	91.66%				
4.3.3	Cancer - 31 day first treatment (1 month in arrears)	96%	R	93.80%	93.92%		↑	93.76%				
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	94%	G	95.00%	96.55%		↑	91.95%				
4.3.5	Cancer – 31 day subsequent treatments - drug (1 month in arrears)	98%	R	100.00%	88.89%		↓	98.73%				
4.3.6	Cancer - 62 day consultant upgrade (1 month in arrears)	N/A		89.47%	66.67%		↓	80.03%				
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	R	82.95%	77.50%		↓	79%			✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	90%	G	100.00%	96.15%		↓	88%			✓	
4.4.1	Diagnostic waits - under 6 weeks (1 month in arrears)	99%	R	95.43%	96.03%	95.16%	↓	92%			✓	
4.5.8	Patients seen by a stroke consultant within 24 hours (Sep to Nov figures reported)	95%	R	47.00%	54.00%	39.00%	↓	54%				✓
4.6.1	Average elective Length of Stay	<5	G	2.04	3.07	1.99	↓	2.6				✓
4.6.2	Average non-elective Length of Stay	<5	R	6.65	6.58	7.01	↑	6.4				✓
4.6.6	Average occupancy	90%	R	94.64%	94.70%	96.67%	↑	94%				✓

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

ımentary	Actions
Please see Executive Summary	Please see Executive Summary

Best of care
Best of people

7. Well led

		Monthly Target	Status	Trend						Alignment		
			Status	Feb-17	Mar-17	Apr-17	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		57.7%		↔	58.0%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	*79%*	R		73.1%		↔	73.0%			✓	
5.3.7	Rolling annual turnover rate	*8%*	R	10.0%	10.0%	10.1%	↑				✓	
5.3.7.1	Executive Team Turnover Rate	*TBA*		7.1%	0.0%	7.1%	↑	3%			✓	
5.3.8	Overall Sickness rate	*4.0%*	G	3.93%	3.96%	3.90%	↓	3.9%				
5.3.9	Sickness rate – Short term	*3.0%*	G	2.8%	2.8%	2.1%	↓	2.7%			✓	
5.3.10	Sickness rate – Long term	*1.0%*	R	1.2%	1.2%	1.8%	↑	1.2%			✓	
5.3.11	Temporary staff % of pay bill	*15%*	G	23.4%	25.4%			23.5%			✓	
5.3.14	Starters	*N/A*		67	68	53	↓	74.8				
5.3.15	Leavers	*N/A*		32	54	53	↓	57.7				

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

8. Enablers

		Monthly Target	Status	Trend: Feb-17	Mar-17	Apr-17	Movement	YTD avg	Data Quality	Alignment: Carter	SQF	Quality Account / CQUIN
7.2.1	APC – NHS number completeness (2 month in arrears)	*99%*	R	98.9%				98.9%				✓
7.2.8	A&E – Attendance disposal (2 month in arrears)	*99%*	R	96.0%				96.5%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	*11*	R	140	226		↑	85.0		✓		✓
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*	R	195	173		↓	341.9		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	*1%*	G	0.8%	0.7%		↓	1.3%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	*103.50*	G	2	15		↑	282.75				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	*0.00*	G	4.00	0.00		↓	3.42				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	*949*	R	2340	2424		↑	1665.1		✓		✓
7.3.13b	A&E % missing breach reason on breached attendances (1 month in arrears)	*50%*	R	100.0%	100.0%		⇔	89.6%		✓		✓
7.3.17	Cancer 2ww invalid NHS Number (1 month in arrears)	*0.25*	R	15	6		↓	5.8		✓		✓
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	*13.25*	G	2	5		↑	21.3		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	*0.01*	G	0	0		⇔	0%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	*2*	G	0	0		⇔	5.6		✓		✓
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	*1.25*	R	0	2		↑	2.7		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	*1.25*	R	0	2		↑	3.7		✓		✓
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	*1*	R	2	4		↑	5.8		✓		✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 1st June 2017 **Agenda Item:** 11a

Title of Report	Finance Report Month 1 April 2017
Presented by	Tracey Cotterill, Director of Finance & Business Services
Lead Director	Tracey Cotterill, Director of Finance & Business Services
Committees or Groups who have considered this report	Finance Committee 25th May 2017
Executive Summary	The purpose of this report is to summarise the M1 year to date and forecast financial performance of the Trust against the agreed plan. The Finance Committee focussed on considering the overall plan and a risk based approach to delivery in order to determine key risks which need to be addressed. Key points are : 1. In month performance reported to NHSI was in line with the planned deficit. 2. Year End Forecast – The forecast outturn is currently aligned to plan but it is recognised that there are a number of risks and opportunities that will arise during the year, and the section below summarises these, giving Worst case, Best case and providing a risk adjusted forecast outturn position. • Forecast per plan is £(37.8)m • Best case is £(34.2)m • Worst case is £(48.9)m (includes all unidentified CIP) • Risk adjusted forecast currently stands at £(39.8)m – as the risks are mitigated it is expected that the risk adjusted forecast will converge towards the planned outturn. 3. Cash – the cash levels are being maintained at or above the minimum requirements as set out in the loan compliance terms. It is anticipated that further loans will be required in June 2017. A resolution from the Board delegating authority to the Chief Executive to draw down funds was considered at FC to be approved by the Board. 4. CIP – the year end forecast for CIP is delivery to plan, however an in depth review of CIP schemes was conducted at the divisional Performance Review

	Meetings (PRM), and challenge made around unidentified plans.
Resource Implications	As outlined
Risk and Assurance	1. The final accounts were approved at Audit Committee, however there is a risk arising on agreement of balances with the commissioners at the year end. **This risk was discussed at FC, and the executive will be meeting with commissioners over the coming days and weeks to agree a final settlement position.** 2. Contract Work plan – this is a large risk to the organisation as the full value of provider intentions is included in our plan, whilst the commissioners have planned a reduced spend to take account of their QIPP (Quality Innovation Productivity and Prevention) programmes. **The Board is asked to note that work is on-going to refine the work plan and confirm the values within this.** 3. CIP Delivery is recognised as a risk with a significant level of unidentified CIP at this time. • **A further £3.4m stretch target has been added to the programme to mitigate.** • **The Board is asked to note that actions are in hand to improve the governance process with appropriate QIA.** • **Appointed an associate director of improvement – working 4 days MFT, I day CCG to provide a consistent approach, particularly with regard to the contract workplan.** • **2020 resource currently diverted to Flow but will resume work on Improvement imminently.** • **Challenge session at PRM regarding the deliverability of identified and how the Trust is going to develop schemes for the unidentified element.** • **Focused approach to specialty contribution targets to highlight areas for savings** 4. Inefficient use of Trust resources remains a risk due to assurance gaps in the financial controls environment. **The Board is asked to note that work has already commenced to enhance the financial controls environment as part of the Trust Financial Recovery Plan and will further roll out through the Spring of 2017 as part of the Trust FRP.** **5.** Trust infrastructure and estate remains a risk due to age and condition. • **The Board is asked to note that improvements**

	have already commenced on both minor and major works, including ED. • **A number of future investments are directly and wholly dependent upon external loan finance and it should be noted that nationally funds for capital investment will be severely constrained in the coming year.** • **In order to obtain approval for central loan funding it will be necessary for each proposal to be supported by an approved, robust and accurate business case that would be subject to challenge by DH before any loan funding could be agreed.** • **The capital programme is being reviewed on a priority basis to ensure that expenditure is reserved for the most essential works.**
Legal Implications/Regulatory Requirements	Lack of achievement of the agreed control total could 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.
Recovery Plan Implication	Financial Recovery is one of the nine programmes of Phase 2 Recovery.
Quality Impact Assessment	All actions will follow an appropriate QIA process
Recommendation	**The Board is asked to note the report**
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒ x

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date:

Agenda Item: 11b

Title of Report	Communications report
Presented by	Glynis Alexander
Lead Director	Glynis Alexander, Director of Communications
Committees or Groups who have considered this report	NA
Executive Summary	The purpose of this report is to provide an update on internal and external communications and engagement activity. Key points are : • Staff communications has focused on improving patient experience by increasing flow through the hospital. • This is part of Better, Best, Brilliant – phase three of our improvement plan. • Our engagement with patients, members of the public, members, and voluntary organisations, has been well received.
Resource Implications	Not applicable
Risk and Assurance	None
Legal Implications/Regulatory Requirements	Not applicable
Recovery Plan Implication	The Communications Team's work is aligned with the improvement plan
Quality Impact Assessment	Not applicable
Recommendation	For noting by the Board
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting x

NHS
Medway
NHS Foundation Trust

Communications report – June 2017

1. EXECUTIVE SUMMARY

1.1. We have embarked on phase three of our improvement plan – Better, Best, Brilliant – with the initial focus on improving flow through the hospital, and increasing the number of patients waiting less than four hours to be seen in our Emergency Department.

1.2. Our internal communications activity has been largely focused around this, ensuring that all staff understand why this is important, and how they can play a part.

1.3. Due to the extended pre-election purdah period (as a result of county council elections followed by the general election) there has been less media activity for the Trust.

1.4. We have continued to develop our community engagement during this time, and look forward to ongoing dialogue with a range of audiences.

2. ENGAGING COLLEAGUES

2.1. We are currently concentrating on the 'flow' workstream within our improvement plan so that staff are clear about the aim – to ensure patients have a quicker journey through the hospital to improve their experience and remove unnecessary delays.

2.2. In mid-May we explained the concept to staff and described a four-week concerted project to achieve a better performance.

2.3. Since then we have been providing staff with daily updates, showing progress and highlight actions for the day.

2.4. This is supplemented with targeted communications between teams to quickly tackle any issues likely to slow flow or create delays for patients. In addition to face-to-face and email updates we have created Whatsapp groups to quickly circulate messages to relevant staff.

2.5. During June we will begin to engage staff in other aspects of the improvement plan.

2.6. Meanwhile, we have a number of campaigns to engage staff in improving care, such as a hand hygiene campaign, currently running to remind staff of the importance of performing hand hygiene and with the right technique. This is the

best way to prevent the spread of infectious diseases in the Trust and is the professional duty of staff. Staff from our infection control team visited wards to promote the campaign, which has been supported by posters and staff messages. The campaign will have further phases which will remind patients and visitors, as well as staff.

2.7. The Trust is supporting the international What Matters to You day on 6 June. This day aims to encourage more meaningful conversations between staff providing care and patients, families and carers. Staff on our wards will be supported to ask 'what matters to you with questions such as 'what's important to you at the moment' and 'when you have had a good day, what are the things that make it good?' The feedback will help influence improvements in future.

3. MEDIA

3.1 We have achieved further national coverage for the STOMP initiative, which succeeded in reducing third and fourth degree tears in women during childbirth from a national average of six per cent, to just one per cent. The award-winning prevention method, that has reduced the number and severity of injuries faced by women, has featured in the Mail on Sunday and The Independent.

3.2 The story has also been picked up by the US TV station CBS, and we have been working to set up filming over the past couple of weeks.

3.3 The Trust was included in news stories about the cyber attack that affected the NHS. Our message was that we hadn't been affected, that our cyber security measures had helped to protect us, and that out IT department continued to be vigilant.

3.4 We have contributed to patient and public advice articles about how to seek healthcare advice and treatment over the bank holidays, and how to be prepared, for example not running out of medicines.

4. SOCIAL MEDIA

4.1 Over the past month we have engaged with 93,500 people (up 3.7%) on Twitter and 123,884 (up 8%) on Facebook. We have shown steady growth, gaining 83 new followers on Twitter and 141 on our Facebook account, taking our total number of followers to 2,796 and 4,518 respectively.

4.2 In our analytics we look at how many times people have 'engaged' with our posts – that is clicked on them, rather than just scrolling past. This is a more important statistic than the number of followers.

4.2 Key topics over the last month were International Nurses' day (44,000 people engaged in posts), Dementia Awareness Week (19,000 engaged in posts), and the celebration of our buddying arrangement with Guy's and St Thomas' (8,000 engaged in posts).

4.3 Other health organisations and stakeholders frequently retweet or share our posts, including Medway and Swale CCGs, Healthwatch Medway and our universities.

4.4 Over the coming month we are planning to create more short videos for posts, as findings show that media content creates more interest than text updates.

5. ENGAGEMENT

5.1 We held a member event on 9 May when we screened Barbara's Story, a moving film that highlights issues faced by vulnerable patients with dementia. The film was made by Guy's and St Thomas' Hospital, and will be used in training for staff at Medway.

5.2 During the evening members heard a presentation by the Trust's Head of Safeguarding, Bridget Fordham, and took part in a lively question and answer session.

5.3 At the next member's event on 14 June we will be discussing our improvement plan.

5.4 We are holding governor elections, and nominations have just opened. The closing date is 24 July. We are promoting the elections, and there will be an induction for new governors once they are in place.

5.5 Our network of voluntary and community organisations continues to grow, and our outreach to these groups has been very well received. We are support initiatives such as Carers' Week from 12 June.

5.6 We are in discussions with Medway and Swale CCGs and local authorities about attending events during the summer. These would provide opportunities for local people to getting involved in discussions about the future of health and social care across Kent and Medway as part of the Sustainability and Transformation Partnership (STP).

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 1 June 2017

Agenda item 12a

Title of Report	Corporate Governance Report
Presented by	Lynne Stuart
Lead Director	Lynne Stuart
Committees or Groups who have considered this report	
Executive Summary	The report outlines current activity and issues in corporate governance.
Resource Implications	N/A
Risk and Assurance	The report outlines the progress of a number of Trust wide initiatives designed to improve corporate governance arrangements.
Legal Implications/Regulatory Requirements	N/A
Quality Impact Assessment	N/A
Recommendation	The Board are requested to note the report and the assurance and risks stated.
Purpose & Actions required by the Board :	Approval ☐ Assurance ☑ Discussion ☐ Noting ☐

NHS Medway NHS Foundation Trust

Corporate Governance Report – 1 June 2017

1. EXECUTIVE SUMMARY

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

2. CARE QUALITY COMMISSION (CQC)

2.1. The Improvement Plan developed in response to the findings from the inspection was received by the Quality Improvement Group (QIG) on 11 May 2017 for scrutiny and by the Quality Assurance Committee (QAC) on 18 May for assurance.

2.2. The Medical Director and Director of Nursing are the responsible officers for ensuring full implementation of the Improvement Plan. Actions within the plan will only be closed once the evidence that has been submitted is quality assured at the QIG, and therefore providing greater assurance on the completeness of the actions.

2.3. Further to the announcement that the general election is to be held on 8 June 2017, the CQC has decided to delay the publication of their response to the consultation on the next phase of regulation, their revised assessment frameworks and the new Hospital Provider Guidance. As a result there will be a corresponding delay in the implementation of the next phase of hospitals inspections and the CQC are working through the implications of this delay and will provide further updates in due course.

3. RISK AND REGULATON QUALITY ASSURANCE

3.1. The Head of Risk and Regulation Quality Assurance has been working with RiskAssure on the next upgrade to the software, which will further enhance the functionality. The final review is almost complete and the upgrade should be available in the next few months.

3.2. There was a Quality Assurance Visit of the Biochemistry Laboratory on 18 May 2017 by NHS Public Health - Fetal Anomaly Screening Programme. The Screening Programme Quality Assures a number of Antenatal and newborn Screening Programmes and in June 2015 MFT were subject to review for those screening programmes to which MFT contributed. Subsequently the Biochemistry Department at MFT commenced the provision of biochemical testing contributing to the Down's Syndrome Screening (DSS) Programme.

3.3. The initial report for factual accuracy is due at the end of June, with the final report due at the end of July. The QA team gave an overview of the day at a closing meeting where some opportunities for improvement were discussed, mainly in relation to the pathway and network arrangements.

4. HEALTH AND SAFETY

4.1. Following the completion of the comprehensive audit of workplace health and safety standards, the resulting report and gap analysis will be shared with the Executive Team and, subsequently, the Board.

5. DOCUMENTATION MANAGEMENT

5.1. Streamlining all of the Trust's policies and procedural documents continues and whilst this is demonstrating positive compliance in many areas, there are still a number of documents to be reviewed and updated. The table below shows the status of the 17 corporate policies which are identified as those requiring Board approval. The Board will note that there are four policies which still require review and approval, one of which is being recommended to the Board for approval this month:

Corporate Policy	Document Owner	Status
Complaints	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Duty of Candour	Medical Director	Approved; Available on intranet and website
Emergency Preparedness, Resilience and Response	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Estates, Facilities and Security	Director of Finance	Approved; Available on intranet and website
Finance	Director of Finance	Approved; Available on intranet and website
Fire Safety	Director of Finance	Approved; Available on intranet and website
Health and Safety	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
HR	Director of Workforce and OD	Outstanding
Information Governance	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website

Corporate Policy	Document Owner	Status
Medicines Management	Medical Director	On the June Board agenda for approval
Patient Care and Management	Director of Nursing	Outstanding
Risk Management	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Safeguarding	Director of Nursing	Outstanding
Serious Incidents	Medical Director	Approved; Available on intranet and website
Standards of Business Conduct	Company Secretary	Outstanding
Violence, Aggression and Disruptive Behaviour	Security Director (currently Director of Finance)	Approved; Available on intranet and website

6. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

6.1. A comprehensive update on EPRR was provided separately in the Annual EPRR report to the Board in May 2017.

7. GOVERNANCE

7.1. In response to some of the recommendations made within the Corporate Governance Report on a Review of the Governance and Effectiveness of the Trust's Clinical Governance Framework carried out in January 2017, the second in a series of three Governance training and development sessions was held on 4 May. These sessions are targeted at all individuals who have some Governance remit within their role. This second session focused on Business Continuity, EPRR and Loggist Training. There were ten staff in attendance from across the Trust (22 invited) and the evaluation was wholly positive.

7.2. Following undertaking a review of the Acute and Continuing Care Directorate's Governance arrangements, the Director of Corporate Governance, Risk, Compliance and Legal and the Head of Integrated Governance met with the Deputy Director of Nursing and the Governance Lead for Acute and Continuing Care to conclude the

review. The DDON and Governance Lead were appreciative of the work undertaken and have agreed to implement the actions identified from the review.

8. INFORMATION GOVERNANCE

8.1. An early sight of the potential new IG toolkit for 2018-19 has been shared. The model reflects a complete overhaul of content and some areas previously reported on (records management / Role Based Access Controls / clinical record keeping) are no longer featured. The revised model centres around the output recommendations from the National Data Guardian Review last year, which relies heavily on technical security audits and controls and security leadership, as well as reporting on the volumes of FOI and subject access requests that are late.

8.2. The new format is very granular and requires specific evidence. The overview has been shared with relevant colleagues in order that they can plan to build requirements into this year as there is the potential for it to take longer than a year for the Trust to meet the required standards.

9. COMPLAINTS

9.1. A detailed report on complaints performance was presented to the Executive Group meeting on 17 May. This was the first report produced by the restructured central team and provided the Executive Group with high level information in relation to the Trust's Complaints Performance. This report will mature going forward, to provide more accurate and meaningful performance information. Through such reports, the Trust will have greater oversight of complaints performance.

9.2. During April the 'new' team established a paperless complaints function, achieving 100% of complaints being logged within three days on Datix and have been working closely with governance colleagues in the clinical directorates to embed the new arrangements.

9.3. The implementation of Datix Web for complaints management also provides the mechanism for capturing the learning and outcomes from complaints systematically. The Clinical Directorates will be focussing on embedding this going forward. Datix Web enables directorates to see the granularity of complaints performance enabling early identification and remediation of under-performance.

9.4. Complaints performance is monitored via the monthly Performance Review meetings with the clinical directorates via the recently developed corporate governance dashboard.

NHS Medway NHS Foundation Trust

Report to the Trust Board

Agenda item 13a

Date of meeting: 1 June 2017

Title of Report	Emergency Planning, Resilience and Response (EPRR) – Change in UK Terrorism Threat Level
Presented by	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Lead Director	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	N/A
Executive Summary	The purpose of this report is to inform the Trust Board about the Trust's preparedness for a major incident in light of the change in the UK terrorist threat level to Critical. It should be read in conjunction with the Board's half-yearly and annual assurance reports on EPRR that demonstrate compliance with statutory duties for EPRR set out in the Civil Contingencies Act.
Resource Implications	N/A
Risk and Assurance	The Trust has well established arrangements for responding to a major incident. These arrangements are subject to regular testing internally and externally as described in the annual report on EPRR and accompanying forward work plan for 2017/18 submitted to the Board in May 2017.
Legal Implications/Regulatory Requirements	Civil Contingencies Act 2004
Quality Impact Assessment	N/A
Recommendation	The Board is requested to note the assurance provided that the Trust is linked in with assurance processes nationally led by NHS England in light of the increased terrorism threat.
Purpose & Actions required by the Executive Group:	Approval ☐ Assurance ☒ Discussion ☐ Noting ☐

NHS
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NHS Foundation Trust

Emergency Planning, Resilience and Response - Change in UK Threat Level
Trust Board: 1 June 2017

1. EXECUTIVE SUMMARY

1.1. Following the Manchester Terror Attack 22 May this report provides assurance to the Board on Trust preparedness should a similar Mass Casualty incident occur, requiring Medway Hospital to respond as part of a whole South East Kent and Medway Trauma Network response.

1.2. The paper is designed to give this assurance specifically based on the agreed Threat Level assurance submission requested by NHS England on the move from a Severe to Critical UK Threat Level on 23 May.

2. INCIDENT TRIAGE

2.1. Assurance can be given that no single hospital site in isolation will ever receive all the casualties from a mass casualty incident. The priority of each casualty is the determining factor as to where they will receive treatment. This triage is undertaken close to the scene of an incident by the Ambulance Service who designates what part/s of the NHS Network will be used.

3. TRUST MAJOR INCIDENT PLAN

3.1. The Trust Major Incident Plan is reviewed annually and audited by NHS England within the Emergency Preparedness, Resilience and Response annual assurance process. At the May 2017 meeting the Board was provided with the EPRR annual report which provided assurance to the Board that the Trust is prepared to respond to and recover from incidents requiring emergency preparedness, resilience and response. The annual report set how the Trust fulfilled its annual plan for 2016/17 and the Board endorsed the annual work plan for 2017/18. A recent exercise (Public Health England managed on behalf of the Trauma Network) for Mass Casualties was conducted in March 2017 (Exercise Watling Street) in conjunction with the South East Kent and Medway Trauma Network Plan.

4. NHS ENGLAND ASSURANCE

4.1. On 24 May the NHS England National Incident Director stated expectations on the increased UK Threat Level (appendix 1) These actions were completed, supported by the activation of the NHS England Local Health Resilience Partnership Plan: Increase in UK Threat Level V1.1

4.2. The following three actions relate back to the Trust's Major Incident Plan:

- Mutual Aid: The NHS England Local Health Resilience Partnership have a published Mutual Aid agreement for response. This is detailed in the Trust

Major Incident Plan and can be accessed strategically via NHS England Incident Control Centre.

- Staff availability, stocks and blood levels: Staffing levels, stock levels and National Transfusion Service were reviewed to ensure that minimum levels are in place, as a baseline, prior to any potential activation of the Major Incident Plan via a cascade process.

- Creating capacity in a Major Incident: The identification of patients to be discharged and those where elective surgery would be suspended are detailed as early actions in a Major Incident response. The Patient Transport Service capability sits alongside this and the Lead Clinical Commissioning Group (East Kent) had previously issued a Major Incident response Flow Chart as part of the contract Business Continuity Plan. This is detailed within the Trust Major Incident Plan.

5. SUMMARY

5.1. The Board is requested to note that the Trust's existing arrangements for EPRR ensure that it fulfills its statutory duties set out in the Civil Contingencies Act 2004. As a Category 1 responder in a major incident, the Trust is required to have the following in place at any time:

- Risk assessment
- Develop emergency plans
- Develop business continuity plans
- Warning and informing
- Sharing information
- Co-operation with other local responders

5.2. The Trust will continue to comply with any requests from NHS England for further assurance or actions to be taken.

NHS England

NHS Provider Organisations CEO
NHS Clinical Commissioning Groups Chief Accountable Officers
Commissioning Support Units

Dr Anne Rainsberry
National EPRR Unit
NHS England
Skipton House
80 London Road
London
SE1 6LH

Publications Gateway Reference 06835

24 May 2017

Dear colleagues,

The Joint Terrorism Analysis Centre (JTAC) has advised that the UK Threat Level should be changed from **SEVERE** (an attack is highly likely) to **CRITICAL** (an attack is expected imminently). Further information regarding this change is available at https://www.mi5.gov.uk/threat-levels.

The consequence of this is that longstanding NHS Emergency Preparedness Resilience and Response (EPRR) protocol means all NHS organisations are now required please to:

- Immediately cascade the change in alert level to your staff
- Review relevant staffing levels and security arrangements across your health facilities, taking account of any additional advice from your local security experts in conjunction with the local police
- Ensure all staff are aware of your organisation's Incident Response Plans, business continuity arrangements and on call notification processes
- Ensure appropriate senior representation is available to join any NHS England Regional or Directorate of Commissioning Operations team teleconferences that may be called to brief on the situation
- Notify your local NHS England EPRR Liaison of any current or scheduled works or operational changes currently affecting service delivery within your organisation
- Review the Home Office advice issued in relation to this threat, and risk assess this against your own organisation, taking steps where possible to mitigate identified risks

- Review mutual aid agreements with other health services including specialist and private providers

Acute care providers are required to:

- Review Emergency Care, Theatre and Support Services, paying particular attention to staff availability, stocks and current blood stock levels
- Clearly identify and review patients who could be discharged safely to create capacity if your organisation is responding to an incident
- Review availability of your Patient Transport Service (PTS) particularly in the event of the local NHS Ambulance Trust requesting mutual aid from your PTS provider

Community and Mental Health providers are required to:

- Review staffing availability for crisis intervention teams
- Prepare to support any accelerated discharge from acute care settings

Clinical Commissioning Groups and Commissioning Support Units are required to:

- Act in support of accelerated discharge and where necessary support Trusts in maintaining their contracted services

NHS England will continue to work with you, the Department of Health, NHS Improvement and other government departments and agencies, and issue further advice as required.

Thank you for your leadership at this time.

Kind regards

Dr Anne Rainsberry
National Incident Director

Copy:
Tom Easterling, Director of Chair and Chief Executive Office, NHS England
Ed Rose, Chief Executive Office, NHS England
Matthew Swindells, National Director, Operations and Information, NHS England
Nicky Murphy, Head of Office, National Director Operations and Information, NHS England
Prof. Sir Bruce Keogh, Medical Director, NHS England
Prof. Jane Cummings, Chief Nurse, NHS England
Karen Wheeler, National Director Transformation and Corporate Operations, NHS England
Prof. Keith Willett, Director for Acute Care, NHS England
Dr Bob Winter, National Clinical Director EPRR, NHS England
Simon Weldon, Director of NHS Operations and Delivery, NHS England
Regional Directors, NHS England
Regional Directors of Operations and Delivery, NHS England
Simon Enright, Director of Communications, NHS England
Stephen Groves, National Head of EPRR, NHS England
National On Call Duty Officers, NHS England
National Second On Call Officers, NHS England
National Media On Call, NHS England
Ash Canavan, National EPRR Communications Lead, NHS England
Regional Heads of EPRR, NHS England
Business Continuity Team, NHS England
Jim Mackey, Chief Executive, NHS Improvement
Kathy McLean, Medical Director, NHS Improvement
Regional Managing Directors, NHS Improvement
Clair Baynton, Deputy Director of EPRR, Department of Health
Department of Health Duty Officer, Department of Health
Public Health England Duty Officer, Public Health England

NHS Medway Foundation Trust

Report to the Board of Directors
Board Date: May 2017 **Agenda item** 14a

Title of Report	Workforce Report
Author/Presented by	James Devine, Executive Director HR & OD Leon Hinton, Deputy Director of HR&OD
Lead Director	James Devine, Executive Director HR & OD
Committees or Groups who have considered this report	Executive Team
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the hospital. The international recruitment plan for nursing continues with a total of 240 nurses being processed for posts at MFT. A further 14 nurses will commence in July from successful EU recruitment. Furthermore, the Trust is taking part in a collaborative regional procurement approach for international recruitment as part of the STP. Trust turnover remains static at just over 10%, sickness remains static under 4%, compliance with mandatory training increased compliance overall by 2.7% to 75%, achievement review compliance reduced to 83%. A significant drop of £1.54m spend on temporary (agency and bank staff) is reported compared to March 2017; similarly a reduction in agency spend as a percentage of paybill by 12% is reported. The Trust's family and friends test (FFT) scores have both improved from the previous quarter with 74% (+1%) of staff recommending Medway to friends and family for care or treatment needs and 61% (+3%) of staff recommending Medway as a place to work.
Resource Implications	None
Risk and Assurance	• Nurse Recruitment • Temporary Staffing Spend The following activities are in place to mitigate this through: 1. Targeted campaign to attract local and national nurses 2. Update on overseas campaign

	3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway 5. Agency/Temporary Staffing Workstream as part of the 2017/18 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.
Recovery 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.
Quality Impact Assessment	n/a
Recommendation	Information
Purpose & Actions required by the Board :	Approval [ ] Assurance [ ] Discussion [x] Noting [x]

Medway
NHS Foundation Trust

WORKFORCE REPORT – MAY 2017

TRUST BOARD MEETING

1. Introduction

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

2. Recruitment

2.1 The international campaigns in both Europe and the Philippines remain on track. 12 European nurses commenced in post on 20 April with a further cohort of 14 arriving in July. 12 EU nurses will be interviewed via Skype on 25 May. Harvey Nash, our international partner agency, is processing the 240 of the 241 Filipino nurses (one individual has withdrawn) that were offered posts in March, with the aim of first cohort nurses arriving towards the end of the calendar year.

2.2 The Trust is partaking in a collaborative regional procurement approach for International Nurse Recruitment as part of the STP. The Trust is undertaking an agency evaluation exercise on 22 May and successful agency partners will be awarded contracts mid-June.

2.3 The Trust has made offers to a high number of qualified nurses and clinical support workers. The table below summarises the position on offers made, starters and leavers for April 2017.

Role	Offers made in month	Actual Starters	Actual Leavers
Registered Nurses	46	15	18
Clinical Support Workers	23	8	10
Associate Practitioners	0	14	0

2.4 Medical Staffing have engaged with permanent recruitment agencies to recruit to hard to fill medical posts (on a permanent basis). This initiative has secured middle grade doctors in general emergency medicine and paediatric emergency medicine, dermatology and respiratory medicine and a locum consultant in neurology. Additionally, 3 Medical Training Initiative scheme doctors (MTI) have been offered posts in medicine; 3 middle grade posts in Neonatology are being interviewed through the MTI scheme in May.

3. Directorate Metrics

3.1 The table below shows performance across five core indicators by directorate. Turnover, at 10.07% (increased by +0.1%), remains above the tolerance level of 8%. Sickness absence (at 3.98%) remains slightly below the tolerance level of 4%.

3.2 Trust achievement review rate stands at 83% (decrease of 3%), below the Trust target of 95%, Mandatory training remains below target (at 75%) but improving (+2.7%) – no directorates are currently meeting either target; HR Business Partners are working with directorates to devise robust plans which better support the achievement review approach as opposed to an annual appraisal system which was replaced in late 2016. Reporting mechanisms for achievement review have been simplified to make it easier to report. Smarter, more transparent reports are currently being worked on based on MOLLIE data to help directorates make sense of their data and support departmental planning for training; these will be in place for end of May. In addition, directorates have been required to review their approach to mandatory training, and utilise the escalation and consequence process detailed within the policy where necessary.

	Acute & Continuing Care			Co-ordinated Surgical			Families & Clinical Support Services			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	Rate	Trend from previous month	12-month trend
Turnover rate (8%)	12%	▼		9%	▲		10%	▲		15%	▲		6%	▲		10%	▲	
Vacancy rate	16%	▶		20%	▶		11%	▶		14%	▶		9%	▼		16%	▶	
Sickness rate (4%)	4%	▶		4%	▶		4%	▶		2%	▶		6%	▶		4%	▲	
Mandatory Training (95%)	70%	▼		73%	▼		76%	▼		63%	▼		69%	▲		75%	▲	
Achievement Review (95%)	89%	▲		78%	▲		93%	▲		82%	▼		91%	▶		83%	▼	

4. Temporary Staffing

4.1 Agency breaches continue to decrease week on week. In December 2016, the Trust was reporting c.1000 shift breaches per week. Since the end of March 2017, the Trust has reported a figure lower than 400 per week, with latest reporting data showing 193 breaches per week; this is an 80% reduction.

4.2 Expenditure on agency decreased in April 2017 compared to March 2017. However, over £700k of March's spend can be attributed to late and disputed invoices. As can be seen from the table below agency, as a percentage of the pay bill, has decreased by 12% in April compared to March and overall temporary spend has decreased by £1.54m.

	March 2017		April 2017	
	Spend in month (£)	% paybill	Spend in month (£)	% paybill
Agency	3,890K	21%	1,573K	9%
Bank	921K	5%	1,696K	10%
Substantive	13,611K	74%	14,009K	81%

4.3 Requests for temporary staffing to cover nursing and doctor vacancies decreased by 160 shifts in April compared to March with 11,685 shifts requested. There was a 4% increase in the medical locum fill rate (94%). However, there was a decrease in the nursing fill rate (69%).

4.4 As is evident in the decrease in NHSI agency price breaches reporting, the majority of agency providers have now reduced their charge rates to now comply with the NHSI price cap rules. Additionally, over 150 agency workers having either joined or are in the process of joining the Trust's in-house bank (resulting in the removal of agency premium); this includes 40 doctors, 38 CSWs and 57 nurses.

5. Other Workforce Updates

5.1 Update on Family & Friends Test:

	Q1 2016/17	Q2 2016/17	Q4 2016/17
How likely to recommend Medway to friends and family if they needed care or treatment	74%	73%	74%
How likely to recommend Medway to friends and family as a place to work	65%	58%	61%

The results from Friends and Family Survey Quarter 4 16/17 demonstrate an improvement to both quarter 2 scores (recommend Medway for care or treatment, recommend Medway as a place to work). The response rate was 21.5%, 2.5% higher than the previous survey. The Staff Engagement Facilitator will be working with the communications team to promote and encourage staff members to complete the next quarterly survey.

- End

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date : 01.06.2017

Agenda item 15a

Title of Report	Research & Development Annual Report for the period 1st April 2016 to 31st March 2017
Presented by	Dr Edyta McCallum
Lead Director	Dr Diana Hamilton-Fairley
Committees or Groups who have considered this report	R&D Innovation and Governance Group will review the report on 6th July 2017. The delay is due to appointment of new Chair in May 2017.
Executive Summary	The purpose of this report is : Key points are : • Inform the Trust Board of the research and innovation activities over the 2016/2017 financial year • Provide update on the development of future strategy
Resource Implications	N/A
Risk and Assurance	N/A
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	N/A
Purpose & Actions required by the Board :	Approval [ ] Assurance [ ] Discussion [x] Noting [x]

NHS Medway NHS Foundation Trust

Research & Development Annual Report for the period 1st April 2016 to 31st March 2017

1. EXECUTIVE SUMMARY

1.1. Participation in clinical research and innovation demonstrates Medway NHS Foundation Trust's (MFT) commitment to improving the quality of care offered to patients and improving healthcare services.

1.2. The report outlines the progress and achievements over the last 12 months.

2. PERFORMANCE IN 2016/2017

2.1. In 2016/2017 there were a total of 159 research studies conducted at MFT.

Figure 1 (Appendices, page 8) presents the number of studies that MFT participated in over seven years, from 1st April 2010 to 31st March 2017.

2.2. For a second consecutive year, MFT was the highest at recruiting patients into clinical Trials in Kent, Surrey and Sussex (out of 20 member organisations).

2.3. 11,622 patients participated in ethically approved research. Out of these 11,046 participated in research supported by the National Institute for Health Research (NIHR).

Figure 2 (Appendices, page 8) presents the annual recruitment target and the actual number of patients at MFT recruited into the NIHR adopted studies in over seven years, from 1st April 2010 to 31st March 2017.

2.4. The Trust encourages research and innovation in all specialties.

Table 1 (Appendices, page 9) presents the number of studies in each specialty in the financial year 1st April 2016 until 31st March 2017.

Table 2 (Appendices, page 10) provides examples of the intent/rationale for six studies.

2.5. In the period between 1st April 2016 and 31st March 2017 the Investigators at MFT published 71 articles (Appendices, List of Publications, pages 11-18).

2.6. The Trust claimed £841k from the Clinical Research Network Kent Surrey & Sussex (CRN KSS). In addition £56k was received as direct income from trials and £20K as a reward and an incentive from the Department of Health.

2. ENGAGEMENT WITH ACADEMIA

2.4. In January 2017, the R&D Department in collaboration with local Universities (the University of Kent, Greenwich and Canterbury) as well as other NHS providers organized a 'Kent and Medway Research Event' which showcased the research and innovation activity taking place at MFT and across the county.

2.5. The event was held at the University of Kent in Canterbury and was very well received. Over 230 delegates registered for the event.

2.6. The Trust Estates Departments formed research links with the University of Greenwich (UoG) and University of Kent (UoK) leading to two PhD studentships taking place at MFT.

2.7. The objective of one project (fully funded by the UoG) is to reduce MFT carbon footprint by 20 percent each year – equivalent to a saving of nearly £492,000. The other project (50:50 funded with the UoG and MFT) addresses the overall water consumption.

2.8. Dr Kumarvel Veerappan (Consultant Anaesthetist) and Dr Heidi Chandler (University of Sheffield) are working in collaboration with the University of Sheffield to develop new software to model the respiratory mechanics of ventilated patients.

2.4. In collaboration with the University of Greenwich (UoG), the National Institute for Health Research (NIHR) funded £50K to deliver Integrated Clinical Academic Programme (ICAP), an introductory training programme for healthcare professionals who wish to become clinical researchers. We had 6 interns.

2.5. The jointly funded post of R&D Officer with the University of Greenwich continues to be a success so much so that the University increased the funding from 1 to 3 days/week.

2.6. The grant applications in 2016/2017 include:

Health Foundation Innovating for Improvement. Dr Ghada Ramadan (Consultant Neonatologist) and Prof Ian McLoughlin (University of Kent and Canterbury). £74,611 applied for in March 2017. Awaiting result.

Wellcome Trust. *'Advanced multi-functional Therapeutic Dressings'.* Hayley Jones (Senior Tissue Viability Nurse) and Dr Joshua Boateng (University of Greenwich). £100,000 applied for in March 2017. Awaiting result.

British Heart Foundation. *'SPIRIT'.* MFT working as partner in a funding bid with University of Greenwich. £287,409 applied for in October 2016. Awaiting result.

National Institute for Health Research (NIHR) i4i. *'Real-time Non-invasive Blood Glucose Monitoring System'.* Dr Rochin Patle (Consultant Chemical Pathologist), Prof Ranjit Akolekar (Fetal Medicine Consultant), Dr Peter Williams (Consultant

Paediatrician) and Dr Ruiheng Wu (UoG). £329,815 applied for in December 2016. Unsuccessful, in a process of re-applying.

3. PUBLIC ENGAGEMENT

4.1. In September 2016, the R&D Department organised a table at the front foyer of the hospital.

4.2. The feedback from the public and staff was extremely positive. A staggering 31 patients/public agreed to become a 'Friend of Research' and provided their contact details.

4.3. The R&D also asked the public and staff to describe what they understand by 'research'. The themes that came up were:

'To help patients'

'Improving care of patients'

'Better care for the future'

'New treatment'

'New knowledge'

'Continuous learning'

'Without research there would be no progress'

'Bench to bedside'

'Evidence based practice'

'Improving standards of care'

'A way forward'

'It is essential'

'Gives people more understanding of their illness'

'Obtaining gold standards of care'

4.4. The R&D Department appointed 'Patient Ambassador for Research'.

4.5. The main objective is to provide expertise on community engagement and involvement in MFT research and innovation.

4.6. In May 2017, as part of International Clinical Trials Day, in collaboration with Kent and Medway NHS and Social Care Partnership Trust (KMPT), Kent Community Health (KCH) and Medway Community Health (MCH), the R&D Department organized a stand at Hempstead Valley Shopping Centre.

4.7. As part of the event key rings and pens were distributed with contact numbers of the R&D Delivery Team.

4.8. The R&D Department also organized a presentation at the Trust by Simon Denegri, National Director for Public Participation and Engagement in Research.

4.9. The event was opened to both Trust staff and public.

4.10. In September 2017, a Commercial Event is being planned where Pharma companies will be invited and MFT will be able to showcase their research and innovation engagement.

4.11. A closer link has been established with the communications dept. and so further publicity is expected to follow.

5. FUTURE STRATEGY

5.6. In order to create a concise, well informed and relevant research and innovation strategy, staff and patients/public were engaged via surveys asking as to what the strategy should entail.

5.7. The staff survey has been completed. The patient survey is due to end 30th June 2017.

5.8. For the staff survey there was a total of 29 responses.

5.9. Following is an outline of some of the responses:

How much do you feel you know about research and innovation activity within the Trust?

38% chose the lowest answer of 0-40%

21% chose 40-60%

18% chose 60-80%

25% chose the highest option of 80-100%

If you were approached to be involved with, or to undertake, a research or innovation project (e.g. as an investigator or part of a research team), would you agree?

A staggering 86% answered 'yes'
8% answered 'No'
8% answered 'Not sure'

If you would like to be involved in research and/or innovation, would you prefer to:

Undertake your own project:	9%
Participate, the Trust being a hosting site:	50%
Both:	42%

In your opinion, what should our core objective(s) be going forward? E.g. best in hosting external research, delivering high quality data, supporting innovation etc.

Unsure.
All of the above.
Balanced portfolio with the external and home grown research and innovation studies.
Supporting innovation looking to improve our local services.
Delivering high quality research/data.
Going forward it must be recruitment figures and making sure we keep recruiting a huge amount of patients into research studies. The data must always be of high quality as make it easier to understand and reuse to show in presentations on how good Medway is at research.
Hosting external research, delivering high quality data and supporting innovation.
Supporting innovation.
Delivering high quality data
More icu based research projects.
Seek for more external fundings.
We should have an easy access to a local statistician.
Promoting good practice and improvements.
Delivery of high quality data ...support of innovation. Focus on the needs of the patient and general public. To make a real and lasting difference to the quality of clinical care that is provided by Medway?

In your opinion what challenges would we have to overcome for the objective(s) to be achieved? What systems, structures and other services do we currently have that could support achieving the objective(s)?'

Oasis for patient demography Metavision Wardwatcher Nurse specialists/matrons P.A.L.S.

Trust need to integrate research as part of the key services; consultants to play key role to integrate research in patient pathway and staff development.
Funding challenges. Research support.
Depends on the research question, participants and other variables.
Having the structures in place to do this, time and money as well.
Clinical IT projects.
Financial, staffing levels to support it, a culture of learning and applying evidence to practice.
Collaborations with other institutes.
Presence of a statistician in the hospital will be a great help.
In my opinion, this is for management to assess
Inadequate capacity.
Strong leadership & drive, Generic working, teamworking sharing good practice - ensuring the Trust promotes active research with all clinicians wherever/whenever possible throughout - across trust strategies working with good recommended systems.

In your opinion, how can the Trust Board support expansion of research and/or innovation within the Trust?

Increase the size of the research team.
To integrate research as part of healthcare.
Giving staff time and opportunity, working with learning institutes to encourage research in the workface - funding for masters in research.
I am not sure. Sadly I think it just comes down to money and bigger offices for new staff.
By providing money and support to staff who wish to participate in research. Paid academic time, paid time to update our evidence base. Access to journals via Open Athens should be more straightforward and promoted. Staffing levels should allow for time to participate in research.
Via collaborations.
More resources for the research team.
No idea.
Unknown.
Promoting research more.
Another question for management.
Generic working with all neighbouring Trusts, clinicians, universities developing strong links so building bigger wider portfolio @ MFT.

Please provide ideas on how we can improve Medway public engagement in Trust research and/or innovation.

Engage with patients and their relatives/carers from the first point of contact - Medway hospital. e.g. out-patients, E.D, sav, pre-assessments. Has Medway carried out any research on the well being of relatives/carers whilst their loved ones are using the service? Advertise trust research in Medway Matters which is delivered to every home.
Research-interested/ keen staff to talk to patients, their family/carers about the on-going research.

Greater awareness, and demonstration of the implications of research on the services here at medway. Stalls around the Hospital or around the Medway towns like shopping centres. More robust :Communication(Newsletters/more proactive comms team run more like a professional media house) :Staff Involvement :Social Media(Facebook, Instagram, Tweeter...etc). More awareness. Show what's worked, what we've learned and put into practice and celebrate that. Through awareness involving everyone. Regular research seminars with involvement of public. Training Posters Email. For the communications team to decide. Media. Sharing good news bulletins from trials newsletters ... intranet/internet updates. promoting ongoing Research wherever possible @ MFT.

APPENDICES

Figure 1. The no. of research studies (within MFT) between 1st April 2010/31st March 2011, 1st April 2011/31st March 2012, 1st April 2012/31st March 2013, 1st April 2013/31st March 2014, 1st April 2014/31st March 2015, 1st April 2015/31st March 2016 and 1st April 2016/31st March 2017.

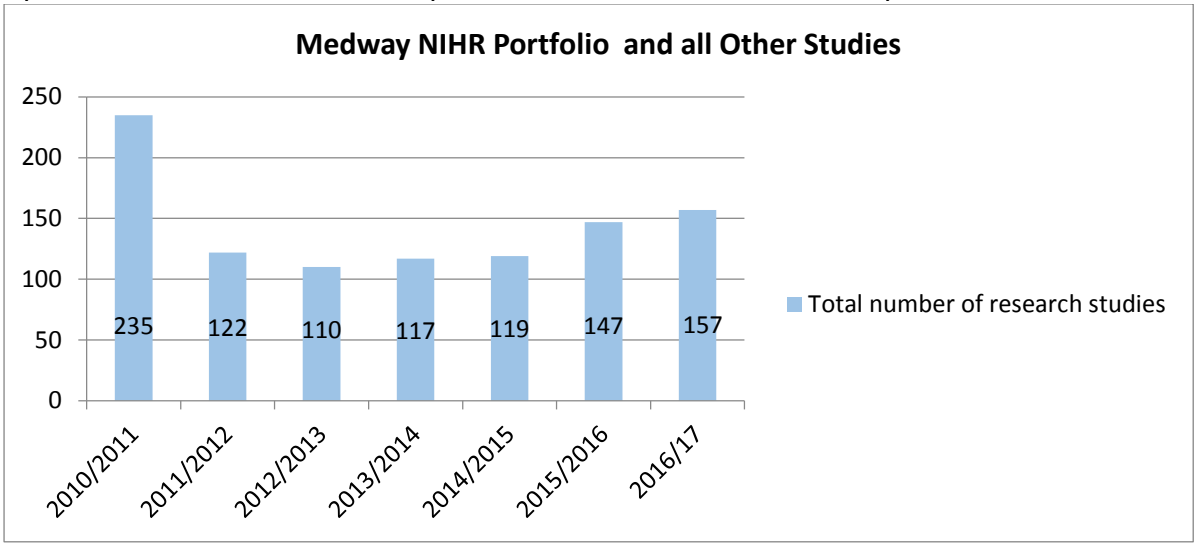

Figure 2. The annual NIHR recruitment target and actual no. of participants in NIHR supported projects (within MFT) between 1st April 2010/31st March 2011, 1st April 2011/31st March 2012, 1st April 2012/31st March 2013, 1st April 2013/31st March 2014, 1st April 2014/31st March 2015, 1st April 2015/31st March 2016 and 1st April 2016/31st March 2017.

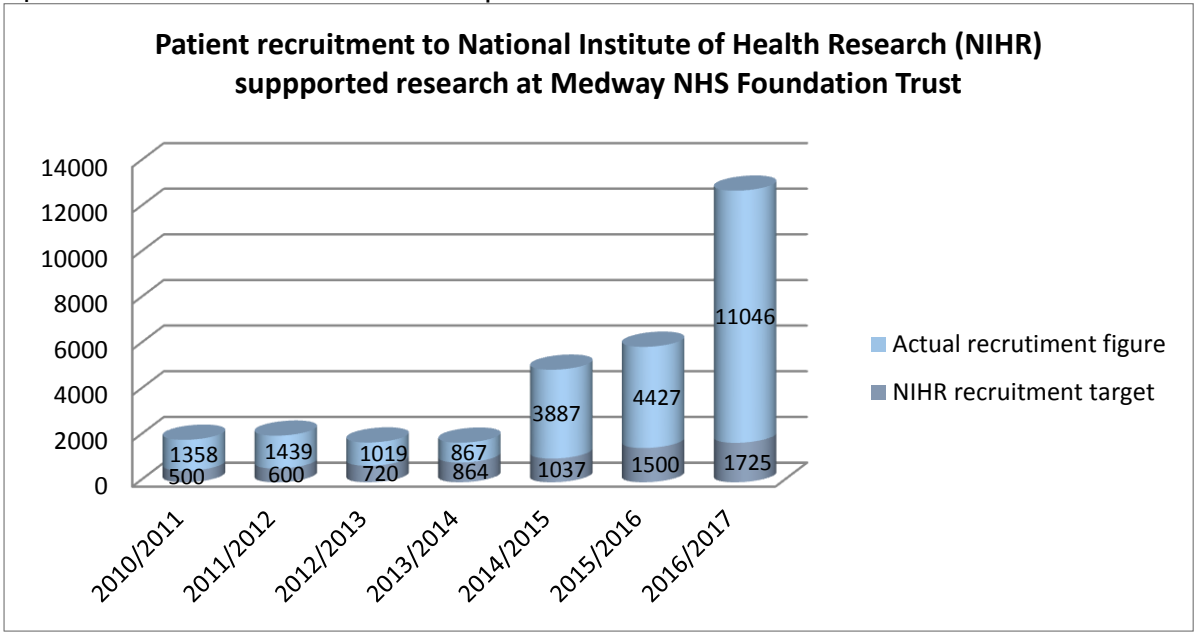

Table 1. The number of research projects by medical speciality being undertaken at MFT for the period 1st April 2016 until 31st March 2017.

Number of Studies by Medical Speciality	2016 - 2017
Cancer	**58**
Cardiovascular	**5**
Cardiology	**2**
Critical Care	**6**
Dermatology	**2**
Diabetes	**4**
Ear Nose and Throat	**1**
Fetal Medicine	**5**
Gastroenterology	**1**
Genitourinary Medicine	**1**
Gynaecology	**3**
Haematology (non-malignant)	**2**
Neonatology	**9**
Neurosciences	**6**
Obstetrics	**6**
Older People	**1**
Orthopaedic	**6**
Other*	**17**
Paediatrics	**6**
Respiratory and Thoracic	**5**
Rheumatology	**2**
Stroke	**4**
Surgery	**3**
Urology	**2**

*Studies outside of clinical speciality for example educations studies or research into overall patient experience.

Table 2. A rationale/intent for 6 studies undertaken at MFT between 1st April 2016 to 31st March 2017.

Study Name / Acronym	Rationale
Catheter Valve	Urinary retention is a common problem in men over the age of 60, and is often treated with a urethral catheter for a fixed period of time. Patients attend a Trial Without Catheter Clinic at the end of their treatment to determine whether they are able to pass urine spontaneously. This involves waiting in the clinic for five or more hours after catheter removal, until the patient has the urge to pass urine. This trial investigates whether using a catheter valve can reduce the waiting times in the Trial Without Catheter Clinic. Patients are asked to close the catheter valve 3-4 hours before their clinic appointment, thereby filling their bladder. Once their catheter is removed they are expected to pass urine much more quickly, eliminating the need to wait in the clinic
CORKA	The trial is comparing usual care rehabilitation versus an at home rehabilitation programme carried out by Rehabilitation Assistants. The Primary objective of the trial is determine if a multi-component rehabilitation programme improves the outcome of patients who undergo a Knee Replacement.
GALACTIC	The study is comparing the use of Obinutuzumab in patients who have recently responded to treatment for chronic lymphocytic leukaemia (CLL) with the current standard practice, which is to receive no treatment. Obinutuzumab is a new generation of monoclonal antibody that is able to target CLL cells. Treatment with monoclonal antibodies has been shown to be effective at reducing the minimal CLL residual disease levels in patients following conventional therapy. As patients with no minimal residual disease have a greater survival advantage in comparison to those patients that do have minimal residual disease, this trial will look to see if Obinutuzumab will reduce minimal residual disease levels and improve patient outcomes.
HeadPoST	How patients are positioned after a stroke differs across the world. For some patients normal care would be lying down, and for some it would be sitting up. This study aims to compare the different practices used in different countries in order to better identify which components of care may benefit individual patients.
POPPI	The Intensive Care unit can be a scary, unusual and unfamiliar environment for someone to be in, especially when critically ill. This can cause distress and upset some patients. This study looks at providing training to the intensive care team to create a calmer, less stressful environment helps reduce the distress and upset some patient's experience.
Spree	Pre-eclampsia is a medical condition characterised by high blood pressure and the presence of protein in the urine of a pregnant woman. It develops in at least 2% of all pregnancies. The effects of pre-eclampsia can be serious both for the mother and the baby, especially when the disease is severe requiring delivery before 37 weeks' gestation and there is associated slow growth of the baby. This study evaluates the effectiveness of a newly developed method against the current standard.

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Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Agenda item 16a

Board Date: 1 June 2017

Title of Report	Corporate Policy: Medicines Management
Presented by	Dr Diana Hamilton-Fairley, Medical Director
Lead Director	Dr Diana Hamilton-Fairley, Medical Director
Committees or Groups who have considered this report	Medicines Management Group
Executive Summary	Further to discussions between the Chief Executive and the Executive Group, it was resolved to map all policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) under one of a number of overarching Policy Areas with a high level Board approved Corporate Policy covering each area. The Corporate Policy is intended to be a high level overview of the organisation's policy in the relevant area, with the detailed instructions / guidance being laid out in supporting documentation which is referenced in the Corporate Policy and therefore linked to the overarching policy document. The corporate policy areas are: • Information Governance • Consent • Complaints • Serious Incidents • Safeguarding • Emergency Planning, Resilience and Response • Human Resources/employee handbook • Health and Safety / Fire Safety • Standards of Business Conduct • Medicines Management • Risk Management • Patient Care and Management • Security and Estates • Duty of Candour • Finance Accordingly, the Corporate Policy for Medicines Management has been drafted and is attached for Board approval.
Resource Implications	N/A
Risk and Assurance	Medicines are used in all areas of the Trust and are the

	responsibility of all healthcare professionals. The importance of appropriate policy and procedures to ensure the quality and safety of all aspects of medicines usage is paramount, and is a key component of clinical governance.
Legal Implications/Regulatory Requirements	Corporate Policies are being drafted to reflect legal and regulatory requirements. The Medicines Management Policy has been produced with particular reference to the Medicines Act (1968) and associated European legislation.
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Medicines Management Group has reviewed the policy and recommends that the Board approves the new Corporate Policy for Medicines Management.
Purpose & Actions required by the Board :	Approval ☑ Assurance ☐ Discussion ☐ Noting ☐

Medway NHS Foundation Trust
Corporate Policy: Medicines Management Policy

Author:	Associate Chief Pharmacist: Quality, Governance & Training
Document Owner:	Medicines Management Group
Revision No:	6
Document ID Number	POLCPCM033
Approved By:	Medicines Management Group
Implementation Date:	April 2017
Date of Next Review:	April 2018

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MEDICINES MANAGEMENT POLICY

Document Control / History	
Revision No	**Reason for change**
1 New	Existing medicines policies to be amalgamated into one Medicines Management policy
1 Minor amendment	Addition of training requirements for prescribing and administration of medication, monitoring the effectiveness of the policy and current prescription pro forma
2	Full review and update.
3	Addition of information regarding loading doses
4	Complete review; removal of procedural details into separate policies
5	Addition of Medicines Protocol details, full review to occur April 2016
6	Full review and update

Consultation
Medicines Management Group

MEDICINES MANAGEMENT POLICY

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MEDICINES MANAGEMENT POLICY

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

1 Introduction

1.1 Medicines are used in all areas of the Trust and are the responsibility of all healthcare professionals. The importance of appropriate procedures to ensure the quality and safety of all aspects of medicines usage is paramount, and is a key component of clinical governance. All members of staff dealing with medicines need to contribute to maximising their effective use and minimising medicine-related harm and morbidity for our patients.

2 Aim

2.1 To ensure that medicines are correctly stored, properly prescribed, and correctly administered in a safe and timely manner.

2.2 To support the Trust's strategic objective of delivering safe, high-quality care and an excellent patient experience.

2.3 To detail the responsibilities of all staff groups involved with prescribing, dispensing, carriage, safe storage, and administration of medicines.

2.4 The key components of this policy include:

- 2.4.1 Storage, security and ordering of medicines
- 2.4.2 Prescribing (and other legal mechanisms for authorising supply/ administration of medicines)
- 2.4.3 Administration of medicines
- 2.4.4 Dispensing and issue of medicines
- 2.4.5 Monitoring of medicines management processes

3 Definitions

3.1 "Medicines Management is a system of processes and behaviours that determines how medicines are used by the NHS and patients. Good medicines management means that patients receive better, safer, and more convenient care. It leads to better use of professional time, and enables practitioners to focus their skills where they are most appropriate. Effective medicines management also frees up resources which means that NHS money can be used where it is most effective, Good medicines management benefits everyone." (National Prescribing Centre).

3.2 Medicines optimisation is defined as 'a person-centred approach to safe and effective medicines use, to ensure people obtain the best possible outcomes from their medicines'. Medicines optimisation embodies the principles of Medicines Management, as applied to individual patients.

4 Relevant legislation

4.1 The control of medicines in the United Kingdom is primarily governed by the Medicines Act (1968) and associated European legislation. The administration of medicines is an important aspect of nursing professional practice (NMC 2008). The Nursing and Midwifery Council recognizes that it is not a mechanistic task to be performed in strict compliance with the instructions of the prescriber but requires thought and expertise with professional judgment. This policy has been formulated to ensure, as far as possible, the safe storage, administration and disposal of medicines. Nurses are reminded of their responsibilities under the Code of Professional Conduct (NMC 2008) in that "each registered nurse, midwife and health visitor is accountable for his/her practice."

4.2 Doctors, other prescribers and pharmacists are reminded of their responsibilities as stated in relevant legislation and the Codes of Ethics produced by the GMC, NMC and GPhC.

4.3 The *Non-Medical Prescribing Policy* (POLCPCM039) sets out the guidelines for non-medical prescribing.

4.4 The GMC's revised guidelines on *Good Medical Practice (2006)* outlines the principles that doctors must follow when prescribing medicines, with particular reference to paragraphs 1 to 3 and 20 to 22.

4.5 The GMC provides further ethical guidance in *Good Practice in Prescribing Medicines: Guidance for Doctors* (2008)

4.6 You must give patients, or those authorising treatment on their behalf, sufficient information about the proposed course of treatment including any known serious or common side effects or adverse reactions. This is to enable them to make an informed decision (for further advice, see *Consent Guidance: Patients and Doctors Making Decisions Together* (GMC 2008).

5 Policy Framework

5.1 **Medway NHS Foundation Trust** is committed to complying with statutory, mandatory and best practice requirements through a supporting framework of documents:

POLCMM007 - Medicines Management Sub-Policy 1 – Safe and Secure Handling of Medicines This document outlines the safe and secure handling of medicines within Medway NHS Foundation Trust aims to ensure compliance with current legislation, and good practice guidance, whilst managing the risks to patients and staff arising from the use of medicines.
POLCMM008 - Medicines Management Sub-Policy 2 – Prescription Writing

This document details the prescribing standards and procedures.
POLCMM009 - Medicines Management Sub-Policy 3 - Controlled Drugs Procedure This document provides detailed procedures on the safe use and security of Controlled Drugs and appropriate availability.
'Purchasing for Safety' Policy This policy details how the trust ensures safe purchasing of medicines
Medicines protocols and Occupational Health standing orders The method of supplying medication in the absence of a prescriber and patient group direction
Homecare Policy This policy promotes good practice in the development, implementation and provision of homecare
GUCMM018 - Self Administration of Medicines Guidelines This document describes the key components for successful implementation of self-administration. The document works in conjunction with national and local policies on medicine storage and administration.
GUCPCM012 - Administration of medicines - Nursing & Midwifery Council (August 2004) The booklet sets standards for safe practice in the management and administration of medicines by registered nurses, midwives and specialist community public health nurses
POLCPCM034 - Unlicensed Products Policy This document describes the trust policy for the procurement and use of unlicensed medicinal products (often called "specials").
POLCMM002 - Medicines Reconciliation on Admission To Medway Foundation Trust Policy This document describes the types of Medicines Reconciliation which are undertaken at Medway NHS Foundation Trust. Medicines Reconciliation (MR) is the responsibility of all staff involved in the admission, prescribing, monitoring, transfer and discharge of patients requiring medicines.

PDGCMM004 - Patient Group Directions - Development and Use Policy and Procedure This document provides good practice recommendations for the systems and processes used when Medway NHS Foundation Trust is considering the need for, developing, authorising, using and updating Patient Group Directions (PGDs).
POLCPCM039 - Non-Medical Prescribing Policy This document describes Non-medical prescribing, it is the prescribing of medications by Nurses, Midwives, Health Visitors, Pharmacists and Allied Health Professionals (AHP) who have successfully qualified as prescribers.
SOP0173 - Use Of FP10 Prescriptions at Medway NHS Foundation Trust Procedure This SOP covers the management of FP10 prescription stock for Medway NHS Foundation Trust, including stock control, ordering forms from suppliers, delivery, receipt, storage and distribution of the forms, and destruction and disposal of forms that are no longer needed.
PROCMM001 - Returning Patient's Own Controlled Drugs or 'Ward Stock' to pharmacy This document details the process for returning Patient's Own Controlled Drugs or 'ward stock' to pharmacy.
SOP0010 - Ward Staff Authorised to Order Controlled Drugs From Pharmacy This document details the procedure to ensure that the person requesting ward controlled drugs as stock are authorised to do so.
POLCMM012 - Antibiotic Stewardship Policy - POLCMM012 This policy aims to ensure correct antibiotic treatment is given.
OTCGR072 - Pharmacy - Business Continuity Plan Pharmacy - Business Continuity Plan sets out the preparations for the department/section to manage and recover from service disruptions.
OTCS025 - COSHH HSE: A Brief Guide to the Regulations Sets out the regulations for using chemicals and other hazardous substances.

POLCOM001 - Medical Gas Pipeline Systems and Associated Equipment Operational Policy This document details how we management medical gases.
Plus other local procedures on specific drugs e.g. Safe Prescribing of Rivaroxaban

6 Roles & Responsibilities

6.1 Chief Executive Officer

6.1.1 The Chief Executive is the responsible officer for the Trust and is legally accountable for medicines management and the associated risks across the organisation

6.1.2 It is the responsibility of the Chief Executive to ensure there are clear lines of accountability established and maintained throughout the organisation, defining interpersonal relationships between the Board, relevant committees (including the Medicines Management Committee and the Patient Safety Committee) and heads of department/ service

6.1.3 The Chief Executive must ensure the Board is kept fully informed of any medicines management risks and any associated medicines management issues

6.2 Executive Directors

6.2.1 The Director of Nursing and the Medical Director are responsible for overseeing the professional standards of nurses and doctors employed by the Trust.

6.2.2 Directorate management teams (Directors of Operations and Divisional Directors) are accountable to the Chief Executive for ensuring that all staff under their control fully implement this policy, and any related sub-policies/ documented procedures. They are required to ensure, so far as is reasonably practicable, that:

3.2.2.1 There are adequate resources available to meet the medicines policy requirements

3.2.2.2 All managers are competent to discharge their medicines management responsibilities

3.2.2.3 The effectiveness of the policy and arrangements for implementation are regularly monitored and reviewed

3.2.2.4 Appropriate instruction, training and supervision is provided for staff under their control and working in their area of responsibility.

6.3 Executive Lead for Medicines Management

6.3.1 The Executive Lead for medicines management has overall accountability for the safe and secure handling of medicines, supported by the Chief Pharmacist and Medicines Management Committee.

6.4 Medicines Management Committee

6.4.1 All aspects of medicines management within the Trust are accountable to the MMC, which reports to the Quality Committee.

6.4.2 See also MMC Terms of Reference.

6.5 Director of Nursing and Chief Pharmacist must:

6.5.1 Ensure safe systems and practices are implemented, maintained and monitored

6.5.2 Ensure staff are made aware of this policy and its contents. New staff must be informed at induction.

6.6 Controlled Drugs Accountable Officer

6.6.1 The Trust, as a 'designated body' under the Health Act 2006, must appoint a fit, proper and suitably experienced person as it's accountable officer for controlled drugs. The Accountable Officer at MFT is the Director of Nursing, who must:

6.6.1.1 Establish and operate appropriate arrangements for securing, monitoring and auditing the safe management and use of controlled drugs by the Trust.

6.6.1.2 Review, or ensure that the Trust reviews, arrangements for the safe management and use of controlled drugs.

6.6.1.3 Ensure that the Trust establishes appropriate arrangements to comply with misuse of drugs legislation.

6.6.1.4 Ensure that the Trust has adequate and up-to-date standard operating procedures (SOPs) in place in relation to the management and use of controlled drugs.

6.6.1.5 Ensure adequate destruction and disposal arrangements for controlled drugs.

6.6.1.6 Ensure relevant individuals receive appropriate training.

6.6.1.7 Monitor and audit the management and use of controlled drugs by relevant individuals, and to monitor and assess their performance.

6.6.1.8 Maintain a record of concerns regarding relevant individuals, taking appropriate action in relation to well-founded concerns regarding individuals.

6.6.1.9 Assess and investigate concerns about the safe management, prescribing and use of controlled drugs and take appropriate action if there are well-founded concerns.

6.6.1.10 Establish arrangements for sharing information with other Trusts and local bodies as part of a Local Intelligence Network.

6.7 **Chief Pharmacist is responsible for:**

6.7.1 Ensuring the procurement of pharmaceuticals of appropriate quality, in accordance with Standing Financial Instructions, Drugs and Therapeutics Committee and Medicines Management Committee policies and ensure value for money.

6.7.2 Establishing a system for the safe and secure handling of medicines.

6.7.3 Establishing and maintaining a system for the supply, distribution, return and destruction of medicines.

6.7.4 Establishing a system for advising all healthcare staff and patients on all aspects of medicines management, to ensure the best use of medicines.

6.7.5 Establishing a system for recording and reporting pharmacists' interventions on prescriptions, in accordance with the Trust's Incident reporting policy (including Serious Incidents Requiring Investigation (SIRIs)) Management Policy and the Risk Management Policy.

6.7.6 Establishing and maintaining a system which ensures the availability of advice and medicines for use in an emergency when the Pharmacy is closed.;

6.7.7 Establishing a system for a senior pharmacist to routinely review all medication-related incidents reported via the Trust's reporting systems, and for producing regular reports and trends on these for the Medicines Management Committee; ensuring that all staff understand how to raise concerns about the safe and secure handling of medicines.

6.7.8 Developing a system to provide an audit trail of all medicines at points of transfer (e.g. on handover from Pharmacy to clinical area), with particular reference to drugs which require special handling, notably Controlled Drugs (CDs) and drugs requiring refrigeration.

6.7.9 Recommending to the Medicines Management Committee on safety and security grounds which drugs must be ordered and supplied in a restricted manner.

6.7.10 Auditing the implementation of medicines handling policies and systems.

6.7.11 Monitoring the use of unlicensed medicines, and the use of licensed medicines for unlicensed indications, and to ensure their quality and suitability for use. The Pharmacy shall provide the prescriber with adequate use on the stability of the preparation in clinical practice.

6.7.12 Production, review and updating of this policy on behalf of the Medicines Management Committee.

6.7.13 Ensuring that the Trust has a nominated Medication Safety Officer, with a key responsibility to promote the safe use of medicines across the Trust, and to act as an expert in Medication Safety.

6.7.14 Ensuring new staff are made aware of this policy and its contents.

6.8 **Heads of Nursing are responsible for:**

6.8.1 Ensuring operational implementation of this policy within clinical areas

6.9 **Senior Sisters/ Senior Charge Nurses are responsible for:**

6.9.1 Ensuring that all relevant policies and guidelines are available and followed within the ward/ department, and that these policies and procedures form part of the core induction for new registered nurses/ midwives joining their clinical area.

6.9.2 Ensuring that all medications are kept in a safe and secure manner, according to the provisions of this, and any other relevant policy; ensuring that appropriate procedures are in place for checking adherence to this.

6.9.3 Ensuring that appropriate levels and range of stock drugs for their ward/ department are established, in conjunction with their pharmacy team.

6.9.4 Ensuring that any Patient Group Directions used within their area are used according to the Trust Policy.

6.9.5 Ensuring that access to controlled stationery such as FP10 prescriptions and controlled drug order books/ registers is restricted to authorised staff.

6.9.6 Ensuring that all drug storage facilities, including fridges, cupboards and Patients' Own Drug boxes, are of appropriate design and standard.

6.9.7 Ensuring that deviations from policy and monitoring requirements are acted on promptly and appropriately.

6.10 **Registered Nurses and Midwives:**

6.10.1 Will administer medicines in accordance with a prescriber's directions whilst ensuring the safety of the patient.

6.10.2 Will check that all particulars of the prescription are safe and appropriate before administering any medicine, referring to the prescriber or a pharmacist if necessary.

6.10.3 May supply/administer to patients via a Patient Group Direction following appropriate training and authorisation. Midwives may administer certain medicines within the course of their professional practice (see policy for use of midwife exemptions).

6.10.4 Will identify medicines management issues, particularly, but not excluding, those relating to administration, and bring these to the attention of the pharmacist or prescriber, e.g. inability to take oral medicines, lack of intravenous access, incomplete or incorrect prescriptions.

6.11 **Prescribers (doctors and non-medical prescribers):**

6.11.1 Will prescribe appropriate medicines for patients in their care.

6.11.2 Will prescribe legally and legibly.

6.11.3 Will only prescribe within their sphere of competence.

6.11.4 Will obtain informed consent (where possible) before prescribing medicines.

6.12 **Pharmacists:**

6.12.1 Are responsible for ensuring that medicines are prescribed, supplied, stored, prepared and administered correctly.

6.13 **Pharmacy Support Staff**

6.13.1 Are responsible for undertaking a range of medicines management tasks, some depending on specific accreditation, including medicines reconciliation, dispensing, checking dispensed items and stock control.

6.14 **All healthcare staff who handle, supply or administer medicines:**

6.14.1 Are accountable for working within current legislation and for working within the code of conduct of their professional body, and within any trust policy.

6.14.2 Are accountable for ensuring that medicines are prescribed and administered only to treat patients of the Trust.

6.14.3 Anyone prescribing, supplying, preparing, administering or disposing of medicines is personally responsible and accountable. That accountability cannot be delegated or shared with another person. Anyone involved in any aspect of medicines management is responsible for bringing to the attention of their line manager any educational needs they may have in relation to ensuring safe practice, and for undertaking the necessary training.

6.15 **Medicines Management Group**

6.15.1 Will oversee all medicines management policies and procedures.

6.15.2 Will bring to the attention of the Quality Improvement Group (or equivalent Committee) any issues which it believes are relevant.

6.15.3 Will oversee all medicines management audits, including compliance with NPSA and NICE guidance and CQC registration requirements.

6.15.4 The Medication Safety Officer will be a key member of the MMC.

6.16 **Medical Gas Group**

6.16.1 To provide assurance to the Trust Medicines Management Group which in turn reports to the Trust Board of Directors, that there are appropriate risk management infrastructure and controls in place to minimise the risk of harm from the use of medical gases and medical gases piped systems.

6.16.2 Provides a forum for those individuals with delegated roles and responsibilities to take collective ownership for ensuring it identifies medical gases-related hazards, assesses risks, identifies and monitors control measures and develops incident protocols.

6.16.3 To ensure the Trust has robust processes in place to meet its regulatory requirements in relation to Medical Gases.

6.16.4 To review and monitor the Trust Medical Gas budget.

6.17 **Drugs and Therapeutics Group**

6.17.1 To apply a multi-disciplinary and multi-organisational approach to decision-making regarding medicines provision.

6.17.2 To promote clinically and cost-effective, safe and equitable use of medicines.

6.17.3 To ensure that robust standards and governance are observed.

6.17.4 To engage stakeholders beyond the Trust and membership organisations as required.

6.18 **Safe Sedation Group**

6.18.1 The main objective of the Sedation group is to promote and provide the highest standard of quality of care for patients receiving sedation for various procedures outside of theatres.

6.19 **Infection Control & Antimicrobial Stewardship Group**

6.19.1 The purpose of this group is to maintain an overview of infection prevention and control / Antimicrobial prescribing priorities within the Trust.

6.20 **Directorate Management Teams**

6.20.1 Will implement policies and procedures as directed by the Medicines Management Committee

6.20.2 Will identify medicines management issues and bring these to the attention of the Medicines Management Committee.

7 Procurement of Medicines

7.1 The Pharmacy Department is responsible for developing, maintaining, implementing and reviewing the Trust's 'Purchasing for Safety' Policy Part of this involves ensuring the procurement process delivers medicines of suitable quality which are well designed for use. Factors include product identification, reconstitution, administration and disposal. Moreover, it is essential that the procurement process assesses the capabilities of the supply chain to the hospital to ensure that products are genuine, have been correctly stored and are available when required

7.2 All medicines on NHS contracts have a product licence and before a product is included on a PaSA contract it is assessed by NHS PharmaQA staff and given a MEPA (medication error potential assessment) score which reflects its suitability for use. Contracts should be adhered to for both financial reasons and because these assessed products present a lower risk. Purchasing "off contract" should only be undertaken with caution and risk assessment. The PharmaQC database contains a list of assessments and should be used to help decide on suitable alternatives to unavailable contract lines.

7.3 Purchasing should use appropriate, trusted sources of supply to ensure the suitability of products purchased to minimise the possibility of counterfeit medicines. Suppliers and wholesalers are required to hold an appropriate licence from the MHRA and this should be checked for authenticity. NHS PaSA holds a list of inspected suppliers who hold or have successfully held a PaSA contract. This database (NHS SID) is held on their website. PharmaQA and procurement staff inspect potential pharmaceutical suppliers and these reports can be used to assess new suppliers. Pharmacy procurement specialists can give advice about potential new suppliers. It is important that the entire supply chain has been assessed since there are a number of stages often involved in obtaining medicines.

7.4 All medicines will be procured by Pharmacy, with the exception of certain dressings and disinfectants which will be supplied via NHS Logistics. The Trust will have a formulary of medicines and pharmacy will only procure non-formulary items in exceptional circumstances. Records will be kept of such purchases.

7.5 Patients' own medication may be used on the wards provided they have been checked to ensure their appropriateness. (See Patient's Own Drugs Policy and Procedures)

7.6 Medicine samples may not be left by company representatives and staff must not accept them. Samples are rarely an effective way of assessing a product and if a prescriber wishes to prescribe a medicine not currently on the formulary this should be discussed with Pharmacy.

7.7 Medicines used in clinical trials are subject to a different policy – Research and Development Policy.

7.8 Pharmacy will ensure they procure medicines with safety in mind and will review the packaging of all new products to ensure they conform to necessary standards. They

will report to the regional procurement specialist/ the Commercial Medicines Unit any identified problems.

7.9 Unlicensed medicines will only be procured when no suitable licensed alternative exists and the Unlicensed Medicines Policy will be adhered to at all times.

7.10 Pharmacy will adhere to national and regional contracts as agreed by the NHS Purchasing and Supply Agency (PaSA); they will only break these contracts in exceptional circumstances.

7.11 Trust staff are aware of anti-Bribery legislation and always act in accordance with this law. Staff work legally and fairly at all times and as such no bribe will ever be offered, or accepted. We expect the same behaviours from those we do business with. If an employee suspects they have been offered a bribe they will report the matter which will be fully investigated. This may lead to the Trust terminating any future business dealings with the organisation offering the bribe.

8 Security of Medicines

8.1 All medicines on wards and departments must be stored in appropriate locked cupboards, cabinets, refrigerators or trolleys. Exceptions to this include intravenous fluids, diagnostic reagents and cardiac arrest boxes. Please refer to separate policy (medicines management sub-policy 3 – safe and secure handling of medicines) for comprehensive details on the storage and security of medicines.

8.2 Controlled drugs: the nurse in charge of a ward or department is responsible for the safe custody of controlled drugs held by that ward or department, and for the controlled stationery used for the ordering/ recording of controlled drugs. They are also responsible for all supplies made from the ward CD cupboard. The controlled drugs cupboard keys must be under her control at all times. Controlled drugs must be stored in a controlled drugs cabinet and all receipts and issues must be recorded in a controlled drugs register, including patients' own controlled drugs. (see medicines management sub-policy 1 – controlled drugs policy, guidance and procedures); A controlled drugs balance check must be carried out by ward/ department staff at least every 24 hours.

8.3 A controlled drugs check will be carried out by pharmacy at least every 3-6 months.

8.4 Ward stocks will be based on a defined list of those medications in regular use on that ward, plus items held for use in emergency situations. The stock list should be reviewed at regular intervals (at least every 6 months) by the senior sister/ charge nurse and ward pharmacist.

8.5 The safe, secure and tidy storage of medicines in the clinical setting are the responsibility of the nurse in charge of the ward. Pharmacy services, including the 'top-up' service, provide support in this function, but do not remove this responsibility from nursing personnel.

8.6 The medicines keys are the responsibility of the nurse in charge although they may be held by any registered nurse or member of pharmacy staff. The key for the

controlled drug cupboard must be separated from all other keys and be kept on the person of the nurse-in-charge of the ward when not being used by another registered nurse. Clinical support workers or student nurses must not hold the keys at any time.

8.7 Medicines security checks for all wards and departments will be carried out at least every 6 months by Pharmacy. These checks assess compliance with the storage requirements for medicines and controlled stationery. A report on the findings of each check will be produced and distributed to the relevant ward manager, Director of Operations and Associate Chief Nurse, so that an action plan can be produced if needed.

8.8 Any incidents where medicines have been stored inappropriately (e.g. wrong patient's medicines in Patient's Own Drugs (POD) locker, controlled drugs not locked in Controlled Drug cupboard) must be reported using the Trust's incident reporting systems.

8.9 Any apparent loss of medicines must be reported to the nurse in charge, Pharmacy, and security and an incident reporting form completed. If there is reason to believe that medicines may have been stolen, then appropriate investigations must be undertaken. This includes contacting the Head of Nursing/Midwifery for the specialty and the Chief Pharmacist, and may include contacting the police.

8.10 If a member of staff is believed to be using medicines inappropriately, this must be managed by the head of department for the specialty in a sensitive manner.

8.11 FP10 prescription pads are of particular interest to parties who want to steal medicines. They must be stored securely in a similar manner to medicines. Any loss must be reported to the Chief Pharmacist, the police, Local Counter Fraud Service (LCFS), NHS Business Services Authority, and to the local Clinical Commissioning Groups who can send out an alert to all local pharmacies. FP10 pads will only be issued to a prescriber if the Chief Pharmacist is satisfied that they can be stored and managed securely. FP10s should not be taken by prescribers to off-site clinics. They should be held securely by the clinic and issued to the prescriber on arrival. See SOP0173 - Use Of FP10 Prescriptions at Medway NHS Foundation Trust Procedure

8.12 Pharmacy will always be secured via a swipe card system. When pharmacy is closed the department is alarmed and locked by key. Keys are held by security and the on-call pharmacists as well as by various members of pharmacy staff. Non-Pharmacy staff must be accompanied at all times when in Pharmacy.

9 Prescribing of Medicines

9.1 Prescription Only Medicines (POMs) may be sold or supplied only in accordance with the written directions of an appropriate practitioner. An appropriate practitioner may be a doctor, dentist or non-medical prescriber. The written direction may be a

patient-specific direction (PSD - e.g. an entry on the patient's drug chart) or an individual prescription.

9.2 Other methods of issuing and administering medication:

- Pharmacy-Only (P) and POM medication may also be supplied or administered using a Patient Group Direction (PGD), in accordance with the Trust's PGD policy and procedures.
- Certain groups of healthcare professionals may supply or administer medicines in the course of their professional practice, without the need for a individual prescription/ PSD/ PGD, if there is a specific exemption to medicines legislation to allow them to do this (e.g. midwife exemptions).

9.3 Medicines Protocols can be used to supply or administer the following; administration and supply of General Sales List (GSL); administration of P medicines; medical gases; dressings; appliances; medical devices; and chemical agents. Within the Trust, the same prescribing rules are applied to General Sales List (GSL) and Pharmacy-Only (P) medicines.

9.4 Prescribers are responsible for:

9.4.1 Issuing a prescription or patient-specific direction that is legible, unambiguous and complete, for the dispensing and administration of the medicines

9.4.2 Monitoring the effects of the treatment

9.4.3 Reviewing the prescription for ongoing need

9.4.4 Informing the patient about their drug treatment (including potential adverse effects)

9.5 All prescribing must adhere to the prescription writing policy and be written on the appropriate stationery.

9.6 Prescriptions may only be written for patients of the Trust.

9.7 Non-registered doctors, i.e. Foundation Year 1 (FY1) doctors, are allowed to prescribe; they must, however, be appropriately supervised. Mistakes are more likely if they have insufficient knowledge to undertake the task safely. They may **not** prescribe on FP10 prescriptions. They may not prescribe any cytotoxic drug, including for non-cancer conditions (for example, methotrexate for rheumatoid arthritis).

9.8 Nursing staff are not allowed to transcribe discharge prescriptions or new drug charts. Pharmacists are authorised to re-write existing drug charts if the administration section is full, or if the prescription chart has become damaged/ unusable. Pharmacists may transcribe discharge prescriptions if they have been authorised to do so by the Chief Pharmacist or delegated Deputy . They may also make changes to discharge prescriptions written by doctors as necessary to clarify the prescription or to correct discrepancies; the reason for any changes should be endorsed in full and documented in the medical records if necessary.

9.9 Under no circumstances can a verbal order, or an order sent via a text message, be accepted as authorisation for the administration of medicines. Only written orders on the appropriate stationery are acceptable.

9.10 Medicine protocols may be used to allow appropriately qualified staff who are not qualified prescribers to write instructions for the administration of certain medications to inpatients, if this is deemed appropriate and necessary by the Medicines Management Committee.

9.11 All prescribers must prescribe within the formulary. Prescribing recommendations made to primary care prescribers must also be on the formulary. Primary care clinicians should not be asked to prescribe medicines not on the formulary. If a hospital prescriber initiates a non-formulary drug, the ongoing prescribing responsibility may need to remain with the secondary care prescriber.

9.12 Non-medical prescribing: non-medical prescribers are legally and professionally accountable for all items prescribed (including controlled drugs), and are required to work within demonstrated competencies, and within their individual scope of practice. They are required to adhere to the provisions of this and any other relevant Trust policy relating to medicines; they are also required to adhere to the Trust formulary and the Non-Medical Prescribing Policy.

10 Administration of Medicines

10.1 **Responsibilities for drug administration.**

10.1.1 The administration of medicines, including medical gases and intravenous fluids, will be undertaken by either:

10.1.1.1 A registered nurse or registered midwife

10.1.1.2 A radiographer

10.1.1.3 Operating Department Practitioners, NVQ Level 3

10.1.1.4 Registered Medical Officers

10.1.1.5 Pre-Registration Medical Officers

10.1.1.6 Student nurses or midwives under supervision.

10.1.1.7 Any other healthcare professional acting in accordance with a Trust-approved Patient Group Direction.

10.1.2 It is the responsibility of line managers to ensure that staff participating in the administration of medicines are competent. Practitioners bear responsibility for maintaining their own competence, and must ensure they decline tasks that they are not able to undertake on a safe and skilled manner, or for which they do not feel they are adequately supervised.

10.1.3 It is recognised that there are situations where checks by a second person may be required and this need should be assessed by the registered nurse

who is responsible for the administration. Such situations may be due to the status of the patient or where a drug dose needs calculation.

10.1.4 The following specific situations require a second person check whatever the circumstances:

10.1.4.1 Controlled drugs (Schedule 2 or 3)

10.1.4.2 Where a calculation of dose is required

10.1.4.3 Administration to children under 12 years of age

10.1.4.4 Cytotoxic agents

10.1.4.5 Specific medicines as defined in individual policies e.g. thalidomide.

10.1.4.6 A second person (a registered nurse, student nurse, doctor or pharmacist) must check all intravenous drugs and all epidural/ intrathecal drugs.

10.1.5 Drugs must only be prepared by the person who is to administer them and must be given immediately after preparation. Drugs prepared for infusion via a medical device and which are checked appropriately may only be prepared in advance under local agreements that have been approved by the Medicines Management Committee e.g. in Critical Care units.

10.1.6 Items may be prepared by pharmacy Central Intravenous Preparation Service (CIPS – including prepared doses of intravenous antibiotics, intravenous chemotherapy and total parenteral nutrition) for later use on wards.

10.1.7 Labels used on injectable medicines prepared in clinical areas should include the following information (MHRA Device Bulletin: Infusion Systems DB2003(02) v2.0, Nov 2010; NPSA Promoting Safer Use of Injectable Medicines, March 2007):

10.1.7.1 Name of the drug

10.1.7.2 Date and time of preparation and date and time of expiry

10.1.7.3 Total amount of drug used

10.1.7.4 Name and total volume of diluent used

10.1.7.5 Final volume of preparation

10.1.7.6 Route of administration

10.1.7.7 Batch numbers of all ingredients

10.1.7.8 Names of persons preparing and checking the solution

10.1.7.9 Name of patient

10.1.8 Intravenous flushes may only be administered against a valid prescription or via a PGD.(NPSA Rapid Response Report, April 2008)

10.2 **Administration of cytotoxic drugs**

10.2.1 Only nurses who have undertaken appropriate Trust training and have been signed off as competent may administer intravenous cytotoxic agents (chemotherapy). Doctors may not administer intravenous chemotherapy unless they have completed appropriate training.

10.2.2 Any registered nurse may administer oral cytotoxic agents, but they should ensure that they understand what precautions need to be taken to handle and dispose of such medicines safely.

10.2.3 Intrathecal chemotherapy may only be administered by a consultant haematologist or a haematology specialist registrar whose name appears on the 'Administration of Intrathecal Chemotherapy Register of Authorised Staff 1B'. For full details please refer to the Intrathecal chemotherapy policy (POLCPCM010-3).

10.3 **Administration using Medicines Protocols**

10.3.1 Staff administering medicines using a Medicines Protocol should adhere to the following;

10.3.1.1 The protocol must state that its purpose is to administer a medicine to a patient

10.3.1.2 They must be listed on the protocol as an authorised healthcare professional.

10.3.1.3 have been trained to use the protocol

10.3.1.4 deemed competent to use the protocol by their line manager

10.3.1.5 be authorised to use the protocol

10.3.1.6 have a copy of the protocol available to follow when administering medication

10.3.2 Medicines Protocols should be created using the Trust Medicines Protocol template. Available on the intranet.

10.3.3 Medicines Protocols will receive approval from the Medicines Management Committee before use.

10.3.4 Pharmacy will retain a database of Medicines Protocols authorised for use in the Trust.

10.4 **Consent and covert administration**

10.4.1 Nurses should, where possible, confirm and document that a patient has given informed consent to taking any prescribed medication. Where patients have been unable to give informed consent or lack capacity e.g. they are unconscious, a best interests decision is taken by the person in charge of their care. Due regard must be given to any known wishes or

advance directives. Where appropriate, relatives or carers should be consulted.

10.4.2 Covert administration directly against a patient's wishes must only occur if it is in the patient's best interests and they lack mental capacity. Assessment of capacity and best interests decisions must be documented on the appropriate form before covert administration takes place. These forms and further guidance are available in the Safeguarding Vulnerable Adults policy (GUCPCM001-3). Where covert administration has taken place an incident report form must be submitted. All professionals have a duty to comply with the Mental Capacity Act (2005).

10.4.3 In exceptional circumstances restraint may be required to administer medication; this is only lawful if the patient lacks capacity to consent to the medication, a best interests decision has been made and documented, and the restraint is proportionate. A DATIX report must be submitted. See Mental Capacity Policy (POLCGR099-1)/ Safeguarding Vulnerable Adults policy (GUCPCM001-3) for further information.

10.5 Non-administration of Medicines

10.5.1 Doses of medication may be omitted or delayed in hospital for a variety of reasons. For certain types of medicines there is potential for delayed or omitted doses to have serious, or even fatal consequences.

10.5.2 It is important that the correct 'medicine not administered' code is recorded on the drug chart if a dose is omitted. A blank space in the medication administration section of the drug chart when a medication should have been administered is unacceptable practice. Such incidences should be treated as a drug error.

10.5.3 When any drug has been omitted for more than two doses, other than because that drug is not required e.g. analgesia, actions must be escalated to prevent further omissions. This may involve contacting the prescriber to prescribe an alternative drug/ route of administration, or pharmacy in order to arrange urgent supply of that, or an alternative, item.

10.5.4 Any omission or excessive delay of a drug on the critical list must result in escalation of action to prevent any further omissions/delays, using the SBAR process if necessary. On every occasion of such an omission/delay, an incident report should be completed.

10.6 Self-administration of medicines

10.6.1 The practice of patients being responsible for self-administering medication in the acute hospital setting has been shown to be beneficial in terms of patient education and rehabilitation, and allows the patient to maintain/ develop more control over their own care.

10.6.2 The Self Administration of Medicines policy should be referred to for full operational details; the **Adult In-patient Diabetes Policy**-GULPCM205 - Insulin Safety Guidelines (1 attachment) also provides additional guidance on self-administration of subcutaneous insulin.

10.6.3 General principles of safe self-administration of medicines include;

10.6.3.1 There should be a multi-disciplinary approach to the practice

10.6.3.2 There should be a formal assessment of each patient's desire and ability to self-administer, considering the degree of support and supervision the patient requires; evaluation of self-care should continue throughout the patient's stay

10.6.3.3 The patient should provide written consent to take part in the scheme

10.6.3.4 The must be facilities for the safe storage of patients' own medicines

11 Supply of Medicines

11.1 Dispensing, checking and supervision within Pharmacy

11.1.1 Every in-patient, discharge and out-patient prescription will be screened and validated by a pharmacist before medication is dispensed. The pharmacist is responsible for resolving any pharmaceutical or pharmaceutical care issues, and for ensuring that the instructions to the staff who will be responsible for dispensing are completely clear.

11.1.2 A pharmacist must always be present in the department to give advice to any patient, if required.

11.1.3 The supply of appropriate, accurately dispensed medicines is the responsibility of all those involved in the process, who must each accept responsibility for the quality of their own work. Accurate working and self-checking of dispensed items are as important as the final check in ensuring that medicines are correctly dispensed.

11.1.4 Liability: The GPhC requires that pharmacists "make sure that all your work, or work that you are responsible for, is covered by appropriate professional indemnity cover". Indemnity cover is provided by the Trust under the NHS Indemnity Scheme. The Trust takes full financial responsibility for any negligence by health professionals, and should not seek to recover any vicarious liability costs from health professionals involved, providing that staff are working within agreed procedures. Pharmacists may still wish to take out their own professional indemnity insurance.

11.2 Dispensing and checking outside of pharmacy

11.2.1 *Unplanned absence/ hurriedly arranged discharges*: In the event that there is not time to have a discharge prescription dispensed by Pharmacy, or a patient decides to self-discharge, all attempts should be made to ensure that the patient receives a supply of discharge medication. A registered nurse/ midwife or doctor should urgently contact their ward pharmacist or the Pharmacy department (or the on-call pharmacist if this occurs outside of Pharmacy opening hours) to discuss the most appropriate solution.

11.2.2 *Routine discharges from specific areas*: some areas of the hospital keep a supply of TTO packs for medicines commonly used in those areas, to expedite discharges, particularly with day-attenders or where planned discharges frequently occur outside of Pharmacy opening hours. For such patients, there must still be an eDN, and the supply may only be made in accordance with the directions on the eDN. The registered nurse/ midwife managing the discharge is responsible for supplying medicines.

11.2.3 Dispensing from ward stock, other than TTO packs, must not occur, this will not meet the legal requirements for labelling of dispensed medicinal products

11.2.4 *Dispensing from Pharmacy 'satellite' stock locations:* in order for ward-based Pharmacy teams to expedite the processing of discharge prescriptions, there are several Pharmacy stock cupboards in ward locations, which are available to Pharmacy staff only. The use of such cupboards, and associated ward-based dispensing, must be risk assessed to ensure standards of quality and security will be maintained. The quality of dispensing form these locations must meet the same professional standards as any medicine dispensed within the Pharmacy.

11.2.5 *Supplying medicines in accordance with a Medicines Protocol:* refer to section 8.3 for criteria needed to supply a medicines. The protocol must state that its purpose is to supply a medicine to a patient.

11.3 Issue of medicines to patients

11.3.1 Medicines should only be issued to patients by staff with an appropriate level of training (medical practitioners, registered nurses, pharmacists, pharmacy technicians, and trainees under supervision of any of the former).

11.3.2 Anyone issuing medicines to a patient or their representative must ensure that:

11.3.2.1 The medicines being issued are for that patient, and that the identity of the person to whom medicines are issued is assured through appropriate checks

11.3.2.2 The medicines being issued are those requested on the prescription

11.3.2.3 That the patient, or carer, is given sufficient information and advice to ensure safe and effective use of the medicine, plus any other information that the patient would like to receive

12 Risk Management

12.1 Managing errors or incidents in the use of medicines

12.1.1 A medication error is a preventable incident associated with the use of medicines that has resulted in harm or potential for harm to a patient. Such incidents may be related to any step in the medicines use process, including prescribing, dispensing, administration, storage or transfer of medication information.

12.1.2 Medication incidents must be reported via the Trust's incident reporting system, currently DATIX. It may also be necessary to report incidents to an individual's line manager

12.1.3 Staff should also report any near misses or potential hazards relating to any part of the medicines management process (including potential or actual prescribing errors, medicines reconciliation discrepancies) via DATIX, with special reference to reporting any near miss relating to medication that is subject to a current or previous NPSA alert.

12.1.4 Following a medication incident, the well-being and safety of the patient is the prime concern, and must be assured first and foremost. The incident must be reported as soon as possible to a member of medical staff, who will decide whether any further action is needed clinically.

12.1.5 Potential safeguarding implications must be given due consideration when an incident involves a child or a vulnerable adult.

12.1.6 In terms of investigating medication-related incidents, the Trust policy should be followed. Serious incidents must be reported and investigated. If a medication incident that may fall within the definition of a Department of Health 'Never Event' occurs, this should be escalated immediately to the relevant Head of Nursing/ Clinical Director/ Head of Governance and Risk.

12.1.7 The patient/ carer should be informed that an error has occurred. The member of staff informing the patient should be a member of the immediate care team, who will be able to have an open and honest discussion with the patient e.g. ward pharmacist, senior doctor, nurse in charge of the ward. (Ref Being Open)

12.2 Learning from incidents

12.2.1 The Medication Safety Officer or delegated senior pharmacist will review all reported medication incidents for accuracy of the medication-related details, to provide professional input, and to escalate incidents for further investigation if necessary.

12.2.2 If any trends are identified, this will be escalated via the Medicines Management Committee.

12.3 Adverse Drug Reaction Reporting

12.3.1 Any drug may produce unwanted or unexpected adverse drug reactions. Detecting and reporting of these is of vital importance.

12.3.2 Prompt reporting should be carried out for any suspected adverse drug reactions to new drugs that are subject to additional monitoring by regulatory bodies. These medicines are identified in the BNF and in product literature by the inverted black triangle symbol (▼). Reporting must also be undertaken for unlicensed medicines and for any serious or unusual reactions to established products. Reporting should be carried out for prescribed drugs, and for medicines obtained by patients over the counter/ herbal products.

12.3.3 Suspected adverse reactions related to a drug or combination of drugs should be reported to the Medicines and Healthcare Products Regulatory Agency (MHRA) using the national yellow card reporting scheme. Copies of the card can be found at the back of the British National Formulary (BNF), or from the MHRA website (www.mhra.go.uk)

12.4 Medicine Defect Reporting

12.4.1 A defect is present if the product, as supplied by the manufacturer, is not of the expected standard. Defects may relate to inadequate or incorrect labelling, ineffective packaging, contamination, discolouration, breakage, or incorrect contents.

12.4.2 If a defect is found or suspected in a medicine, it should be reported to Pharmacy. Any remaining product and associated equipment should be retained and quarantined. If the product has been administered to a patient, the patient's doctor should be informed, and details of the defect should be recorded in the patient's medical record. The incident should be reported via DATIX.

12.5 Medication Safety Alerts and Drug Recalls

12.5.1 If a defect is identified in a medicinal product that may pose a hazard to health, the MHRA may issue a 'drug alert' letter. These drug alerts will be actioned by Pharmacy; out of hours, this will be led by the on-call pharmacist.

12.5.2 Medication safety alerts may be issued from various sources, included NHS England, the MHRA, or direct from pharmaceutical companies. The responsibility for ensuring such alerts are actioned rests with the Medicines Management Committee, who will make decisions as to what actions the Trust needs to take, and who will be responsible for these actions. The Chief Pharmacist and delegated senior pharmacists will provide professional guidance on dealing with medication safety alerts.

12.6 Control of substances Hazardous to Health Regulations (COSHH)

12.6.1 Some medicines are, by their nature, hazardous. COSHH regulations is the UK legislation on chemical hazards at work. The main legal duties of employers under COSHH are contained in regulations 6 -12, which cover risk assessment, prevention or control of exposure, use and maintenance of controls, monitoring exposure, health surveillance and provision of information and training.

13 Safe Disposal of Medicines

13.1 Medicines that are no longer to be administered to a patient, for whatever reason, should be returned to Pharmacy for disposal. Pharmacy will comply with all relevant legislation and good practice around the handling of unwanted medicines.

13.2 All out-of-date medicines and any stock no longer required must be returned to Pharmacy.

13.3 Medicines brought into the Trust by the patient remain the property of the patient and may only be returned to Pharmacy for destruction with the prior agreement of the patient and/or his/her representative. Consent for this destruction should be documented.

13.4 Where a patient has died, the items should generally be returned to Pharmacy for destruction. Where this includes controlled drugs they must, wherever possible, be returned to Pharmacy. In the unlikely event that a relative insists on taking them they must all be signed out of the controlled drugs register by the nurse in charge and by the relative. They must never be returned to any other healthcare professional other than Medway Pharmacy staff.

13.5 Some medicines are cytotoxic or cytostatic and must be disposed of in containers separate to those used for routine waste drug disposal, with appropriate identification. Spills of these medicines can represent a risk to healthcare workers. Any area handling liquid cytotoxic agents must have access to cytotoxic spill kits at all times. A list of cytotoxic/ cytostatic medication can be obtained from Pharmacy Distribution.

13.6 Destruction of controlled drugs must comply with the Medicines Act (1968) and the Misuse of Drugs Act (1971) and *Safer management of controlled drugs: a guide to good practice in secondary care (England)* (Department of Health, Oct 2007). Refer to the Medicines Management Sub-Policy 1 – controlled drugs policy, guidance and procedures.

13.7 Pharmacy will not normally accept pharmaceutical waste that is not generated by Medway NHS Foundation Trust or by patients admitted to the Trust.

13.8 In the case of product recalls, the drug must be quarantined until a decision has been made about disposal. The drugs will be kept in the designated area of pharmacy until disposal is arranged. The pharmacy drug recall procedure will be followed at all times.

14 Medical Representatives and Standards of Business Conduct

14.1 Trust staff should refer to the ABPI (The Association of the British Pharmaceutical Industry) code of practice.

14.2 Representatives must not visit wards, clinics or departments unless the relevant manager has given prior agreement. Casual visits are not acceptable. Appointments must be made with the relevant nurse manager, head of department or consultant. Visits should be limited to providing information regarding significant product changes.

14.3 Details of new products should be provided to the Pharmacy. Introduction of new products may only be permitted in accordance with the procedures of the Drugs and Therapeutics Committee.

14.4 It is accepted that liaison with pharmaceutical companies can sometimes be beneficial to the Trust and individual practitioners, but due probity must be observed. Staff must ensure they are not placed in a position which risks conflict between their private interests and their NHS duties, or gives the appearance of such a conflict. It is an offence for a member of staff to corruptly accept gifts as an inducement. No purchase order may be issued for any item for which an offer of gifts or hospitality has been received from the person interested in supplying goods and services. Any offers of gifts, conference attendance or hospitality should be discussed by members of staff with their line manager (or the Medical Director for consultants), and if approved should be entered in the register of hospitality. Overt disclosure of any hospitality offered to a consultant, or to any member of the Drugs and Therapeutics Committee, from a pharmaceutical company in relation to a new product must be disclosed to the Drugs and Therapeutics Committee.

14.5 All posts funded (or part-funded) by drug company sponsorship must be notified to the Chair of the Trust's Medicines Management Committee. If a nursing post, the Chief Nurse must be notified directly.

15 Training requirements for prescribing, administration and dispensing of medication

15.1 Training will be provided to all staff groups including medical, nursing and pharmacy personnel as outlined in the tables below.

Table 1: Medical Staff

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
FY1 and FY2 Doctors	Training in safe prescribing practice	To ensure accurate and safe prescribing of medication	Divisional induction, consultant mentoring and pharmacy-led teaching. Part of curriculum for foundation years. FY1 prescribing assessment	In-house plus use of BMJ eLearning packages where appropriate. Assessed by educational supervisors. Delivered in-house by pharmacy and medical education	Ongoing Once only, at induction
Haematology Consultants and Specialist Registrars	Intrathecal chemotherapy	To ensure correct administration of intrathecal chemotherapy.	Local training package including video, presentation, reading policy and short assessment.	Lead nurse for chemotherapy/ aseptic services manager	Annual

Table 2: Nursing Staff

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
All registered nurses and midwives	Drug dose calculation	To ensure the correct calculation of drugs before administration	Via CD-ROM training programme	In-house	Once
All registered nurses and	Safe administration of	To ensure the safe	Competency based assessment and	In-house	Annual

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
midwives	medicines and knowledge of medicines management	administration of medication	identification of training needs		
All registered nurses and midwives required to give intravenous drugs	IV drug administration	To ensure the safe administration of IV medication	In-house training programme including a period of supervised practice	In-house	Once
Chemotherapy trained registered nurses	Administration of cytotoxic medication	To ensure the safe administration of cytotoxic regimens	Training programme including a period of supervised practice	Canterbury College	Once
Chemotherapy-trained nurses administering intrathecal chemotherapy	Intrathecal chemotherapy	To ensure correct administration of intrathecal chemotherapy	Local training package including video, presentation, reading policy and short assessment.	Lead nurse for chemotherapy/ aseptic services manager	Annual
Registered nurses and midwives delivering care through the use of PGDs	Patient Group Directions	To ensure that PGDs are used legally and that all supplies made via PGD are safe.	Face-to-face teaching/ self-study pack/ e-learning (in development at time of writing)	In-house	Once

Table 3: Pharmacy staff – see POLLMM003 - Pharmacy Department Education and Training Policy

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
Pharmacy Assistants	The Dispensing Assistant Course (Level 2 Equivalent)	GPhC Requirement	Buttercups Level 2 equivalent	Buttercups plus in-house training	Once
Medicines Management Pharmacy Assistants	Medicines Management	To improve patient care through completion of medicines reconciliation process	HEE LaSE Pharmacy Accredited Medicines Management qualification with portfolio collection and OSCE assessment.	HEE LaSE Pharmacy and in-house	Once plus biennial reaccreditation .
Pre-Registration Trainee Pharmacy Technicians	National Diploma and NVQ – level 3	GPhC Requirement	BTEC National Diploma and National Vocational Qualification level 3	Buttercups, Westminster Kingsway College and in-house training	Once
Medicines Management Pharmacy Technicians	Medicines Management	To ensure the safe management of medicines on wards without supervision	HEE LaSE Pharmacy Accredited Medicines Management Qualification with portfolio collection and OSCE assessment	HEE LaSE Pharmacy and in-house	Once plus biennial reaccreditation
Accredited Checking Pharmacy Technicians	Accredited Checking	To ensure the safe checking of dispensed medicines	HEE LaSE Pharmacy Accredited Accuracy Checking Pharmacy Technician qualification with documentation of 1000 accurately checked items and OSCE assessment.	HEE LaSE Pharmacy and in-house	Once plus biennial reaccreditation
Aseptic services Pharmacy Technicians	Preparation of intravenous medicines, cytotoxic	To ensure the safe preparation of medicines	In house training manual	In-house	Once

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
	medicines and parenteral nutrition solutions				
Aseptic Services Pharmacy Technicians	Pre- and in-process checking	To ensure the safe checking of aseptically prepared products	HEE LaSE Pharmacy PIPC course with documentation of 1000 accurately checked items and OSCE assessment.	HEE LaSE Pharmacy and in-house	Once plus biennial reaccreditation
Warfarin counselling assistants, technicians and pharmacists	Warfarin counselling	To provide patients newly started on oral anticoagulants on how to take their medication safely plus clinic monitoring arrangements	In-house programme	In-house	Once, with annual reaccreditation
Pharmacists	Clinical pharmacy practice	To ensure the safe management of patients' medication in order to facilitate optimal outcomes	Diploma in General Pharmacy Practice Competency based assessments	HEE LaSE Pharmacy, Medway School of Pharmacy and in-house training	Once
Pharmacists working in aseptic services	Checking CIPS, cytotoxics and TPN		In-house training programme	In-house	Once
Pharmacists working in aseptic services	Intrathecal Chemotherapy	To ensure correct administration of intrathecal chemotherapy	Local training package including video, presentation, reading policy and short assessment.	Lead nurse for chemotherapy/ aseptic services manager	Annual
TPN Pharmacists	Prescribing adult TPN	To ensure that TPN solutions are prepared safely	Local training package and short assessment.	Lead pharmacist for nutrition.	Once

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
		and meet the clinical needs of the patient.			
Anticoagulation pharmacists	Anticoagulation prescribing	To ensure the safe dosage of anticoagulation and monitoring of therapy	In-house programme including competency based assessment	Principal pharmacist for anticoagulation.	Once

Table 4: Other Staff Groups

Staff Group	Training Requirement	Rationale	Type of Training / Qualification	Training Delivered By	Frequency
HCPs administering medicines using PGDs	Patient Group Directions	To ensure that PGDs are used legally and that all supplies made via PGD are safe.	Face-to-face teaching/ self-study pack/ e-learning (in development at time of writing)	In-house	

15.2 Ongoing competency assessment will be undertaken for pharmacy and nursing staff.

15.3 Ensuring the ongoing competency of medical staff is the responsibility of the clinical department employing them, and is overseen by the Medical Director.

16 EQUALITY IMPACT ASSESSMENT STATEMENT

16.1 All public bodies have a statutory duty under the Race Relations (Amendment) Act 2000 to "set out arrangements to assess and consult on how their policies and functions impact on race equality." This obligation has been increased to include equality and human rights with regard to disability, age and gender.

16.2 The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. This strategy was found to be compliant with this philosophy.

16.3 Equality Impact Assessments will also ensure discrimination does not occur on the grounds of Religion/Belief or Sexual Orientation in line with the protected characteristics covered by the existing public duties.

16.4 Refer to appendix 1.

17 MONITORING & REVIEW

What will be monitored	How/ Method/Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions	Implementation of any required change
Contents of policy for accuracy and legality	To be checked against new legislation or good practice guidance	Chief Pharmacist	Chair of MMC	Policy to be rewritten as needed	Changes advertised to all relevant staff
Incident reports of adverse drug events	Report compiled quarterly	Patient Safety Manager	MMC	Actions implemented as needed	Usually via pharmacy staff. Or specific group set up to action changes.
Various aspects of Medicines Management as per audit plan, including audits as required by NPSA and audits of various aspects of antimicrobial therapy.	Regular Audit	Pharmacy Audit Lead	Audit Committee	Depends on results of audits	By pharmacy or Directorates
Antibiotic prescribing	Regular audit	Lead antimicrobial pharmacist	Director of Infection Control	Monitored via Quality Improvement Group	By directorates and reviewed by pharmacy and infection control teams

What will be monitored	How/ Method/Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions	Implementation of any required change
Controlled Drugs	Audit of CD registers by pharmacy every 3 months. Annual audit of incident reports relating to CDs. Quarterly feedback of CD incidents by CDAO to CDLIN Annual audit of aspect of care by Accountable Officer	Accountable Officer	Trust Board	Accountable Officer and Chief Pharmacist	Accountable Officer
Dispensing errors/ near misses	Continuous reporting via near miss reporting forms and dispensing error forms	Dispensary manager and aseptic services manager	Chief Pharmacist	Error trends identified and measures identified to reduce risk of reoccurrence.	Dispensary manager/ aseptic services manager via change in local procedure and dissemination to staff
Administration errors	Continuous reporting via DATIX and drug error pack. To be reviewed/ compiled quarterly.	Chief Nurse	MMC NMAS	Any necessary change in procedure/ need for additional training identified.	Chief Nurse via Associate Chief Nurses.
Safe storage of medicines	Continuous reporting via DATIX. To be reviewed/ compiled quarterly	Chief Pharmacist	MMC	Gaps identified by MMC and necessary actions fedback to Directorates/ pharmacy	By wards or pharmacy
Training requirements	To be reviewed at annual appraisals for pharmacy and nursing staff by line managers.	Chief Pharmacist	MMC	Gaps identified by MMC and necessary actions fedback to Directorates/ pharmacy	Nursing/Pharmacy Management
Safe disposal of medicines	Audit of practice	Wards Senior Sister Pharmacy Operational Manager	MMC	Gaps identified by MMC and necessary actions fedback to Directorates/pharmacy	Directorates
Non-administration of medicines	DATIX to be reviewed quarterly. Audit of missed doses	Chief Pharmacist	MMC	Gaps identified by MMC and necessary actions fedback to Directorates	Directorates

What will be monitored	How/ Method/Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions	Implementation of any required change
Covert administration of medicines (Rare)	DATIX	Chief Pharmacist	MMC	Any inappropriate actions to be reviewed with Directorates	Directorates

18 Equality Impact Assessment Tool – Appendix 1

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	▪ Race	No	
	▪ Disability	No	
	▪ Gender	No	
	▪ Religion or belief	No	
	▪ Sexual orientation including lesbian, gay and bisexual people	No	
	▪ Age	No	
2	Is there any evidence that some groups are affected differently?	No	
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4	Is the impact of the policy/guidance likely to be negative?	No	
5	If so can the impact be avoided?		
6	What alternatives are there to achieving the policy/guidance without the impact?		
7	Can we reduce the impact by taking different action?		

19 References

Document	Ref No
References:	
CQC Fundamental standards 2010	Regulation 12
Nursing and Midwifery Council 2015 “The Code”	
Building a Safer NHS for Patients: Improving Medication Safety	

(DoH, January 2004)	
The Medicines Act, 1968	
The Misuse of Drugs Act 1971	
The Misuse of Drugs Regulations 2001	
A Spoonful of Sugar: Medicines Management in NHS Hospitals (The Audit Commission, December 2001)	
Medicines, Ethics and Practice 34: a guide for pharmacists and pharmacy technicians (RPSGB, July 2010).	
An Organisation with a Memory (DoH, June 2000)	
Good Medical Practice (GMC, November 2006)	
Medicines Matters: a guide to mechanisms for the prescribing, supply and administration of medicines (DoH, July 2006)	
HSC 2000/026 Patient Group Directions (DoH, August 2000)	
Safer Management of Controlled Drugs: a guide to good practice in secondary care (DoH, October 2007)	
The Safe and Secure Handling of Medicines: a team approach (RPSGB, March 2005)	
Standards for Medicines Management (NMC, Nov 2007; replaces Guidelines for the Administration of Medicines)	
Standards for Infusion Therapy (RCN, January 2010)	
Modernising Medicines Management: a guide to achieving benefits for patients, professionals and the NHS (National Prescribing Centre, April 2002)	
NPSA Rapid Response Report: Intravenous Heparin Flush Solutions (NPSA, April 2008)	
NPSA Patient Safety Alert: Promoting Safer Use of Injectable Medicines (NPSA, March 2007)	
Hazardous Waste (England and Wales) Regulations 2005 ISBN 0110726855	
NPSA Patient Safety Alert: Preventing fatalities from Medication Loading Doses (NPSA, November 2010)	NPSA/2010/RRR018
Bribery Act	

Trust Associated Documents:	
Antibiotic Prescribing Policy	POLCPCM041
Consent Policy	POLCGR034
COSHH HSE: A Brief Guide to the Regulations	OTCS025
Delivery of CDs to outlying hospitals	
Doctors' Self-Prescribing.	
Drug Recall Procedure	P.DIST.22 (Pharmacy procedure)
Endorsement of Prescription Charts by Pharmacy Staff	Pharmacy Procedure
Intrathecal Chemotherapy	POLCPCM0103

Non-Medical Prescribing Policy	POLCPCM039
Oral Anticoagulants in the Perioperative Period Policy	POLCMM005
Overactive Bladder OAB and Mixed Urinary Incontinence UI in Women	OTLPCM029
Patient Group Directions - Development and Use Policy and Procedure	PDGCMM004
PGD - Misoprostol	PGDCMM004
PGD - PlasmaLyte	PGDCMM005
PGD - Sterile Water Injections	PGDCMM006
Pharmacological management of Chronic Non-Malignant Pain in Adults in Non-Specialist Settings	GUCMM021
Pharmacy - Business Continuity Plan	OTCGR072
Pharmacy Department Education and Training Policy	POLLMM003
POD checking guidelines	POD flowchart v2
Prescribing - Assessment and Management of Falls	GUCMM022
Prescribing Anti-Thrombotic and Anticoagulation in Patients with Acute Coronary Syndromes	OTCMM004
Prescribing of Oral Nutritional Supplements (ONS) for Adult Inpatients	PROTLMM002
Prescribing Policy - Drugs and Devices used in the treatment of Erectile Dysfunction	POLLMM002
Research and Development Policy	POLCGR075
Returning Patient's Own Controlled Drugs or 'Ward Stock' to pharmacy	PROCMM001
Safe Disposal of Waste	PROCS002
Safe Prescribing of Rivaroxaban	GUCMM023
Safeguarding Vulnerable Adults	GUCPCM002
Self-Administration of Medicines Guidelines	GUCMM018
Supplying Discharge Medication in Dosettes - Multi-compartment Compliance Aids	POLCMM011
Teicoplanin Guidelines - GUDLMM001	GUDLMM001
Unlicensed Medicines Procedure	POLCPCM034
Use Of FP10 Prescriptions at Medway NHS Foundation Trust Procedure	SOP0173
Use of Intravenous Potassium in Medway NHS Trust	POLCPCM017
Use of Sodium Chloride 2.7% (Hypertonic Saline)	POLCMM013
Ward Staff Authorised to Order Controlled Drugs From Pharmacy	SOP0010

END OF DOCUMENT

NHS Medway NHS Foundation Trust

Report to the Trust Board

Date of meeting: 1 June 2017 **Agenda item** 17a

Title of Report	NHS Improvement (NHSI) Self-Certification 2017
Presented by	Tracey Cotterill, Director of Finance Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Lead Director	Tracey Cotterill, Director of Finance Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Executive Team
Executive Summary	Providers need to self-certify the following after the financial year end: • The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3)) • The provider has complied with required governance arrangements (Condition FT4(8)) • If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3) The Director of Corporate Governance, Risk, Compliance and Legal has prepared the self-certification for Condition FT4(8). The Director of Finance has prepared the self-certification for Condition G6(3) and Condition CoS7(3).
Resource Implications	N/A
Risk and Assurance	
Legal Implications/Regulatory Requirements	Self-certification before 30 June 2017 is an NHSI regulatory requirement.
Quality Impact Assessment	N/A
Recommendation	The Board are requested to review and approve the self-certification

Purpose & Actions required by the Executive Group:	Approval [x] Assurance [ ] Discussion [ ] Noting [ ]

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Self-Certification for Trusts – 1 June 2017

1. EXECUTIVE SUMMARY

1.1. A Trust's Provider Licence contains obligations for providers of NHS services that enable Monitor to fulfil its duties as the regulator of NHS Foundation Trusts and to oversee the way that Foundation Trusts are governed. Since 1 April 2016 Monitor has been grouped with a number of other organisations within the operational name of NHS Improvement (NHSI).

1.2. The standard licence conditions are grouped into seven sections (https://www.gov.uk/government/publications/the-nhs-provider-licence). The first section, containing the General Conditions, sets out standard requirements and rules for all licence holders. Sections 2 to 5 of the licence are about Monitor's functions: setting prices, enabling services to be provided in an integrated way, safeguarding choice and competition and supporting commissioners to maintain service continuity. Section 6 is about translating the well- established core of Monitor's current oversight of Foundation Trust governance in to the new provider licence (2013). The final section, 7, contains definitions and notes.

1.3. The Single Oversight Framework (SOF) (https://improvement.nhs.uk/resources/single-oversight-framework/) bases its oversight on the NHS provider licence. Foundation Trusts are subject to provider licence conditions (including Condition G6, Condition FT4 and Condition CoS7(3)). From April 2017 NHS foundation trusts are required to self-certify whether or not they have complied with the conditions of the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009, and the Health and Social Care Act 2012, and have regard to the NHS Constitution), have the required resources available if providing commissioner requested services, and have complied with governance.

1.4. Providers need to self-certify the following after the financial year end:

- The provider has taken all precautions necessary to comply with the licence, NHS Acts and NHS Constitution (Condition G6(3))
- The provider has complied with required governance arrangements (Condition FT4(8))
- If providing commissioner requested services, the provider has a reasonable expectation that required resources will be available to deliver the designated service (Condition CoS7(3)

1.5. From 2017 NHSI have removed the requirement for these compliance assessments to be submitted to them. Instead, there is no set process for assurance of how the conditions are met and it is at providers' discretion as to how they carry this process out but Boards need to understand and sign off on compliance.

1.6. NHSI have supplied templates to assist with the process and these have been completed and attached.

2. CONDITION G6

2.1. Condition G6(2) requires NHS foundation trusts to have processes and systems that:

- Identify risks to compliance
- take reasonable mitigating actions to prevent those risks and a failure to comply from occurring

2.2. Providers must annually review whether these processes and systems are effective.

3. CONDITION FT4

3.1. NHS foundation trusts must self-certify under Condition FT4(8).

3.2. Providers should review whether their governance systems achieve the objectives set out in the licence condition.

3.3. There is no set approach to these standards and objectives but NHSI expect any compliant approach to involve effective board and committee structures, reporting lines and performance and risk management systems

3.4. Providers should select 'confirmed' or 'not confirmed' for each declaration as appropriate and set out relevant risks and mitigating actions in each case. Where providers choose 'not confirmed' for any declaration, they should explain why in the free text box provided.

3.5. Providers must review whether their governors have received enough training and guidance to carry out their roles.

4. CONDITION COS7

4.1. Only NHS foundation trusts designated as providing commissioner requested services (CRS) must self-certify under Condition CoS7(3).

4.2. A CRS designation is not simply a standard contract with a commissioner to provide services. Commissioner requested services are services commissioners consider should continue to be provided locally even if a provider is at risk of failing financially and which will be subject to regulation by NHS Improvement. Providers can be designated as providing CRS because:

- there is no alternative provider close enough
- removing the services would increase health inequalities
- removing the services would make other related services unviable

5. AUDITS

5.1. From July, NHS Improvement will contact a select number of NHS trusts and foundation trusts to ask for evidence that they have self-certified. This can either be through providing the templates if they have used them, or by providing relevant Board minutes and papers recording sign-off.

6. RECOMMENDATION

6.1. The Board are requested to review and approve the Submission for Conditions G6(3) and CoS7(3) prepared by the Director of Finance and the Submission for Condition FT4(8) prepared by the Director of Corporate Governance, Risk, Compliance and Legal.

Condition FT4(8)			
1	**Corporate Governance Statement**	**Response**	**Risks and Mitigating Actions**
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed *(2016 – not confirmed)*	The Board receives a corporate governance report at each of its public board meetings. This highlights to the Board any areas of deficiency and remedial actions/improvements are built into the annual work plan and objectives for the Corporate Governance Directorate. Progress is monitored by the Director of Corporate Governance, Risk, Compliance and Legal.
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	The Board is kept updated on corporate governance and applicable NHS Improvement guidance through the Board report from the Director of Corporate Governance, Risk, Compliance & Legal.
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation	Confirmed *(2016 – not confirmed)*	All Board committees have terms of reference and report after each meeting via a Key Issues Report to the Board. A governance structure for the layers below Board Committees is in place, with all Groups having terms of reference that reflect reporting lines and accountabilities.
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards	Not confirmed *(2016 – not confirmed)*	In March 2017 the Trust exited the special measures regime. Enforcement Undertakings were agreed between the Trust and NHS Improvement (previously Monitor) in August 2015 due to breaches in the following conditions of its Licence: Standards of corporate governance and financial management - CoS3(1); NHS Foundation Trust governance arrangements FT4(5)(a) and FT4(5)(d); FT4(5)(a,b,c,e,f); FT4(6)(c,d,f) and

	specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements		FT4(7). Under NHSI's Risk Assessment Framework, as in previous years, the Trust has significant financial risk and it also continues to have a Governance rating of "red". NHSI are currently reviewing the Licence Undertakings and considering the extent to which they can be removed or updated to reflect the significant improvements that have been achieved over 2016/17 in governance and the stabilisation of the financial deficit.
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on	Confirmed	Board member capability is reviewed by the two Nominations and Remuneration committees - one is a Non-Executive Committee that considers Executive performance and capability and the other is a Council of Governors led committee which considers Non-Executive performance. The Board approves and reviews the Quality Accounts and progress against their delivery, retaining oversight and assurance of areas identified for improvement, why priorities have been chosen, how improvement will and has been achieved and measured.

	quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate		

TRAINING FOR GOVERNORS

2	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role	Confirmed

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.		Please Respond

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.	Confirmed	Please fill details in cell E22

OR

3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The annual plan for the Trust projects a deficit of £37m. The Trust is reliant on revenue support to enable it to continue to deliver services. At this time the board anticipates requiring external funding in the form of PDC and loans from DH, having insufficient internally generated funds to meet the Trust's needs in the financial year. This position is being closely monitored.
The board has agreed a financial control target with NHSI and there is a significant cost improvement plan in year. Further work continues on the deveopment of a longer term financial recovery plan tomove the Trust towards a return to financial balance. The financial recovery plan is linked to programmes across the STP where appropriate to maximimise efficiencies.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Lesley Dwyer	**Name**	Stephen Clark
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Quality Assurance Committee held on 18/05/2017

Report to:	**Trust Board**	**Date of meeting:** **18 May 2017**		**1**
Presented by:	**Ewan Carmichael, Chair Quality Assurance Committee**	**Prepared by:**	**Ewan Carmichael Non-Executive Director**	

Matters for escalation	• The April Board requested that QAC look at 'incidents resulting in death'. QAC is not in a position to report this month, but should be in June/July. • MFT exceeded its C. Diff trajectory in Q4. Inappropriate antimicrobial prescribing is a factor, which can be mitigated by following the Trust's Green Book app. • The Local Authority is unable to keep up with the scale of DOLS cases across its jurisdiction and, whilst, it issues written authority to exceed upper time limits, this is a concern to the Trust. • The Restructuring Clinical Governance review is proving to require further work, so there are no specific recommendations this month.
Other matters considered by the group:	• IQPR: Once again, because of sequencing issues, IQPR was not available. This should be resolved by QAC's adjustment of dates (see below). However, the Med Dir gave a view that there were no particularly odd features to note. • Directorate Report – Families & Clinical Sp Svcs. A multi-agency Claims Summit has resolved many potential claims, with a considerable saving in costs. • CQC Quality Improvement Plan. • Mortality Review. This follows on from the 'Leach' report (reported last month). The trust will be reporting , probably quarterly, to Board. Currently the Trust has a well-established mortality review form, but is assessing whether it ought to be replaced by a new Formal Structured Judgement Review, which may be particularly resource intensive. A specific review of Surgery mortality has reduced surgery HSMR, both at weekends and across the week. • Report from Medicines Management Group. This still required added value from QIG. • Infection Control & Antimicrobial Stewardship Group Report. Although ED Blood sample contamination is above the national average, its rate is reducing, which is encouraging.

	• QIG. Child and Adolescent Mental Health Services (CAMHS) have inadequate capacity to meet demand which has led to recent incidences on the ward. The staff were commended for their professionalism. • BAF. • Programme of Work: Next month QAC will continue with its structured programme, with additional looks at Dementia and Consideration of Lessons from the IT Ransom Demands faced by other Trusts.
Key decisions made/ actions identified:	• Reporting for Adult and Child Safeguarding ought to be done at the same time. • Report on ratio of midwives to mothers in labour is required. • Anticipating the Clinical Governance review, the QAC would move to the Friday of the 4th week in the month.
Risks:	• Although part of a nationwide problem, CAMHS has inadequate capacity for adolescents, which impacts on the Trust. • Whilst the Local Authority may issue written authority to exceed DOLS upper time limits, this has been added to the BAF.
Assurance:	Mortality and morbidity review, audit and learning continue to improve at MFT.

Key Issues Report

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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 & Chair	✓	✓										✓
Vivien Bouttell, Governor Representative	✓	✓										✓
Lesley Dwyer, Chief Executive	x	✓										x
Diana Hamilton-Fairley, Medical Director	✓	✓										✓
Martin Nagler, Patient Representative	✓	✓										✓
Karen Rule, Director of Nursing	✓	x										✓
Jan Stephens, NED	✓	✓										✓

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Best of people

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Finance Committee held on 25/05/2017

Report to:	**Board of Directors**	**Date of meeting:**	**01/06/2017**
Presented by:	**Tony Moore Chair Finance Committee**	**Prepared by:**	**Tony Moore Chair Finance Committee**

1

Matters for escalation

1. It was agreed that the standard reporting pack would not prepared for month 1 as there had been a number of factors that delayed the month end process, including DDoF vacancy and system outages;
2. The Finance Committee received reports on a number of key financial matters.
    a. Risk adjusted forecast
    b. CIP progress
    c. Capital programme
    d. Loan requirements for 2017/18
3. The Finance Committee considered the risks and opportunities schedule at length and discussed the longer term prospects of financial recovery.
4. The Finance Committee also considered the loan requirements for 2017/18 and the implications of increasing borrowing. There was discussion around the longer term ability to repay loans once the Trust returned to surplus.

Other matters considered by the group:

1. Month 1 performance as reported to NHSI
2. Developing the divisional information provided to FC
3. CIP performance
4. Contract work plan
5. STP finance update
6. Business Cases
    a. ED – assurance received over ongoing project management
    b. North Kent Pathology Service update
    c. Urology Robot update
7. Board Assurance Framework – all risks had been discussed

	during the meeting
Key decisions made/ actions identified:	1. Approved progressing the North Kent Pathology Service 2. Approved progressing the Urology Robot
Risks:	The Finance section of the Board Assurance Framework was considered. All risks apart were considered by the Committee under the agenda.
Assurance:	Assurance was provided on; 1. Risks within the delivery of the plan, CIPs, Capital and Cash management 2. Risk identification and risk management under the Board Assurance Framework 3. ED project governance

Key Issues Report

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