NHS Medway NHS Foundation Trust

Agenda

Public Meeting of the Trust Board

Date: On 03 November 2017 at 2.00pm – 5.00pm

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

Item	Subject	Presenter	Time	Action
1.	Presentation: General Data Protection Regulation Update	Katy White	2.00pm	Discuss
Opening of the Meeting				
2.	Chair's Welcome	Chairman	2.30pm	Note
3.	Quorum	Chairman		Note
4.	Register of Interests	Chairman		Note
Meeting Administration				
5.	Minutes of the previous meeting held on 7 September 2017	Chairman	2.35pm	Approve
6.	Matters Arising Action Log	Chairman		Note
Main Business				
7.	Chair's Report	Chairman	2.40pm	Note
8.	Chief Executive's Report	Chief Executive	2.45pm	Note
9	Strategy a) STP Update b) Trust Improvement Plan Better Best Brilliant	Chief Executive / Director of Communications Director of HR & OD	2.50pm	Note Discussion
10.	Quality a) IQPR b) Annual Medical Education Report	Executive Medical Director	3.05pm	Discussion
11	Performance			

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	a) Finance Report b) Communications Report	Director of Finance & Business Services Director of Communications	3.25pm	Discussion Discussion
12.	Governance a) Corporate Governance Report b) Health & Safety Report c) Winter Resilience Plan d) SIRO report incorporating the annual FOI report e) Emergency Preparedness, Resilience and Response Report	Acting Director of Corporate Governance	3.50pm	Assurance
13.	People a) Workforce Report	Director of HR & OD	4.15pm	Assurance
For Approval				
14.	Corporate Safeguarding Policy	Director of Nursing	4.20pm	Approval
15.	Corporate HR Policy	Director of HR & OD	4.23pm	Approval
16.	Risk Appetite Statement	Acting Director of Corporate Governance	4.26pm	Approval
Reports from Board Committees				
17.	Quality Assurance Committee Report	QAC Chair	4.30pm	Assurance
18.	Finance Committee Report	Finance Chair	4.35pm	Assurance
19.	Charitable Funds Committee Report	Charitable Funds Chair	4.40pm	Assurance
AOB				
20.	Council of Governors' Update	Governor Representative	4.45pm	Discussion
21.	Any other business	Chairman		Note

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22.	Questions from members of the public	Chairman		Discussion
Close of Meeting				
23.	Date and time of next meeting: 4 January 2018 Boardroom, Post Graduate Centre, Medway NHS Foundation Trust			

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 • Chair of the Medway NHS Foundation Trust Quality Assurance Committee
3.	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 • Chairman of the Medway NHS Foundation Trust • Access Bank UK Limited – Non Executive Director
4.	James Devine Director of HR & OD	• Member of the London Board for the Healthcare People Management Association
5.	Lesley Dwyer Chief Executive	• Member of the Corporate Trustees of Medway NHS Foundation Trust Charitable Funds
6.	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
7.	Anthony Moore Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Chair of the Medway NHS Foundation Trust Finance Committee
8.	Joanne Palmer Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Director of Lloyds Bank (Fountainbridge 1) Limited • Director of Lloyds Bank (Fountainbridge 2) Limited • Director of Halifax Premises Limited • Director of Gresham Nominee1 Limited

		• Director of Gresham Nominee 2 Limited • Director of Lloyds Commercial Properties Limited • Director of Lloyds Bank Properties Limited • Director of Lloyds Commercial Property Investments Limited • Director of Target Corporate Services Limited
9.	Karen Rule Director of Nursing	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
10.	Mark Spragg Non-Executive Director	• Trustee for the Marcela Trust • Trustee of the Sisi & Savita Chartiable Trust • Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Director of Mark Spragg Limited
11.	Tracey Cotterill Director of Finance	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.

Meeting in Public

NHS Medway NHS Foundation Trust

Board of Directors Meeting in Public on 07/09/2017 held at Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Mrs L Dwyer	Chief Executive	LD
	Mr J Billings	Non-Executive Director	JB
	Mr E Carmichael	Non-Executive Director	EC
	Mrs T Cotterill	Director of Finance and Business Services	TC
	Mr J Devine	Director of HR and OD and Director of Improvement	JD
	Mr T Moore	Non-Executive Director	TM
	Mrs J Palmer	Non-Executive Director	JP
	Mrs K Rule	Director of Nursing	KR
	Mr M Spragg	Non-Executive Director	MS
	Dr D Hamilton-Fairley	Medical Director	DH
	Dr K Mukherjee	Deputy Medical Director	KM
Attendees:	Ms G Alexander	Director of Communications	GA
	Mrs K McIntyre	Co-Director of Clinical Operations – Family and Clinical Support Services Directorate	KMc
	Michael Addley	Head of Communications	MA
	Doreen King	Governor Board Representative	DK
	Ms R Tan	2020 (item 9c only)	RT
	Dr. Paul Hayden	Consultant in Anaesthesia & Critical Care Medicine (item 10d only)	PH
	Dr Gill Fargher	Chairman, Organ Donation Committee/Clinical member, Medway	GF
	Ms S Murphy	Trust Secretary	SMM
	Ms K White	Acting Director of Corporate Governance, Compliance, Risk and Legal	KW
	Mr J Lowell	Director of Clinical Operations – Acute and Continuing Care Directorate	JL

	Mr B Stevens	Director of Clinical Operations – Co-ordinated Surgical	BS
Apologies:	Adrian Ward	Non-Executive Director	AW

Items were taken out of order but the minutes correspond to the agenda

1. Patient Story

1.1 A patient attended to provide detailed account of her diagnosis, referral and treatment at the Trust. The Board was grateful to the patient for sharing such a personal account of her treatment and feelings at the time and since treatment and was grateful for such positive feedback of the care provided.

2. Welcome and Apologies for Absence

2.1 The Chairman welcomed everyone to the meeting.

2.2 Apologies for absence were noted as stated above.

3. Quorum

3.1 It was confirmed that the meeting was quorate.

4. Register of Interests

4.1 This was noted

5. Confidential Minutes of the Previous Meeting

5.1 The confidential minutes of the previous private meeting were approved as a true and accurate record.

6. Matters Arising and Action Log

6.1 Actions 387 will be addressed at 14; infection at 10B and smoking now closed.

6.2 Discussion took place surround smoking wardens being on site yet people still smoking on site; TC confirmed this had been reported by staff and SC reminded all vigilance is still required.

7. Chair's Report

7.1 SC commented that the fire safety issues raised following Grenfell have been taken very seriously with considerable resource put into fire evacuation plans, looking at the robustness of processes and the estate; there will be further updates and reports.

7.2 SC informed the Board that he had attended CCG public consultations with LD to discuss Acute Care Units and was pleased to report the warmth and positive comments made by those attending from Sheppey about the care and compassion of the Trust. Many of the CCG's proposals were already implemented by the Trust such as streaming patients in ED. A further Health Education visit resulted in a change of mind and their decision to continue sending trainees to the Trust which will progress the required changes. In October LD will go to Australia to present to the Australian equivalent of the

CQC detail of what has been achieved at Trust. External to the Trust, GP referral reviews have been set up. Whilst this has not happened in Medway the process will be monitored.

8. Chief Executive's Report

8.1 The Trust is increasing the number of staff trained in improvement. We did have a significant incident, plans were followed which confirms staff do know what is expected of them. HEE visit considered we needed time to put in better structure to support undergraduate trainees however HEE revisited and have confirmed they will continue with a pre-registration trainee programme and we will continue to make improvements.

8.2 At the end of September LD will attend the Australian College of Health Service management and Health Service standards to speak on achievement at Medway.

8.3 GP referral panels have been set up, not in Medway and no discussions to date on how it would happen but will look at pilots in the north of England to see if makes a difference and specifically delays.

8.4LD confirmed the retire and return guidance is a case by case managed process and something that is not done lightly.

9. Strategy

9a) **STP Update**

9.1 LD updated the Board on the STP discussions. LD informed the Board that there had been a consultation in the Medway area. The urgent care centre is comparable with the Trust's existing Medoc service and the closure of Balmoral Gardens. Consultation has gone well and interest from community has been very important particularly through the STP to work through issues such as location of services. The Trust would look to establish accountable care partnerships and move forward with development of a clinical strategy reporting back in the next few months. Reviews around the stroke and vascular services (with East Kent) continue with the stroke consultation becoming particularly complex but distilling down to 3 options; the feedback from the national group has been very positive. LD noted the importance of the initiative as delay in treatment means the patient does not receive the treatment they deserve. LD said she would consider DK's comment that PFOs are useful tool in stoke prevention and feedback.

9b) **Well Led Review**

9.2 LD summarised the findings of the Well Led Review highlighting that there were no issues identified as red and drawing attention to the 16 recommendations including that the Board could meet two monthly rather than monthly; this would give the Trust more time to address strategic issues, implement actions and report back to the Board. It was noted by DK that the Governors' Finance and Performance Group had not been included in the Groups listed in the summary.

9c) **Trust Improvement Plan**

9.3 RT updated the Board on performance specifically the 4hour ED performance with more work to do; there had been a step change since the beginning of the week and had reached 90% with variation and work was continuing to

identify key areas of focus namely embed model, standardisation of processes and improve discharge processes. RT drew attention to the focus on cost improvement with events across the Trust to make staff aware of the financial challenge and to maintain improvement. CIPs continue to be monitored and look at opportunity to create CIPs. RT commented that the next steps for the team would be to continue the current work but also to expand their scope including workforce review and savings in estates.

9.4 SC thanked RT and the team and noted the good work in progress.

9.5 JL responded to TM's question on ED variability link to demand that performance is multifactorial, not just being linked to demand but includes patient flow, acuity of patients and having systems in place that could provide a better outcome. JL responded to TC's comment that this would be of interest to the Board that looking at how flow works makes the Trust better informed. TM commented it would be helpful that this was made clear if it is not entirely an issue of demand.

9.6 LD referred to the presentation pack; known issues and what has been implemented. When we see performance does not improve when demand decreased it leads to other areas and mapping where there were subsequent delays. LD informed the Board that the Trust has been granted 1 million for work around our Medical Assessment Unit (MAU) which will help to reduce delay.

9.7 It was commented that it would be useful to be reminded of the building blocks for the deficit reduction as transformation and sustainability which we might like to bring forward may not happen and this would affect whether it was possible to reduce the financial deficit.

9.8 TC commented that work will be necessary on longer term sustainability over a 3 – 5 year period. A lot of opportunity has been identified which may overlap; much will depend on sector wide approach as it is not possible to deliver it alone over that period. The risk is can the Trust do enough this year; it is intended to ask 2020 to continue to support our staff and deliver savings on some of our CIP programmes.

9.9 TM encouraged by what has been presented on ED and that mortality has improved. LD commented that it is not an easy process but the Trust succeeded because it was determined, provided staff training and the Trust needed to be determined and focus on safety.

9.10 SC noted the work done had been very interesting and the results needed to be maintained.

10 Quality

10a. IQPR

10.1 KR reported that infection rates were reasonably static with a potential bacteraemia for August; one case of post 48 hours c difficile with no actions identified regarding training however c difficile infections were reported as 10 this financial year as opposed to the projection for the year of 20; this is undergoing regular review and audit. An increase in emergency caesarean section rate was noted; this is regularly reviewed monthly and a recent audit is being presented to their governance Board on Monday which does not highlight areas of concern. HSMR is down to 98.5 the lowest the Trust has reported which whilst a good position, there is no complacency. KR reported that there had been good progress on the backlog of SI investigations with 44

submitted to the CCG for review which will prepare a template for pressure ulcers and falls. There are 50 SI investigations outstanding and the Board would continue to be updated. The CCG was informed the Trust wanted to maintain the momentum in closing the outstanding SIs. KR reported there had been some breaches with mixed sex accommodation; an audit will be undertaken when the audit tool is received from NHSI. NHS South suggests the focus is on patient experience and complaints recognising some of the limitations at Trusts. There has been a slight increase in complaints but those dissatisfied with the Trust's response has settled. The complaints process, investigation and signing off has been improved.

10.2 JB commented on the emergency caesarean section rate increase and questioned when next reported to the Quality Committee (QAC) it could have more detail from the Directorate particularly with reference to their audit. KR responded that a report has gone to QAC.

10.3 BS updated the Board on the 18 week referral to treatment target (RTT) commenting that the Trust is currently ahead of its own target at 84.1% against national standard of 92%; RTT continues to improve.

10.4 JL commented that the 4 hour target is not only for ED. A 12 hour breach was noted in July due to a lack of flow and which was been reported to NHSI.

10.5 AL updated the Board on diagnostics and cancer targets commenting that diagnostic six week targets of 99% are not being met but are improving with on-going work to create capacity to meet demand including a reduction in GP referrals on working with Commissioners. It was noted that cancer reporting was on June rather than July meeting 31 day first treatment and subsequent treatment but not other standards. There was a significant increase in the two week wait due to capacity with our dermatology clinics so no up to 88 v 83% standard requiring on-going work to manage capacity. The 62 day standard had improved to 80% against a standard of 85%; there are a number of initiatives in place to improve on the standard.

10b. Annual Infection Prevention and Control

10.6 KR presented the report noting the annual report requirements of report are to describe performance against mandated infection reporting as set out. Whilst there were increases in bacteraemia cases last year there was no lack of care identified however there have been two breaches identified this year which will have financial penalties. There is now a fully compliant infection prevention control team. Reporting gram negative bacteria is now mandated however the Trust has always done so and rates are lower than the national average. It is necessary to provide adequate isolation specifically side-rooms with en-suites therefore the Trust considers itself to be partially compliant with the criteria and has appropriate mitigation in place. Whilst there has been a 10% increase in patients having catheters the infection rate is relatively unchanged.

10.7 SC asked the Board to note that the report sets out due diligence in terms of standards.

10.8 MS asked for clarification on hand hygiene and was informed by LD that there is an on-going initiative. KR added that there is a review of all infection prevention control.

10c. NQB Learning from Deaths

10.9 KM informed the Board there is a new national format for NHS with a focus on improving governance requiring executive director and NED presence on committee with greater involvement of family and carers throughout.

10.10 LD commented that DHF and KM should consider relevant policy and when a NED is appointed they could work with patient safety. LD noted the report, assurance and need to ensure compliance with guidelines. JP agreed with LD; could not see in the policy circumstances where external person would be brought in to Trust to undertake a review if necessary and there may be circumstances when this was desirable. LD commented there may be something in NHSE's policy that could be considered.

Action: NED to be appointed
Action: KM to consider need for reference to external review

10d. Organ Donation

10.11 PH introduced the presentation on organ donation. DK commented that the Governors might be able to assist with the organ donation group. Discussion took place around awareness of organ donation programme and how to promote it effectively.
Action: Governors to be made to participate in the organ donation group

11 Performance

Finance Report

11.1 TC provided a financial update noting that month 5 was on track. TC informed the Board that the Carter meetings were well attended and well received by staff; it was anticipated this would help with CIP delivery. Cashflow continued to be the main concern with a focus on debtors.

Communication Report

11.2 MA informed the Board the Communications team is looking at new ways to communicate effectively with staff and how to obtain their feedback. A staff App is in development and the Trust's instagram has been launched to complement the existing twitter and facebook accounts.

11.3 SC commented on the good work being undertaken by the team.

12 Governance

Corporate Governance Report

12.1 KW informed the Board that Check and Challenge had been established and would continue to March 2018. KW also informed the Board that the safeguarding policy was to be presented at the next Board meeting. Complaint responses were being sustained at 59% against 8% last year. The compliance dashboard was reviewed at monthly meetings.

Board Assurance Framework

12.2 The BAF is compliant with requirements and was presented and discussed at the Audit Committee where it was agreed that it would be reviewed with the corporate risk register to see if the two can be incorporated in an overarching framework.

13 People

Workforce and Equality and Diversity Reports

13.1 LH updated the Board on nursing recruitment with 12 nurses due to start in October. The language test remained the main issue for some applicants. Agency pay had remained static and substantive costs had reduced slightly.

13.2 LH responded to EC asking if there specific areas more difficult to recruit into that persistent vacancies had been identified and clinicians are using a work force model to assess possible reasons. KR commented that there is a process in place to mitigate any risk and to ensure safe staffing. The Board discussed the national position and challenges recruiting from outside the UK.

13.3 SC confirmed the Board **APPROVED** s 4.1 and 5.1 of the report subject to executive sign off.

14 Medical Appraisal and Revalidation Report

14.1 KM informed the Board that this paper had been presented in July but JB requested further assurance. KM explained that doctors have to revalidate every five years and that on-going resources would be required for appraisals as appraisers retire or leave the Trust. Two requests were on hold by the GMC pending further investigation. Further explanation was given on the process of reporting complaints concerning doctors, how the Trust would be informed by an external body if there were concerns, self-declarations by new starters and that the Trust requests information from previous employer.

14.2 The Board **APPROVED** the report.

15 Standing Financial Instructions and Scheme of delegation Policy

15.1 TC presented the Standing Financial Instructions and on confirming to the Chair that the Audit and Finance Committees had given approval to the document was **APPROVED**.

15.2 The Trust Secretary would comment if necessary.

16 Corporate HR Policy

16. LH presented the paper for approval however on discussion the Board asked for further detail in the policy therefore it will be returned for consideration at a subsequent Board.

Action: Corporate HR Policy to be represented for approval

17 Board Committee Reports

17.1 EC updated the Board as Chair of QAC commenting improve its performance. EC questioned the standard of IQPR when presented to QAC and the role of QIG in reporting to QAC to ensure the Chair could provide assurance to the Board.

17.2 TM updated the Board as Chair of the Finance Committee commenting that it would be appropriate to review what the Committee needs to do considering its crucial role.

AOB

18.1 DK commented all issues had been addressed.

18.3 LD commented that there would be a second business case to continue 2020 support for another six months. The overall budget was approved earlier in the year and the cost should be slightly less than the previous period.

18.3 SC thanked those attending.

Date of the next Private/Public Board 3 November 2017 at 12.30 in the Boardroom, Post Graduate Centre, Medway NHS Foundation Trust

NHS Medway NHS Foundation Trust

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB - 0390	07/09/17	10.10	NQB Learning from Deaths – A NED to be appointed	Chair/Trust Secretary	NED appointed	Closed
PUB - 0391	07/09/17	10.10	NQB Learning from Deaths – KM to consider need for reference to external review	Medical Director /Deputy Medical Director	Policy to be reviewed next year	Closed
PUB - 0392	07/09/17	16.1	Governors to be made to participate in the organ donation group	Trust Secretary	Work in progress	Open

Medway
NHS Foundation Trust

Chief Executive's Report – October 2017

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

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

In and around Medway

Performance

Emergency Department four- hour target

Achieving consistent high performance against the 4 hour target has been disappointing and far from where we should be over the last month. This is despite the effort and hard work by staff. What we need to deliver is a more consistent level of flow – from the front door through to discharge – to ensure we are delivering the best of care to all our patients.

Flow

For the last 3 weeks we have held daily teleconferences with system partners – CCG, Local Government, Community providers to review the patients who are considered "delayed transfers of care". This has provided greater visibility and focus and we are starting to see a reduction in the numbers and more importantly patients being transferred to where they will receive appropriate care.

Next week we are undertaking a stranded patient audit with the system partners. The NHS definition of a stranded patient is anyone in hospital more than 7 days where there is not a plan of on-going acute care. Currently 48% of our patients have been in hospital more than 7 days. The purpose of the audit is to review these patients, understand what the plan is for treatment and determine what they are waiting for – and then make it happen.

These actions will enable us to close the escalation ward that has been open since December 2014. Having escalation space is a critical aspect of our winter planning.

62-day cancer standard

As an organisation, we are working hard to meet the mandated target of 85 per cent of patients starting treatment within 62 days of an urgent referral with suspicion of cancer..

There are a number of confirmed actions being undertaken to help us meet the target, including introducing forecasting, daily cancer huddles with senior

management to drive earlier diagnostics and treatments; improved engagement with clinicians, managers and the diagnostic imaging department to reduce pathway delays and introducing a number of improved pathways and processes to reduce delays.

We have been successful in being awarded £172,000 from the Cancer Improvement Fund and this will be used to increase ultrasound and CT capacity (specifically in urology where the greatest benefit will be realised) as well as additional cancer management support to improve validation, tracking and finalise implementation of the 10 high impact actions. This funding has not yet been received via the CCG but the initiatives are ready to be implemented as soon as funding is received.

Our financial position

The Trust's financial position remains very challenging and the executive, supported by 2020 Delivery, has implemented a four-week Finance Sprint to achieve improvements at pace. We have continued to engage staff in our financial improvements and more detail is provided in the Better Best Brilliant update at agenda item 9b.

Fire Safety

Fortnightly meetings are now being undertaken by the dedicated Fire Safety Improvement Assurance Group chaired by one of our Non-Executive Directors, Mark Spragg, to ensure that the Trust is working to meet all national and statutory requirements, in particular those relating to fire evacuation plans. I have delegated James Devine as Executive Lead and in addition to the fortnightly meetings, James is undertaking twice weekly meetings to maintain the momentum and work around fire safety assurance.

The required improvements in fire safety are now being defined clearly with the adoption of a work plan and detailed reporting of progress towards stated outcomes. The work plan and performance report were endorsed at the Fire Safety Improvement Assurance Group on 19 October 2017. The report monitors performance across six areas: System of Control, Strategy, Trained Staff, Fire Prevention, KFRS Recommendations /Relationship and Remedial Works.

In addition, Trenton Fire has been appointed as the Trust's Fire Engineer and is currently working to establish the role of Authorising Engineer (Fire), as well as providing input to the work plan.

Trenton Fire is working with the Trust on remediation strategies which will define the full building work required. The Trust is working closely with NHS Improvement and keeping them informed of progress.

Progress is being made across a number of fronts including improved rates of training which reduces the risk of fire events and improves our ability to deal with any event. Vigilance continues to be a priority for staff and all staff are reminded to monitor their local environments to remove any obstructions and potential fire hazards.

Emergency Department development

Work continues on the new Emergency Department (ED). During the construction phase the operational plans have continued to evolve, in conjunction with our commissioners, to reflect the clinical pathways being developed across the Sustainability and Transformation Partnership.

Progress on the development of the ED has, however, been hampered by a number of issues that have been identified over recent weeks. The Trust is working closely with the building contractor to ensure that the building is of the necessary standard and specification. Some identified defects have required repair or replacement which has led to delay in the planned completion of Phase 1. We anticipate the building of the new ED will complete in late January 2018, with the move being planned soon after that. In the meantime the Trust will continue to deliver ED services from the current department. The Trust believes that it is in the best interests of our community to accept a delay now in order to deliver a high quality ED that will serve our patients for many years to come.

In addition to the new development, plans are being delivered to establish the initial phase of an Urgent Care Centre. This will augment the current primary care clinic at the hospital and will be in place before Christmas.

This will provide additional support for our community through the winter months, with enhanced GP-led services for those with non-Emergency conditions and a new streaming model providing additional focus on ensuring our attendees are getting the most appropriate care as quickly as possible.

Freedom to Speak Up Guardians

As many of you will know, the role of the Freedom to Speak Up Guardian came as a result of the Sir Robert Francis review, published in 2015, into failings at Mid-Staffordshire NHS Trust.

At Medway, we introduced the role around 12 months ago – and when seeking a Guardian, we received a number of applications. Following a selection process, we decided to appoint six Guardians (rather than one), as they came from varied backgrounds (clinical and non-clinical).

I am proud that six individuals stepped forward to support our value of ‘every person counts’; and that they remain committed to evolving the Guardian role, so that we truly embed the commitment to an open and responsive culture where staff feel confident to speak up when things go wrong.

In November 2017, we will be facilitating a reflection day with our Guardians, our workplace listeners, and our trade unions so that we can improve our collective practice and learn from the past 12 months together.

JAG Accreditation for Endoscopy

I am very proud to say that Medway Maritime Hospital endoscopy unit has successfully achieved JAG accreditation following reassessment of the unit in August 2017. This is formal recognition that our endoscopy service has demonstrated the competence to deliver against the measures in the endoscopy Global Rating Scale standards and demonstrates our commitment to providing high-quality, safe and appropriate endoscopy services.

In correspondence received from the Joint Advisory Group, there was praise for our high standard of achievement as well as the hard work and excellent dedication of the staff involved in the process.

It is wonderful to be able to evidence the hard work that I know is carried out by teams across the Trust and the accreditation for the endoscopy unit is another step forward in our move towards brilliant. I would like to thank and congratulate the teams involved in making this happen.

Nursing and Midwifery Language Tests

From 1 November 2017, the Nursing and Midwifery Council (NMC), is to expand the range of options that overseas nurses can use to prove their English language credentials are sufficient to join the NMC register. Under the move, overseas nurses whose first language is not English will now be able to take one of two recognised language tests to prove their competence:

- the current single International English Language Testing System (IELTS) option
- the Occupational English Test (OET)

In addition, nurses and midwives who have qualified outside EEA will now also be able to demonstrate English language capability in two other ways.

- They can provide evidence that they have undertaken a pre-registration nursing or midwifery qualification taught and examined in English' or
- They can provide evidence that they have registered and practiced for a minimum of one year in a country where English was the first and native language, and where a successful pass in an English language test was required for registration. This should speed up the process for on-boarding our international applicants.

We recognise and value the great contribution our overseas nurses make to our hospital and welcome this move as a step in the right direction to allow us to continue to build and strengthen our workforce.

Quality Special Measures Conference November

Diana Hamilton-Fairley, Stephen Clark and I have been invited by NHS Improvement and Philip Dunne MP, Minister of State for Health to attend and present at a Special Measures for Quality leadership event due to take place on Thursday 2 November.

The key purpose of the conference is for trusts which have exited special measures, such as Medway NHS Foundation Trust, to share their experiences and clear, practical steps that made a difference.

The event will include presentations and Q&A sessions with colleagues from other trusts who have been in Special Measures for Quality, as well as a keynote speech from the Secretary of State for Health. NHS Improvement will also share lessons and experiences from work they are undertaking with trusts that have exited Special Measures for Quality.

At the time of writing, we are preparing for this event and anticipate that this will give us the opportunity to talk about our journey out of special measures and the improvements we are consistently making. I fully anticipate that this will be a valuable exercise, not least in showing us and others how far we have come in our journey towards brilliant.

Away from Medway

Winter resilience

As we approach winter, there is a major emphasis across the NHS on being prepared for increased demand. This is a priority at a national level, and a priority for us. We know that it is likely to be a long, hard winter with as potentially serious flu outbreak. I am pleased to say our teams have been working hard to ensure we have resilience plans in place.

At the time of writing, we are preparing to attend a Pan Kent system pressures exercise which is being hosted by NHS England and NHS Improvement and forms part of the focus on winter planning. This exercise is intended to further test the efficiency of our winter planning and resilience to ensure that the actions we have taken to mitigate the potential seasonal risks are robust and effective.

Pauline Philip, the National Urgent and Emergency Care Director, has written to Trust chief executives about winter readiness in the NHS and care sector. In it, she sets out actions being taken to support winter planning as we enter what is expected to be a long and tough winter, with a potentially serious flu outbreak, such as free flu vaccinations for care home staff, and for additional patient groups.

The letter makes clear that for all NHS staff, having the vaccination is the default position, and organisations must make the jab easily accessible. At Medway we

have offered numerous clinics, and group vaccination sessions for clinical areas, as well as making it available on wards through our peer vaccinators, with a clear message that all staff, especially those caring for patients, are expected to have the vaccination.

The letter also reiterates the emphasis on reducing Delayed Transfers of Care.

In addition, Pauline Philip outlines a new system of escalation levels, based on learning from previous years. A new National Emergency Pressures Panel will identify levels of system risk and recommended contingency responses.

Medway CCG community services

Medway CCG has launched a review and redesign of community services in the area. Patients and public, as well as professionals, are being asked to give their views. The engagement process will run for eight months.

The contract for delivering community services is due to be awarded in September 2019 and will be in place from April 2020. Details are on the CCG website.

Elsewhere in Kent and Medway

East Kent University Hospitals NHS Foundation Trust Chief Executive Appointment

Susan Acott has been appointed as the interim Chief Executive of East Kent University Hospitals NHS Foundation Trust, following the resignation of Matthew Kershaw in September.

Susan is currently Chief Executive at Dartford and Gravesham NHS Trust, where she has been for eight years. She will act in the interim role until the end of March 2018, during which time they will conduct a recruitment and selection process. Susan will then return to Dartford and Gravesham.

Also at EKHUFT, Dr Peter Carter is to take on the role of Interim Chair, replacing Nikki Cole who had resigned. As you will recall, Peter served as Medway's interim chair until the end of March, so it will be a pleasure to work closely with him once again.

Meanwhile, it was recently announced that Glenn Douglas has been appointed as Chief Executive of the Kent and Medway Sustainability and Transformation Partnership, a role he has held on a part-time basis. Jim Lusby is Acting CEO while a permanent replacement is sought.

Antibiotic resistance

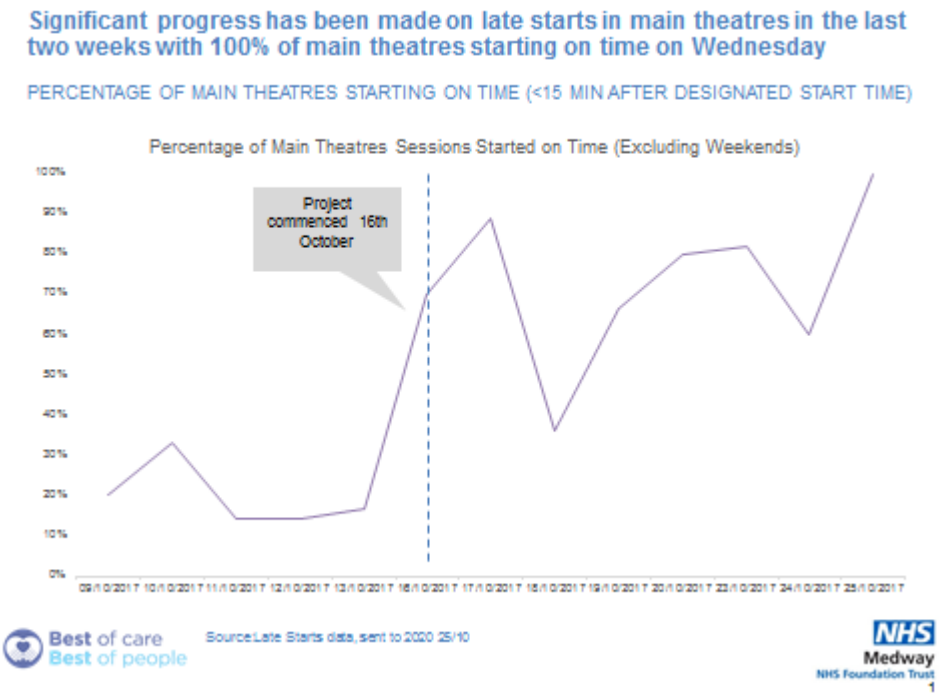
A campaign has been launched by Public Health England aiming to raise public awareness and understanding of antibiotic resistance.

The campaign – Keep Antibiotics Working – highlights that taking antibiotics when you don't need them puts you and your family at risk. It is estimated that at least 5,000 deaths are caused every year in England because antibiotics no longer work for some infections. Further details of the campaign are attached.

Theatre Utilisation and efficiency

A recent article by BBC News highlighted the lost efficiency in operating theatres across the country due to poor organisation of operating theatre schedules, according to the results of a survey looking at data from 2016.

We have already commenced a theatre efficiency programme and are making improvements in theatre start times in the last week, as the graph below shows. The focus will now be on reducing patient cancellations on the day of surgery, reducing the number of patients not attending their scheduled appointments and improving the scheduling of theatre lists."



Fighting obesity, diabetes and tooth-decay

NHS England has instructed Trusts not to sell super-size chocolate bars and ‘grab bags’ of sugary snacks in the latest step of the NHS plan to fight obesity, diabetes and tooth-decay.
NHS England chief executive Simon Stevens has announced a 250 calorie limit on confectionary sold in hospital canteens, stores, vending machines and other outlets.

Trusts will have to ensure that four out of five items purchased on their premises do not bust the limit, which is an eighth of a woman’s and a tenth of a man’s recommended daily intake, or lose out on funding ring-fenced for improving the health of staff, patients and their visitors.
Claire Lowe, our Director of Estates and Facilities, has provided assurance that we do not sell these items in our restaurant. She is also liaising with the League of Friends and advising them that they should not sell the products.

The development of e-Prescribing technology

Keith McNeill, NHS England’s first chief clinical information officer has told the HSJ (Health Service Journal) that boards not prioritising e-prescribing technology “need to be sacked”. His comments followed the release of new research that found e-prescribing technology could halve serious prescription errors.

He also said that Care Quality Commission inspections of acute services should explicitly include the uptake of electronic prescribing and medicine administration.

As an organisation, we recognise the importance of e-prescribing technology and we are currently exploring a collaborative bid through the STP to procure an electronic patient record system with an e-prescribing module.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/11/2017 Item No. 9a

Title of Report	**Sustainability and Transformation Partnership**
Prepared By:	Glynis Alexander
Lead Director	Lesley Dwyer
Committees or Groups who have considered this report	Not applicable
Executive Summary	This report provides an update on recent progress in Medway, North and West Kent, as well as across the county.
Resource Implications	As previously reported, the Trust is contributing to the STP financially and through the involvement of our staff
Risk and Assurance	Not applicable
Legal Implications/Regulatory Requirements	Not applicable
Improvement Plan Implication	Our improvement plan is aligned with the objectives of the STP
Quality Impact Assessment	Not applicable
Recommendation	The Board is asked to note the report
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

NHS Medway NHS Foundation Trust

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 The Medway, North and West Kent Delivery Board meets every four to six weeks. Established in the summer, the Board is now making progress in considering how services could be improved for MNWK, in line with the wider Kent and Medway Sustainability and Transformation Plan.

1.2 The Kent and Medway STP Programme Board oversees the work programme of the wider STP and its workstreams, and scrutinises key areas of focus. Most recently they focused on stroke services across the county, and urgent and emergency care services in east Kent.

2 EMERGING PRIORITIES

2.1 The Medway, North and West Kent Delivery Board recently commissioned a detailed analysis of the overarching Kent and Medway Case for Change to identify areas of relevance and significance for people living in these parts of the county.

2.2 Following discussion at its September meeting the Board agreed that cancer, elective care, diagnostics (including endoscopy, CT, MRI), specialist care in cardiology, neurology and dementia, and services for children and families, should be early clinical priorities for their delivery programme.

2.3 These emerging priority areas will sit alongside ongoing work to deliver more ‘local care’ (joining up health services delivered outside of hospital settings in local communities, and with social care services, such as that described in the Medway Model), and to improve stroke services in the area.

3 PROGRESS AND CHALLENGES

3.1 The Board agreed that it was important to align with the clinical strategy and priorities currently being reviewed by the Kent and Medway STP Clinical Board, while making sure they give the right focus to improvements in areas most needed by people in the north and west Kent. It is expected that the full list of clinical priorities will be agreed by the end of 2017.

3.2 At its September meeting the Board also discussed progress and challenges within the ‘productivity’ workstream. There is recognition of the urgent need to tackle staffing challenges, for example, through working across organisational boundaries to align agency and bank rates; developing shared temporary staffing arrangements; and taking a collaborative – rather than competitive – approach to recruitment, retention and training.

3.3 The Delivery Board is also looking at how Medway, North and West Kent STP partners can work together to generate efficiencies in the way they run corporate and

Report to the Board of Directors

back office services and purchase supplies and some clinical support services, including medicines and pathology services.

4 THE WIDER KENT AND MEDWAY PICTURE

4.1 The wider Kent and Medway STP Programme Board at its September meeting undertook a 'deep dive' – more detailed scrutiny – of hospital care and system transformation.

4.2 This focused on stroke services for Kent and Medway, and plans for urgent and emergency care services in east Kent.

4.3 Work has been underway for several years to review and improve stroke services across Kent and Medway and the Board looked at the latest proposals for stroke services, including how detailed financial and activity modelling data, clinical co-dependencies and the results of recent patient engagement have informed their development.

4.4 A number of possible models are being considered, and the shortlist is likely to include a number of options, each involving three specialist hyper-acute stroke centres at existing acute hospitals including Medway.

4.5 Public engagement has been a key part of the review, with feedback from stroke patients demonstrating support for proposals to move from the existing provision of seven units to three highly-specialist units. Over the summer, an online survey and a series of focus groups with patients and the public took place to help develop the evaluation criteria. The Board discussed the initial findings from this engagement activity which will be published in due course.

4.6 Additional work looking at travel times, access and workforce considerations is ongoing and will inform the development of the final short-list of options for stroke services.

4.7 At a national level, health and care economies across England are being encouraged to become Accountable Care Systems (ACSs) as the next step in supporting the delivery and implementation of sustainability and transformation plans. ACSs will be an 'evolved' version of the partnerships that are in place now, to better integrate health and care locally. The 'accountable care systems' are intended to support NHS organisations (both commissioners and providers) to work in partnership with local authorities to take on collective responsibility for resources and population health, providing better integrated and coordinated care.

4.8 In Kent and Medway, work is now underway to look at how health and care commissioners and providers can operate in a more integrated way. There is agreement amongst health and social care leaders that there should be one single strategic commissioner for Kent and Medway. There are also proposals for a small number of Accountable Care Partnerships (two or three) to plan, buy and deliver services for local people across this geographical area.

Report to the Board of Directors

5 PATIENT, STAFF AND PUBLIC INVOLVEMENT

5.1 A member of the STP Patient and Public Advisory Group will be invited to future meetings of the MNWK Delivery Board, to help give a patient/public perspective to the discussions and to support and help shape their plans for engagement activity on their work over the coming months.

5.2 Plans are also being developed to involve staff more fully in the development of plans.

5.3 Consideration is being given to how consultation will be carried out across Kent and Medway in 2018.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/11/2017 Agenda item: 9b

Title of Report	Better, Better, Best, Brilliant – Our Trust Improvement Programme
Prepared By:	James Devine, Executive Director of HR&OD and Improvement
Lead Director	Lesley Dwyer, CEO
Committees or Groups who have considered this report	Executive Group
Executive Summary	Patient Flow (ED 4 hour): The performance ranges between 93.9% (week 22) to 81.6% (week 20) in the last four weeks, this range shows a significant improvement in comparison to the performance range in the preceding four weeks (weeks 16 to 19).The important step is toward sustaining performance at or above the target. The methodology we are using to support the programme means that we are constantly evaluating and looking at where changes need to be made to achieve a sustained improvement in meeting the four hour performance target. To do this, we are focussing on embedding and communicating the new flow model; standardisation of processes in flow-critical areas; co-ordination of flow- critical activity; and improving discharge processes and reducing length of stay. Financial Recovery Workstream: As part of the BBB programme, we have started four week sprints with regard to a number of schemes to expedite the project, or release financial efficiencies earlier than originally anticipated. The paper summarises progress made to date, and actions to address shortfalls with the aim of sustaining performance at the required level.
Resource Implications	As outlined in the presentation.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Risk and Assurance	There are regulatory risks associated with both the four hour ED target, and finance.
Legal Implications/Regulatory Requirements	As above
Improvement Plan Implication	Flow and Financial Recovery are two components of the Better Best Brilliant Improvement programme.
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 and the further work required.**
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

Better, Best, Brilliant

Our improvement programme

Board Update 3rd November 2017

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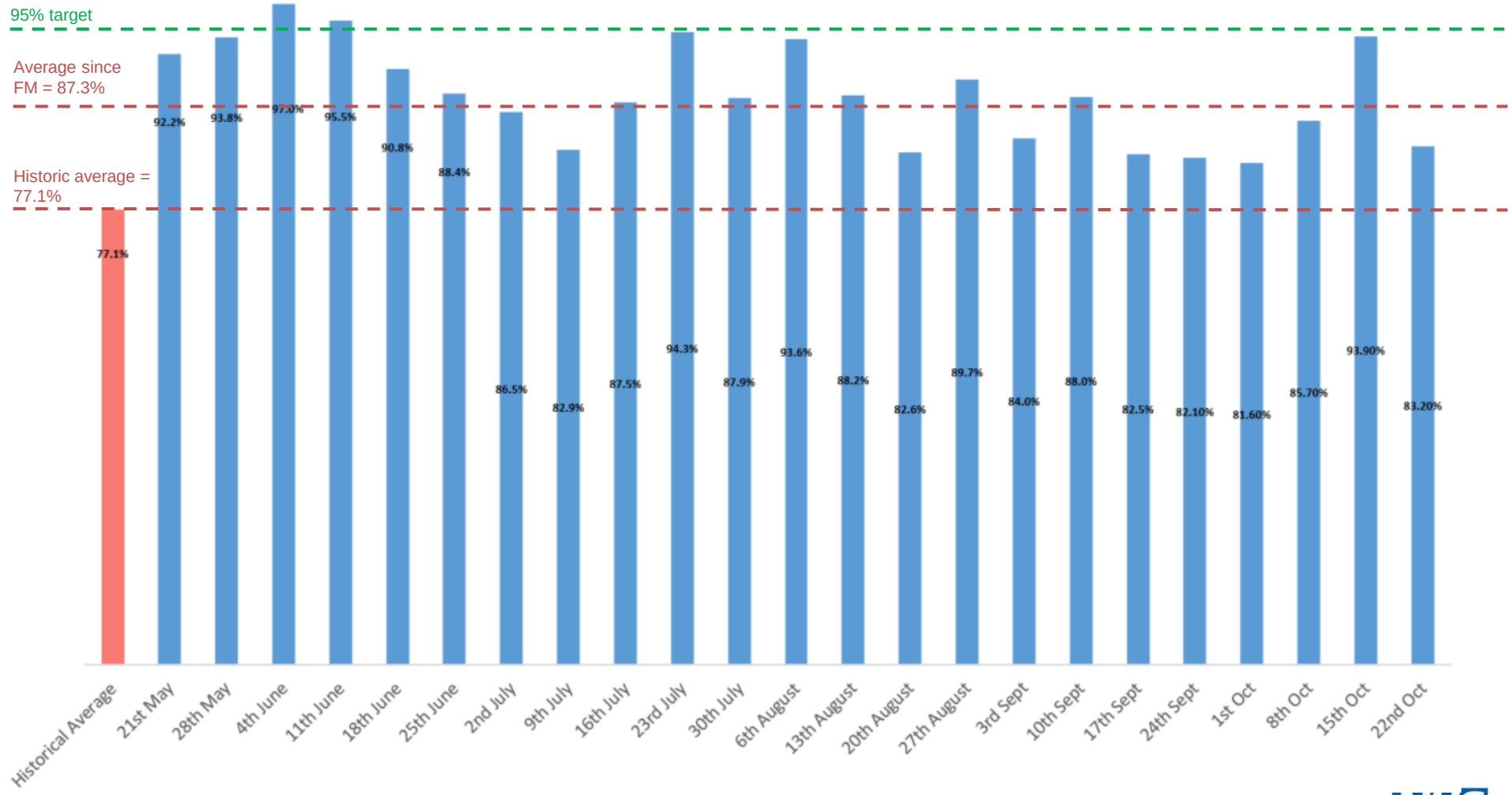
We continue to focus upon flow; although 4 hour ED performance has been variable, since Flow Month we have outperformed the historic average by 10%

AVERAGE WEEKLY PERFORMANCE AGAINST THE 4 HOUR ED TARGET



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Source: Trust data from QlikView
Historical average: 1st January to 14th May 2017

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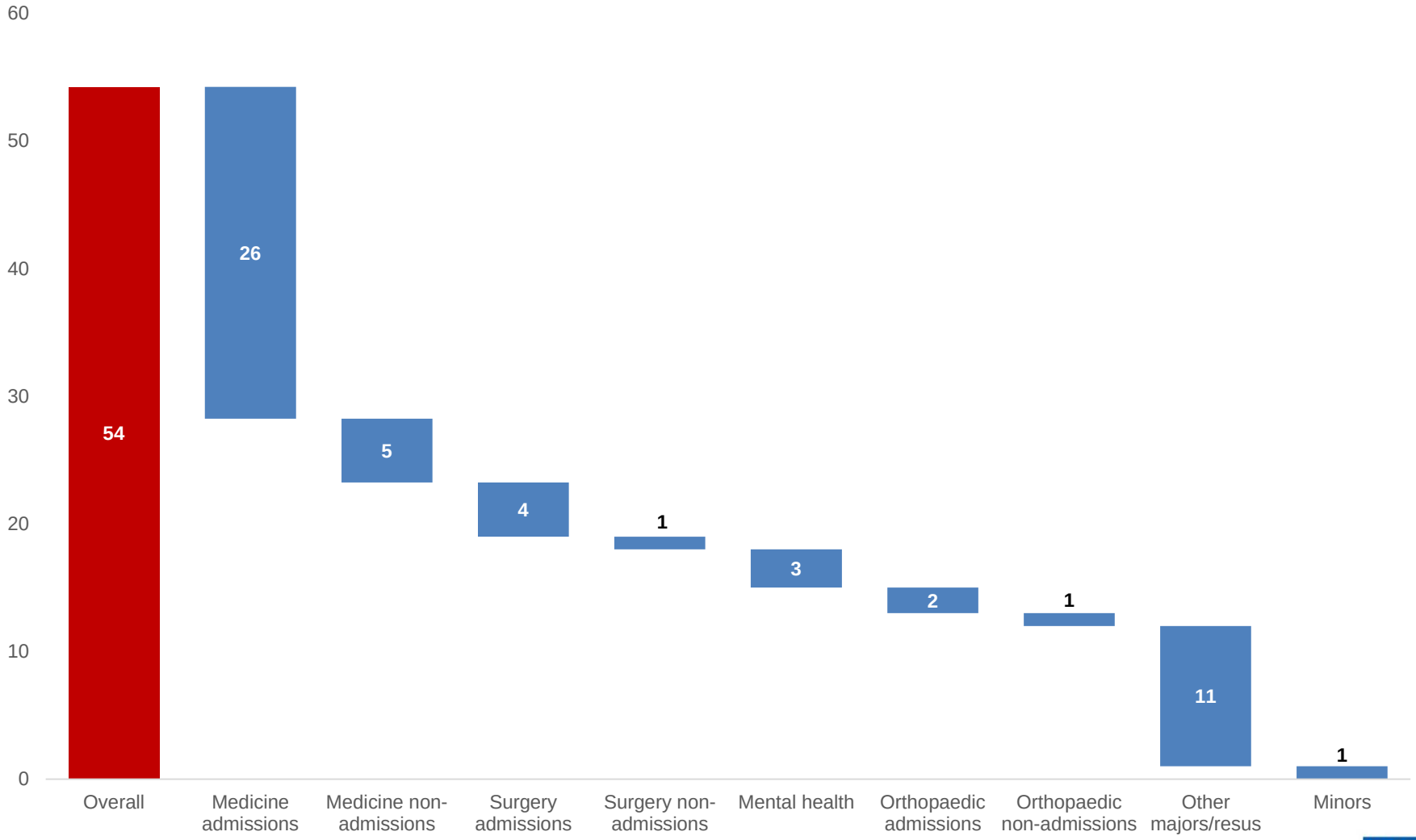
We have averaged 54 breaches per day, over half of which can be attributed to medicine, and in particular, an insufficient number of discharges

AVERAGE DAILY ED BREACHES AND PATIENT CATEGORY FROM 1 SEPTEMBER 2017



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Source: Symphony data provided by Business Intelligence, 17th October 2017

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In response to this, we are targeting a number of key areas to restore and sustain performance

Embedding and communicating the flow model	• **Embedding the urgent admission process** to ensure patients are admitted to the correct bed base on admission • **Accountability for the main bed base wards** in managing their acute take. Each ward to ensure they have capacity to meet predicted admissions • **Communication to front-line staff**, through posters, face-to-face engagement, and electronic comms
Ensuring alignment with the SAFER model	• Ensuring that key areas of focus address the **essential elements of NHSI's SAFER** model for improving patient flow • Ensuring **consistent and transparent standards of board round with a focus on SAFER** and ensuring all patients have clear plans, accountability for actions and discharge is progressed
Continued focus on discharge processes and reducing length of stay	• **Identification of patients for discharge 24 hrs in advance** to ensure discharges prior to midday • **Achieving 20 discharges by 10am**, of which 50% are in the ADL by 8am • Ensuring **EDNs** are completed the day before discharge • Ensuring completion of **Board Rounds** by 10.30 am on every ward • Developing a report to enable **ward level discharge by hour tracker**
Preparing for winter	• Ensuring that robust plans are in place to **maintain patient flow over winter** • Includes close working with community partners
Standardisation of processes and roles in flow-critical areas	• Further development, dissemination and implementation of **SOPs, one-page guides and directives** in flow critical areas • **A new CCC huddle approach**, with reporting from each of the 11 Programs and responsibility/accountability given back to front-line staff • Clarity on **roles and responsibilities** for staff in flow-critical areas e.g. CSPs

We have completed a four week sprint to improve portering efficiency and quality, and a new way of working will be trialled in November

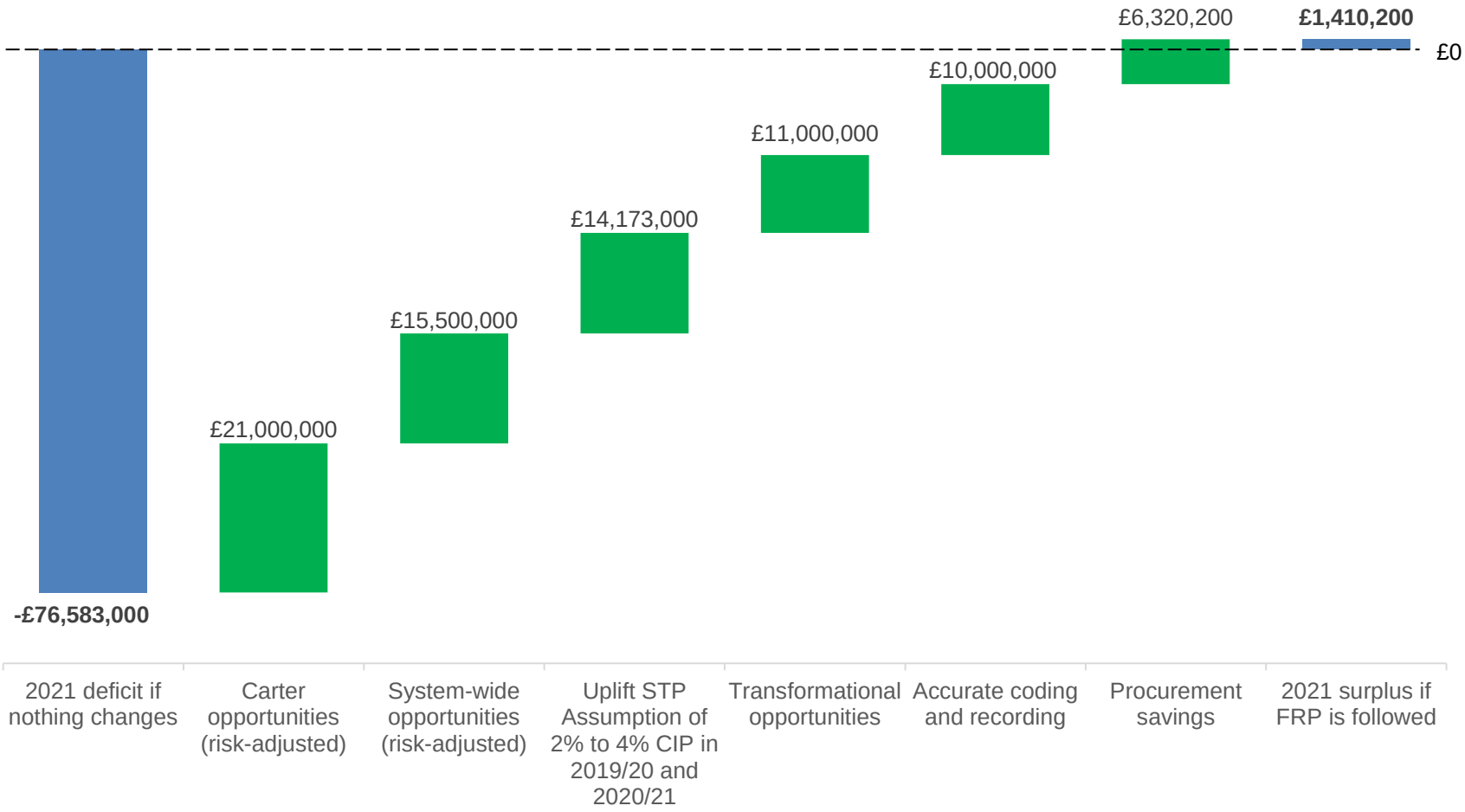
Project Aim	To **improve service quality** so that it meets service needs and demand, and **deliver cost savings through more effective patient flow**
Overview	Portering throughout the trust is disparate, with **separate governance structures and referral and allocation of jobs**. This project explored: 1) potential areas for consolidation and restructuring 2) areas for efficiency and quality improvements om line KPIs)
In order to increase efficiency and quality, we will trial two key changes:	1. **New governance structure** for overall portering in the trust • Some consolidation of portering services into the general portering team • Regular reporting of KPIs 2. **New way of working** within the general portering team • Split into critical services with allocated porters, and a general pool • **Structured and standardised way of referring** to the general portering team • A **supervisor at base** who can dispatch tasks to porters, reducing travel and response times • New radios to allow this contact on hospital site, and **more accurate recording** of tasks • The new way of working for general portering will be **trialled over a one month period**, with KPIs measured before and during to establish effect (task response time; staff feedback from porters, service leads and clinicians)

We completed internal and external benchmarking to identify opportunities in admin and clerical, which will be tested through a new working group

Project Aim	To **review admin and clerical workforce** and identify both quick wins and longer term strategies to **increase efficiency and quality and reduce costs**
Overview	The current admin and clerical staff across the organisation has organically grown to meet service needs, with **total workforce in this area exceeding the levels of similar acute trusts**. There is an opportunity for efficiency savings and quality improvements
Progress to date	• **External benchmarking** to identify key bands for focus – **Band 2 and 4 FTEs are very high compared to Kent, Surrey and Sussex acute trusts** when scaled to activity and finance • Internal benchmarking across directorates and programmes • Developed hypotheses to test across 5 key areas: 1. **Streamline A&C processes** and stop 're-work' 2. Create an **efficient governance system and structure** 3. Eradicate the need for paper notes 4. Create a **clinically-led, exciting and engaging vision for A&C staff** 5. Encourage local innovation in Directorates • These will be taken forward by the working group which has been established with HR, finance and operational representation • A comms pack has been developed for staff engagement to frame the project

Our Financial Recovery Plan sets out in detail how we will close a £76.6m gap and return to a sustainable position by the end of 2020/21

COMPONENTS OF MEDWAY'S RETURN TO BALANCE



Source: Medway Financial Recovery Plan, September 2017

We know that we need to accelerate pace and have established a 4-week finance sprint to focus on delivering 20 priority projects

Progress to date:

- **Identified 20 priority projects** with the executive and project leads, with consideration of size of financial opportunity and deliverability
  - The project list will be further scoped by leads and then re-iterated according to scale of savings
- **Developed and established the governance structure**
  - 2x weekly executive led finance huddles which project leads report into
  - All project leads to complete Problem Definition Sheets and a high level project plan to generate common understanding, estimate savings and aid implementation
- Project Leads have received **white belt training and problem-solving / finance support**

Next steps:

- Continue using the twice weekly finance huddles to **drive progress at pace,** with executive members leading huddles to unblock obstacles and provide support
- **Track KPIs and progress** across the 20 priority areas
- Continue to iterate which projects report into huddles as more projects move into delivery
- **Review the success and lessons learnt from the 4-week finance sprint** and agree what we need to change as we progress further waves of projects

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Report to the Board of Directors

Board Date: 3rd November 2017 Agenda item: 10a

Title of Report	Integrated Quality Performance Dashboard - Update
Presented by	Executive Team
Lead Reporting Director	Executive Team
Committees or Groups who have considered this report	

Executive Summary	To inform Board Members in the form of a flash report of September's performance across all functions and key performance indicators.
	
	Key points are:
	• The Trust did not achieve the **four hour ED target** for September and performance has decreased from 87.72% in August to 83.78% in September. The main reasons for this are;
	  ○ Reduction in performance is primarily through lack of internal flow from the main bed base to discharge.
	  ○ The drivers for delays in the time of day for discharge alongside delays in actual discharge are multifactorial and span the entire continuum both internal and external to the Trust.
	  ○ There was a 1.9% increase in total attendances and the flow out of ED remained challenged.
	  ○ September saw the continuance of the Better, Best, Brilliant (BBB) Flow work stream. Ongoing work is focused on embedding the urgent admission process to ensure patients are admitted to the correct bed on admission, reducing the number of patient handovers and ward changes. It is also focused on accountability at granular level for the main bed base wards in managing the acute take.
	  ○ Bed occupancy has increased at 95.30% for September compared to 93.29% in August.
	
	• There was one **12 hour breach** in September.
	
	• **HSMR** data reported in this month's IQPR is for the period from July 2016 to June 2017. This is currently 100.50, which is in line with the national benchmark.
	
	• This month saw an 18.03% increase in the number of

	Mixed Sex Accommodation breaches totalled 72 in September. The recent inclusion of assessment areas in the reporting of breaches has contributed to a month on month deterioration in MSA performance. The Trust continues to participate in the NHSI project group which is considering best practice in relation to MSA. • **RTT** performance has slightly decreased to 83.65% from 83.71%. This is below the national standard of 92%, as well as the agreed 85% trajectory. Corrective actions include reducing outsourcing and improved theatre utilisation and the Trust is close to eliminating 52+ week waits. • **Cancer targets** have not all been achieved. The 2 week wait performance was not achieved in August, and has decreased by 2.23% to 91.08%. This was predominantly due to patients being unavailable due to holidays and patients rescheduling booked appointments. • There was a 6.45% increase in the number of **falls** in September (67) when compared to August (63). However overall performance to date is an improved position. • 83 complaints were reported in month, an increase on August's 66. Analysis of the complaints received in month has not identified any new themes.
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

October 2017

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

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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.

10012 Patients visited our ED , which is a **1.9% increase** on the previous month, with **83.78%** seen within 4 hours, compared to 87.72% . **2257** Patients were admitted, with a **decrease** in conversion rate of **22.54%** compared to 22.58% in August.

There were **5554** total patient admissions in September, and **5556** patients were discharged.

Bed Occupancy **increased** by **2.01%** in September to **95.30%**.

3110 patients arrived at ED via ambulance which is a **1.68% decrease** on last month.

39.0% Of ambulance patients were seen in under 15 minutes.

September's Story....

457 Babies were delivered in the month of September (13 more than August) with Emergency C-Section rate with a slight **decrease** of **1.21%** from the previous month to **18.16%.**

HSMR is **100.50** and within expected parameters (94.79 – 106.47) compared to 100.1 as reported in August.

79% of staff have had an appraisal compared to **80%** in August.

23637 Patients attended an outpatient appointment with **9.60%** DNA rate which is an increase of **0.36%** on last month.

There were **67** total falls in September, compared to **63** in August.

RTT Overall Incomplete Pathways for September was **83.65%** which declined by **0.06%** on previous month. We remain on our improvement trajectory. The trust also reported **23 x 52** week waiters which decreased by **14** compared to August.

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

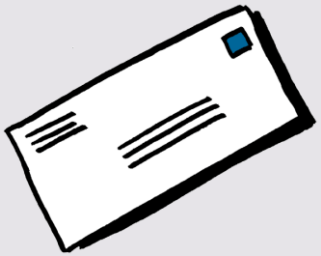
2 Week Wait symptomatic breast was below the target of **93%** in August with performance of **92.41%** - improved by 3.30%.

2 Week Wait cancer performance for August was **91.08%** (reported one month in arrears) . This is a **2.23%** decrease from July's performance.

September's Performance....

96.17% of patients waited under 6 weeks for diagnostic tests in the month of September, which has improved by **0.39%** since August's reported performance.

We received **83** complaints in September, increasing from those received in August by **17**. The number of complaint returners remained at **2** in September.



There were **72** Mixed Sex Accommodation breaches in September which is an **18.03%** increase on August's performance.

Legend
- Compliant with target
- Breaching target

Infection Control

MRSA acquisitions and bacteraemia

- The reported increase in the number of MRSA acquisitions is secondary to an outbreak of MRSA colonisation in Keats ward. A formal outbreak has been declared and is being investigated as a Serious Incident. Immediate action was taken in accordance with Infection policy and protocols.
- We reported two MRSA bacteraemia cases:
    - One post 48-hour MRSA bacteraemia is Trust-attributable. Source unknown at this time and investigations continue. This patient was one of the outbreak cases.
    - A second pre 48-hour MRSA bacteraemia case is currently at arbitration as it is considered to be 'third party' and not Trust-attributable. Source is unknown.

C Diff post 72 hours

- The Trust reported three post 72-hour cases in September This is above the monthly trajectory of 1 case. However, the trajectory for the quarter has been met. The Trust currently has 14 cases for the year against trajectory of 20.
- All reported cases are within the Acute and Continuing Care Directorate. The Directorate have actions in place to address compliance issues and the IPCT are working closely with the wards involved.
- Two cases were considered to be avoidable (level 2 lapses of care) and one case unavoidable.
- The recurrent theme with nearly all the avoidable cases continues to be antimicrobial stewardship. Actions to improve compliance with infection prevention practice are being led by the Medical Director and Director of Nursing.
- The Trust is still at risk of breaching the end-of-year target.

Safe Page 11

Legend: Compliant with target; Breaching target

Never Event

The Coordinated Surgical Directorate reported a Never Event with the classification of 'a retained foreign object post-procedure' on 26 September 2017. The incident has been escalated as a serious incident within the required timeframes and is currently subject to an RCA investigation. The incident relates to a guide wire that was discovered left in situ following removal of a CVC line.

Serious Incidents

The Trust reported 14 new SIs on STEIS in September.

As at 2 October 2017, there are a total of 126 open Serious Incidents (SIs)

- 88 - subject to an active investigation
- 7 - submitted for review at the CCG SI Closure Panel and referred back to the Trust for further information
- 31 – SI investigations reports submitted to the CCG SI Closure Panel

In line with the NHS England SI Framework (2015) and Schedule C (Quality) of the NHS Standard Contract 2017/18, the Trust is required to achieve SI reporting standards. Trust performance against these standards is

- Reported on STEIS within 48 hours – 43%
- Reported to CCG within 72 hours – 73%
- Submission of final report within 60 days – 16%

The Trust has a remedial action plan to deliver improvements in SI management and performance. Trajectories for closure of backlog SIs have been agreed with each directorate, these are monitored at the Trust SI group and at Directorate PRMs.

Root Cause Analysis (RCA) training has been in place since July 2017 and there is a regular programme in place through to March 2018. Training dates have been distributed to all Governance Leads and Directorates and are being promoted via global email and Trust intranet. There is currently capacity for training 164 staff; to date, 34 staff have been trained.

NRLS (National Reporting & Learning System)

The latest Organisation Patient Safety Incident Report (relating to incidents reported between 1 October 2016 and 31 March 2017) was published on 27 September 2017. The reports shows that MFT reported a total of 4,375 incidents for the period; an increase from the 3,725 incidents that were reported in the April to September 2016 period. In the cluster of 136 acute (non-specialist) organisations, our reporting rate per 1,000 bed days was 46,74 (against a median reporting rate of 40.14) which puts MFT in the highest 25% of reporters. MFT reported higher than our peer group in the following incident types: implementation of care and ongoing monitoring / review, access, admission, transfer, discharge (including missing patient) and infrastructure (including staffing, facilities, environment).

Duty of Candour
Compliance with duty of candour remains a challenge; Directorates have advised that they are complying with duty of candour legislation but are not fully utilising Datix to store the compliance information. A task and finish group will be held in October to focus on the improvements that are required and agree an improvement plan.

NICE Technology Appraisals (TA)
There were 6 TAs published in September 2017, of which 3 were assessed as not applicable to the Trust. The remaining 4 relate to Dermatology and Cancer Services. 1 TA has been assessed, with a further 3 to be assessed by 31 December 2017 (the 90 day standard deadline).

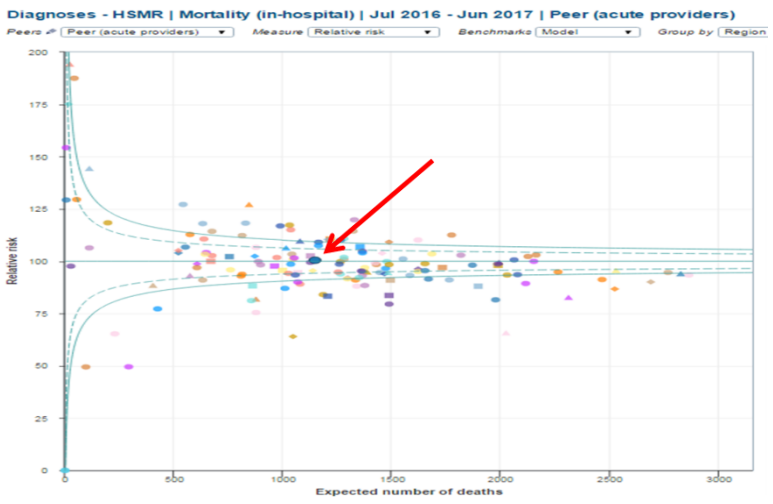
NICE Clinical Guidelines (CG)
There were 8 CGs published in September 2017, of which 1 was assessed as not applicable to the Trust. The remaining 7 relate to Breast, Dermatology, Diabetes, Emergency & Elective Gynaecology and Trust wide. 3 CGs have been assessed, and the remaining 4 are within the 90 day deadline of 31 December 2017.

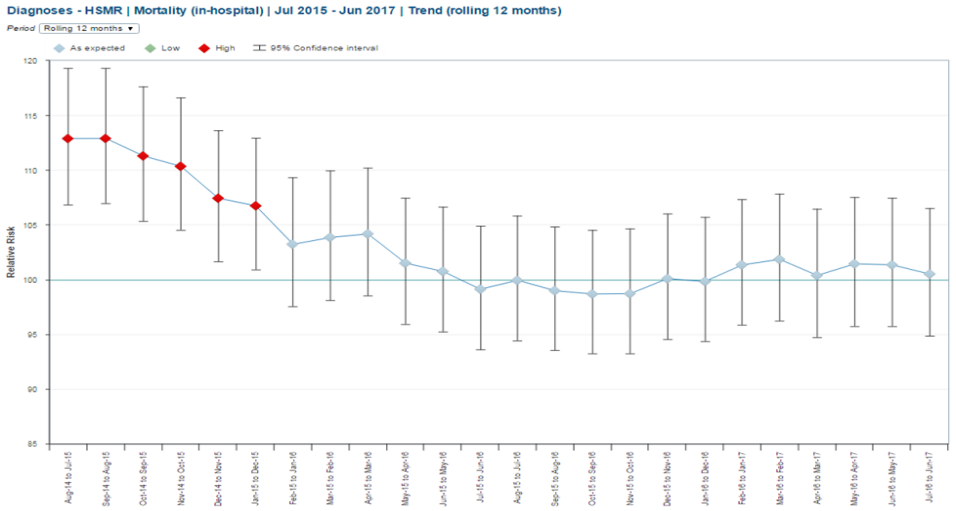
NICE Quality Standards (QS)
There were 6 QSs published in September 2017, relating to Critical Care, End of Life Care and Trust wide. 1 QS has been assessed, and the remaining 5 are within the 90 day deadline of 31 December 2017.

Other news
A new process for the review of NICE guidelines has been implemented, with set escalation deadlines. This is designed to support the directorates and specialty leads in completing reviews of guidelines. Since April 2017, 106 guidelines have been published by NICE, and of these, 80 have been reviewed, 78 (97.5%) within 90 days. Of the remaining 26 guidelines awaiting review, 20 remain within their 90 days of publication, and these continue to be escalated to the individual clinicians, specialty leads, governance teams and Directorates.

Mortality

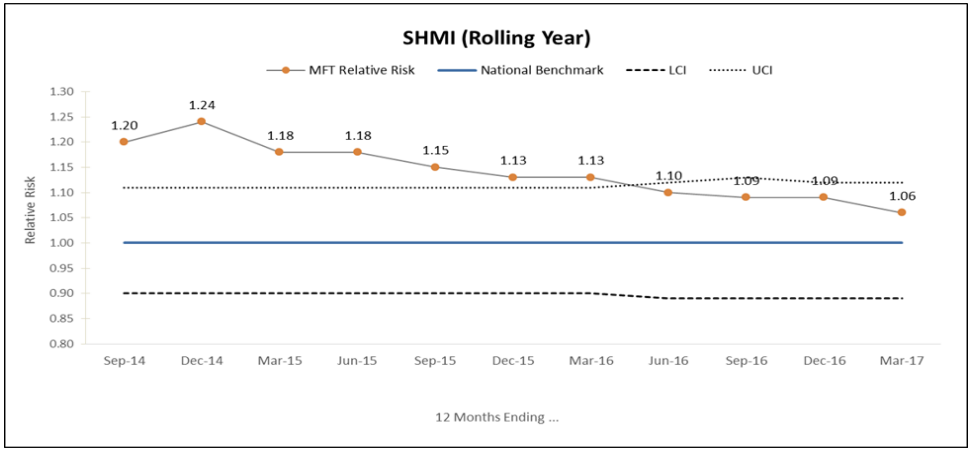
The Hospital Standardised Mortality Ratio (HSMR) is currently 100.5 (for the period from July 2016 to June 2017) which is in line with the national benchmark. The current peer comparison and rolling HSMR trend are demonstrated in the following graphs.





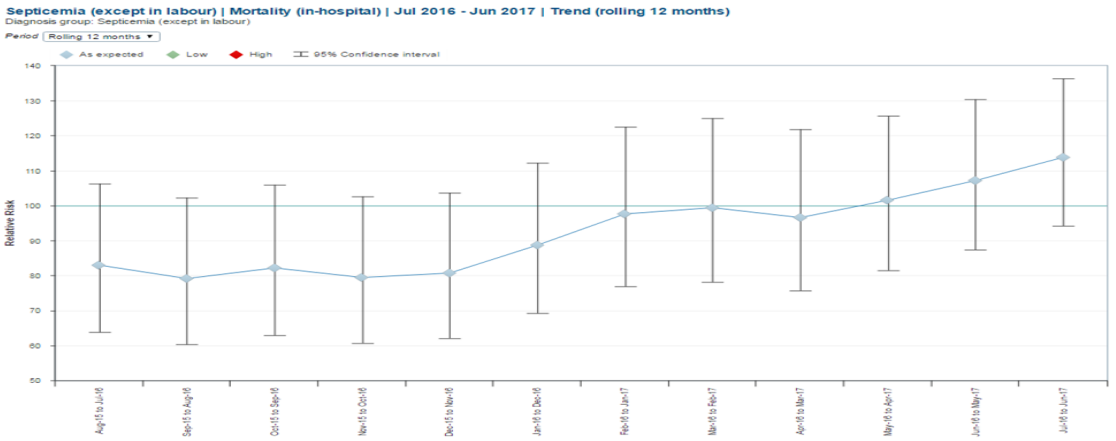
The latest SHMI value for the period April 2016 – March 2016 was published on Thursday 21 September 2017. The value has decreased from 1.09 in December 2016 to 1.06 in March 2017. The SHMI continues to remain within the expected range but the latest value represents the positive work that is ongoing within the Trust.

The rolling year trend is illustrated on the right.

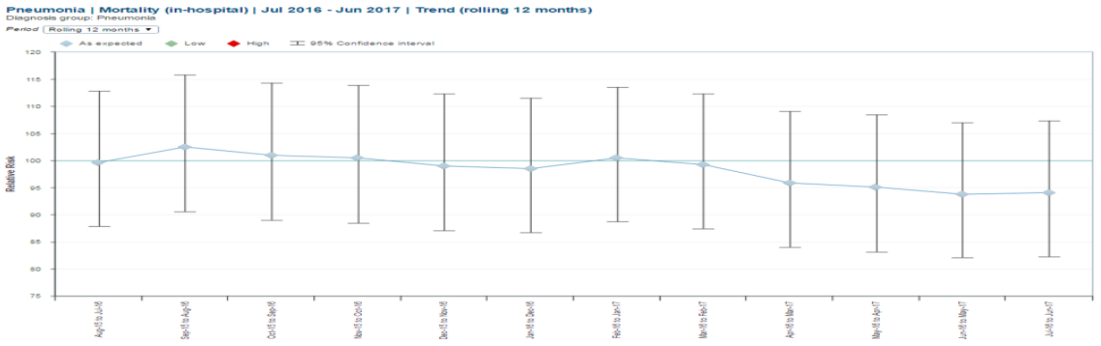


The HSMR for Septicaemia is currently above the national benchmark (100) at 113.79 but remains within the expected range. Coding regulations in this group changed in April 2017, meaning that more spells will fall into this category than would have done previously. It was expected that this would result in an increased HSMR for this diagnosis group.

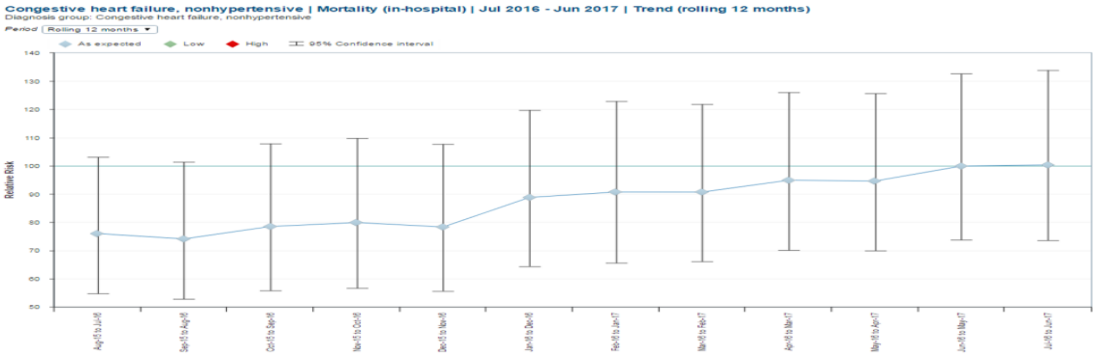
As part of the revised mortality review process which was introduced in August 2017, all sepsis deaths will be subject to mortality review in order to help inform the existing sepsis quality improvement initiative.



The HSMR for Pneumonia remains below the national benchmark (100) at 94.06.



The HSMR for Congestive Cardiac Failure is currently in line with the national benchmark (100) at 100.31.

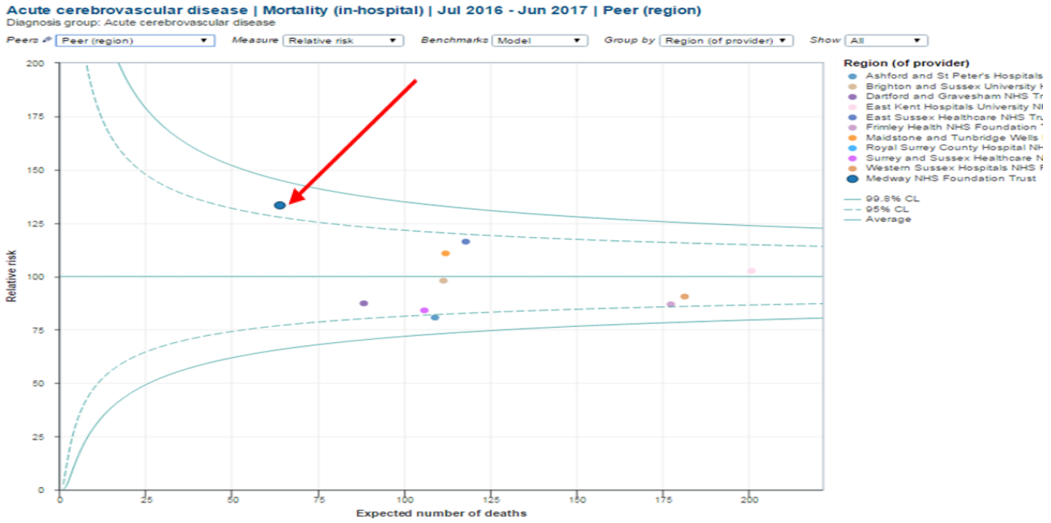


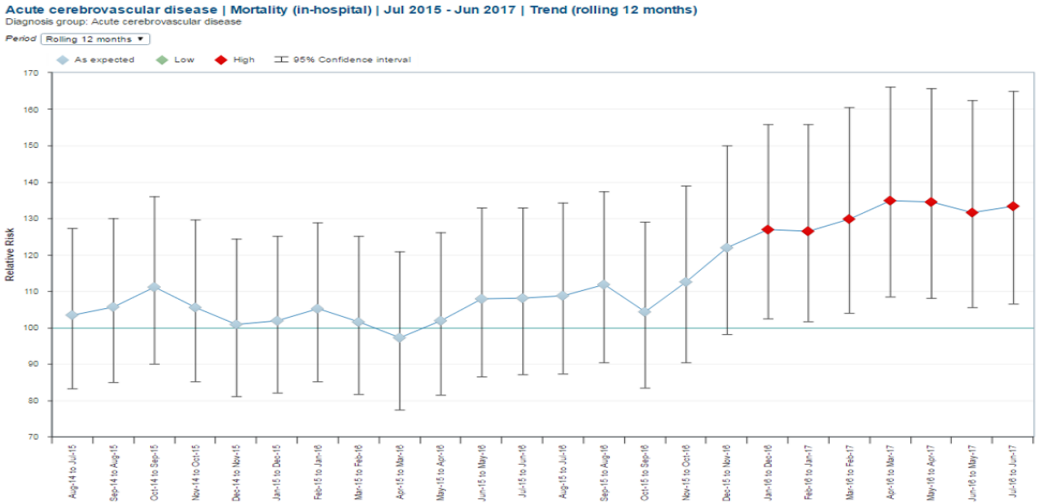
The HSMR for Acute Cerebrovascular Disease is currently 133.3 which is significantly high statistically. The current peer comparison and rolling trend for this diagnosis group are demonstrated by the following graphs.

A working group has been established and a coding audit has already taken place which identified potential areas of improvement for the documentation of comorbidities in this group. A clinical audit is currently being undertaken by Dr Richard Leach (Associate Medical Director – Clinical Effectiveness and Research) and Dr Sanmuganathan (Stroke Lead).

In line with recent National Quality Board Guidance on learning from deaths (March 2017), all stroke deaths will be subject to mortality review and will remain so whilst the diagnosis group remains an outlier.

The data is reflective as at Monday 2nd October 2017.





Effective Page 12

CQUIN

Reported quarterly – Q2 report due to be submitted to the CCG for validation on 31 October 2017

Caring Page 13

Complaints and Complaints Response Rate <30 Days

The Central Complaints Team received and logged 83 complaints during September 2017. This is a 34% increase from last month. The tables below show the numbers broken down by RAG rating and Directorate.

RAG rating	
Red	8
Amber	64
Green	11
Total	**83**

Directorate	
ACC	34
CSD	32
F&CSS	15
Estates	2
Total	**83**

The increase in complaints was discussed with the Directorate management teams at the October Performance Review Meetings (PRMs). The directorates have undertaken a review to identify reasons for the increase in complaints and no new issues identified therefore continue to monitor.

There continues to be an increased response performance across all of the Directorates but is most noticeable within the Coordinated Surgical Directorate and the Families & Clinical Support Services Directorate.

Mixed Sex Accommodation (MSA)

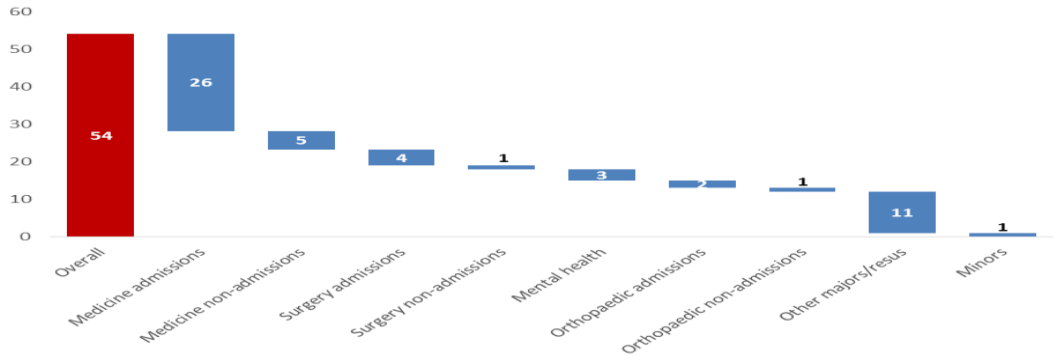
The surge activity within the assessment units is contributing to a deterioration in performance against the MSA standards. The Trust continues to participate in the NHSI led MSA improvement work.

- **ED**

The Trust's performance against the national 4-hour standard for September was 83.78%. August performance was 87.67% and July's was 88.48%.

September saw a 3.89% deterioration in 4-hour performance and was 11.22% below Medway NHS Foundation Trust's (MFT) planned trajectory of 95% for the month.

Reduction in performance for September is primarily through lack of internal flow from the main bed base to discharge. The Trust observed an average of 54 4-hour breaches each day, the majority of which are within Medicine and due to bed availability.



The drivers for delays in the time of day for discharge alongside delays in actual discharge are multifactorial and span the entire continuum both internal and external to the Trust.

With a 1.9% increase in total attendances, flow out of the ED remained challenged.

- Admitted 4-hour performance for September was 31.48%, down on August's 58.82%
- Non-admitted pathway was 94.47%, an improvement on August's 89.82%
- Minors and ED paediatrics both performed above 98%

MFT remains consistently one of the top performers in the region for ambulance handover with 39% of offloads within 15 minutes, seeing the largest number of conveyances in the region (3,110), 3.2% above the next highest Trust ambulance attenders.

- **ED (continued)**

September saw the continuance of the Better, Best, Brilliant (BBB) Flow workstream. The BBB work began to focus on unblocking the Trust's urgent care flows thus allowing staff to provide care in the manner and place where it would be optimised.

The work focused on eliminating blocks within pathways and increasing patient facing time for clinical staff. Ongoing work is focused on the following:

- Embedding the urgent admission process to ensure patients are admitted to the correct bed base on admission reducing numbers of patient handovers and ward changes. This also ensures that the short stay units are 'ring fenced' for patients with a length of stay of less than 48 hours ensuring efficacy of short stay units and continuous flow.
- Accountability at a granular level for the main bed base wards in managing their acute take.
- Agreed Board round standard operating procedure aimed at ensuring consistent and transparent standards of Board round with a focus on SAFER bundle and ensuring all patients have clear plans, accountability for actions and discharge is progressed.

There is a continual monitoring of the length of stay on the acute admissions wards to ensure patients spend no more than 48 hours. This, again, is a key metric of the CCC discussion.

The Kent and Medway NHS and Social Care Partnership Trust (KMPT) has been working in collaboration with MFT and the CCG to introduce mental health triage and streaming at the front door of ED. This will be a major component of the accelerated CORE24 model being rolled out in October.

Pharmacy has commenced a phased roll out of transcribing onto EDNs for patients who are to be discharged that day which will ameliorate some of the delays related to TTOs. Initial phasing is for short stay units and patients on the day of discharge. The goal is to move this throughout the Trust and include patients being discharged within 24 hours.

The SAFER care bundle and a reduction in the stranded patient rate is a key focus for improving bed availability in October and as part of the winter resilience work.

- **RTT**

Incomplete pathways (overall) – Work is progressing to reduce or stop outsourcing, impact assessments to determine operational uplift to mitigate this stream of activity are underway, for example improved theatre utilisation, greater day care utilisation. General Surgery/Colorectal have had significant pressure with non-elective and urgent activity which reduces the capacity to maintain routine elective activity, Saturday lists will remove this cohort of patients from the intensity of Monday to Friday.

Treatment over 52 weeks -patient choice continues to be the most significant factor impacting on performance, however we will shortly have no more over 52 weeks and the Trust has seen a significant improvement to the over 45 and 35 week profiles.

Cancer

August performance against the cancer waiting time standard is variable on last month although the 31-day standards have improved and continues to maintain compliance. The 62-day GP referral performance is non-compliant against the 85% standard performance improvement trajectory.

2WW - The Trust failed to achieve the GP 2-week wait and symptomatic breast standards.

- There were 111 breaches in August across a number of tumour sites predominantly as a result of patients being unavailable due to holidays or patients rescheduling booked appointments.
- 32 out of the 52 2-week wait breaches were booked within the target 48 hours from receipt of referral.
- Unfortunately the majority were offered first appointments very late in the 2-week wait pathway.
- Tumour site clinicians and managers are receiving these reports so that they can increase clinic capacity to reduce these delays and allow for alternative dates to be offered within the 2-week standard.
- The Trust narrowly missed the symptomatic breast standard due to 6 breaches. Two breaches were due to clinic capacity. 3 breached as a result of patients changing appointments and 1 HMP delay.

31D – The Trust achieved all of the 31-day treatment standards.

- There were no patient breaches for the subsequent surgical and drug treatment standards.

62D - The Trust failed to achieve compliance with the GP 62-day referral and screening standards.

- The 62-day GP standard performance was 80.11%, failing both the 85% standard and the improvement trajectory.
- The shadow 38-day reporting performance was slightly improved at 82.61% against the 62-day GP standard.
- There were 18.5 breaches against the 62-day GP referral standard, an increase on July's breaches. These are detailed as 2 Breast, 1.5 Haematology, 1.5 Head & Neck, 2.5 Lower GI, 5 Skin, 1 Upper GI and 5 Urology patients.
- Pathway breaches were varied due to diagnostic capacity, complex pathways and patient choice.
- There were 6 breaches over 104 days which was a reduction since the previous month.
- Daily cancer huddles led by senior management were introduced in September to review the cancer patient waiting list and bring forward cancer patient diagnostic and treatment procedures to reduce pathway delays and meet the 62-day standard. This initiative has reduced breaches, diagnosed and treated patients earlier along with improving Trust-wide engagement in cancer performance.

Cancer 62 day GP Referral trajectory

Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Trajectory	82.00%	83.50%	85.10%	85.10%	85.10%	85.10%	85.10%	85.10%	85.10%	85.10%	85.10%	85.10%
Actual	84.70%	74.24%	80.00%	82.07%	80.11%							

- **Diagnostics**

The Diagnostic performance fell below trajectory for September to 4.91% (95.09%) with breaches predominantly in Non-Obstetric Ultrasound and MRI due to capacity issues. Although overall the diagnostic waiting list backlog continues to reduce. To manage demand and improve performance, some CT requests are being converted to MRIs. DEXA scan capacity is being created by training Radiographers to respond to peaks in demand and the mobile MRI scanner is on site for October and November.

Well Led Page 23

Voluntary turnover (across all staff groups) has increased slightly to 9.8% (+0.2%) and above the tolerance level of 8%. Sickness absence (at 3.76%) remains slightly below the tolerance level of 4% and is also a slight decrease from the previous month (-0.04%), remaining stable. Ratios of long-term sickness to short-term sickness remain largely static.

In September, the Trust saw a net increase in staffing (significantly more starters than leavers) by 19 FTE. The number of leavers of the last three months is largely in line with the year to date average. September saw a significant number of doctors come into the Trust (26) and registered nurses (15).

Temporary staff (as a percentage of our pay bill) has reduced slightly (by -1%) to 20.9% from August to September. Plans continue to be implemented to further reduce our agency expenditure and support staff in moving from temporary to substantive posts and working with agency suppliers across Kent.

Data Quality Validation Update

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

Emerging work projects:

- **Cancer PTL Open Pathways** – the Data Quality Team is to provide data quality support to the Cancer Services MDM Team relating to patient records pre-2014/15 time period. This will provide a clean outpatient PTL enabling operational staff to continue to accurately monitor patients.

Existing work projects:

- **Emergency Department (ED) DQ project update** – work continues to support the ED Department by identifying data items entered late or incorrect onto the Symphony System.
- **E-referral bookings** – DQ team are assisting the e-referral project team, to identify potential data quality issues that might affect the changeover to complete e-referral booking system. Potential issues such as incorrect outcome linking, how information is displayed on the PAS system, are just a couple of identified quality issues.
- **Extramed/PAS** – DQ team are working with coding and patient safety team analysing some of the inpatient data, ensuring the implementation of the new system is not having a negative effect on the Trusts inpatient data.

Data Quality Training

The Team are currently involved in bespoke data quality training projects which have been developed in-conjunction with Training Department:

- RTT Decision Making: DQ Team has delivered the first revised training as part of the recently approved RTT Training Policy.

- Review List: regular awareness training sessions have been devised for administrative staff following on from the Data Quality review list project findings. The purpose of the training is to support operational staff management of Waiting Lists, particularly patient follow-up appointments/discharges entered correctly on the PAS system.

Other DQ Validation Work:

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

3. Safe

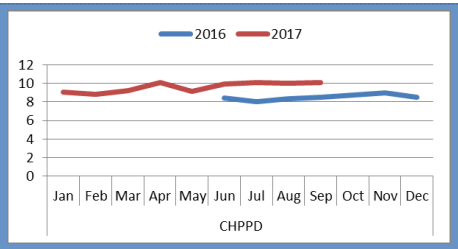
		Monthly Target	RAG Status	Trend Jul-17	Aug-17	Sep-17	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
1.1.3.2	NRLS Organisational Reporting Rate (6 monthly)		G	46.74 (national median 40.14)								
1.1.4	Never events	0	R	0.00	0.00	1.00	↑	0.2				✓
1.1.4.1	Never Events - Incidence Rate	0.00%	R	0.00%	0.00%	0.01%	↑	0.0			✓	
1.1.5	Incidents resulting in death	0	R	5.00	4.00	5.00	↑	4.3				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days)	0.30	G	0.34	0.30	0.08	⇓	0.28				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days)	2.20	G	1.44	1.12	1.59	↑	1.5				✓
1.1.10	Incidents with moderate or severe harm with duty of candour response	100%	R	7.7%	8.7%	10.7%	⇑	9.3				✓
1.1.14	Pressure ulcers (grade 2) attributable to trust	10	G	5.00	6.00	6.00	⇔	9.4				✓
1.1.15	Pressure ulcers (grade 3&4)	0	R	1.00	0.00	1.00	↑	1.0				✓
1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	0.2	R	0.00	0.00	0.23	↑	0.1				
1.1.18	Falls per 1000 bed days	6.63	G	5.00	4.71	5.06	↑	5.0				
1.1.19	Number of falls to fracture (per 1000 bed days)	0.2	G	0.00	0.00	0.08	↑	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	100%	R		4.3%	3.6%	↓				✓	
1.2.2	New VTEs - point prevalence in month	0.36%	R	0.43%	1.41%	1.17%	⇓	0.7%			✓	
1.2.7	Emergency c-section rate	<15%	R	23.0%	19.4%	18.2%	⇓	18.3%				
1.3.1	MRSA screening of admissions	95%	G	95.9%	88.8%	95.6%	⇑	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	R	0.00	1.00	1.00	⇔	0			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	R	1.00	1.00	3.00	↑	2			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	100.50 (94.79-106.47)							✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	106.16 (94.85-118.45)							✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	1	G	1.06 (0.89-1.12)							✓	✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

Safe Staffing – Nursing Update - Highlights

Care Hours per Patient per Day

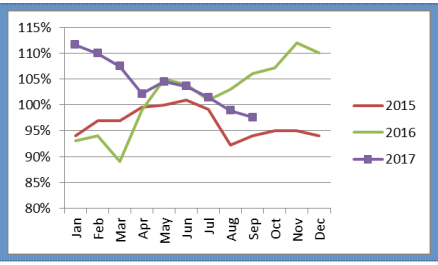
We have continued to report CHPPD above our peer group. A peer review of our staffing levels will be undertaken in November



Daily huddles are being undertaken to make sure wards are staffed correctly for patient safety.

Safe Staffing

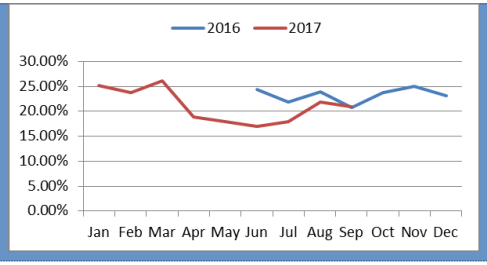
Safe staffing remains below 100% for September.



Staff issues are being risk assessed multiple time daily. Nursing days are being held with good turnout which has led to more recruitment in the pipeline.

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.

Staffing Levels – Nursing & Clinical Support Workers

			Day				Night				Day		Night		Internal KPIs				
			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 (%)	Total Planned Hours (registered & care)	Total Actual Hours (registered & care)	Overall fill rate	Difference total Actual vs Planned hs	Difference total Actual vs Planned %
Acute & Continuing Care	Bronte Ward	18	1486	1008	1089	1007	999	1010	740	740	*68%*	*92%*	*101%*	*100%*	*4,314*	*3,764*	*87%*	*-550*	*-13%*
Acute & Continuing Care	Byron Ward	26	1437	1208	1902	1829	1001	1046	1159	1354	*84%*	*96%*	*104%*	*117%*	*5,498*	*5,438*	*99%*	*-61*	*-1%*
Acute & Continuing Care	CCU	4	934	679	0	0	679	695	0	10	*73%*		*102%*		*1,612*	*1,383*	*86%*	*-230*	*-14%*
Acute & Continuing Care	Gundulph	25	1312	960	1604	1298	1001	974	1148	1193	*73%*	*81%*	*97%*	*104%*	*5,064*	*4,424*	*87%*	*-640*	*-13%*
Acute & Continuing Care	Harvey Ward	24	3655	3279	0	0	3345	3005	0	0	*90%*		*90%*		*7,000*	*6,284*	*90%*	*-717*	*-10%*
Acute & Continuing Care	Keats Ward	27	1057	1044	419	420	696	672	660	661	*99%*	*100%*	*97%*	*100%*	*2,832*	*2,797*	*99%*	*-36*	*-1%*
Acute & Continuing Care	Lawrence Ward	19	1791	1636	1056	1776	1257	1706	990	1353	*91%*	*168%*	*136%*	*137%*	*5,094*	*6,471*	*127%*	*1,377*	*27%*
Acute & Continuing Care	Milton Ward	27	1498	1055	1165	1325	836	966	649	892	*70%*	*114%*	*116%*	*137%*	*4,147*	*4,237*	*102%*	*90*	*2%*
Acute & Continuing Care	Nelson Ward	24	3386	3369	150	150	3381	3376	0	0	*99%*	*100%*	*100%*		*6,916*	*6,894*	*100%*	*-22*	*0%*
Acute & Continuing Care	Sapphire Ward	28	1350	904	2247	2016	825	748	1320	1342	*67%*	*90%*	*91%*	*102%*	*5,741*	*5,010*	*87%*	*-731*	*-13%*
Acute & Continuing Care	Tennyson Ward	27	1618	881	1693	1593	1013	907	1159	1261	*54%*	*94%*	*90%*	*109%*	*5,482*	*4,642*	*85%*	*-841*	*-15%*
Acute & Continuing Care	Wakeley Ward	25	1920	1384	1476	1475	1294	1317	1328	1318	*72%*	*100%*	*102%*	*99%*	*6,016*	*5,494*	*91%*	*-523*	*-9%*
Acute & Continuing Care	Will Adams Ward	26	1504	1076	1098	1459	902	1066	979	1232	*72%*	*133%*	*118%*	*126%*	*4,482*	*4,833*	*108%*	*351*	*8%*
Co-ordinated Surgical	Arethusa Ward	27	1679	1717	1422	1514	1287	1320	1089	1276	*102%*	*106%*	*103%*	*117%*	*5,477*	*5,827*	*106%*	*350*	*6%*
Co-ordinated Surgical	ICU	9	1545	968	1126	1733	891	865	990	1262	*63%*	*154%*	*97%*	*127%*	*4,552*	*4,828*	*106%*	*275*	*6%*
Co-ordinated Surgical	Kingfisher SAU	14	1088	958	853	827	675	654	675	687	*88%*	*97%*	*97%*	*102%*	*3,291*	*3,126*	*95%*	*-165*	*-5%*
Co-ordinated Surgical	McCulloch Ward	29	1392	1284	356	332	1150	1079	196	299	*92%*	*93%*	*94%*	*153%*	*3,094*	*2,994*	*97%*	*-99*	*-3%*
Co-ordinated Surgical	Medical HDU	6	1520	1495	1568	2300	945	1543	1327	1863	*98%*	*147%*	*163%*	*140%*	*5,360*	*7,201*	*134%*	*1,841*	*34%*
Co-ordinated Surgical	Pembroke Ward	27	1591	1570	1207	1817	1243	1584	1133	1650	*99%*	*150%*	*127%*	*146%*	*5,174*	*6,620*	*128%*	*1,446*	*28%*
Co-ordinated Surgical	Phoenix Ward	30	2078	1495	1564	1291	1430	1526	1298	1363	*72%*	*83%*	*107%*	*105%*	*6,370*	*5,674*	*89%*	*-696*	*-11%*
Co-ordinated Surgical	SDCC	26	2063	1621	1366	944	528	477	517	264	*79%*	*69%*	*90%*	*51%*	*4,474*	*3,306*	*74%*	*-1,168*	*-26%*
Co-ordinated Surgical	Surgical HDU	10	2203	2119	367	339	1642	1963	0	22	*96%*	*93%*	*120%*		*4,212*	*4,443*	*106%*	*232*	*6%*
Co-ordinated Surgical	Victory Ward	18	1385	902	641	589	924	1000	550	472	*65%*	*92%*	*108%*	*86%*	*3,500*	*2,963*	*85%*	*-537*	*-15%*
Women & Childrens	Delivery Suite	15	2875	2700	721	648	2832	2754	420	408	*94%*	*90%*	*97%*	*97%*	*6,847*	*6,509*	*95%*	*-338*	*-5%*
Women & Childrens	Dolphin (Paeds)	34	1987	1055	1547	1500	1265	1137	1302	1214	*53%*	*97%*	*90%*	*93%*	*6,101*	*4,905*	*80%*	*-1,196*	*-20%*
Women & Childrens	Kent Ward	24	2185	1194	861	813	1386	1464	363	497	*55%*	*94%*	*106%*	*137%*	*4,794*	*3,967*	*83%*	*-827*	*-17%*
Women & Childrens	NICU	25	870	877	518	519	720	719	360	360	*101%*	*100%*	*100%*	*100%*	*2,467*	*2,475*	*100%*	*8*	*0%*
Women & Childrens	Ocelot Ward	12	3075	2936	677	977	2415	2300	299	426	*95%*	*144%*	*95%*	*142%*	*6,466*	*6,638*	*103%*	*172*	*3%*
Women & Childrens	Pearl Ward	23	1073	1217	570	550	1068	1032	324	251	*113%*	*96%*	*97%*	*78%*	*3,035*	*3,050*	*100%*	*15*	*0%*
Women & Childrens	The Birth Place	9	1083	1032	360	348	1080	969	360	361	*95%*	*97%*	*90%*	*100%*	*2,883*	*2,710*	*94%*	*-173*	*-6%*
	Trust total	**638**	**52,637**	**43,618**	**29,620**	**31,386**	**38,709**	**39,871**	**21,334**	**24,030**	***82.9%***	***106.0%***	***103.0%***	***112.6%***	**142,298**	**138,905**	**98%**	**-3393**	**-2.4%**

Safe Staffing– Nursing Update KPIs

		Monthly Target	RAG Status	Trend Jul-17	Aug-17	Sep-17	Movement	YTD avg	Trend	Data Quality
1.5.2	Vacancy Rate (Overall)	*8%*	R	26.04%	25.97%	26.64%	↑	26.13%		
1.5.3	Total Vacancies (WTE)	*TBC*		406.00	404.00	422.72	↑	408.2		
1.5.4	Vacancy Rate (Band 5)	*TBC*		36.40%	35.76%	37.25%	↑	36.39%		
1.5.5	Vacancy Rate (Band 6)	*TBC*		20.97%	19.13%	23.95%	↑	22.04%		
1.5.6	Vacancy Rate (CSW)	*TBC*		17.52%	16.32%	17.74%	↑	17.59%		
1.5.7	Nursing Starters	*TBC*		13	5	15	↑	12.0		
1.5.8	Nursing Leavers	*TBC*		21	14	14	↔	15.3		
1.5.9	CSW Starters	*TBC*		13	5	9	↑	10.3		
1.5.10	CSW Leavers	*TBC*		8	7	8	↑	7.3		
1.5.11	Rolling annual turnover rate	*8%*	R	9.40%	9.63%	9.84%	↑	9.71%		
1.5.16	Safe Staffing	*94.00%*	G	101.5%	98.9%	97.6%	↓	100.6%		
1.5.17	CHPPD	*8.00*	G	10.08	10.01	10.11	↑	9.84		

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

Commentary	Actions
Further nursing assessment days are being arranged as they are proving successful.	We continue to work with recruitment agencies to assist the recruit of overseas nurses.

4. Effective

		Monthly Target	Status	Trend						Alignment		
			Status	Jul-17	Aug-17	Sep-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
2.5.4	Emergency Readmissions within 28 days	*10%*	R	8.0%	10.7%	10.7%	↔	11%			✓	
2.5.4.1	Emergency Readmissions within 28 days Under 65	*10%*	R	7.5%	9.9%	10.3%	↑	9%			✓	
2.5.4.2	Emergency Readmissions within 28 days 65 +	*10%*	R	8.8%	12.0%	11.3%	↓	10%			✓	
2.6	Discharges before noon	25%	R	18.66%	20.18%	21.78%	↑	16%			✓	✓

5. Caring

		Monthly Target	RAG Status	Trend Jul-17	Aug-17	Sep-17	Movement	YTD avg	Data Quality	Alignment Carte	SOF	Quality Account / CQUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	*83%*	G	87.6%	87.7%	86.2%	↓	87%			?	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	*65%*	G	82.6%	81.1%	79.5%	↓	78%			?	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	*79%*	G	99.2%	97.7%	98.3%	↑	99%			?	
3.1.3	Mixed Sex Accommodation breaches	*15*	R	44.00	61.00	72.00	↑	33.8			?	
3.4.1	Number of Complaints	*45*	R	69.00	66.00	83.00	↑	54			?	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	*85%*	R	59.0%				47%			?	
3.4.3	Number of complaint returners	?	G	4.00	2.00	2.00	↔	5.3			?	

Commentary	Actions
Please see Executive summary	Please see Executive summary

6. Responsive

		Monthly Target	Status	Trend						Alignment		
			Status	Jul-17	Aug-17	Sep-17	Movement	YTD avg	Data Quality	Carte	SOF	Quality Account / CQUIN
4.1.1	RTT – Incomplete pathways (overall)	*92%*	R	84.08%	83.71%	83.65%	↓	78.56%			?	
4.1.2	RTT - Treatment Over 52 Weeks	*0*	R	25	37	23	↓	22				
4.2.3	A&E 4 hour target	*95%*	R	88.48%	87.72%	83.78%	↓	81.07%			?	
4.3.1	Cancer – 2 week wait (1 month in arrears)	*93%*	R	93.31%	91.08%		↓	83.59%				
4.3.2	Cancer - 2 Week Wait Breast (1 month in arrears)	*93%*	R	89.11%	92.41%		↑	90.54%				
4.3.3	Cancer - 31 day first treatment (1 month in arrears)	*96%*	G	95.71%	96.36%		↑	94.62%				
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	*94%*	G	96.00%	100.00%		↑	93.34%				
4.3.5	Cancer – 31 day subsequent treatments - drug (1 month in arrears)	*98%*	G	100.00%	100.00%		⇔	98.37%				
4.3.6	Cancer - 62 day consultant upgrade (1 month in arrears)	*N/A*		72.73%	76.19%		↑	79.37%				
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	*85%*	R	82.07%	80.11%		↓	79%			?	
4.3.9	Cancer – 62 day screening (1 month in arrears)	*90%*	R	93.75%	88.89%		↓	88%			?	
4.4.1	Diagnostic waits - under 6 weeks	*99%*	R	97.79%	95.78%	96.17%	↑	94%			?	
4.5.8	Patients seen by a stroke consultant within 24 hours (Apr to Jul figures reported)	*95%*	R	55.00%	55.00%	53.90%	↓	54%				?
4.6.1	Average elective Length of Stay	*<5*	G	2.13	2.43	2.32	↓	2.5				?
4.6.2	Average non-elective Length of Stay	*<5*	R	5.70	5.51	7.85	↑	6.7				?
4.6.6	Average occupancy	*90%*	R	94.92%	93.29%	95.30%	↑	94%				?

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

Commentary	Actions
Please see Executive summary	Please see Executive summary

7. Well led

		Monthly Target	Status	Trend						Alignment		
			Status	Jul-17	Aug-17	Sep-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		52.7%		↓	58.0%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	*79%*	R		66.6%		↓	73.8%			✓	
5.3.7	Rolling annual turnover rate	*8%*	R	9.4%	9.6%	9.8%	↑				✓	
5.3.7.1	Executive Team Turnover Rate	*TBA*		5.0%	0.0%	7.7%	↑	3.5%			✓	
5.3.8	Overall Sickness rate	*4.0%*	G	3.81%	3.80%	3.76%	↓	3.9%				
5.3.9	Sickness rate – Short term	*3.0%*	G	1.80%	1.81%	1.83%	↑	2.5%			✓	
5.3.10	Sickness rate – Long term	*1.0%*	R	2.01%	1.99%	1.93%	↓	1.4%			✓	
5.3.11	Temporary staff % of pay bill	*15%*	R	18.0%	21.9%	20.9%	↓	22.0%			✓	
5.3.14	Starters	*N/A*		80	158	80	↓	78.3				
5.3.15	Leavers	*N/A*		56	165	61	↓	62.0				

Commentary	Actions
Results from the Friends and Family Test show a reduction in the number of staff who would recommend the Trust as a place for treatment by 8%. This remains as a midpoint between the Trust's highest result of 75% in quarter 1 2017/18 and lowest result of 59%. Similarly, there is a reduction in the number of staff who would recommend the Trust as a place to work by 5%. This also remains as a midpoint between the Trust's highest result of 61% and lowest result of 42%. The results are based on a response rate of 19.3%, similar to last quarter's response rate. The Trust will be using the results and associated breakdown by staff group to support interventions across the organisation in conjunction with the NHS Staff Survey running from October to December.	Please see Executive Summary

8. Enablers

		Monthly Target	Status	Trend: Jul-17	Aug-17	Sep-17	Movement	YTD avg	Data Quality	Alignment: Care	SOF	Quality Account / Commiss
7.2.1	APC – NHS number completeness (2 month in arrears)	*99%*	R	98.8%				98.9%				?
7.2.8	A&E – Attendance disposal (2 month in arrears)	*99%*	R	95.1%				96.3%				?
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	*11*	R	94	137		↑	99.9		?		?
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	111	126		↑	273.8		?		?
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	*1%*	G	0.5%	0.6%		↑	1.1%		?		?
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	*103.50*	G	6	0		↓	200.65				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	*0.00*	R	2.00	2.00		↔	3.24				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	*949*	R	1254	1204		↓	1554.1		?		?
7.3.13b	A&E % missing breach reason on breached attendances (1 month in arrears)	*50%*	G	100.0%	100.0%		↔	92.6%		?		?
7.3.17	Cancer 2ww invalid NHS Number (1 month in arrears)	*0.25*	G	1	0		↓	4.6		?		?
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	*13.25*	G	0	0		↔	15.3		?		?
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	*0.01*	G	0.01	0.01		↔	1%		?		?
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	*2*	G	0	1		↑	5.1		?		?
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	*1.25*	G	1	1		↔	2.0		?		?
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	*1.25*	G	0	1		↑	3.8		?		?
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	*1*	R	1	2		↑	4.5		?		?

Commentary	Actions
Please see Executive summary	Please see Executive summary

Medway NHS
NHS Foundation Trust

Report to the Board of Directors

Board Date: November 2017

Item No. 10b

Title of Report	**Medical Education Report**
Reporting Officer	**Dr Janette Cansick, Director of Medical Education** **Carol Atkins, Medical Education Manager**
Lead Director	**Dr Diana Hamilton-Fairley**
Responsible Sub-Committee	**Local Academic Board**
Executive Summary	To inform/advise the Board of: 1. The structure of Medical Education, with key recent changes particularly reorganisation at HEKSS and Junior Doctors Contract 2. The responsibilities of Medical Education 3. Results of GMC National Training Survey 2017 4. Key results of recent HEKSS and Medical School Quality Visits 5. Medical Education strategy, with progress against 2016 objectives with current opportunities, focus for improvements and potential threats to delivery MFT has 1 Director of Medical Education supported by 2 deputies and Medical Education Manager to oversee medical training, with leads within different programmes and specialties to oversee delivery. The DME is accountable to the Trust Medical Director and Health Education Kent Surrey Sussex Postgraduate Dean. Enhancing trainee voice and improving morale remains a priority and we are proud to be the highest scorer for overall satisfaction in acute Trusts in KSS in the 2017 GMC Trainee survey, with our score being above the average national mean. Morale has also picked up following the introduction of the new Junior Doctors' Contract and the Trust coming out of special measures. Much work has been done in working closely with service leads, Clinical Directors and Directors of Operations, to improve patient safety and trainee experience. There has been significant progress in this area particularly in Emergency Medicine and Medicine. There continue to be some rota gaps which remain a concern. The other significant area of focus in the last year has been to improve induction for trainees joining the Trust. Progress has also been made in obtaining oversight of the Postgraduate Medical Education (PGME) budget. A Report is provided to show progress against our 2016 Medical Education Strategy. A revised strategy has been formed

	following further analysis identifying opportunities and threats, review of GMC red flags, and consultation with medical education (Local Faculty Group) leads.
Risk and Assurance	Clinical Risks ☒, Finance & Performance risks ☒, Reputation risks ☒ Governance risks ☒ Monitor risks☒
Legal Implications/Regulatory Requirements	Meeting the requirements of HEE is essential to maintaining our training posts with a financial and reputational risk if we have trainees removed.
Recovery Plan Implication	Doctors in postgraduate training are an essential part of our workforce and have a key role in improving the quality of our services.
Quality Impact Assessment	
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	The Board is requested to: 1. Understand the responsibilities of Medical Education to the Trust and HEE (London and South East - LaSE) 2. Receive summaries of Quality Visits, with positives identified as well as areas for improvement 3. Receive this paper as an update on medical education strategy 4. Be aware of the risks identified within training and their mitigation: a. Rota gaps particularly Medicine registrars b. Implementation of new Junior Doctors' Contract c. Oversight of budget d. Re-organisation at HEKSS e. Concerns in pharmacy leading to the withdrawal of Pre-Registration Pharmacists
Recommendation	

Introduction

Health Education England (HEE) is committed to the provision of quality education and training for the development of healthcare professionals and accordingly it allocates a budget to every Local Education and Training Board (LETB) to fund specific education and training and to meet strategic education and training objectives. The Department of Health requires HEE to use the funding appropriately and monitors HEE against certain key performance indicators set out in the mandate from the Secretary of State. The Learning and Development Agreement is a 3 year contract managed on behalf of HEE by Health Education Kent, Surrey and Sussex (HEKSS). Recently HEKSS has merged with HEE London to become HEE London and South East (LaSE).

Accordingly, the HEE commissions a broad range of education and training services from a variety of Placement Providers (such as MFT) to ensure staff and prospective staff are properly trained at all times. They expect the Trust to provide high quality learning and training environments that support the learning and development of Learners undertaking education/training within the Trust to ensure that the trainees have the appropriate skills. In allocating funds to the Trust, HEE expects the Trust to support national workforce priorities and those identified locally through HEKSS, and to make investment plans and decisions based on long-term workforce planning using local and national data sources including that currently produced by the Centre for Workforce Intelligence.

The Trusts have a duty to demonstrate that the quality of the education and training that they provide in the clinical environment is maintained and continuously enhanced so that Training posts and Practice Placement programmes are effective and responsive to needs of the learners, patients, service users and carers, employers, commissioners and professional/regulatory bodies. The Trust must identify an Executive Education Lead (EEL) at Board level (this is the Medical Director) who will form the main point of contact for the organisation with HEKSS on all matters involving workforce or education contained within the Agreement. The expected outcome of quality placements and training is excellent patient care provided by competent and capable staff.

There are specific additional requirements which relate to medical, dental and pharmacy professions to ensure that education and training meets the requirements of the specific regulators and assures the LETB can quality manage the training programmes and environments for which they are responsible. Specific to medical training the annual GMC survey indicates areas required for improvement in the training of the Medical Doctors. The Trust must implement a remedial action plan and provide appropriate updates back to HEKSS where issues are identified. Where HEKSS determines there are instances of material non-compliance for all trainees whether medical, dental or pharmacy they will communicate with the Trust to seek a resolution. Both Parties will seek to resolve the issue within an eight week timescale. HEE is entitled to withhold up to 10% of monthly payments to the Trust after that or until the issue is resolved.

Each Provider has an educational infrastructure, as set out in Graduate Education and Assessment Reference (GEAR). There are a number of Local Faculty Groups (LFGs). They are the first tier of local management at specialty / departmental level and accountability for postgraduate and undergraduate medical education in all HEKSS Providers. LFGs in each specialty meet three times a year to review the progress of every trainee doctor and consider their educational development needs as well as the needs of their trainers. Trainee doctors in need of additional support are discussed confidentially at these meetings. Each Trust has a Local Academic Board (LAB) to which the LFGs report. Pharmacy and Library also report into LAB. The LAB, chaired by the DME, meets three times a year, after the LFG meetings, and receives reports from each LFG. The LAB is responsible for signing off both the

satisfactory progress of trainee doctors and the learning needs of trainers, and is also the first point of contact between the Provider and HEKSS. The DME is responsible for informing the MD on any issues having a detrimental effect on trainees. The DME meets with the MD at least twice a month to discuss postgraduate medical education.

All trainees must have a named Educational Supervisor (ES) and the ES should meet regularly with the trainee to review educational progress and to encourage reflection and the collection of appropriate supporting information on all aspects of Good Medical Practice for Revalidation. The Responsible Officer for doctors in PG training is the HEKSS Postgraduate Dean not the MD of MFT. For every placement the doctor must have a named Clinical Supervisor (CS). In some instances this will be the same person as the ES. The CS should be involved with teaching and training the trainee in the workplace and should help with both professional and personal development.

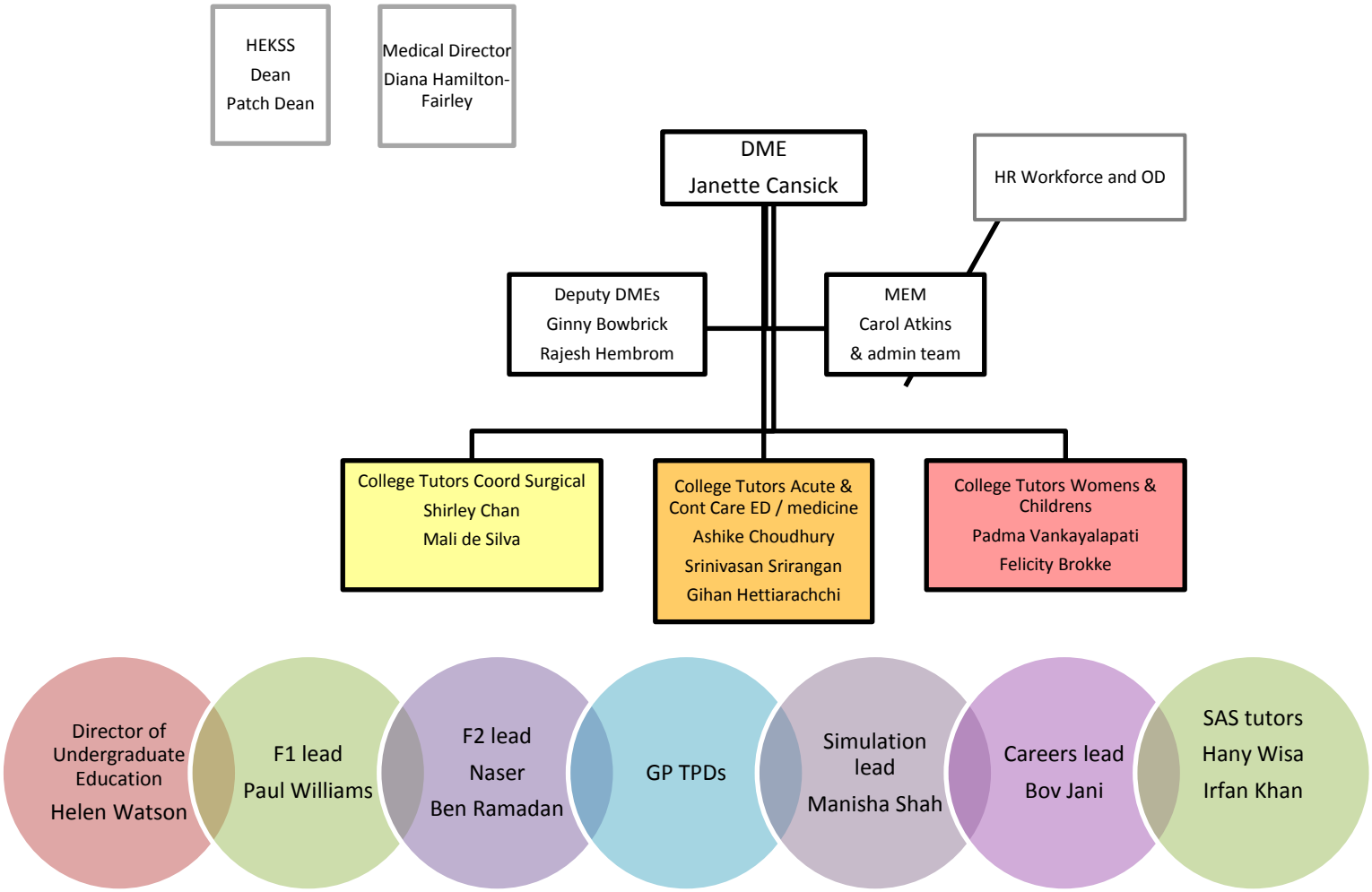
HEKSS expects the quality of training to be maintained and improved in the following areas:

- Access to study leave – study leave should be maintained at the same rate as the previous year i.e. £860 per trainee;
- Administrative support for PGME;
- Clinical medical education;
- Programmed activities;
- Local course delivery;
- Provision of library services and resources supporting IT access;
- Provision of simulation facilities; and
- Faculty development.

The contractual educational infrastructure requirements are attached in the full Learning & Development Agreement – PGME Quality Requirements are set out in *Appendix 1*.

Structure of Medical Education at MFT

The Director of Medical Education (Dr Janette Cansick) is accountable in the Trust to Dr Diana Hamilton-Fairley, Medical Director, and at HEE to Dr Graeme Dewhurst, Postgraduate Dean. There are two deputy DMEs (Miss Ginny Bowbrick and Dr Rajesh Hembrom). The Medical Education Manager (Carol Atkins) is functionally responsible to the DME. The MEM has an operations manager and team of (including the Simulation team) four full time and one part-time administration staff as well as one full-time and one part-time clinical staff. There are LFG leads (College Tutors) in all clinical areas, Foundation Training Program Directors, Director of Undergraduate Medical Education (DUME) and specialist leads (e.g. Simulation, Careers, SAS tutors), who report into the DME. There are currently 105 Educational Supervisors with HEKSS approval and 31 Clinical Supervisors with local approval.



The Local Academic Board meets three times a year drawing together reports from all areas of medical education, with joint learning; in addition simulation, pharmacy and library reports to LAB. Trainee Representatives provide feedback and the GMC survey results and HEKSS visits are also discussed. All quality metrics are discussed. Trainee representatives from the different groups provide feedback and issues from Trainee in Action groups are reviewed. Opportunity is given for any patient safety concerns to be raised followed by information and discussion of details arising from CQC reports, GMC trainee survey and Quality Visits. A

report is given by the Medical Education Manager; a DME report is given with an update against strategy and junior doctors' contract. All LFG leads provide a summary of improvements and concerns arising in their individual areas. Actions are logged for ongoing improvement; significant concerns are discussed elsewhere in this document.

Dr Ali Bokhari (County Dean) has congratulated us at LAB on two fronts:
1. In April 2017 he congratulated the Trust on being removed from special measures after the last CQC visit.
2. In July 2017 he congratulated Medical Education for achieving the highest overall satisfaction score within KSS for acute Trusts in the GMC trainee survey.

Trainee Establishment

Development of training establishment

New Training Posts

Following on from being awarded three new Core Medical Trainee (CMT) posts last year, there has been a complete fill of all 8 CMT posts this August 2017. Two new clinical radiology posts (ST3+) have been recruited into this August as well as the extra ACCS training post. There have been funding opportunities for the following:
- Chief registrar in medicine – unfortunately no suitable applicant
- Application to Canterbury Christ Church University at Medway (CCCU) for three clinical fellows in Clinical Simulation, Obs & Gynae and Medical Education (Simulation) with bursaries from CCCU for £30,000 per fellow.

Medical Training Initiative Schemes (MTIs)

Many Royal Colleges have schemes to provide opportunities for overseas doctors to work in the NHS at junior doctor level. We have had a few MTIs in Trust (e.g. paediatrics) but there is currently a significant recruitment drive into medicine with up to 14-16 starting by the autumn 2017. Dr Hembrom (Deputy DME) is working closely with the Clinical Director and College Tutors in medicine to ensure their training needs will be met effectively.

Rota gaps and recruitment

HEKSS are responsible for the recruitment and allocation to the Trust training posts and programmes. HEKSS have been unable to fill all the training posts this academic year and we currently have trust based posts out to advert for FY1, FY2, GPVTS and higher trainee starters (total 16 posts). We do not recruit into the community based posts of GP practices and Psychiatry.

Re-organisation and reduction in number and experience of staff at HELaSE has led to delays in communication generally and regarding rotations as well as errors in GP tariff.

Post fill rate for August, September and October rotations

The fill rate of the training posts currently is at 90.3% with 15 vacancies out for recruitment. There is a plan for recruitment with close working with Medical Staffing. The MTI recruitment initiative will address some of the vacancies, and the development of the Physicians Associates programme will support the trainees.

Trainee Progression and Competency

Annual Review of Competence Progression (ARCP) - Outcomes (Academic Year 2016-2017)

All doctors in training must be reviewed at least once a year to ensure that they are progressing satisfactorily through their training programme. This review is carried out at the ARCP panel, which normally takes place 6-8 weeks before the trainee's scheduled training year end.

Trainees are notified of the date and place of their ARCP panels. In some specialties, trainees attend in person; in others only some trainees are invited to attend panel. The review is based on the evidence within the e-portfolio, which confirms achievement of specified competences based on satisfactory assessment.

Each of the specialist royal colleges organise the ARCP panels with the exception of the Foundation Training Programme which is organised at Trust level.

Medway's cohort of Foundation Doctors is made up of 41 FY1s and 43 FY2s training posts. The 2016-17 cohort saw 39 FY1s and 42 FY2s undertake successfully led ARCPs here at Medway Maritime Hospital with all of the trainees achieving satisfactory outcomes.

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Funding

Medical Education in MFT oversees the funding and quality for the training programmes and posts in a wide variety of specialties in the Trust and community.

Undergraduates

Total of 44 teaching posts rotating in 6 week blocks. 22 Year 4 and 22 Year 5	
Income for 2017/2018	**£847,392**

Postgraduates

Total of 227 training posts (Foundation, GPVTS, Cores and Higher trainees) with 201 of these posts being in hospital placements, 8 in community posts and 18 in General Practice ST3 (employed and managed by MFT).	
159 posts are HEKSS funded – **50%** Salary cost + Tariff of £12,152 placement support uplifted by Market Factor Forces (MFF) to **£13,387** this includes study leave expenses of £860 per trainee and provision of ES time of 0.25 PA per trainee.	**£5,204,014**
Single Employer Contract provides funding for GP ST3 trainees, and out of hospital placements.	**£925,000**
F2 placements in General Practice – **100%** funded	**£266,200**
Other Education and Training (to include admin support for DME, CTs.) + Direct Allocations	**£127,720**
Less Than Full Time trainees attract additional payment when in slot shares	**£19,694**
Foundation Training Programme Directors and Administration support – calculated on 85 foundation doctors in trust.	**£51,000**
General Practice – Training programme and Administration support	**£16,400**
Total	**£6,610,028**

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GMC National Trainee Survey

The General Medical Council National Trainee Survey (GMC NTS) provides the GMC, Commissioners, Lead Providers and Local Education Providers (Trusts) with a unique view, annually, on the quality of education and training from a trainee perspective.

This year, 99.52% of London trainees and 99.50% of KSS trainees (we receive a mixture of both London and KSS trainees) completed the GMC National Trainee Survey. This is a very high completion rate and provides a set of results that reflect the views of a significant percentage of the trainee population in London and the South East.

The HEE Local Offices across London and the South East are required, by the GMC, to have in place suitable quality management mechanisms to respond to issues that are highlighted via the GMC National Trainee Survey. They send to us an excel workbook, and the action plans that are required to be completed by the trust, within it, fulfil part of the quality management processes required by the GMC.

Patient safety and bullying & undermining issues have a separate action planning and monitoring process in place, and we received **one** immediate patient safety concern from a trainee within the EM department; this concern has been addressed.

There are **two** undermining/bullying concerns, one immediate, one non-immediate. These were both known about. Appropriate support had already been offered to the trainees involved and both had been escalated and addressed by HR and MD office.

Any open red outlier items from the GMC NTS 2016 action planning process have now been addressed and closed.

GMC NTS Results 2017

It's been the 'Best' year for us in terms of ranking (for acute trusts) in the region. Indeed, our trust score of 79.64 is above the national mean of 79.32. See *Appendix 2* for our Trust poster that shows overall improvements in this year's results.

Trust / Board	2017
Ashford and St Peter's Hospitals NHS Foundation Trust	75.54
Brighton and Sussex University Hospitals NHS Trust	76.85
Dartford and Gravesham NHS Trust	75.42
East Kent Hospitals University NHS Foundation Trust	75.85
Frimley Health NHS Foundation Trust	75.03
Maidstone and Tunbridge Wells NHS Trust	78.04
Medway NHS Foundation Trust	79.64
Royal Surrey County Hospital NHS Foundation Trust	75.99
Surrey and Sussex Healthcare NHS Trust	79.58
Western Sussex Hospitals NHS Foundation Trust	76.06

The specialties of Anaesthetics, Emergency Medicine, Medicine F1 & F2, Paediatrics & Child Health F1, Obs & Gynae and Surgery F1 & F2 programmes reported no red flags this year in all categories. See tables below with some highlighted programmes of positive outcomes.

Indicators with positive movement:				
Programme Group	**Trust / Board**	**Indicator**	**2016**	**2017**
Obstetrics and gynaecology	Medway NHS Foundation Trust	Clinical Supervision out of hours	PINK	GREEN

Improvement/continuous excellence across programme:				
Paediatrics	Medway NHS Foundation Trust	Local Teaching	GREEN	GREEN
Paediatrics and Child Health F1	Medway NHS Foundation Trust	Work Load	GREEN	GREEN

Reports have to be provided back to the GMCs with action plans against red flags (poorest performing). Acute Care Common Stem and Core Surgical Training were our poorest performing specialties with areas of concern in Emergency Medicine and Elderly Care. Areas to focus on for this year include handover, teamwork and workload, and these have been discussed with all the LFG leads with strategy across the Trust to drive forward improvement.

Comprehensive plans have been returned and are attached in *Appendix 3*.

The Medical Education Team lead on these returns and are supporting the new cohort of doctors in training posts for the year ahead.

Quality Visits

Medicine and Emergency Medicine

There was a further HEKSS visit focussing on Medicine and ED trainees in December 2016 followed by a Senior Leadership Conversation in February 2017. This meeting was held between CEO, MD, DME and HEKSS Dean, with input from Medicine CD and College Tutors which reassured the HEKSS Dean of significant improvements within Medicine and Trust commitment to continue this trajectory. Nineteen out of the twenty-four Medicine open actions were closed as a result.

Five actions in Medicine and three in EM, however, now remain open. Two have been rectified but there are still significant concerns raised by Medicine trainees in the following areas:

1. No hospital at night system in place with bleep filtering leading to excess workload and unsafe on call
2. Gaps in Medicine Registrar rota, sometimes leaving one Registrar out of hours, and therefore holding both Registrar bleeps plus the stroke bleep.
3. Concerns regarding safety of the Medicine on call at night

There have been numerous meetings between DME, MD, CDs, Managers and LFG leads in Medicine to try to mitigate the impact of gaps in the Medicine Registrar fill. Two initiatives will provide the best reduction in risk and reduce the impact on patient safety and care: recruitment into the MTI scheme and introduction of a Hospital at Night system.

The most recent update to the Trust response is attached as *Appendix 4*; we are awaiting response from HEKSS.

Pharmacy

An on-site Urgent Concern Review took place on 24th July 2017, due to concerns raised by trainees regarding levels of supervision and support. The report is attached as *Appendix 5*.

Some important areas of positive working were identified: Individuals providing excellent training and support to trainees; corporate and local induction; supervision of Preregistration Technicians.

The main concerns were raised around the following areas:

1. The strategic direction and workforce development plans
2. Departmental culture, and inability for staff and trainees to raise concerns
3. Very high turnover of pharmacy staff and high vacancy rates, leading to inability to fulfil requirements of training programs. Particular concern was raised about senior staffing numbers within dispensary.
4. Lack of space in job plans of two pharmacists covering the Education Programme Director role.

An Immediate Mandatory Requirement (IMR) was issued around plans detailing rotations and supervision for all groups of trainees as well as plans for dispensary training. Given the excellent level of support for the Preregistration Technicians (PTPTs), this group remain in Trust as do the Foundation Pharmacists (FPs). The Preregistration Pharmacists (PRPs),

however were withdrawn with immediate effect, despite a rigorous response and a comprehensive improvement program in place.

There is ongoing work in pharmacy supported by the DME, in order to ensure the foundations are in place for excellent training, in order that the PRPs may be re-allocated to MFT for training in 2018. The most recent return is attached in *Appendix 6* .

Undergraduate Medical Education

Dr Helen Watson has been appointed into the position of Director of Undergraduate Medical Education, following the sad death of Dr Rosemary Toye in the autumn of 2016. Kings College Medical School undertook a Quality Visit on March 23rd 2017. The report is attached as *Appendix 7.* Commendations were given for the high quality of the medical education team including administration and skills teams, and for the development of financial transparency. Recommendations included development of an undergraduate Local Faculty Group and improving Medical School support for the block leads.

The new 2020 curriculum has begun to be rolled out in Trust; this has required reorganisation of many of the training blocks across the Trust. Three students were chosen to be finalists presenting their Medway QI projects at the Kings' QI Conference; two went on to be winners and will present their work nationally and internationally.

Opportunities for development include:

1. There is increased liaison with the Simulation team regarding skills training and a dedicated Skills lab is being developed.
2. An extra four year 5 students have been allocated to us requiring increased numbers of supervisors but also extra accommodation.
3. Working with Estates to reconsider the oversight of accommodation; this is off site and of poor quality. Rectification could lead to ability to accept more students.

Physicians Associates

Professor Has Ahmed has been appointed as Champion. He with Miss Bowbrick (Deputy DME) and Vanessa Davies (Operations Manager Med Ed) attended a national conference in June on Developing the Role of the Physician Associate at which Medway was mentioned for its role in PA training within Kent. The nine students in the first cohort have had a very positive experience both clinically and in Quality Improvement Projects. They continue in specialty training in September, when the second cohort of students also commences. The University have provided very positive feedback. Has Ahmed is working to introduce PA Internships in conjunction with CCCU at Medway in the near future thereby allowing for PA recruitment from the current cohort of PA students; two have already expressed an interest in such a scheme. The first Physicians Associate has been recruited in Orthopaedics, and is due to start employment in December 2017.

Two visits have been undertaken (Informal Mid-placement reviews) in February and June 2017. (Combined report *Appendix 8*). Placements for students are "working extremely well with enthusiastic supervisors who can see the benefit of the role." There was excellent feedback around educational experience, preparation, orientation, communication, induction, pastoral care, and support from the medical education team. No further reviews are planned by the KSS School of PAs.

Medical Education Strategy

In June 2016 the Medical Education Strategy was produced (*Appendix 9*)

Vision:

To design, develop and deliver the best education and training to enable and empower trainees to be the best doctors to deliver the best care to patients.

Purpose:

1. Support delivery of best education and training programmes in all departments and Directorates
2. Achieve high quality outcomes by improving links with Directorates, innovating through training leads and engaging trainees and trainers
3. Assess and respond to workforce requirements, to support service and provide best training opportunities
4. Empower trainers to perform their best in supervision and delivery of training
5. Enable and empower every trainee to be their best and achieve success

A revised education strategy (*Appendix 10*) has been created with domains in line with responsibilities to HEE:

1. Management, organisation and development of medical education meeting standards required by GMC
2. Development of Educational Governance
3. Development of Trainers
4. Oversight and Provision of support, advice and guidance for Trainees in Difficulty
5. Effective Management of Education Centre and Facilities
6. Management of Education Tariff (PGME funding)

In addition there are specific areas which deserve individual focus:

1. Development of Learning and Development Resources including Library
2. Coordination of the Management of Pharmacy Training
3. Management of Undergraduate Medical Education
4. Facilitation of Education and Training within Primary Care
5. Facilitation of Education and Training within Psychiatric Care
6. Management of Simulation
7. Support of Educational Development of Doctors outside Tariff
8. Support of Educational Development of PAs and PA Students

Update against Strategy:

1. **Management, organisation and development of medical education meeting standards required by GMC**

Induction

Corporate Induction for doctors in training has been overhauled with a focus on welcome, statutory training (fire), patient safety overview, what they need to know to get started in Trust – patient flow, systems etc. MOLLIE has been welcomed and will improve the experience of induction for our cohort of doctors.

We have secured over £30k funding from HEKSS to make induction films for different departments. Filming was completed in October and 16 fifteen minute videos are in process. These will then be available on YouTube but only accessible to view via direct links provided with induction information. The first film (Medical Director) was used in rotational doctor induction in August.

Morale has been addressed. Several "pizza" meetings with DME and MD/CEO have been welcomed by trainees. The Doctors' Mess has been refurbished.

New Junior Doctors' Contract

The Foundation Year 1 trainees were the first cohort to transfer to the new Contract in December 2016; as from August 2017 all junior doctors are employed under the new Contract. Medical Education has worked closely with the Guardian of Safe Working (Miss Delilah Hassanally) to establish the Junior Doctors' Forum.

The vast majority of exception reports have been around hours and safe working. Of the twenty six education focussed reports submitted up to end of July 2017, nine have been due to inability to attend teaching due to workload and fifteen due to gaps in junior doctor rotas (SHO and registrar) leading to the F1 feeling unsupported.

A process has been put in place for exception reporting which means if it is not signed off in a timely manner then a reminder is issued and, if not completed, thereafter the matter is escalated to Clinical Directors and then onto the MD.

As the remainder of trainees have transferred onto the new Contract, there are issues as they and their ESs learn the system in particular for exception reporting. Two short clips of "how to fill in" and "how to respond to" an exception report have been produced by Medical Staffing in order to aid the process for both trainees and supervisors.

Looking forward

The focus for the coming year are around the three areas with the most red / pink flags identified in the GMC Trainee Survey: Handover; Workload; Teamwork.

2. **Development of Educational Governance**

Following changes in HR personnel and restructure, positive links are being built and work to improve integrated team working with a multiprofessional education strategy will recommence.

There are pockets of good practice with Simulation, and two multi-professional LFGs (EM and O&G). This is being shared amongst training leads to identify more areas where this will benefit trainees and other health professionals, and remains a priority for development.

A Trainee in Action group has been successfully modelled in Medicine, with meetings three times a year in-between Local Faculty Groups. This is chaired by a trainee representative, and enables problems to be aired and solutions to be proposed, with support from the LFG lead.

Looking forward

Work closely with HR to strengthen areas for inter-professional working and support the development of a Trust education strategy.

Development of an educational website.

Further Trainee in Action group to commence in Pharmacy.

3. **Development of Trainers**

Improvement in quality of educational supervision

Medical Education commissioned an external provider to deliver a series of approved half day workshops in October 2016 and March/July 2017 for all Consultant Educational Supervisors (ES). These workshops update the HEE requirements for medical educators. There is now a clear document stating requirements for ES for ongoing professional development and to support the Trust appraisal and revalidation processes.

Governance

A guide for appraisal and revalidation has just been completed to enable supervisors and appraisers to clearly see what is required. The database of supervisors is now up to date. 56 ESs are still in need of refresher training, and are being encouraged to book on the upcoming ES workshops.

Looking forward

Further update half day workshops are booked for late 2017 in order to bring up to date the remainder of the ESs needing this training for revalidation.

In-house workshops are also being developed to provide more in-depth training for ESs: priorities include “Best practice use of e-portfolio” and “Trainees in need of support”.

4. **Oversight and Provision of support, advice and guidance for Trainees in Difficulty**

   There is a confidential password-protected spreadsheet of all trainees in difficulty. The ES is the key person to work with the trainee, with support and advice from the LFG leads and DME. Liaison occurs with the Heads of Specialty School, Learning Support at LaSE and Occupational Health as appropriate according to need.

5. **Effective Management of Education Centre**

   With the HR restructure, the oversight of the Postgraduate Education Centre rooms has been moved to HR from Medical Education. There is opportunity to work closely to ensure education is prioritised in the use of education centre rooms for the benefit of all.

6. **Management of Education Tariff**

   There has been clearer oversight of the postgraduate and undergraduate budgets with support from the business partner in finance.

Other

Work has progressed on providing accessible information for the junior doctors on digital platforms eg. Drs Toolbox and the Green Book. Work is being undertaken on further development of smartphone apps including recording of Foundation teaching sessions so those absent due to leave can catch up, and education website.

Work has been done with the Datix department to ensure adequate feedback to trainees filling in Datix reports. Trainees now receive feedback if they give a Trust or nhs.net e-mail.

Looking forward

Two areas are currently in focus for support:

1. SAS Doctors - currently we have two SAS tutors who require job planning support to fulfil their roles. We are currently bidding for SAS funds from HEKSS for additional funds for SAS development.

2. MTIs – a Trust document of what is required for the support of MTIs is in progress. Support is being provided through LFG leads to provide the adequate training and assurance of competency for the MTIs in medicine to enable progression to work on the Registrar rota.

LDA Appendix

Post Graduate Medical Education

In addition to the general terms in Schedule B relating to quality assurance and performance management, there are specific additional requirements which relate to medical, dental and pharmacy professions to ensure that education and training meets the requirements of the specific regulators and assures the LETB can quality manage the training programmes and environments for which they are responsible.

A SPOC will be maintained within HEKSS relevant to the various post graduate workstreams and detail contained within this appendix. These are:-

Foundation – Marc Terry mterry@stfs.org.uk
GP – Sandra Forster sforster@kss.hee.nhs.uk
Specialty – Angela Fletcher afletcher@kss.hee.nhs.uk
Dental – Roxanne Costin rcostin@kss.hee.nhs.uk
Pharmacy – Wendy Wilmer wwilmer@kss.hee.nhs.uk

Educational Infrastructure

Local Academic Boards and Faculty groups should ensure

1) Its operation is compliant with GEAR including any updates provided by HEKSS in year
2) Ensures programme delivery in line with the regulator
3) Provide formal LAB minutes to HEKSS within one month of each meeting including a confidential section identifying which Trainees requiring support have been discussed via the Sharepoint portal
4) Provide formal LFG minutes to HEKSS within one month of each meeting – this should include as a subset discussion on individual trainees with an appropriate RAG rating. Ensure all trainees are discussed at a LFG. Attendance should be declared on the minutes. Submit via the Sharepoint portal
5) Adopt standardised documentation for medical LFGs
6) Each LAB and LFG must have clearly identified trainee representatives who have time to contribute and appropriate training to support them in these roles and have opportunity to provide feedback.
7) Ensure trainee feedback is prioritised at the top of all agendas
8) Provide and maintain HEKSS with a list of LEP appointed trainee representatives (via Sharepoint)
9) All GMC reporting requirements are progressed, resolved and reported as required to HEKSS this will include as a minimum GMC survey reporting on patient safety, green and red flags and undermining issues to the timeframes outlined

10) Supports School visiting processes and tracking of mandatory requirements to completion
11) Ensures that reasonable steps are taken to so that programmes can be adjusted for trainees who have disabilities, special educational or other additional needs

Educational & Clinical Supervision

1) Ensure all postgraduates are allocated an Educational Supervisor at the start of their programme, with name and contact details provided as part of each postgraduate learners induction
2) Ensure all Educational Supervisors know who their new postgraduate learner is, where they will initially be working, and how long they will be working within the LEP.
3) Ensure all Clinical Supervisors meet with their postgraduate learner within the first two weeks of the clinical placement to agree a mutual understanding of the training and service objectives for the post
4) Ensure HEKSS is advised of each Educational Supervisor assigned to a postgraduate learner and updated on any changes in year
5) Ensure sufficient time is available within job plans to enable these roles as per the HEKSS guidance document (0.25 Supporting Professional Activities (SPAs) per week per postgraduate learner, with a maximum of six postgraduates supervised by any one Educational Supervisor and one 0.25 per clinical supervisor). Formally report on this to the LAB.
6) Ensure that all educational and clinical supervisors regularly support and document progress within the specialty specific e-portfolio systems to meet the requirements of interim reviews, ARCPs and revalidation.

Trainer Accreditation

1) Meet GMC and HEKSS requirements for the accreditation of existing named Educational & clinical supervisors in secondary care
2) LEPs to maintain an up to date accurate database of all clinical and educational supervisors to the minimum data set provided by HEKSS such that this information is readily available on request. This should track the progress of supervisors through the various methods of accreditation that may be in place
3) Ensure all supervisors have valid and up to date equality training and that this is updated every 3 years as a minimum.

Clinical responsibility of the LEP

1) Carry out a realistic assessment of the competence of postgraduate learners they are supervising including those returning from a significant period of absence, and on the basis of that assessment judge the appropriate level of

exposure to clinical responsibility commensurate with ensuring safe patient care

2) Ensure that before seeking consent both postgraduate learner and supervisor are satisfied that the learner is following best NHS practice including South Thames Foundation School specific guidance
3) The LAB must ensure that an appropriate diagnostic service is available on a 24-hour basis, in order to provide high-quality patient care and to ensure that activities of no educational value, including in appropriate duties such as phlebotomy services, do not obstruct education

Specialty Schools

1) Provide a consultant trainer representative, and identify a short-term cover substitute, to contribute to relevant STCs for all specialties in which the LEP employs postgraduate learners in training
2) Ensure that a pro-rata number of interviewers, based on the number of postgraduate learners your LEP expects to receive, are released to support HEKSS Secondary Care School recruitment episodes
3) Ensure that trainers attending school events are able to reclaim travel expenses at LEP level to support their roles
4) Audit attendance of postgraduate learners at local formal teaching sessions and include a formal report within the LAB and LFG minutes
5) Ensure that formal induction into the LEP for all postgraduate learners and grades of specialties is structured, effective and inclusive, including induction for late starters and locums
6) Ensures induction includes NHS statutory and mandatory training requirements, including Schools' Child Protection requirements, and that it is recorded on NHS secure management systems
7) Ensures foundation shadowing requirements for F1 learners are met in line with HEE requirements.
8) To provide one simulation training session for F1 and F2 learners
9) To host ARCP panels for F1 and F2 learners within host LEPs
10) To contribute to ARCP panels for secondary care and GP

Marketing

1) Ensure up to date information is available on the HEKSS e-prospectus relating to the training offered at the LEP in each specialty. Reviews for core training to be completed by October each year and higher training by January.

Data requirements

1) Maintain those areas of the “minimum data set” that are the responsibility of the LEP for all postgraduate learners within their LEP as an up to date at that point of time record
2) Maintain up to date records on study leave spend per individual
3) Maintain the GP INSITE database on workplace based assessments (WPBAs) prior to GP LFG meetings and ARCP panels
4) Provide representation at development forums e.g. Medical Staffing Managers
5) Access to e-portfolios is maintained for learners, their teachers and assessors so that WPBAs can be completed and entered
6) Complete the Collective Exit reports for both HEKSS and London managed postgraduate learners and provide to HEKSS as required twice per annum as part of revalidation
7) Comply with the HEKSS serious incident policy so that the respective Responsible Officer is informed IMMEDIATELY of any significant concern about a trainee, irrespective of when the collective exit report or the exception visit report is submitted

Less Than Full Time Training (LTFT)

1) LEPs accepts LTFT postgraduate learners into both reduced session and slot-share arrangements
2) Programmes can be adjusted to accommodate postgraduate learners with well-founded individual reasons that fulfil the eligibility criteria for being unable to work full time, according to the HEKSS policy, to follow LTFT
3) Arrangements are in accordance with national guidance and HEKSS policy and that time frames for the return of documentation are met
4) Changes to placement types are advised to HEKSS as this has implications for funding arrangements
5) Applicants are fully supported locally in the process when applying

Recruitment, selection & appointment

1) Meet the NHS employment check requirements
2) Comply with the DH Code of Practice regarding information made available to applicants and new employees and related timeframes
3) Ensure that each postgraduate learner receives a written legal contract of employment before commencing their post, and that even under exceptional circumstances it is received no later than six weeks after commencing their post
4) Ensure that every placement has an up-to-date and accurate Job Description at the point of vacancies being advertised, in line with the Code of Practice, which is then given to each postgraduate learner when entering the LEP

Medical Training Initiative (MTI)

1) Ensure any postgraduate learners employed through the MTI scheme are processed through the HEKSS MTI process in line with the Academy of Medical Royal Colleges framework

Single Employer Contract

To ensure consistency in Broad Based Training (BBT) & GP postgraduate learners' employment, HEKSS has signed a Single Employer Acute LEP Service Level Agreement ('the SEAT SLA') with KSS LEPs. The SEAT SLA provides a single lead Acute LEP employer for BBT & GP postgraduate learners throughout their training programme, and identifies other LEPs where they work and learn as host organisations. The LAB, through the LEPs HR Department and/or the LEP Responsible person, must:

1) Ensure compliance with the SEAT SLA
2) Maintain appropriate systems for regular and frequent communications with host organisations (complying with the DH code of practice)
3) Maintain a system for ensuring that accurate reports on salary and non-pay expenses are made to HEKSS in the required format and time frame as specified by the SEAT SLA
4) Maintain a system for collecting and transmitting to the Lead Acute LEP Employer accurate reports on absence
5) Ensure accurate reports of absence are made to HEKSS in the required format and time frame as specified by the SEAT SLA

Immigration requirements

The LAB, through its LEPs HR Department, must ensure compliance with requests for information from KSS to meet UK Border Agency monitoring requirements as follows:

Tier Two

Required documentation

To enable KSS to fulfil its requirements as Sponsor of a postgraduate learner, the LEP must send copies of the following documentation within ten days of the postgraduate learner's arrival in the LEP:

a) Copy of contract of employment
b) Copy of the postgraduate learner's National Insurance number, unless the migrant is exempt from requiring one. For example, where applicable, copy of the migrant's NI card (or NI number notification letter from HMRC or the Department for Work and Pensions), wage slip, P45, P46, P60, P11 (employer's declaration to HMRC), P14 (employer's return to HMRC), P35 (employer's annual return to HRC).

c) Up to date contact details: residential address, telephone number and mobile telephone number
d) Record of the postgraduate learner's absence/attendance

Notification to KSS during the postgraduate learner's employment

KSS is required to ensure that its on-going responsibilities as Sponsor of each postgraduate learner are being fulfilled, and so must be informed should any of the following circumstances arise:

a) The postgraduate learner does not turn up for their first day of work; or
b) The postgraduate learner is absent from work for more than 10 consecutive working days without their employer's permission; or
c) The postgraduate learner chooses to resign from their post; or
d) The postgraduate learner's salary is reduced for any reason; or
e) The postgraduate learner's working hours are reduced for any reason; or
f) The LAB becomes aware of any information that may suggest the postgraduate learner is engaging in terrorism or other criminal activity.

Should any of the above occur, please inform the KSS Head of Specialty Workforce immediately, quoting both the postgraduate learner's GMC Number and their Certificate of Sponsorship Number as listed above, by emailing afletcher@kss.hee.nhs.uk.

Tier Four

Checks to be undertaken by the LEP

a) On commencement of the programme (August), check visa/biometric card to ensure that the foundation learner has an on-going right to work in the UK and provided a copy to the Foundation School.
b) Check the visa/biometric card again within 6 months (end of January) for specific postgraduate learners with visas expiring prior to 31 December.

Reports to be made by the LEP

a) In order for KSS to fulfil the requirements of the national service level agreement with the UK Foundation Programme Office, LEPs are required to report to tier4@stfs.org.uk, within seven working days of the information becoming known, all occasions when the foundation learner:
b) Has a change in circumstance (name change, new address etc.)
c) Does not turn up for the first day of work (e.g. a missed flight, illness etc.)
d) Moves / requests to move to another Foundation School
e) Has a change to the length of the programme (e.g. extended / remedial training required)
f) Begins / requests to work less than full time
g) Has a change in salary (but not an annual pay rise/bonus)
h) Takes more than 10 consecutive days leave without permission OR misses 10 'expected contacts' (expected contacts could be teaching sessions etc.)
i) Discontinues the foundation programme (for example resigns or is dismissed)
j) Is suspected of breaching or actually breaches the conditions of their visa (e.g. undertakes part-time work unrelated to the foundation programme).

Study Leave

1. Ensure study leave appropriate to the career choice of each postgraduate learner is available and operates within the HEKSS Study Leave Guidance and the relevant Terms and Conditions for Hospital Medical Staff, so that the process for applying for study leave is fair and transparent and information about the KSS appeals process is readily available
2. All postgraduates are given, or have access to, KSS and/or the LEP local study leave guidance, including guidance on how to apply for study leave
3. All postgraduates are guided as to appropriate use of study leave funding and time, and are made aware of appropriate courses and funding within the LEP
4. Access to study leave is equitable for all postgraduate learners in training grade posts

Academic education & careers guidance

1. Ensure postgraduate learners are exposed to the generic, cross-curricular, non-clinical, academic opportunities available in their specialty, including Leadership and teacher education.
2. Ensure postgraduates on NIHR accredited programmes have access to appropriate academic placements, bursary funding etc.
3. Postgraduate learners who recognise that their particular skills and aptitudes are well suited to a clinical academic career should be encouraged and guided in that endeavour
4. Co-ordinate the provision of career advice and support for all grades and all specialties to ensure appropriate advice is available. This includes liaison with the GP Specialty Training Programme Directors, who have responsibility for providing appropriate career advice and support to those intending or considering general practice as a career

Post Schedules

These form part of the LDA ad covers both LEP and HEKSS funded placements. Figures quoted are as at 1st April 2014. Any alterations that are planned to be implemented in the academic year are captured within the notes section.

Where posts are left vacant for greater than one year the placement fee at the prevailing rate (currently £12,400) will cease to be paid until such time as the post is filled. There may be exceptions to this which will be agreed by the relevant Heads of departments e.g. where LTFT slot sharing has caused the vacancy.

Where a post remains vacant for greater than one year then discussions between the LEP and HEKSS will need to determine the ongoing requirement for the training placement.

Dental Local Development Agreement

The host LEP will ensure:

That all Dental Core Trainees (DCT) receive full induction which should, where possible, include shadowing.

That no DCT is allowed to undertake any activity which is outside their registrable scope of practice.

That no DCT is left unsupervised in any situation for which they have not been fully trained.

The DCTs attend all regional study days related to their chosen Diploma modules. Duplicate study days for each module are run, to facilitate this.

All trainees not engaged in the Postgraduate Diploma attend all study days in Minor Oral Surgery, Oral Medicine and Research skills.

Trainees can claim from their study leave funding towards the cost of their postgraduate diploma, the maximum allowable funds.

Trainees are fully supported academically by their Educational Supervisor, for all their chosen modules, including assisting with the drafts of their academic submissions.

Trainees have adequate access to IT facilities for CPD and their electronic portfolio, and are given sufficient time for study

Educational Supervisors monitor the supervision by the trainees clinical supervisors.

At least one LEP Educational or Clinical Supervisor is available for the regional trainee selection interviews

Active engagement with HEKSS quality management processes.

The Dental Dean’s office is informed of the Educational and Clinical Supervisors of each dental core trainee within two weeks of appointment.

The Dental Dean’s office is informed immediately of any concerns over the performance or health of any trainee.

That academic and hands on facilities are provided and maintained for the Dental Foundation trainees and dental teams undertaking CPD that use the Education Centre.

Pharmacy Local Development Agreement

The host LEP will ensure:-

The pre-registration training and experience programme meets both the requirements of the GPhC and those expressed within the regional pre-registration trainee pharmacist training guide.

The trainees attend all the regional study days and assessment days, provided as part of their programme of training and experience, unless prevented from doing so by sickness or other exceptional circumstances

When the trainees attend an optional regional educational event e.g. GPhC Fitness to practice hearings in work time, their travel expenses are paid by the LEP

The trainees are given sufficient time and access to IT facilities to complete the regional programme of e-learning activities.

The trainees undertake and submit audit proposals and projects to HE KSS Pharmacy by the required deadlines.

The pre-registration trainee pharmacist Educational Supervisors are trained in tutoring and undertake CPD to develop these skills

One OSCE representative (Actor or trained Assessor) is provided for each pre-reg over the two OSCEs days

The trainees continue to have LEP support via their Educational Supervisor when attending LEP organised external rotations to third party organisations. For example a Cross Sector Placement and/or Mental Health rotation to an external third party organisation.

There is a written placement agreement in place for when trainees rotate to external rotations which clarifies the liabilities of all parties.

Active engagement in HE KSS quality management processes

In addition the LEP will provide

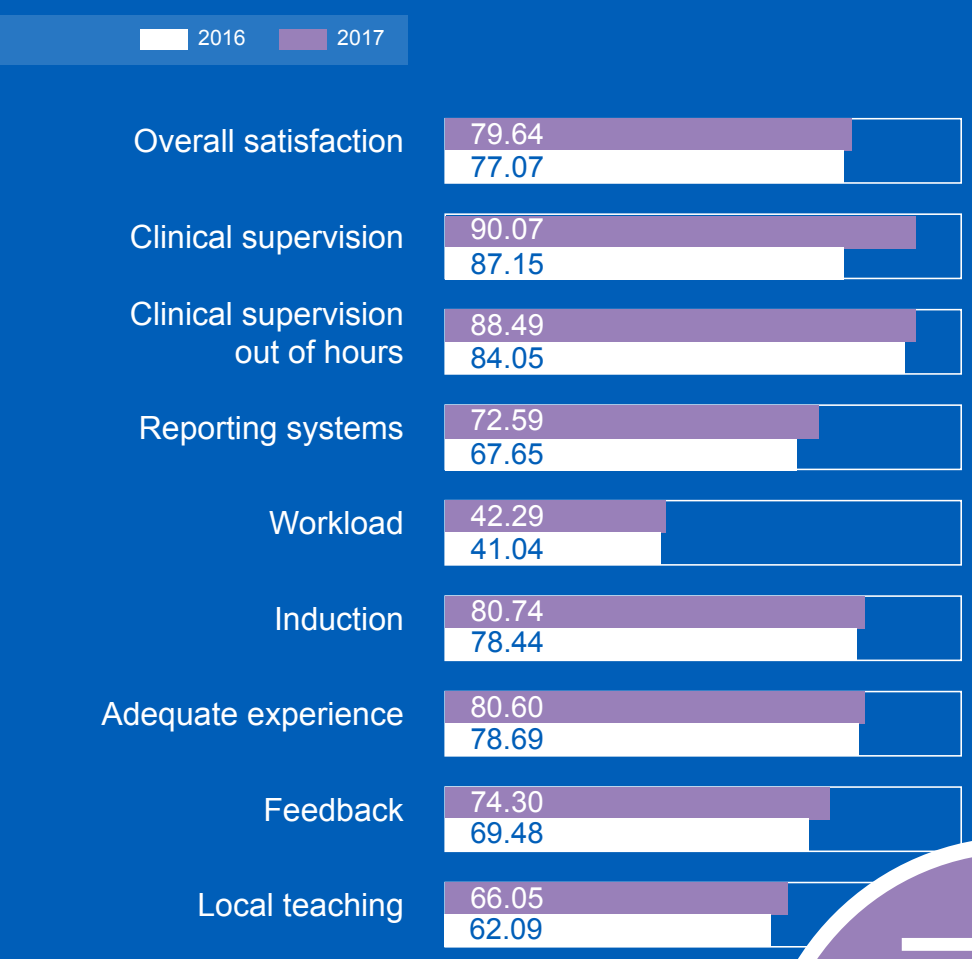
The Host NHS LEP will provide the HE KSS pharmacy team with -

- confirmation of their GPhC approval as a training establishment
- confirmation of the names of the pre-registration trainee pharmacist and their respective Educational Supervisor and the Educational Programme Director by the 28th June 2014
- immediate notice of any change in circumstances which would affect completion of the training and experience period
- immediate notice of any trainee's performance which would suggest that the trainee would not meet the GPhC required standards at the end of the training and experience period or whose performance, conduct or health may put patients, colleagues or themselves at risk
- an outline of the pre-registration trainee pharmacist rotational training and experience programme in terms of specialty and duration in each department
- a list of the named person(s) responsible for pre-registration trainee pharmacist training (Practice Supervisor) in each of the various rotations

Our 2017 **GMC Trainee Survey** Results

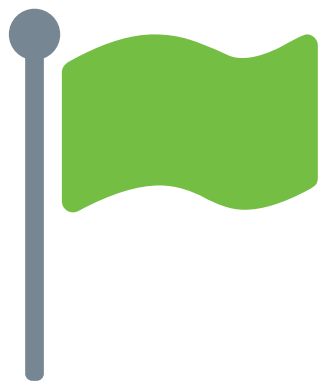
NHS Medway NHS Foundation Trust

Our overall **improvements**



Green flags

- Clinical supervision
- Induction
- Local teaching
- Education governance



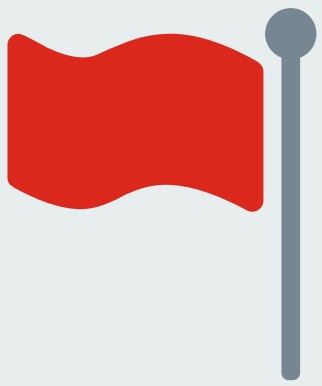
Top ranking in HEKSS* for overall satisfaction

*acute trusts

TRUST / BOARD	2017
Medway NHS Foundation Trust	**79.64**
Surrey and Sussex Healthcare NHS Trust	79.58
Maidstone and Tunbridge Wells NHS Trust	78.04
Brighton and Sussex University Hospitals NHS Trust	76.85
Western Sussex Hospitals NHS Foundation Trust	76.06
Royal Surrey County Hospital NHS Foundation Trust	75.99
East Kent Hospitals University NHS Foundation Trust	75.85
Ashford and St Peter's Hospitals NHS Foundation Trust	75.54
Dartford and Gravesham NHS Trust	75.42
Frimley Health NHS Foundation Trust	75.03

Red flags and areas to focus

- Handover
- Workload
- Teamwork



Our score of 79.64 is above national mean of 79.32

Best of care
Best of people

Programme Group	Trust / Board	Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Reporting systems	Work Load	Teamwork	Handover	Supportive environment	Induction	Adequate Experience	Curriculum Coverage	Educational Governance	Educational Supervision	Feedback	Local Teaching	Regional Teaching	Study Leave
ACCS	Medway NHS Foundation Trust	7	9	9	6	3	5	6	6	8	7	6	5	8		7		6
Anaesthetics	Medway NHS Foundation Trust	9	9	9	7	5	7	7	8	9	9	9	8	9	7	7	6	7
CMT	Medway NHS Foundation Trust	6	7	7	7	2	5	5	5	6	6	5	4	7		4		1
CST	Medway NHS Foundation Trust	6	8	8	5	1	4	4	5	6	6	7	6	8	7	4	5	4
Core Anaesthetics	Medway NHS Foundation Trust	8	9	9	8	5	5	6	8	8	8	8	8	9	7	7		6
Emergency Medicine F2	Medway NHS Foundation Trust	7	8	9	8	2	6	7	6	8	6	6	6	7	6			5
Emergency medicine	Medway NHS Foundation Trust	8	8	8	8	4	8	6	7	8	8	8	8	9	8	7	7	6
GP Prog - Emergency Medicine	Medway NHS Foundation Trust	7	8	9	7	1	7	6	7	9	7	7	6	9	8	7	7	4
GP Prog - Medicine	Medway NHS Foundation Trust	7	9	9	6	4	7	6	6	7	7	7	6	8	7	6		3
GP Prog - Obstetrics and Gynaecology	Medway NHS Foundation Trust	7	8	8	7	4	7	7	7	8	7	6	6	8		5	5	4
GP Prog - Paediatrics and Child Health	Medway NHS Foundation Trust	7	9	9	6	3	6	7	6	8	7	7	6	9	7	8	6	5
GP Prog - Psychiatry	Medway NHS Foundation Trust	7	8		7	7	6	5	7	7	6	5	8	8	8	8	7	4
General Practice F2	Medway NHS Foundation Trust	8	8		7	6	6		8	9	8	7	5	8	9			6
General surgery	Medway NHS Foundation Trust	9	9	9	7	3	6	5	7	8	9	8	7	9	7	5	6	5
Geriatric medicine	Medway NHS Foundation Trust	8	9	8	7	2	6	4	7	8	8	8	6	9	8	5	6	6
Medicine F1	Medway NHS Foundation Trust	7	8	7	6	2	6		5	6	7	6	6	7	6			
Medicine F2	Medway NHS Foundation Trust	7	9	9	7	3	7	6	7	7	7	7	7	8	6			5
Obstetrics and gynaecology	Medway NHS Foundation Trust	8	9	9	8	3	7	7	7	9	8	8	8	9	7	6	6	5
Paediatrics	Medway NHS Foundation Trust	7	9	9	7	3	7	7	7	8	8	8	7	8	7	7	5	6
Paediatrics and Child Health F1	Medway NHS Foundation Trust	8	9		6	6	6		7	7	7	6	7	8	6			
Psychiatry F1	Medway NHS Foundation Trust	9	9		8	7	7		8	9	7	8	7	9	8			
Psychiatry F2	Medway NHS Foundation Trust	7	8	6	7	7	6		6	6	6	6	5	9	8			5
Surgery F1	Medway NHS Foundation Trust	7	8	8	6	3	6		6	7	8	7	7	8	7			
Surgery F2	Medway NHS Foundation Trust	7	8	8	5	4	6	6	6	7	8	7	6	7	5			3
Trauma and orthopaedic surgery	Medway NHS Foundation Trust	8	9	9	7	4	6	6	7	8	8	8	7	9	9	5	6	6

Specialty	Requirement Type (IM/M/R)	Action Open/Closed	Specific Finding	Realistic & achievable outcome required	How will this be measured	LEP Response	LV Response
Medicine	Mandatory Requirement	Open	The trainees reported that at night the calls to their bleeps were not filtered and they were regularly called to carry out inappropriate activities.	The Trust is to look into implementing bleep filtering at night for trainees.	Trust to provide details of any plans to introduce bleep filtering including timescales involved. This could be added as an agenda item at local Medical Faculty Group meetings. \\medway.nhs.uk\Shares\Users_A_D\Carol Atkins\ S:\Medical education\Medicine Trainee in Action	This was discussed at LFG on 20/04/2016. There is a team led by a Consultant Anaesthetist addressing Hospital at Night. There are now two site practitioners during the day and one at night, working clinically undertaking intentional rounds and safety huddles to identify sick patients. There is a plan to expand to an acute response team (to be full by end of October 2016), with critical care outreach and site overnight; this will provide clinical and administration support, to include bleep filtering. S:\Medical education\LFG\LFG 2016-2017\MED \\medway.nhs.uk\Shares\Users_A_D\Carol Atkins\ S:\Medical education\LFG\LFG 2016-2017\MED	Please carry out an audit of bleep filtering post the October implementation to confirm that bleep filtering happens at night.
Medicine	Immediate Mandatory Requirement	Open	The medicine trainees reported that at night on-call they would be alone as a higher trainee due to rota gaps and they would be carrying the medical take bleep, stroke bleep and ward bleep. The trainees reported the bleeps went off constantly such that they would not always know which to respond to first. The trainees reported that the Trust had tried to source extra support at night and on weekends. The trainees reported that there were rota gaps within the core trainee rota which resulted in there being only two core trainees or Trust equivalents at night and weekend on-call.	The review team was informed that some trainees were carrying up to three bleeps on one occasion when there was not enough staff to cover the rota.	Please ensure that this ceases immediately. Please confirm the Trust process for dealing with this.	The establishment is set for 2 registrars to be on call overnight, in which case the three bleeps (ward, on take, stroke) are shared. On four occasions in the last 6 weeks has there only be one registrar on call. Prior to 18 months ago, the thrombolysis bleep was held by a nurse overnight (it still is during the day); however due to staff shortages this was no longer tenable; in the interest of patient safety it was moved to the medical registrar. The Trust is putting in place the following plan: 1. When there is a gap on the medical registrar rota (currently 4 gaps out of 18 rota), we will go to agency for two extra registrars rather than one, in order to mitigate the risk that the locum may not turn up. 2. The Director of Operations has commenced discussions with MCH stroke team (who inreach and provide extended day time cover) and the MFT Stroke lead consultant to move the thrombolysis bleep back to a senior nurse overnight.	Thank you for your response. 1. Please provide evidence within the next four weeks that the gaps on the on-call rota are now filled consistently with the locums and that higher trainees are not required to carry any more than one on-call bleep covering either the inpatient or the emergencies. 2. Please also provide evidence that the stroke bleep is no longer carried by the higher trainee on call.
Medicine	Immediate Mandatory Requirement	Open	The trainees reported that there was no formal handover from ambulatory care to the medicine take team. The trainees reported that patients would be sent to ambulatory care and then not be seen and at 5pm when ambulatory care had finished they would still be waiting to be reviewed yet the higher trainees on the medical take was unaware.	The review team heard that there was no defined process of handing over patients who were still waiting assessment from ambulatory care to medicine.	Please ensure a robust handover process is implemented from ambulatory care to the medicine take team.	1. There is a consultant (acute physician) to consultant (GIM) at 5pm when the on call changes. From Friday 16th December a junior doctor from ambulatory (F2) will now attend the evening 9pm handover to discuss any patients from ambulatory care. 2. There is an electronic medical handover in place; this is being reassessed to ensure it is robust and completed by the medical teams.	Thank you for your response. 1. Please provide evidence within the next four weeks of a consistent process of handover between the ambulatory care and the on-call team when the ambulatory service closes. 2. Please update on the improvements planned for the electronic handover system.
Medicine	Mandatory Requirement	Open	The medicine trainees commented that the on-call general internal medicine (GIM) shifts were unmanageable and unsafe. The trainees reported regularly starting a shift with up to 10 to 15 patients waiting to be reviewed. The trainees commented that there was limited support from a core trainee or Trust equivalent to support them in clerking patients whilst on-call, the trainees felt that due to the lack of staffing this was unsafe and did not create a safe working environment. The review team heard that during an average 24-hour medical take the trainees would review 50 plus patients.	The Trust is to review the staffing of the general internal medicine on-call rota to ensure that the rota gaps do not have a negative impact on the trainees education and training and patient safety.	The Trust is to provide an outcome of this review and consult with the trainees on any planned changes. Please provide evidence that this has been resolved.	1. The medical model has been revamped to have a single point of clerking for the medical patients (ie ED proforma with follow on page for specialty review). This will free up the CMT / F2 grades to not duplicate work and reduce workload enabling them to meet their educational needs. This has been piloted over the last 2 weeks, with positive informal feedback; there are some revisions planned. 2. Consultants will be proactively reviewing patients up to 8pm providing improved supervision and patient care. 3. Dr Banerjee (medicine CD) has had an initial meeting with juniors (1/2/17) to review GIM staffing plan. There is a proposed plan for the CMTs to hold the referral bleep overnight to free up the registrar for patient review. Further consultation with junior doctors will be held at the TiA meeting on 3/2/17 4. The new referral pathway for ED referrals to come to the CMT/SHO rather than the registrar overnight was ratified at the TIA meeting (3/2/17) with agreement from the CMTs and registrars. This will commence as a trial with monitoring.	Thank you for your response. We will need to see the outcome of these changes, via feedback given in the LFG, in which there is trainee representation and this matter is discussed.
Emergency Medicine	Mandatory Requirement	Open	The review team were informed that the ED shift pattern was highly variable and the trainees found it hard to adapt to as it changed from day to day and week to week. The trainees reported undertaking a 12noon till 9pm then an 8am to 5pm followed by a 12noon till 9pm. The trainees reported that they would not have a set pattern for that week. This was felt to be due to the department's reliance on locums as if the trainees had a set shift pattern then only one shift pattern would be guaranteed to be covered with a higher trainee. The trainees reported that they had raised this with their educational supervisor.	The Trust is to review the emergency medicine rota shift pattern to ensure that the significant variability that currently exists does not impact on the trainees' education and training.	The Trust is to provide an outcome of this review and consult with the trainees on any planned changes. Please provide evidence that this has been resolved.	One of the ED consultants (Dr Alex Tsolov) and rota manager are in process of reviewing the middle grade and junior rotas. An ST5 is also closely involved in designing a new rota with fewer night shift commitments that will be more attractive when they pick their choices. This serves as a management exercise for him as well, which is part of the EM Fellowship. Once the new rota has been designed, checked for compliance and agreed through governance it will be adopted.	Thank you for your response. Please demonstrate this is ocurring via LFG feedback, in which there is trainee representation and this matter is discussed.
Medicine	Mandatory Requirement	Open	The medicine trainees stated that they had not been able to complete any acute care assessment tool (ACAT) following a night shift due to the continuing need to clerk patients from on take and there were limited opportunities for the trainees to go on the post-take ward round. The trainees commented that during the day they would be able to complete some of their ACATs.	The Trust is to ensure that trainees are able to complete ACATs at the end of a night shift	The Trust is to inform HEE KSS of how trainees will be supported to complete ACATs. Please provide evidence that this has been resolved.	There have been no issues raised generally around completion of WBPAs in medicine. The issue raised is around completing ACATs at end of night shift. 1. The improvements already stated above will help ensure that there are fewer patients waiting to be clerked (single proforma, consultant review until 8pm) 2. Handover occurs at 8am at which point the referral bleep can be given to the incoming day SHOs who start at 8am. This enables the night trainees to attend the post take ward round until 9.30am when their shift ends.	Thank you for your response, this sounds promising. Please triangulate with LFG feedback.
Emergency Medicine	Mandatory Requirement	Open	The trainees did report that they did not feel there was set departmental pathways for certain conditions and clinical guidelines within the ED and one trainee was hoping to use this as their quality improvement project. The trainees commented it would be useful to have them all easily accessible in one area on the Trust intranet.	The Trust is to clarify the ED protocols and pathways and ensure these are accessible to all staff.	The Trust is to ensure these are communicated to all staff. Please provide evidence that this has been resolved.	Previously there was a desktop folder with ED policies. This is being updated and refreshed by one of the ED consultants (Dr Brendan Conway) with liaising to link the document to Drs Toolbox so it is readily available for all trainees. In addition the green book is available with all the current Trust algorithms. There is also a departmental handbook which is being updated by ED consultant (Dr Bayo Da'Costa) for the 2017 edition. Trainees are involved in the updating and editing.	Thank you for your response. Please provide relevant LFG feedback.
Emergency Medicine	Mandatory Requirement	Open	The emergency medicine trainees reported that they generally did not have a problem in accessing equipment. The review team heard that the ED majors overflow patient area was not suitably equipped although the trainees reported no concerns in accessing the necessary equipment.	The Trust is to review the ED overflow area especially with regards to the availability of equipment required to manage sick patients.	The Trust is to ensure that all equipment can be easily accessed in a timely manner. Please provide evidence that this has been resolved.	The overflow area is designed to be used for majors patients with low NEWS and they should be moved back into majors when deteriorating. It is fully equipped and staffed 1 nurse to 4 patients. We have encouraged staff to speak to senior staff or DATIX when there are patient safety issues for any reason, including any equipment issues. The overflow area was adopted as a preferable alternative to those patients being in the ED corridor with no equipment, and compromised privacy or dignity. The lack of piped Oxygen in 2 of the cubicles in the overflow area is recognised in the SOP and mitigated by use of cylinders. These spaces are also held back as a last resort by the Nurse in Charge.	Thank you for your response. Please provide relevant LFG feedback.

Specialty	LEP Update 1	Updated By	Updated On	LV Response	LEP Update 2	LV Response
Medicine	Bleep filetring at night is being reviewed by a team led by Dr Priya Krishnan. This was discussed in the LFG (minutes 2.1) (see attached minutes above). This will be audited in October.	Janette Cansick	20/07/2016	Please provide the audit in October 2016	The issue was discussed at the LFG 2.1.1. Registrars confirmed that non urgent bleeps had reduced significantly. Acute response team would further reduce the burden of bleeps at night for trainee doctors. Possibility of night practitioners being involved in bleep filtering is being explored. The hospital at night pathway is still in progress. The acute response team is not fully recruited into but the plan is for bleep filtering to occur once this is in place. This has again been escalated to MD office to identify whether some bleep filtering could be performed by the night practitioner in the interim.	Thank you for this update. A further audit is needed. Please undertake and submit the results.
Medicine	1. Since Monday 19th December there has been 2 Registrars at night every night. See embedded document. Each would have held one of the two emergency bleeps. 2. The stroke bleep has been held in the last week by a senior nurse from MCH stroke team overnight; this is under ongoing review, with negotiations in progress to consider amendment to the SLA.	Dr Janette Cansick	06/02/2107	Thank you for the response, which seems satisfactory. We now require evidence from the trainees that the processes have actually resulted in improvements for their education experience / support. Please could you submit evidence of this via the LFG minutes or a trainee survey. Please send update by 15 March 2017.	As discussed in the LAB today 20th april 2017, the trust Director of Operations has committed with a plan of diverting the stroke bleep at night (held by the MCH nurses in the daytime) to the medicine on-call bleep (through the switchboard) which will result in the trainees carrying a single on-call. The Medical Director has discussed the options of changing the rota from a 18 to 12 person rota for the medical registrars. The medicine on-call referral bleep can be shared between the registrars and/or the junior doctors. LAB minutes to follow.	Thank you for the update. With regards to the stroke bleep, you told us in your initial response to the IMR that the stroke nurse would carry this bleep around the clock, therefore we would like to understand why your initial plans have changed and why the nurse will now have her bleep diverted to the medical registrar at night. We are concerned a about your response which indicate a reduction in the doctors on the rota. We would like to be reassured that this would still mean two Registrar-level doctors acting at middle grade during the night shift, as in our opinion a reduction would adversely impact on trainees' experience and learning opportunities. The rota of course needs to remain complaint with the current working hours regulation. Please could we receive a formal statement from the Medical Director outlining the plans for this rota.
Medicine	The handover processes for GIM and acute admissions are attached, which define expectations of attendance and handover process.	Dr Janette Cansick	06/02/2107	Please could you forward us a copy of the handover document audit that you refer to. An audit over 4 weeks is acceptable, therefore we require an update by 15 March 2017. We also require evidence from the trainees that the processes have actually resulted in improvements for their education experience / support.	Please see enclosed (above) Medicine LFG minutes from 8th March 2017, 1.3 and 1.3.3. The acute medicine consultant confirmed that adequate and appropriate handover takes place at 08:00 - 08:30 in the morning and 21:00 - 21:30 at night. The FY1 Trainee doctor rep. will forward the results of the audit that is underway to the college tutor before the next LFG.	Thank you. We look forward to receiving the results of the trainee audit around ambulatory service handover.
Medicine	Please see enclosed LFG minutes from the 8th March 2017, 1.4 - Trainee feedback, patient safety. Please see enclosed LAB minutes from the 20th April 2017, Considerable progress has been made to improve patient safety and trainee experience in regard to their workload and supervision. 5/6 MTI doctors are due to start in the trust in due course which will reduce the work intensity.	Dr Raj Hembrom	08/05/2017	Unfortunately the feedback in March LFG or later LAB doesn't provide evidence that rota gaps are no longer a cause for concern. We would like to see evidence that recruitment efforts by the Trust have minimised these gaps and they now no longer have any significant impact on trainee experience	There are ongoing rota gaps as outlined above which lead to trainee concerns about patient safety when there is only one registrar (19% of nights). This is the only patient safety concern raised at LFG. Other improvements are in place, including 1. Acute Response Team support (24 hours) 2. Ambulatory care open throught the evening 3. HDU SHO now rostered until midnight. 4. Four MTIs have been recruited; all will have started by 10th July 2017 **Update 13.7.17** A meeting was held DME witih Director of Ops, CD for Acute specialist Medicine Programme, CT for Medicine on 10.7.17 5. 8 CMTs have been allocated by HEKSS from August 2017.	
Emergency Medicine	This item is ongiong and is aiming for July implementation; the trainee, Dr Malik Hussian ST5 and Dr Tsolov, Consultant are currently testing the rota for compliance/banding. This item was not discussed during LFG, however the trainee, consultant and tutor met in May to discuss ongiong progress.	Dr Ashike Choudhury	08/05/2017	We are disappointed that despite cosiderable time this matter remains unresolved. Please provide the ecidence requested and a start date of the new rota. Please esnure this matter is fully discussed In the next LFG and provide evidence of its implementation from July 2017	**Update 17.7.17** The rota was discussed in EM LFG on 5th July, item 2.1. The rota, designed by ST5 with consultant support, has been approved. It will be implemented from the next cohort in October 2017. The current trainees "elected not to adopt it as they had planned leave and exam preparation around the existing rota". The rota demonstrating regular shift patterns is attached.	
Medicine	Please see enclosed LFG minutes from the 8th March 2017 (above), 5.4.1 Please see enclosed LAB minutes from the 20th April 2017,	Dr Raj Hembrom	08/05/2017	The LFG minuts don't provide evidence requested that the issue is now resolved. Please provide this in the form of trainee feedback at next LFG	Trainee reps at LFG reported that no further concerns have been raised. At TiA meeting on 9th June 2017, trainees reported (8.1) about post night ACATs, "if you identified with the consultant then you can specifically do those patients. Should no longer be an issue."	
Emergency Medicine	Tutor, Dr Choudhury is currently liaising with the editor of Dr Toolbox (Medicine tutor - Dr Srirangan) to incorporate the EM guidelines for August 2017 intake of trainees.	Dr Ashike Choudhury	08/05/2017	We need to see evidence that guidelines in ED are consistently available to trainees. This needs to be evidenced through the discusison at next LFG	**Update 17.7.17** EM LFG 5th July 2017, item 2.1. The Dr Toolbox and Green Book are available as apps; the Green Book contains management of acute and emergency conditions and is available on the desktop and as mobile phone apps. The full upddated ED guidelines are undergoing revision before being uploaded. will be availabe on Doctors toolbox from August 2017.	
Emergency Medicine	No further concerns on this item are noted from the trainees. Dr Choudhury met with ST5 rep in the dept to clarify any ongoing issues. This item will be reviewed in the next LFG.	Dr Ashike Choudhury	08/05/2017	We require evidence in the form of a discussion with trainee input at next LFG that this issue has now resolved	**Update 17.7.17** This was discussed at EM LFG on 5th July, item 2.1. "Trainees agreed that the Overflow area was equipped appropriately for its patient load and that there were mechanisms for escalating the deteriorating patient as necessary."	

Specialty	LEP Update 3	LV Response	LEP Update 4	Updated By	Updated On	LV Response	LEP Update 5	Updated By	Updated On
Medicine	The Trust reproted that the SHO carried the bleep, improvement but not in place. All referalls go to SHO so there is a division of number oif referrals. Senior nurse in addition to site practioner to support this in interim get SHO to cover. ART being implemented. Looking at PA roles and going to guarentee them a job, heekss supported with courses and cpd for them.	Please submit LFG minutes and an update on this action.	Please see attached LFG minutes and in point 2.1.1. Action point still open and being addressed. Please see also enclosed the LAB minutes from 20th April 2017 - Point 5 The trust are proactively recruiting to the Acute Response Team (ART) so that in the near future they will be able to filter the night bleeps.	Miss Ginny Bowbrick, Dr Raj Hembrom, Deputy DME	08/05/2017	We still have not seen improvement requested orignally. This is disappointing and needs to be addressed urgently. Bleep filtering works elsewhere and LEP is advised to seek both internal solutions and if required also learn from other Trusts who have made more progress in this area. Please provide a further update.	1. Following a trial of the SHO holding the bleep, the Registrars took this back in order to facilitate their oversight of the workload. 2. Currently there is no bleep filtering by nurses at night. Registrars and CMTs reported at LFG (2.1.1) ongoing issues with high volume of non-urgent bleeps. DME in urgent conversation with MD regarding Hospital at Night. **Update 13.7.17** A meeting was held DME witih Director of Ops, CD for Acute specialist Medicine Programme, CT for Medicine on 10.7.17 1. The Hospital at Night project is now being overseen by the MD as part of the 7 day service plan 2. In the meantime the Director of Ops will undertake urgent discussions with the Director of Nursing, and Site and ART teams to discuss bleep filtering and process for implementation. Furthermore, the MD is in discussion with Director of Nursing about implementation of all calls to trainees or ART to go through ward nurse in charge to effectively manage the workload.	Dr Janette Cansick, DME	29/06/2017
Medicine	The lead stroke physician has assessed the safety of the senior ward staff on the stroke unit holding the thrombolysis bleep at night and has come the conclusion that it is not appropriate to do so. This is notwithsatnding the fact that the number of calls on this bleep are not onerous and this is a training opportunity for the medical registrar in his opinion. Following discussion with Diana Hamilton-Fairley, Medical Director, we can confirm that there will be no reduction in the number of middle grades on call at night in Medicine which will remain at 2 for registrars level.	We still have not seen evidence either via the discussion at LFG or through trainee middle grade survey that they are not carrying multiple bleeps, that there are always two registrars at night and that the stroke bleep is not producing unmanageable pressure on trainees. Please submit this as a matter of urgency, since this was meant to be an immediate mandatory requirement.	At Medicine LFG on 21st June, the Registrar rep reported that there are ongoing gaps in the night rota. It was confirmed that locums are still sought but the gap is not always filled. 13 week data is attached which shows there is 1 Registrar for 19% of the time. There are ongoing discussions with the CD and MD, with trainee rep involvement, about the viability of altering the Registrar rota to a 14 person rota, which will maintain two Registrars at night. **Update 13.7.17** A meeting was held DME witih Director of Ops, CD for Acute specialist Medicine Programme, CT for Medicine on 10.7.17 1. On the shifts where there has only been one Registar, support and mitigation of risk has been addressed by aiming to increase the number of overnight SHOs from 2 to 3. 2. From August 2017 there is a full MHDU SHO rota until midnight. This will reduce the work load and pressure on the overnight registrar. 3. Director of Operations and CD to hold further meeting in the next 2 weeks with Medical Registrars to work out an acceptable redesigned on call rota.	Dr Janette Cansick, DME	29/06/2017				
Medicine	Audit to follow before the next LFG (June).	We will leave this open until we have seen a satisfactory audit from trainees.	This was discussed at LFG and trainee reps confirmed that there was no longer an issue in the handover from ambulatory care to the on call medical team. The ambulatory care unit is now open for longer hours (until 20.30) and the SHO attends night handover. See 2.1.2 item in the LFG minutes above.	Dr Janette Cansick, DME	29/06/2017				
Medicine									
Emergency Medicine									
Medicine									
Emergency Medicine									
Emergency Medicine									

Health Education England

Medway NHS Foundation Trust

Pharmacy

Urgent Concern Review (on-site visit)

Quality Review report

24 July 2017

Final Report

Developing people for health and healthcare

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Quality Review details

Background to review	The Urgent Concern Review (on-site visit) was arranged in order to assess the quality of pre-registration and foundation pharmacist training offered at Medway NHS Foundation Trust. The review was triggered by serious concerns that had been raised by trainees regarding the levels of supervision and support for clinical training.
Training programme / specialty reviewed	Pharmacy
Number and grade of trainees and trainers interviewed	The review team met with the following groups of trainees: • Four foundation pharmacists (FPs) • Three pre-registration pharmacists (PRPs) • Three pre-registration trainee pharmacy technicians (PTPTs) The review team also met with: • The chief pharmacist • Two educational supervisors (ESs) for FPs, two ESs for PRPs and one ES for PTPTs • Three practice supervisors (PSs) for medicines management and clinical pharmacy training for all trainee groups • Five PSs for PTPTs • Three education programme directors (EPDs) for FPs, PRPs and PTPTs • The director of medical education (DME), medical education manager and associate medical director
Review summary and outcomes	The review team identified the following areas of good practice: • The Trust and departmental induction programmes for PRPs and PTPTs were well structured and commended by trainees. • The medicines information rotation at Guys and St Thomas' NHS Foundation Trust received extremely positive feedback. • Training in antimicrobials was well supported. However, the review team also noted the following serious concerns, for which an immediate mandatory requirement was issued: • From September 2017 there would be no experienced senior managers in the dispensary, procurement or stores. An experienced deputy dispensary manager is in post. High levels of staff turnover in clinical pharmacist posts had led to reduced levels of available clinical supervision. Additionally, the review team highlighted the following areas for improvement: • The senior pharmacists covering the EPD role were not utilising 50% of time to lead the education agenda. • FPs did not have named PSs or educational objectives for their rotations.

	• Clinical teaching sessions for PRPs had not taken place in 2016/17. • FPs reported that they did not all have regular, scheduled and documented one-to-one meetings with their ESs. • New FP ESs had not been trained. • PTPTs were not always able to take annual leave and time accrued through working late nights and weekends in a timely manner. • Actions agreed at local faculty groups (LFGs) were not completed in a timely manner.

Quality Review Team			
HEE Review Lead	Gail Fleming, Pharmacy Dean, Health Education England (London and the South East)	**Health Education England Representative**	Liz Fidler, Associate Head of Pharmacy, Health Education England (London and the South East)
Pre-registration Pharmacist Education Programme Director	Aamer Safdar, Principal Pharmacist Lead for Education and Development, Guy's and St Thomas' NHS Foundation Trust	**Lay Member**	Della Fallon, Lay Representative
Observer	Aarti Shah, Lead Education and Training Pharmacist, The Royal Marsden NHS Foundation Trust	**Scribe**	Heather Lambert, Learning Environment Quality Coordinator, Health Education England (London and the South East)

Educational overview and progress since last visit/review – summary of Trust presentation

The chief pharmacist provided an overview of the department:

- The Trust had been placed in special measures following a visit undertaken by the Care Quality Commission (CQC) in 2013. Following this visit the Trust was required to undertake improvements in medicines management, among a number of other areas. The Trust was revisited by the CQC in November 2016 and was given the rating 'requires improvement'. The Trust was subsequently removed from special measures.
- The departmental structure:
    - One PRP and FP EPD (post covered by two experienced ESs due to sickness absence of the current EPD);
    - One PTPT EPD;
    - Three FP ESs;
    - Two PRP ESs;
    - One PTPT ES;
    - Six PTPT PSs;

- FPs – three year one (FS1) and one year two (FS2);
- Three PRPs;
- PTPTs – two year one and one year two.

- The Chief Pharmacist reported that the department had numerous strengths, including: a staff development programme, links with the Medway School of Pharmacy (MSoP), multi-professional working, workforce review approved by the Trust board to include the introduction of a full-time education and training pharmacist, introduction of directorate pharmacist posts, coaching and mentoring of staff and a comprehensive departmental induction.
- The Chief Pharmacist also reported that it had the following weaknesses: the previous EPD had left and the current EPD was on long-term sick leave, retention and recruitment of staff due to the geographical location of the hospital, lack of communication and support from Health Education England (HEE) and the lack of a full-time education and training pharmacist.
- The department highlighted many opportunities that were available, including: to develop a formal educational strategy, collaborative working with other trusts within Kent and Medway to introduce a regional staff development programme, further develop clinical training for all staff and scope improving links with MSoP.
- The department's next steps were: to review and develop an educational strategy, to appoint an education and training pharmacist, to review where the department was and what improvements needed to be made. This was planned to take place in phase two with a timeframe of 12 to 18 months.

Findings

GPhC Standard 1) Patient Safety

Standards

There must be clear procedures in place to address concerns about patient safety arising from initial pharmacy education and training. Concerns must be addressed immediately.

Consider supervision of trainees to ensure safe practice and trainees understanding of codes of conduct.

Ref	Findings	Action required? Requirement Reference Number
PH 1.1	**Patient safety** The review team was informed that the department had current and forthcoming vacancies. The chief pharmacist reported one vacancy within the department, but the review team heard that the current vacancies included one long-term absence of a senior staff member, critical care and surgery pharmacist, haem-oncology pharmacist and one band five pharmacy technician. The department also had planned vacancies for the dispensary manager, procurement lead technician, stores manager and the operational manager. Therefore, post August 2017 there would be no experienced senior managers in the dispensary, procurement or stores departments to act as practice supervisors (PSs). The foundation pharmacists (FPs) and pre-registration pharmacists PRPs reported concerns that there was a lack of experienced senior support within many rotations and that this had often resulted in the lack of a named lead to provide support or to review work. The FP year ones (FS1s) stated that they were unsure if they were making the right decisions in their current rotations. However, it was noted that senior staff were approachable and would provide advice when asked.	Yes, see PH 1.1a and 1.1b below Yes, see PH 1.1a below

	The chief pharmacist stated that if there was a known gap in a service and a trainee was due to rotate there, the trainee's rotation was then delayed. However, the PRPs perceived that the number of staff recruited to posts did not equate to that of staff resigning. Furthermore, the review team was concerned to learn that the critical care and surgery pharmacist post (Band 8a), vacant due to maternity leave and subsequent unsuccessful recruitment to the post, was covered by the FP year two (FS2). The FS2 was based in critical care for just two weeks with the critical care and surgery pharmacist before this post became vacant. In addition to covering the Band 8a post the FS2 was also covering the work of Band 6 and Band 7 pharmacists in this area, as these posts were vacant. Support was available to this post holder through external networks and by asking for advice and support from senior pharmacists in another area as required. The ESs were aware that trainees did not feel supported in their placements and that they had very high workloads, but commented that they could not identify solutions to resolve these issues. The PTPTs reported that they were often required to cover outpatients and that although a pharmacist was present, the intensity of the workload for both the pharmacist and trainee meant that they did not feel they could ask questions and that the focus was on service delivery. The outpatients department was on a higher floor than the main dispensary within the hospital building which made it more difficult for the trainees to ask their peers for guidance.	Yes, see PH 1.1a and 1.1c below
PH 1.2	**Serious incidents and professional duty of candour** All trainees agreed that there was a good culture of submitting Datix reports following a serious incident.	
PH 1.3	**Appropriate level of clinical/practice supervision** The PRPs commented that the high levels of staff turnover in clinical pharmacist posts had led to reduced levels of available clinical supervision, as replacement staff were new and less experienced. FPs were unable to identify the department lead in some rotations, such as cardiology. However, it was highlighted that training in antimicrobials was well supported. The review team was informed that new registered staff would have on call buddies for their first two to three weeks, either with an experienced Band 6 pharmacist or a Band 7 pharmacist. The department also had weekly on call meetings, which included opportunities for shared learning. PTPTs reported that practice supervision had been good during the early part of the year, but a reduction in available staff had led to a decrease in learning opportunities. This was then supported by PS feedback in a subsequent session.	Yes, see PH 1.1a below
GPhC Standard 2) Monitoring, review and evaluation of education and training		
Standards **The quality of pharmacy education and training must be monitored, reviewed and evaluated in a systematic and developmental way. This includes the whole curriculum and timetable and evaluation of it.** **Stakeholder input into monitoring and evaluation.** **Trainee Requiring Additional Support (TRAS).**		
PH 2.1	**Educational governance** It was reported that the pharmacy local faculty group (LFG) minutes were reviewed by the director of medical education (DME), who also took on the role of local academic	

	board (LAB) chair. Documents supplied to Health Education England (HEE) before the review indicated that there had been no pharmacy attendance at the LAB for 12 months. When this was raised at the review, the PRP and FP EPDs stated that they had not received invites to the LAB since taking on their role which had hindered attendance. The chief pharmacist commented that they had not monitored EPD attendance as it was assumed that they were regularly present. The LAB chair stated that no pharmacy LFG minutes had been presented to the most recent LAB but that they had previously been provided. The LAB chair commented that they had not been actively involved in the pharmacy department. The review team was informed that future actions produced as a result of the LFG Were recorded on an action log with a deadline and a named owner. These actions were then reviewed at the departmental management meetings. The LAB chair emphasised that the LFG chair was responsible for meeting these actions, unless it was of serious nature. Recent LFG minutes provided to the review team at the time of the review identified that actions agreed at the LFG were not completed in a timely manner. The PTPT EPD had sent copies of the pharmacy LFG minutes to the LAB chair but it had not been identified as part of their role to attend the LAB. Education was a standing agenda item for the pharmacy senior management team meetings. However, LFG minutes were not routinely circulated to this group and issues were reported by exception.	Yes, see PH 2.1a below Yes, see PH 2.1b below
PH 2.2	**Local faculty groups** The review team was informed that the department had one pharmacy LFG for FPs, PRPs and PTPTs. The review team was informed that although issues were raised at the LFG and solutions were discussed, this did not materialise into action. Subsequently the FPs and PRPs questioned the usefulness of the LFG. Similarly, the PTPT ESs reported that they frequently fed into the LFG but had not been informed of subsequent actions taking place. Trainee representatives reported that they were unable to bring issues to the LFG unless this had previously been discussed with both the ES and PS and a solution had not been found. The trainee representatives highlighted that FP ESs were not always available to discuss issues and therefore they were unsure in these instances whether they were able to raise issues at the LFG. PTPT representatives attended the LFG but were not sure of its purpose. Actions from the March LFG had not been actioned due to the absence of the substantive EPD. Furthermore. there was a large number of actions in the June LFG minutes which did not have deadlines associated with them.	
PH 2.3	**Trainees in difficulty** The review team was informed that two FPs were deferring their continuation of the foundation programme. The FP ESs reported that those deferring the programme would not continue to undertake assessments or have as frequent meetings with their ES. The review team was concerned to hear that these trainees would not be given any additional support by the Trust and questioned how the Trust would be sure that they continued to meet basic requirements in relation to patient safety. The review team was informed that ESs discussed all trainees, including those in difficulty, in the closed session of the Pharmacy LFG. PTPT PSs reported that they would discuss trainees' progression at operational leads meetings, as they did not have time to attend the LFG due to service pressures. PSs were not invited to the LFG, but feedback was given to the EPD to take to the LFG.	Yes, see PH 2.3 below

	One PTPT reported challenges in relation to the marking of assessments with their education provider earlier in the year. However, the review team was informed that this had been rectified with the support of the EPD.	

GPhC Standard 5) Curriculum delivery and trainee experience

Standards

The local curriculum must be appropriate for national requirements. It must ensure that trainees practise safely and effectively. To ensure this, pass/ competence criteria must describe professional, safe and effective practice.

This includes:

- **The GPhC pre-reg performance standards, Pre-registration Trainee Pharmacist Handbook and local curricular response to them.**
- **Range of educational and practice activities as set out in the local curriculum.**
- **Access to training days, e-learning resources and other learning opportunities that form an intrinsic part of the training programme.**

PH 5.1	**Rotas** The review team heard that PRPs consistently had their study leave cancelled close to their exams. The PRPs had only recently been informed that they were able to reschedule cancelled study leave and so had previously lost some of their study leave allowance. In addition, it was reported that PTPTs were not always able to take annual leave and time off in lieu (TOIL), accrued through working late nights and weekends, in a timely manner. PTPTs reported that they were informed they could not take TOIL on a Monday, Tuesday (college day) or Friday. The departmental policy was that no more than nine staff members could be off at one time. Trainees applied for leave with the PTPT EPD and then had to seek approval from the operational manager. They felt disadvantaged as this lengthened the process and they often had to wait four to eight weeks for a decision on whether leave was approved.	Yes, see PH 5.1 below
PH 5.2	**Induction** All of the PRPs praised the Trust induction. The PTPTs reported that the trust chief executive officer (CEO) had met them personally and that they felt they were a valued member of the Trust. The FPs and PRPs felt that the departmental induction was good and contained the necessary information. The review team heard that the induction period lasted for one to two months; some trainees were appreciative of this time whilst others commented that it was slightly too long. The review team heard that one FP had received a shortened induction as they had previously worked at the Trust as a locum. The FP had raised this issue with the department, as it was felt that the induction did not sufficiently cover all of the relevant information. The FP EPDs reported that they had planned to improve the FP induction to become more formalised for the next cohort of FPs; this would be achieved by adapting the PRP induction. It was reported that the revised induction would additionally include signposting FPs to named PSs and clarifying what was expected of FPs, including when completing supervised learning events (SLEs) and having regular meetings. PTPTs had no feedback or comments regarding their induction and reported that on the whole the department and rotational inductions had been good.	

PH 5.3	**Education and training environment** PRPs stated that they felt that they were equal members of the department and highlighted the pharmacy technicians were very friendly. However, some of the FPs stated that they had previously experienced issues with some of the pharmacy technicians and that they had to be assertive in order to prevent certain behaviour from continuing. PTPTs reported that typically they were seen as part of the staffing establishment and often not treated as trainees. They informed the review team that the pharmacy staff were very friendly and supportive, but due to service pressures were not able to dedicate adequate time to training.	
PH 5.4	**Progression and assessment** Although the FPs stated that they had used e-portfolio to submit evidence and to record their workplace-based assessments, they indicated that they did not use e-portfolio to log regular meetings and some commented that they were unaware that such meetings could be recorded on the system. In contrast, the ESs for FPs and PRPs stated that they used e-portfolio to log summaries of meetings, assessments, to record objectives and to record appraisals. However, evidence available to the Dean of Pharmacy indicated that PRPs and their ESs were frequently using e-portfolio but some FPs and their ESs had never logged onto the system. The review team heard that the progression of PRPs was monitored and if they did not meet the required standard, this was often apparent during their end of rotation review. The review team was informed that in such instances the PSs would meet with the ESs to discuss the trainees' progress and review the end of rotation forms. However, when questioned by the review team not all of the section leads were aware of the end of rotation forms or their responsibility to complete them. The FPs progression during the dispensary rotation was reported to be monitored by the operations manager and any arising issues were discussed between the operations manager and the line manager. Although this discussion was a formal meeting, it was not minuted. For PTPTs, the ES would meet with the PTPT every two to three weeks and document progression on a feedback form, but this was not a formal meeting. PTPTs reported that the progression and assessment system in place was robust, with a mix of practice supervision and EPD oversight. PTPT PSs reported that they did their best to complete documentation in a timely manner but the workload increase over the last year had made this challenging.	Yes, see PH 5.4 below
PH 5.5	**Rotations and integrated curricula** The PRPs highly praised the medicines information (MI) rotation at Guys and St Thomas' NHS Foundation Trust and also commented that the mental health and cardiology rotations were of good quality. However, the PRPs commented that the medicines information rotation at Medway NHS Foundation Trust was of poor quality with limited structure. During the Trust MI rotation PRPs also covered a gynaecology ward in which they were expected to screen prescriptions and transcribe to take out (TTOs). PRPs would then bring their work back to the dispensary for the dispensary pharmacist to check. However, in practice often they did not receive such feedback as they had to leave their work for the dispensary pharmacist to review during a quieter period later in the day. It was reported that the medicines management rotation was three weeks in length for PRPs and covered logs for PODs, transcribing and medicines reconciliation. For PTPTs, the rotation was four months in length in both their first year and second year. In the first year, PTPTs would cover PODs and transcribing and in the second year PTPTs would cover medicines reconciliation. Additionally, FPs had scheduled visits to shadow different staff in medicines management during their induction.	Yes, see PH 5.5 below Yes, see PH 5.5 below

	The review team was informed that the PRP programme had been amended following trainee feedback, so that the PRPs started to work on the wards sooner than in previous years. PRPs reported that a lack of staffing impacted upon their clinical training as they often had to undertake a lot of medicines reconciliations. The review team was informed that the PRPs were removed from their rotations for one week to take part in 'the perfect week'. The PRPs stated that during this week their work focussed on facilitating discharge and that they did not find this educationally valuable. Some of the PRPs and FPs stated that occasionally when on the wards they had worked outside of their comfort limits, but in these instances they always tried to access additional support and that senior staff were supportive and approachable. PTPTs reported that they were in support of the increase in Medicines Management rotations as this would prepare them for post registration posts. The stores rotation was highly commended as trainees felt this gave a great introduction to pharmacy. PTPTs reported that they enjoyed the aseptics rotation but were unable to make items on occasion, as the senior was often covering junior staff roles and unable to provide the level of supervision required. They acknowledged that they met the learning objectives of the rotation but would have valued more practical learning opportunities.	
PH 5.6	**Evidence of the impact of teaching and learning strategies on course delivery and student experience** The PRPs felt that the teaching within the department needed more structure and to better integrate and incorporate their curriculum. Although PRPs initially received formal clinical teaching, this had stopped once the individual responsible for organising this had resigned. Subsequently, one PRP had been asked to organise the remainder of the PRP teaching sessions, as agreed at the Pharmacy LFG. The PRP felt that this was an impossible task and did not receive adequate support or engagement from others in the department when attempting to organise the sessions. However, it should be noted that the PRPs stated that external rotations included teaching sessions and that sufficient time was allocated for these. The PRPs and PTPTs reported that they were frequently relied upon for service delivery in the department and were often not supernumerary. At times, this impacted on the educational value offered by certain rotations. PRPs and FPs commented that they did not always have set objectives when undertaking some rotations, such as in acute medicine. The review team heard that some PSs would set objectives for PRPs and FPs when a rotation commenced, such as in aseptics, but that this varied depending on the individual PS. The FPs stated that they had raised this issue but it did not appear that this had been resolved. The EPDs stated that they had begun to review FP objectives to ensure that there were set objectives for each rotation and acknowledged that they needed to work on ensuring FPs were aware of the objectives. A deadline for completion of this work was not specified. The review team was informed that FP objectives for the surgical rotation were being devised by the FS2 at the time of the review.	Yes, see PH 5.6a below Yes, see PH 5.6b below

GPhC Standard 6) Support and development for trainees

Standards

Trainees on any programme managed by the Pharmacy LFG must be supported to develop as learners and professionals. They must have regular on-going educational supervision with a timetable for supervision meetings. All LFGs must adhere to the HEE LaSE Trainees requiring additional support reference guide and be able to show how this works in practice. LFGs must implement and monitor

policies and incidents of grievance and discipline, bullying and harassment. All trainees should have the opportunity to learn from and with other health care professionals.		
PH 6.1	**Mechanisms in place to support trainees to develop as learners and professionals** It was reported that all PTPTs had the opportunity to undertake a mentoring course delivered by the Centre for Pharmacy Postgraduate Education, which enabled the trainees to mentor year one trainees once they were in their second year of training. The review team was informed that PRPs had been allocated named mentors at the start of the year but they had all left the organisation and replacements had not been assigned.	
PH 6.2	**Students must have access to support for their academic and welfare needs. Appropriate support mechanisms in place.** The review team was informed that an external facilitator had delivered an anti-bullying workshop in the department. Additionally, the departmental induction included a 'raising concerns' workshop and the chief pharmacist stated that they had worked with staff at management level to address behavioural issues highlighted in the staff survey. There was also a poster on display in the department detailing how to raise such concerns. Some trainees stated that although they were aware of the process for raising concerns they were not comfortable to engage in the process. Trainees reported having been concerned about the quality of some clinical interventions they had witnessed but would not report it within the organisation. FPs, PTPTs and PRPs stated that when they raised an issue, they would not see a change or be informed of a definitive timescale for change. PRPs and FPs commented that they knew who to raise concerns with in the wider team and that they also could attend the weekly staff communications meeting on a Tuesday, but indicated that if they raised concerns they would often be dismissed. Furthermore, the first year PTPTs attended college on a Tuesday, and therefore felt they missed the opportunity to attend the management meetings. However, one trainee reported that on one occasion they had escalated their concerns regarding cancelled study leave to the chief pharmacist and this had been resolved quickly.	Yes, see PH 6.2 below Yes, see PH 6.2 below
PH 6.3	**Feedback** It was reported that there was no formal feedback given to PTPTs that highlighted their strengths and developmental needs with documented evidence until the end of their rotation. However, the review team was informed that the FPs had assessed ward visits which included a SLE and feedback was then delivered. PRPs also had regular meetings with their line manager/ESs which involved progress mapping.	
PH 6.4	**Educational supervision** The Trust stated that every trainee had an allocated ES. The majority of the PRPs confirmed that they met with their ESs regularly, initially every two weeks and then monthly. Some of PRPs reported that they had protected time with their ESs and that during meetings their ESs would discuss developmental needs. One PRP had four ESs during their placement and commented that this had caused some uncertainty with regards to who would undertake their 39-week appraisal. In addition, the second ES had scheduled no meetings with the PRP apart from appraisals. The FPs commented that generally their ESs were helpful, supportive and completed assessments with them. However, the FPs reported that they did not all have regular,	

	scheduled and documented one-to-one meetings with their ESs; the FPs felt that they should have been meeting with their ESs more regularly. The PTPTs reported that the EPD was their ES and that they were fully supported.	Yes, see PH 6.4 below
PH 6.5	**Practice supervision** The FPs stated that they did not feel that they were developing in line with their expectations and that their development was hindered by a lack of senior support. All of the FPs the review team met with commented that there was not a named PS in a number of rotations, with the exception of aseptics and antimicrobials, which was well-organised. In contrast, the ESs stated that although previously there was not a named PS in each rotation, this had been resolved. However, the ESs acknowledged that this could be better signposted for the FPs. The FP EPDs stated that the induction for all FPs was the same irrespective of their previous experience e.g. community pharmacy. Following induction, the PSs would undertake a ward visit to assess the FPs' competence. PTPTs and PSs reported that they were concerned about the practice supervision arrangements post summer, due to a number of key experienced staff leaving the department. They indicated that they had not been made aware of who would replace those members of staff who were due to leave. It was reported that other members of the team had the potential to become PSs for PTPTs, but due to some working part-time this had proved difficult in practice. The PRPs reported that not all of the pharmacists who provided their clinical supervision were aware of what was expected of them in this capacity and what their responsibilities entailed.	Yes, see PH 5.6b below
PH 6.6	**Inter-professional multi-disciplinary learning** The PTPTs reported that they had been encouraged to shadow other professions and had been disappointed when they had to cancel this due to staffing issues. PRPs had requested via the LFG to attend junior doctor training at the start of their year but at the time of the review, this had not been actioned.	Yes, see PH 6.6 below

GPhC Standard 7) Support and development for education supervisors and pre-registration tutors

Standards

Anyone delivering initial education and training should be supported to develop in their professional role.

PH 7.1	**Range of mechanisms in place to support anyone delivering education and training (time for role and support)** The review team was informed that the department allocated PSs in each rotation based upon the experience that the individual had. Although the Trust acknowledged that experience did not correlate with being a good PS, it did not appear to the review team that PSs were offered any training regarding their responsibilities as supervisors. The review team was informed that the PRP EPD had discussed with PRPs and clinical supervisors jointly what to expect from both groups. However, this had not been carried out with FPs. The review team was informed that there was one permanent PTPT EPD and that the PRP and FP EPD role was being covered in the interim by two experienced ESs. Their work plan was dictated by weekly priorities. The time allocated for this role in the job plans of the interim PRP and FP EPDs was unclear to the review team, but it did not appear that they were utilising 50 percent of their time to lead the education agenda. It was not clear what backfill arrangements were in place at the time of the review.	Yes, see PH 7.1a below Yes, see PH 7.1b below

	Some of the ESs reported that they kept up to date with changes in curriculum and assessments through HEE communications and would also rely on being informed by their trainees. It did not appear to the review team that ESs were being informed of these updates by the Trust. PTPT PSs reported that they received regular updates from the PTPT EPD and felt well informed. All the PTPT ESs/PSs were either PS accredited or held an Assessor qualification and Train the Trainer. The experience was noted by trainees and other staff. During the review, the review team had an unusually large number of private discussions with staff members who raised concerns in regard to the culture within the department, which appeared to be closed and, for some, unsupportive. The cultural tension was reflected by trainees' reluctance to engage in the process of raising concerns.	
PH 7.2	**Staff appraisals and development** The review team was informed that the new FP ES had not received any formal training. Similarly, although the PRP ESs had received training historically, they had not then always been offered refresher training by the Trust. Instead, new ESs followed guidance given by HEE, utilised their previous experiences as PSs and relied on trainee feedback to develop themselves. The FP and PRP EPDs reported that at the time of the review, based on feedback, the EPDs were intending to establish a monthly ES meeting to enable the discussion of issues and to provide peer support. The PTPT PSs attended operational meetings and used this as a forum to report by exception, and indicated that they would welcome appropriate time within their roles to support educational governance and delivery.	Yes, see PH 7.2 below
GPhC Standard 8) Management of initial education and training		
Standards **Initial pharmacy education and training must be planned and maintained through transparent processes which must show who is responsible for what at each stage.**		
PH 8.1	**Accountability and responsibility for education. Education and training supported by a defined management plan.** The chief pharmacist informed the review team that the department was reviewing its ability to work with Maidstone and Tunbridge Wells NHS Trust and East Kent Hospitals University NHS Foundation Trust to deliver training, such as the possibility of trainees rotating between sites at the trusts. In addition, as part of Medway's Hospital Pharmacy Transformation Plan, work was underway in partnership with other NHS trusts in Kent to look at shared medicines information and aseptics services. The Chief Pharmacist anticipated that a rotational Foundation Programme with Maidstone and Tunbridge Wells would be established within a year. The chief pharmacist stated that current staff had been informed of this idea and that new staff were informed during interviews. When the trainees were asked by the review team, all FPs and PRPs reported that they had not been informed of this suggestion. Furthermore, FPs commented that rotating between the Trust and Maidstone and Tunbridge Wells NHS Trust would not add educational value to the placement, as there were no additional specialties at Maidstone and Tunbridge Wells NHS Trust. FPs felt that rotating to a Trust that could offer a good quality medicines information rotation or that had a specialised renal unit would be of greater value.	

PH 8.2	**Systems and structures in place to manage the learning of students and trainees in practice** The PRPs and FPs commented that rotations and the training offered needed more structure. PRP EPDs reported that the pre-registration pharmacist programme would be updated in response to any problems identified each year. The PTPTs reported that the EPD had been key to ensuring that they completed learning outcomes and assessments on rotations. The PTPT PSs often worked collaboratively to share staff to ensure that trainees could complete.	
GPhC Standard 9) Resources and capacity		
Standards **Resources and capacity are sufficient to deliver outcomes.**		
PH 9.1	**Sufficient staff to deliver the curriculum to trainees** The review team was informed that the chief pharmacist had developed a departmental workforce review. This has not yet been shared or consulted with staff. It was reported that this had been signed off by the Trust board and included the introduction of a full-time education and training pharmacist. However, the Trust anticipated that this post would not be advertised or filled for at least 12 months. The chief pharmacist stated that the income generated by the hosting of undergraduate placements would be used to part fund the education and training pharmacist post. However, at the time of the review, the review team were led to believe that the department did not receive any income from MSoP for the training of approximately 25 students per annum. The review team felt that this was a highly unusual arrangement. The review panel heard consistently from a range of staff that the department was understaffed and concerns over future experienced supervisor availability may impact on the ability to provide the quality training they wanted to provide.	Yes, see PH 9.1 below
GPhC Standard 10) Outcomes		
Standards **Outcomes for the initial education and training of pharmacists.**		
PH 10.1	**Registration, pass rates** The Year 2 PTPTs were on track to complete their training by mid-August 2017.	
PH 10.2	**Retention** The PRPs reported that they had all accepted permanent roles with the Trust from August 2017. However, the majority of the FPs and PRPs stated that they would not recommend the Medway training programmes due to the lack of structure and senior support, and the remainder were unsure. Some of the FPs commented that the additional training opportunities that they had undertaken were as a result of their proactivity, rather than being directly offered by the Trust. The second year PTPTs had not been informed that they were going to be offered a post. They reported that they had considered leaving pharmacy but had been supported and encouraged by the PTPT EPD to continue. They were currently seeking employment opportunities. All PTPTs reported that they would recommend training at the Trust, but only because of the additional support provided by the PTPT EPD.	

Good Practice and Requirements

Immediate Mandatory Requirements		
Req. Ref No.	**Requirement**	**Required Actions / Evidence**
PH 1.1a	In August 2017 there will be no experienced senior staff in the dispensary, procurement or stores. High levels of staff turnover in clinical pharmacist posts has led to reduced levels of available clinical supervision.	• A holistic plan is required which sets out how many trainees (pre-registration trainee pharmacy technicians, pre-registration pharmacists, foundation pharmacists, assistants) will be based in which section of the department over the next six months and how/by whom each trainee will be supervised. • A detailed plan for dispensary training for the next six months must be provided which sets out for each trainee (pre-registration pharmacists, foundation pharmacists and pre-registration trainee pharmacy technicians) o Training activities and assessments o Name of practice supervisor and training undertaken for the practice supervisor role o Time allocated for practice supervisor duties and backfill arrangements in place to enable this if not part of current post o A detailed plan for stores and procurement must be provided as above but in respect of pre-registration trainee pharmacy technicians only. o A detailed plan for clinical and medicines management training to be provided for the next six months for pre-registration pharmacists, which sets out who the named practice supervisors are for each rotation, what training they have for their practice supervisor role and their level of experience and expertise in the clinical area they are providing supervision in. This evidence must be provided by 28 July 2017.

Mandatory Requirements		
Req. Ref No.	**Requirement**	**Required Actions / Evidence**
PH 2.1b	The Trust must ensure that actions agreed in LFG minutes are completed in a timely manner.	Actions from pharmacy LFG meetings should be reviewed to ensure all are completed in a timely manner. A report must be submitted to HEE by 31 December 2017.
PH 5.1	The Trust must ensure that pre-registration trainee pharmacy technicians are always able to take annual leave and time accrued through	The Trust is to agree a clarified process for annual leave and time accrued through working late nights and weekends. This process should be provided and the Trust must confirm that all leave

	working late nights and weekends in a timely manner.	has and can be taken in a timely manner. This should be submitted by 30 September 2017.
PH 5.6a	The Trust is required to reinstate clinical teaching sessions for pre-registration pharmacists.	The education programme directors must arrange a programme of clinical teaching for pre-registration pharmacists and submit the programme to HEE by 30 September 2017.

PH 5.6b	Foundation pharmacists must have named practice supervisors and educational objectives for their rotations.	• A detailed plan must be provided by 31 December 2017 which sets out:
		  ○ Objectives for each rotation
		  ○ A named practice supervisor for each rotation
		• The training and experience of practice supervisors listed on the plan above must be provided by 31 December 2017.
		• Compliance with the above rotational plan must be audited and a report provided by 31 January 2018, which will determine availability of HEE funding for PG Diploma in March 2018.

PH 6.4	All foundation pharmacists must have at least monthly scheduled and documented review meetings with their educational supervisor(s). These meetings should be held in a private setting.	The Trust is required to audit meeting frequency through the LFG, using e portfolio, and submit the report by 31 December 2017.
PH 7.1b	The senior pharmacists covering the education programme director role must utilise 50 percent of time to lead the education agenda.	The Trust is required to provide revised interim job descriptions, job plan and backfill arrangements by 30 September 2017.
PH 7.2	The Trust is required to ensure that new foundation pharmacist educational supervisors have been trained.	The Trust is required to provide evidence by 31 December 2017 that new foundation pharmacist educational supervisors have been trained.

Recommendations		
Rec. Ref No.	**Recommendation**	**Recommended Actions / Evidence**
PH 1.1b	Staff turnover and exit data should be reviewed to inform future workforce plans and improve the retention of staff.	The Trust to provide a copy of the review and evidence subsequent actions taken.
PH 1.1c	The Trust should review the supervision arrangements when foundation pharmacists are providing a clinical service to high risk clinical areas e.g. critical care.	The Trust to provide a copy of the review and evidence subsequent actions taken, including revised supervision arrangements.
PH 2.1a	The chair of the pharmacy local faculty group should be actively engaged in the Trust local academic board.	The Trust to provide evidence of engagement. This could be in the form of local academic board

		minutes which evidence attendance by the pharmacy local faculty group chair.
PH 2.3	All foundation pharmacists, including and particularly those that are not undertaking an academic PG diploma, should have a named educational supervisor and have a clear training plan which sets out objectives and associated assessments.	The Trust to provide evidence that all foundation pharmacists have a named educational supervisor and a training plan which sets out objectives and associated assessments.
PH 5.4	Two-way mid and end of rotation feedback forms should be introduced for all rotations for all trainee groups.	The Trust to provide evidence that end of rotation feedback forms are used for all rotations for all trainee groups.
PH 5.5	The medicines information rotation for pre-registration pharmacists at Medway Maritime Hospital (not at Guy's and St Thomas' NHS Foundation Trust) should be reviewed to determine whether it is achieving its desired outcomes and the level of practice supervision associated with this.	The Trust to provide a copy of the review and evidence subsequent actions taken, including revised supervision arrangements.
PH 6.2	The Trust should undertake further work to support the development of an open culture in the department and address the barriers to staff raising concerns.	The Trust to provide evidence of further work undertaken and to submit trainee feedback to evidence resolution of this issue.
PH 6.6	Pharmacy trainees should be provided with opportunities to learn alongside other healthcare professionals as part of a wider organisational education strategy.	The Trust to provide evidence that pharmacy trainees are provided with opportunities to learn alongside other healthcare professionals.
PH 7.1a	A training needs analysis should be undertaken for all practice supervisors for pre-registration pharmacists and pre-registration trainee pharmacy technicians. Training plans should be put in place to address identified needs and ongoing development.	The Trust to provide a copy of the training needs analysis and inform HEE of training plans in place.
PH 9.1	There should be a pharmacy workforce and education strategy that clearly links to an organisational vision and plan.	The Trust to provide evidence that this has been considered and inform HEE of subsequent actions.

Other Actions (including actions to be taken by Health Education England)	
Requirement	**Responsibility**
Not applicable.	

Signed

By the HEE Review Lead on behalf of the Quality Review Team:	Gail Fleming
Date:	16 August 2017

Faculty of Life Sciences & Medicine
Department of Medical Education

King's Visit to Medway Maritime Hospital, Gillingham
23rd March 2017

Report from Visit day held on 23rd March

Present During the Day:

Visit Team
Dr Nicki Cohen – Deputy Dean of Admissions and Assessments
Michael Baty – LEP Relations Manager
Will Van der Byl – Senior Quality Officer
David Eames – Lay Member

Medway Maritime Hospital Team
Dr Diana Hamilton-Fairley - Medical Director
Dr Rajesh Hembron – Deputy Director of Medical Education
Miss Helen Watson – Director of Undergraduate Medical Education
Ms Carole Atkins – Head of Medical Education Service (Medical Education Manager)
Ms Daniella James – Medical Undergraduate Education Facilitator
Ms Lynne Cox – Undergraduate Administrator
Ms Rebecca Melia – Finance Business Partner
Ms Sue French – Assistant Staff Residence Manager
Mr Howard Cottam – LTC Block Lead
Dr Paul Williams – Child Health Block Lead
Dr Ashike Choudhury – EMCC Consultant Representative
Dr Paul Kitchen – Phase 5 Lead (Medicine & Surgery)
Ms Elaine Woodhams – Clinical Skills Facilitator

Introduction

The Visit Team were pleased to visit Medway Maritime Hospital and noted the recent appointment of Dr Anna Jones, Faculty Development Lead at GKT, who will be exploring more opportunities for the school to support Local Education Providers. The faculty at Medway had appreciated a recent training session led by Dr Louise Dubras.

Finance

- The Trust reported that work is currently underway on increasing financial transparency; enabling each directorate to clearly identify what tariff is available for teaching, overheads and other relevant costs. This would be welcomed by Directorates who had been aware of a tariff underspend but needed clarity on where additional funds could be spent in future years, e.g. providing additional support to the Undergraduate Administrator. Due to the initial financial situation, work to identify each Directorate's budget requirements for education and to allocate accordingly will be ongoing; although appropriate roles within the Finance department have been created and filled.
- A local faculty group had been formed to increase transparency between finance and Postgraduate education delivery. It was recommended this be extended to Undergraduate education, as at other Local Education Providers. The Local Education Team see the value in such a group to enable closer monitoring of tariff allocation; and they have the capacity to support this.
- As part of this work, the accommodation costs will be moved from Estates to the Undergraduate Education budget from April 2017. Recruitment is currently underway to Finance posts to allow the delivery of this work. The Education Team praised the positive work by the Finance Business Partner, Rebecca Melia, in making financial matters understandable and clear. They understand this work will take time to complete, but can see there is a commitment by the Trust to improve matters.

Facilities

- There have been a number of recent staff changes within the Hospital Estates department that have caused disruption and meant that the Undergraduate Administrator, Daniella James, has had to be more involved in issues relating to the off-site accommodation. Her role should be limited to allocating students to flats. However she has recently managed, amongst other things, booking repairs and purchasing appliances - tasks she felt would not have been done otherwise. When Daniella is on leave this is covered by Lynne Cox who works fewer hours and, therefore, sees a vast increase in her workload.
- Off-site accommodation is leased from Medway Housing on a long-term lease. Additional accommodation is not likely to be available at Melville Court and options at other locations have been explored. An increase in tariff and alterations in the timing of student placements with the implementation of Stage 3, Year 5 will increase flexibility and scope for different options.
- Students report difficulty in reporting housing issues out of hours, which has included being locked in their property. Understanding is that the out of hours response is the responsibility of Estates. Carole Atkins will liaise with them regarding this issue. Greater transparency in finance would help further illustrate that Estates are being paid to supply this service.
- In the event of becoming locked out of their flat, students are advised to contact the Fire Brigade. Emergency contact numbers are displayed in each property.

Organisation

- The Local Education Team have been realigned and restructured, matching Undergraduate and Postgraduate delivery to increase the capacity for cross-cover.
- The School stressed that the Trust must ensure that the role of Undergraduate Administrator is protected allowing them to focus on supporting undergraduate students and the delivery of Undergraduate education, rather than having it diluted by other responsibilities.
- The Director of Undergraduate Medical Education stressed the importance of ensuring the effective existing dynamic of the undergraduate team is not disrupted; and that responsibilities of each role are clarified.
- The Local Education Team have noted challenges in preparing for, and implementing, Curriculum 2020. They have planned thoroughly and are putting in place staff and teaching to ensure its effective delivery. The Trust prides itself on the quality of education delivered to Undergraduates and wishes to maintain this reputation.
- The hospital occasionally provides activities to students allowing them to practice their clinical skills, which contain elements similar to formative OSCEs. The visit team clarified that local teams were not planned to provide formative OSCEs in addition to the multisite formative, delivered at the cluster lead site. Innovative means to watch students' skills and provide feedback are commended, but these should not extend to the provision of an additional OSCE. The term Clinical Skills Learning opportunity was suggested to avoid the use of the term OSCE.
- No issues with accessing KEATS were reported, although navigation was often unintuitive for both staff and students, e.g. finding log book information and learning outcomes. It was suggested that the provision of periodic summaries by the School providing key information relating to upcoming assessments may be a means for providing consistency across all provider sites.

Clinical Teaching (meetings with local block leads)

1. Stage 3 Year 4 - EMCC

- EMCC had slightly amended the timetable in response to student feedback from the first rotation. This involved increasing the prominence of the acute medicine component to reduce the amount of time when students had nothing to attend.
- Sometimes more obvious signposting was required to help students understand how activities related to the requirements listed in their log books.

2. Stage 3 Year 4 – Women's Health

- The team have developed a newsletter for clinicians, to provide basic guidance in delivering training and details of student placements.
- Following completion of the QIP, students were voluntarily attending Women's Health on Wednesdays

to receive additional teaching. The hospital would like to encourage students attached to all departments to emulate this, as many teaching opportunities exist at this time.

3. Stage 3 Year 4 – Child Health

- Clinical Skills are delivered by consultants rather than the Clinical Skills Facilitator as in other specialties. This may give students in the Child Health rotation the perception they are missing out although they are still receiving the necessary training. It was suggested that Block Leads may wish to organise a session, perhaps included in the Faculty Forum, where students from all rotations can share their experiences in presentations to emphasise the similarities.
- Dr Williams expressed confidence in the delivery of education on the Child health rotation and was not of the view that the formation of a support cluster group with Child Health Block Leads from other hospitals was necessary.
- Minor changes were made to the timetable to incorporate Community care teaching.

4. Stage 3 Year 4 – Long Term Conditions

- The students were mostly enthusiastic. The local team felt that poor scores on EOPS were related to uncertainty around Curriculum 2020 delivery. This included a lack of understanding of what the learning objectives for the rotation were. Better communication from the school was requested to enable the teaching to be aligned with the learning objectives.
- It was anticipated that once the stage-based curriculum had become more familiar to students, and the school and hospital more practiced at delivering it, then feedback would improve.
- The Block Lead avoids assigning teaching duties to those very few consultants who aren't keen to teach.
- Students assigned to LTC were very engaged and enthusiastic about QIP.

5. Phase 5

- The Head of Phase 5, Dr Paul Kitchen, is very keen to engage students and provides opportunities to present cases during grand rounds. Previous students had requested more consultant teaching, but a compromise where the session was split had subsequently been very successful.
- In conjunction with the FY1 Lead, Harry Alcock, a system where students would have a junior doctor "buddy" had been formalised and feedback on this was awaited.
- Students had reported that they felt they were not receiving feedback on their performance during work on the wards. Feedback is often not well-signposted, but is provided on an on-going basis. A more formal weekly session could be introduced as a compromise.
- Students had expressed concern that their Clinical Supervisors often worked on different wards to them which made logbook completion difficult. These difficulties include perceived unfamiliarity with the consultant and difficulties obtaining a signature. Consultants have regular meetings to discuss the students so are familiar with their students' progress even if they do not work closely together. Students are encouraged schedule log book signing in advance with their Clinical Supervisors. Dr Kitchen signs if necessary.
- Preparations are currently underway for the delivery of Curriculum 2020, including allocation of staff to provide teaching.
- As described earlier, the visit team advised that conducting additional OSCEs at only one site would be unfair to the students at other sites who would be of the view they were missing out; and suggested that opportunities for practice could be provided in less OSCE-like ways.

Conclusions of Visit team:

Commendations

1. In difficult circumstances, the Director of Undergraduate Medical Education, Miss Helen Watson, has quickly built an effective team dedicated to the delivery of high quality medical education.
2. The progress of the Finance team, particularly Rebecca Melia, in creating better financial transparency, and Directorate-level information around tariff allocation.
3. The excellent work of the Education Team, particularly Daniella James.
4. The collaborative and supportive culture of the institution such that enthusiastic junior medical staff,

particularly Dr Harry Alcock, are enabled to contribute.

5. The quality of Clinical Skills training delivered by Elaine Woodhams, Clinical Skills Facilitator.

Requirements

Requirement	Date Required by	Measured by
1. Ensure there is a clear understanding amongst all undergraduate education stakeholders of the role of the Education team following restructuring.	July 2017	Minutes of Cluster Management Group / Written follow-up with the Trust
2. Provide clarity to all relevant departments regarding their contractual obligations and who is responsible for the various aspects of Estates; and ensure adherence to these.	June 2017	Minutes of Clinical Placement Operations Group / Ongoing monitoring of student feedback
3. Continue the work on improved transparency of tariff allocation to ensure all Divisions have visibility of their tariff distributions and that underspent funds receive appropriate attention and planning.	December 2017	Minutes of Cluster Management Group / Written follow-up with the Trust

Recommendations

1. Formation of a forum where the Education administration team and representatives from other departments can liaise on matters relating to undergraduates, e.g. education and accommodation.
2. Director of Undergraduate Medical Education to establish a Local Faculty Group with representation from Finance, Estates and Teaching.
3. Chair of the Quality visit to liaise with the Head of Stage 3 regarding the potential need to assist Block leads in understanding how learning opportunities may differ across different trusts, so that they can predict the learning requirements of students who come to Medway from different Trusts and clinical blocks.

KSS School of Physician Associates

PA Training Placements

Informal Mid-placement Reviews – February and June 2017

Introduction

Michelle Chapman and Jo Piper from the KSS School of PAs were very grateful to be invited to Medway Maritime Hospital to conduct informal mid-placement reviews with PA students on placement there from Canterbury Christ Church University. We were met by the Trust PA Lead – Professor Has Ahmed, DME – Dr Janette Cansick, Deputy DME - Dr Ginny Bowbrick and Vanessa Davis from the Medical Education team. Present also was Sue Graham - PA Programme Director, CCCU.

Supervisors attending at the June meeting were: Dr Peter Kitchen – Gastro, and Dr Antoine Azzi – ED
Placements reviewed were:

From year 1 – General Medicine – 5 students (Feb), 2 students (June)
From year 2 – Emergency Medicine – 4 students

The objectives of the reviews were to understand how well the placements were bedding in, whether there were any general issues the School could help with and to learn lessons which could be passed onto other Trusts or that may affect how placements are structured in the future.

This was not a formal quality assurance audit nor was it a review of specific student performance or concerns.

Summary

After some initial teething problems, the placements are working extremely well with enthusiastic supervisors who can see the benefit of the role. The students seem to be receiving an excellent educational experience in all departments.

Preparation the Trust carried out in advance of the placements has been key, including initial supervisor introduction and orientation, communication to the MDT, student induction and appointment of key members of staff to champion the role and to provide student pastoral care.

The Trust are keen to employ qualified PAs and are collaborating with CCCU to offer MSc internships in Surgery and Medicine.

Review

The vast majority of student responses (90%) on the questionnaire were of a positive or highly positive nature. Some minor negative feedback received in the areas of: opportunities for competencies, education of staff about the PA role, and having more time in minors.

Students voice: “multiple opportunities to learn and practise with real patients”, “we’ve been very well accepted”.

Improvements in the following areas are noted between mid-placement reviews held in February and June, suggesting the placements are developing well: MDT understanding, contact with supervisors and more structured/defined role.

Recommendations

Subsequent placements will take place in Sept (O&G, Paeds and Surgery) and in again October (ED). Given the quality of the placements and support available from the medical education team and the named supervisors, it is felt unnecessary to carry out a further placement review by the KSS School of PAs, unless specifically requested by the Trust.

Note: the University will carry out its own ongoing placement review process to ensure quality and deal with any specific concerns.

Medical Education Strategy June 2016

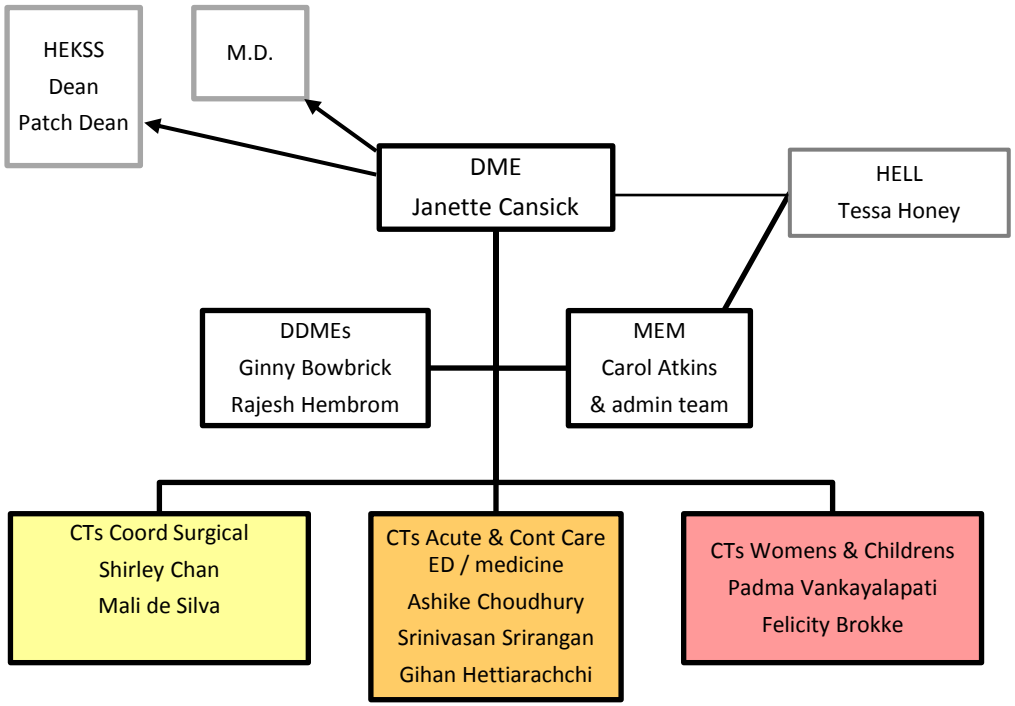
Vision:

To design, develop and deliver the best education and training to enable and empower trainees to be the best doctors to deliver the best care to patients.

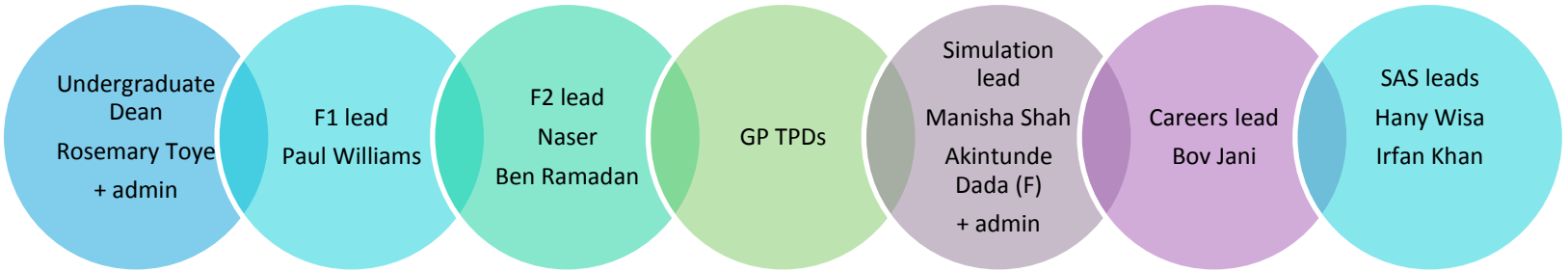
Purpose:

1. Support delivery of best education and training programmes in all departments and Directorates
2. Achieve high quality outcomes by improving links with Directorates, innovating through training leads and engaging trainees and trainers
3. Assess and respond to workforce requirements, to support service and provide best training opportunities
4. Empower trainers to perform their best in supervision and delivery of training
5. Enable and empower every trainee to be their best and achieve success

Overview of PGME:



GMC	HEKSS	Trust
•Induction •Educational Supervision •Local Teaching •Regional Teaching •Access to Educational Resources •Feedback •Handover •Study Leave •Workload •Educational Resources •Supportive Environment •Undermining	•Links with Heads of School and TPDs •Links with GP school and TPDs •Visits •CTAG •TSS	•TiA groups •LFGs •LAB •Library •Pharmacy •Faculty of education



SWOT Analysis May 2016:

Strengths

- Relationship with both MD and Dean / patch Dean at HEKSS
- Faculty complete, with two DDMEs appointed and strong MEM
- Simulation
- Trainees in need of support (Foundation prize)
- Wifi
- Secured 4 new trainees (3 CMT, 1 ACCS) August 2016; 3 radiology trainees from August 2017
- Busy DGH with committed consultants
- Job planning for educational supervisors
- Medilead project

Weaknesses

- Financial accountability – budget statements not accurate (Tariff, SIFT funding)
- I.T.
- Interprofessional working
- Induction
- Datix reporting feedback
- Undermining & bullying
- General trainee morale
- Reputation

Opportunities

- Strengthen relationship with CDs and Directors of Operations
- Interprofessional working – faculty of education; educational structure
- Human Factors – multiprofessional working to develop training and excellence in delivery across the Trust
- Finances – working group set up with Isla, Tessa Honey, MEM and DME
- I.T. – educational webpage, technology-enhanced learning
- Developmemt of supervisors
- Guardian / junior doctor fora
- Physicians assistants

Threats

- Junior doctors' morale - CQC (patient safety), rota gaps, undermining & bullying, junior doctors' contract
- Trainee vacancies & recruitment
- Reputation
- Protection of tariff and SIFT funding

Strategy:

1 Provide best education and training

a. Induction

• 1 year goals:	Deliver good Trust induction	- feedback (survey monkey) - GMC survey 2017
	Ensure good quality Directorate and Departmental inductions in all areas	- feedback (survey monkey) - GMC survey 2017
	Clear roles and responsibilities for all trainess in all Departments	- documents
• 3 year goals:	Induction videos – Trust and department	- on youtube pre induction
	Define and deliver best induction process (pre – start – post)	

b. Morale

• 1 year goals:	Enhance trainee voice	- joint MD / DME meetings - DME open door sessions
	Establish JD fora with Guardian	- JD fora
• 3 year goals:	Recognition ofachievements	- JD poster displays - Trainee teacher of the month - Trainer of the year (ES/CS)
	Improved overall satisfaction	- GMC trainee surveys

c. 2020 Curriculum (Undergraduate curriculum)

• 1 year goals:	Establishment of trainers to deliver curriculum	
	Implementation of the revised curriculum	

2 Strengthen Interprofessional Working

• 1 year goals:	Strengthen working relationships with H.E.L.L. and education leads through Faculty of Education	
	Define best education structure and strategy	- Trust education strategy

	Establishment of Human Factors working across Trust	- Human Factors working group
	Raise profile of medical education	- Directorates, Clinical Council
	Multiprofessional LFGs and LAB	- minutes
• 3 year goals:	In situ simulation in all departments	- reports to simulation faculty
	Integrated learning events in all directorates	

3 Budget

• 1 year goals:	Clear oversight of budget with tariff and SIFT monies accounted for	- accurate monthly statements
• 3 year goals:	Established budget statements	

4 Development and innovation in use of I.T. for training

• 1 year goals:	Accessibility of IT resources via generic log ins	
	Use of smartphone apps	
	Technology-enhanced learning to support teaching	- use to improve F teaching
	Oversight of Datix and trainee concerns	- trainees receive feedback
		- monthly Datix reports
• 3 year goals:	Educational website established with links	- internal / external availability

5 Improvement in quality of educational supervision

• 1 year goals:	Job planning for all educational and clinical supervisors	- job plan sign off
	Identifiable criteria for appraisal and revalidation	- document circulated
	Programme of events to support and enhance individual supervisors' learning	- program published
• 3 year goals:	Improve quality of individual supervision	- individual feedback - trainer of year nominations

6 Development of training establishment

• 1 year goals:	Start of Physicians Assistants in training	- training program
	Establishment of 4 new medical trainees	- posts established
• 3 year goals:	Establishment of radiology trainees in Trust	- training program
	Physicians Assistant embedded into departments to support best care	
	Trainee engagement in R&D	

7 Undermining and Bullying

• 1 year goals:	Enable and support trainees to voice concerns early when issues	- DME open door
	Establish links with HR to support trainees and address specific issues	
• 3 year goals:	GMC survey – no reported undermining or bullying concerns	- GMC trainee survey

Medical Education Strategy October 2017

Vision:

To design, develop and deliver the best education and training to enable and empower trainees to be the best doctors to deliver the best care to patients.

Purpose:

PGME carries responsibility for the management, organisation and development of medical education within the Trust

To ensure the LEP delivers its KSS contract, including the quality standards
To ensure that the LEP meets the standards required by the General Medical Council
To ensure the Education Centre offers appropriate educational programmes and support.
To ensure the educational governance structure meets the requirements of GEAR, including production of LAB reports

1. Support delivery of best education and training programmes in all departments and Directorates
2. Achieve high quality outcomes by improving links with Directorates, innovating through training leads and engaging trainees and trainers
3. Assess and respond to workforce requirements, to support service and provide best training opportunities
4. Empower trainers to perform their best in supervision and delivery of training
5. Enable and empower every trainee to be their best and achieve success

Quality assurance is provided to GMC and HEE :

Management of Annual GMC Trainee Survey and Ensurance of Appropriate Operation of Outcomes
Management of HEKSS Quality Visits and Ensurance of Appropriate Operation of Outomes

The action plan is divided into several domains to support this vision and purpose:

1 Management, organisation and development of medical education meeting standards required by GMC
2 Development of Educational Governance
3 Development of Trainers
4 Oversight and Provision of support, advice and guidance for Trainees in Difficulty (performance management, conduct and capability)
5 Effective Management of Education Centre and Facilities
6 Management of Education Tariff (PGME funding)

There are also specific areas with individual focus:

1 Development of Learning and Development Resources (including library)	Head of Library, DME
2 Coordination of the Management of Pharmacy Training	Pharmacy EPDs
3 Management of Undergraduate Medical Education	Director of Undergraduate Medical Education (DUME)
4 Facilitation of Education and Training within Primary Care	GP TPDs
5 Facilitation of Education and Training within Psychiatric Care	Psychiatry DME
6 Management of Simulation	Simulation Lead
7 Support of educational development of doctors outside tariff - SAS doctors, MTIs	DME, SAS leads
8 Support of educational development of PAs and PA students	PA champion

Management, organisation and development of medical education meeting standards required by GMC

Strategy	Date added	Deadline	Aims	Measures	Update	Closed
Induction	Jun-16	Jul-17	To deliver good Trust induction	Feedback GMC survey 2017	collate feedback - Vanessa	
		Jul-17	To ensure good quality Directorate and Departmental inductions in all areas	Feedback GMC survey 2017	cqc assure review	
		Jul-17	Clear roles and responsibilities for all trainees in all departments	Documents	cqc assure review	
	Jun-16	Jul-18	Induction videos - Trust and department	You tube pre-induction	5.10.17 filming complete	
		Jul-19	Define and deliver best induction (pre-start-post)		JC to meet KA to discuss onboarding	
Reduce undermining and bullying	Jun-16	Jul-17	To enable and support trainees to voice concerns early when issues arise	DME open door - told at induction	part of welcome presentation	5.10.17
		Jul-17	Establish links with HR to support trainees and address specific issues			5.10.17
		Jul-19	No reported undermining or bullying concerns to GMC	GMC trainee survey		
Development of Training Establishment	Jun-16	Jul-17	Establishment of 4 new medical trainees	Posts established		5.10.17
			Establishment of radiology trainees in Trust	Training program		5.10.17
Trainee engagement in R&D	Jun-16	Jul-18	Establish formal links with the R&D dept.			
Development and Innovation in use of IT for training	Jun-16	Jul-17	Accessibility of IT resources via generic logins			
			Use of smartphone apps			
			Technology-enhanced learning to support teaching	Use to improve Foundation teaching		
			Oversight of Datix and trainee concerns	Trainees receive feedback Monthly datix reports	Audit if give Trust or nhs.net e-mail address	
		Jul-19	Educational website established with links	Internal & external availability		
Handover - 2017	Oct-17		CTs to discuss possibilities for multiprofessional & multidisciplinary handovers / Board rounds			
Workload - 2017	Oct-17		CTs to ensure trainees can attend protected teaching			
			Development of workforce - MTIs			
Teamwork - 2017	Oct-17		Explore with trainees possibility of night-time registrar huddles ?midnight to aid working together			
	Oct-17		More meetings for Registrars to meet each other and listen / support	Food / social with sharing and brainstorming		

Development of Educational Governance

LFGs, LAB

Development of Integrated Cross-Professional Approach to Training

Strategy	Date added	Deadline	Aims	Measures	Update	Closed
Strengthen working relationships with HELL and education leads through Faculty of Education	Jun-16	Jul-17	Define best education structure and strategy	Trust education strategy		
			Raise profile of medical education	Directorates, Clinical council		
			Multiprofessional LFGs and LAB	Minutes		
		Jul-19	Integrated learning events in all directorates			
LFG	Oct-17		Work with College Tutors to establish development of multiprofessional feedback for trainees to inform educational supervision and LFG process			
	Oct-17		Establish use of questionnaire matrix for ongoing temperature check of training during the year			
Enhancing trainee voice	Oct-17		Establish trainee links with managers to aid the resolution of trainee issues	Pilot manager-trainee meetings in medicine		
	Oct-17		Establish Trainee in Action groups in areas where there are identified issues	Medicine Pharmacy		
To increase trainee and trainer awareness of governance structure	Oct-17		Trainee rep forum with DME/MEM Welcome to MFT overview of PGME with governance as part of handbook	Annual meeting in October		
To establish strong oversight of ACCS training	Oct-17		Discuss with Mali, Mandy, Tzvetka			

Development of Trainers

Strategy	Date added	Deadline	Aims	Measures	Update	Closed
To ensure requirements met for accreditation of Supervisors	Jun-16	Jul-17	Job planning for all ES and CS	Job plan sign off		
	Jun-16	Jul-17	Identifiable criteria for appraisal and revalidation	Document circulated Spreadsheet	Completed	5.10.17
	Oct-17		To keep contemporaneous records of training of all ES	Communicate to ESs needing updating		5.10.17

Development of Trainers

Strategy	Date added	Deadline	Aims	Measures	Update	Closed
Improvement in Quality of Educational Supervision	Jun-16	Jul-17	Program of events to support and enhance individual supervisors' learning	Program published	3 yearly updates spreadsheet	
	Jun-16	Jul-19	Improve quality of individual supervision	Individual feedback		
	Oct-17		Provision of feedback regarding supervision	Trainer of year nominations - trainees to nominate		
Support regarding changes	Oct-17		To provide training to all ES to be able to respond to exception reports	you tube clips		5.10.17

Oversight and Provision of support, advice and guidance for Trainees in Difficulty (performance management, conduct and capability)

Strategy	Date added	Deadline	Aims	Measures	Update	Closed
To improve Morale	Jun-16	Jul-17	Enhance trainee voice	Joint MD/DME meetings DME open door sessions	pizza lunches DME/MD established	5.10.17
		Jul-19	Recognition of achievements	JD poster displays Trainee teacher of the month Trainer of the year	BEST Awards - Foundation JD trainer of rotation (every 4 months - core & higher)	
			Refurbishment of Mess	Completion	New computers, sofas, kitchen renovated	
To support Trainees in Difficulty	Oct-17		Confidential spreadsheet of all Trainees in need of Support with evidence trail of conversations and actions taken	Spreadsheet kept & up to date		5.10.17
JD Contract Issues	Jun-16	Jul-17	Establish JD forum with Guardian	Regular meetings		5.10.17

Effective Management of Education Centre

Ensure room booking processes prioritise education bookings

Maintain education room establishment ie Simulation suite, Lecture theatre, Common room, Seminar rooms 1 and 2

Strategy	Date added	Deadline	Aims	Measure	Update	Closed
Maintain availability of PGME rooms for education events		Oct-17	Re-establish with HR prioritisation of room bookings for medical & other education events			
Ensure adequacy of function of rooms		Oct-17	Update Sem 7 to facilitate a clinical skills lab			
			Obtain room for use by PAs & students			

Management of Education Tariff (PGME funding)

Appropriate Systems to identify and control income and expenditure
Working with LEP finance staff to ensure accountability

Strategy	Date adc	Deadline	Aims	Measures	Update	Closed
	Jun-16	Jul-17	To obtain clear oversight of budget with tariff and SIFT monies accounted for	Accurate monthly statements		
		Jul-19	To work with finance to achieve established budget statements			
	Oct-17		To hold PG and UG budgets within PGME to enable clear lines of monies transfer			

Specific Areas

1	**Development of Learning and Development Resources (including library)**	Head of Library, DME
2	**Coordination of the Management of Pharmacy Training**	Pharmacy EPDs
3	**Management of Undergraduate Medical Education**	Director of Undergraduate Medical Education (DUME)
	Management of funding	
	Provision of excellent placement programmes for medical students	
	Maintain strong links with Medical Schools	
4	**Facilitation of Education and Training within Primary Care**	GP TPDs
5	**Facilitation of Education and Training within Psychiatric Care**	Psychiatry DME
6	**Management of Simulation**	Simulation Lead
7	**Support of educational development of doctors outside tariff - SAS doctors, MTIs**	DME, SAS leads
8	**Support of educational development of PAs and PA students**	PA champion

	Strategy	Date ad	Deadline	Aims	Measures	Update	Closed
1	Coordination of the Management of Library and Knowledge Services	Jun-16		Establish payment for UptoDate	To ensure funded 50% from each of PG and UG budgets	agreed	5.10.17
		Jun-16		To support increased opening hours of library	Plan in place for opening hours		
		Oct-17		To create links to support incoming head of library, to provide support	Meeting, head of library report at LAB		
2	Pharmacy			To establish strong links with EPDs to create and provide effective educational governance	LFG action plans complete Minutes taken by PGME staff EPD attendance at LAB		
				To establish Trainee in Action group	Attendance by trainees, minutes		
3	Undergraduate	Jun-16	Jul-17	Establishment of 2020 curriculum	Establishment of trainers to deliver curriculum Implementation of revised curriculum		5.10.17
		Oct-17		To establish clear budget statements			
		Oct-17		Undergraduate strategy	To support DUME		
7	MTIs	Oct-17		To write Trust document to enable all to understand the requirements for MTIs in the Trust			
				To support the introduction of MTIs into medicine			
8	Development of PA Training Establishment	Jun-16	Jul-17	Start of Physicians Associates in Training	Appointment of PA Champion Training program established		5.10.17
				PAs embedded into departments to support best care		5.10.17 ongoing	

NHS Medway NHS Foundation Trust

Report to the Board

Committee Date: 03/11/2017 Item No. 11a

Title of Report	**Finance Report Month 6**
Prepared By:	Tracey Easton, Deputy Director of Finance
Lead Director	Tracey Cotterill – Director of Finance & Business Services
Committees or Groups who have considered this report	Finance Committee 26th October 2017
Executive Summary	The purpose of this report is to summarise the M6 year to date and forecast financial performance of the Trust against the agreed plan. Key points are : 1. In month performance has been reported in line with the planned deficit, however, the current levels of clinical income being identified via the Trust systems for months 1-6 are lower than would be expected based on the 2017-18 planning. Discussions with commissioners continue with regard to the contract work-plan which forms part of the income contract. The Trust is also working to identify potential opportunities where additional activity and income can be generated. Remedial actions are being identified to reduce expenditure to ensure that the control total is achieved at year end. The Trust has taken a pragmatic approach to income which could potentially be achieved as the current contractual issues are taken though the stages of contractual resolution. In addition the Trust has instigated a programme of 4 week 'financial sprints' to push hard on high value cost releasing savings plans that will assist in reducing the current cost base in the event that income is not achieved. 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. The finance committee reviews the risks and impacts in detail, and considers the worst case, best case and most likely impacts, to determine a risk adjusted forecast outturn position. As

NHS Medway NHS Foundation Trust

Report to the Board of Directors

	noted at 1. above, the largest risk in the forecast is clinical income and delivery of CIP. 3. Expenditure – Month 6 expenditure is below plan by £615k, £1,213k over spend on pay and £1,828k favourable on non-pay due to reserves. There are significant pay overspends in most of the Directorates with the exception of Corporate 4. Income – Clinical income is below plan by £228k in month 6, following accruals estimates whilst activity is reviewed, and discussions on the contract work plan continue. 5. Other income – at month 6 other income is below plan by £631k. In addition £202k of STF funding has been lost at Q1 due to the failure to achieve the A&E performance target. 6. CIP – the year end forecast for CIP is delivery to plan. At month 6 CIP delivery is behind plan by £3.3m.This largely relates to the current unidentified CIP target, and the phasing of the plan, as well as savings delivered not yet captured and reported as Non-recurrent CIP. 7. Cash has been drawn down from DH in the form of loans in line with the revenue plan. Additional cash has been provided to support the ED build. With the current shortfall on income year to date, there is an additional pressure on the cash balance, which is impacting creditor terms. Pressure on cash will increase if STF funding is lost relating to non-achievement of the A&E target. This is a potential full year loss of income and cash of £2.499m. 8. Capital – The 2 year operational plan submitted in March 2017 included £32m capital spend. The current forecast is for c. £21m based on ED works and programmes funded by internally generated funds. A further £1m of PDC has been granted for extension to the medical assessment unit, this will be reflected in the full year forecast next month. Any additional capital projects would be reliant on DH funding approval.
Resource Implications	As outlined
Risk and Assurance	• Contract Work plan – this is a large risk to the organisation as the full value of provider intentions is included in our plan, leading to a system gap.

Report to the Board of Directors

- **The Board is asked to note that work is on-going to refine the work plan and confirm the values within this.**

- CIP Delivery is a risk with a significant level of unidentified CIP and a further £3.4m stretch target.
  The Board is asked to note that actions are already being taken to improve the delivery process.
  - **2020 are currently supporting the Improvement workstream for Financial Recovery with a 4 week "sprint" on transformation schemes, as well as implementation planning of projects that have previously been through the sprint process.**
  - **Focus on specialty contribution to highlight target areas for savings**
  - **Cost centre detailed review and challenge of areas with high adverse variances.**
  - **Expenditure controls enhanced for non-essential non-clinical spend.**
  - **Enforcement of the Ordering controls relating to no Purchase order, no payment policy.**
  - **Clinical and operational engagement on CIP opportunities is occurring, with further workshops planned over coming weeks.**
  - **Communications across the Trust are now enhanced to reflect the financial position and raise awareness, as well as providing opportunity for all staff to contribute ideas for savings.**
- 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 Autumn of 2017 as part of the Trust FRP. The Grip and Control Toolkit provided by NHSI has been completed with actions**

Report to the Board of Directors

	identified to close gaps and seize opportunities. • Trust infrastructure and estate remains a risk due to age and condition, and lack of cash for capital investment. **The Board is asked to note that improvements have already commenced on both minor and major works, including ED. However, as there will be no additional capital funding made available to the Trust over and above ED funding, the capital programme has had to be scaled back, and there is a re-prioritisation of schemes.**
Legal Implications/Regulatory Requirements	Lack of achievement of the agreed control total will lead to Further Regulatory actions. Inappropriate Estate and insufficient Facilities lead to higher than acceptable risk to Patients, visitors and staff and could lead to further regulatory action.
Improvement Plan Implication	Financial Recovery is one of the nine programmes of Phase 2 Recovery. In year, financial stability is one of 4 programmes in Better, Best, Brilliant which includes financial recovery, commercial efficiency and estate planning.
Quality Impact Assessment	All actions will follow an appropriate QIA process
Recommendation	To note the contents of the report
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

Finance Report

Month 6

2017/18

Best of care
Best of people

Medway NHS
NHS Foundation Trust

Finance Report for September 2017

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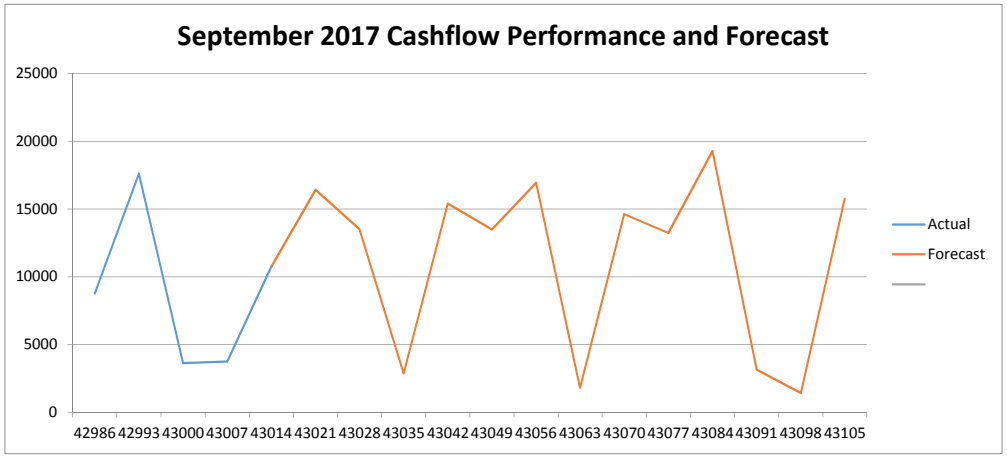
1. Liquidity

1a. Cash Flow

13 Week Forecast

	Actual				Forecast												
£m	08/09/17	15/09/17	22/09/17	29/09/17	06/10/17	13/10/17	20/10/17	27/10/17	03/11/17	10/11/17	17/11/17	24/11/17	01/12/17	08/12/17	15/12/17	22/12/17	29/12/17
BANK BALANCE B/FWD	**10.26**	**8.76**	**17.61**	**3.62**	**3.73**	**10.75**	**16.43**	**13.50**	**2.85**	**15.40**	**13.48**	**16.95**	**1.79**	**14.62**	**13.23**	**19.27**	**3.14**
Receipts																	
NHS Contract Income	0.37	3.69	4.07	0.80	10.43	3.31	3.92	0.60	14.27	0.00	3.37	0.00	14.27	0.00	3.37	0.00	0.00
Other	0.12	0.58	0.13	0.25	0.31	0.37	0.24	2.31	0.40	0.61	0.40	0.28	0.40	0.61	0.40	0.28	0.28
STF Funding	0.00	0.00	0.00	1.15	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.80
Total receipts	**0.49**	**4.27**	**4.20**	**2.20**	**10.74**	**3.69**	**4.16**	**2.90**	**14.67**	**0.61**	**3.77**	**0.28**	**14.67**	**0.61**	**3.77**	**0.28**	**2.08**
Payments																	
Pay Expenditure (excl. Agency)	(0.31)	(0.33)	(15.41)	(0.33)	(0.33)	(0.31)	(7.10)	(8.93)	(0.32)	(0.30)	(2.74)	(12.93)	(0.31)	(0.30)	(0.30)	(15.41)	(0.31)
Non Pay Expenditure	(1.68)	(2.57)	(2.09)	(0.82)	(3.39)	(2.30)	(3.29)	(0.34)	(1.41)	(2.23)	(3.47)	(2.37)	(0.12)	(1.63)	(2.41)	(2.78)	0.16
Capital Expenditure	0.00	0.00	0.00	(0.95)	0.00	0.00	0.00	(1.69)	0.00	0.00	0.00	0.00	(1.41)	0.00	0.00	0.00	(1.79)
Total payments	**(1.98)**	**(2.89)**	**(17.50)**	**(2.09)**	**(3.72)**	**(2.61)**	**(10.38)**	**(10.96)**	**(1.73)**	**(2.53)**	**(6.21)**	**(15.30)**	**(1.85)**	**(1.93)**	**(2.71)**	**(18.18)**	**(1.94)**
Net Receipts/ (Payments)	**(1.50)**	**1.38**	**(13.30)**	**0.11**	**7.02**	**1.07**	**(6.22)**	**(8.06)**	**12.94**	**(1.92)**	**(2.45)**	**(15.02)**	**12.83**	**(1.33)**	**1.06**	**(17.91)**	**0.14**
Funding Flows																	
FTFF/DOH - Revenue	0.00	6.15	0.00	0.00	0.00	0.00	3.18	0.00	0.00	0.00	3.92	0.00	0.00	0.00	2.55	0.00	0.00
STF Advance	0.00	1.35	0.00	0.00	0.00	0.00	(1.15)	0.00	0.00	0.00	1.99	0.00	0.00	0.00	2.31	0.00	0.00
FTFF/DOH - Capital	0.00	0.00	0.40	0.00	0.00	0.00	3.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Incentive Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	(1.09)	0.00	0.00	0.00	(0.12)	0.00	0.00	0.00	0.00	(0.14)	0.00	0.00	0.00	(0.03)	0.00
Dividend payable	0.00	(0.02)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	0.00	**7.47**	**(0.69)**	**0.00**	**0.00**	**0.00**	**4.92**	**0.00**	**0.00**	**0.00**	**5.92**	**(0.14)**	**0.00**	**0.00**	**4.87**	**(0.03)**	**0.00**
BANK BALANCE C/FWD	**8.76**	**17.61**	**3.62**	**3.73**	**10.75**	**11.82**	**10.52**	**2.46**	**15.40**	**13.48**	**16.95**	**1.79**	**14.62**	**13.29**	**19.22**	**1.28**	**1.41**

Fig1. Cashflow Forecast



Commentary

The opening cash balance for September 2017 was £2.3m, with a closing balance of £3.7m. This is above the minimum liquidity level (£1.4m) required by DH by £1.4m. This additional cash balance is mainly due to receipt of Q1 STF income (£1.1m) on the last day of the month.

The graph shows the actual cashflow for September and the projected weekly cashflow up to and including w/e 5 January 2018.

Receipts in the month were £21.1m, plus £6.8m loans & funding, therefore the total cash inflow for September was £27.9m.
Payments, including capital in the month were £26.5m.

The Trust has received £20.2m of deficit loan funding YTD in the form of an uncommitted revenue loan. In addition, the Trust has received £1.1m STF YTD with a further £1.3m STF advance in relation to Q2. The Trust has also drawn PDC of £2.2m and a capital loan of £3.7m in relation to the Emergency Department capital project and CT scanner. A further £1m PDC has also been awarded to the Trust in relation to A&E streaming.

Monthly payments for 17/18 have so far averaged at £27.6m, with 59% relating to payroll costs. This includes £9.5m per month for direct salary payments and £6.7m in relation to employer costs. Monthly receipts (excluding loans & STF) for 17/18 have averaged at £23.3m, however it should be noted that this includes an additional monthly contract payment received from Medway CCG during April.

Agreement in relation to settlement of 2016/17 additional clinical performance with the Trust's main commissioners is expected imminently. The Trust continues to experience significant cash pressures with non-pay expenditure subject to stringent monitoring and control.

1b. Loan agreement - status of compliance with additional terms

The full year revenue support loan agreement with the Department of Health requires the Trust to comply with a number of additional terms. These have been agreed by the Board and are summarised here, along with the current status of each and required timeframes for compliance.

Loan Agreement Clause	Description	Implementation Timeframe	Progress	Compliance with Loan Status	Risk to Organisation	Comments
8 – 1	Notification to Monitor / DH if anticipating to miss reforecast and require additional cash support	Immediately if anticipating missing reforecast and not less than 2 months prior to requiring the cash support	Trust reported a V3 plan on 29 June in line with new control totals. NHSi/DH are aware of revenue and capital funding required in 17/18			Trust is reporting an operating deficit within the Control Total
8 – 2	Agency nursing procured through approved frameworks and within maximum cap	Immediately	Notice given to agencies breaching the cap. Action plan in place to substitute the non-framework agency nurses with bank and framework workers.			Trust is still using Thornberry.
8 – 3	Consultancy spend in excess of £50K pre-approved by Monitor	Immediately	Working through all business cases with Monitor team.			No new contracts introduced without prior approval.
8 – 4	Implementation of controls over VSMs and off-payroll workers	Immediately	In progress			Review completed
8 – 5	Review / benchmarking of Estates and Facilities costs	31st May 2016	In progress			We are benchmarking via the annual ERIC return as well as against live information on the Model Hospital portal.
8 – 6	Produce an Estates strategy	Dec-17	In progress			Estates strategy is progressing but is an emerging and changing strategy and needs to be developed in conjunction with overall Trust strategy.
8 – 7	Use P21+ Procurement framework for publicly funded capital work	Immediately	Major capital works are being undertaken for the ED project. Specific dispensation was sought from Monitor for these works to be tendered outside of the P21+ contract.			ED redevelopment of Majors using P21+
8 – 8	Commission an assessment from SBS of benefit in outsourcing Finance, Accounting and Payroll services	9th May 2016	Payroll is being provided by SBS since February 2016. Outsourcing of other Finance and Accounting services to be further reviewed.			STP Finance Working Group assessing and producing business case, alongside an option for a local hosted service.
8 – 9	Assess benefit of outsourcing staff bank provider	9th May 2016	Completed - benefit is in moving in-house with a go-live date of 26th March 2016.			
8 – 10	Review savings opportunities in increased usage of NHS Supply Chain and provide copies of medical capital asset register and procurement plans	9th May 2016	Savings opportunities from using NHS Supply Chain are regularly reviewed by Procurement. Medical capital asset register is available.			
8 – 11	Test savings opportunities in use of CCS framework	9th May 2016	CCS framework used			
8 – 12	Become a member of the EEA portal and report relevant activity	Not specified	Member since 2010, activity is reported.			
8 – 13	Provide access to relevant authorised individuals to allow monitoring of progress on above conditions	Immediately	On-going			

2. Financial Performance

2a. Consolidated Income & Expenditure

Consolidated I&E (September 2017)

	Current Month			Year to Date (YTD)			Annual		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Forecast*	*Plan*	*Variance*
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical income	-19,820	-19,691	-129	-118,300	-118,903	604	-233,948	-237,854	3,906
High Cost Drugs	-1,690	-1,718	28	-10,757	-10,381	-376	-21,853	-20,596	-1,257
Other Operating Income	-1,878	-1,985	107	-11,617	-12,248	631	-23,195	-24,819	1,624
Total Revenue	**-23,389**	**-23,394**	**5**	**-140,673**	**-141,532**	**859**	**-278,996**	**-283,269**	**4,273**
Expenditure									
Substantive	13,920	16,030	-2,110	84,993	96,492	-11,499	171,828	193,552	-21,724
Bank	2,307	-49	2,356	11,534	-282	11,816	21,786	1,104	20,682
Agency	1,380	1,273	107	8,586	7,690	896	17,384	13,445	3,939
Total Pay	**17,607**	**17,254**	**353**	**105,113**	**103,900**	**1,213**	**210,998**	**208,101**	**2,897**
Clinical supplies	3,258	3,043	215	18,985	18,820	165	38,423	37,268	1,155
High Cost Drugs Expense	9,184	0	9,184	9,184	0	9,184	0	0	0
Drugs	-6,343	2,590	-8,933	7,006	15,153	-8,147	32,723	30,210	2,513
Consultancy	116	94	22	1,037	556	481	1,048	959	89
Other non pay	2,548	3,349	-801	16,499	20,010	-3,511	29,696	40,623	-10,927
Total Non Pay	**8,763**	**9,076**	**-313**	**52,711**	**54,539**	**-1,828**	**101,890**	**109,060**	**-7,170**
Total Expenditure	**26,370**	**26,330**	**40**	**157,824**	**158,439**	**-615**	**312,888**	**317,161**	**-4,273**
EBITDA	**2,981**	**2,936**	**45**	**17,151**	**16,907**	**244**	**33,892**	**33,892**	**0**
Post EBITDA									
Depreciation	811	808	3	4,877	4,846	31	9,693	9,693	0
Interest	218	266	-48	1,110	1,592	-482	3,186	3,186	0
Dividend	7	7	0	42	42	0	81	81	0
Profit/(loss) on sale of asset	0	0	0	0	0	0	0	0	0
Net (Surplus) / Deficit - Pre STFF	**4,017**	**4,017**	**0**	**23,180**	**23,387**	**-207**	**46,852**	**46,852**	**0**
STF Income	**-601**	**-601**	**0**	**-2,950**	**-3152**	**202**	**-8,806**	**-9,006**	200
Net (Surplus) / Deficit - Pre STFF	**3,416**	**3,416**	**0**	**20,230**	**20,235**	**-5**	**38,046**	**37,846**	**200**

Commentary

Net (Surplus) / Deficit

The Trust reported a £3.4m deficit in August, which is on plan. The YTD position is a deficit of £20.2m (£5k favourable to plan). The YTD position includes £2.9m of Sustainability & Transformation Fund (STF) income.

Clinical Income

Clinical Income is adverse to plan by £228k at month 6. This is split £0.6m adverse on clinical income, £0.4m favourable on high cost drugs. The actual income for month 6 assumes that the Trust is successful in achieving income linked to several areas of the current contract work plan. This is a risk for the Trust as resolution is still to be agreed with the CCGs.

Other Operating Income

Other Income is adverse to plan by £0.1m in month 6 and £0.6m adverse YTD, reflecting CIP under-delivery and a change in categorisation of actual income from Other Operating Income to Clinical Income.

Pay

Pay expenditure is adverse to plan in month by £0.4m and shows an adverse variance YTD of £1.2m. However the position in the individual Directorates shows significant overspends in CSD, FCSS and Estates and Facilities of £1.1m, £1.7m and £0.5m respectively.

Non Pay

Non pay expenditure is £1.8m favourable to plan at month 6.

Clinical supplies and other non pay are both favourable as a result of planned service changes which are now being picked up by the CIP programme. Consultancy and Drugs are adverse to plan. Higher than expected consultancy reflects a shift from the use of agency staff to contracting whilst drug overspends are partially offset by increased High Cost Drug Income.

CIP

As of Month 6 £3.0m of CIPhas been achieved, £3.3m adverse to the YTD NHSI plan submission. Despite this it is felt the programme is on track, a variance on the phasing on the expected savings is the reason for the current variance not a lack of achieving or identified schemes. Schemes to the value of £11.1m (PYE) have been identified for the year. This represents 88% delivery against the £12.6m target. In addition, pipeline schemes of £2.4m have been identified and are in the process of being scoped and validated.

Whilst the identified CIP total has increased by £0.5m, the risk assessed value has increased significantly by £1.4m, due to the improved assurance of delivery gained during the validation and reconciliation process in month. The risk assessed value is now £7.5m (PYE) represents 60% delivery to target. Work continues as priority with the Directorates to identify the CIP gap of £2.5m, with pipeline schemes being scoped in order to close the gap to the stretch CIP target of £16m.

Risks and Mitigations

A high level of CIP remains unidentified for 2017/18 and remains one of the main priorities for the Trust.

Sustainability & Transformation funding will be contingent upon achievement of the financial and A&E performance targets. The risk to STF income for the non achievement of A&E targets is £2.499m for the full year. It is possible that some of this will not be received but this has not been reflected in the forecast posiiton with the exception of the £200k relating to Q1.

2b. Run Rate Analysis - Financial

Anaylsis of 15 monthly performance - Financials

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue															
Clinical income	19.2	17.9	19.3	19.9	19.5	18.4	19.7	18.6	22.6	18.5	19.1	19.8	20.0	20.7	19.8
High Cost Drugs	1.7	1.6	2.0	1.8	1.7	1.5	1.8	1.6	1.6	1.7	1.9	1.9	1.8	1.8	1.7
STF Income	0.7	0.7	0.7	0.7	0.7	0.7	0.7	1.0	2.4	0.1	0.9	0.5	0.6	0.4	0.6
Other Operating Income	2.1	1.9	2.2	2.0	1.7	2.0	2.3	2.1	3.0	2.0	1.6	2.1	2.0	2.0	1.9
Total Revenue	**23.7**	**22.2**	**24.2**	**24.4**	**23.6**	**22.6**	**24.6**	**23.4**	**29.5**	**22.3**	**23.6**	**24.3**	**24.4**	**24.9**	**24.0**
Expenditure															
Substantive	-13.6	-13.7	-13.7	-13.6	-14.0	-13.6	-13.9	-14.0	-13.6	-14.0	-14.3	-14.3	-14.1	-14.3	-13.9
Bank	-0.8	-0.7	-0.6	-0.6	-0.9	-0.8	-0.7	-0.8	-0.9	-1.1	-1.2	-2.7	-1.8	-2.4	-2.3
Agency	-2.8	-3.1	-3.6	-3.5	-3.8	-3.5	-3.7	-3.6	-3.9	-2.2	-1.9	-0.2	-1.3	-1.6	-1.4
Total Pay	**-17.2**	**-17.5**	**-17.8**	**-17.6**	**-18.6**	**-17.9**	**-18.3**	**-18.3**	**-18.4**	**-17.3**	**-17.4**	**-17.2**	**-17.2**	**-18.3**	**-17.6**
Clinical supplies	-3.4	-3.3	-3.2	-2.8	-2.7	-2.8	-2.9	-3.1	-3.0	-2.7	-3.8	-2.8	-3.1	-3.3	-3.3
High Cost Drugs Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-1.5	-1.5	-1.5	-1.5	-1.5	-1.7
Drugs	-2.5	-2.7	-2.8	-2.5	-2.1	-1.7	-2.4	-2.4	-2.4	-1.0	-1.2	-1.1	-1.1	-1.4	-1.2
Consultancy	-0.1	0.0	-0.1	0.0	0.1	0.0	-0.1	0.0	0.0	-0.2	-0.1	-0.2	-0.2	-0.3	-0.1
Other non pay	-2.6	-2.6	-2.4	-2.9	-3.0	-3.0	-3.0	-2.9	-7.0	-3.5	-2.5	-2.5	-3.3	-2.1	-2.5
Total Non Pay	**-8.6**	**-8.6**	**-8.5**	**-8.2**	**-7.8**	**-7.4**	**-8.5**	**-8.4**	**-12.4**	**-8.9**	**-9.1**	**-8.1**	**-9.2**	**-8.5**	**-8.8**
Total Expenditure	**-25.8**	**-26.1**	**-26.3**	**-25.8**	**-26.4**	**-25.3**	**-26.8**	**-26.7**	**-30.8**	**-26.2**	**-26.5**	**-25.3**	**-26.4**	**-26.9**	**-26.4**
EBITDA	**-2.1**	**-3.9**	**-2.1**	**-1.4**	**-2.8**	**-2.7**	**-2.2**	**-3.3**	**-1.3**	**-4.0**	**-2.9**	**-1.0**	**-2.0**	**-1.9**	**-2.4**
Post EBITDA															
Depreciation	-0.8	-0.8	-0.8	-0.8	-0.9	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8
Interest	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.1	-0.2	-0.2	-0.2	-0.2
Dividend	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fixed Asset Impairment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Profit on sale of asset	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	-1.0	**-1.1**	**-1.1**	**-1.0**	**-1.2**	**-1.1**	**-1.1**	**-0.9**	**-1.0**	**-1.1**	**-0.9**	**-1.0**	**-1.0**	**-1.0**	**-1.0**
Net Surplus / (Deficit)	**-3.1**	**-5.0**	**-3.2**	**-2.4**	**-3.9**	**-3.8**	**-3.3**	**-4.2**	**-2.2**	**-5.1**	**-3.8**	**-2.0**	**-3.0**	**-2.9**	**-3.5**

2c. Workforce

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
		WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Substantive	Consultants	189	213	-24	2.37	2.44	-0.07	2.29	14.81	14.44	0.37	14.00
	Junior Medical	346	372	-26	1.81	2.00	-0.19	1.95	11.59	12.03	-0.44	11.42
	Nurses & Midwives	1142	1587	-445	4.05	5.59	-1.54	3.92	24.54	32.39	-7.85	23.61
	Scientific, Therapeutic & Technical	442	521	-79	1.37	1.53	-0.16	1.42	8.16	9.17	-1.01	8.46
	Healthcare Assts, etc.	492	616	-124	1.04	1.32	-0.28	0.96	6.18	7.68	-1.50	5.75
	Admin & Clerical	839	952	-113	2.20	2.42	-0.22	2.02	13.02	14.37	-1.35	12.03
	Chair & NEDs	6	7	-1	0.01	0.01	0.00	0.01	0.08	0.08	0.00	0.08
	Executives	6	9	-3	0.09	0.15	-0.06	0.13	0.70	0.93	-0.23	0.75
	Other Non Clinical	442	499	-57	0.92	1.00	-0.08	0.93	5.52	6.00	-0.48	5.45
	Pay Reserves	0	0	0	0.07	-0.44	0.51	0.00	0.39	-0.60	0.99	0.00
	Substantive Total	**3,904**	**4,775**	**-871**	**13.93**	**16.03**	**-2.10**	**13.64**	**84.99**	**96.49**	**-11.50**	**81.56**
Agency	Consultants	10	0	10	0.15	0.26	-0.11	0.44	1.11	1.70	-0.6	2.00
	Junior Medical	24	0	24	0.12	0.36	-0.24	0.64	1.37	2.14	-0.8	3.50
	Nurses & Midwives	153	0	153	0.69	0.31	0.38	1.58	3.86	1.45	2.4	7.13
	Scientific, Therapeutic & Technical	46	0	46	0.32	0.09	0.23	0.14	1.45	0.56	0.9	1.55
	Healthcare Assts, etc.	0	0	0	0.00	-0.02	0.02	0.16	0.14	0.11	0.0	0.57
	Admin & Clerical	4	12	-8	0.04	0.25	-0.21	0.42	0.27	1.55	-1.3	2.88
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	21	0	21	0.06	0.03	0.03	0.16	0.39	0.18	0.2	0.76
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Agency Total	**258**	**12**	**246**	**1.38**	**1.27**	**0.11**	**3.55**	**8.59**	**7.69**	**0.90**	**18.40**
Bank	Consultants	13	0	13	0.25	0.00	0.25	0.00	0.90	0.00	0.9	0.00
	Junior Medical	41	0	41	0.48	0.00	0.48	0.00	2.22	0.01	2.2	0.00
	Nurses & Midwives	126	0	126	0.61	-0.09	0.70	0.16	2.96	-0.61	3.6	1.26
	Scientific, Therapeutic & Technical	12	0	12	0.05	0.00	0.05	0.06	0.17	0.01	0.2	0.32
	Healthcare Assts, etc.	207	0	207	0.57	0.00	0.57	0.24	3.07	0.12	3.0	1.51
	Admin & Clerical	74	4	70	0.23	0.02	0.22	0.08	1.48	0.13	1.4	0.52
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	59	4	55	0.11	0.01	0.10	0.01	0.72	0.06	0.7	0.06
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Bank Total	**532**	**8**	**524**	**2.30**	**-0.06**	**2.36**	**0.55**	**11.53**	**-0.28**	**11.81**	**3.67**
	Workforce Total	**4,694**	**4,795**	**-101**	**17.61**	**17.25**	**0.36**	**17.74**	**105.11**	**103.90**	**1.21**	**103.63**

	Current Month						Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
Staff Group:	WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Consultants	212	213	-1	2.77	2.70	0.07	2.73	16.82	16.14	0.68	16.00
Junior Medical	411	372	39	2.41	2.36	0.06	2.59	15.18	14.18	1.00	14.92
Nurses & Midwives	1,421	1,587	-166	5.35	5.82	-0.47	5.66	31.36	33.23	-1.87	32.01
Scientific, Therapeutic & Technical	500	521	-21	1.74	1.62	0.12	1.62	9.78	9.74	0.04	10.33
Healthcare Assts, etc.	699	616	83	1.61	1.30	0.31	1.36	9.39	7.91	1.48	7.83
Executives	6	9	-3	0.09	0.15	-0.06	0.13	0.70	0.93	-0.23	0.75
Chair & NEDs	6	7	-1	0.01	0.01	0.00	0.01	0.08	0.08	0.00	0.08
Admin & Clerical	917	968	-51	2.47	2.69	-0.22	2.52	14.77	16.05	-1.28	15.43
Other Non Clinical	522	503	19	1.09	1.04	0.05	1.10	6.63	6.24	0.39	6.27
Pay Reserves	0	0	0	0.07	-0.44	0.51	0.00	0.39	-0.60	0.99	0.00
Workforce Total	**4,694**	**4,795**	**-101**	**17.61**	**17.25**	**0.36**	**17.74**	**105.11**	**103.90**	**1.21**	**103.63**

Commentary:
Pay expenditure is over spent compared to plan in month by £0.4m. Month 6 YTD pay is over spent by £1.2m. Bank and agency have reduced slightly from month 5 but bank is still much higher than previous trend levels.

Substantive establishments have increased by 1% when compared to March, these have been set on a run rate basis including vacancies and agreed opening budgets with Directorates.

WTE for agency and bank staff for the majority of areas are included in the substantive WTE as they are covering established posts whereas the financial premium cost is included in the agency/bank budget. The planned agency WTE relates to the PMO as these are non recurrent posts.

2d. Run rate analysis pay

		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	177	179	179	180	181	180	179	178	179	180	184	187	186	189	189
	Junior Medical	307	335	334	328	329	327	321	321	330	315	320	320	320	348	346
	Nurses & Midwives	1,089	1,084	1,097	1,105	1,106	1,098	1,118	1,134	1,120	1,087	1,096	1,148	1,148	1,152	1,142
	Scientific, Therapeutic & Technical	452	451	456	442	446	450	448	448	446	437	437	426	425	429	442
	Healthcare Assts, etc	461	450	457	458	459	463	455	472	479	470	478	491	489	492	492
	Admin & Clerical	802	801	809	808	809	809	812	821	817	894	889	825	835	840	839
	Chair & NEDs	7	7	7	6	6	6	6	6	5	3	11	7	2	6	6
	Executives	7	7	8	8	10	6	5	7	7	7	8	8	7	7	6
	Other Non Clinical	467	464	458	464	458	434	433	438	441	440	445	446	445	449	442
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Substantive Total	**3,768**	**3,778**	**3,805**	**3,801**	**3,804**	**3,772**	**3,777**	**3,823**	**3,824**	**3,833**	**3,868**	**3,857**	**3,853**	**3,912**	**3,904**
Agency	Consultants	16	19	25	20	18	18	19	20	28	20	15	14	9	14	10
	Junior Medical	54	59	65	68	61	70	62	53	56	47	40	33	28	24	24
	Nurses & Midwives	201	254	340	324	364	290	366	339	411	168	125	141	102	171	153
	Scientific, Therapeutic & Technical	55	61	28	35	54	63	50	37	35	46	32	38	35	50	46
	Healthcare Assts, etc	26	44	63	49	57	45	82	63	53	1	1	-	-	-	-
	Admin & Clerical	58	30	22	22	57	57	51	47	24	12	8	8	5	4	4
	Chair & NEDs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Executives	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Non Clinical	35	35	35	44	45	45	45	51	47	31	22	26	2	28	21
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Agency Total	**444**	**502**	**578**	**562**	**656**	**588**	**675**	**611**	**654**	**325**	**243**	**261**	**181**	**291**	**258**
Bank	Consultants	-	-	-	-	-	-	-	-	-	-	-	7	11	10	13
	Junior Medical	51	47	44	53	57	57	39	64	107	71	79	97	96	45	41
	Nurses & Midwives	-	-	-	-	-	-	-	1	3	5	22	21	33	137	126
	Scientific, Therapeutic & Technical	27	18	17	18	20	21	6	3	11	1	1	10	12	11	12
	Healthcare Assts, etc	120	117	108	114	124	127	121	134	209	130	142	161	173	249	207
	Admin & Clerical	62	106	51	59	78	59	67	64	52	263	105	84	83	114	74
	Chair & NEDs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Executives	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Non Clinical	4	9	3	13	45	40	41	44	40	37	41	44	47	71	59
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Bank Total	**264**	**297**	**223**	**257**	**324**	**304**	**274**	**310**	**422**	**507**	**390**	**423**	**455**	**637**	**532**
	Workforce Total	**4,476**	**4,577**	**4,606**	**4,619**	**4,784**	**4,664**	**4,726**	**4,743**	**4,900**	**4,665**	**4,502**	**4,540**	**4,489**	**4,840**	**4,694**

Analysis of 15 monthly performance - £

		Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.38	2.33	2.30	2.48	2.48	2.34	2.40	2.46	2.19	2.55	2.36	2.55	2.52	2.47	2.37
	Junior Medical	1.88	1.99	1.95	1.96	2.10	1.95	2.01	1.86	2.08	1.84	1.95	2.00	1.90	2.09	1.81
	Nurses & Midwives	3.89	3.91	3.92	3.92	3.91	3.89	3.91	4.14	3.96	3.94	4.03	4.12	4.04	4.13	4.05
	Scientific, Therapeutic & Technical	1.38	1.38	1.42	1.18	1.39	1.40	1.40	1.42	1.36	1.33	1.36	1.34	1.32	1.33	1.37
	Healthcare Assts, etc	0.96	0.94	0.97	0.94	0.96	0.94	1.02	0.97	0.93	1.00	1.05	1.04	1.03	1.03	1.04
	Admin & Clerical	2.01	2.01	2.02	2.03	2.04	2.08	2.06	2.07	2.08	2.26	2.43	2.14	2.20	2.20	2.20
	Chair & NEDs	0.01	0.01	0.01	0.01	0.02	0.00	0.01	0.01	0.04	0.01	0.02	0.02	0.01	0.01	0.01
	Executives	0.15	0.12	0.13	0.10	0.10	0.12	0.09	0.10	0.14	0.17	0.16	0.12	0.11	0.10	0.09
	Other Non Clinical	0.93	0.96	0.94	0.93	0.96	0.85	0.89	0.92	0.91	0.90	0.94	0.93	0.90	0.91	0.92
	Pay Reserves	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.02	0.07	0.06	0.07	0.07
	Substantive Total	**13.59**	**13.65**	**13.66**	**13.56**	**13.96**	**13.57**	**13.78**	**13.96**	**13.69**	**14.01**	**14.32**	**14.32**	**14.09**	**14.34**	**13.93**
Agency	Consultants	0.37	0.37	0.44	0.31	0.29	0.37	0.41	0.37	0.42	0.37	0.18	0.03	0.14	0.25	0.15
	Junior Medical	0.56	0.60	0.64	0.57	0.62	0.72	0.61	0.64	0.52	0.39	0.24	0.18	0.23	0.21	0.12
	Nurses & Midwives	1.01	1.18	1.58	1.56	1.81	1.43	1.82	1.69	2.03	0.19	1.25	0.37	0.61	0.76	0.69
	Scientific, Therapeutic & Technical	0.27	0.26	0.14	0.24	0.29	0.25	0.21	0.10	0.18	0.29	0.19	0.16	0.23	0.26	0.32
	Healthcare Assts, etc	0.06	0.11	0.16	0.12	0.15	0.13	0.31	0.19	0.14	0.01	0.00	0.00	0.02	-	-
	Admin & Clerical	0.40	0.52	0.42	0.56	0.52	0.50	0.49	0.41	0.21	0.13	0.01	0.06	0.04	0.01	0.04
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-
	Other Non Clinical	0.14	0.09	0.17	0.10	0.08	0.09	0.08	0.16	0.11	0.21	0.07	0.07	0.04	0.08	0.06
	Agency Total	**2.81**	**3.13**	**3.55**	**3.47**	**3.76**	**3.49**	**3.94**	**3.55**	**3.61**	**1.58**	**1.94**	**0.87**	**1.27**	**1.57**	**1.38**
Bank	Consultants	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.21	0.19	0.21	0.25
	Junior Medical	0.30	0.17	0.16	0.10	0.27	0.31	0.20	0.24	0.29	0.25	0.03	1.16	0.45	0.59	0.48
	Nurses & Midwives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.01	0.05	0.09	0.23	0.50	0.39	0.53	0.61
	Scientific, Therapeutic & Technical	0.08	0.06	0.06	0.06	0.06	0.07	0.02	0.01	0.04	0.00	0.01	0.04	0.04	0.03	0.05
	Healthcare Assts, etc	0.28	0.26	0.24	0.26	0.28	0.27	0.30	0.31	0.58	0.33	0.35	0.81	0.47	0.54	0.57
	Admin & Clerical	0.13	0.21	0.09	0.05	0.14	0.11	0.12	0.15	0.15	0.97	0.58	0.89	0.21	0.39	0.23
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-
	Other Non Clinical	0.00	0.02	0.01	0.09	0.10	0.09	0.07	0.08	0.09	0.07	0.08	0.23	0.09	0.16	0.11
	Bank Total	**0.79**	**0.72**	**0.57**	**0.55**	**0.85**	**0.85**	**0.71**	**0.80**	**1.20**	**1.70**	**1.21**	**2.05**	**1.84**	**2.45**	**2.30**
	Workforce Total	**17.19**	**17.50**	**17.78**	**17.58**	**18.58**	**17.91**	**18.43**	**18.30**	**18.50**	**17.29**	**17.47**	**17.23**	**17.20**	**18.36**	**17.61**

3. Balance Sheet

3a. Statement of Financial Position

	Note	Last Month Actual £m	Current Month Actual £m	Plan £m	Variance £m
Non current Assets					
Property, Plant and Equipment	5a	182.2	182.8	185.0	-2.2
Trade and Other Receivables: Other		0.4	0.4	0.5	-0.2
Total Non current Assets		**182.5**	**183.1**	**185.5**	**-2.4**
Current Assets					
Inventories		7.4	7.4	6.4	1.1
Trade and Other Receivables: Trade	4b	27.0	27.4	10.1	17.3
Trade and Other Receivables: Accruals		23.5	27.9	10.3	17.6
Trade and Other Receivables: Prepayments		4.2	4.4	1.6	2.7
Trade and Other Receivables: Other		1.9	1.0	0.4	0.6
Cash and Cash Equivalents	2a	2.3	3.7	1.4	2.4
Total Current Assets		**66.2**	**71.8**	**30.0**	**41.7**
Current Liabilities					
Borrowings		-66.2	-73.3	-1.3	-72.0
Trade and Other Payables: Trade	4c	-37.0	-37.2	-22.8	-14.4
Trade and other payables: Accruals		-9.7	-11.8	-7.2	-4.6
Trade and other payables: Other		-5.9	-5.0	-3.1	-1.9
Other liabilities: Deferred Income		-15.8	-16.3	-10.8	-5.5
Provisions		-4.3	-0.1	0.0	-0.1
Total Current Liabilities		**-138.9**	**-143.9**	**-45.4**	**-98.5**
Total Assets Less Current Liabilities		**109.8**	**111.0**	**170.2**	**-59.2**
Non Current Liabilities					
Borrowings		-84.2	-84.6	-151.5	66.8
Provisions		-0.9	-5.0	-0.9	-4.2
Total Non Current Liabilities		**-85.1**	**-89.7**	**-152.3**	**62.7**
Net Assets Employed		**24.7**	**21.3**	**17.9**	**3.5**
Taxpayers Equity					
Public Dividend Capital		136.7	136.7	138.8	-2.1
Retained Earnings		-149.1	-152.5	-153.2	0.7
Revaluation Reserve		37.1	37.1	32.3	4.8
Total taxpayers' equity		**24.7**	**21.3**	**17.9**	**3.5**

Commentary

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

Current Assets
Trade and Other Receivables have been reported over four separate headings to provide further detail:
Trade, these are balances owed to the Trust for trading activities for which sales invoices have been raised and are yet to be paid. The balance at month 6 is currently higher than the plan due to high levels of unresolved balances with commissioners in relation to previous financial years. Please see note 4b. which further analyses over debtor categories and age.
Accruals, these relate to balances owed to The Trust which are yet to be invoiced for. Contract Invoicing is up to date the current balance mainly relates to Partially Completed Spells(PCS) which always remains as an accrual.
Prepayments, payments made in advance for purchases such as equipment, software, maintenance. Payments for some of these services are paid annually in advance which is the reason for the current variance on plan. This balance should reduce each month unless additional prepayments are made in the month.
Other, included in other are further RTA debts, VAT Contracted Out Services refunds.

Cash and Cash Equivalents
A condition of the deficit loans is for The Trust to hold a balance of £1.4m to ensure there is always an adequate balance from which to deal with any emergency payments. The balance as at 30th September 2017 was £3.7m and this was largely due to the Trust receiving £1.1m of STF on the last day of the month.

Current Liabilities
Borrowings, the variance on plan mainly relates to a re-classification between current and non current borrowing as advised by the Department of Health in March. A further update on this is expected, for the debt to be classified as current repayments would be expected in the financial year. However, this is not the case on this balance as the balance mainly relates to prior year deficit funding which as yet is not repayable. Regardless of classification borrowing is, as we expected, in excess of the plan due to the increase required to cover this years deficit.

Trade and Other Payables
Trade, please see note 4c for further information. The main reasons for the variance on plan relate to, 1. A process change in Finance, it is estimated the previous manual Accounts Payable system undertstated the value of payables significantly as invoices were not immediately being registered. 2. Reduced cash to pay creditors due to the increase in receivables.

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

Deferred Income, this balance mainly relates to a £13.7m cash advance made by Medway Clinical Commissioning Group(CCG). This advance means no payment wil be received from the CCG in March. The remaining deferred Income relates to the agreed accounting treatment for Maternity Income billed at the start of the Clinical Pathway, Research & Development Funds and some private patients fees.

Non Current Liabilities - see narrative for the same categories in Current Liabilities

Taxpayers Equity
Variances relate to the phasing of the PDC drawdown (-£2.1m) and the year end upwards revaluation of the hospital site and associated residences and dwellings (£4.8m).

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

3b. Debtors

Aged Debtors

	Total	Current	31 to 60 Days	61 to 90 Days	91 to 180 Days	6 Months +
NHS						
CCGs and NHS England	21.78	1.04	0.42	0.75	2.85	16.72
NHS FTs	1.94	0.35	0.18	0.06	0.36	0.99
NHS Trusts	1.29	0.25	0.10	0.15	0.30	0.49
Health Education England	0.25	0.11	0.00	0.00	0.14	(0.01)
Special Health Authorities	0.05	0.00	0.00	0.00	0.00	0.05
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.00	0.00	0.00	0.00	0.00	0.00
Total NHS	**25.30**	**1.75**	**0.70**	**0.96**	**3.66**	**18.24**
Non NHS						
Bodies external to Government	2.22	0.24	0.09	0.17	0.25	1.48
other WGA bodies	0.01	0.00	0.00	(0.00)	(0.00)	0.01
Local Authorities	0.39	0.06	0.06	0.00	0.16	0.11
Total Non NHS	**2.63**	**0.30**	**0.15**	**0.17**	**0.40**	**1.60**
Bad Debt Provision	(0.53)	0.00	0.00	0.00	0.00	(0.53)
Other Receivables	0.03					
Total Receivables	**27.44**	**2.05**	**0.85**	**1.13**	**4.06**	**19.31**

Commentary

Total outstanding Trade Receivables as at the 30 September 2017 are £27.44m. This includes a £0.53m bad debt provision & £0.03m of other receivables.

NHS Debt excluding PCS is £25.30m (92.2%), the majority of which is with Clinical Commissioning Groups and relates to unpaid invoices for overperformance, non contract activity and High Cost drugs.

Negotiations with the Trusts' commissioners continue in efforts to resolve the outstanding 2016/17 overperformance.

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

Fig 1 Aged Receivables Analysis

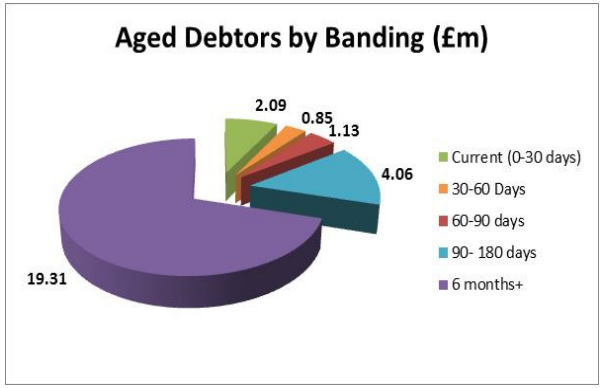


Fig 2 - Debtor Trends

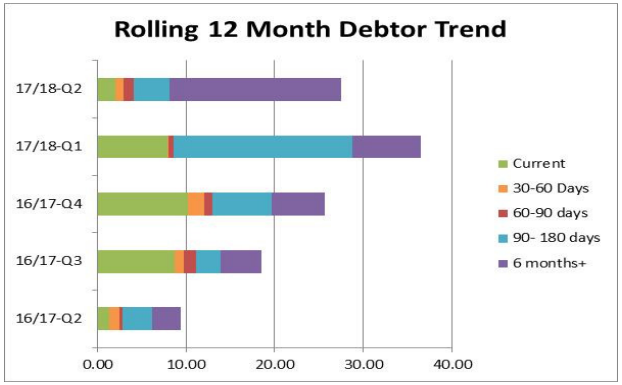


Fig.3 Top Ten Debtors

Top 10 Debtors

		£m
1	NHS MEDWAY CCG	10.81
2	NHS SWALE CCG	6.49
3	NHS DARTFORD GRAVESHAM & SWANLEY CC	1.84
4	EAST KENT HOSPITAL UNIVERSITY NHS FOUNI	0.92
5	MEDWAY COMMUNITY HEALTHCARE CIC	0.75
6	MAIDSTONE AND TUNBRIDGE WELLS NHS TRI	0.66
7	QUEEN VICTORIA HOSPITAL NHS TRUST	0.66
8	NHS ENGLAND	0.45
9	NHS WEST KENT CCG	0.41
10	MEDWAY COUNCIL	0.37

3c. Creditors

Aged Creditors

	Total	Current	31 to 60 Days	61 to 90 Days	91 - 180 Days	6 months +
	£m	£m	£m	£m	£m	£m
NHS						
NHS FTs	2.53	0.25	0.17	0.22	0.73	1.16
NHS Trusts	4.23	0.47	0.63	0.35	1.19	1.58
DH	0.00	0.00	0.00	0.00	0.00	0.00
Public Health England	0.02	0.00	0.00	0.01	0.00	0.01
Health Education England	0.00	0.00	0.00	0.00	0.00	0.00
CCGs and NHS England	0.00	0.00	0.00	0.00	0.00	0.00
Special Health Authorities	0.49	0.12	0.13	0.12	0.12	0.01
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.58	0.01	0.02	0.04	0.04	0.47
Total NHS	7.86	0.85	0.95	0.73	2.08	3.24
Non NHS						
other WGA bodies	0.14	0.12	0.01	0.00	0.00	0.00
Local Authorities	0.02	0.01	0.00	0.00	0.00	0.01
Bodies external to Government	21.59	4.69	7.28	3.62	3.38	2.61
Total Non NHS	21.75	4.82	7.30	3.63	3.38	2.62
Uncleared Payment Run	2.55	0.00	2.55	0.00	0.00	0.00
Total Purchase Ledger	32.16	5.67	10.80	4.36	5.47	5.86
Other Trade Payables						
Capital	2.36	2.36	0.00	0.00	0.00	0.00
Payroll	2.52	2.52	0.00	0.00	0.00	0.00
Other	0.21	0.21	0.00	0.00	0.00	0.00
Total Non NHS	5.09	5.09	0.00	0.00	0.00	0.00
Total Trade Payables	**37.25**	**10.76**	**10.80**	**4.36**	**5.47**	**5.86**

Commentary

Total outstanding creditors as at 30th September are £37.25m of which 71% (£26.5m) are overdue based on 30 day payment terms. However it is noted that this includes an Uncleared Payment run of £2.55m which would reduce this to 64%. From July 2017, this slide includes liabilities relating to Capital and Payroll Payables.

The Trust endeavours to maintain payments for all approved invoices between 45 and 60 days from the invoice date. However there are significant issues with purchase orders that haven't been goods received on the purchase orders system and invoices not been sent to the Finance Department. An action plan has been implemented to address this.

Average payment days for 16/17 were 61.31 days.

The Trust has £5.86m creditors over 6 months; Fig. 1 shows aged creditors analysed by ageing category; Fig.2 shows the rolling creditor trend; & Fig.3 provides a list of the top 10 creditors by value.

Fig.1 - Aged Payables Analysis

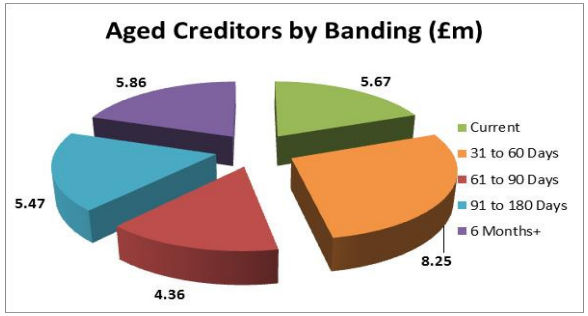


Fig.2 - Creditor Trends

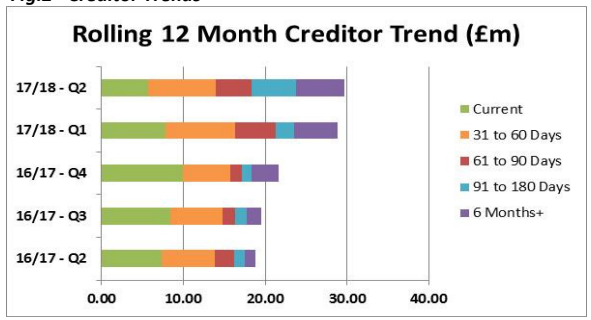


Fig.3 - Top 10 Creditors

	Top 10 Creditors	£m
1	MAIDSTONE TUNBRIDGE WELLS NHS TRUST	2.50
2	DARTFORD & GRAVESHAM NHS TRUST	1.56
3	NHS SUPPLY CHAIN	1.16
4	HEALTHCARE AT HOME LTD	0.91
5	KENT COMMUNITY HEALTH NHS FOUNDATION TRU	0.89
6	4FRONT HEALTHCARE LTD	0.67
7	MEDWAY COMMUNITY HEALTHCARE CIC	0.67
8	CARE UK CLINICAL SERVICES LTD	0.66
9	DAY WEBSTER	0.65
10	EAST KENT HOSPITALS NHS TRUST	0.64

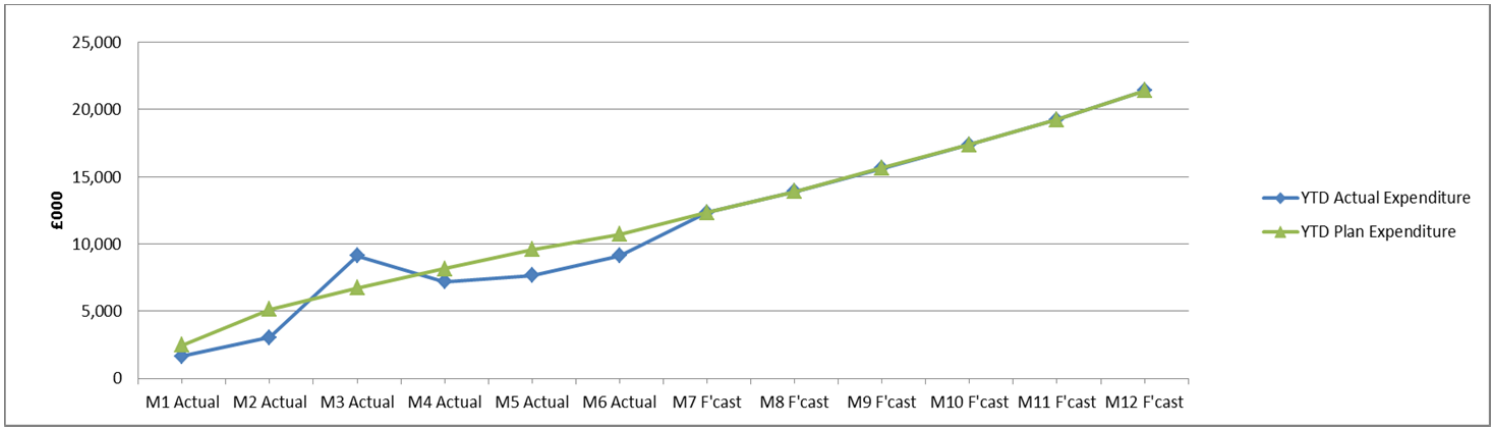
4. Capital

4a. Capital

Capital Programme Summary

	Current Month			Year to Date			Forecast year end position		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Original Plan £m	Forecast Out-turn £m	Forecast Variance £m
Expenditure									
Recurrent Estates & Site Infrastructure	0.65	0.33	0.32	1.70	1.77	-0.07	4.90	5.93	-1.03
IM&T	0.17	0.23	-0.06	0.74	1.08	-0.34	2.85	3.65	-0.80
Medical & Surgical Equipment	0.10	0.11	-0.01	0.29	0.56	-0.27	1.50	1.42	0.08
Specific Business Cases	0.04	0.13	-0.09	0.90	0.83	0.07	1.84	0.10	1.74
Transform Projects (ED/AAU)	0.49	0.37	0.12	5.49	6.33	-0.84	10.32	10.32	0.00
Total	**1.45**	**1.17**	**0.28**	**9.12**	**10.57**	**-1.45**	**21.42**	**21.42**	**0.00**

Cumulative capital spend as at Month 6 amounted to £9.12m. This represents an underspend of £1.45m and comes just under the original plan of £10.57m for the period to date. The underspend is mainly attributable to ED (almost 60%), Estates projects (34%) and Medical Devices (27%). However, there is an in month overspend of around £30k representing spend on Fire Urgency repairs identified within Estates.
Expenditure is still dominated by the ED project and CT Scanner. All remaining projects continue to be carefully monitored against a planned funding envelope of £21.42m to identify cost escalation at the earliest opportunity wherever possible.



5. Cost Improvement Programme

5a. 2016/17 Cost Improvement Programme Summary

	Acute & Continuing Care £0	Surgery £'000	Womens & Childrens £'000	Corporate £'000	Estates £'000	Central £'000	TOTAL £'000
Divisional Schemes	2,111	2,002	1,186	877	263	260	**6,699**
Medicine Management						2,100	**2,100**
Procurement	2,112	509	163	1		1,061	**3,846**
TOTAL	**4,223**	**2,512**	**1,349**	**878**	**263**	**3,421**	**12,645**

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/11/2017 Item No. 11b

Title of Report	**Communications report**
Prepared By:	Glynis Alexander, Director of Communications and Engagement
Lead Director	Glynis Alexander, Director of Communications and Engagement
Committees or Groups who have considered this report	None
Executive Summary	The purpose of this report is to provide an update on internal and external communications and engagement activity. Key points are : ○ The main focus for our internal communications has been on winter preparedness. ○ We also continue to engage staff in our Better, Best, Brilliant programme, particularly around flow and finance. ○ In the media we have received a good level of positive coverage, and been proactive in seeking out opportunities to promote improvements for our patients. ○ We have engaged with a wide range of people in our community on a diverse range of subjects.
Resource Implications	None
Risk and Assurance	None
Legal Implications/Regulatory Requirements	Not applicable

to the Board of Directors

Improvement Plan Implication	The Communications Team's work is aligned with the Better, Best, Brilliant improvement plan			
Quality Impact Assessment	Not applicable			
Recommendation	The Board is asked to note the report.			
Purpose & Actions required by the Board :	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒

NHS
Medway
NHS Foundation Trust

Communications report – November 2017

1. EXECUTIVE SUMMARY

1.1. The main focus for our internal communications has been on winter preparedness.

1.2. We also continue to engage staff in our Better, Best, Brilliant programme, particularly around flow and finance.

1.3. In the media we have received a good level of positive coverage, and been proactive in seeking out opportunities to promote improvements for our patients.

1.4. We have engaged with a wide range of people in our community on a diverse range of subjects.

2. ENGAGING COLLEAGUES

2.1. Internal communications have supported the flu prevention programme, with repeated messages urging staff to get vaccinated.

2.2. To increase uptake, particularly among frontline staff, we have promoted clinics, ward visits, and peer vaccinators, and widely advertised incentives.

2.3. The Chief Executive's weekly message has included regular reminders, which have been firm in tone, so staff are in no doubt that they are expected to have the vaccination if they are caring for patients, both to protect the patients and themselves.

2.4. Posters, pop-up messages on computers, screensavers, and social media have all been used to spread the word. It is also the front page article on the current News@Medway. The tannoy outside the hospital is playing a message about hand hygiene as part of our wider infection prevention campaign.

2.5. Meanwhile, we have also been engaging staff in the Better, Best, Brilliant improvement programme. Our approach to this has been to keep the widest range of staff informed about flow and finance, encouraging them to think how they can help improve performance. For more senior staff there have been workshops and workstreams where they are actively involved in delivering priority improvements.

2.6. We are now embarking on a cultural change project which will help embed engagement throughout the organisation.

3. MEDIA

3.1 The Trust has received a steady stream of positive publicity on regional TV and radio, in the local press, and in specialist journals.

3.2 The visit by Health Secretary Jeremy Hunt resulted in extensive media coverage, with Mr Hunt issuing extremely encouraging comments about our progress in relation to patient safety.

3.3 The media also ran the news about an additional £1million being allocated to support the Trust over the winter period.

3.4 The first anniversary of going smokefree was widely covered locally, regionally and nationally, in print and on TV.

3.5 To mark World Alzheimer's Day we have coverage in the local papers about the Trust's adoption of dementia care initiatives John's Campaign, which allows 24-hour visiting access to families and carers of patients with dementia, and the Butterfly scheme, which discretely identifies individuals with dementia to staff so they can be more responsive to their needs.

3.6 The BBC filmed in the Birth Place and Oliver Fisher Unit for a feature about how we are supporting women to breastfeed and the use of breast milk for feeding our neonatal patients.

3.7 We had further positive coverage across a number of media after the Trust was chosen as a pilot to trial a new bereavement care pathway.

3.8 We were also pleased to see reporting on the junior doctors' survey which highlighted high levels of satisfaction with the training provided at the Trust.

3.9 Our recruitment programmes continue to generate media interest, with several opportunities for us to explain how we are recruiting locally, nationally and internationally. Some of the coverage around our Philippines recruitment campaign focused on the number of applicants who had failed the required English test. We emphasised that many more had yet to take the test, and that the Philippines programme is just one strand of our recruitment strategy.

3.10 A nursing journal featured our ED nursing team, describing the improvements that have taken place in the department to improve the safety and care of patients. The front page of Nursing Management magazine carried a photo of our own Cliff Evans.

3.11 The Medway Messenger is supporting our campaign to increase breast screening rates, with regular features and interviews.

4. SOCIAL MEDIA

4.1 Over the last 28 days we have engaged with 61,700 followers on Twitter (approx. 100 per cent increase) and 110,100 on Facebook (two per cent increase).

4.2 The team has been using Crowd Fire, a social media management tool, to help manage and grow our social media presence. This, along with engaging content, has led to an increased following across all three channels. Trust social media account followers now total 3,064 on Twitter, 4,876 on Facebook and 189 on Instagram; this represents a steady increase across all platforms.

4.3 In addition to promoting key news and events throughout the Trust, we have used our social media accounts to raise awareness of two major campaigns – Stoptober and 'Get it Checked, it's for the Breast'. The latter, a joint breast screening awareness campaign launched with the Medway Messenger, received a considerable amount of interaction on Twitter – MP Tracey Crouch retweeted the Medway Messenger's post about it, (in which we were tagged), while a separate Tweet by local journalist Amy Nickalls, which also mentioned the Trust, received more than 130 likes and retweets.

4.4 Stoptober's social media accounts continued to regularly interact with our posts across Twitter, Facebook and Instagram throughout the month, and we also linked in with Medway Council on our smokefree anniversary. The campaigns have gained widespread support across all channels, resulting in an increase in all analytics, including reach, page views and post engagement.

4.5 Moving forward, we plan to stream a live Twitter feed in the staff restaurant on Fab Change Day (Thursday 16 November) to highlight the participation of staff, volunteers and patients on the day.

4.6 We are also due to host a live Twitter Q&A session during a nursing debate in the lecture theatre on Wednesday 29 November. The events will also be featured on our other social media channels and will provide us with an effective way of promoting the Trust's overall social media presence.

5. COMMUNITY ENGAGEMENT

5.1 Our AGM on 26 September, attended by around 100 people, was a great opportunity to celebrate our achievements over the past year, and to talk about Better, Best, Brilliant, as well as to describe how we will meet the challenges

that lie ahead. Attendees heard a review of the year, a thorough update on our financial position and a presentation about meeting the challenge of reducing smoking in pregnancy. The Lead Governor gave an excellent report on the work of the governors.

5.2 Governors continue to engage with networks across Medway and Swale. There was a Governor coffee morning in Hoo on 16 September, which was well-received, and another is planned for Luton on 16 November.

5.3 Membership recruitment stands have been scheduled for the next few months. There was one in the main entrance on 6 September when conversations were had with a number of patients and visitors.

5.4 We are also working closely with our STP partners and supported their August and September meetings with local people on their urgent care review and the Medway Model for local care.

5.5 As always, we are keen to ensure key stakeholders such as local MPs and councillors are kept informed about the progress the Trust is making, and that we create opportunities for them to see for themselves developments taking place. A number of MP meetings have been held over the past month, with others scheduled for the coming weeks.

5.6 Our community engagement has led to a number of useful connections, for example speaker opportunities for senior clinicians, and a close link with a Rainham school who are keen to support our fund-raising.

5.7 We continue to build a database of organisations and community groups who want to engage more fully with the Trust, with regular requests being received for our Community Engagement Officer to visit.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/11/2017 Item No. 12a

Title of Report	Corporate Governance Report
Presented By:	Katy White, Acting Director of Corporate Governance.
Lead Director	Katy White, Acting Director of Corporate Governance.
Committees or Groups who have considered this report	Not Applicable (N/A)
Executive Summary	The report outlines current activity and issues in corporate governance.
Resource Implications	N/A
Risk and Assurance	The report outlines the progress of a number of Trustwide initiatives designed to improve corporate governance arrangements.
Legal Implications/Regulatory Requirements	N/A
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	The Board is 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

Report to the Board of Directors

1 EXECUTIVE SUMMARY

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

2 CARE QUALITY COMMISSION

2.1 The Trust had a very productive Engagement Meeting with the CQC on 14 September as part of the on-going engagement process, during which our CQC Inspector shared the Draft NHS Trust Engagement Schedule - next phase inspection, for 2018

There will continue to be monthly Engagement meetings and in each quarter the CQC will be spending a whole day on-site. It is envisaged that the first one of these will be in February 2018. The mornings will consist of the standard Engagement meeting with the Director of Nursing plus another board member, followed by a meeting with a Clinical Leadership team on rotation throughout the year.
The afternoons will involve staff focus groups similar to those held during inspections.

Twice per year the CQC Inspector will be required to attend both private and public Board meetings as an observer, but won't be included in any discussions.
Also twice per year the CQC will host off-site Stakeholder Engagement meetings, which they will organise and facilitate.

In addition to the above, there will be a Trust Engagement session facilitated by the Medicines Management section of the CQC which will be arranged directly with the Chief Pharmacist. These are independent of the standard Engagement meetings arrangements.

The new Head of Hospital Inspection (name not yet confirmed) will be holding quarterly meetings with both NHSI and NHSE.

2.2 A full update on progress against the CQC Improvement Plan was shared with the CQC and the actions being taken to move the reds and ambers to green to closed were explained. The latest position as to progress is shown in the table below (the numbers in brackets refer to the September position).

	Closed	Green	Amber	Red
Must Do	8 (6)	3 (3)	2 (3)	3 (4)
Should Do	13 (10)	11(9)	1 (3)	2 (5)

Report to the Board of Directors

2.3 The 'check and challenge validation panel' has now been established under the leadership of the Director of Nursing, to which all Directorate leads are invited to attend to present their CQC Improvement Plan evidence.

3 RISK AND REGULATION ASSURANCE

3.1 The Human Tissue Authority will be carrying out an inspection of the Trust on 26 October 2017 regarding the HTA licencing framework at MFT. The Executive Team has received assurance that the Trust is well prepared for each area of the Corporate HTA licence that will be inspected.

4 DOCUMENTATION MANAGEMENT

4.1 The table below shows the status of the 17 corporate policies which are identified as requiring Board approval. The Board will note that there are two policies which require approval and one which requires review.

Corporate Policy	Document Owner	Status
Complaints	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Consent	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Duty of Candour	Medical Director	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	On Board agenda for approval
Information Governance	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Medicines Management	Medical Director	Approved; Available on intranet and website

Report to the Board of Directors

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	On Board agenda for approval
Serious Incidents	Medical Director	Approved; Available on intranet and website
Conflicts of Interest	Company Secretary	Approved; Available on intranet and website
Violence, Aggression and Disruptive Behaviour	Security Director (currently Director of Finance)	Approved; Available on intranet and website

5 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

5.1 The Trust undertook a Table Top Exercise to launch and test the Winter Resilience Plan, Exercise Vivaldi 2, on 12 October 2017 against the following objectives:

- To communicate the content of the Winter Resilience Plan and maximise understanding of the capabilities of SHREWD (Single Health Early Warning Database)
- To increase uptake in use of SHREWD by using it to consider the impact against a range of scenarios (Flu, Norovirus, Weather and the associate Staffing impacts).
- To give the Executive Group assurances of a robust Winter Resilience Plan launch and highlight any additional items for immediate consideration
- To give assurance of the application of the NHS E/ NHS I Winter Preparedness Requirements for Local A&E Delivery Boards.

5.2 The Executive Team received their annual Significant Incident Training, which was based on testing the Fire Response Plan. All agreed that this was a very worthwhile exercise.

6 COMPLAINTS

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

6.2 Complaints response performance continues to steadily improve against the 10 day and 30 day response times as shown on the table below. However, the response time for red rated complaints, which are often associated with a serious incident, still requires more focused improvement.

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	Target	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
Number of complaints received	N/A	52	61	62	66	66	83
% of red assessed complaints with final response within 60 working days	85%	40%	61%	28%	N/A	N/A	N/A
% of amber assessed complaints with final response within 30 working days	85%	48%	57%	60%	68%	N/A	N/A
% of green assessed complaints with final response within 10 working days	85%	28%	37%	58%	54%	N/A	N/A
% complaints acknowledged within 3 working days	100%	100%	100%	100%	100%	100%	100%
Number of referred complaints taken up by the Ombudsman	N/A	1	0	0	0	1	0
Ombudsman Outcomes - upheld	N/A	0	0	0	0	0	0
Ombudsman Outcomes - partially upheld	N/A	0	1	1	0	0	0
Ombudsman Outcomes - not upheld	N/A	2	0	1	1	0	0

6.3 The Central Complaints Team received and logged 83 complaints during September 2017. This is a 34% increase from August. The table below shows the numbers of complaints received broken down by RAG rating and Directorate.

RAG rating		**Directorate**	
Red	8	ACC	34
Amber	64	CSD	32
Green	11	F&CSS	15
Total	**83**	Estates	2
		Total	**83**

7 COMPLIANCE DASHBOARD

7.1 The compliance dashboard gives an overview of performance across a range of corporate governance key performance indicators and is monitored at the monthly Directorate Performance Review Meetings. There is an overarching Trust level dashboard (attached at appendix 1) and each directorate (clinical and corporate) has a dashboard tailored to the relevant KPIs of that service.

Freedom of Information		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
1.1	% of closed FOIs completed in 20 working days	90%	47%	62%	61%	78%	40%	70%	94%	38%	54%
1.2	No. of FOIs overdue	N/A	0	0	93	72	64	43	65	75	56

Information Governance		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
2.1	IG Training (>95%)	95%	0%	0%	81%	80%	78%	77%	77%	75%	80%
2.2	No. breaches reported to the ICO	N/A	1	0	1	0	1	1	1	0	0

Data Protection		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
3.1	% of closed SARs completed in 40 calendar days	85%	74%	81%	95%	87%	93%	95%	88%	88%	82%

Complaints		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
4.1	Number of complaints received	N/A	N/A	N/A	N/A	52	61	62	66	66	81
4.2	% of red assessed complaints with final response within 60 working days	85%	0%	0%	33%	40%	61%	28%	N/A	N/A	N/A
4.3	% of amber assessed complaints with final response within 30 working days	85%	19%	25%	19%	48%	57%	60%	68%	N/A	N/A
4.4	% of green assessed complaints with final response within 10 working days	85%	52%	41%	57%	28%	37%	58%	54%	N/A	N/A
4.5	% complaints acknowledged within 3 working days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
4.6	Number of referred complaints taken up by the Ombudsman	N/A	1	1	3	1	0	0	0	1	0
4.7	Ombudsman Outcomes - upheld	N/A	0	0	0	0	0	0	0	0	0
4.8	Ombudsman Outcomes - partially upheld	N/A	0	0	1	0	1	1	0	0	0
4.9	Ombudsman Outcomes - not upheld	N/A	0	1	0	2	0	1	1	0	0

Serious Incident Reporting		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
5.1	No. of Serious Incidents reported on STEIS in month	N/A	13	20	20	9	24	21	7	13	14
5.2	No. of Serious Incidents reported on STEIS within 48 hours of incident date	N/A	2	6	1	2	3	4	5	4	6
5.3	48 hour breach rate	0%	85%	70%	95%	78%	88%	81%	29%	69%	57%
5.4	No. of Serious Incident 72 hour reports due for submission in month	N/A	8	24	19	9	21	25	5	14	11
5.5	No. of Serious Incident 72 hour reports submitted in month	N/A	2	6	2	4	15	14	4	13	8
5.6	72 hour report breach rate	0%	75%	75%	89%	56%	29%	44%	20%	7%	27%
5.7	Number of Serious Incident Reports due for Submission (60 Working Day)	N/A	15	6	7	15	16	20	15	20	19
5.8	Number of Serious Incidents Reports submitted	N/A	0	2	3	9	9	2	1	1	3
5.9	60 Day Report Submission Breach Rate	0%	100%	67%	57%	40%	44%	90%	93%	95%	84%

Incident Reporting		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
6.1	Number of incidents triggering Duty of Candour	N/A	29	30	30	27	39	35	33	23	28
6.2	Number of incidents triggering DOC where this was applied	N/A	2	2	1	1	8	0	2	2	3
6.3	Number of incidents awaiting review	N/A	57	58	86	123	209	175	281	395	527
6.4	Number of incidents overdue review	N/A	57	58	86	123	209	65	183	272	407
6.5	Number of incidents being reviewed and overdue	N/A	182	159	263	243	305	2357	2261	2244	2367
6.6	Awaiting final approval and overdue	N/A	157	310	618	296	280	156	707	1594	2342

Risk		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
7.1	% of risks within review period by Directorate	100%	20%	24%	20%	28%	20%	31%	52%	39%	53%
7.2	% of staff trained on MOLLIE risk management module by Directorate	85%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	53%
7.3	% of risk where current score is less than the initial score by Directorate	85%	35%	38%	36%	35%	41%	37%	25%	28%	27%

Policies		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
8.1	% of Corporate policies in date	95%	0%	0%	85%	85%	85%	86%	86%	87%	71%
8.2	% of other procedural documents in date	95%	N/A	N/A	71%	71%	71%	72%	72%	78%	69%

Central Alerts System		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
9.1	CAS alerts outstanding	0	0	0	0	0	0	0	0	0	0

EPRR and Business Continuity Planning		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
10.1	% of Business Continuity Plans overdue	0%	0%	0%	22%	21%	22%	27%	38%	41%	41%
10.2	% Major Incident Training (Gold)	95%	0%	0%	0%	0%	0%	0%	85%	85%	77%
10.3	% Significant Incident Training (Gold)	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%
10.4	% Significant Incident Training, Silver	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%
10.5	% Major Incident Training, Silver	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%
10.6	% Major Incident Training, Bronze	95%	0%	0%	0%	0%	0%	14%	14%	14%	22%

Health and Safety		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
11.1	No. reports sent within 10 days and investigated (RIDDOR 2013)	N/A	0	0	1	0	0	1	0	2	1
11.2	No. of incidents which were RIDDOR reportable but not sent within 10 days and investigated (RIDDOR	0	0	0	1	0	0	0	1	0	0
11.3	No. manual handling key workers in post	192	72	72	72	69	69	69	69	74	74
11.4	No. H&S key workers in post	128	90	90	90	62	62	62	62	62	62
11.5	% Fire safety training completed	95%	100%	100%	86%	87%	86%	83%	83%	83%	81%
11.6	% H&S training completed	95%	89%	91%	91%	89%	89%	85%	89%	90%	83%
11.7	% Manual Handling training completed	95%	87%	93%	93%	88%	88%	84%	87%	87%	82%

Legal		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
12.1	No. of inquests	N/A	7	6	4	0	0	0	0	0	7
12.2	% of documentation returned to coroner on time	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
12.3	No. Claims Received - Clinical Negligence	N/A	2	4	6	0	0	4	4	8	5
12.4	No. Claiims Received - Employers Liability Claims	N/A	0	0	1	2	1	0	0	0	0
12.5	No. Claiims Received - Public Liability Claims	N/A	0	0	1	0	0	0	1	0	0
12.6	% of documentation returned to NHSLA on time	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

EDN Completion		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
13.1	% completed in 24 hours	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80%
13.2	% completed in 48 hours	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	84%
13.3	Backlog - All Outstanding EDNs	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1180
13.4	Backlog longest wait time, in days (average for 3 Directorates)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1668

		Q4 (Jan - Mar 17)				Q1 (Apr 17-Jun 17)				Q2 (Jul 17-Sep 17)	
Care Quality Commission		ACCD	CSD	W&CD	Trustwide	ACCD	CSD	F&CSD	Trustwide	ACCD	CSD
13.1	Compliance against Safe domain (as per CQC Assure)	Req Improvement	Good	Req Improvement	Req Improvement	Req Improvement	Req Improvement	Req Improvement	Req Improvement		
13.2	Compliance against Effective domain (as per CQC Assure)	Req Improvement	Req Improvement	Good	Good					Req Improvement	
13.3	Compliance against Caring domain (as per CQC Assure)	Req Improvement	Good	Good	Good						
13.4	Compliance against Responsive domain (as per CQC Assure)	Req Improvement	Req Improvement	Good	Req Improvement						
13.5	Compliance against Well led domain (as per CQC Assure)	Req Improvement	Req Improvement	Good	Good						
13.6	No. of Requirement actions (as per CQC Quality Report 17/3/17)	N/A	N/A	N/A	13	N/A	N/A	N/A	13	N/A	N/A
13.7	No. of Enforcement actions (as per CQC Quality Report 17/3/17)	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A
13.8	No. of Warning notices (as per CQC Quality Report 17/3/17)	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A

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Report to the Board of Directors

Board Date: 03/11/2017 Item No. 12b

Title of Report	Health and Safety Board Report
Presented By:	Katy White, Acting Director of Corporate Governance.
Lead Director	Katy White, Acting Director of Corporate Governance.
Committees or Groups who have considered this report	Executive Group and Integrated Audit Committee.
Executive Summary	A Workplace Health and Safety Standards Audit was conducted during the period 03/01/17 - 31/03/17, driven by the HSE management model, Plan, Do, Check, Act which offers a prescriptive systematic approach to the audit process. By applying this process and methodology the audit was able to segment particular areas of the Trust to focus upon. This approach offered a valuable insight in highlighting non-compliant working processes, site observations added further weight to the audit. The audit applies the traffic light system of red, amber and green to the accompanying time sensitive action plan using the indicators of amber and red. The red indicators have been given the key focus.
Resource Implications	N/A
Risk and Assurance	The Workplace Health and Safety Standards Audit is currently reported on the Corporate Risk Register where progress against actions is monitored on a weekly basis by the Head of Legal Services, Corporate Compliance and Resilience. The Integrated Audit Committee (IAC) had been presented with the both the audit findings and the accompanying time sensitive action plan on two separate occasions, 19 June and 31 August. The (IAC) will continue to monitor progress. The Fire, Health and Safety Group chaired by the Acting Director of Corporate Governance is the formal group that has authority and plays a key role in monitoring the Trust's compliance with current legislation and the requirements of the Health and Safety Executive (HSE).

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Legal Implications/Regulatory Requirements	The Health and Safety at Work Act 1974, (HSAW), is the main piece of UK health and safety legislation. It places a duty on all employers to ensure so far as is reasonably practicable, the health, safety and welfare at work of all their employees. The Act also extends to include all "relevant persons" such as members of the public/contractors and sub-contractors. The HSWA is an enabling act. The Management of Health and Safety at Work Regulations 1992 (amended 1999) (MHSWR) underpins the main legislation and should there be a breach of the Act this will give rise to prosecution. The Health and Safety Executive (HSE), is one of several enforcing authorities acting on behalf of HM Government. The HSE have a number of roles in addition to the enforcement of the Health and Safety at Work Act 1974 (HSWA) and the associated Regulations such as reviewing existing legislation and making recommendations for change. In turn the HSE provide information, guidance and conduct research. Environmental Health officers working for local authorities have the same powers under the HSWA as the HSE Inspectors. The Fire and Rescue Authorities are the main enforcing agents for general fire precautions under the Regulatory Reform (Fire Safety) Order 2005 (RRFSO). Fire Safety is however recognised by the HSWA.
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	1. In order to be complicit with Health and Safety at Work Regulations 1999, section 5 and the HSAWA section 7 and 37, the Trust is required to nominate a Non-Executive Director to scrutinize the health and safety performance. The Board is requested to note that Trust Chairman has recently appointed a Non-Executive Director to this role. 2. The Trust is required to recognise the Workplace Health and Safety Standards Audit progress within the Trust Annual Report for the purpose of assurance. *This is over and above the requirement set by NHS I for an

NHS Medway NHS Foundation Trust

Report to the Board of Directors

	Annual Report			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☐	☒	☐	☒

1 EXECUTIVE SUMMARY

1.1 In accordance with the Trust duties under Health and Safety at Work Act 1974, (HSAW), and the Management of Health and Safety at Work Regulations 1992, amended 1999) (MHSWR), this report looks to provide assurance to the Board on how the current framework for the management of health and safety is working and with the recognition that a significant improvement was required in several areas of the Trust as outlined in the Workplace Health and Safety Standards Audit. However, this report is able to offer assurance in the progress to date, along with a commitment to achieve the agreed deadline of 28/02/18 in the completion of the Workplace Health and Safety Standards Audit action plan, thus ensuring the Trust is able to evidence safe systems of work and the required compliances.

2 THE WORKPLACE HEALTH AND SAFETY STANDARDS AUDIT 03/01/2017 – 31/03/2017

2.1 The audit comprises the elements Plan, Do, Check, Act and considered the following key components.

Rating as at 31/03/2017	Red	Amber
The Management of Health and Safety		x
Incident Reporting	x	
DATIX	x	
Slips Trips and Falls	x	
Violence and Aggression		x
Lone Working		x
Work related stress		x
Bullying and Harassment		x
COSHH	x	
Workplace Equipment		x
DSE		x
The Workplace, Asbestos Containing Materials (ACMs)		x
The Workplace, Temperature		

Best of care Best of people

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The Workplace, Transport		
The Workplace, Electricity		
The Workplace, Noise		
The Workplace, Contractors and Sub-Contractor		
Radiation	x	
First Aid	x	
Working Time Directives		x
New and Expectant Mothers		x
Mortuary Services	x	
Laundry Services	x	
Medical Gases Storage Facilities Liquid Oxygen	x	
House Keeping		x

As at 19/10/2017	Closed	Amber
The management of Health and Safety		x
Incident Reporting	x	
DATIX		x
Slips Trips and Falls	x	
Violence and Aggression		x
Lone Working	x	
Work related stress (Induction Training)	x	
Bullying and Harassment (Induction Training)	x	
COSHH		x
Workplace Equipment		x
DSE	x	
The Workplace, Asbestos Containing Materials (ACMs)	x	
The Workplace, Temperature		x
The Workplace, Transport		x
The Workplace, Electricity		x
The Workplace, Noise		
The Workplace, Contractors and Sub-Contractor		x
Radiation		x
First Aid	x	
Working Time Directives		x
New and Expectant Mothers		x
Mortuary Services	x	
Laundry Services	x	
Medical Gases Storage Facilities Liquid Oxygen	x	
House Keeping		x

Report to the Board of Directors

3 THE WORKPLACE HEALTH AND SAFETY STANDARDS AUDIT PROGRESS

3.1 The audit status update as of the 19/10/17 is able to evidence the progress that has been achieved in the past seven months by either the closure of the identified risks or indeed the reduction of the risk from status red to that of amber.

3.2 The Health and Safety Team will continue their programme of work to ensure that the action plan is completed in full by 28/02/18.

4 COMPLIANCE IMPROVEMENT

4.1 The health and safety team will deliver a number of new initiatives to ensure greater engagement with staff. This will be achieved through various means such as; engaging training which highlights individual accountability and clear supervisor instruction. Also planned is a programme of individual service audits focusing on the suitability and sufficiency of risk assessments.

4.2 The Fire, Health and Safety Group chaired by the Acting Director of Corporate Governance is the formal group that has authority and plays a key role in monitoring the Trust's compliance with current legislation and the requirements of the HSE. The group meets quarterly. The group last met in 25/09/17 with the next scheduled meeting is the 13/12/17. If there is a serious incident between meetings, the group will hold an extraordinary meeting to address the incident to ensure a rapid response and also to ensure compliance with regulatory bodies.

5 RECOMMENDATION: THE HEALTH AND SAFETY STANDARDS AUDIT

5.1 In order to be complicit with Health and Safety at Work Regulations 1999, section 5 and the HSAWA section 7 and 37, the Trust is required to nominate a Non-Executive Director to scrutinize the health and safety performance. The Board is requested to note that the Trust Chairman has recently appointed a Non-Executive Director to this role.

5.2 The Trust is required to recognise the Workplace Health and Safety Standards Audit progress within the Trust Annual Report for the purpose of assurance. *This is over and above the requirement set by NHS I for an Annual Report

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Report to the Board of Directors

Board Date: 03/11/2017 Item No. 12c

Title of Report	**Emergency Preparedness, Resilience and Response Winter Resilience Plan Assurance 2017**
Prepared By:	Jess Scott, Emergency Preparedness, Resilience and Response Manager
Lead Director	Katy White, Acting Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Executive Group
Executive Summary	Annually the Trust Emergency Preparedness, Resilience and Response (EPRR) function within the Annual EPRR Work Plan anticipate Winter risk and use defined methodology to prepare the update of the Winter Resilience Plan to mitigate the consequence.
Resource Implications	N/A
Risk and Assurance	Winter Resilience has been added to the Corporate Risk Register (CRR-2017-003) The Winter Resilience Plan has been managed via the Integrated Emergency Management methodology and was launched via Exercise Vivaldi 2 on 12 October.
Legal Implications/Regulatory Requirements	In compliance with our duties under the Civil Contingencies Act (2004) as a Category One responding organisation.
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A

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Report to the Board of Directors

Recommendation	It is recommended that the Board of Directors accept this report for Assurance.			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☐	☒	☐	☐

1 EXECUTIVE SUMMARY

1.1 In compliance with our duties under the Civil Contingencies Act (2004) as a Category One responding organisation, annually the Trust Emergency Preparedness, Resilience and Response (EPRR) function anticipate Winter risk and use defined methodology to prepare the update of the Winter Resilience Plan to mitigate and control the consequence.

2 METHODOLOGY

2.1 The methodology applied, for the review of the Plan, is that of Integrated Emergency Management. This consists of:

- 2.1.1 Anticipation of the risk,
- 2.1.2 A review of changes to the risk profile and associated guidance,
- 2.1.3 Assessment of the risk,
- 2.1.4 Prevention strategies,
- 2.1.5 Preparation of resources and plans that are finalised by exercising in readiness for Response and Recovery; should that be required.

3 THE WINTER RISK

3.1 Winter Resilience has been added to the Corporate Risk Register (CRR-2017-003)

3.2 The Winter Risk without treatment is identified to have an initial score of (4x4) =16

3.3 The revised current score reflecting the controls as described below is (3x3) =9

4 THE WINTER RESILIENCE PLAN AS A CONTROL MEASURE

Anticipation:

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4.1 Annually, commencing each April, the Trust EPRR function anticipate Winter risk and identify lessons identified within the previous winter and look for guidance and policy changes in relation to Winter preparedness.

Assessment and Prevention:

4.2 The assessment of Winter risk allows for confirmation of those elements that fall into the prevention of risk, such as the launch of campaigns for Flu vaccination, Hand Hygiene and greater awareness of Norovirus via a plan of warning and informing staff and the public who use our services.

Preparation:

4.3 For those Winter risks that cannot be prevented the Winter Resilience Plan seeks to be the central repository of information; pulling together disparate policies, plans and guidance; such as the Surge and Escalation Plan (OTCOM010), Adverse Weather Plan (OTCCOM022), Arrangements for the Control of an Outbreak of Infection (POLCGR39), Gritting and Snow Clearance Standard Operating Procedure (SOP0158), Service Business Continuity Plans and contracted Services Business Continuity Plans, such as that of G4S (Patient Transport), to support staff in any period of response which would be managed via the Trust Significant Incident Plan.

4.4 In the preparation of the Plan, resources have been mapped and checked, such as, the stock holding of salt grit, the Trust Snow Plow, the arrangement for Mutual Aid with Medway Council 4X4 response and the arrangements for using Staff Accommodation to retain staff on site (SOP0157).

4.5 The Winter Resilience Plan maps the Single Point of Contact details for cascade to the Trust Clinical Co-ordination Centre and Directors for any Warning and Informing communication from wider resilience community; inclusive of the Met Office, Public Health England and Cabinet Office via Resilience Direct.

5 VALIDATION OF THE WINTER RESILIENCE PLAN AS A CONTROL MEASURE

5.1 The Winter Resilience Plan was launched on 12 October and was subject to a Table Top Exercise (Exercise Vivaldi 2)

Exercise:

5.2 The exercise stress tested the Winter Resilience Plan to ensure that it would stand up to the scrutiny of the Operational Staff on the subjects of Norovirus, Seasonal Influenza and High Winds with Snow Drifts, all of which had an element related to the potential reduction in the workforce as a consequence.

5.3 The structured feedback confirmed it did and additionally highlighted four areas for immediate improvement in the linked documents: These have been shared with the

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authors of each document and will be evidence as closed prior to the Trust EPRR Group (13 November).within the Exercise debrief document.

5.4 The Acting Deputy Director of Corporate Governance was invited to the Exercise to review the effectiveness of the control measure on the initial risk rating. The residual risk rating i.e. current score has been assessed and recorded as (3x3) =9

5.5 The Winter Plan was submitted to NHS I in September following approval by the Chief Executive.

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Report to the Board of Directors

Board Date: 03/11/2017 Item No. 12d

Title of Report	**Senior Information Risk Owner (SIRO): Mid-Year Report to the Board 2017-18**
Prepared By:	Beverley Adams-Reynolds
Lead Director	Katy White Acting Director Corporate Governance
Committees or Groups who have considered this report	IG Group
Executive Summary	1.1. The Trust's Information Governance (IG) toolkit closed in March with a score of 66% - satisfactory. A number of aspects had weak evidence and addressing these was factored into the IG Strategy for 2017-18 with a target to improve the performance score by between 5 and 10 percent. As at 30/09/2017 the performance achieved is 68%. 1.2. As at 09/10/2017, 80% of staff had completed IG training against the target of 95%. To support the implementation of the National Data Guardian Review, NHS Digital have introduced Data Security Awareness Training which will replace all current IG training content, once Learning and Development are able to implement it via the MOLLIE platform. This training will be in three levels and introduces senior management and Board level specific training. 1.3. Trust performance for Freedom of Information Act (FOIA) requests against the mandatory ICO target of 90% compliance continues to be poor, achieving 55% on average. The Disclosure log launched on the trust website in April this year is proving popular receiving in excess of 3,000 hits per month on average. 1.4. Data Protection Act Subject Access Request compliance is cumulatively exceeding the 85% KPI with volumes running 5% higher than in 2016-17.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

	1.5. The General Data Protection Regulation (GDPR) will ascend parliament through the UK Data Protection Bill. All organisations that process personal information must ensure a robust state of preparedness when the new Act becomes enforceable in May 2018. The Trust is currently 35% compliant against a framework spanning the breadth of the legislation. A strategy is underway to improve compliance to a satisfactory level before the legislation
Resource Implications	With the introduction of the GDPR, there is a legal requirement to have in place a quasi-independent senior Data Protection Officer. The case of need in respect of this post is currently being developed, and is likely to be within the Agenda for Change Payband 8A/ 8B.
Risk and Assurance	The IG Group provides assurance on monitoring of the IG agenda. Assurance for the trust to maintain a level 2 'satisfactory' status on the IG toolkit is assured if the following areas are confirmed: • A 95% compliance with staff completing mandatory IG refresher training • The patient experience strategy evidences compliance with NICE clinical guideline 138 Quality standard 15 statements 12 & 13 Assurance cannot be given that the trust will be 100% compliant with the incoming GDPR by May 2018, however it is unlikely that many organisations will be fully compliant by that time. The Trust is making progress in its compliance status and has risen for an initial starting position of 12% to 35% compliance as at September 2017.
Legal Implications/Regulatory Requirements	Compliance with the Freedom of Information Act, the current Data Protection Act, and the incoming General Data Protection Regulation
Improvement Plan Implication	No improvement plan implication

Report to the Board of Directors

Quality Impact Assessment	Not applicable			
Recommendation	• For the Board to note the current status of the 2017-18 Information Governance toolkit and proposed changes for 2018-19. • For the Board to note progress on the Information Governance work programme currently underway during 2017/18. • For the Board to note the current level of security breaches and near misses to date.			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☐	☒	☐	☒

Senior Information Risk Owner (SIRO): Mid-Year Report to the Board 2017-18

October 2017

1. EXECUTIVE SUMMARY

1.1. The Trust's Information Governance (IG) toolkit closed in March with a score of 66% - satisfactory. A number of aspects had weak evidence and addressing these was factored into the IG Strategy for 2017-18 with a target to improve the performance score by between 5 and 10 percent. As at 30/09/2017 the performance achieved is 68%.

1.2. As at 09/10/2017, 80% of staff had completed IG training against the target of 95%. To support the implementation of the National Data Guardian Review, NHS Digital have introduced Data Security Awareness Training which will replace all current IG training content, once Learning and Development are able to implement it via the MOLLIE platform. This training will be in three levels and introduces senior management and Board level specific training.

1.3. Trust performance for Freedom of Information Act (FOIA) requests against the mandatory ICO target of 90% compliance continues to be poor, achieving 55% on average. The Disclosure log launched on the trust website in April this year is proving popular receiving in excess of 3,000 hits per month on average.

1.4. Data Protection Act Subject Access Request compliance is cumulatively exceeding the 85% KPI with volumes running 5% higher than in 2016-17.

1.5. The General Data Protection Regulation will ascend parliament through the UK Data Protection Bill. All organisations that process personal information must ensure a robust state of preparedness when the new Act becomes enforceable in May 2018. The Trust is currently 35% compliant against a framework spanning the breadth of the legislation. A strategy is underway to improve compliance to a satisfactory level before the legislation

2. BACKGROUND

2.1. This is the mid-point 2017-18 report from the Trust Senior Information Risk Owner (SIRO) to the Trust Board as required by NHS Digital. The report highlights progress within the IG Work Programme and feeds back on areas of statutory performance oversight.

2.2. A concluding report will be submitted to the Board in March 2018.

3. RECOMMENDATIONS

3.1. For the Board to note the current status of the 2017-18 Information Governance toolkit and proposed changes for 2018-19.

3.2. For the Board to note progress on the Information Governance work programme currently underway during 2017/18.

3.3. For the Board to note the current level of security breaches and near misses to date.

4. INFORMATION GOVERNANCE WORK PROGRAMME 2017-18

Background

4.1. The Trust submitted a final position of 66% on the Information Governance Toolkit in March 2017. This denoted a 'satisfactory' level of compliance and ensured our continuing access to a secure N3 connection and data sharing facilitated through the Kent and Medway Information sharing protocol. Within this level of achievement there were a number of areas where the evidence utilised remained weak and these formed a basis for improvement for 2017-18.

4.2. The IG strategy for 2017-18 has an aim of improving the March position by between 5 and 10 percent. Improving the quality of the weaker evidence is integral to this as the toolkit will be subject to formal audit in January 2018.

4.3. As at September2017 the percentage compliance has increased to 68%, with proposed improved quality of evidence in the following areas over the coming months:

- Governance: assurance statements from Information Asset Owners (IAOs confirming compliance against a dedicated set of governance criteria
- Updated policies and guidance
- Audit compliance
- Clinical records management and
- Corporate records management

4.4. This is the last year that the toolkit will exist in its current format and contributory requirements. Version15 of the toolkit will be released for 2018-19 based on the National Data Guardian Review of 2016. Early drafts indicate greater evidential requirements around senior management responsibility and accountability, and a bias towards data security.

5. IG WORKSTREAM SUMMARIES

IG Management

5.1. An overarching IG Corporate Policy was published in 2016 (and refreshed for 2017-18), which updated the suite of IG policies and Standard Operating Procedures (SOPs). The IG Group has met quarterly chaired by the SIRO with representation from key areas of the Trust.

5.2. Compliance with mandatory training continues to remain an issue. Overarching compliance data as at 09/10/2017 as generated by MOLLIE is below, generating an overarching position of 80%. The Trust is required to evidence a 95% compliance status for the IG toolkit. Compliance with mandatory IG training is one of the areas of assurance that IAOs will be required to comment upon in their annual assurance statement to the SIRO.

Directorate	Overall % compliance
Family & Clinical Support	88%
Co-ordinated Surgical	86%
Acute and Continuing	70%
Corporate	80%
Facilities and Estates	49%

(Excluding Bank staff)

5.3. NHS Digital has recently introduced revised mandatory training to replace current IG models which focuses on *data security awareness*. Access is currently only through the E-Health learning hub for which staff must independently register to access. At the current time it cannot be pulled into the MOLLIE delivery platform. The Trust Learning & Development team is seeking clarification on whether this is feasible through other routes. The alternative will be to build new on-line training from scratch. Face to face delivery of refresher training will require revision to align to these new modules.

5.4. Concern has also been raised through the regional Strategic Information Governance Network (SIGN) as to the suitability of the content for all audiences as this is denoted as Level 1 training (levels 2 and 3 target specific audiences when released including senior and Board members). Experienced IG professionals take (on average) around 75 minutes to complete the four mandatory modules – certification is only awarded after completion of all four.

Confidentiality and Data Protection Assurance

Data sharing:

5.5. The strategic review of Information Sharing (together with Data flow mapping) has commenced to establish the legal basis for processing patient and staff personal and confidential information. The initial 150 instances of formal information sharing (via formal contractual or statutory routes) has risen to over 200, with 62% of these relationships reviewed and risk scored. Themes emerging in areas of non-compliance include data exported outside the UK and European Economic Area, lack of contracts existing with suppliers in legacy relationships and lack of SOPs for data shared under Kent based frameworks. The Trust is required to publically evidence the lawful basis for sharing personal and confidential information under the General Data Protection Regulation via the Trust Privacy Notice (albeit as a sub-page to the website).

5.6. Data flow mapping is the complementary aspect of information sharing and captures both internal and external flows of personally identifiable information. In previous years the trust evidenced a total of 332 data flows for the whole of the Trust. The Information Governance team are currently working on the returns for 2017-18 which (whilst not yet completed) have returned 774 flows. 706 of these risk assess as green, 68 are amber. We have received no red risk flows to date.

5.7. We have received full responses from:

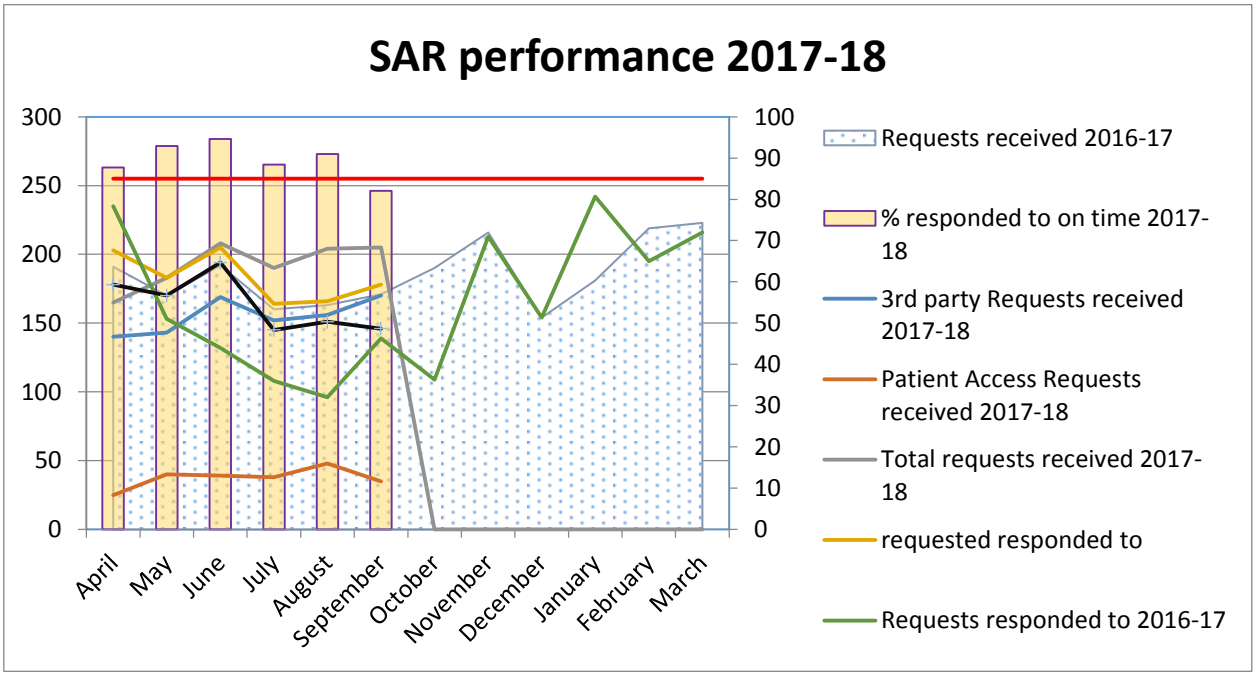
- Corporate Governance
- Risk
- Compliance & Legal
- Communications
- Health informatics
- Estates
- HR
- Director of nursing office and the
- Medical Director's office.
- A partial response has been received from finance.
- Family and clinical support have submitted seven worksheets with over 300 flows
- Acute and Continuing Care, 3 worksheets and
- Co-Ordinated surgical, 1 worksheet.

Subject Access Compliance:

5.8. DPA requests received by the Trust between 1 April 2017 – 30 Sept 2017

	3rd party Requests	Patient requests	Total Received	Total responded to*	Total responded to on time	% responded to on time
April	140	25	165	203	178	88
May	143	40	183	183	170	93
June	169	39	208	205	194	95
July	152	38	190	164	145	88
August	156	48	204	166	151	91
September	170	35	205	178	146	82
Total to date	**930**	**225**	**1155**	**1099**	**984**	**90% average**

* This figure may be more than the volume received in month because of the rolling nature of the statutory response deadline



5.9. The level of requests received is already evidencing an overarching increase of 5% on 2016-17 volumes, with a 15% increase in requests from members of the public.

5.10. A significant rise (83%) in court orders has been noted to date this year (20 to date Vs 24 in total in 2016-17). These are often received at late notice requiring immediate action to short deadlines. Police requests are running on par with 2016-17 (61 received to date this year).

5.11. The Trust has a KPI of responding to 85% within the statutory Data Protection Act deadline. In September 2016 the Trust adopted a pre-payment approach to Subject Access. There has been continued difficulty in obtaining accurate and timely finance reports since the inception of this approach, which has impacted compliance with

the 40 calendar day timescale for completion. In January 2017 Finance amended their reporting mechanism and whilst this has reduced the level of inconsistency in payment data, there still exists a delay in receiving timely and accurate data. This has been escalated with the finance team now sharing their 'debtor list' on a monthly basis which acts a reconciliation document. This process has highlighted the inconsistency of the quality of the oversight report with many cases appear on the debtors list that have not been notified to the team as having paid and placing requests immediately into a negative position in terms of timeliness. This is being worked through with the Finance team.

5.12. Under the General Data Protection Regulation the provision of the SAR service becomes free to all requesters, and the timeframe for compliance reduces to one calendar month.

General Data Protection Regulation (GDPR)

5.13. The Data Protection Bill will progress through parliament as published by the Dept. for Culture, Media and Sports in their statement of intent in August 2017. This bill will repeal the current Data Protection Act and confirm the UK's intent on adopting the GDPR.

5.14. The Trust has a strategy to achieve a pragmatic level of compliance by the time the GDPR becomes enforceable on May 25 2018. A summary of progress against the 49 areas to evidence compliance is tabled below – this has increased form the initial 12% at the beginning of the year with the majority of areas under review.

5.15. Activities RAG rated as Green signifies that the Trust is fully compliant with the requirements. Amber confirms that action has commenced but is not yet completed, and Red as not yet started or non-compliant. Please note that the revision to policy documentation cannot be published in advance of the legislation becoming enforceable, though it can completed and is currently scheduled for spring 2018.

	Sep-17		
Compliance Summary	Red	Amber	Green
Governance structure	1	0	4
Personal Data Inventory	0	4	1
Data Privacy policy	0	2	0
Embed data privacy	4	4	0
Maintain training and awareness	0	1	0
Manage information security risk	0	1	5
Manage third party risk	0	3	0
Maintain notices	0	2	0
Requests and complaints	3	0	1
Privacy by Design	2	2	3
Breach Management	0	2	1
Data Handling processes	0	1	1
Track External Criteria	0	0	1
componant elements	10	22	17
percentage compliance	35		

Information Security Assurance

5.16. In May 2017 the Board supported the introduction of a formal Information Asset Owner (IAO) Group at General Manager/ Head of Service level to strengthen management ownership and accountability of information assets within the Trust. The group has met monthly with varying degrees of attendance and engagement. Dedicated IAO training has taken place, and all IAOs will be required to submit an assurance statement to the SIRO towards the end of the calendar year confirming their compliance with a number of activities.

5.17. Weekly leaver action has been undertaken, along with email, system, building and shared folder access activity.

Audit of Access to patient information

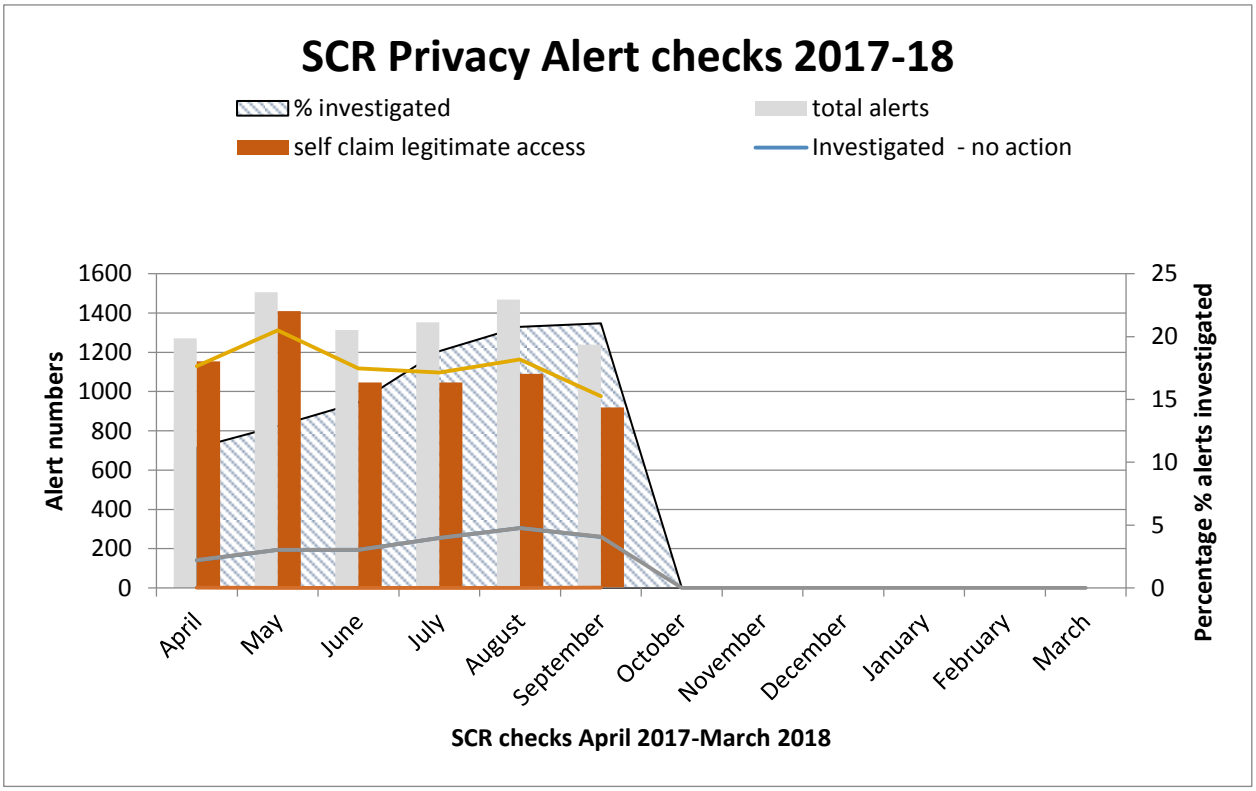
5.18. Access to patient information is on a need-to-know basis and any access must be for a legitimate reason. The Trust is required to evidence that it ensures only legitimate and lawful access to patient confidential information. In 2016-17 these audits were not executed with any consistency, and as a result a revised SOP has been produced in consultation with relevant service areas and based on approaches taken by other Trusts.

5.19. There has been one incident of staff inappropriately accessing patient records. This was referred to HR to investigate under the appropriate process and submitted to the ICO for consideration under s55 of the DPA. The ICO concluded that the action taken by the Trust in summarily dismissal was proportionate and appropriate and advised that there would be no criminal prosecution.

Summary Care Record (SCR):

5.20. Every organisation that has access to SCRs must monitor the SCR viewing activities of users. Alerts are generated on the SCR when users override the information governance controls in place. Activities that trigger an alert are:

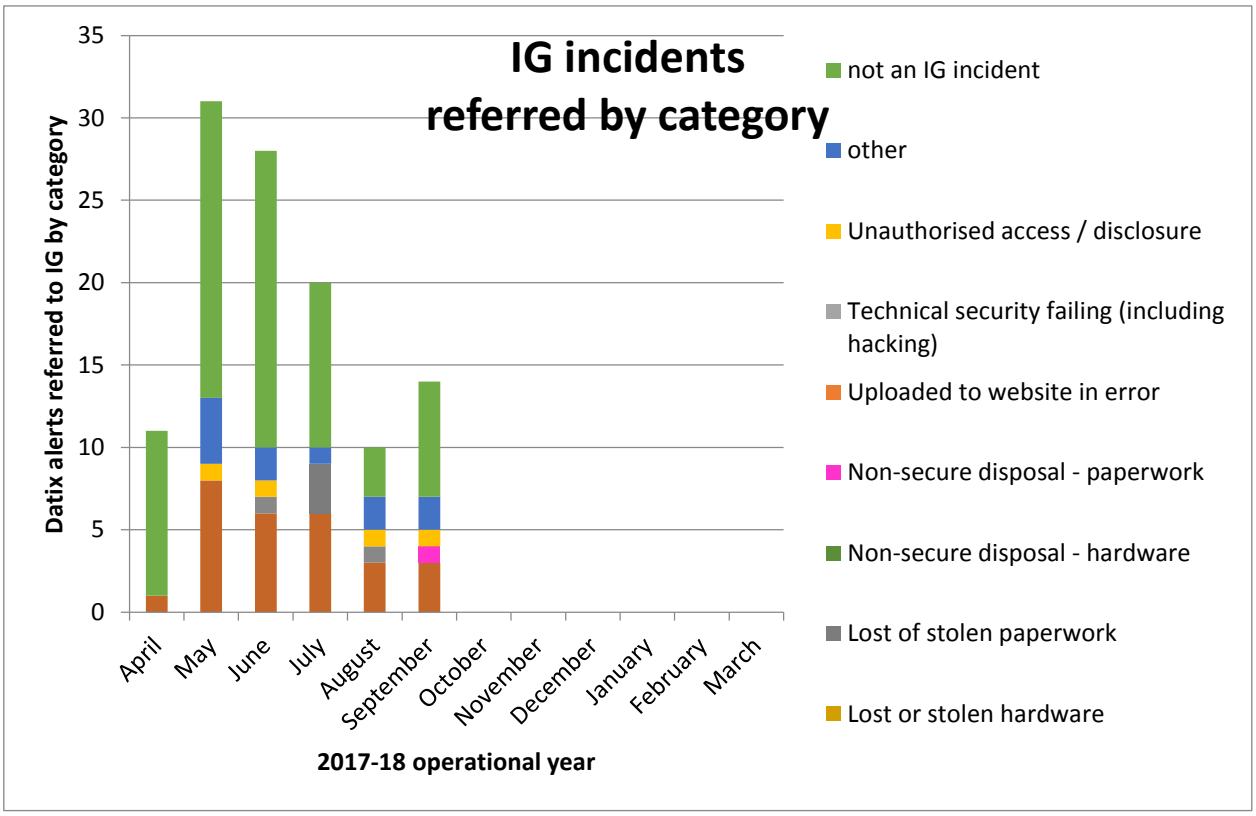
- When a clinician makes a self-declaration that there is a legitimate reason for overriding the control
- Emergency access of SCR (i.e. without gaining permission e.g. the patient is unconscious or confused)
- Within the Trust the main users are Pharmacy staff, who utilise the SCR to view current medication and allergies for patients who are admitted to the Trust.
- The Trust is required to audit a minimum of 10% of all SCR alerts – this minimum temperature check has been increased to 20% following the recent unlawful access issues.
- Very few issues are encountered; those that are can be summarised as:
    - New style NHS numbers not recognised on PAS
    - Duplicate NHS numbers
    - Duplicate patient records on PAS with different spelling of names
    - Delays in admitting patients on PAS



Reportable breaches and near misses:

5.21. A summary of breaches and near misses is tabulated below (to Sept 2017). The level of near misses has increased 62% on the same period in 2016-17, but this may be due to increased reporting and not necessarily an increase in the number of incidents.

Category	NHS digital rating	Definition	Total: April 2017 – October 2018
Serious Incident Requiring Investigation	2	Loss of multiple patient or very high sensitive patient records where the information has either not been recovered or recovered after an external breach	4
Incidents	1	A breach of confidentiality, data protection identified by a member of the public	0
Near miss	0	A loss of data within the Trust, or breach of Trust IG policy, identified by a member of staff and not a member of the public	55
Complaint	n/a	Patient complaints to the Trust about a breach of confidentiality or data protection	1



Notified themes and 'other' breach notifications:

- By far the biggest breach area is where disclosure of patient data has been made in error which includes such incidents as:
  - Allowing a patients partner to view patient data on screen
  - Sending information by text to the wrong person
  - Patient being sent home with another patient's eDN
- Notes - dropped in Trust grounds / premises
- Patient information sent to the wrong address (hardcopy)

Clinical Information Assurance

5.22. The effective management of (predominantly paper) clinical records continues to be a risk on the IG risk register. The trust has recently recruited a dedicated Medical Records Manager and takes up post in November 2017. The role currently has oversight by the General Manager of Imaging and Outpatients.

A Data Quality strategy was approved by the Board in 2016. The Data Quality Team assembled end of 2016/beginning 2017 to tackle data quality issues apparent within PAS sourced data. Since its formation, the team has developed a data quality dashboard; supporting operational staff to identify and diagnose daily reporting

errors. Collaboration with system vendors and system trainers is key to improving data processing and configuration errors to support delivery of data quality assurance at the Trust.

5.23. The Clinical tracking audit has been executed and will be incorporated into the end of year report to the Board.

5.24. Unannounced ward IG spotchecks (against an approved framework) have been executed throughout the year, with wards scoring amber or red receiving secondary visits. These spotchecks are scheduled throughout the 2017-18 operational year.

5.25. There is clear evidence of good practice throughout the process, with some wards evidencing robust compliance and others showing marked improvement on a second audit. The most improved ward being Pembroke.

	1 - Ward access	2 - Computer security	3 - Printers	4 - Paper records	5 - oral discussion	6 - org security	7 - Comms	8 - Staff	Total
Bronte	10	10	10	7	10	8	6	6	67
Byron	2	2	9	3	8	6	5	6	41
Byron 2nd audit	8	6	10	7	10	4	6	7	58
Lawerence ward	5	4	10	5	10	6	8	8	56
Tennyson Ward	4	8	8	4	4	8	4	0	40
Dickens Ward	6	9	10	9	10	8	7	6	65
Harvey ward	2	2	10	2	5	4	7	8	40
Nelson ward	8	7	10	8	10	10	8	7	68
Wakeley Ward	6	9	6	6	10	6	6	8	57
Will Adams Ward	8	10	10	10	10	8	6	0	62
Will Adams Ward #2	6	6	10	8	9	7	5	8	59
Lister ward	10	8	8	8	9	8	9	7	67
Pembroke ward	0	4	10	5	10	8	8	6	51
Pembroke ward 2nd aud	9	8	10	8	10	9	10	10	74
Penguin	10	10	10	8	6	8	4	9	65
Kent ward	4	9	10	10	10	9	10	7	69
McCulloch ward	5	7	10	7	10	5	10	8	62
Ocelot ward	5	4	7	4	10	10	10	7	57
Pearl Ward	10	10	10	9	8	9	7	8	71
Trafalgar Ward	8	7	9	6	10	8	9	8	65
Victory ward	4	3	10	4	10	6	4	8	49
Elliot ward	9	6	10	6	10	10	3	8	62
Elliot ward	5	4	10	3	10	10	4	8	54

Secondary Use Assurance

5.26. The clinical record keeping audit is underway by the Head of Clinical Effectiveness in adherence with Clinical Classifications Service requirements.

5.27. Clinical coding audit scores confirmed level 2 toolkit accuracy in March with the potential to attain level 3 for this year.

Corporate Information Assurance

Corporate Records Management

5.28. The Trust is required to evidence that it has effective systems and processes governing the management of both health and corporate information. Corporate

information is required to be classified and captured under guidance within the Information Governance Alliance Records Management Code of Practice and evidenced via an audit mechanism that requires a full audit of at least four areas of activity within the Trust on an annual basis. Details of corporate records have historically been maintained on a corporate records database contributed to by service areas, but there is no evidence that the deeper audits have ever been centrally executed.

5.29. In line with NHS Digital's 'An approach to Records Management' guidance an initial review of four areas was undertaken in quarter four of 2016-17. This review showed that effective maintenance of corporate records is not an embedded feature of Trust activities and that there had been very limited maintenance of the database. Paper records appear to be retained without reference to retention periods, with significant volume of documents continuing to be stored without review.

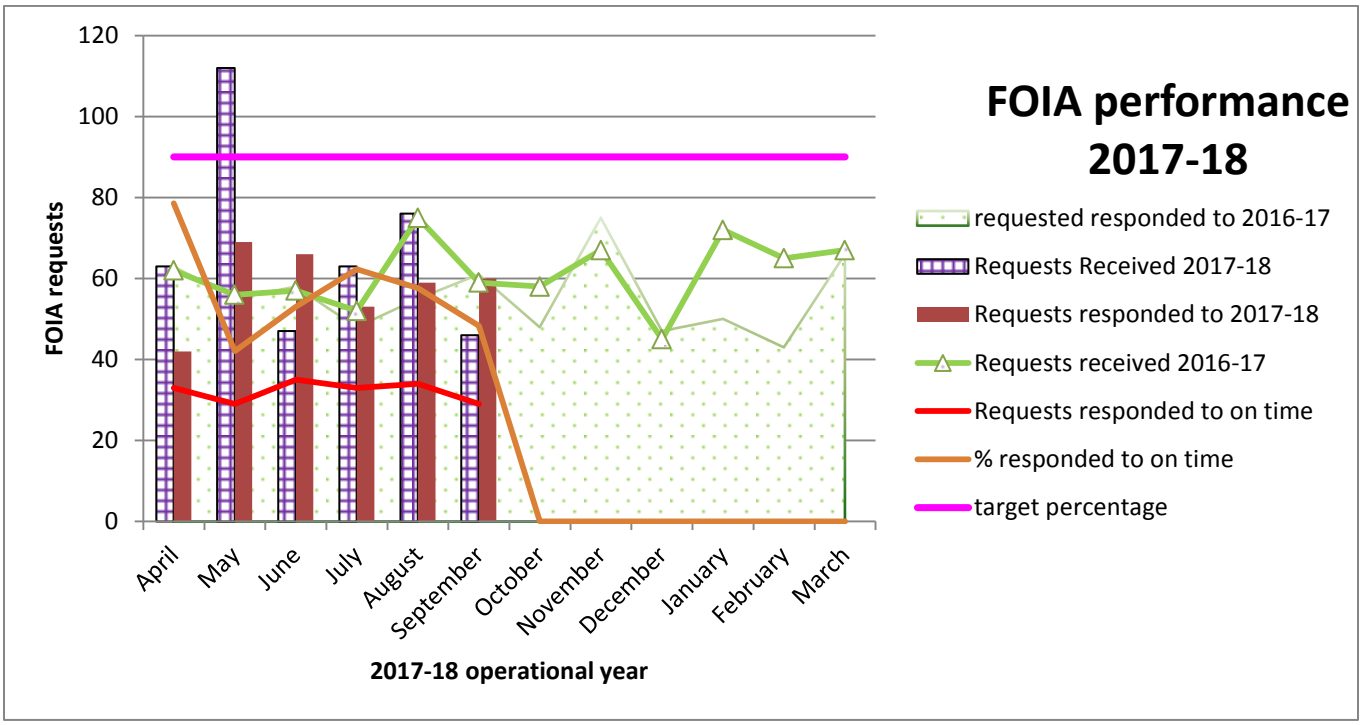
5.30. The Trust Company Secretary is the sponsor for Corporate Records and is currently reviewing the existing strategy in conjunction with the IG Manager. Currently the Trust is not able to evidence compliance with toolkit requirements, but is refreshing the existing strategy to improve compliance before the Toolkit closure in March 2018.

Freedom of Information Act (FOI) Requests

5.31. FOI requests received by the Trust between 1 April 2017 – July 2017

	Requests Received	Responded to	Responded to in time	Performance level %
April	63	42	33	79
May	112	69	29	42
June	47	66	35	53
July	63	53	33	62
August	76	59	34	58
September	46	60	29	48
Performance to date	407	349	193	55%

* This figure may be more than the volume received in month because of the rolling nature of the statutory response deadline



FOI requests volumes are running on par with volumes for 2016-17, but the complexity of them is perceived to have increased.

The Trust has a mandatory KPI set by the ICO of responding to 90% within the statutory deadline.

5.32. The Trust has received two requests for internal review by the SIRO to date, with both reviews upholding the original decision by the Trust.

5.33. With the launch of the new Trust website in April, a goal was achieved in publishing a Disclosure log under FOIA for the first time in over four years. Since its launch the webpage traffic has risen considerably:

- April: 2091hits
- May: 2886 hits
- June: 3513 hits
- July: 3032 hits
- August: 3646 hits
- September: 11,581 hits

The Trust has also achieved a further goal in maintaining transparency by publishing FOIA performance at the end of July for 2016-17, and quarters one and two of this year.

5.34. A comprehensive review of the Trust's compliance with the ICO requirements for its Publication Scheme has been undertaken, with specific reference to the requirements within the 'Definitions' document for the NHS. Compliance with this has been assessed and a project workstrand is underway to improve compliance in this area.

5.35. The first Annual Report on FOIA performance was produced in May this year (see Appendix 1) which generated the published dashboard. The report breaks down the theme of requests received, levels by directorate and volumes of refusals by exemption used. Board members may find of interest the cost analysis for FOIA for 2016-17 which although indicative, suggests that the Trust expended £33,351 to fulfil FOIA compliance.

Appendix 1

Freedom of Information Act Requests – Annual Report 2016/17

Information Governance Officer (FOIA Lead)

01 MAY 2017

NHS Medway NHS Foundation Trust

Contents

NHS Medway NHS Foundation Trust

1 INTRODUCTION

1.1 The purpose of this report is to provide an overview of FOIA performance for Medway Foundation Trust and highlight key issues over the year.

2 EXECUTIVE SUMMARY

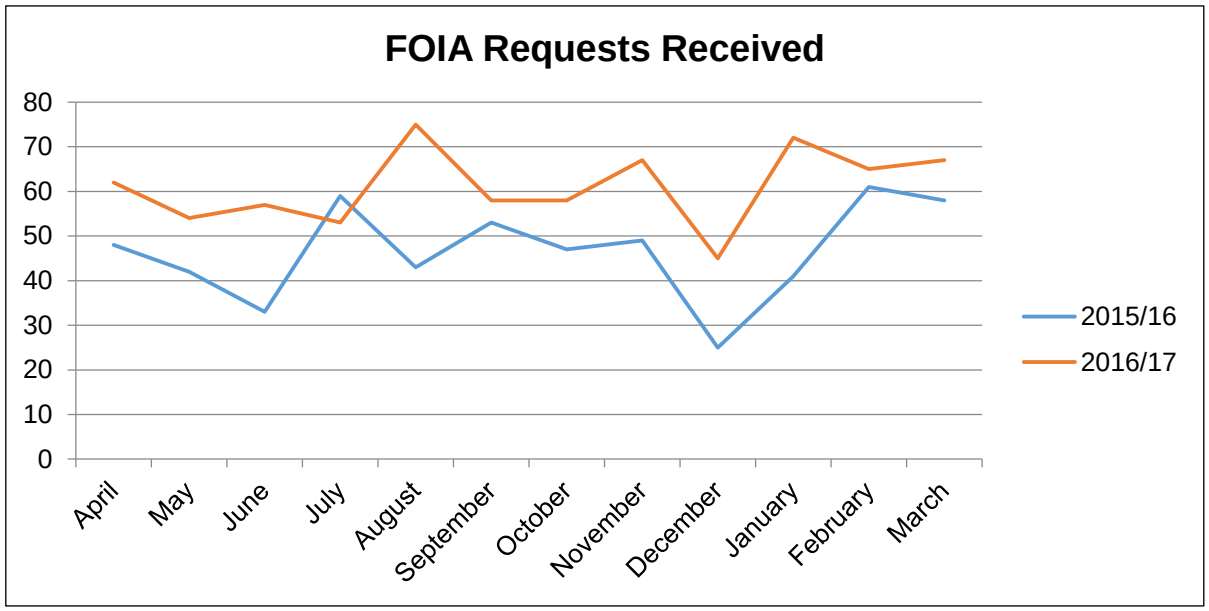
2.1 Group members are asked to note:

- The end of year average performance of 55% (370 cases) of requests disclosed within 20 working days against an 85% compliance target, and the increased compliance target of 90% for 2017/18.
- The cost pressure of FOIA requests to the Trust (see Appendix 2) estimated to be a minimum of £33,351.
- The marked increase in volumes of requests received during 2016/17, which is also reflected nationally within the NHS.
- The improvements in transparency by the publication of the Disclosure Log, upgrade of the Publication Scheme and the publication of performance.

3 PERFORMANCE 2016/17

3.1 For 2016/17 the Trust had a performance target of 85% of FOIA responses to be issued within 20 working days – this is a statutory deadline. During March 2017 the ICO increased this performance target to 90%. Neither target was achieved throughout the year.

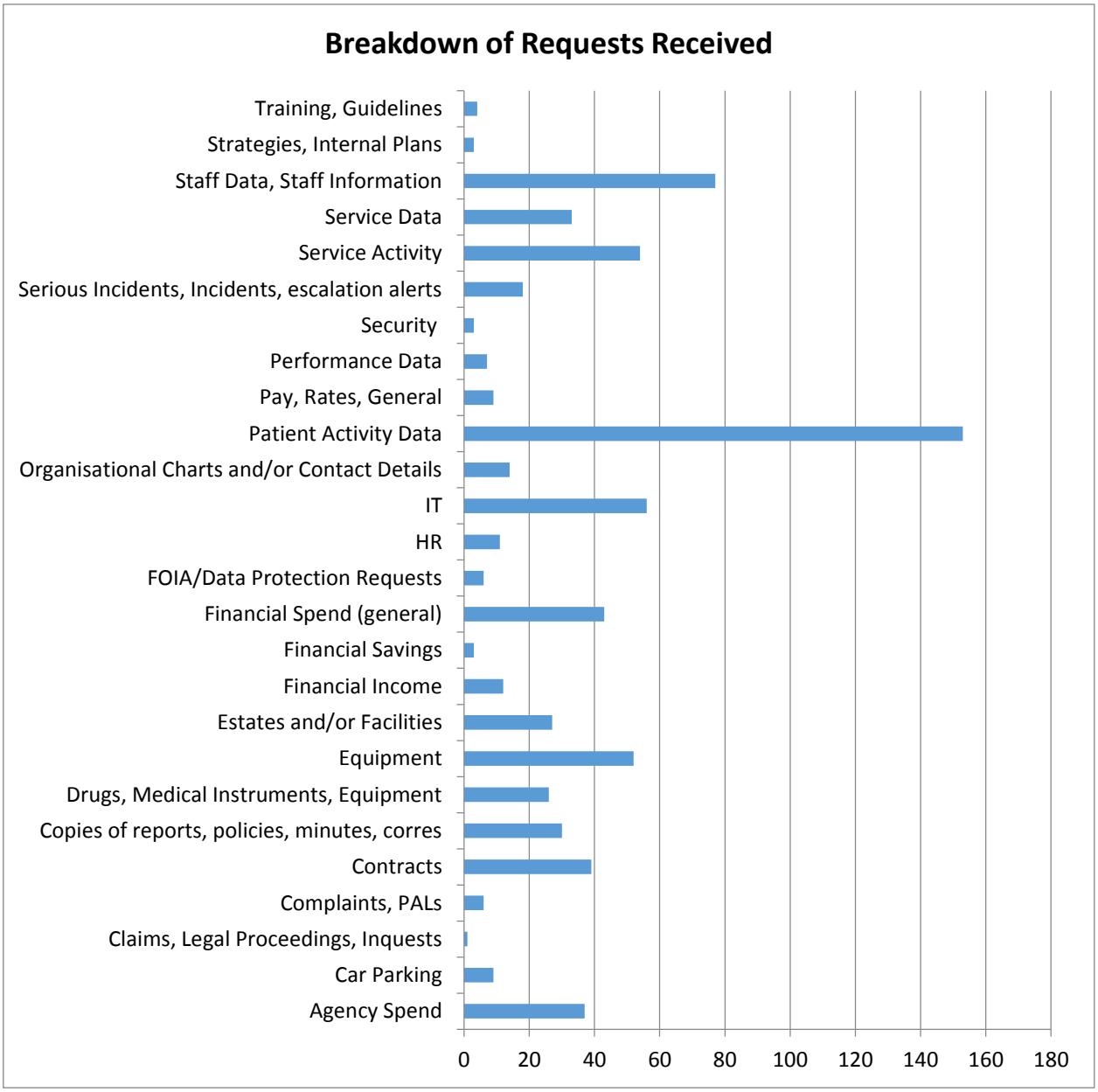
3.2 This poor performance must be set against an increase in volumes of requests as evidenced below:



3.3 Requests in 2016/17 were up 31% on 2015/16 (559 against 733) and comparative volumes in 2015/16 were similar to 2014/15 (559 against 550).

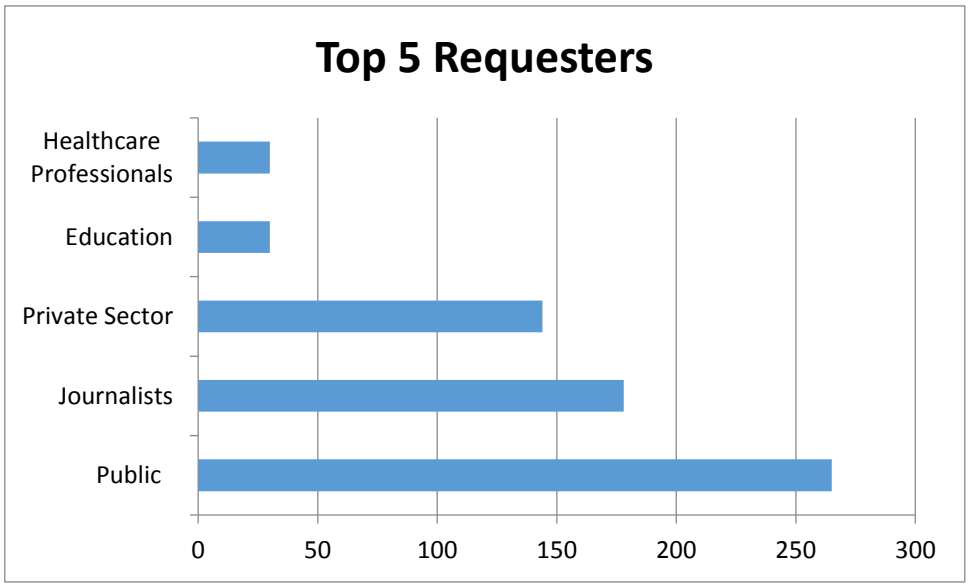
3.4 The increase in requests does not specifically relate to Medway NHS Foundation Trust, but appears to be a national occurrence with other trusts also noting the increase of requests and associated pressures.

3.5 Medway NHS Foundation Trust does not hold a breakdown by service area for previous years, however, for 2016/17 a breakdown of requests is shown below:

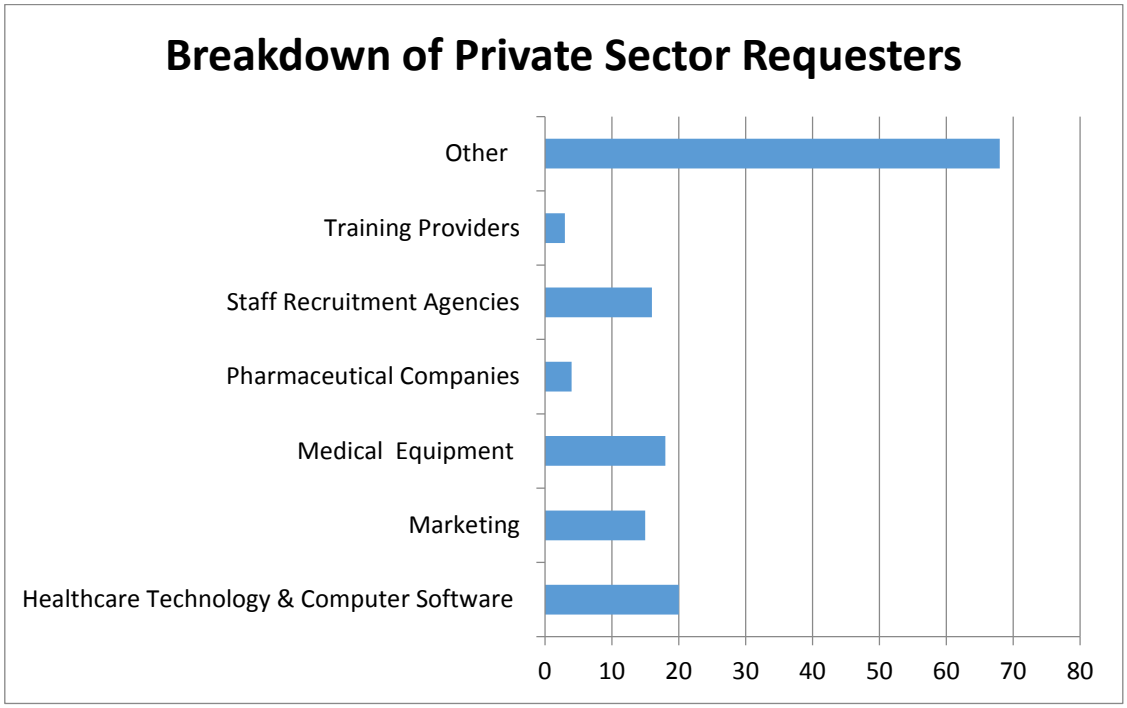


3.6 This data is caveated in that it is generated manually and therefore indicative, rather than absolute and subject to error in the interpretation of subject area.

3.7 The largest number of requesters appear to be members of the general public followed by journalists; the breakdown of the top 5 requester groups is below:

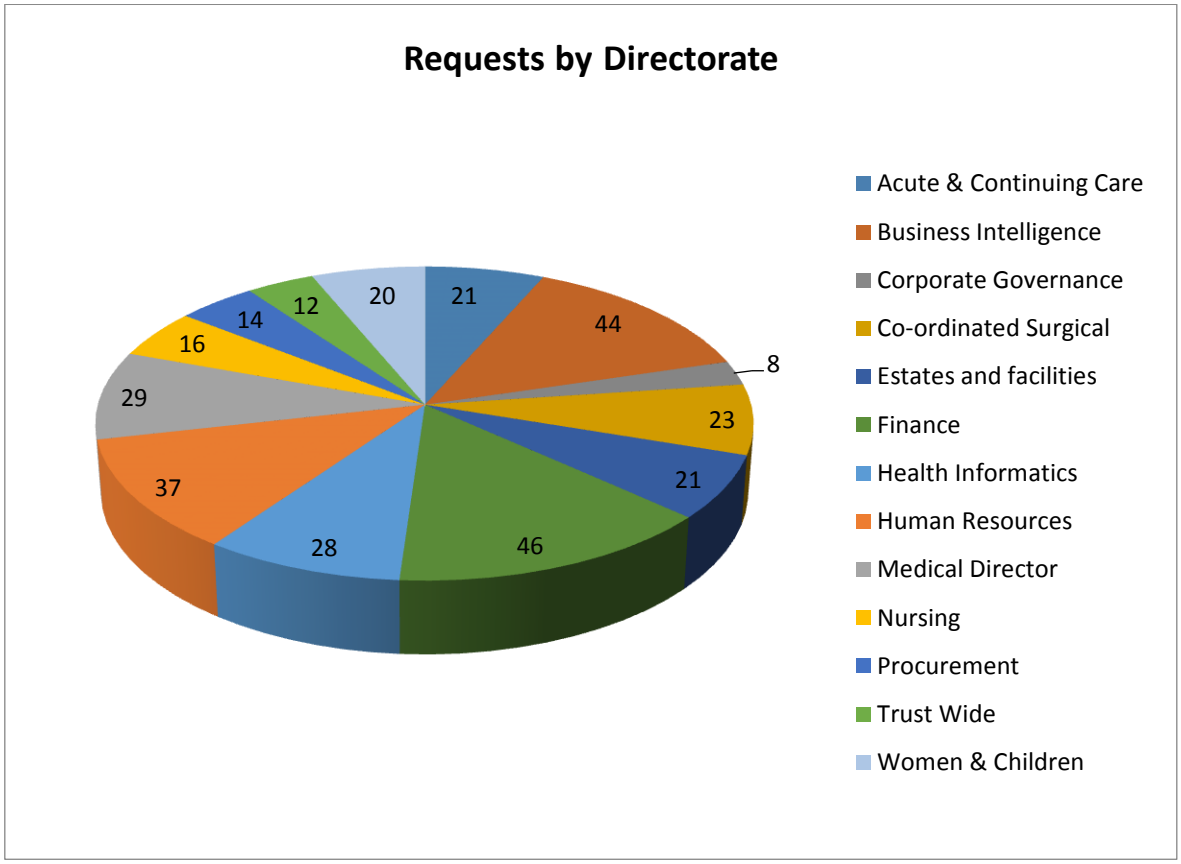


3.8 A further breakdown of private sector requesters is below:



4 KEY SERVICE AREAS

4.1 A complete record of key service area data was not collected for 2016/17 however, this data is now being collected and will be available in future reporting. It must be noted that many of the Trust's requests are complex and cover more than one specialty or service area. From the data collected, Finance, Human Resources and Business Intelligence receive the highest number of requests. This is followed by Health Informatics and the Medical Director's Office. The remaining directorates are broadly even in their requests received with the Corporate Governance Directorate receiving the lowest number. A breakdown of the data held for 2016/17 is as follows:



4.2 No compliance data for the key service areas was collated during 2016/17, although there are several services who offered responses quickly, notably Business Intelligence, Health Informatics and Corporate Governance. Finance had the highest number of responses out of time.

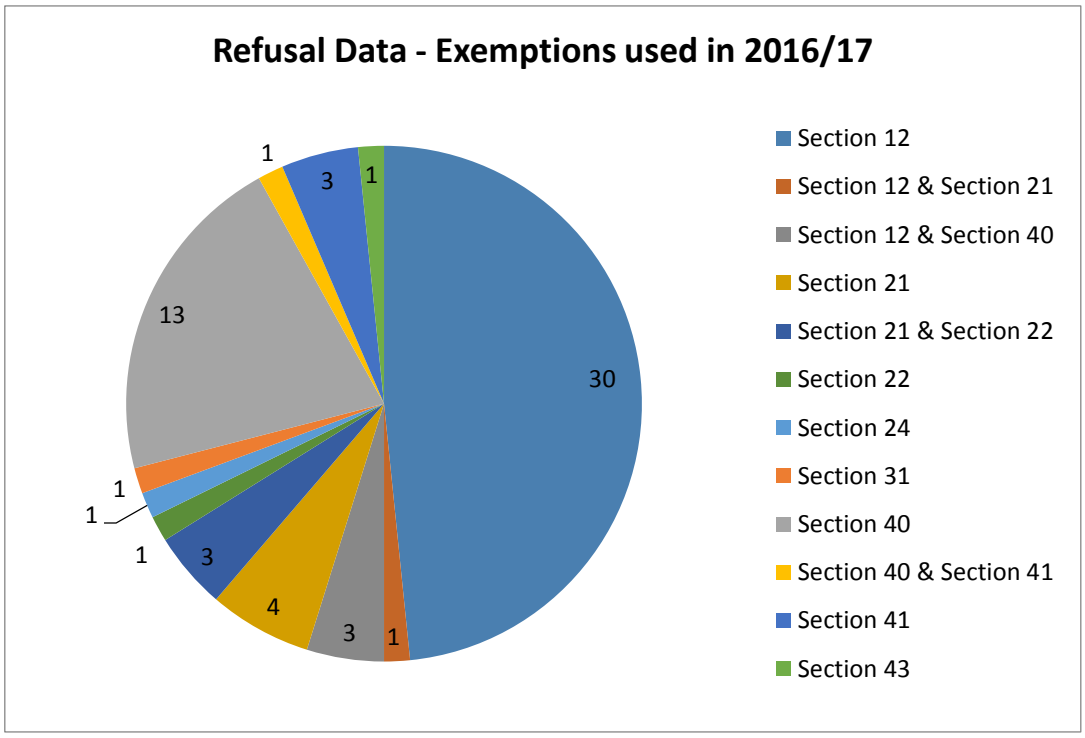
4.3 Compliance data for 2017/18 is now being collected for each area and reported on the monthly Compliance Dashboard.

5 REFUSED FOIA REQUESTS

5.1 The FOIA allows for the Trust to refuse a request, but this refusal must be accompanied by a valid exemption (with the exception of a refusal because information is not held). There are 25 exemptions in total of which 7 are 'absolute' (the Trust does not need to qualify the exemption). The remaining 18 are 'qualified' and require the Trust to execute a public interest test in that withholding the information outweighs the public interest in releasing it.

5.2 During 2016/17 there were 60 refusals, around 8% of the total requests received. 19 of these were full refusals and 43 were partial refusals, where some of the information requested was given. There were a total of eight requests that had more than one exemption applied:

- The majority of refusals (32) were refused using Section 12 – the cost of compliance exceeds the appropriate limit. This is a limit set by the ICO and equates to £450 or 18 hours work; the calculation is £25 per hour regardless of the salary paid to the officer collating the response. Wherever possible the Trust provided a limited response or advised how the requester could reduce or vary their request to bring it within the financial limitations.
- Seven refusals under Section 21 – information already available to the requester by other means.
- Two refusals under Section 22 – information intended for future publication.
- One refusal under Section 24 – safeguarding national security.
- One refusal under Section 31 – law enforcement.
- 17 refusals under Section 40 – that the information constitutes personal information
- Three refusals under Section 41 – information provided in confidence.
- One refusal under Section 43 – commercial interests and trade secrets.



6 ESCALATION

6.1 The FOIA allows for the requester to question the response issued by the Trust by way of an Internal Review (colloquially a complaint). This is conducted by the Trust's Senior Information Risk Owner (SIRO) who will review the request and the subsequent response and advise the requester whether she upholds the complaint or not, giving the reasons for her decision. If the requester remains unhappy he/she can then refer the request and refusal to the Information Commissioner's Office (ICO) for their consideration. The ICO will ask the Trust to explain its reasons for refusal and provide any evidence that may be associated with the request and after deliberation the ICO will confirm whether or not they uphold the Trust's decision and if not what the Trust has to do to correct the situation. The ICO will also publish its decision on their website.

6.2 During 2016/17 the Trust received two requests for Internal Review one of which was upheld and one of which was overturned and the information requested subsequently released. None were escalated to the ICO.

7 FINANCIAL IMPLICATIONS

7.1 Although the majority of requests received are complex and require input from a number of service areas and specialties and do cost the Trust much more, responding to straightforward FOIA request in 2016/17 is conservatively estimated as:

	Time per case	Approx. Cost 2016/17
FOI Office Administration	45mins	£ 5,497.50
Response from specialty	2hours	£20,524.00
Executive Approval	10mins	£ 7,330.00
Average cost for straightforward cases:		**£33,351.50**

7.2 For a full breakdown of costs and analysis please see Appendix 2.

8 INCREASED TRANSPARENCY

8.1 The launch of the new Trust website in April saw the publication of a Disclosure Log, which shows FOIA requests received and responses issued. It is anticipated that this may slightly reduce the number of incoming FOIA requests, which in turn will reduce the cost of processing requests internally.

8.2 In addition, during 2017-18 a project is underway to improve the quality of the Trust Publication Scheme on the Trust website.

8.3 In response to a Cabinet Office directive, the Trust is increasing its transparency by publishing FOIA performance data (see Appendix 1 – FOIA Annual Report Dashboard).

9 LEGAL IMPLICATIONS

9.1 The Freedom of Information Act is a statutory requirement placed upon all public authorities.

9.2 If a complaint is made to the Information Commissioner's Office and a Decision Notice issued against the Trust, which we then fail to comply with, the Commissioner can ask the court to look into the case. The court may then deal with the Trust as if it

has a committed a contempt of court, which is punishable by a fine. However, if there is a Criminal contempt of court, such as 'deliberately destroying, hiding or altering requested information to prevent it being released', then criminal contempt of court could mean up to a two year prison sentence for the Chief Executive.

10 RECOMMENDATIONS

10.1 The Group is asked to note the:

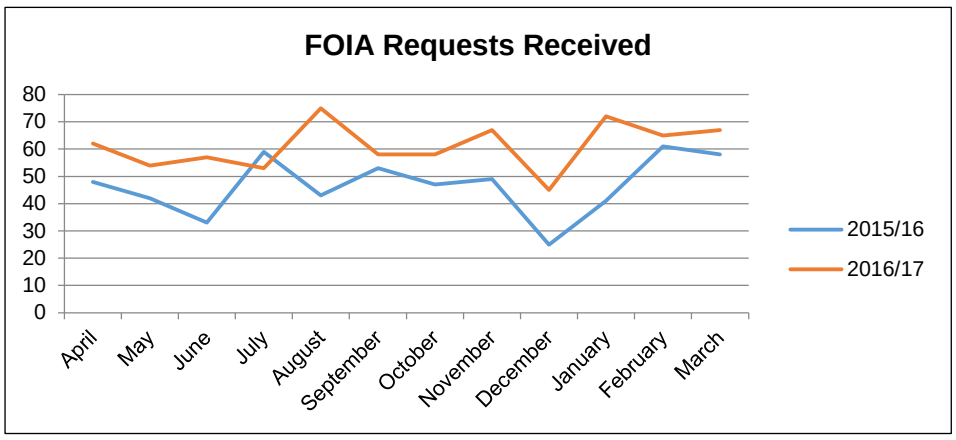
- ICO increase in compliance target to 90%.
- Increase in requests received for 2016/17
- Cost of responding to requests, both estimated on real-time costs and at £25 per hour.
- Compliance with increased transparency in publishing Trust performance data.

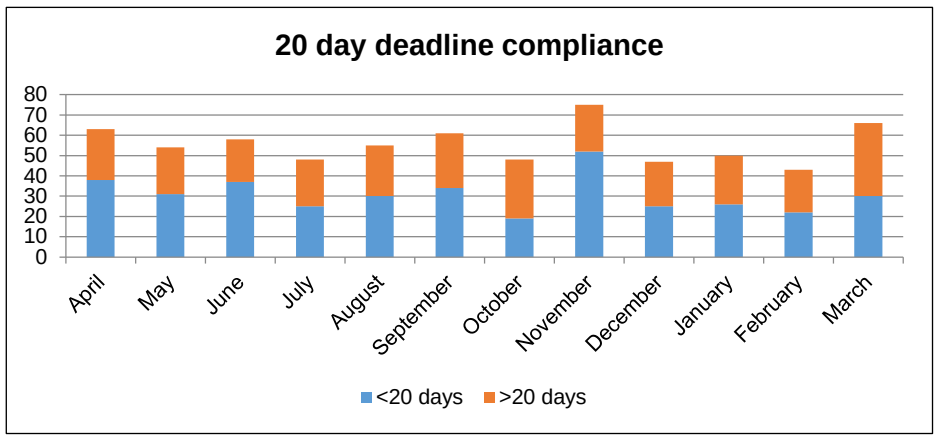
Medway NHS Foundation Trust

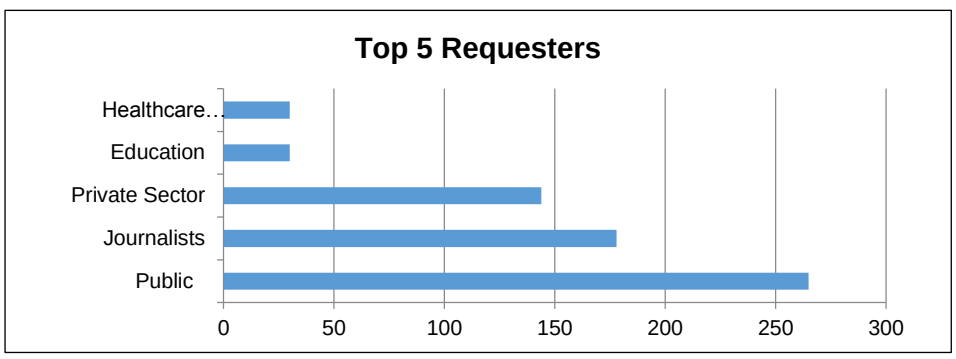
11 APPENDIX 1: FOIA ANNUAL REPORT DASHBOARD 2016/17

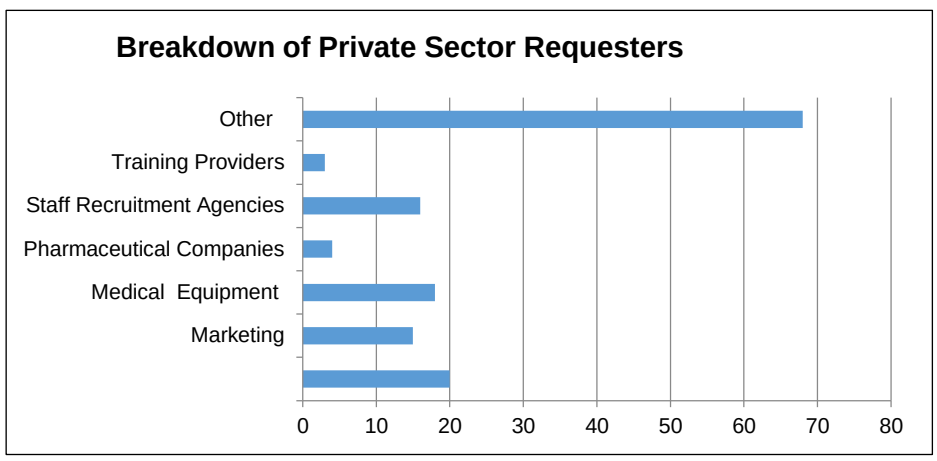
Medway NHS Foundation Trust FOIA Annual Report Dashboard 2016/17

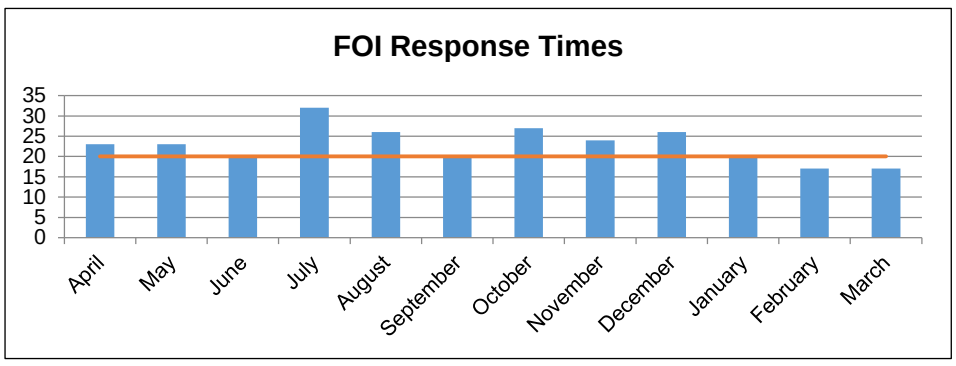
Requests Received 733	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR
Requests received	62	54	57	53	75	58	58	67	45	72	65	67
Requests responded to	63	55	58	48	55	61	48	75	47	50	43	66
Closed, withdrawn, no clarification	0	2	1	1	1	3	2	1	2	3	2	2
Pending/open	0	0	0	0	0	0	1	0	4	19	19	24
Internal Review	0	0	0	0	0	0	1	0	0	0	0	1
Complaint to ICO	0	0	0	0	0	0	0	0	0	0	0	0
Average days to respond	23	23	20	32	32	26	27	24	26	20	17	17

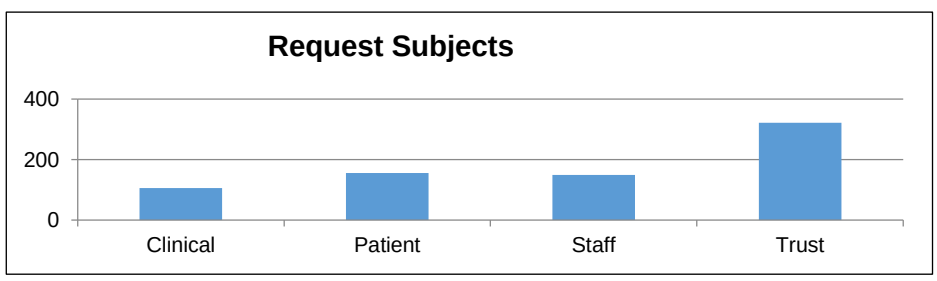


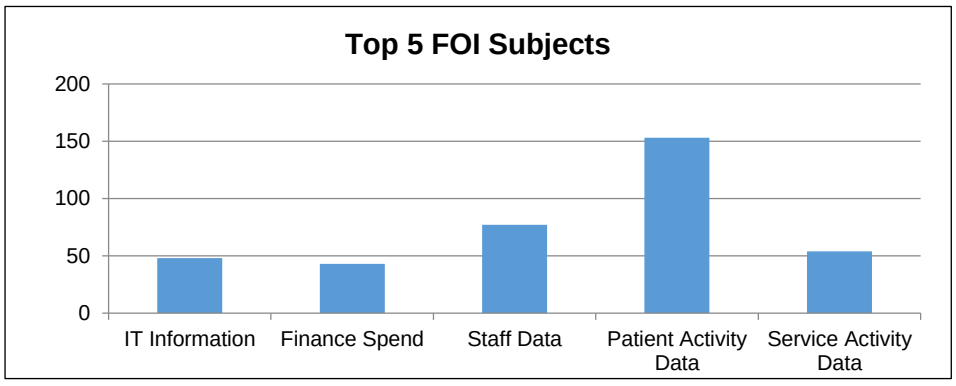


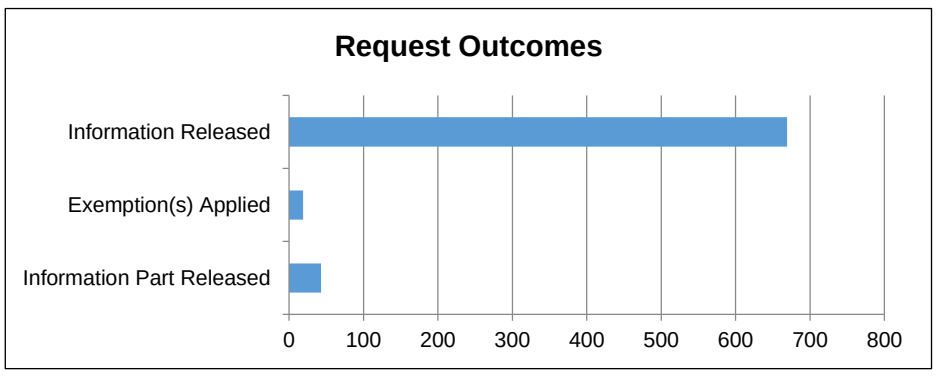


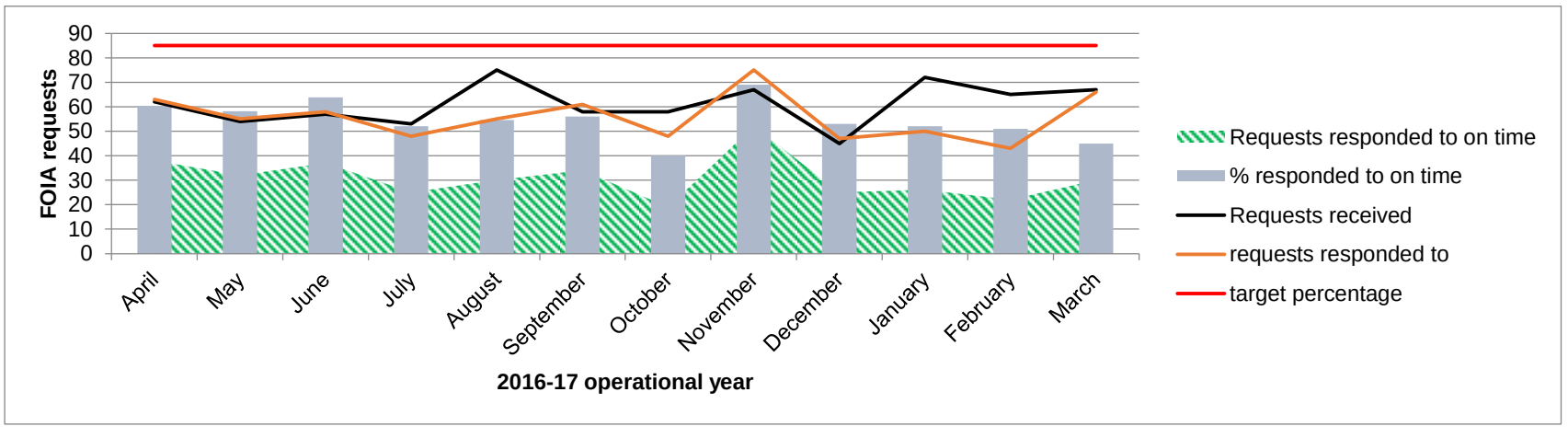












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12 APPENDIX 2: FOIA COSTINGS 2016/17

12.1 Straightforward FOIA request costing estimate based on £10 per hour for FOIA Administration, £14 per hour for directorate/speciality input and £60 per hour for Executive Approval.

	Time per case	Approx Cost 2016/17
FOI Office Administration	45 mins	£ 5,497.50
Response from specialty	2 hours	£20,524.00
Executive Approval	10 mins	£ 7,330.00
Average cost for straightforward cases:		**£33,351.50**

12.2 Estimated costing compared to the ICO's staff rate of £25 per person per hour, regardless of who does the work.

	Time per case	Approx Cost 2016/17
FOI Office Administration	45 mins	£13,743.75
Response from specialty	2 hours	£36,650.00
Executive Approval	10 mins	£ 3,056.61
Average cost for straightforward cases:		**£53,450.36**

12.3 Please note that as well as the cost pressures detailed above, there is additional business pressure on each specialty which is conservatively estimated at a total of 195 work days for 2016/17.[1]

12.4 The majority of FOIA requests received by Medway NHS Foundation Trust are complex and cover more than one service area or specialty and require input from several members of staff. Therefore the actual cost is estimated to be significantly higher.

[1] Based upon averaging 2 hours from a speciality x 733 requests received divided by a 7.5 hour day.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/11/2017 Item No. 12e

Title of Report	**NHS England Emergency Preparedness, Resilience and Response Annual Assurance Programme 2017**
Presented By:	Katy White, Acting Director of Corporate Governance, Risk, Compliance and Legal
Lead Director	Katy White, Acting Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Executive Group – September 2017 Trust Emergency Preparedness, Resilience and Response Group - August 2017
Executive Summary	Annually the Trust is requested to make an assurance submission via self-assessment to NHS England against compliance with the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework. The submission is subsequently audited by Medway Clinical Commissioning Group (CCG) who confirm back via the Local Health Resilience Partnership (LHRP) the audit outcome. The 2017 audit has confirmed the Trust Self –Assessment position that the Trust is Fully Compliant with the Core Standards. Annually NHS England includes a ‘Deep Dive’ into one area of assurance and collates evidence on best practice; which influences changes in standards via the NHS England EPRR Framework. The 2017 Deep Dive was on the subject of Governance. Following the audit the Trust Self-Assessment was amended to reflect the agreement between Medway CCG and NHS E. The Trust position was confirmed as “Not compliant but evidence of progress and in the EPRR Work Plan for the next 12 months” against two out of the six standards, with the remaining four standards being fully compliant.
Resource Implications	N/A

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Risk and Assurance	The two standards which did not achieve fully compliant are subject to inclusion on the 2017/18 Trust EPRR Work Plan as additions.
Legal Implications/Regulatory Requirements	In compliance with our duties under the Civil Contingencies Act (2004) as a Category One responding organisation and as required within the NHS England Emergency Preparedness, Resilience and Response Framework (Version 2, 10 November 2015. Gateway reference 04295)
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	NHS England has recommended that the Board of Directors support the following two activities: 1. The Trust will nominate a Non-Executive Director to hold the Portfolio for EPRR and attend the Trust EPRR Group; subsequently a Non-Executive Director has appointed to this role by the Trust Chairman 2. The Trust will include the EPRR Assurance Audit results within the Trust Annual Report.
Purpose & Actions required by the Board :	**Approval** ☒ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

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Report to the Board of Directors

1 EXECUTIVE SUMMARY

1.1 In compliance with our duties under the Civil Contingencies Act (2004) as a Category One responding organisation and as required within the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework (Version 2, 10 November 2015. Gateway reference 04295). Annually the Trust is requested to make an assurance submission via self-assessment to NHS England against compliance with the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework.

2 THE SELF ASSESSMENT

2.1 The self-assessment comprises of 85 elements which are 'Core' and annually NHS England include a 'Deep Dive' into one area of assurance and collates evidence on best practice; which influences changes in standards via the NHS England EPRR Framework.

EPRR Core Standards		Trust Self-Assessment		
Governance	4	4		
Duty to assess risk	3	3		
Duty to maintain plans	19	19		
Command and Control	6	6		
Duty to communicate with the public	2	2		
Information Sharing	1	1		
Co-operation	4	4		
Training and exercising	4	4		

Governance (Deep Dive)		Trust Self-Assessment		
Governance	6	5	1	

HAZMAT/CBRN Core Standards		Trust Self-Assessment		
Preparedness	5	5		
Decontamination Equipment	5	5		
Training	4	4		

HAZMAT/CBRN Equipment Checklist		Trust Self-Assessment		
Equipment	28	28		

3 AUDIT OF THE TRUST SELF ASSESSMENT

3.1 The submission is subsequently audited by Medway Clinical Commissioning Group (CCG) who confirm back via the Local Health Resilience Partnership (LHRP) the audit outcome.

Report to the Board of Directors

3.2 The 2017 Deep Dive was on the subject of Governance. Following the audit the Trust Self-Assessment in relation to the Deep Dive was amended to reflect the agreement between Medway CCG and NHS E.

4 THE AUDIT FEEDBACK

4.1 The 2017 audit has confirmed the Trust Self –Assessment position that the Trust is Fully Compliant with the Core Standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

4.2 Within the Deep Dive the Trust position was confirmed as “Not compliant but evidence of progress and in the EPRR Work Plan for the next 12 months” against one out of the six standards and ‘Not compliant with Deep Dive Standard and not in the EPRR Work Plan within the 12 months’, with the remaining four standards being fully compliant.

Governance (Deep Dive)		Position Agreed by NHS E post Audit		
Governance	6	4	1	1

Red	Not compliant with Deep Dive Standard and not in the EPRR Work Plan within the 12 months
Amber	Not compliant but evidence of progress and in the EPRR Work Plan for the next 12 months
Green	Fully compliant with Deep Dive Standard

Report to the Board of Directors

4.3 The audit identified and fed back on eight points of best practice within the 2016/17 EPRR Work Plan of the Trust to be shared via the Local Health Resilience Forum.

5 COMPLIANCE IMPROVEMENT CLARIFYING INFORMATION

5.1 The two areas of non-compliance as laid out by NHS England are against the following statements within the Deep Dive on the subject of Governance:

5.1.1 The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.

- The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio.
- The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report
- The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body
- The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings

5.1.2 The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report*.

- There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report

*This is over and above the requirement set by NHS I for an Annual Report.

6 RECOMMENDATION: TRUST EPRR ANNUAL WORK PLAN 2017/18 ADDITIONS

6.1 NHS England has recommended that the Board of Directors support the following two activities:

6.2 The Trust will nominate a Non-Executive Director to hold the Portfolio for EPRR and attend the Trust EPRR Group; subsequently a Non-Executive Director has appointed to this role by the Trust Chairman

6.3 It is requested that the Board of Directors approve the addition of the following two items to the EPRR Annual Work Plan, previously agreed in May 2017:

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/11/2017 Item No. 13

Title of Report	**Workforce Report**
Prepared By:	Leon Hinton, Deputy Director of HR & OD
Lead Director	James Devine, Executive Director of 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 Trust's recruitment campaigns, including national, local and international have delivered 34 candidates to-date from India via Cpl, 15 candidates to-date via HCL and 24 from other partner agency providers. The initial Philippines recruitment plan for nursing continues with a total of 197 nurses being processed for posts at MFT. Trust turnover remains static (slight increase) at 9.8%, sickness remains under 4% (continued decrease) at 3.8%, compliance with mandatory training compliance has improved to 76.3%, achievement review compliance worsened to 79%. An increase in the percentage of pay bill spent on substantive staff is reported for September (to 79% by +1%) with a decrease (of 1%) in agency usage and no change to bank usage.
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

NHS Medway NHS Foundation Trust

Report to the Board of Directors

	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.
Improvement Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).
Quality Impact Assessment	Not applicable
Recommendation	Not applicable
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

NHS Medway NHS Foundation Trust

Report to the Board of Directors

1 INTRODUCTION

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

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. The emergency department assessment day and the nursing open evening held on 12 October were both well-attended and resulted in 20 nurses being offer posts (of which 16 are newly-qualified nurses available in Apr 18). A further assessment that took place on 18 October resulted in one band 6 registered nurse (RN) accepting a job offer. There are planned recruitment activities in place for the remainder of the year including a further nursing open day on 11 November 2017, with both HR &OD and nursing colleagues attending.

2.2 Further to the collaborative regional procurement approach to International Nurse Recruitment, the Trust selected two partner providers; Cpl Healthcare (Cpl) and HCL Clarity (HCL). Cpl is working with the Trust on developing a pipeline of nurses with start dates from April 2018 onwards. To date, 34 nurses have been offered posts via Cpl.

2.3 HCL is working with the Trust to recruit 75 NMC-ready nurses from the UK and the EU. Fortnightly Skype and face-to-face interview have been scheduled up until December. Four cohorts of NMC-ready nurses have been interviewed resulting in 22 experienced nurses accepting posts. However, over the last two weeks 7 RNs have withdrawn: 3 for personal reasons; 4 accepted offers elsewhere.

2.4 The Trust is also working with two additional permanent recruitment agency providers. The Trust undertook Skype interviews with both providers over September and October resulting in an additional 24 nurses accepting posts.

2.5 The Trust has commissioned the services of HealthSectorJobs, a specialist health sector advertising company to undertake a four-week targeted nurse recruitment advertising campaign on behalf of the Trust. The campaign will commence on 23 October with the aim of securing 100 band 5 and band 6 nurse candidate applications, of which 33 are expect to convert into hires. HealthSectorJobs has agreed a shared cost risk approach to this campaign.

2.6 The international campaign in the Philippines continues. Harvey Nash, our international partner agency working on our Filipino nurse recruitment campaign, is continuing to process 197 of the Filipino nurses that remain engaged in the process (14 individuals have withdrawn and 30 individuals have failed to follow-up on the

Report to the Board of Directors

offer). We anticipate the first cohort of Filipino nurses will arrive towards of the calendar year.

2.7 The table below summarises offers made, starters and leavers for September 2017. Five of the 'registered nurse' leavers are ward-based nurses and ward-based midwives. The remainder are community midwives, school nurses, nurse consultants, nurse educators and specialist nurse practitioners. Sixteen of the 'registered nurse' new starters are ward-based staff.

Role	Offers made in month	Actual Starters	Actual Leavers
Registered Nurses	65 (25 via NHS jobs & 40 via additional recruitment activity)	20	14
Clinical Support Workers	12	11	13

(Table 1: Monthly starters and leavers)

2.8 Four consultants and nine medical training initiative doctors accepted posts in September. Additionally, 14 training doctors and 5 non-training doctors commenced in post during the month.

3 DIRECTORATE METRICS

3.1 The table below (table 2) shows performance across five core indicators by directorate. Turnover, at 9.84% (+0.21% from August), remains above the tolerance level of 8%. Sickness absence (slightly reduced to 3.76%) remains below the tolerance level of 4%.

3.2 Trust achievement review rate stands at 79% (-0.93%), below the Trust target of 85%, Mandatory training remains below target (at 76.3%, improved by 0.36%) – one directorate is now meeting the mandatory training target (no change to previous month) and two directorates are meeting the achievement review target (Estates & Facilities and Families & Clinical Support Services); 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 based on MOLLIE data have now been published to help directorates make sense of their data and support departmental planning for training. 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.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

	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%)	11%	▲		10%	▲		8%	▼		15%	▲		5%	▼		10%	▲	
Vacancy rate	22%	▼		19%	▼		15%	▲		16%	▲		10%	▶		17%	▲	
Sickness rate (4%)	4%	▼		4%	▲		3%	▲		2%	▲		5%	▼		4%	▼	
Mandatory Training (85%)	72%	▶		79%	▼		82%	▲		87%	▼		59%	▼		76%	▲	
Achievement Review (85%)	63%	▼		75%	▶		92%	▼		70%	▲		91%	▲		79%	▼	

(Table 2: Key workforce metrics)

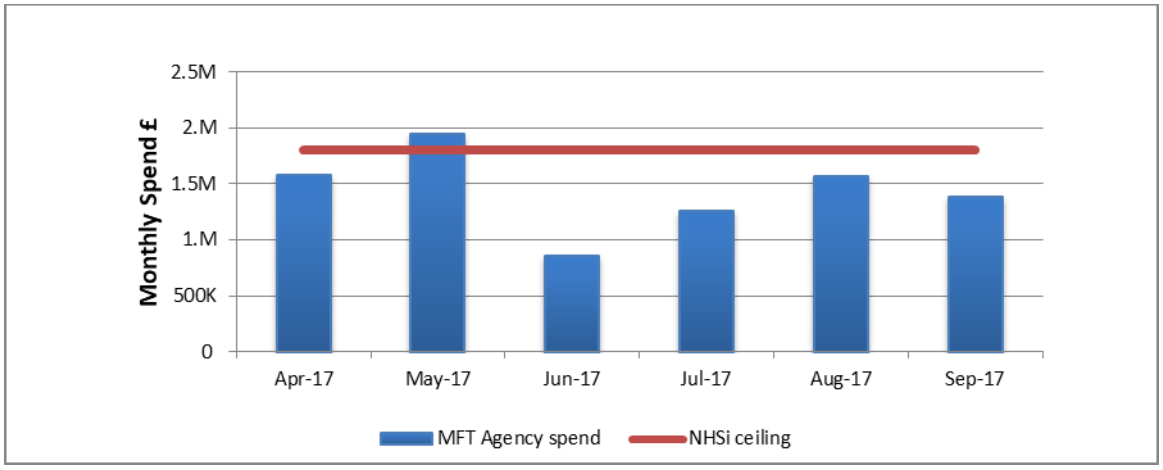
4 TEMPORARY STAFFING

4.1 Table 3 below demonstrates that temporary staffing expenditure decreased in September compared to August. However, August's increased spend can be attributed to the increase in flexible medical reliance over the peak holiday period. September's £3.8m temporary spend remains high compared to £3.1m average spend in previous months.

	April 2017		May 2017		June 2017		July 2017		August 2017		September 2017	
	Spend in month (£)	% paybill	Spend in month (£)	% paybill	Spend in month (£)	% paybill	Spend in month (£)	% paybill	Spend in month (£)	% paybill	Spend in month (£)	% paybill
Agency	2,212K	13%	1,944K	11%	860K	5%	1,256K	7%	1,571K	9%	1,380K	8%
Bank	1,057K	6%	1,214K	7%	2,047K	12%	1,830K	11%	2,440K	13%	2,307K	13%
Substantive	14,009K	81%	14,303K	82%	14,327K	83%	14,097K	82%	14,338K	78%	13,920K	79%

(Table 3: Workforce profile based on contractual arrangement)

4.2 Agency cap breaches across all staff groups for September remain fairly static. As shown in the below graph, the Trust has met the NHSI monthly ceiling consistently over the last four months.



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Report to the Board of Directors

4.3 Temporary nursing demand in September increased compared to August and was comparable to July (11,201 shifts requests in September compared to 10,119 in August) and fill rate decreased by 2% to 77%. Medical locum requests decreased by 311 shifts to 819. Conversely, the fill rate increased by 9% to 75%.

-End

Medway NHS
NHS Foundation Trust

CORPORATE POLICY: Safeguarding

Author:	Safeguarding Team
Document Owner	Head of Safeguarding
Revision No:	1
Document ID Number	POLCPCM082
Approved By:	
Implementation Date:	
Date of Next Review:	

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Medway NHS Foundation Trust
Safeguarding Policy

Document Control / History	
Revision No	**Reason for change**
1	New high level document combining adults and children

Consultation
Executive Group
Trust Board

Medway NHS
NHS Foundation Trust

Medway NHS Foundation Trust
Safeguarding Policy

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Medway NHS Foundation Trust
Safeguarding Policy

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

1 Introduction

1.1 The Safeguarding policy provides an overarching framework to co-ordinate, lead and develop services to prevent harm occurring and protect the most vulnerable Adult's and Children, embracing both acute and community services.

2 Purpose / Aim and Objective

2.1 Safeguarding children, young people and adults is everyone's business, however specialist safeguarding staff are employed in dedicated roles, and we have clear safeguarding structures within the Trust. These staff, with executive support will embed and drive the safeguarding agenda forward, provide a framework that supports best practice and allows the Trust to fulfil its key responsibilities. All Trust business and activity relating to safeguarding will follow the Trust's governance processes for oversight and monitoring purposes.

2.2 The Policy framework ensures that key compliance areas sets out how we will improve services in five key domains:

- Effective safeguarding structures and governance.
- Mainstream safeguarding children, young people and adults into everyday business
- Working in partnerships
- Learning through experience and the development of knowledge and skills for staff
- Engaging with service users

2.3 The MFT Safeguarding Assurance Group will provide assurance to the Trust Board that there are robust and effective safeguarding measures in place to execute statutory safeguarding duties

2.4 The Trust aims to 'Be the BEST' in everything it sets out to, and this extends to embedding safeguarding at the heart of how it protects and manages vulnerable patients.

3 Policy Framework

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

STRCS016 - Safeguarding Strategy 2016-2018 The strategy outlines the objectives the Trust will achieve over the next two years to strengthen its safeguarding arrangements whilst working in partnership with other key stakeholders.
Adult GUCPCM001 - Safeguarding Vulnerable Adults This document then has been developed to meet and work within the safeguarding adult lawful requirements set out within the Care Act 2014; it's supporting Statutory Guidance and the associated Schedules and Regulations.
SOP0194 - Safeguarding Adults - Making Safeguarding Referrals Explains how to make a safeguarding referral.
SOP0195 - Safeguarding Adults - Process for Applying for a Deprivation of Liberty Safeguards - DoLS Explains how to apply for a Deprivation of Liberty Safeguards – DoLS.
STRCPCM001 - Safeguarding and Protecting Children Training Strategy (1 attachment) Training required to ensure all staff in the Trust understand their role in safeguarding children and can recognise when a child is at risk and know what to do if they are concerned about a child.
Children POLCPCM055 - Kent & Medway Safeguarding Procedures Joint procedures that reflect the level of cross boundary work undertaken by many of the agencies and organisations who use the procedures. They reflect those local procedures that relate only to Kent or Medway.
POLCPCM027 - Safeguarding and Protecting Children Policy Local policy document used in conjunction with Kent and Medway procedures.
SOP0053 - Safeguarding Children - Raising Concerns Provides guidance on how to raise a concern about children.
SOP0051 - Safeguarding Children - Child Abuse Neglect Sexual Exploitation and trafficking This guidance is to support staff in the management of children who are at risk of abuse or where abuse has been identified.
SOP0050 - Safeguarding Children - Community This document is produced to assist staff working in the community to fulfil their safeguarding responsibilities.
SOP0054 - Safeguarding Children - Interagency Working This document ensures all staff know what is expected in their role particularly when working with partner agencies.
SOP0052 - Safeguarding Children - Female Genital Mutilation - FGM

Local guidance for clinicians who have direct contact with patients where this practice may be identified or where a disclosure may be made.
GUDNM228 - Safeguarding Children - Kent and Medway Female Genital Mutilation Kent and Medway guidance for clinicians who have direct contact with patients where this practice may be identified or where a disclosure may be made.
SOP0055 - Safeguarding Children - Looked After Children - Consent Explains how to obtain consent for Looked After Children.
SOP0117 - Safeguarding Children - In the Emergency Department including gangs Principles of safeguarding children in ED and information on gangs.
SOP0060 - Safeguarding Children - Useful Contacts Supplies staff with contact details of safeguarding teams both in and out of the Trust to support their work in safeguarding children.
PROCPCM001 - Safeguarding Children - Responding to Child Death Procedure Describes the mandatory process that must be followed when a child dies.
GULPCM202 - Safeguarding Children - Safeguarding Children who may have been trafficked - HM Government Home office guidance for trafficked children
GUDNM231 - Safeguarding Children on the Neonatal Unit - Neonatal Nursing Local guidance for the Neonatal Unit.

4 Roles and Responsibilities

4.1 Trust Board

4.1.1 The Care Act 2014 provides a clear legal framework for how all healthcare organisations will work in partnership with other public services, to protect adults at risk. As a statutory partner of the Kent and Medway Safeguarding Adult Board (SAB), Medway NHS Foundation Trust (MFT) has corporate commitment to safeguard our patients and our local community.

4.2 Chief Executive

4.2.1 The Chief Executive devolves the responsibility for compliance and monitoring to the Chief Nurse

4.3 Board Lead for Safeguarding Children (Director of Nursing)

4.3.1 The Board Lead is the Director of Nursing whose role it is to represent the Trust at the Safeguarding Children Board in Medway and the Health Safeguarding Group in Kent.

4.3.2 The Board lead will be responsible for senior strategic leadership and decision making on behalf of the Trust and will report to the Trust Board on safeguarding arrangements within the Trust.

4.3.3 The Board Lead will also provide reassurance to the Board that we meet our statutory requirements.

4.4 Head of Safeguarding

4.4.1 Work at a strategic level across the health and the social care community, fostering and facilitating multi-agency working and training in respect of Safeguarding Adults and Children.

4.4.2 To be the strategic lead within the Trust for safeguarding of adults and children

4.4.3 To facilitate policies and procedures related to safeguarding adults and children

4.4.4 Providing assurance reports for the Executive Lead on Safeguarding Adult and children legal compliance.

4.5 MFT Safeguarding Assurance Group

4.5.1 Medway NHS Foundation Trust has an established multidisciplinary Safeguarding Assurance Group which provides strategic direction to safeguarding activities across the Trust. The membership of the Safeguarding Assurance Group includes representatives from local Clinical Commissioning Groups and Kent and Medway Safeguarding Adult Board.

4.5.2 The Safeguarding Assurance Group provides assurance to both the Trust Board (via the Quality Assurance Committee) and the Commissioners via the Kent and Medway Safeguarding Adults Board.

4.6 Safeguarding Steering Group

4.6.1 The Children and Adult Safeguarding Group provides an operational overview to influence our strategic aims for Safeguarding services at Medway Foundation Trust. This group will share information in relation to their work plans and representation at multi-agency meetings and learning events. The group will also discuss operational issues and concerns in relation to their specific area of work, identify solutions and support mechanisms required to ensure that actions are taken to lead and execute safeguarding practices across Medway Foundation Trust.

4.7 Named Nurse Safeguarding Children

4.7.1 The Named Nurse will provide leadership at an operational level to all staff within the Trust.

4.7.2 The Named Nurse will ensure the Trust is compliant with its duties and ensure policies are in place and up dated and available for all staff.

4.7.3 The Named Nurse will ensure processes to safeguard children and young people are in place and that staff at the frontline are supported in their day to day work

4.7.4 The named nurse will represent the Trust at the Safeguarding Boards', subgroups ensuring there is good participation and information sharing when contributing to Multi agency audits.

4.7.5 The Named Nurse ensures there is a robust training programme in place to support staff in their understanding of safeguarding children and young people.

4.7.6 The named nurse will provide supervision and support to staff at the frontline on a day to day basis

4.7.7 The Named nurse ensures there are processes in place to collect data as required by the safeguarding children boards and the CCG.

4.7.8 The named nurse works closely with external partners sharing information and contributing to assessments of risk to vulnerable children and young people

4.7.9 The named nurse chairs the Trust safeguarding forum

4.8 Named Midwife for Safeguarding

4.8.1 The Named Midwife is responsible for the coordination of all cases where there are vulnerable babies

4.8.2 The named Midwife works closely with the frontline midwives in both the community and on the maternity wards, providing supervision and support on any difficult cases

4.8.3 The named midwife works closely with external partners ensuring information sharing is provided in the best interest of the babies

4.8.4 The named midwife contributes to assessments when a vulnerable woman or young person is pregnant.

4.8.5 The named midwife coordinates the maternity hub where vulnerable cases are discussed.

4.8.6 The named midwife provides information to the MARAC process when vulnerable pregnant women are discussed.

4.9 **Line Managers**

4.9.1 Line managers are responsible for ensuring that the Safeguarding Policies are implemented within their group or directorate.

4.10 **All Staff**

4.10.1 All staff are responsible for adhering to the policy and fulfilling mandatory training requirements.

5 Monitoring and Review

What will be monitored	How/Method / Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Head of Safeguarding	Director of Nursing	Where gaps are recognised action plans will be put into place

6 Training and Implementation

6.1 To support the implementation and embedding of the IG policy and procedures;

6.1.1 Mandatory e-learning training supported by face to face sessions available to all staff;

6.1.2 Bespoke training for dedicated cohorts and staff groups.

7 Equality Impact Assessment Statement & Tool

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

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

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

9 References

Document	Ref No
References:	
Trust Associated Documents:	

See framework	

END OF DOCUMENT

Medway NHS
NHS Foundation Trust

Medway NHS Foundation Trust
Corporate Policy: Human Resources and Organisational Development

Author:	Deputy Director of HR & OD
Document Owner	Executive Director of HR & OD
Revision No:	1
Document ID Number	
Approved By:	Trust Board
Implementation Date:	
Date of Next Review:	1 year after approval of Trust Board

Best of care
Best of people

Medway NHS
NHS Foundation Trust

Medway NHS Foundation Trust
Human Resources and OD Policy

Document Control / History	
Revision No	**Reason for change**
1	New document

Consultation
JSC
Executive Group

Medway NHS Foundation Trust
Human Resources and OD Policy

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Medway NHS Foundation Trust
Human Resources and OD Policy

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

1 Introduction

1.1 Human Resources and Organisational Development (HR & OD) supports Medway NHS Foundation Trust achieve the Best of Care through the Best of People. The department supports excellent patient care through the recruitment, retention and development of all employees. The HR & OD directorate also focuses on employee engagement and helps shape the culture of the Trust.

1.2 The directorate also ensures compliance with employment legislation and best practice when dealing with any workforce issues.

2 Purpose / Aim and Objective

2.1 The purpose and aim of this document is to provide an overview of the key elements of HR & OD and to identify through supporting policies and procedures the various employment legislation and local processes to which the directorate is expected to work to.

The key elements of the HR & OD Directorate are:

- HR Strategy and Planning; this includes Employee Relations, Workforce Intelligence, Occupational Health and Tiny Tugs Nursery;
- HR Resourcing; this includes Resourcing, Temporary Resourcing, Medical Resourcing and e-Rostering;
- Workforce Development and Organisational Development; this includes Medical Education, Simulation Service, Workbased Learning, Library and Knowledge Management, Organisational and Professional Development and Reception and Administration.

2.2 The objective of this document and all supporting policies and procedures is to identify, at high level and in detail, the relevant employment legislation and standards which govern the provision of HR and OD services, and to provide all Trust staff with detailed guidance, references and clarity on a range of topics relating directly to HR and OD service provision.

2.3 The Trust aims to ‘Be the BEST’ in everything it sets out to, and this extends to the management of staff who are at the heart of the Trust and its commitment to patient care.

3. Policy Framework

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

Employee Relations
Respect - Countering Bullying in the Workplace Policy (POLCHR002) **Respect - Countering Bullying in the Workplace Procedure (SOP0168)**
Grievances Policy (POLCHR003) **Grievance Procedure (SOP0249)**
Performance Management Policy (POLCHR004) **Performance Management Procedure (SOP0227)** **Probationary Period Procedure (SOP0252)** **Medical and Dental Policy for Managing Conduct, Capability and Health (PROCHR004)**
Organisational Change Policy (POLCHR005) **Organisational Change Procedure (SOP0242)**
Long Service Recognition Policy (POLCHR009)
Freedom to Speak Up - Raising Concerns at Work - Whistleblowing Policy (POLCHR014) **Freedom to Speak Up Guardians Procedure (SOP0251)**
Attendance Management Policy (POLCHR017) **Attendance Management Procedure (SOP0286)** **Attendance Management - Return to Work Form (OTCHR050)**
Worklife and Family Policy (POLCHR019a) **Flexible Working Procedure - Worklife Balance (SOP0250)** **Paternity Leave Procedure (SOP0274)** **Parental Leave Procedure (SOP0275)** **Maternity Leave Procedure (SOP0276)** **Carer Dependant Leave Procedure (SOP0277)** **Other Leave Procedure (SOP0278)** **Adoption Leave Procedure (SOP0279)**

Career Break Policy (POLCHR034) Annual Leave Procedure (SOP0287) Medical Staff Leave Procedure (SOP0290)
Managing Work Related Stress Policy (POLCHR021)
Partnership Agreement Between Medway NHS Foundation Trust and NHS Trade Unions Policy (POLCHR030)
Inclusion Policy (POLCHR044) Disability in Employment Policy (POLCHR045)
Disciplinary Policy (PROCHR002) Disciplinary Procedures (SOP0226) Bank Worker Disciplinary Procedure (SOP0320)
Exit Procedure (SOP0317)
Occupational Health
Occupational Health Clearance and Immunisations for New Healthcare Workers Guidelines (GUCGR015)
Avoidance and Management of the Effects of Latex Allergy Policy (POLCGR002) Avoidance and Management of the Effects of Latex Allergy Screening Questionnaire for Employees at Risk of Increase Occupational Latex Exposure (OTCHR037) Avoidance and Management of the Effects of Latex Allergy Procedure (SOP0237)
Prevention and Management of Tuberculosis in Health Workers Policy (POLCPCM076) Prevention and Management of Tuberculosis in Health Care Workers Procedures (SOP0241) Prevention and Management of Tuberculosis in Health Care Workers - Annual Tuberculosis Symptom Questionnaire (OTLS030)
Misuse of Drugs and Alcohol Policy (POLCHR013)
Management and Procedure for the Provision of Post Exposure Prophylaxis (PEP) following a Sharps or Blood/Body Contamination Incident (POLCS014)

Organisational & Professional Development
On Boarding - New Employee Departmental Welcome Record - Local Induction (OTCHR035) On Boarding 1 - Final Preparations for New Starter Joining the Trust (SOP0209) On Boarding 2 - MFT Welcome (SOP0210) On Boarding 3 - Role Relevant Training and NSDWR (SOP0211) On Boarding 4 - Settling and Performing into the Role (SOP0213) On Boarding 5 - Performing into the Role (SOP0214) Statutory and Mandatory Training Procedure (PROCHR006)
Apprenticeship Policy (POLCHR043)
Work Placement - Work Experience Policy (POLLHR001)
Achievement Review Guidelines (GUCHR007)
Appraisal and Revalidation of Medical Staff Policy (POLCHR037)
Study Leave and Funding Policy (POLLHR002) Study Leave and Funding Procedure (SOP0322) Applying for Funding Towards Continuing Professional Development Procedure (SOP0291) Study Leave Process for Doctors in Training (PROCHR007)
Resourcing & Rostering
Recruitment and Selection Policy (POLCHR039) Recruitment Procedure (SOP0178) Secondment Procedure (SOP0180) Disclosure and Barring Service Check Procedure (SOP0177) Managers Guide to Checking - Duty of Care - Documents (SOP0013)
Temporary Workforce Policy (POLCHR042) Temporary Workforce - Principles of Engagement Guidance (GUDCHR001)
Fit and Proper Persons Policy (POLCHR041) Fit and Proper Persons Procedure (SOP0174)
Job Evaluation Policy (POLCHR036)

eRostering Policy (POLCNM017)
Remediation of Medical Staff Policy (POLCM006)
Honorary Contracts Procedure (SOP0179)
Removal and Relocation Expenses Procedure (SOP0319)
Terms & Conditions/Contractual Terms Signposting
Employment Terms & Conditions – Local Terms & Conditions (Note)

4. Roles and Responsibilities

4.1 Trust Board

4.1.1 The Trust Board is ultimately responsible for ensuring that the Trust corporately meets its legal responsibilities.

4.1.2 The Trust Board is responsible for approving the Trust's Corporate Policy for HR & OD.

4.2 Chief Executive

4.2.1 The Chief Executive has overall responsibility for ensuring that sufficient resources are provided to support HR & OD requirements.

4.3 Executive Director of HR and OD

4.3.1 Has overarching responsibility for the effective and efficient management and delivery of all HR & OD services within the Trust and for development of policies and procedures in support of these functions.

4.3.2 Ensure that all policies and procedures are in line with relevant employment legislation and best practice.

4.3.3 Development of the Workforce Strategy that all policies and procedures underpin.

4.3.4 Advises the Board on the effectiveness of HR & OD management across MFT.

4.4 Deputy Director of HR & OD

4.4.1 Has responsibility for ensuring that Employee Relations processes are fair and thorough; following policies and procedures accordingly;

4.4.2 Ensuring that Workforce Intelligence is accurate and readily available when required. Also, to ensure that ESR and EPay are fit for purpose and utilised effectively to bring efficiency to payroll processing and workforce information;

4.4.3 Leading an effective occupational health service provision across the Trust;

4.4.4 Has responsibility for the onsite nursery, Tiny Tugs, ensuring that the service is run safely, efficiently and in line with relevant legislation.

4.5 Group Head of HR - Resourcing

4.5.1 Has responsibility for ensuring that all resourcing functions (including medical staffing and temporary staffing) processes are fair and thorough; following policies and procedures accordingly;

4.5.2 Ensure all resourcing policies and procedures are in line with relevant employment legislation and best practice;

4.5.3 Monitor all resourcing policies to ensure compliance across the Trust.

4.6 Associate Director of Workforce Development and OD

4.6.1 Has responsibility for ensuring that all Organisational & Professional Development processes are fair and thorough ensuring equity of access; following policies and procedures accordingly;

4.7 HR and OD Team

4.7.1 The whole HR & OD Team are responsible for:

- Providing expert advice and guidance to all staff on all elements of HR & OD;
- Developing internal HR and OD policies and procedures to meet employment legislation, Agenda for Change and best practice;
- Developing HR and OD awareness and training programmes for staff;
- Ensuring compliance with policies, procedures, legislation and best practice.

4.8 Line Managers

4.8.1 Line managers are responsible for ensuring that the HR & OD Policy is implemented within their group or directorate;

4.8.2 They are also responsible for seeking advice from a relevant member of the HR and OD team if they are unsure about the application of a policy or procedure;

4.8.3 Line managers should discuss any concerns they have regarding their staff with a relevant member of staff as soon as the issue arises.

4.9 All Staff

4.9.1 All staff are responsible for adhering to all HR & OD policy.

5. Monitoring and Review

What will be monitored	How/Method / Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Deputy Director of HR and OD		Where gaps are recognised action plans will be put into place

6. Training and Implementation

6.1 To support the implementation and embedding of HR and OD policies and procedures;

- Bitesize training sessions for staff on different policies will be run regularly;
- Bespoke training and coaching for managers will be delivered on an ad hoc basis.

7. Equality Impact Assessment Statement & Tool

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

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

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

9 References

Document	Ref No
References:	
Trust Associated Documents:	

END OF DOCUMENT

Employment Terms and Conditions – Local Terms and Conditions

Author:	Deputy Director of HR & OD
Document Owner:	Deputy Director of HR & OD
Revision No:	1
Document ID Number	
Approved By:	
Implementation Date:	01 October 2017
Date of Next Review:	31 August 2020

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Document Control / History	
Revision No	**Reason for change**
1	Initial publication

Consultation
Senior HR Team

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

1 Introduction

1.1 This document highlights terms and conditions of employment that are determined locally and supplements national terms and conditions.

1.2 Policies may relate to specifics in terms and conditions that should be read in conjunction. In addition, there may be specific codes of conduct, frameworks or other supplementary requirements specifically in relation to roles.

2 Purpose / Aim and Objective

2.1 To highlight local terms and conditions of service by contractual type.

2.2 To signpost employees to national terms and conditions of service.

3 National terms and conditions of service

3.1 Staff employed on Agenda for Change (AfC) terms and conditions, which includes all staff but excludes:

- executives on local pay;
- medical and dental staff;
- apprentices;
- bank staff;
- students seconded to training.

Full terms and conditions of service can be found at: http://www.nhsemployers.org/tchandbook.

3.2 Staff employed on Medical and Dental (M&D) - terms and conditions can be found at: http://www.nhsemployers.org/your-workforce/pay-and-reward/medical-staff.

3.3 Executives employed on local conditions will follow national agenda for change conditions with exception to terms governing remuneration and other terms referenced in respective contracts.

3.4 Individuals registered via the bank are issued with a letter of engagement which sets out the main terms and conditions of registration.

3.5 Non-executives contracted for services to the Trust do not have national terms and should refer to their agreement for service/appointment documentation which should cover the term (how long they will be in role), responsibilities, allowances, location of work, hours of work expected, and termination provisions including notice periods.

4 Local terms - notice periods

Contract	Notice period
AfC Bands 2 to 6	Two calendar months
AfC Bands 7 to 9	Three calendar months
Local – Executives	Six calendar months
Local – Non-executive	Equivalency with AfC banding (see contract)
M&D Consultants, SAS doctors, StR Higher (including Trust appointments)	Three calendar months
M&D FY1, FY2, StR Lower (including Trust appointments)	One calendar month
Bank staff (on assignment)	One calendar week

5 Local terms – probation period

5.1 The Trust operates a probation period policy, this can be found at: http://qpulse-drs.medway.nhs.uk/Corporate/Documents.svc/documents/active/attachment?number=SOP0252.

6 References

Document	Ref No
References:	
AfC Handbook http://www.nhsemployers.org/tchandbook	
M&D T&C http://www.nhsemployers.org/your-workforce/pay-and-reward/medical-staff	
Trust Associated Documents:	
HR & OD Corporate Policy for a list of employment related policies and procedures.	

END OF DOCUMENT

NHS Medway NHS Foundation Trust

Risk Appetite Statement to the Board of Directors

Board Date: 03/11/2017 Item No. 16

Title of Report	**Risk Appetite Statement**
Prepared By:	Fiona Egan – Acting Deputy Director of Corporate Governance
Lead Director	Katy White – Acting Director of Corporate Governance
Committees or Groups who have considered this report	Not Applicable (N/A)
Executive Summary	• The Trust Risk Appetite Statement, being due for review November 2017, was discussed at the Board Development Session on 05 October 2017, where a draft revised Risk Appetite Statement was presented, debated and the recommended changes to the risk appetite for Financial and Quality risks agreed. • Risk appetite for Financial risks was reduced from 06 (2x3) to 04 (2x2) and for Quality risks from 04 (2x2) to 2 (1x2). • The Quality Assurance Group will monitor the reduction in risk appetite for Quality risks going forward, in order to review the impact of this change. • The Revised Risk Appetite Statement is presented at Appendix 1 for Board Approval.
Resource Implications	N/A
Risk and Assurance	Within the risk appetite statement
Legal Implications/Regulatory Requirements	The Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver its strategic and operational plans and comply with the registration requirements of the quality regulator. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks.

	For Foundation Trusts, this also includes risks to compliance with the terms of authorisation. The Trust Board is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives.
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	The Board is requested to approve the Risk Appetite Statement presented at appendix 1
Purpose & Actions required by the Board :	**Approval** ☒ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

Appendix 1

Medway NHS
NHS Foundation Trust

Risk Appetite Statement

Author:	Acting Deputy Director of Corporate Governance, Risk, Compliance & Legal – Fiona Egan
Document Owner	Acting Deputy Director of Corporate Governance, Risk, Compliance & Legal – Fiona Egan
Revision No:	2
Document ID Number	OTCGR176
Approved By:	Trust Board
Implementation Date:	03.11.2017
Date of Next Review:	04.11.2018

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Medway NHS
NHS Foundation Trust

Risk Appetite Statement

Document Control / History	
Revision No	**Reason for change**
2	Revised document

Consultation
Board Development Meeting

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Risk Appetite Statement

1 Risk Appetite Statement

The Trust Board has considered and agreed the principles regarding the risks that Medway NHS Foundation Trust is prepared to seek, accept or tolerate in the pursuit of its objectives.

As a Trust which has exited quality special measures with its regulators and moving through a dynamic phase of rapid improvement, the Trust Board has taken a cautious view regarding the risks that it is prepared to take in terms of risks to quality and patient safety, compliance and regulation, reputation, workforce and external stakeholders.

In recognition of a challenging financial climate, the Trust Board has taken a view to reduce its risk appetite for financial controls.

In all these areas the Trust expresses a preference for safe delivery options that have a low degree of risk and which may only have a limited potential for reward.

Alternatively, the Trust Board has set a high appetite for innovation, indicating an open approach and willingness to consider all potential delivery options while also providing an acceptable level of reward, (value for money).

This Statement sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds therefore supporting delivery of the Trust's Risk Management Strategy and Policy.

The Board understands that there is a balance to be maintained between key risk areas and that sometimes risks in some areas will need to be taken to manage risks to an acceptable level in other areas. The Trust's risk management framework requires that where the Trust's risk appetite is exceeded the risk review governance process includes:

- scrutinising the adequacy of mitigating actions and controls
- agreeing the timeline for bringing the risk within the acceptable risk tolerances
- monitoring progress
- determining any further actions and escalation routes if needed

2 Finance

Until such times as financial sustainability is re-established, the Trust's strategy will be based mainly on low-risk opportunities and on a highly controlled basis. The Trust is cautious in accepting the possibility of some limited financial loss. Value for money is still a primary concern.

3 Compliance and Regulation

The Trust has been, and continues to be under regulatory scrutiny, having been rated "Requires Improvement" by the Care Quality Commission. The Trust is keen to move at pace on its "Better Best Brilliant" Programmes of improvement, as this is key to optimising

quality and financial sustainability and the Trust takes a minimal or avoidance approach to risks that will compromise this.

The potential for non-compliance with legal and statutory requirements undermines public and stakeholder confidence in the Trust and therefore the Trust has minimal appetite in relation to these risks. The Trust has a preference for safe delivery options rather than risk breaching legislative and regulatory obligations.

4 Innovation

The Trust has greatest appetite to pursue innovation and challenge current working practices in terms of its willingness to take opportunities where positive gains can be anticipated and it supports the use of systems and technology developments within service delivery. The Trust is eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risks). The Trust is supportive of innovation, with demonstration of commensurate improvements in management control. It supports the use of information and patient management systems and technological developments being used to enhance operational delivery of current operations.

The Trust will consider risks associated with innovative technology and research and development approaches to enable the integration of care, development of new models of care and improvements in clinical practice to support sustainability.

5 Reputation

The Trust recognises that patient confidence and trust in the organisation is important for good outcomes. The Trust therefore has a moderate appetite for risks that may cause reputational damage and undermine public and stakeholder confidence. The Trust's tolerance for risks relating to its reputation is limited to those events where there is little or no chance of **significant** repercussions for the organisation.

The Trust will maintain high standards of conduct, ethics and professionalism and will not accept risks or circumstances that could cause reputational damage to the Trust and/or the wider NHS.

6 Quality and Patient Safety

The Trust is responsible for ensuring the quality and safety of services it delivers. The provision of high quality services is of the utmost importance to the Trust and the Trust has low appetite for risks that impact adversely on quality of care. The Trust is strongly adverse to risks that could result in non-compliance with standards of clinical or professional practice, unintended outcomes or poor clinical interventions. The Trust has low appetite for options that impact on patient safety, the Trust will avoid taking risks that will compromise patient safety.

Risk Appetite Statement

7 Workforce

The Trust will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual or a team's competence to perform roles or tasks safely, nor any incidents or circumstances which may compromise the safety of any staff member or group.

The Trust will only tolerate lower substantive staffing levels where there is visible competent leadership, a robust management plan is in place and prevailing shortages of staff are supported by trained and competent temporary staffing to keep within safe staff numbers.

For patient safety, quality care and service and financial sustainability reasons the Trust is willing to consider risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.

8 External Stakeholders

The Trust has a greater appetite to seek out opportunities and take greater inherent risks for higher rewards in pursuit of partnership development and collaborative working where this is considered advantageous to the Trust or wider health economy through implementing sustainability and transformation plans.

9 Good Governance Institute – Risk Appetite Descriptions

Appetite Level	Described as:
None	**Avoid**: the avoidance of risk and uncertainty is a Key Organisational objective.
Low	**Minimal** (as little as reasonably possible): the preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious**: the preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	**Open**: willing to consider all potential delivery options and choose, while also providing an acceptable level of reward (and Value for Money).
Significant	**Seek**: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk. **Mature**: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Risk Appetite Statement

10 Risk Appetite Summary Table

The diagram below summarises the Trust's risk appetite across these domains.

Domain	Appetite	Consequence	Likelihood	Score (trigger level)
Financial/Value for money	Moderate	2	2	4
Compliance and regulation	Moderate	2	2	4
Innovation	High	3	3	9
Reputation	Moderate	3	2	6
Quality and Patient Safety	Low	1	2	2
Workforce	Moderate	2	2	4
External Stakeholders	Moderate	3	2	6

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Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Quality Assurance Committee held on 27/10/2017

Report to:	**Trust Board**	**Date of meeting: 27 October 2017**		**1**
Presented by:	**Jon Billings** **Chair, Quality Assurance Committee**	**Prepared by:**	**Jon Billings** **Non-Executive Director**	

Matters for escalation

- QAC proposes to begin development work for defining a quality model to underpin "Best of Care'. A quality dashboard showing trends in key areas will be developed to support this.
- A review of clinical and quality governance groups will be underway shortly.
- Learning from review of Clostridium *difficile* cases to date: need for continued vigilance in relation to avoidance measures, especially rigorous antimicrobial stewardship and hand-hygiene. Targeted communication plan will highlight team and individual responsibilities in this area.
- Learning from a review of recent MRSA outbreak: continued education and training from IPCT regarding avoidance measures and outbreak protocols; regular floor-walks with nursing leadership and IPCT; need to continuously seek opportunities to improve the fabric of some ward areas - but this is a complex challenge due to the need to create decant capacity.

Other matters considered by the committee:

- Update on elevated rates of haemolysation and cross-contamination of blood samples in ED – improvement plan in place including enhanced training for staff. To be monitored via QIG.
- Audit of elective and emergency caesarean sections – report to QAC requested by Board. It was good practice to have undertaken the audit and useful recommendations have emerged. Some assurance provided that the CS rates at Medway is similar to other centres, but discussion highlighted the need for further work to relate audit findings to neonatal outcomes and drill-down in some areas such as verifying diagnosis of foetal distress.
- Safeguarding quarterly report:
  - Need identified to do some work around 'transition' between child to adult safeguarding processes.
- CQUINs – improved performance reported and expected to show in next monitoring report.

Best of care Best of people

	• Trust Quality Risks >12 – The three risks discussed include: medical staffing, nursing staffing and flow. All three are subject to concerted improvement plans. • QIG key issues – main focus had been on improving Serious Incident review position. • Programme of work.
Key decisions made/ actions identified:	• Develop a definition of 'quality' to underpin 'Best of Care' • Instigate a targeted communication plan regarding C. *difficile* avoidance. • Explore options for enhancing the fabric of some ward areas to promote effective infection prevention and control • Periodic report to be commissioned pulling together thematic learning from complaints, coronial determinations, SIs and legal claims. • Mirror the Board with alternate formal and developmental meetings.
Risks:	• There is a need to take stock of risk register risks relating to the estate and infection prevention to ensure there is adequate read-across and prioritisation where these issues coincide.
Assurance:	Due to the proximity of the QAC meeting to the board, it was not feasible for the IQPR presented at the Board meeting to have been previously reviewed. However, many of the issues discussed at QAC relate to key areas reported in the IQPR. The co-directors of quality have been asked to work with the trust secretary to recommend the optimum sequencing of QAC in relation to board and other key governance fora.

Key Issues Report

Medway NHS
NHS Foundation Trust

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

Name and Job Title of Member	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Insert name and job title												
Ewan Carmichael, NED & Chair until September 2017				✓	✓		✓					
Jon Billings, NED & New Chair				✓	x		✓					
Vivien Bouttell, Governor Representative				x	✓		✓					
Lesley Dwyer, Chief Executive				✓	x		✓					
Diana Hamilton-Fairley, Medical Director				x	x		✓					
Martin Nagler, Patient Representative				✓	✓		✓					
Karen Rule, Director of Nursing				✓	✓		✓					

Best of care
Best of people

Key Issues Report

Medway NHS Foundation Trust

From a meeting of Finance Committee held on 26/10/2017

Report to:	**Board of Directors**	**Date of meeting:**	**03/11/2017**
Presented by:	**Tony Moore Chair Finance Committee**	**Prepared by:**	**Tracey Cotterill, Director of Finance**

1

Matters for escalation

1. The standard reporting pack was reviewed and the risks relating to income and directorate forecast positions were discussed. Discussed that the optimistic approach to income recognition was now accumulating. M7 will reflect billed activity (instead of accrued income) based on the Trust's view of the achievable level of income within the current system constraints. This is likely to have an adverse impact on income reported ytd, with the impact felt in month 7. It was agreed that there would need to be communication with governors to update them.
2. The directorates are forecasting adverse variances to plan, and there are a number of transformation schemes being implemented to reduce future months' run-rate. These schemes aim to impact in the latter months of the current year, but the full benefit will be felt in 18/19 and will assist with delivery of the control total for that year.
3. Discussion was held relating to the difference between the control total (£46,851k deficit) and the planned position of £37,846 deficit, with STF being the differentiating element. The committee was advised on the importance of separating the plan from the control total as STF is partially linked to performance, and failure to achieve STF does not equate to missing the control total.
4. Cash – the cash position has been increasingly pressured, but invoices relating to year end balances are now being paid, some aged debt is being collected, and additional working capital funding has been approved by NHSI.
5. ED Development – the programme was discussed and a paper has been included in the Private Board pack to update on slippage to the timeline.
6. STP programme costs were discussed and this has been escalated to the Private Board for approval. It was suggested that the Board write to the STP lead expressing our concern as to the programme costs, and stating the support that the Trust hopes to receive from its investment.
7. Board Assurance Framework – Corporate Risk on delivery of the control total was discussed and a recommendation is made to Board to consider changing the likelihood score from 3 to 4

	recognising the mitigations in place may take longer than the current financial year to be effective.
Other matters considered by the group:	8. Month 6 performance as reported to NHSI 9. The Finance Committee received reports on a number of key financial matters. a. Financial position YTD and Forecast Outturn, including risk adjusted scenarios. b. CIP progress – including a quarterly profile review c. Contract performance including update on the contract workplan and Q1 CQUINs 10. STP Financial Principles were reviewed and a copy of these has been provided to Private Board. 11. North Kent Pathology Service progress update 12. KPIs for the procurement department were reviewed and it was noted that NHSI have invited the Trust to meet to look at further savings opportunities. 13. Board Assurance Framework – all risks associated with the financial position had been updated prior to the meeting 14. The Trust has been selected for a review of the reference costs submission 15. The Trust was invited by the Model hospital team to be part of the pilot for the corporate costs collection 16. The committee was updated on the meetings that will be taking place with NHSI over coming weeks to provide assurance on the financial position for both 17/18 and 18/19.
Key decisions made/ actions identified:	17. Position will be reviewed at M7 to advise the Board regarding year end forecast for the Q3 submission. 18. Escalation process for Directorates that are off track for financial performance to attend FC.
Risks:	19. The Income plan contains a number of risks which will start to be recognised in month 7 and may affect the ytd position against plan. 20. The CIP schemes are behind plan, and the clinical divisions will overspend if they continue on the current trajectory. 21. The Finance section of the Board Assurance Framework was considered with a recommendation to Board on likelihood score.
Assurance:	Assurance was provided on; 22. Income and activity reviews have led to improvements in the

process controls

23. Progress with the financial recovery plan through use of Carter model hospital, SLR and the transformation programme.
24. Risk identification and risk management under the BAF
25. ED project compliance with specifications
26. Management of Debt
27. Liquidity with additional cash expected into the Trust
28. Costing, following the engagement of a managed service provider
29. Procurement performance particularly in relation to the Carter metrics

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 03/11/2017 Agenda item: 19

Title of Report	Charitable Funds – Statement of Financial Position as at 31st July 2017
Prepared By:	Tony Moore, Non-Executive Director
Lead Director	Tony Moore, Non-Executive Director
Committees or Groups who have considered this report	Charitable Funds Committee
Executive Summary	The attached Statement of Financial Position was presented to the last charitable funds committee and is now presented to Board. A verbal report will follow of the key issues.
Resource Implications	.
Risk and Assurance	
Legal Implications/Regulatory Requirements	
Improvement Plan Implication	
Quality Impact Assessment	

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Recommendation				
Purpose & Actions required by the Board :	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒

Medway NHS Foundation Charitable Funds

Statement of Financial Position
as at 31st July 2017

	Unrestricted Funds	Restricted Funds	Total 2017/18
Fixed Assets			
Investments	539,446	116,301	655,747
Total Fixed Assets	**539,446**	**116,301**	**655,747**
Current Assets			
Stocks	0	0	0
Receivables	-185	9,325	9,140
Short Term Investments And Deposits	0	0	0
Cash At Bank And In Hand	232,679	-14,696	217,983
Total Current Assets	**232,494**	**-5,371**	**227,123**
Creditors: Amounts Falling Due Within One Year	6,219	1,254	7,474
Net Current Assets	**6,219**	**1,254**	**7,474**
Total Assets Less Current Liabilities	**226,275**	**-6,625**	**219,649**
			0
Creditors: Amounts Falling Due After More Than One	0	0	0
Provisions For Liabilities And Charges	0	0	0
Net Assets	**765,721**	**109,676**	**875,396**
Funds of the Charity			0
Endowment Funds	0	0	0
Restricted	0	81,696	81,696
Unrestricted	793,700	0	793,700
Total Funds	**793,700**	**81,696**	**875,396**