Medway **NHS**
NHS Foundation Trust

PUBLIC MEETING OF THE TRUST BOARD
THURSDAY 24 NOVEMBER 2016, 1.30pm – 4.00pm
BOARDROOM, POST GRADUATE CENTRE, MEDWAY MARITIME HOSPITAL

Time	Item	Subject	Presenter	Format	Action
1.30pm		CQC Trust Wide Presentation	Chief Executive	Presentation	For Noting
		OPENING OF THE MEETING			
	1.	Chair's Welcome	Chairman	Verbal	For Noting
	2.	Quorum	Chairman	Verbal	For Noting
	3.	Register of Interests	Chairman	Paper	For Noting
		MEETING ADMINISTRATION			
	4.	Minutes of the previous meeting held on 27 October 2016	Chairman	Paper	For Approval
	5.	Matters Arising Action Log	Chairman	Paper	For Noting
		MAIN BUSINESS			
	6.	Chair's Report	Chairman	Verbal	For Noting
	7.	Chief Executive's Report	Chief Executive	Paper	For Noting
	8.	Trust Recovery Plan	Kevin Tallett	Paper	For Noting

	9.	Finance and IQPR
		    a) IQPR Report
		    b) Clinical Operations Report
		
		    c) Chief Quality Officer
		    d) Medical Director
		    e) Director of Nursing
		    f) Director of Workforce
		    g) Director of Finance Report
		    h) Director of Corporate Governance, Risk, Compliance & Legal Report
			
			Chief Quality Officer
			Clinical Operations Director
			
			Chief Quality Officer
			Medical Director
			Director of Nursing
			Director of Workforce
			Director of Finance
			Director of Corporate Governance, Risk Compliance & Legal
				Papers	For Noting

	10	Risk & Corporate Governance:
		Plan for Approval :
		    a) Winter Resilience Plan
		
		Corporate Policies For Approval :
		    b) Consent Policy
		    c) Health & Safety Policy
		    d) Violence & Aggression Policy
		    e) Medicines Management Policy
		    f) Estates & Facilities Policy
		    g) Finance Policy
		
		Corporate Governance for Noting :
		    h) Corporate Risk & Assurance Framework
			
			Director of Corporate Governance, Risk Compliance & Legal
			
			Director of Corporate Governance, Risk Compliance & Legal
			Medical Director
			Director of Finance
			Director of Finance
			
			Director of Corporate Governance, Risk Compliance & Legal
				Papers	

	11	Access Policy and NHS IST	Chief Quality Officer	Verbal	For Noting
	12	Communications Report	Director of Communications	Paper	For Noting

		FURTHER INFORMATION ITEMS			
	13	Single Quality Oversight Committee Report	Chief Executive	Paper	For Noting
	14	A&E Delivery Board Report	Chief Executive	Paper	For Noting
	15	Quality Assurance Committee Report including Minutes : Quality Assurance Committee : 20/10/16	QAC Chair	Paper	For Noting
		AOB			
	16	AOB	Chairman	Verbal	For Noting
	17	Questions from members of the public relating to the Agenda	Chairman		
		CLOSE OF MEETING			
		Date of next meeting: 26th January 2017 Boardroom, Post Graduate Centre, Medway Maritime Hospital			

MEDWAY NHS FOUNDATION TRUST

REGISTER OF INTERESTS FOR BOARD MEMBERS

1.	Patricia Bain Director of Health Informatics	• Director of Qualitas Independent Consultancy Ltd • Specialist Advisor CQC • Associate Consultant Capsticks Legal • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
2.	Rebecca Bradd Director of Workforce	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
3.	Ewan Carmichael Non-Executive Director	• Timepathfinders Ltd • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
4.	Darren Cattell Interim Director of Finance	• Director and shareholder of Mill Street Consultancy Limited • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
5.	Stephen Clark Non-Executive Director	• Pro-Chancellor and chair of Governors Canterbury Christ Church University • Deputy Chairman Marshalls Charity • Chairman 3H Fund Charity • Non-Executive Director Nutmeg Savings and Investments • Member Strategy Board Henley Business School • Business mentor Leadership Exchange Scheme with Metropolitan Police • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Chair of the Medway NHS Foundation Trust Integrated Audit Committee
6.	Lesley Dwyer Chief Executive	• Member of the Corporate Trustees of Medway NHS Foundation Trust Charitable Funds
7.	Diana Hamilton-Fairley Medical Director	• Director of Education Transformation at Guy's and St. Thomas' Hospitals NHS FT • Member of London Clinical Senate Council • Elected Fellows Representative for London South for RCOG • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
8.	Martin Jamieson Non-Executive Director	• Director, Lightpoint Medical Ltd • Senior Adviser, ArchiMed Private Equity • Non-Executive Director – C-Major Ltd • Strategic Planning Consultant, Rocket Medical Pl • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
9.	Anthony Moore Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
10.	Joanne Palmer Non-Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
11.	Karen Rule Chief Nurse Designate	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
12.	Jan Stephens	• Trustee of Medway Youth Trust

	Non Executive Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
13.	David Rice Company Secretary	• Director and shareholder of Shooters Hill Management Co Limited

PUBLIC MINUTES OF THE BOARD OF DIRECTORS MEETING HELD ON THURSDAY, 27 OCTOBER 2016 AT 1.30PM IN TRUST BOARDROOM, MEDWAY MARITIME HOSPITAL

Present:	Mr. M Jamieson, Chairman
	Dr. D Hamilton- Fairley, Acting Chief Executive
	Mrs. G Alexander, Director of Communications
	Dr. T Bain, Chief Quality Officer
	Ms B Bradd, Acting Director of Workforce
	Mr. E Carmichael, Non-Executive Director
	Mr. D Cattell, Interim Finance Director
	Mr. S Clark, Non-Executive Director
	Dr. K Mukherjee, Acting Medical Director
	Mrs. J Palmer, Non-Executive Director
	Mrs. K Rule, Director of Nursing

In attendance:	Mrs. M Dalziel, Director of Clinical Operations, Acute & Continuing Care Directorate
	Mr. T Emeakaroha, (Energy and Sustainability Manager) (Presentation only)
	Ms. E McCallum, (The Trust R&D Manager) (Presentation only)
	Mr. K Tallett, Director of Programme Management Office (item 8 only)
	Mr. D Rice, Trust Secretary
	Mr. D Small, Interim Head of Procurement (item 11 only)
	Ms. K White, Head of Integrated Governance

Apologies:	Mrs. L Dwyer, Chief Executive
	Mr. T Moore, Non-Executive Director
	Mrs. J. Stephens, Non-Executive Director

Observers:	Mrs. D King, Governor Board Representative
	Members of the public/staff/Governors (6)

QUALITY INSIGHT – TRUST'S ENERGY AND CARBON EMISSION RESEARCH PROJECT

Dr. Emeakaroha gave a presentation on the Trust's strategy to reduce energy costs and carbon emissions. The Trust spent around of £2.5m per annum on utilities and this relate to a carbon footprint of 14,500 tonnes of carbon dioxide. At the current time the costs for annual consumption of electricity was £675k, gas £1.35m and water £420k.

Cost savings could be achieved by ensuring that the various types of energy were supplied by one provider which could lead to reductions of cost relating to £500,000 per annum. A more innovative approach was to work with local universities like those of Greenwich and Kent in the development of energy research projects.

Dr. Emeakaroha explained that under ISO 50001: 2011 Energy Management Standard, it was set out that there were four potential areas on which to focus the strategy; procurement, technological, information and people solutions.

Sub-metering of the whole Trust which would involve metering on a ward basis was being considered but there were issues which complicated this process including determining the base line data and the inability to detect hidden costs. There was also no means of obtaining real time data from various wards. Research focused on technological and people based solutions which included:

- Hardware and software applications which related to monitoring energy wastage;
- Having a dedicated Medway NHS Trust Interface to monitor energy usage;
- Mobile energy alerts for ward managers;
- Testing of software applications to ensure detailed base line data; and
- Developing a model to understand staff's use of energy.

The research collaboration with the University of Greenwich would aim to:

- Save 20% on utilities per year (approximately £491,387.29);
- Reduce the Trust's Carbon Footprint per year by 2,900 tonnes;
- Attract collaborative funding;
- MFT would be the first Trust to lead a collaborative PhD initiative in the Estates Engineering Department; and
- The funds saved could be used to improve patient care.

EC queried the expected timetable for the initiative and it was explained that the project was at its initial stages and a Memorandum of Understanding had been signed with the University of Greenwich but there was no proposed date from which the savings would start to benefit the Trust. Dr Edyta McCallum confirmed that the Trust had secured funding from the University of Greenwich for a PhD student who will be working at the Trust under the supervision of Dr Emeakaroha.

The Chairman asked when the Trust was likely to see a reduction in its energy costs and TE explained that the objectives of the project should start to be realized in around two years' time.

DK queried whether staff and the public were to be made aware of the initiative and it was agreed that this should be followed up in due course.

The Chairman queried whether the targeted 20% saving of £491,387 quoted in the presentation included all the Trust's utilities and this was confirmed as correct.

DC suggested that the Board would find it helpful to have regular updates and the Chairman suggested that these could be provided by the PhD student.

16/10-01   WELCOME AND APOLOGIES FOR ABSENCE

1.1   The Chairman welcomed everyone to the meeting. Apologies had been received from Lesley Dwyer, Tony Moore and Jan Stephens.

16/10-02   QUORUM

2.1   The Chairman confirmed that a quorum was present.

16/10-03   REGISTER OF INTERESTS

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

16/10-04   MINUTES OF THE PREVIOUS MEETING

4.1   The minutes of the meeting held on 29 September 2016 were APPROVED for signature as a true and accurate account of the meeting subject to minor amendments.

16/10-05   MATTERS ARISING – ACTION LOG

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

16/10-06   CHAIRMAN'S REPORT

6.1   The Chairman noted that Shena Winning had resigned as Chair on 14th October and the Board wished her well in her future activities. Mr Jamieson explained that as Deputy Chairman he would be managing the Board until an Interim Chair had been appointed. NHSI had been informed and were helping to find a replacement. An experienced individual had been identified who had previously lead a mental health trust to foundation trust status.

6.2   The individual had met with the Acting Chief Executive and the Deputy Chairman would be meeting with the Chief Executive the following week and there would be a meeting of the Governors Nominations and Remuneration Committee ("the Committee") following the Board meeting that day to consider the terms of appointment for the Interim Chair. On the basis that the outstanding interviews were successfully concluded the individual could take on the role of Interim Chair within two or three weeks.

6.3   The Chairman explained that the Committee would also be considering the profile of the substantive Chairman. It was expected that the person appointed would be spending two days per week at the Trust, that the salary would be within a pre-determined range and also live in the local community. An external agent would be selected by the Committee to source some external candidates but applications from internal candidates would also be welcomed.

6.4   The Chairman noted that it should be stressed to external applicants that the Trust was is a stable position with an effective management team.

16/10-07   CHIEF EXECUTIVE'S REPORT

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

- The "ED Corridor" had been closed by the Trust, with patients awaiting an ED cubicle now being located in the former CDU site which gave them more privacy.
- The Trust went into black escalation on 20 September 2016.
- Additional mental health liaison support provided by Kent & Medway NHS and Social Care Partnership had improved access and the patient experience with improved ED flow.
- There was continued delivery of the Trust's Referral to Treatment (RTT) and the 62 day cancer improvement trajectories with above-peer benchmark achievement of ambulance handover times.
- The Hospital Standardised Mortality Ratio (HSMR) stood at 100.19 which was a considerable achievement being within benchmarked limits and significantly the Trust was providing this improved level of service 7 days a week.
- Angela Helleur from NHSI would be helping with preparations for the forthcoming CQC inspection.
- The new junior doctors would be employed using the new terms and conditions for NHS Doctors and Dentists in Training (England) 2016 as published in July with effect from October 2016.
- There had been reference to the Trust in the cases of two former employees who had been criminally charged and it had been made clear that the individuals would never be re-employed by the Trust.

- The Trust was the first in the country to screen the film "Starfish" which highlighted the issues around Septicaemia and the importance of early detection and there would be further work with the Sepsis Trust.
- The new bereavement suite would be opened by the Countess of Wessex on 1 November.

7.2   Further to a question from EC regarding what improvements had been made regarding mental health liaison support, DHF confirmed that there were now beds which were specifically ring-fenced in Beaverbrook which avoided potential delays. MD noted that there was also greater transparency for the matters to be raised with the Mental Health Trust.

16/09-08   TRUST RECOVERY PLAN

8.1   The Board noted the paper from Kevin Tallett, Director of the PMO. KT explained that the PMO had made good progress during October and there was positive engagement by staff. The PMO had developed processes and started to carry out a range of assurance activities. There were less than five weeks until the forthcoming CQC inspection and the progress was on target and the Financial Recovery programme had moved from a conceptual phase towards delivery and implementation. KT welcomed questions from the Board.

8.2   The Chairman noted that it was important to ensure that there was a consistent approach cross the Executive team, the non-executive directors and governors. KT agreed, noting that this had been highlighted on the previous CQC visit which had stated that there was not a consistent approach as to how the non-executive directors held the Executive team to account and, whilst considerable work was carried out by the Governors, they did not have unified voice.

8.3   The Acting Chief Executive noted that Angela Helleur from NHSI had offered to work with the non-executive directors and Governors to help them to understand the approach of the CQC and what questions they were likely to ask and DK appreciated this offer.

8.4   KT distributed a handbook directed at providing background information to the non-executive directors and governors about the forthcoming CQC inspection and it was agreed that there should a focus on the level of preparedness at the private Board meeting in November.

8.5   KW noted that Governors and non-executive directors would be attending Focus Groups with the CQC to provide their views of the Trust.

16/10-09   FINANCE, QUALITY & PERFORMANCE REPORTS

9.1   The executive directors presented their reports which were included in the Board pack. The Carter Dashboard highlighted the results of the key performance areas which was a summary of the full Integrated Quality & Performance Report.

9.2   The Chief Quality Officer outlined the status in relation to serious incidents (SIs) which had been raised as a concern at QIG with ten being reported during September. There were 59 open SI's identified which was 19 more than for the same period in the previous year. There was an increase in SIs relating to treatment delays and pressure ulcers but fewer relating to maternity and ED. Swarm events had been arranged for pressure ulcer incidents with falls and nutrition identified as topics for the next two events. The increase in SI reporting reflected a more rigorous identification process through better handovers and monitoring of

complaints which were picked up on a weekly basis with all 52 week breaches receiving a clinical review.

9.3 A "never event" had been reported this month; the incident had involved the insertion of a Vascath into a patient prior to surgery. The stiffening wire that is used to aid insertion was left in the device. The wire was enclosed within the device and therefore could not be dislodged or have harmed the patient, however, after consultation with NHSI it was confirmed that this met the criteria for a "never event".

9.4 The Trust published mortality indicator, the Hospital Standardised Mortality Ratio (HMSR) continued to demonstrate a downward trend and for the period July 2015 to June 2016 stood at 100.19 being the lowest in two years and was within benchmarked limits and in line with the Trust's South East Coast peers.

9.5 Duty of Candour patient leaflets had been circulated and an e-learning module for staff developed. The last CQC visit had highlighted that this was an area where there was limited understanding. There were 25 SI's in relation to Duty of Candour breaches and 14 of these were being reviewed by the CCG. The system of "virtual sign-off" for SI's had ceased and it was expected that there would be a leveling off in the number of breaches in the near future.

9.6 There would be a PAS upgrade overnight on Tuesday 1st November which represented a two week delay to the original planned date and this had been due to technical issues detected during testing. Once the PAS upgrade was complete it would be possible to Return to Reporting as this was the only was the only outstanding condition.

9.7 The Chairman congratulated the Executive team on the falling HMSR trend and queried whether this was now stable and likely to continue at this rate. The Acting Chief Executive confirmed that there had been a downward trend for the past 9 months and that the change in culture across the Trust would ensure that it was sustained.

9.8 There was a discussion regarding management information following a question from JP and it was confirmed that there was considerably more management information than was produced previously and coding had improved although it was acknowledged that this was not the key driver for bringing down the HMSR. The Chief Quality Officer confirmed that there would be further analytical tools made available in the coming months to further interrogate the data.

9.9 MD introduced the Operations Update which was taken as read. MS highlighted the following areas:

- Total ED attenders for October had totalled 9,649 which represented a 16% increase on September 2016;
- There had been an increase in admissions of patients over the age of 65;
- Ambulance attendances totaled 3,200 which was an increase of 11% from September 2016 and the Trust remained the top performer in the region with 55.1% of handovers made within 15 minutes compared to September 2015 when the Trust stood 7th in the region;
- On length of stay for patients the under 65's were generally turned around in 48 hours, the over 85's between 4 and 5 days although this was decreasing due to the implementation of the frailty pathway, however, the overall increase in elderly patients being admitted was adding the pressures on the Trust;
- There was an 18% fall in the number of discharges for those staying more than 7 days which represented those patients who were medically fit but did not have suitable accommodation to move to after discharge; and

- The Trust had received an award from the ambulatory network in recognition for recent improvements.

9.10 Mrs King queried whether the Trust was working harder at meeting the targets when on treatment pathways. MD responded with the following points:

Cancer Update – there had been a general improvement in performance against the cancer waiting time standards, most notably the 31 day first treatment target and the 62 day GP referral. The Trust had failed to meet the two week cancer wait target which had been due to the lack of dermatology clinic capacity resulting from consultant vacancies. The appointment of an agency locum should improve the trajectory.

RTT – there had been a visit in September from a support team which had scored the Trust three points higher than the Trust had scored itself. The total incomplete waiting list size had increased by approximately 15 patients for September and additional capacity would be arranged to support further waiting list reductions. Incomplete performance for September was at 77.8% slightly behind the trajectory and actions were in place to recover this position with a target of 92% for March 2017. A trajectory for the reduction of the number of patients breaching the 52 week target had been developed as performance was currently worse than expected. The specialities giving concern were ENT, Orthapaedics, Cardiology and Respiratory.

Diagnositics – the Trust's performance against the 6 week diagnostic target had deteriorated for September 2016. MRI scanning had fallen but this would be improving with a mobile scanner. There would also be a strategic review this year to assist generally with diagnostics.

9.11 The Acting Medical Director noted the following from her report:

- A Guardian of Safe Working hours was required in every NHS hospital to ensure that issues of compliance with safe working hours were addressed and their report was attached;
- The Clinical Council had formally approved the first edition of the Medway NHS Foundation Trust Green Book and this was a set of algorithms on how to manage Acute Clinical Emergencies;
- The Trust had launched its Improving Safety campaign which aimed to highlight various components of the Deteriorating Patient Programme;
- The Coroner, Patricia Harding, had addressed the Clinical Council on October 12th to help increase understanding of how medical staff could improve the way they interact and support the coroner's service;
- The appraisal and revalidation team were entering the peak season for appraisals with the majority of the medical workforce being appraised between September and February and to support this process 15 new appraisers had been trained;
- There continued to be a high level of new research and innovation project applications received by the R&D department and one involved a study on a hip replacement implant;
- The GMC National Trainee Survey had highlighted some areas of exceptional practice (green flags), which included clinical supervision, handover and local teaching in Paediatrics and handover in Obstetrics and Gynaecology; and
- There had been 53 applications for Clinical Excellence Awards and of these 22 consultants had been successful.

9.12 EC noted the effort which had been made by KM with regard to appraisals and this was welcomed.

9.13   The Director of Nursing noted the following from her report:

- The actual hours of planned versus actual hours was 5.9% above the planned hours which had led to an increase in spend on agency staff and this had been due to the continuing high levels of activity across the Trust;
- The Neonatal Intensive Care Unit (NICU) had less than 10% of their planned hours however safe staffing had been maintained in this area;
- There was continuing focus on pressure ulcers and those categorised as Grade 3 and 4 would be reviewed in detail at the next meeting of QAC in November;
- In the month of October there had been 28 cases of hospital acquired infections and the Trust had breached its CDiff trajectory for Q2 reporting 9 cases but post infection reviews did not identify any common themes;
- There would be an Infection Prevention & Control week beginning on 14 November with awareness sessions across the Trust;
- The Trust had reported 33 Mixed Sex Accommodation breaches in September and all these had occurred on the Surgical Assessment Unit and a review was being carried out to find an additional escalation area; and
- The Transforming Care Programme had a number of actions to address the common themes arising from complaints.

9.14   The Acting Director of Workforce noted the following from her report:

James Devine, the new Director of HR & OD will be joining the Trust on 31 October and would be building on the foundations of work undertaken over the past nine months including:

- the introduction of the in-house Temporary Staffing Service in March.
- the launch of the Trust Vision and Values in April (it was noted that 97% of the responding Friends and Family were aware of the Vision and Values).
- the response rate to the Staff Survey had been at 38% for 2015 and the Trust was aiming for 55% in 2016 (as at 14 October it stood at 28%).

9.15   EC noted that one of the CQC must-dos was to improve the level of safe-guarding. The Director of Nursing confirmed that the safeguarding improvement plan, which was being regularly monitored by the CCG, was making good progress in achieving the actions such as reviewing training needs.

9.16   The Director of Finance Board highlighted the following points on Estates and Facilities:

- The Trust's infrastructure was being improved with the ED redevelopment stage 4 contract having been signed and this project would be completed by December 2017.
- Ward refurbishment had started with matrons identifying minor jobs that needed to improve the working environment on the wards.
- There were now twenty additional housekeepers and new equipment to ensure that the hospital was clean.
- The Energy team had energy champions and were developing an engineering collaboration with Greenwich University.
- On waste and transport all transport checks were now in place.
- The use of body cameras worn by security staff had reduced the number of security related incidents by a half so both staff and patients were safer at the Trust.
- There were updated policies for fire safety.

- A new catering manager had started and he would be introducing healthy options for staff and patients.

9.17 The Director of Finance updated the Board on the Trust's Financial Performance:

- The increase in non-elective admissions were increasing which was placing more pressure on the Trust's finances.
- There would therefore be a need to increase temporary staff to cope with the increased demand.
- Elective Inpatient and Day case activity continued to over perform against the planned levels by approximately 8% due primarily to the increase in additional capacity.

16/10-10 CORPORATE GOVERNANCE REPORT

10.1 The Head of Integrated Governance gave a summary of the following points from the Corporate Governance Report:

- Corporate Governance activity was focusing on working closely with the PMO in ahead of the CQC inspection in planning the logistics for the on-site focus group meetings on 22 November and preparing for the inspection on 29 and 30 November.
- The Imaging Department had been accredited under the Imaging Services Accreditation Scheme (ISAS) since December 2012 and following a maintenance visit on 28 and 29 September the accreditation had been maintained and the service received some very complimentary comments.
- Executive responsibility for winter planning had recently moved from the Acute and Continuing Care Director of Clinical Operations to the Director of Corporate Governance, Risk, Compliance and Legal. The winter plan is based on the 2015 plan and was tested in a challenge session on 13 October which was attended by representatives from various functions, SECAMB and Swale and Medway CCG's.
- Work was continuing on the streamlining of corporate policies.
- On Emergency Planning, Resilience and Response the Trust had responded as a receiving hospital to a major incident but South East Coast Ambulance Service stood the Trust down and casualties were managed within business as usual.

10.2 EC noted that there had been a discussion on the Trust's appetite for risk and his view was that the Trust should have a low appetite for risk. The Acting Chief Executive stated that matter would continue to be reviewed and monitored.

NHSI Quarterly Submission

10.3 The Board noted and APPROVED that there was no requirement to submit the In Year Governance Reporting Return Q2 to September 2016.

SI Policy

10.4 The Chief Quality Officer explained that the SI Process Delivery process had been reduced from 60 to 35 days and there was greater accountability and learning from the SI process. The Board APPROVED the new SI Policy.

Access Policy

10.5 The Chief Quality Officer explained that the Trust's Access Policy was intended to ensure that all patients referred and treated within the Trust received high quality care, fair and equitable access and services in line with the 18 week Referral to

Treatment. The policy had been reviewed by the RTT support team and the policy would be closely monitored in the future. The Board APPROVED the new Access Policy.

Fire Safety Policy

10.6   The Director of Finance noted that the last CQC report had highlighted that there was a lack of accountability for corporate policies and given that there were too many there was no clarity on who was ultimately responsible. This was being addressed with a process of creating an overarching corporate policy for each area. The Fire Safety policy had been reviewed by the appropriate governance channels and improved processes were in place which involved regular meetings with the Kent Fire and Rescue Service. The Board APPROVED the Fire and Safety Policy.

Procurement Transformation Policy

10.7   The Board took the paper from the Head of Procurement as read. DS explained that in July 2016 NHSI had written to all Trusts asking them to develop a Procurement Transformation Plan (PTP) to transform their procurement services in order to achieve the Carter procurement recommendations and targets. The Board was asked to approve a PTP in order that this could be submitted to NHSI by the end of October 2016.

10.8   The Chairman queried the level of engagement from the Trust about the importance of involving Procurement.   DS noted that it was necessary for Procurement to improve their communications to ensure that the Trust involved them from an early stage and, once it was demonstrated that a good service was provided, the procurement processes would become embedded at the Trust.

10.9   The Chief Quality Officer explained that Procurement could assist in patient safety with greater standardization of equipment.

10.10   SC commented that DS required the support of the Executive as this approach would require staff to be aware that supplies had to be pre-approved before being ordered. DS responded that in the last 18 months he considered that he had the support of the Executive and DS also advised that as Procurement was an area covered by the recommendations of the Carter Report, which was a focus for the whole Trust, this support and awareness of the role which Procurement will play would become more evident.

10.11   JP queried where services were provided to the Trust whether the supplier had to adhere to our terms and conditions. DS noted that usually the terms and conditions were standard but they were tested. JP commented that the integrity of the supply chain had to be maintained and queried whether we checked the ratings of the suppliers. DS noted that suppliers were engaged if they had a Business Continuity Plan. DK commented that she appreciated the transparency of the discussion and this was helpful for Governors to witness.

10.12   The Board APPROVED the Procurement Transformation Plan as a roadmap to developing and enhancing the function within the Trust and assisting with the delivery of the Carter recommendations.

16/10-11 HEALTH INFORMATICS REPORTS

QGAF Biannual Assessment

11.1   The Board noted the paper which was taken as read.

11.2   The Chief Quality Officer explained that it was a requirement for the Trust to undertake a QAGF assessment annually and an independent assessment will be undertaken by NHSI in January 2017. Subsequent to the meeting it was confirmed that the assessment would be made by an independent team in March 2017.

11.3   The Quality Improvement and Assurance Framework and Quality Governance Assurance Framework had been updated for changes in the directorate structure since 2015 and the Trusts quality aims.

11.4   The Board APPROVED the revisions to the framework and QAGF assessment.

16/10-12   COMMUNICATIONS REPORTS

12.1   The Board took the Communications report as read.   The Director of Communications updated the Board on the following recent developments regarding internal and external communications.

- Daily messages were being introduced, seven days a week, under an overall Theme of the Week and these were disseminated at handovers, team meetings, screen savers, displayed on posters in staff areas and by texting staff groups.
- There was a CQC explanatory handbook and also one for non-executive directors, governors and board members to help provide confidence ahead of the forthcoming inspection.
- NHS Fab Change Day took place in the staff restaurant on 19 October where there was a live twitter feed for social media sharing of pledges;
- There had been some positive media coverage with filming by ITV Meridian in the Sunderland Day Care Centre regarding the new procedure for frozen shoulder patients;
- Paul Lehmann had been interviewed live on Radio Kent and there was expected to be further reports and photographs regarding the Smokefree launch.
- Staff were encouraged to promote the Trust on social media and over the past 30 days there had been engagement with 35,000 on Twitter and 35,600 on Facebook.
- The Medway Youth Parliament will be a meeting between the Women's and Children's Directorate to gain an insight into how the services meet the needs of children and young people.
- There would also be more engagement with ethnic minority representative groups.
- There would be a workshop with governors to assess the effectiveness of community engagement.

16/10-13 QUALITY ASSURANCE COMMITTEE REPORT

13.1   The Chair of the Quality Assurance Committee gave an overview of the workings of the Committee and highlighted the following from the October meeting:

- At the meeting in October the Committee had heard a patient story delivered by the daughter of a patient;
- There had been an informative presentation on safeguarding; and
- The Committee had carried out an internal review of its effectiveness.

16/10-14 QUESTIONS FROM THE GOVERNOR REPRESENTATIVE

14.1   Mrs King queried when the written communications between the Trust and patients would improve. The Chief Quality Officer confirmed that a review of the outpatient

service was being carried out by Ben Stephens, Director of Clinical Operations for the Co-ordinated Surgical Directorate and after this had been completed it was hoped that this would provide the necessary assurance.

16/10-15 AOB

15.1   It was noted that the Chief Executive had been in Australia for the arrival of her granddaughter for which the Board gave their congratulations.

15.2   Rebecca Bradd had been Acting Head of Workforce for the last nine months and she would be leaving the Trust in January to take up the post of Workforce Programme Director for the STP. The Chairman thanked RB for all her assistance to the Board and particularly in the last month as a support to him as Deputy Chair.

15.3   JP suggested that it would be helpful to have regular updates from all the Board Committees, in the same way as there had been a report from QAC to ensure consistency. This was noted, however, the other Committees met on a quarterly rather than a monthly basis as was the case with QAC but there would be a review of the Board Committee structure in future.

16/10-16 DATE OF NEXT MEETING

The next meeting of the Trust Board will be held on Thursday 24 November 2016 in the Trust Boardroom, Medway Maritime Hospital.

The meeting closed at 3:50pm

Martin Jamieson: Date:
Chair

Medway **NHS**
NHS Foundation Trust

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB-0364	28/07/16	13.1	People & Organisational Development Strategy to be brought back before the next Performance meeting with any comments to be provided to the Acting Director of Workforce prior to the meeting	Director of Workforce	23/09/16 – New Director of Workforce to progress, April 2017 meeting.	Open (red)
PUB - 0371	29/09/16	13.14	The Risk Appetite Statement to be discussed further in consultation with the Board.	Director of Corporate Governance, Risk, Compliance & Legal	24/10/16 – To be brought back to a future Board meeting	Open (red)
PUB-0372						

1

Report to the Board of Directors

Board Date: 24 November 2016

Title of Report	Chief Executive's Report
Presented by	Lesley Dwyer
Lead Director	Lesley Dwyer
Committees or Groups who have considered this report	N/A
Executive Summary	The purpose of this report is to provide the Board with an update on key issues since the last meeting of the Board that are not covered elsewhere on the agenda: Key points to note are: • Care Quality Commission (CQC) Inspection Preparation • National and Regional Issues
Resource Implications	
Risk and Assurance	Detailed within the report.
Legal Implications/Regulatory Requirements	
Recovery Plan Implication	The content of this report supports the recovery plan.
Quality Impact Assessment	Not required.
Recommendation	The Board are asked to note the information contained within the portfolio reports and to direct any questions to the responsible executive to provide views on their assurance in relation to the information and responses given.
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Chief Executive's Report – November 2016

1. EXECUTIVE SUMMARY

The Chief Executive's report provides the Board with an update on key issues since the last meeting of the Board, items that are not covered elsewhere on the agenda and an overview of national and regional issues.

2. SMOKE-FREE

The move to go smoke-free has been very successful with smoking almost completely eliminated on site. The main outstanding piece of work is to continue to work with staff, local councillors and residents to tackle people smoking outside homes in Windmill Road. The smoke-free committee is continuing to meet to review progress and the implementation of the new policy.

3. CARE QUALITY COMMISSION (CQC) INSPECTION PREPARATION

3.1. The Trust is ready for the inspection in November: logistical arrangements that need to accompany the inspection are all in place; and we have submitted a further 50 documents to CQC in the last month.

3.2. The 'day zero' presentations have been completed and were sent to the CQC on the required date. All 10 presentations will be delivered simultaneously on the first day of the inspections. The presentations, which have a consistent look and feel, tell a really good story of the improvement journey we have been on for the last year. As a reminder the presentations, as set by the CQC, will cover the following:
- Issues raised at last inspection
- Improvements made since then
- Evidence of these improvements
- How staff have been engaged in these improvements
- Areas that still pose a challenge and how they will be addressed
- Latest statistics

3.3. We have held two dress rehearsals to prepare. Firstly, to get the content and format of the presentations consistent. Secondly, to coach the presenters to give their best and show how proud they are of their achievements while recognising areas where we will continue to improve.

3.4. We now have the names of the 48 strong inspectorate team, led by Alan Thorne Head of Hospital Inspections. I am pleased to say we have

been given a very experienced team who will give us a thorough but fair examination.

4. STRATEGIC PLANNING

4.1. Kent and Medway Sustainability and Transformation Plan (STP)

    4.1.1. Publication of the 44 STPs has begun to take place across the country, with the Kent and Medway STP likely to be published in the very near future.

    4.1.2. There is a high level of media interest in the plans with speculation about the implications for services in some parts of the country. However, it is being stressed that the publication of high level plans marks the beginning of conversations with patients and public about services needed in their areas in future, and no decisions about any potential changes have been made.

    4.1.3. Discussions are ongoing with STP colleagues over appointments to key posts within the STP governance structure.

4.2. Joint strategy with Maidstone and Tonbridge Wells NHS Trust (MTW).

    4.2.1. Discussions with MTW over the development of a joint clinical strategy have commenced. The intention is that we will be in a position to jointly describe the two organisations' ambition, the clinical services where joint working will deliver maximum benefit to our populations, and the associated governance structures by the end of 2016.

5. NATIONAL AND REGIONAL ISSUES

Recent issues concerning the NHS are listed below:

5.1. Junior doctors have said they will work with the Government on new contracts, and have lifted all threats of strike action.

5.2. The Department of Health has launched a 'listening programme' to find out more about the experiences of people with dementia and their carers starts in England. It will include different ways of gathering people's views and experiences, both in person and online.

5.3. A report from the Royal College of General Practitioners (RCGP) has said that GP practices are not currently set up to deal with patients living with multiple long-term conditions. The report said that the average GP appointment is insufficient to address everything, especially as some patients have over five conditions.

    5.3.1. The RCGP estimated that by 2025, the number of people living with multimorbidity in the UK is expected to go up from 8.2 million to 9.1 million, costing an additional £1.2bn for health and social care.

5.4. The Care Quality Commission (CQC) has rated the care provided by Demelza, a Hospice Care for Children based in Sittingbourne, as Outstanding following an inspection in August 2016.

    5.4.1. Inspectors rated the hospice in Sittingbourne, Outstanding for being caring and responsive to people's needs and Good for being safe, effective and well-led.

    5.4.2. Demelza, Hospice Care for Children is a local registered charity that provides specialist end of life care to children and young people, both within the hospice and in the comfort of their own homes.

6. REGULATORY ISSUES

6.1. NHS England and NHS Improvement have introduced a new joint approach to accountability and oversight of operational plan and performance delivery for both providers and CCGs (Joint Single Accountability & Performance Review / JSAPR).

    6.1.1. The purpose of the JSAPR process is to ensure that a consistent approach is taken by NHS England and NHS Improvement to delivery of finance and performance by both commissioners and providers.

    6.1.2. The first JSAPR meeting is scheduled for 25 November 2016; further meetings are expected to be held at least quarterly. The JSAPR meetings do not replace the Trust's existing formal accountability processes with NHS Improvement.

6.2. NHS England and NHS Improvement have introduced a new single national escalation framework for use by local health care systems.

    6.2.1. The framework requires use of a new escalation terminology - Operational Pressure Escalation Levels (OPEL). These are numbered (from 1-4) and replace the previous colour-rated terminology of Green, Amber, Red and Black.

    6.2.2. Internal plans may continue to use the colour-rated terminology, but external communications must refer to OPEL from 1 November 2016.

6.3. St George's University Hospitals NHS Foundation Trust (St George's) was placed into Special Measures by NHS Improvement in early November. CQC rated the St George's as Inadequate and reported that services had deteriorated in the past two years.

    6.3.1. St George's is one of the UK's largest teaching hospitals and comprises St George's and Queen Mary's hospitals in south-west London, serving 1.3 million people.

7. PERFORMANCE

7.1. The monthly Clinical Operations Report, item 9b on the Public Trust Board agenda, provides the Board with an update on issues impacting on the overall clinical performance of the Trust.

7.2. The Board is aware from previous briefings at the meeting that following a positive external validation in regards to the quality of data, the Trust will formally return to reporting treatment for waiting times on 20 November 2016.

Report to the Board of Directors

Board Date : 24 November 2016

Title of Report	Trust Recovery Programme Update
Presented by	Kevin Tallett
Lead Director	Kevin Tallett, PMO Director
Committees or Groups who have considered this report	Executive Recovery Group
Executive Summary	The purpose of this report is : Key points are : • Update on progress • Identify key risks
Resource Implications	None
Risk and Assurance	Risks have been identified and mitigated
Legal Implications/Regulatory Requirements	Key vehicle for removing the Trust from Special Measures
Recovery Plan Implication	Fully aligned
Quality Impact Assessment	Covered by individual programmes
Recommendation	The board are asked to discuss and note the report
Purpose & Actions required by the Board :	Approval ☐ Assurance ☑ Discussion ☐ Noting ☑

Trust Recovery Programme Update – November 2016

1. EXECUTIVE SUMMARY

The Trust Recovery Programme has continued to make good progress during November. The PMO has primarily been focussed on getting ready for the CQC inspection. I would highlight the following key points:

1. We are well prepared for the CQC inspection with a layered approach aimed at ensuring we are keeping everyone informed and minimising the risk of issues on the day. The burn down process is complete and the one remaining red item from the must do/should do actions will be cleared by the time of the inspection.

2. The Planned Care programme is progressing with positive engagement around the process mapping phase.

3. The Deteriorating Patient programme has seen significant improvement in the compliance of safety briefs and intentional hospital rounding. The Trust Operational Centre has undergone a makeover and the site team and acute response teams will sit next to each to improve coordination of unwell patients.

4. The Unplanned Care programme has continued to embed the new concept of operations model and continued to focus on improving flow through ED.

5. The Workforce programme has launched the new recruitment campaign with great success including on-going overseas recruitment activities.

6. Transforming Outpatients continues to define its scope and approach but is making slower progress than plan.

7. The Financial Recovery programme has made good progress around CIP's and positioning work for Carter.

8. The Transforming Care programme has made good progress in a number of areas around reinforcing the fundamentals of care.

In summary, we are better prepared than before for the CQC inspection and are delivering across most of the programmes. Our biggest risk remains that of the inspections on the day if any red flags are raised by the CQC Inspectors.

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1. GOVERNANCE & STANDARDS PROGRAMME

The programme remains on track, with all preparations progressing well. The Trust has responded to a number of data requests from the CQC about the organisation's plans for recruitment, staffing and complaints, with several requests on the same subject, an indication perhaps as to what they will examine on the day.

All 10 Day 1 presentations have now been prepared and two dress rehearsals completed. The Chief Executive gave her presentation to around 500 people at the staff meeting and it was well received. It is worth noting this is the largest staff gathering to date. All presentations have been submitted to the CQC as requested and on time.

Good progress has been made with the agile Burndown approach with all tasks completed on time.

We remain on schedule to close the complaints backlog by the time of the inspection, eliminating the backlog of 165 complaints.

The arrival of Angela Helleur, an experienced Improvement Director from NHSI, has added value and an additional level of scrutiny and support. She has looked at the recovery plans and is satisfied with what has been achieved and the rigour of the approach.

Following a recent Quality and Oversight Improvement Committee (QOIC) our approach and evidence was also subject to a detailed review during a visit by the Head of Quality from NHSI. Our structure, content, governance processes, evidence trail and document submissions were all scrutinised and explanations provided. This exercise provided a significant degree of assurance and useful reinforcement of our readiness.

2. PLANNED CARE PROGRAMME

Good progress is being made with all three work streams engaging positively in the process mapping phase. Two of the work streams have identified early stage quick wins and the third is due to deliver theirs at the next workstream meeting; roll out of a number of these has already commenced.

The Planned Surgical Care Programme monthly newsletter - Cutting Edge - has been developed with the first issue due to be circulated once approved. This will compliment other communication activities that will take place across the Directorate throughout the lifecycle of the programme.

3. DETERIORATING PATIENT

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The Deteriorating Patient Programme continues to make progress in key areas. Highlights for the programme this month include:

- The Trust reported zero cardiac arrests for the week 22 – 28 October. This highlights that we are now recognising and responding to deteriorating patients much better than previously
- There has been a significant improvement in the compliance of Safety Briefs and Intentional Hospital Rounding and the audit of Safety Huddles has shown that huddles are now embedded into daily practice
- A continued effort to embed a safety culture continues following the week long Improving Safety campaign. The campaigning continues each Tuesday throughout November with key DPP staff visiting clinical staff in ward areas and taking key campaign messages to front line staff
- The Trust Operational Centre refurbishment has been completed and will co-locate the Clinical Site Practitioners and the newly appointed Acute Response Team to ensure a seamless coordination of unwell patients or patients of concern 24:7
- The Acute Response Team model of care is in place. The team is not fully established, with 4.8 WTE vacancies remaining to be filled, another recruitment drive is underway to ensure high calibre staff is recruited to enhance the team and deliver the full model of care.

4. UNPLANNED CARE PROGRAMME

The Programme is making steady progress and a number of key products have been delivered within November.

The highlights for this month include:

- Internal Professional Standards and Concept of Operations launched , with regular reviews and ongoing improvements being applied
- GSTT review of Frailty Flow has completed and identified a number of areas that will be considered for improvement
- Emergency Department have introduced a Rapid Assessment Process to stream admissions earlier to the appropriate pathway.
- Revised fractured hip pathway has been put in place in ED
- Criteria Led Discharge Standard Operating Procedure, Choice Policy and e-DNs presented at Medical Staff Committee and will be launched mid-November
- Medical Model Stakeholder event held and Formal handover to Business As Usual

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- Daily review of Medically Fit for Discharge (MFFD) being held to focus on improving discharge numbers

5. WORKFORCE PROGRAMME

Following the Board meeting in October, significant progress has been made in many areas within Workforce, with particular focus on recruitment and retention

The Trust launched a new recruitment campaign on 21 October at the British Medical Journal careers fair in London. The event was very well attended and the team secured expressions of interest from 31 doctors. The recruitment campaign itself is a 3 month staggered campaign across the region and supports a number of open days that have been organised by the Recruitment Team to attract more staff and promote the Trust. A Nursing Open Day was held on site on 09 November and expressions of interest were secured from 33 nurses. Following on from this, the team have organised Surgery Assessment Days between 12-14 November and the NICU & Paediatric Open Day on 23 November.

KPMG carried out an audit of our recruitment processes which will support the review of Bank staff, carried out by GSTT via the Buddying agreement. Both reports have been received and are under review.

The Recruitment Team have also been rolling out the Health Roster and SafeCare Live systems, since September, both of which are significant enablers in improving safer staffing through matching staffing hours more accurately to staffing requirement, based on real time patient acuity assessment.

In regard to EU and international recruitment, the Trust has made job offers to 27 EU nurses, with 10 of those due to start on 03 January. The ongoing recruitment of EU nurses, through the 'Medacs' contract, will continue until our target of 70 nurses is reached. In terms of international recruitment, the Trust interviewed 26 NICU nurses from the Philippines in October and made 12 job offers.

The Learning & Development Team launched a new Learning Management System (MOLLIE) on 25 October. It is a web based system allowing access anywhere, anytime via smart phones, tablet devices, laptops or desktops and allows learners to view and complete training on the move, and book themselves on courses. The LMS will allow the Trust to move towards staff self-service for booking training courses, removing the need for the L&D team to be involved in the booking process. It will facilitate a rapid move to modern e-learning, with completion of such courses automatically recorded. The improved management information and visibility of employees' records will facilitate

the Trust in its objective of improving rates of compliance for statutory and mandatory training.

6. TRANSFORMING OUTPATIENTS

The four key work streams in the Outpatients programme continue to be defined together with the scope of the final project initiation document. Progress on work stream 2 (External Outpatient models) has been slower than expected due to the difficulty in arranging meetings between Trust and CCG staff, however, individual task and finish groups are making good progress. The implementation of the main actions in work stream 4 (Patient Service Centre reconfiguration) has commenced but requires further scoping to agree the interdependencies with a number of Health Informatics projects. The programme still requires a formal governance structure to include an executive sponsor, clinical lead and substantive work stream leads for the four work streams.

7. FINANCIAL RECOVERY PROGRAMME

The Financial Recovery Plan is progressing to plan looking at both deliveries in year and for the coming years. The focus of the plan is around four key areas:

1. CIPs 2016/17

The benefits realised on CIPs to Month 7 is £4.1m against the full year target of £12.6m. In month 7 drugs savings at Month 6 of £1.08m were released, work has been ongoing to validate the level of savings that have now been agreed and a process is being developed to transfer this to business as usual for reporting.

Further savings are being validated with Procurement against their savings plan; this has required Integra to write a specific report at service level to extract data for validation. It is expected this will be finalised for month 8 reporting and will deliver savings at the end of October of at least £1.2m bringing the YTD saving to £5.3m.

The programme is at a full year delivery of £7.6m of which £1m for estates is still being validated by Finance. In addition, validated data for drugs stands at £2m for the year. This currently gives £11.6m of the CIP and, assuming the estates CIP is validated fully, we will hit the target of £12.6m.

A review of governance of the existing CIP programme is underway and due for completion at the end of November, the validation exercise covers a review of QIAs and Project briefs/Project Initiation Documents.

There are over 100 schemes in the pipeline which are schemes not yet fully formed, and which are working through the process of Project, QIA and Financial validation before they are approved for financial release.

2. Income

There has been work undertaken to validate income that has to date not been claimed by the trust or is related to incorrect penalties. Currently there are 23 projects representing potential income opportunities of approximately £8m. This income flow is anticipated to start this financial year but with the majority of the benefit being taken in 2017/18.

Benefits realisation to ensure validation for 2016/17 is underway and targeted to start delivery in month 9.

3. Carter

Work is underway to produce the data packs for validation based on Carter and the Model Hospital. It was expected that they would be available for issue the end of the first week of November, due to parallel work requirements for the CQC visit this will slip by two weeks with a new target issue date of late November early December.

The validation of that data will inform the development of projects that will be captured and processed through the established gateways to inform the savings programme for 2017/18. The projects will cover medical and corporate costs and as the projects are developed and captured they will be reported.

4. Sustainability Transformation Plan

We continue to work with the STP on future opportunities that may deliver financial benefit. PA Consulting are working for Medway on a business case looking at the Corporate Services, this will dovetail into a wider review of Corporate Services and a review being carried out by SBS commissioned by the Finance Director.

We are in the process of concluding negotiations on both Pathology and Laundry services working in collaboration with Darenth Valley Hospital and Maidstone Tunbridge Wells hospitals respectively, both of these collaborative pieces of work

will run in the Carter work stream and also form potential future blueprints for the STP.

Procurement is working with all regional provider procurement functions to deliver an action plan to all Trusts by the end of November. They will present on behalf of the four Procurement functions a way forward on collaborative Procurement working.

8. HEALTH INFORMATICS PROGRAMME

See update in health informatics programme

9. TRANSFORMING CARE PROGRAMME

The Programme has successfully delivered a number of key products this month:

The highlights for this month include:

- Appointment of Nutritional Specialist to support the Food and Drink workstream completed
- Appointment of 'Mouth Care Matters' specialist to the programme and baseline assessments commenced
- New thickened fluids solution identified and being presented for approval
- New improved Pureed diet identified and tasted and being presented for approval
- Standard for ward drug trollies completed and launch across the trust being developed
- Issue of yellow alert falls band commenced
- Completion of 'windows audit' for privacy and work has started on priority windows to be made opaque

A numbers of solutions identified to improve communication with patients and families being purchased and implementation planned for next month.

10. COMMUNICATIONS

Support for phase 2 of the Trust Recovery Plan continues through the newsletter; intranet; Chief executive's weekly email; global emails and staff meetings. Further support will come from the news@medway newspaper and local media coverage.

The fortnightly newsletter, Aiming for BEST, continues its focus on CQC with stories about individual members of staff and how they are preparing for the inspection and beyond.

Following the CQC staff handbook, a further handbook for the CQC inspectors and the 'Board Book' providing information for Executive and Non-Executive Directors, Governors and Senior Managers has been delivered and circulated.

For much of the period, communications focus has been on preparing the ten CQC presentations to be given on 29 November.

11. RISKS TO DELIVERY

Key risks are being managed but residual risks will remain. The highest risk at present around the CQC inspection is one of not getting the basics right on the day. This is being mitigated by the layered approach but only vigilance and challenge can help us ensure this risk is eliminated.

Risk	Mitigation
Trust fails the CQC Inspection in November	The Trust has held two mock inspections. The second of which has used an extensive range of external assessors and focussed actions plans have been enacted following both. The Mock Inspection held 8th /9th September has been prioritised into a series of actions that will be managed using agile techniques such as a burn down chart to closely monitor progress. We have taken a layered defence through the use of Agile, clinical & nurse led reviews combined with cold eye reviews.
Change is not sustained beyond the high visibility recovery period	Care is being taken to ensure ownership of change sits with the operational level of the Trust. The PMO provide support but does not lead clinicians, senior nurses and managers in planning, delivering and implementing change
Resource constraints negatively impact pace and/or quality of change.	Following the CQC inspection, the Trust has entered Phase 2 of its Recovery Plan. All programmes have a Project Initiation

	Document and are subject to assurance processes which are used to determine the programmes ability to deliver.
Reporting and monitoring divert focus from the process of improvement and change.	The Trust is pleased to have had the support of CQC and NHSI (amongst others) in planning the next stage of its recovery. Indications are that both CQC and NHSI appreciate the need for a core focus on delivery activities. The level of oversight has been discussed at the Quality & Oversight Improvement Committee on a regular basis
Lack of staff buy-in to recovery	The Trust has recognised the need for strategic, targeted communications campaign to support the next stage of its recovery programme. The Trust's communications team have mobilised accordingly and a communications strategy is now being followed to compliment the recovery activities

The board are asked to note progress

Kevin Tallett

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Report to the Board of Directors

Board Date: 24th November 2016

Title of Report	Integrated Quality and Performance Report
Reporting Officer	Emma Birdsey, Head of Information Analysis
Lead Director	Dr Trisha Bain CQO
Committees or Groups who have considered this report	N/A
Executive Summary	Key points: Mortality - The Hospital Standardised Mortality Ratio (HSMR) continues to maintain the trend and is now 100.68 for data to October 2016 and is within the expected range. SHMI also remains at 1.13 for the current dataset. **MSA -** Unfortunately there has been an increase in MSA breaches to 99. The reason is down to clinical reasons, and due to red and black escalation. Further investigation is being undertaken to improve the position. There has been a slight improvement in the performance against the incomplete referral to treatment standard however this has fallen slightly behind trajectory for the first time. The additional capacity in Cardiology is being delivered and additional insource weekend capacity in ENT is expected to commence at the end of November. **RTT** There were 22 patients reported RTT waits over 52 weeks for incomplete pathways at the end of September. Clinical harm reviews are taking place for all patients whose waiting time exceeds 52 weeks with zero instances of moderate or severe harm identified. **Diagnostics -** We have seen an increase in the waiting list in September, up to 7067 from 6148 in August. Our performance has remained relatively stable at 90.86% The majority of breaches (536) were due to capacity issues. **A&E -4 Hour Performance and Flow –** The Trust's four hour performance deteriorated in October compared to September. Further work is being done to develop and implement new pathways to speed patients through the department. A new RAT/Triage model has been implemented in ED, which should see an increase of 13-20% more patients being seen within 4 hours.

	Cancer - 2 Week Wait - The Trust failed to meet the 2 week wait standard across four tumour sites. This was predominantly due to patient choice in Dermatology and capacity due to Consultant vacancies affecting both Skin & Children. **Cancer – 62 day urgent GP referrals -** The Trust failed to meet the 62 day GP referral standard across the majority of tumour sites. Pathway breaches were varied due to complex pathways, patient choice and delays in diagnostic tests. These figures also take into account the patients for whom we are partially responsible with other Trusts. The Trust have formally given notice to return to reporting treatment waiting times from November 20th.
Risk and Assurance	N/A
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	N/A
Recommendation	N/A
Purpose & Actions required by the Board :	Approval ☐ Assurance ☒ Discussion ☐ Noting ☒

Integrated Quality and Performance Dashboard

November 2016

To be read in conjunction with Board Executive portfolio updates.

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Contents

Section		Page

Please note from December onwards PMO updates will be included

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

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9656 Patients visited our ED Department, which is a 0.3% decrease on previous month, with **79.82%** seen within 4 hours and **1939** ED attendances turned to inpatients

2972 Patients arrived at ED via ambulance which is a 1% increase on last month

55% Of ambulance patients seen in under 15 minutes

There were **5075** admissions , **5035** patients were discharged. Bed Occupancy increased by 2% in October to 96%

25756 Patients attended an outpatient appointment which has decreased since previous month by 1679

October's Story….

397 Babies were delivered in the month of October (54 less than September) with **98.8%** of patients saying they would extremely likely/likely to recommend the Maternity Service

HSMR has slightly increased from previous month, however remains at **100**, the best performance for over 12 months

97% of admissions had MRSA screening which is an 8% increase on previous month

82% of staff have had an appraisal which is an **11.3%** increase on previous month

3

Executive Summary

Safe Page 7

● **Total Serious Incidents 1.1.3 –** As of November 2016 there are 64 open Serious Incidents; 11 of which are historic incidents from 2015/16. The remaining 53 incidents are from 2016/17 and include 1 Never Event.
36 cases are breaching, the status of which is as follows:
- Awaiting CCG Closure – 24
- Awaiting Directorate Sign Off – 7
- Under Investigation – 5
The remaining 26 incidents are within timeframe and investigators have been assigned.
The average number of breach days has decreased by 69% when compared to the same period in 2016.

● **Proportion of Harm Free Care 1.2.1 –** Proportion of harm free care has started to improve, with a position of 89.35% in October. However, in regards to new harms we are at a position of 99.78% , the best performance in over 12 months.

● **Mortality -** The Hospital Standardised Mortality Ratio (HSMR) has remained at 100 (100.65) for the 12 month rolling period of August 15 – Jul 16. The HSMR Weekend value continues to show a downward trend, and is currently sitting at 105.

The most recently published SHMI value, for the period April 2015 – March 2016, is 1.13. This remains the same as the previous figure for Jan 15-Dec 15, but is still a reduction on previous periods. The Trust is optimistic that the SHMI will continue to demonstrate a reduction moving forward and aims to be within benchmarked limits by the end of 2016/17.

Effective Page 8

CQUIN - Please find attached an update on the CQUINs on Page 8.

Caring Page 9

● **MSA -** Unfortunately there has been an increase in MSA breaches to 99. The reason is down to clinical reasons, and due to red and black escalation. Further investigation is being undertaken to improve the position.

● **RTT 4.1.1 -** There has been a slight improvement in the performance against the incomplete referral to treatment standard however this has fallen slightly behind trajectory for the first time. The additional capacity in Cardiology is being delivered and additional insource weekend capacity in ENT is expected to commence at the end of November.
 There were 22 patients reported RTT waits over 52 weeks for incomplete pathways at the end of September.   Clinical harm reviews are taking place for all patients whose waiting time exceeds 52 weeks with zero instances of moderate or severe harm identified.

● **Diagnostics -** We have seen an increase in the waiting list in September, up to 7067 from 6148 in August. Our performance has remained relatively stable at 90.86% The majority of breaches (536) were due to capacity issues.

● **A&E**

- **4 Hour Performance and Flow 4.2.2 & 4.2.3 –** The Trust's four hour performance deteriorated in October compared to September. This follows the reconfiguration of CDU. Further work is being done to develop and implement new pathways to speed patients through the department.   A new RAT/Triage model has been implemented in ED, which should see an increase of 13-20% more patients being seen within 4 hours.
 In November through to January extra work is being undertaken to avoid admissions.
  Cancer

● **2 Week Wait - 4.3.1 & 4.3.2 -** The Trust failed to meet the 2 week wait standard across four tumour sites.
This was predominantly due to patient choice in Dermatology and capacity due to Consultant vacancies affecting both Skin & Children. One breach for Brain was as a result of patient availability. Breaches in Lower GI were as a result of patient choice and clinic capacity within the Directorate.

● **Cancer – 31 day first treatments 4.3.3 -** The Trust has failed to achieve the 31 day first definitive standard.
Two skin breaches were as a result of Consultant availability and an admin delay in processing paperwork.
The 2 Urology breaches were as a result of Consultant availability and patient choice.
 capacity. The five breast patients were as a result of patient choice, clinic capacity and consultant availability.

● **Cancer – 31 day subsequent treatments – surgical 4.3.4** -The Trust failed to comply with the 31 day subsequent surgery treatment standard in Breast, Skin and Urology as a result of patient choice, theatre capacity and Consultant availability.

● **Cancer – 62 day urgent GP referrals 4.3.7 -** The Trust failed to meet the 62 day GP referral standard across the majority of tumour sites.
Pathway breaches were varied due to complex pathways, patient choice and delays in diagnostic tests. These figures also take into account the patients for whom we are partially responsible with other Trusts.

Well Led _{Page 11}

Recruitment and retention remain a priority for the Trust. Vacancy levels remain at the same level in month. There was an increase in leavers in month, this includes the TUPE of staff in GUM (14 staff).

Mandatory training, appraisal and local induction has slightly improved this month.

An update in terms of actions being taken to improve compliance can be found in the Workforce update.**.**

Enablers _{Page 12}

Data Quality

The DQ team is in the final stage of recruiting to a substantive structure from an agency team.

The following progress has been made to our Top 5 DQ issues

RTT data quality, is currently maintained to a high standard across the Trust due to a collaborative approach from both DQ team and Divisional services

Patients potentially omitted from waiting lists, have been fully validated and back log cleared and is being maintained daily by Divisional services.

Dynamic outcome form, is due to launch on wed 16th November across all remaining clinic areas, following a successful ENT trial.

Radiology project, the DQ team in conjunction with the Finance department have just embarked on a project of unbundling imaging procedures from block contract. With a potential worth in excess of million pounds.

Discharged with future follow up, currently in diagnosis stage, solutions have a potential clinic capacity gain, due to incorrect appointment bookings.

As a brand new DQ team we are extremely motivated to improve Trust DQ and income and are currently developing a DQ performance dash board which will be shared in due course.

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			RAG	Trend						Alignment		
		Monthly Target	Status	Aug-16	Sep-16	Oct-16	Movement	YTD avg	Data Quality	Carter	SDF	Quality Account / CQUIN
1.1.3.2	Potential under-reporting of patient safety incidents (Quarterly)	Information on NRLS under review from DOH.										
1.1.4	Never events	0	R	0	0	1	↑	0.1				✓
1.1.4.1	Never Events - Incidence Rate	0.00%	R	0.00%	0.00%	0.04%	↑	0.0			✓	
1.1.5	Incidents resulting in death (1 month in arrears)	7	G	4	1		↓	4.0				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days) (1 month in arrears)	0.11	R	0.27	0.14		↓	0.22				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days) (1 month in arrears)	1.87	G	2.0	1.6		↓	1.7				✓
1.1.10	Incidents with moderate or severe harm with duty of candour response (1 month in arrears)	1.00	G	0.13	0.41		↑	0.2				✓
1.1.14	Pressure ulcers (grade 2) attributable to trust	10	R	3	9	13	↑	9.7				✓
1.1.15	Pressure ulcers (grade 3&4)	0	G	2	2	0	↓	1.0				✓
1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.0	0.0	0.0	↔	0.0			✓	
1.1.21	% Duty of Candour with first letter	Datix system being reconfigured to allow accurate data capture.										
1.2.2	New VTEs - point prevalence in month	0.4%	G	0.2%	0.6%	0.0%	↓	0.6%			✓	
1.2.7	Emergency c-section rate	<15%	R	18.0%	15.0%	17.0%	↑					
1.3.1	MRSA screening of admissions	95%	G	94%	89%	97%	↑	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	G	0	1	0	↓	1			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	R	2	6	4	↓	1			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G		100.7		↑	102.8			✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	R		105.0		↓				✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	100	R		112.7		↔	115			✓	✓

Commentary	Actions
Serious Incidents - Thematic analysis has taken place, with all Directorates having monthly learning events. Corporate Directorate begin quarterly events from December onwards. New SI process has been launched and it is anticipated the breach rate and timeliness of reports will improve over the next few months **Proportion of harm free care** - Has shown improvement, with a position of 89.35% in October. However, in regards to new harms we are at a position of 99.78% , the best performance in over 12 months. **Mortality** - The Hospital Standardised Mortality Ratio (HSMR) has remained at 100 (100.65) for the 12 month rolling period of August 15 – Jul 16. The HSMR Weekend value continues to show a downward trend, and is currently sitting at 105.	**Serious Incidents** - Incident reporting system is now being improved and remapping of codes is taking place on November 21st by NRLS team. We are expecting our incident reporting rate to increase just below national average for time of next national report as part of this excercise

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4. Effective

		Status		Trend							Alignment		
		Monthly Target	Status	Aug-16	Sep-16	Oct-16	Movement	YTD avg	Data Quality		Carter	SOF	Quality Account / CQUIN
2.5.4	Emergency Readmissions within 28 days	5%	R	12.4%	8.4%	11.1%	↑	11%				✓	
2.6	Discharges before noon	25%	R	11%	12%	14%	↑	12%				✓	✓

CQUINs		
Indicator	**Status**	**Commentary**
NHS Staff and Wellbeing Physical, Mental & Physio		On target
NHS Staff and Wellbeing food		The Baseline review is presently being undertaken. Some indicators are already achieved. Staff Menu to be reviewed shortly to introduce healthier options. High Risk remains with "League of Friends" shops within the hospital as their products do not meet the set critera.
NHS Staff and Wellbeing flu		Awaiting update
Sepsis 2a		There is a large amount of audits which are required for this CQUIN, and so in order to support nursing staff who are completing the audits, a business case for additional support is with Execs.
Sepsis 2b		
Antimicrobial Resistance 5a - reduction		Awaiting update
Antimicrobial Resistance 5b - review		Awaiting update
Joint Formulary		On target to deliver
Medicines Reconcilliation		On target to deliver
Review of patients on Oral Nutritional Supplements		On target to deliver
Reduction in Community Acquired Pressure Ulcers		On target to deliver. However, investigations are not being completed in a timely manner and so there is currently about 20 investigations outstanding. A new process is being written and this will be in place by 1st December 2016.
Discharge Before Midday		Target for Q3 is 30%. For October, reporting 14%
Paediatric outpatient referral management system		Awaiting update
Development of Electronic Discharge Note		On target to deliver. Received confirmation from CCG that achieved Q1 and Q2 milestone. Q2 reconcillation is yet to be completed.
Paediatric asthma and wheeze pathway		Awaiting update
Optimal Device		Data for Q1 and Q2 submitted to NHSE. Awaiting reconcillation
Adult Critical Care Timely Discharge		Data for Q1 and Q2 submitted to NHSE. For Q2, 25% discharged within 4 hours, 32% discharged between 4 and 24 hours, 43% discharged after 24 hours. Awaiting reconcillation.
Increase take up of School Immunisation		The action plan to increase uptake of school aged immunisations has been submitted to the PHE Screening & Immunisation Team (SIT)who are monitoring this on behalf of NHSE. Following a teleconference on 02.11.16 with the SIT and the NHSE commissioner it was agreed that there needs to be some further additions to the plan, and this will be re-submitted in the next two weeks.

5. Caring

		Monthly Target	RAG Status	Trend Aug-16	Trend Sep-16	Trend Oct-16	Trend Movement	Trend YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	83%	G	85.2%	82.3%	85.2%	↑	85%			✓	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	65%	G	74.7%	74.4%	78.2%	↑	75%			✓	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	79%	G	97.9%	99.0%	98.8%	↓	99%				✓
3.1.3	Mixed Sex Accommodation breaches	15	R	28	33	99	↑	25.7			✓	
3.4.1	Number of Complaints	45	R	44	59	57	↓	46			✓	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	85%	R	20%			↑	16%			✓	
3.4.3	Number of complaint returners	↓	G	7.0	7.0	2.0	↓	6.6			✓	

Commentary	Actions
MSA - Increase in MSA breaches due to clinical reasons and Trust being in red and black escalation Complaints - Team of complaints responders working through the backlog. As of week beginning 14th Nov 43 were left to complete	Further investigation into MSA breaches taking place New process rapid review process should prevent any further significant back log from development

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6. Responsive

		Status	Trend							Alignment		
	Monthly Target	**Status**	**Aug-16**	**Sep-16**	**Oct-16**	**Movement**	**YTD avg**	Data Quality	Carter	SOF	Quality Account / CQUIN
4.1.1	RTT – Incomplete pathways (overall)	92%	R	77.71%	77.75%	77.89%	⬆	76.54%			✓	
4.1.2	RTT - Treatment Over 52 Weeks	0	R	18	22	16	⬇	17				
4.2.3	**A&E 4 hour target**	95%	R	81.49%	81.13%	79.82%	⬇	80.50%			✓	
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	R	88.97%	82.29%		⬇	79%			✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	90%	R	72.73%	87.50%		⬆	81%			✓	
4.4.1	Diagnostic waits - under 6 weeks (1 month in arrears)	99%	R	91.18%	90.86%		⬇	92%			✓	
4.5.8	**Patients seen by a stroke consultant within 24 hours (May to Jul figures reported)**	95%	R	53%	76%	45%	⬇	55%				✓
4.6.1	Average elective Length of Stay	<5	G	2.3	2.29	2.41	⬆	2.3				✓
4.6.2	Average non-elective Length of Stay	<5	R	5.7	6.34	6.72	⬆	3.7				✓
4.6.6	Average occupancy	90%	R	92%	94%	96%	⬆	92%				✓

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

Commentary	Actions
RTT - The Trust returns to reporting which is a significant acheievement and the team have received positive feedback from the IST. **ED** - The Trust's four hour performance deteriorated in October compared to September. This follows the reconfiguration of CDU. A new RAT/Triage model has been implemented in ED, which should see an increase of 13-20% more patients being seen within 4 hours. **Cancer** - The Trust failed to meet the 62 day GP referral standard across the majority of tumour sites. Pathway breaches were varied due to complex pathways, patient choice and delays in diagnostic tests. These figures also take into account the patients for whom we are partially responsible with other Trusts. Please see Executive Summary for further cancer metric updates **Diagnostics** - We have seen an increase in the waiting list in September, up to 7067 from 6148 in August. Our performance has remained relatively stable at 90.86% The majority of breaches (536) were due to capacity issues.	**RTT** - Launch Dymanic outcome form and board 24th Nov and shared nationally conituning programme of work **ED** - Further work is being done to develop and implement new pathways to speed patients through the department and in November through to January extra work is being undertaken to avoid admissions.

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7. Well led

		Monthly Target	Status	Aug-16	Sep-16	Oct-16	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
			Status	**Trend**							**Alignment**	
5.2.1	Staff Friends and Family – Recommend as place to work (Quarterly)	62%	R		58.0%		↔	48.8%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	79%	R		73.0%		↔	67.5%			✓	
5.3.7	Rolling annual turnover rate	8%	R	9.1%	9.1%	9.2%	↑	9%			✓	
5.3.7.1	Executive Team Turnover Rate	TBA		0.0%	0.0%	7.1%	↑	0%			✓	
5.3.8	Overall Sickness rate	4.0%	G	3.9%	3.9%	3.9%	↔	3.9%				
5.3.9	Sickness rate – Short term	2.0%	R	2.7%	2.7%	2.7%	↔	2.8%			✓	
5.3.10	Sickness rate – Long term	1.0%	R	1.3%	1.3%	1.2%	↓	1.1%			✓	
5.3.11	Temporary staff % of pay bill	15%	R	23.9%	20.7%		↓	23.4%			✓	
5.3.14	Starters	N/A		129	89	93	↑	87.7				
5.3.15	Leavers	N/A		154	51	99	↑	70.9				

Commentary	Actions
Recruitment and retention remain a priority for the Trust. Vacancy levels remain at the same level in month. There was an increase in leavers in month, this includes the TUPE of staff in GUM (14 staff). Mandatory training, appraisal and local induction has slightly improved this month.	- PMO work force programme continues

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8. Enablers

		Monthly Target	Status	Trend Aug-16	Sep-16	Oct-16	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
7.2.1	APC – NHS number completeness (1 month in arrears)	99%	R	98.8%	98.9%		↑	98.8%				✓
7.2.8	A&E – Attendance disposal (1 month in arrears)	99%	R	96.0%	96.2%		↑	96.2%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	0	R	88	43		⇓	51.0		✓		✓
7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	0	G	0.0%	0.0%		↔	0.0				
7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	0	R	393	397		↑	438.7		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	0%	R	1.49%	1.55%		↑	1.6%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	0.00	R	421	414		⇓	461.17				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	0.00	G	1	0		⇓	3.83				
7.3.13a	A&E No. missing breach reason on breached attendances	0	R	1768	1806	1991	↑	1123.0		✓		✓
7.3.13b	A&E % missing breach reason on breached attendances	0%	R	100.0%	100.0%	100.0%	↑	82.1%		✓		✓
7.3.17	Cancer 2ww invalid NHS Number	0	R	5	0	1	↑	5.3		✓		✓
7.3.21	Cancer 2ww missing breach reason	0	R	39	8	45	↑	32.6		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex	0	R	0.71%	0.01%	0.01%	↔	4%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis	0	R	11	3	5	↑	9.6		✓		✓
7.3.29	Cancer 31 day missing breach reason	0	R	4	3	2	⇓	3.6		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis	0	R	5	0	5	↑	5.6		✓		✓
7.3.36	Cancer 62 day missing breach reason	0	R	5	2	2	↔	6.4		✓		✓

Commentary	Actions
RTT data quality - is currently maintained to a high standard across the Trust due to a collaborative approach from both DQ team and Divisional services **Radiology project** - the DQ team in conjunction with the Finance department have just embarked on a project of unbundling imaging procedures from block contract. With a potential worth in excess of million pounds. **Patients potentially omitted from waiting lists** - have been fully validated and back log cleared and is being maintained daily by Divisional services.	- Continue to recruit substanively within the Data Quality Team - Supporting in the roll out of the Dynamic Outcome form

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Note: Indicators that have been green for 6 months or more have now been archived and will be monitored separately

Report to the Board of Directors

Board Date: 24th November 2016

Title of Report	Monthly Operations Report
Reporting Officer	Ben Stevens, Director of Clinical Operations CSC
Lead Director	Margaret Dalziel, Ben Stevens, James Lowell
Responsible Sub-Committee	Performance Review Access Board ED Improvement Group
Executive Summary	To provide the Board with an update on performance in the following areas: • RTT: ↑ 77.9% – target 81.6% (national 92%) • Diagnostics: ↑ 93.36% - target 99% • ED performance: ↓ 80% - target 89% (national 95%) Cancer performance • 2ww: ↓ 69.7% - target 93% • 2ww Sym Breast: ↑ 94.9% - target 93% • 62d referral ↓ 82.29% - target 85% • 62d screening ↑ 90.91% - target 85% • 62d upgrade ↑ 72.7% - target 85%
Risk and Assurance	• Performance against the access standards for Emergency and RTT pathways does not meet the national targets. • Improvements continue to be made and action plans remain in place to support the maintenance of the improvement trajectory.
Legal Implications/Regulatory Requirements	The updates are provided in the context of national requirements for access and emergency pathway standards and against requirements from CQC inspections and improvement expectations.
Recovery Plan Implication	The subject matter of the report supports the recovery plan in the following areas: • Continuing to modernise our Emergency Department and pathway, reducing the time it takes for patients to be seen and assessed. • Improving care for patients with cancer, reducing waiting times, replacing our scanners and providing additional capacity for patients to see specialists.
Quality Impact Assessment	QIA not required.
Recommendation	The report is provided for information only.
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

ED Update – October 2016 Position

Summary of October 2016 position:

October saw 9656 total attenders, a slight raise on September's 9649. This is an over 11% increase on October last year. Ambulance attendances were 3247, over 5% up on September 2015. MFT remains consistently the top performer in the region with 53.2% of handovers within 15 minutes despite seeing significantly more ambulances than the next top performer. Last September only 39% were managed within 15 minutes. This year to date, MFT has seen over a 12% increase in total attenders and an over 5% increase in ambulance attendances. Performance against the 4 hour standard was 79.82% for October.

Quality indicators:

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

The corridor use ceased on the 4th October with only a small number of patients managed in the corridor as opposed to the around 1000 per month previously.

Ambulance performance – Medway saw 3247 ambulances with 53.2% offloaded within 15 minutes. This put MFT top for the region despite receiving significantly more ambulances than the next best performer.

Measurement of the ED LOS at the 80th percentile for October saw it at 4 hours 17 minutes, the worst performance in the last 3 months and an indication of arrested flow through and out of the ED. At the 95th percentile it was 10 hours 38, an increase on previous months but reflective of the loss of CDU functionality in the ED and delayed speciality patient movement. Robust pathway mapping takes place which looks at Specialities which highlights the largest amount of breaches over 4 hours attributable to Speciality beds and responses contributes significantly to increased LOS.

The DTA process continues to be monitored through pathway mapping to assure it happens as soon as the necessity for admission is identified.

Weekly breach meetings have commenced across directorates using the process mapping as the data source for discussion. This has highlighted delays across all specialities in review, decision making and time to leaving the department – not always bed related.

1769 admissions, up on September and over 10% up on October 2015
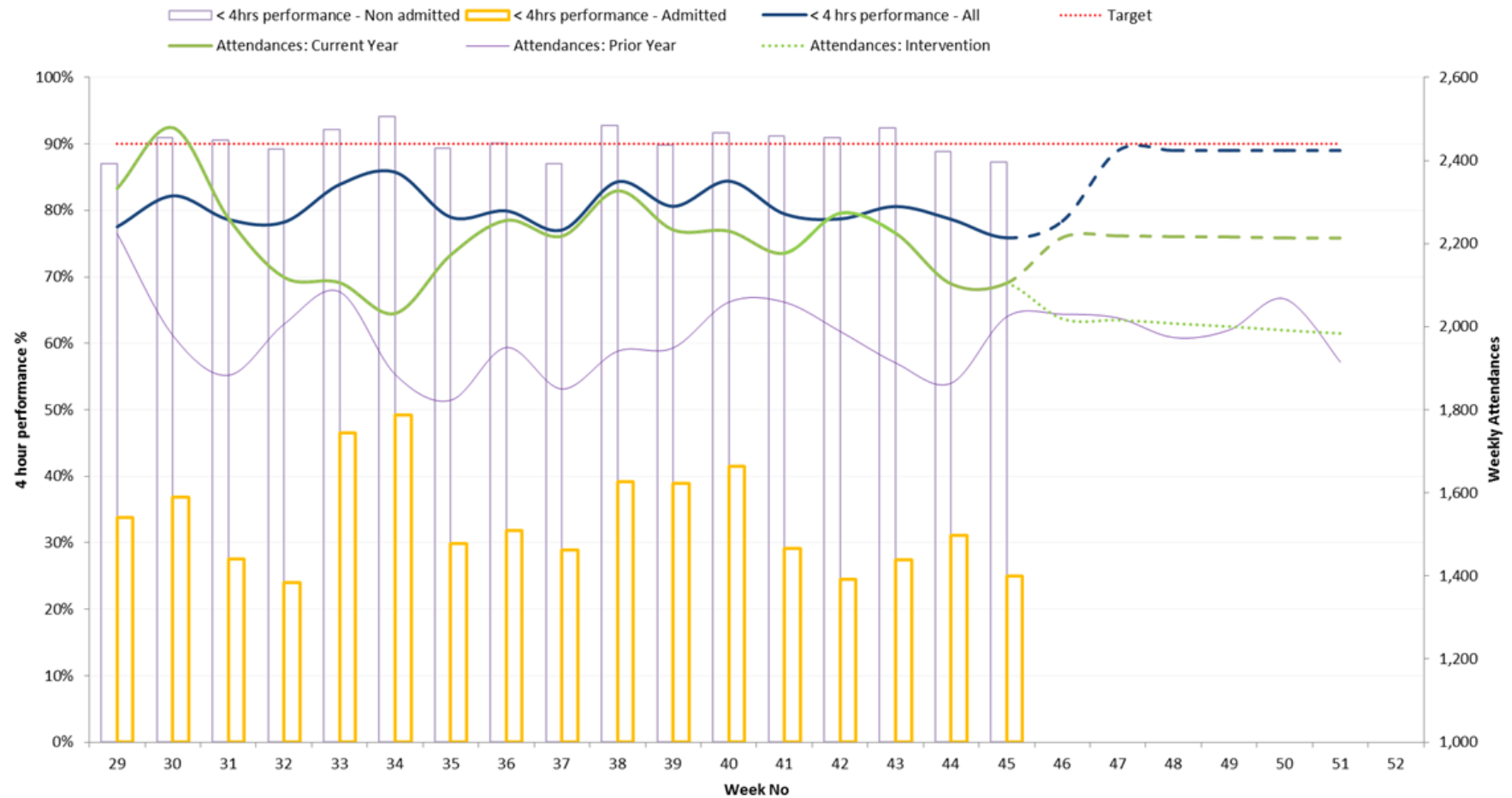
Octobers Site Position:

The site continues to experience delays in progressing patients through the department once speciality referral takes place and a DTA is in place. The CDU functionality in ED ceased on October 4th with this area changing from 8 beds to 12 trolleys allowing the corridor use to cease. Mental health delays for beds had contributed to delays and a length of stay of up to 7 days before; this has been 35 hours at its highest for October with a "red" bed available externally for MFT use only. Additional staffing is in place for the mental health liaison team overnight and weekly operational meetings are in place.

The trust's "Concept of Operations" was launched on the 17th October which describes the daily process required to improve flow – it provides an operating and reporting framework. This has contributed to a greater understanding of the site position but requires some further work to embed and revise.

Emergency flow remains poor with a deficit between demand and capacity resulting in significant delays and one breach of the 12 hour standard on October 31st.

A Rapid Assessment Process (RAP) was instigated at the ED front door providing a combined senior nurse and Associate Practitioner allowing much earlier interventions and streaming. This is being closely monitored with expectations it will improve the time to be seen by an ED clinician significantly as well as the number of patients streamed to alternate pathways.

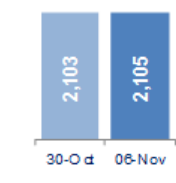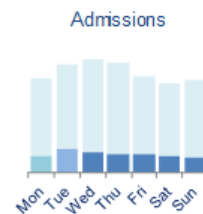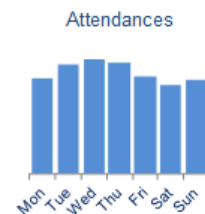# ED Improvement : week ending 6th Nov 2016

Total attendances

	Mon 31-Oct	Tue 01-Nov	Wed 02-Nov	Thu 03-Nov	Fri 04-Nov	Sat 05-Nov	Sun 06-Nov		16-Oct	23-Oct	30-Oct	06-Nov
Attendances	282	325	341	328	289	264	276		2,273	2,225	2,103	2,105
Emergency Admissions	48	72	59	54	57	48	46		420	404	373	384
%	17%	22%	17%	16%	20%	18%	17%		18%	18%	18%	18%

Hospital

Attendances — Admissions — 2,103 / 2,105 (30-Oct / 06-Nov) **Weekly +0%**
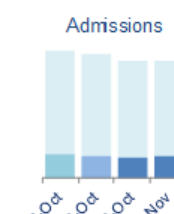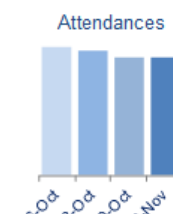
Attendances — Admissions — 86,487 / 97,115 (2015 / 2016) **YTD: +12%**

Handover <15mins

	31-Oct	01-Nov	02-Nov	03-Nov	04-Nov	05-Nov	06-Nov	Target	16-Oct	23-Oct	30-Oct	06-Nov	
	35%	42%	44%	41%	51%	58%	51%	60%	53%	60%	52%	46%	●

Seen by A&E Doctor <1hr

	31-Oct	01-Nov	02-Nov	03-Nov	04-Nov	05-Nov	06-Nov	Target	16-Oct	23-Oct	30-Oct	06-Nov	
	44%	43%	32%	54%	54%	66%	48%	50%	41%	55%	42%	48%	●
95th Perc to A&E Doctor	03:14	03:39	03:34	03:10	03:11	02:05	02:10		02:56	02:38	02:54	03:17	

Seen by Specialist <2hr

	31-Oct	01-Nov	02-Nov	03-Nov	04-Nov	05-Nov	06-Nov	Target	16-Oct	23-Oct	30-Oct	06-Nov	
	45%	49%	56%	45%	68%	61%	68%	70%	56%	56%	52%	55%	●
95th Perc to Specialty	04:33	05:00	05:30	05:30	04:45	03:29	03:37		04:15	04:35	04:39	05:01	

4 hour performance

	31-Oct	01-Nov	02-Nov	03-Nov	04-Nov	05-Nov	06-Nov	Target	16-Oct	23-Oct	30-Oct	06-Nov	
All	80%	73%	68%	70%	77%	81%	86%	90%	79%	81%	79%	76%	●
Admitted	19%	17%	10%	20%	37%	31%	48%	50%	25%	27%	31%	25%	●
Non Admitted	92%	89%	80%	80%	87%	92%	94%	95%	91%	92%	89%	87%	●

WEEK ENDING: Sunday 6th November 2016

Hospital

Total attendances

	16-Oct	23-Oct	30-Oct	06-Nov
Attendances	2,273	2,225	2,103	2,105
Emergency Admissions	420	404	373	384
%	18%	18%	18%	18%

2015: 86,487 2016: 97,115

Attendances

Admissions

YTD: +12%
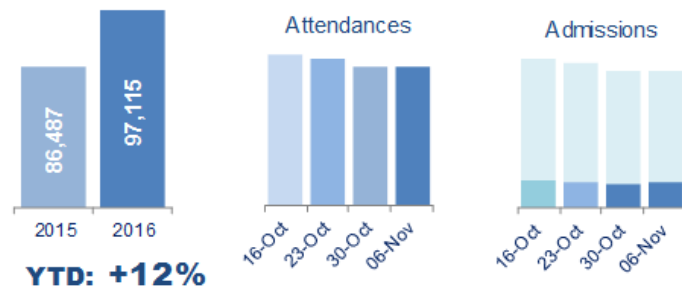
Seen by A&E Doctor <1hr

	Target	16-Oct	23-Oct	30-Oct	06-Nov	
	50%	41%	55%	42%	48%	🟡

4 hour performance

	Target	16-Oct	23-Oct	30-Oct	06-Nov	
All	90%	79%	81%	79%	76%	🔴
Admitted	50%	25%	27%	31%	25%	🔴
Non Admitted	95%	91%	92%	89%	87%	🔴

by Ambulance

Ambulance attendances

	16-Oct	23-Oct	30-Oct	06-Nov
Attendances	772	688	711	762
Emergency Admissions	277	264	240	263
%	38%	32%	38%	35%

Attendances = Total patient handovers per Secamb

2015: 31,095 2016: 32,869

Attendances

Admissions

YTD: +6%
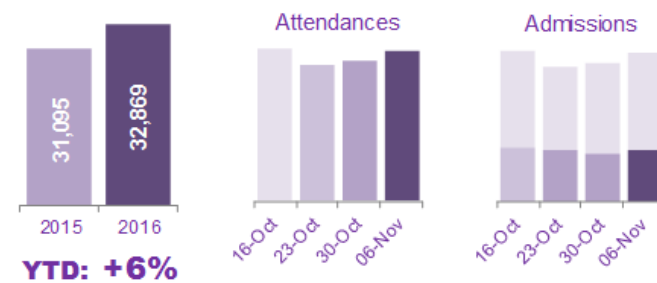
Handover < 15mins

	Target	16-Oct	23-Oct	30-Oct	06-Nov	
	60%	53%	60%	52%	46%	🔴

4 hour performance

	Target	16-Oct	23-Oct	30-Oct	06-Nov	
All	90%	53%	54%	56%	51%	🔴
Admitted	50%	17%	17%	22%	19%	🔴
Non Admitted	95%	77%	81%	70%	71%	🟡

Unplanned Care - October

Admissions	Flow	Discharge

Medical Model

4 hour performance

	Target	Sep-16	Oct-16	
All	90%	81%	80%	●
Admitted	50%	35%	29%	●
Non Admitted	95%	90%	91%	●

Total Attendances

YTD: 84,769 (2015) 95,293 (2016) +12%

Month: 9,694 (Sep-16) 9,656 (Oct-16) -%

Emergency Admissions

Month: Sep-16 Oct-16 — 17% 18%
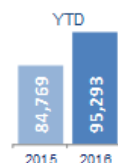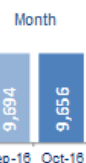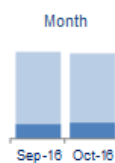
Handover < 15mins
by Ambulance

Target	Jan-16	Sep-16	Oct-16	
60%	37%	55%	53%	●

Ambulance attendances

YTD: 30,448 (2015) 32,221 (2016) +6%

Month: 3,200 (Sep-16) 3,247 (Oct-16) +1%

Emergency Admissions

Month: Sep-16 Oct-16 — 33% 37%

	Target	Sep-16	Oct-16	
Seen by A&E Doctor < 1hr	50%	42%	45%	●
95th Perc to A&E Doctor		03:12	02:59	
Seen by Specialist < 2hr	70%	56%	53%	●
95th Perc to Specialty		05:00	04:44	

Admissions via A&E

Age Range	Oct-15	Oct-16	% Change
<65	627	464	-26%
65-79	403	337	-16%
80+	432	400	-7%
Total	1,462	1,201	-18%

Admissions via A&E

Ward	Oct-15	Oct-16
Gundulph	69	278
Wakeley	68	291

Average LOS

Ward	Oct-15	Oct-16
Gundulph	4.9	2.3
Wakeley	6.0	1.8

Position at 27 Oct

	MFFT	DToC
Medical	80	29
Surgery	28	12
Other	0	0
Total	108	41

LOS reduction - Days

Age Range	Jan-16	Oct-16	Change
<65	3.9	3.6	-0.4
65-79	7.7	7.5	-0.2
80+	10.4	11.8	1.4
Average	7.0	7.3	0.3

Age Range	Mar-16	Oct-16	Change
<65	4.0	3.6	-0.5
65-79	8.3	7.5	-0.8
80+	11.6	11.8	0.1
Average	7.6	7.3	-0.3

Discharges from Medical Ward

LoS Range	Weekly Average		% Change
	Jan-16	Oct-16	
Zero LoS	58	52	-11%
7+ LOS	82	76	-8%

LoS Range	Mar-16	Oct-16	% Change
Zero LoS	59	52	-12%
7+ LOS	90	76	-16%

Prenoon discharges from an Acute Ward

Jan-16	Mar-16	Sep-16	Oct-16
11.8%	11.9%	12.5%	14.0%

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Cancer Update – September 2016 Position

Summary of validated September Open Exeter position

There has been varied performance against the cancer waiting time standards but the Trust failed the 62 day GP referral standard and trajectory due to variopus reason including delays by other providers. The GP 2 week wait standard deteriorated further due to lack of Dermatology capacity also affecting Children's performance but the symptomatic breast 2ww standard was met for the first time in over a year.

2WW – Trust has failed the GP 2 week wait but was compliant with the 2 week wait symptomatic breast standard.

- Failure to comply with the 2ww standard is due to lack of Dermatology clinic capacity resulting from Consultant vacancies. An agency locum is now in post and additional weekend clinics and commissioner initiatives to reduce demand are being implemented.
- The Trust achieved the symptomatic breast standard for the first time in 14 months and all breaches were due to patient choice/cancellations.

31D - The Trust failed to achieve the first definitive treatment & subsequent surgical treatment standards but maintained compliance with the drug subsequent treatment standard.

- Breaches in Breast, Skin & Urology were due to service capacity as a result of consultant leave and patient choice.
- The Subsequent surgical treatment standard achieved 100% compliance.

62D – The Trust failed to maintain compliance with the GP 62 day referral standard but achieved compliance with the screening standard.

- The Trust achieved 82.29% performance against the 85% standard & trajectory with 2 more breaches than allowed for compliance.
- Breaches were due across a number of tumour sites as a result of complex pathways, patient choice and delays in diagnostic tests.
- Cancer performance improvement workshops are scheduled for the most challenged tumour sites of Urology & Lower GI to identify issues, themes and develop remedial action plans.
- A number of breaches were shared with other providers contributing to deterioration in compliance and will be investigated with partners to reduce delays.
- The Trust achieved the 62 day screening standard and had only a 0.5 shared breach for consultant upgrade standard for which there is no target.

Cancer Waiting Time Summary Performance

|	Target	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
2WW cancer	93%	93.40%	92.57%	75.44%	76.39%	80.23%	69.73%
2WW symptomatic breast	93%	89.81%	86.00%	91.87%	82.61%	82.41%	94.87%
31D first treatment	96%	95.61%	94.39%	87.50%	92.31%	94.78%	93.88%
31D sub treatment surgery	94%	94.29%	97.14%	96.88%	100.00%	92.86%	76.67%
31D sub treatment drug	98%	100.00%	95.83%	100.00%	100.00%	100.00%	100.00%
62D GP referral	85%	73.77%	81.10%	74.48%	73.04%	88.97%	82.29%
62D screening	90%	84.85%	86.67%	100.00%	74.29%	75.76%	90.91%
62D consultant upgrade	n/a	100.00%	75.00%	100.00%	57.14%	72.73%	87.50%

Cancer Remedial Action Plan

There are 6 outstanding Cancer Remedial Action Plan actions with the expectation of reducing to 4 following the next RAP meeting with commissioners.
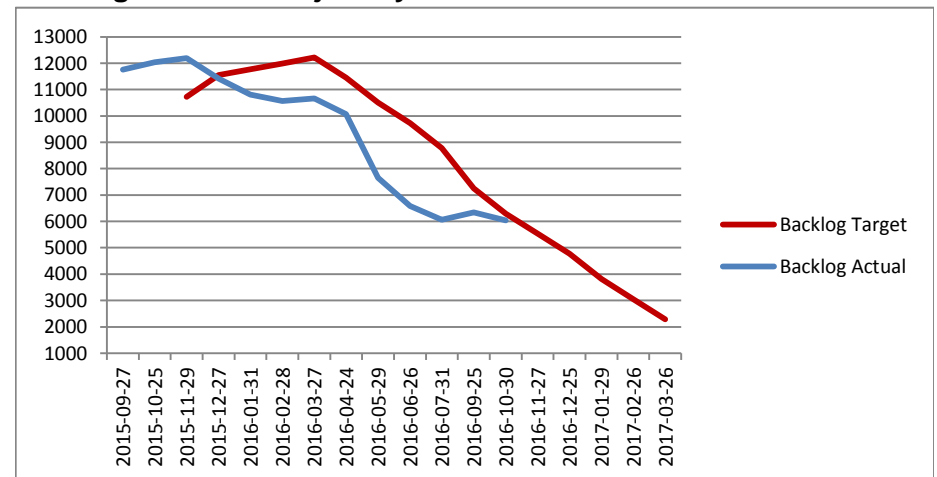
RTT Update – October Position

Summary of October position

- Prior approval has been given by the Trust Board to return to reporting for RTT. This was delayed due to the NHSi/NHSE request that the planned Oasis upgrade be completed first. Following the successful completion of the Oasis upgrade the Trust will recommence reporting of RTT performance in November for October data.
- The final report has been received following the IST assessment of the Trust current position. As anticipated there is only very minor variance between the self-assessment and the IST assessment. A summit will be held in November, led by the IST, with external partners to review the recommendations and agree the next level of support to be offered.
- The total incomplete waiting list size decreased by 247 patients across the month of October. Additional Capacity is being arranged which will support further waiting list reduction.
- Incomplete performance for October is 77.9% which is slightly behind the trajectory.
- The current backlog size decreased in October and remains below trajectory. Following detailed discussions the Trust is continuing to work towards delivery of the 92% incomplete RTT standard by the end of March 2017. It is acknowledged by all parties that this is particularly challenging and delivery is reliant on additional supporting actions from the CCG.
- A trajectory for the reduction of the number of patients breaching 52 weeks has been developed. Performance has improved in October but remains above trajectory.
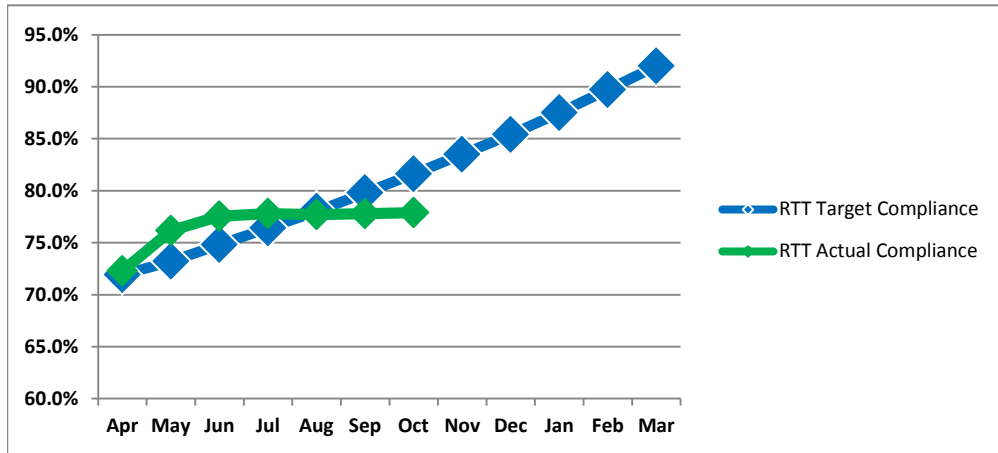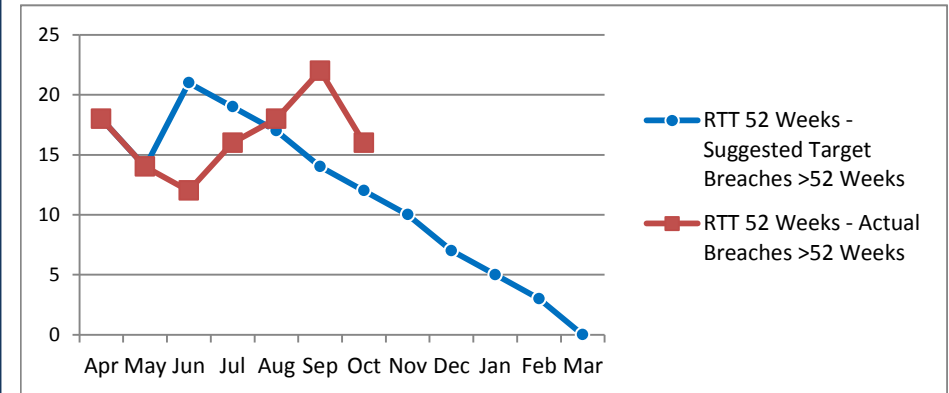
Total Waiting List Size
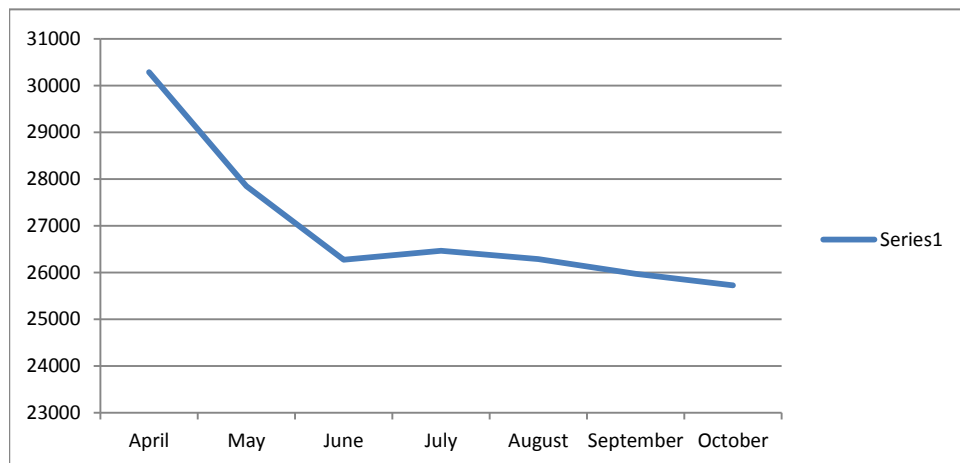
Backlog Actual vsTrajectory

Incomplete Trajectory & Performance

Legend: RTT Target Compliance, RTT Actual Compliance

52+ Week Breaches Trajectory & Performance

Legend: RTT 52 Weeks - Suggested Target Breaches >52 Weeks; RTT 52 Weeks - Actual Breaches >52 Weeks

18 week RTT Sustainability Plan

- The final Intensive Support Team diagnostic report was received in October an action plan based on the report has been developed and will form part of the overall RTT recovery plan.
- The outsourcing of orthopaedic activity to Ashford one is now in progress.
- Cardiology in-sourcing commenced in October. ENT in-sourcing will commence at the end of November.
- The planned care programme work streams have now launched.
- 60 clinical harm reviews have been undertaken for patients that have been waiting in excess of 52 weeks. No instances of severe or moderate harm have been identified.
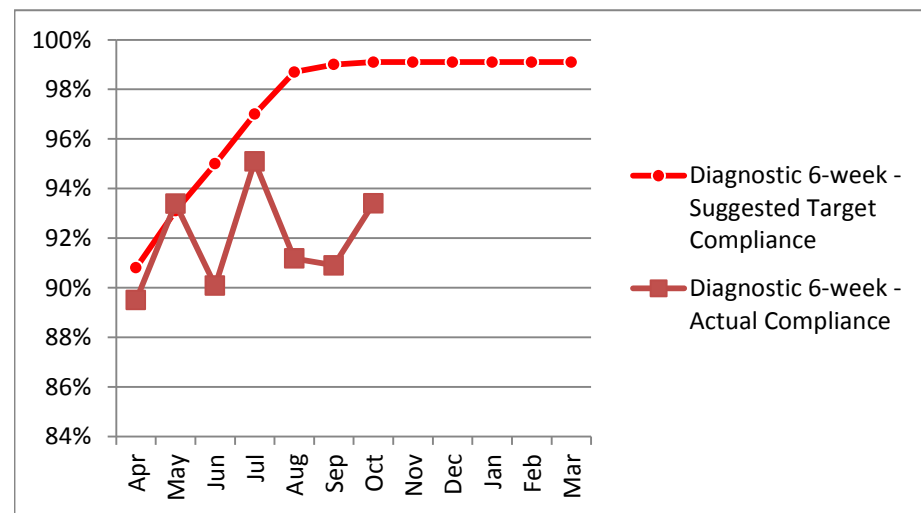
Diagnostic Update – October Position
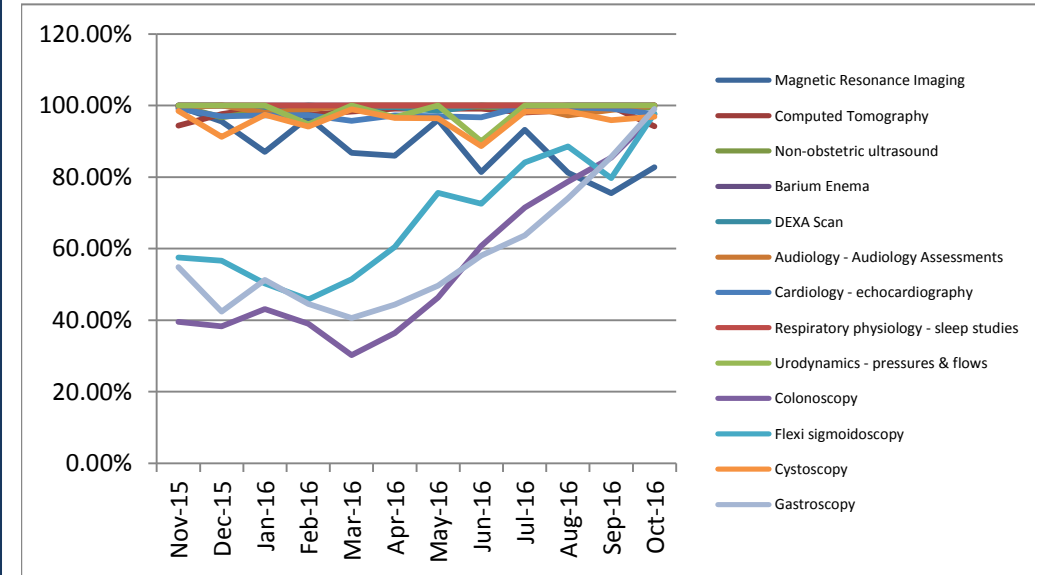
Summary of October position

- Trust performance against the 6 week diagnostic target has improved for October.
- MRI scanning has seen a slight improvement through the addition of capacity with a mobile scanner.
- Flexi sigmoidoscopy, gastroscopy and colonoscopy continue to improve as a result of the additional capacity that has been introduced through the in-source model.

Diagnostic Performance

Access Standard - 99% within 6 weeks

Legend:
- Diagnostic 6-week - Suggested Target Compliance
- Diagnostic 6-week - Actual Compliance

Diagnostic Performance by Modality

Legend:
- Magnetic Resonance Imaging
- Computed Tomography
- Non-obstetric ultrasound
- Barium Enema
- DEXA Scan
- Audiology - Audiology Assessments
- Cardiology - echocardiography
- Respiratory physiology - sleep studies
- Urodynamics - pressures & flows
- Colonoscopy
- Flexi sigmoidoscopy
- Cystoscopy
- Gastroscopy

Diagnostic Sustainability Plan

- Work is on-going to define the endoscopy estate required to deliver both JAG accreditation and the increasing demand.
- The in-source contract for endoscopy service will continue in support of a further reduction in waiting times .
- Additional capacity for MRI is in place with the leasing of a mobile scanner. The on-going requirement for the use of the mobile MRI to meet demand is currently being assessed.
- A strategic review of all areas within imaging is planned for completion by the end of 2016.

Medway **NHS**

NHS Foundation Trust

Report to the Board of Directors

Board Date : 24th November 2016

Title of Report	Chief Quality Officer Update
Presented by	Chief Quality Officer
Lead Director	CQO
Committees or Groups who have considered this report	n/a
Executive Summary	The purpose of this report is to update the Board on the progress/issue relating to the quality and health informatics team work programmes : Key points are : 1.1 The report (Appendix 1) outlines the current status in relation to serious incidents, themes and trends and actions 1.2 Of the 25 reports that were submitted for closure to the CCG this month – all reports were closed . The Trust therefore have currently 24 reports being investigated within timeframes and a further 8 awaiting sign-off by the directorates and 5 under investigation , these reports will be submitted to December CCG closure panel which will bring the breach position to zero. 1.3 The CCG acknowledge the improved position in relation to timeliness of recording SI onto the STeIS system within 48hours and the improved quality of the reports. 1.4 **Health informatics –** the majority of programmes are on target to be delivered. The PAS upgrade was successfully completed on w/beg 1st November 1.5 Bed management will be fully rolled out to across the whole of the medical directorate from January onwards. 1.6 The Trust following agreement with NHSIST and NHSI to return that we can commence RTT formal

	reporting in November (October data) following completion of the successful PAS upgrade.
Resource Implications	n/a
Risk and Assurance	n/a
Legal Implications/Regulatory Requirements	n/a
Recovery Plan Implication	Aligned to Aiming for Best
Quality Impact Assessment	n/a
Recommendation	For information and discussion
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☒ Noting ☐

Chief Quality Officer: Quality Update

1. EXECUTIVE SUMMARY

1.1 The report (Appendix 1) outlines the current status in relation to serious incidents..

1.2 Of the 25 reports that were submitted for closure to the CCG this month – all reports were closed . The Trust therefore have currently 24 reports being investigated within timeframes and a further 8 awaiting sign-off by the directorates and 5 under investigation , these reports will be submitted to December CCG closure panel which will bring the breach position to zero.

1.3 The CCG acknowledge the improved position in relation to timeliness of recording SI onto the STeIS system within 48hours and the improved quality of the reports.

1.4 **Health informatics –** the majority of programmes are on target to be delivered. The PAS upgrade was successfully completed on w/beg 1st November

1.5 Bed management will be rolled out to across the whole of the medical directorate from January onwards.

1.6 The Trust following agreement with NHSIST and NHSI to return that we can commence RTT formal reporting in November (October data) following completion of the successful PAS upgrade.

1. SERIOUS INCIDENTS UPDATE

1.1 The attached report (Appendix 1) outlines the position in relation to serious incidents as and including the w/ending 11th November. An extraordinary closure panel was held on 15th November and all 25 reports submitted were closed . The current position is that the Trust have 26 open cases that are being investigated within the timeframe, and the 11 remaining reports that are over the timeframe by 1-2 weeks will be submitted for closure at the next CCG panel in the first week of December

2. MORTALITY AND DATIX UPDATE

1.2 Trust's position within the published mortality indicator the Hospital Standardised Mortality Ratio (HSMR) continues to demonstrate a downward trend and is 100.68 for the latest period (July 2016 – Nov 2016) which is within benchmarked limits and in line with our South East Coast peers. The Summary Hospital-level Mortality Indicator (SHMI) for the latest period (Sept2015 – Sept 2016) remains higher than expected level at 1.13, however this is the lowest value demonstrated by the Trust in this indicator in over 2 years and the Trust is optimistic that the SHMI will continue to demonstrate a reduction moving forward and aims to be within benchmarked limits by the end of 2016/17.

2.1 The Trust's incident reporting system Datix is currently undergoing a review and work will be undertaken to upgrade and re-design the system to improve the incident reporting functionality for end users over the coming months.

2.2 Incident reporting when nationally benchmarked is within the lowest 20%, however following the review the reasons for this were identified. The incidents were not being uploaded until all incidents were closed which meant that many incidents were not being uploaded to NRLS (external system) in a timely manner. In addition the Datix system had not been updated to ensure that all incidents externally reported (all incidents are still reported internally) were mapped to the new NRLS Codes Set 2. The NRLS team are attending the Trust on November 21st to map all incidents to the new code set, they will then be uploaded to the external database. These 2 changes will mean that the Trust should then fall within or just below the average reporting rates nationally.

2.3 Key features of the developed system will include real time dashboards at directorate and ward level, improved feedback to reporters following the resolution of an incident and comprehensive staff training. A Datix User Group is also being established and will hold its initial meeting within the next month, this group will enable end users to input in to the design of the system and will establish super users at directorate level to support with incident reporting, in addition it will form the

governance process by which future changes to the system will gain approval. A detailed action plan has been produced outlining the changes and the Trust has worked with Guys and St Thomas' NHS Trust (GSTT), Bart's Health and Rotherham NHS Foundation Trust to ensure that all changes are in line with best practice.

3   HEALTH INFORMATICS UPDATE

3.1 Electronic Order Comms Programme

- The Project Team are working towards a Go Live date in Q1 of 17/18 following the launch of the Medway and Dartford joint pathology partnership in April 2017.
- The team have begun more in depth discussions with other Healthcare partners to progress the project
- We are awaiting confirmation from Swale CCG on contribution to additional resource for the project team (Medway CCG have already confirmed and agreed) as both CCGs have been unable to provide their own project resources to support the solution deployments at the GP practices, as was initially agreed.

3.2 Bed Management and Electronic Observations

- Initial meetings to assess device acceptability with clinical and nursing staff have commenced.
- The project team are working towards a December implementation in one ward for piloting purposes and mid-January 2017 Go Live for touchscreens across the whole of the Medicines Directorate. The plan was to initially implement a rolling programme however the value of a 'big bang' approach was deemed to higher.
- The team are refining hardware quotes and orders and are working with Estates to prepare the areas in readiness for the new touch screens to be installed and connected early January.
  .

3.3 Electronic Document Management (EDM)

- The Pre-Qualification Question (PQQ) phase of procurement closed recently. The team are reviewing responses to narrow the field of suppliers in order to move to the next stage of procurement in December.

3.4 Mobile Interoperability Gateway (MIG)

- MIG Web Viewer (Also known as the Summary Record Viewer or SRV) has been successfully deployed to Lister Ward and the Penguin Assessment Unit. At time of submission, the project team were working with Surgical Assessment Unity (SAU) to confirm the Clinicians for deployment to there, and will be moving onto the ED by the end of November.

- Work is also now in early planning stages to integrate the MIG with Symphony in the ED. Medway CCG are potentially funding this piece of work, and the project team are now in early planning discussions with the CCG, EMIS (Symphony Software Supplier), Health Care Gateway (MIG supplier) and South East Commissioning Support Unit (SECSU – who are supporting Medway CCG from a deployment perspective) to plan for a Feb/March 2017 deployment.

3.5 Child Protection Information Standards (CP-IS)

- This project is awaiting confirmation from the local authority partners that they have progressed with their system input and compliance, before internal work streams can move into delivery phase.

3.6 Oasis PAS upgrade to version 2016.1

- The overarching software upgrade to version 2016.1 was successfully delivered overnight on 1st November, with business continuity packs being fully shared and deployed across the main hospital and ward areas.
- The HI Project Team and supplier (Allscripts) Project Manager, were on site overnight with a colleague from emergency planning, to remediate any issues during the overnight down time. Service was restored in the early hours of Wednesday 2nd November, with all patient data successfully loaded onto PAS by 9am that morning.
- There have been a few small pockets of issues with the new version of the software, but these have been within the expected tolerances of a Trust Wide upgrade, and have not posed clinical or patient risk. The HI team have worked closely with Allscripts to remediate and fix these issues as they have been flagged by Trust staff.
- The project team are now focused on testing and analysing the final software patch (Cumulative Update 5 or CU5 from Allscripts) which is required to complete the overarching system upgrade and deliver the new interface functionality needed for the Bed Management and other solutions. This final software update, which will require a small amount of downtime overnight (2-3 hours as opposed to the larger upgrade of 10-12 hours) will be delivered during w/c 21st November.

3.7 NHS Mail 2

- Final details are anticipated from Accenture (solution provider for NHS England) to complete a Trust Wide migration to NHS Mail 2 in early 2017.

3.8 Maternity Solution

- HI PMO continue to work with W & C Team in preparing a business case for Executive Group approval, to go to tender for a complete paperless Maternity Solution. It is expected that the business case will be submitted to the December Executive Group meeting and if approved, will mean a full tender process, with

revised full business case being submitted to Executive and Trust Board in early 2017.

3.9 Other Programmes

- Integration Programme – interfacing work continues to support many of the other HI Programmes (including those mentioned above). This will increase during late November and December as new functionality is enabled by the final piece of the PAS upgrade.
- Chemotherapy ePrescribing – Is progressing to revised plan, of rollout by March 2017 with Paeds following in September 2017.
- E-Prescribing – Pharmacy and HI PMO are awaiting a proposal from an E-Prescribing specialist to inform the scope of the programme and prepare a business case.
- Upgrades – The HI team have successfully delivered an upgrade to the Galaxy System (theatres) in November, and will also be upgrading the Endovault Solution (endoscopy) at the end of November. The team are also supporting ED in the preparation of a business case to upgrade Symphony and it is hoped that this can be delivered in Feb/March of 2017.
- Digital Dictation and Voice Transcription – HI PMO are working with procurement to draft a high level programme plan and business case costings.
- DrDoctor – HI PMO are working with the Clinical Directorates and finance to prepare a business case for discussion and review at the December Executive Group, where the feasibility, financial opportunity and strategic fit of this patient engagement solution will be discussed.
- Check In Kiosks – HI are planning, in conjunction with Women and Children's, to pilot PAS check in kiosks in the W&C clinic areas of Green Zone. This will be an extension of the Allscripts PAS solution (this functionality was included in the initial procurement) and it is hoped that this can be made live in W&C by the end of the financial year, with a view to extending functionality during 17/18 to Outpatients and other areas.

Appendix 1: Patient Safety Summary

November 2016

Current Position

Number of Open Serious Incidents	Number of Breaching Serious Incidents	Average Number of Breach Days

| **November 2016** 64 | **November 2016** 36 | **November 2015** 103.5 Days | 69% | **November 2016** 32.18 Days |

- As of November 2016 there are 43 open Serious Incidents; 1 of which are historic incidents from 2015/16. The remaining 42 incidents are from 2016/17 and include 1 Never Event.

- 19 cases are breaching, the status of which is as follows:
    - **Awaiting CCG Closure** – 1
    - **Awaiting Directorate Sign Off** – 8
    - **Under Investigation** – 5
    - Maternal Death – 1 under external review in discussion with NHSE on breach situation

The remaining 24 incidents are within timeframe and investigators have been assigned.
- The average number of breach days has decreased by 69% when compared to the same period in 2016. The breach number will be zero following the December SI closure panel.

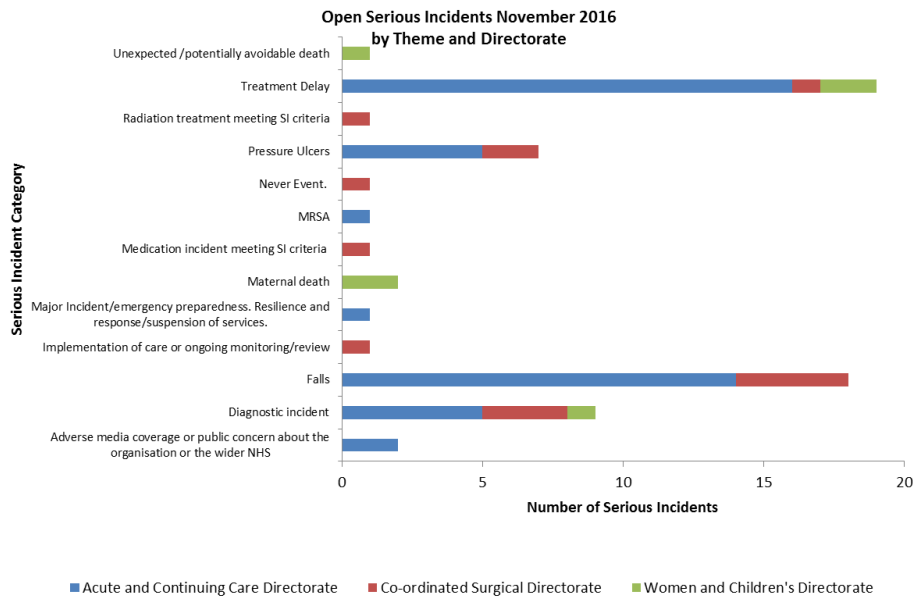**Best** of care
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Serious Incident Closures

25 Serious Incidents are due to be closed at an extraordinary CCG closure meeting on 15th November 2016, themes from the incidents to be closed include Treatment Delay, Misdiagnosis, Falls and Delayed Diagnosis.

Detailed action plans have been produced for each incident, a summary of which is as follows:

Theme	Actions
Treatment Delay	• Findings to be shared at Grand Round Events • Implementation of best practice guidelines • Training in administration of NAC and treatment of overdoses
Misdiagnosis	• ED education programme to include regular teaching from the vascular team • Simulation exercise for the management of patients with a AAA
Falls	• Review of escalation policy • Refresher safeguarding awareness training for staff in ED • Random audits of falls risk assessments to be undertaken
Delayed Diagnosis	• Repeat attenders to be flagged on the ED system • Senior review of patients who re-attend within 7 days with similar symptoms • Introduction of the Rapid Assesment and Treatment (RAT) protocol in ED, monitored through the use of audit

Themes and Trends

Medway NHS Foundation Trust

Open Serious Incidents November 2016 by Theme and Directorate

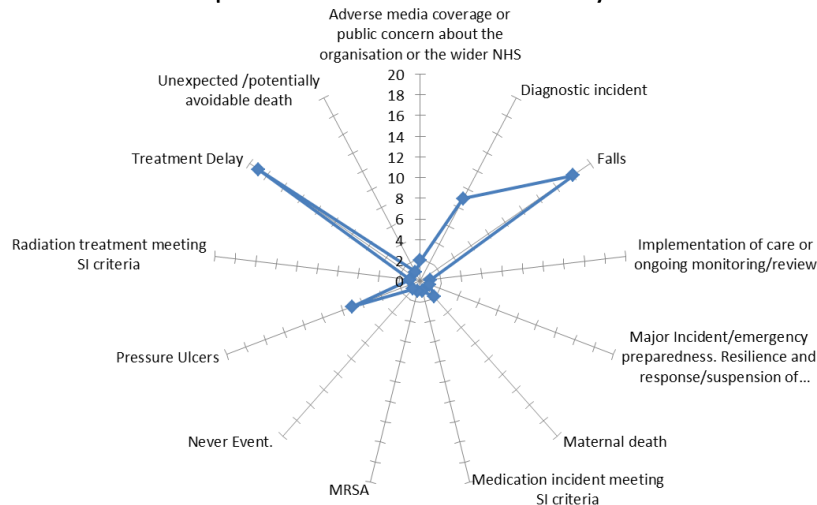Of the Open Serious Incidents the proportion by Directorate is as follows:

Acute and Continuing Care – 69%
Co-ordinated Surgical Directorate -22%
Women and Children's Directorate – 9%

Treatment Delay, Falls, Pressure Ulcers and Diagnostic Incidents are the common themes across Acute and Continuing Care and the Co-ordinated Surgical Directorate. Two of the incidents recently reported by the Women and Children's Directorate relate to Maternal Deaths that have occurred, these are mandatory Serious Incidents.

Category	Acute and Continuing Care Directorate	Co-ordinated Surgical Directorate	Women and Children's Directorate
Adverse media coverage or public concern about the organisation or the wider NHS	2	0	0
Diagnostic incident	5	3	1
Falls	14	4	0
Implementation of care or ongoing monitoring/review	0	1	0
Major Incident/emergency preparedness. Resilience and response/suspension of services.	1	0	0
Maternal death	0	0	2
Medication incident meeting SI criteria	0	1	0
MRSA	1	0	0
Never Event.	0	1	0
Pressure Ulcers	5	2	0
Radiation treatment meeting SI criteria	0	1	0
Treatment Delay	16	1	2
Unexpected /potentially avoidable death	0	0	1
Total	**44**	**14**	**6**

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Themes and Trends

Open Serious Incidents November 2016 by Theme

Treatment Delay Meeting SI Criteria April - October 2015/16 in Comparison with April - October 2016/17

Treatment Delay, Falls and Pressure Ulcers are the key themes of the current Serious Incidents being investigated.

There has been an increase in clinical Serious Incidents relating to Treatment delay, in 2016/17 60% of these have occurred with ED. In addition to the clinical Serious Incidents there have also been a number of non-clinical Serious Incidents relating to this category, i.e. black escalation and 12 hour breaches.

SWARM events have been held for Falls and Pressure Ulcers to identify immediate actions that can be taken in response to the increased numbers being seen in 2016/17. In addition the Trust has obtained agreement with the CCG to complete an aggregated SI for the 4 most recent Fall to Fracture SIs raised.

Themes and Trends Continued

Overall the number of incidents (by month incident reported) have increased in 2016/17. This is as a result of improved reporting following the developed Serious Incident Process.

Serious Incidents April - October 2015/16 in Comparison with April - October 2016/17 (Month Incident Occured)
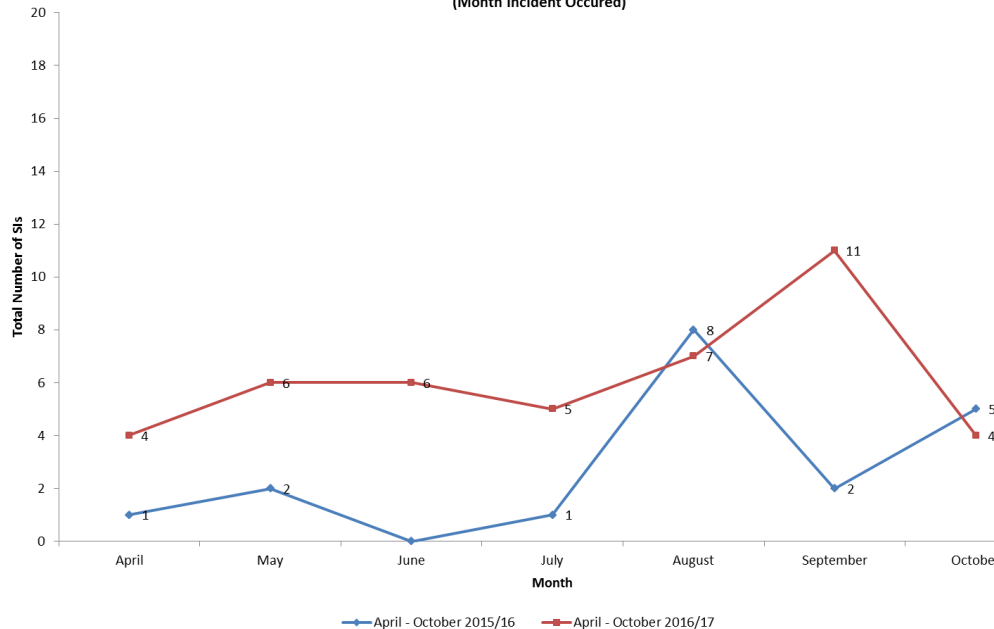
September 2016/17 saw an increase in Serious Incidents; of these 72% occurred in Acute and Continuing Care and concerned fundamentals of care such as Falls and Pressure Ulcers. The Transforming Care project will incorporate all of these elements moving forward and SWARM events around both Falls and Pressure Ulcers have been arranged to identify immediate learning and promote learning with experts in the field.

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Themes and Trends Continued

**Serious Incidents raised from Complaints, Inquests and M&M Reviews
April - October 2015/16 in Comparison with April - October 2016/17**
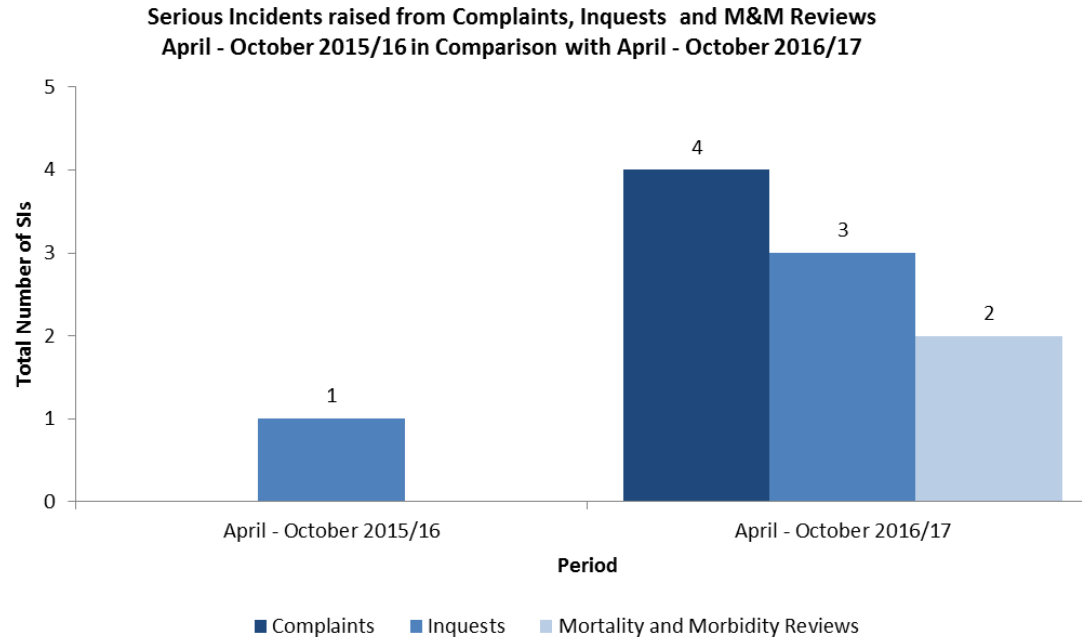
The Trust is triangulating patient safety concerns and linking information from Complaints, Inquests and the Trust Mortality and Morbidity reviews via the weekly Harm Free meeting. The chart above shows how many SIs have been identified in this way in 2016/17, an increase upon the position in 2015/16.

Recent Achievements

- Global 'Theme of the Week' (24th - 30th October) promoting incident reporting, learning from incidents and Duty of Candour.

- SWARM events

- Learning events

- Development of the Incident Reporting System, Datix to provide incident reporters with feedback following incident investigation, promoting learning.

- Anonymous incident reporting enabled, allowing staff Trust-wide to report incidents in confidence if required.

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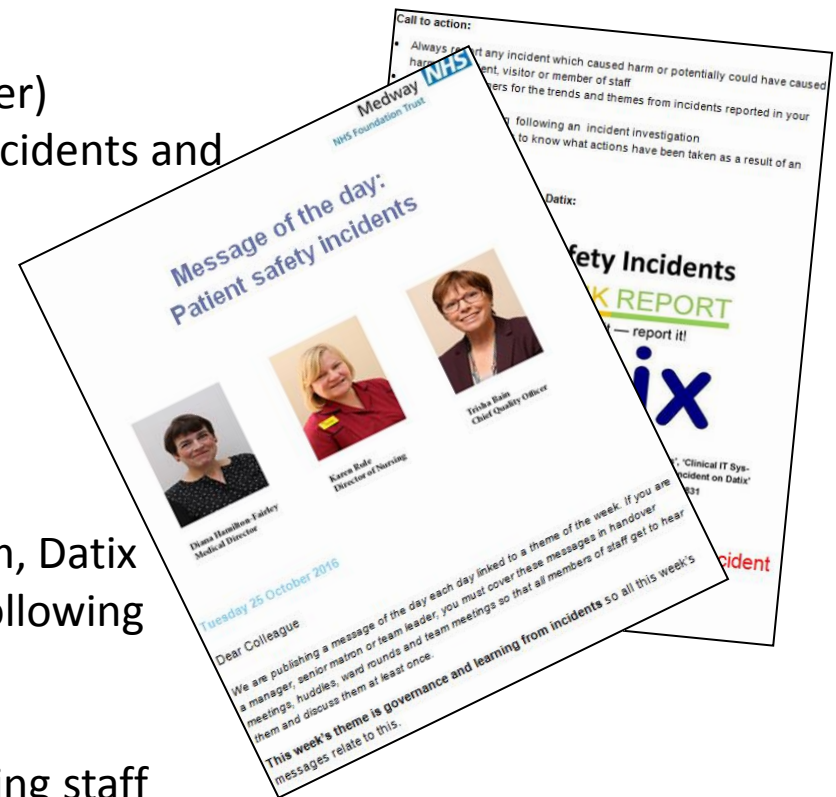
Continued Focus

- Revised Serious Incident Process launching on 21st November 2016.

- Revised Serious Incident Policy and Standard Operating Procedures (SOPs) to support the Serious Incident process and Incident reporting.

- Trust wide awareness sessions focusing on the lessons learnt from Serious Incidents and Duty of Candour (Commenced October 2016).

- Duty of Candour training sessions for clinicians.

- Development of a Quality, Assurance and Learning Unit linking internal/external review, investigation training, engagement and Quality Intelligence.

- Integrated Patient Safety Intelligence Report, triangulating intelligence in relation to Incidents and Patient Safety to provide assurance.

- Further development of the Incident Reporting System, Datix including increased training for staff Trust wide.

Revised Serious Incident Process

Medway **NHS**
NHS Foundation Trust

SI Process Delivery Timeline

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Report to the Board of Directors

Board Date : November 2016

Title of Report	Medical Director's Board Report
Presented by	Diana Hamilton-Fairley
Lead Director	Diana Hamilton-Fairley
Committees or Groups who have considered this report	None
Executive Summary	• Short summary of key highlight's attached
Resource Implications	None
Risk and Assurance	None
Legal Implications/Regulatory Requirements	None
Recovery Plan Implication	Not applicable
Quality Impact Assessment	Not applicable
Recommendation	
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Medical Director's – November 2016

1. EXECUTIVE SUMMARY

1.1. This report outlines progress and development within the Medical Director's office and direct reports for the reporting period.

1.2. Progress has been steady across all areas with notable issues and progress identified as follows;

2. RESEARCH & DEVELOPMENT

Every year the National Institute for Health Research (NIHR) produces a Research Activity League Table, which details research activity across all NHS Trusts in England. The table provides a picture of how much clinical research is happening, where, in what types of Trusts, and involving how many patients. Out of 450 Trusts,

•   Medway was 22nd due to the high number of patients participating in research studies (Top 5%). Overtaking East Kent Hospitals University NHS Foundation Trust which is in position 109 (top 24%), Maidstone and Tunbridge Wells hospitals which is in position 226 (top 50%) and Dartford and Gravesham NHS Trust in position 259 (58%).

•   MFT are 117th for the Number of studies recruiting in 2015/2016 (Top 26%).

The NIHR has also published an article titled 'Patients more likely to survive in research-active hospitals'. The article is about a study where it was found that bowel cancer patients are more likely to survive in research-active hospitals. The researchers also found that 'Even patients who are not involved in trials themselves benefit from being in hospitals where a large amount of clinical research is taking place'.

Jonathan Sheffield, Chief Executive at the NIHR, said: "These findings boost our belief that a research-active NHS can improve care and outcomes for all patients."

3. MEDICAL EDUCATION

3.1   Junior Doctors Contract

This has been implemented for higher Obstetrics and Gynaecology trainees since October, with the next group being Foundation year 1 doctors moving over

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to the new contract in December. There is a new MFT handbook to summarise the contract, roles and responsibilities being released this week; educational supervisors will be informed formally at a Grand Round style meeting on Thursday 17th November

3.2   Physicians Associates
We have appointed a member of consultant staff into the Physicians Associates Champion role to drive forward the programme, both in recruiting trained PAs as well as overseeing the PA student's clinical placements, working with Christchurch Canterbury.

4. DR RICHARD LEACH

4.1   Dr Richard Leach

Dr Richard Leach will be leaving Medway at the end of November 2016. I would ask the Board to join me in thanking Richard for his immense contribution in introducing the medical model, leading the introduction of mortality reviews and chairing the Clinical Effectiveness Group.

Report to the Board of Directors

Board Date: 24 November 2016

Title of Report	Director of Nursing Update
Reporting Officer	Karen Rule, Director of Nursing
Lead Director	Karen Rule, Director of Nursing
Responsible Sub-Committee	N/A
Executive Summary	**Safe Staffing** The Trust continues with a high level of activity and acuity demands, requiring high levels of nursing hours to deliver safe effective patient care. A review of staffing establishment in inpatient wards and in maternity has been undertaken. In light of developments since the review commenced it is recommended that the Trust maintains current staffing establishments in inpatient wards and the staffing establishment in midwifery increases by 5 wte **Infection** The Trust has reported 13 CDiff cases to date. The risk of breaching our 16/17 trajectory of 20 is high. **MSA** The Trust reported 99 MSA breaches due to increased activity and reduced patient flow. **Transforming Care** This programme launched in September and has already achieved a number of actions to improve patient experience.
Risk and Assurance	**Safe Staffing** Nurse staffing levels remains a Trust quality risk. Actions to mitigate the risk of current staffing levels are in place and embedded. **Transforming care** Providing good standards of nursing care is fundamental to the

	safety of our patients. This programme aims at ensuring that we mitigate the risk as much as possible of providing poor nursing care which is detrimental to the safety of our patients.
Legal Implications/Regulatory Requirements	
Recovery Plan Implication	**Safe Staffing** As a key quality risk the ability to improve our staffing levels is critical to the delivery of our recovery actions. **Transforming care** Whilst this programme of quality links closely with the recovery programme and our overall goal to get out of special measures in November, it is an improvement which aims to provide sustainable long term change in the way which we deliver care to our patients.
Quality Impact Assessment	N/A
Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	The purpose of this report is to provide the Board with information.
Recommendation	The Board of Directors is asked to note the information contained in this report and the actions that are in place.

Director of Nursing Update: October 2016

Monthly Safe Staffing Report

Introduction

The purpose of this staffing report is to:

- Provide an overview of the nursing and midwifery staffing levels and to highlight any workforce issues identified across the inpatient ward areas during the month of October 2016.

- Highlight any specific areas of concern or risk related to the nursing and midwifery workforce in the delivery of safe care.

- To provide the Board with an overview of nurse, midwifery staffing levels in inpatient areas as outlined in the Nurse Staff Guide 'How to ensure the right people, with the right skills are in the right place at the right time!' Published by the National Quality Board and the NHS Commissioning Board.

The UNIFY data submission and Nursing, Midwifery and care Staff Return is at Appendix 1.

Planned versus actual hours

The actual hours worked was 9.4% above the planned hours. The underlying reason behind this increase is due to the continuing high levels of activity across the trust necessitating the use of extra beds in line with the escalation procedure and a subsequent increase in staff to maintain patient safety. This also reflects the need to support many complex patients who need constant 1:1 supervision in order to maintain patient safety. Figure one shows the accumulative overall fill rates as per month.
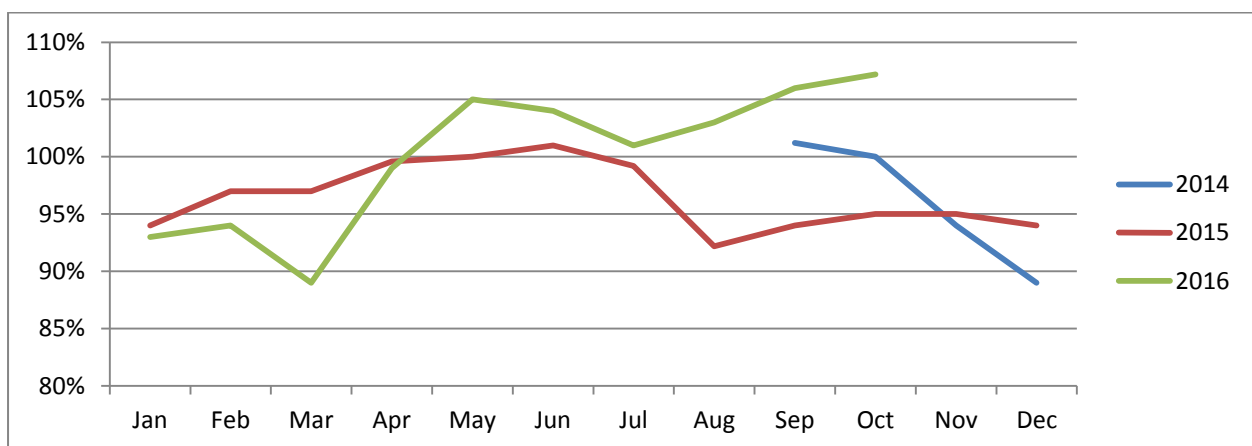
Figure 1 Overall fill Rate September 2014- October 2016

During October ten wards utilised over 10% or more actual hours then had been planned. Three wards recorded over 40% of their planned hours; McCulloch (surgical ward) which has had extra beds open throughout October to support the increased levels of activity across the Trust. The other two areas are Keats (medical ward) and Victory (cohort MRSA ward) who have required an increased level of 1:1 supervision to support complex patients. Other areas reporting over 10% of actual hours include Byron, Milton and Sapphire (all elderly care wards) Arethusa (orthopaedic ward), Will Adams (medical Ward), Gundolph and Wakeley (short stay medical wards). These wards are reflective of the above indicators where there has been a need to support complex patients who need 1:1 supervision.

Temporary Staffing

There continues to be a high demand on the resources of temporary staffing. Temporary staffing requests for October have increased by 265.2 hours to 103567.6 hours from the previous month. The percentage of overall shifts filled is 82.9%, which is an increase fill rate of 5.8%. Most of these shifts continue to be filled by Agency staff (55.3%) whilst temporary staffing have filled 2% more than previous month (27.6 %) The majority of the requests made were to cover vacancies which accounts for 63% of all requests. The other main reasons for requests are 1:1 specialing for our vulnerable patients (17%), staff sickness (10%) and the provision of escalation beds due to operational pressures (8%) This remains consistent with the previous month.

Starters and leavers

In the month of October 14 registered Nurses commenced employment, alongside three registered Midwives and six Clinical Support Workers. In addition to this 4 Registered nurses and 15 Clinical support workers were employed via the temporary staffing as bank workers only. In the same period nine Nurses, three Midwives and three Clinical Support Workers left the organisation.

CHPPD data

In response to the Carter review all Trusts are required to submit care hours per patient day (CHPDD) data. The overall figure for October is 8.76. This is consistent with the data since reporting started earlier in the year. Although there remains a wide variance with the figures across wards and departments, with the Critical Care areas, The Birth Place and Delivery suite recording higher care hours analysis over the last four months shows that CHPPD data of individual wards and departments have been consistent. Please see figure 2 for the Trust overall CHPPD data

Care Hours per Patient Per Day

◆ Trust total

| | June 16 | July 16 | August 16 | Sep 16 | Oct 16 |
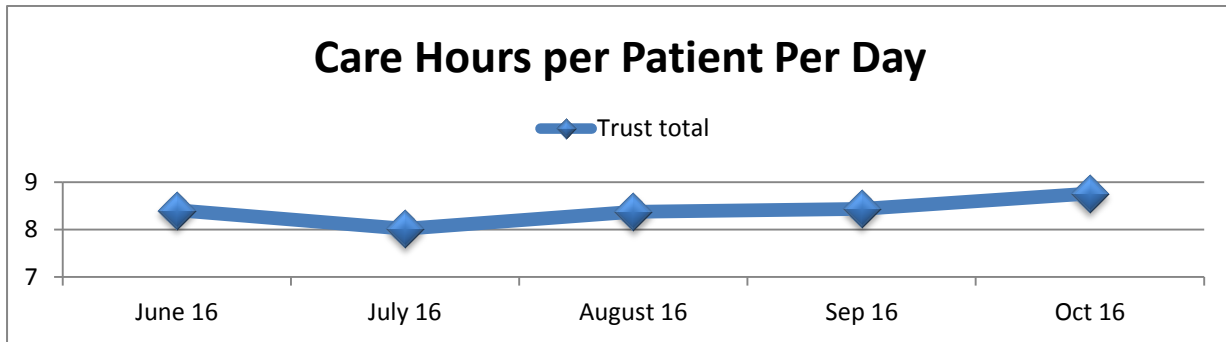
Figure 2 Overall Trust Score for Care hours per patient per day

Staff Escalation

There were 28 Incidents relating to staffing issues reported via Datix. This is a decrease from the previous month. Analysis of these incidents identify that they mainly relate to shifts where there are less than agreed minimum staffing levels per shift. Actions were taken in line with the Trust escalation policy to mitigate risk and maintain patient safety.

Recruitment activity

Recruitment and retention of nurses remains a priority for the Trust. Thirty three nurses attended recruitment open evening on 9 November with another specific evening for NICCU nurses planned the 23 November. Theatres also have an open evening planned for 14 December.   Links have been established with both partner universities and the Trust now has opportunities to attend their open days and careers event. The recruitment team is awaiting agreement to be able to attend the RCN careers fayre at the end of 2016 or in the spring of 2017. The Circus Recruitment Campaign goes live in November and will allow Trust to gather a much wider reach of candidates and look to attract candidates who may not have considered the Trust as an employer.

EU nurses

The Trust continues to work with MEDACS to recruit EU nurses. Following a programme of Skype interviews 10 nurses are due to commence employment January 2017, with a further 17 nurses due to join the trust in April 2017. A bespoke induction period is being planned for this group of staff with training over a two week period and then a period of supernumery time in the ward/ department areas to help with the transition to nursing in the UK. There is a plan for one more overseas trip, likely to be in Italy, in the New Year. Skype interviews have taken place for NICU nurses with the conditional offers made to 12 nurses.

Assessment Days

Assessment days for nurses and clinical support workers continue to be successful with conditional offers made to 15 nurses and 42 CSW during October. Assessment Days are booked to continue

to into the New Year. A review of these days is taking place to ensure they remain compliant with the trust requirements.

Bi annual establishment review

The NHS England *Hard Truths* report requires six monthly updates to Boards regarding review of nursing and midwifery workforce, an overview of the nurse and midwife staff levels, benchmarked against other regional units where possible. The last report presented to Board was in June 2015.

In the early part of 2016 the Trust commenced a review of the nursing and midwifery workforce. Within each directorate the senior management team agreed the methodology to be used to define their workforce based on the specific requirements within the speciality including aspects such as ward activity, patient dependency and acuity and nationally defined staffing tools such as Birthrate Plus®.

The Director of Nursing, alongside the Deputy Directors of Nursing agreed a set of principles to be followed to formulate the nursing establishment for each ward. These were to be considered alongside the acuity and dependency data for each ward and professional judgement of the Deputy Directors of Nursing within each directorate to ensure not only accurate data interpretation, but also a sense check of the exact staffing requirements based on professional knowledge of the speciality.

Due to the complexity of the review and a number of challenges that arose, multifactorial in nature, the review did not progress as planned. The current position is that all inpatient wards, excluding the acute admissions unit, have been reviewed and a recommended staffing establishment identified by the Directorates.

However since the review commenced a number of initiatives and reports both internally and nationally have happened which need to be considered as part of the decision making process about staffing establishments. These include

- Internal budget setting and business planning for 16/17
- Implementation of Care Hours Per Patient Day (CHPPD)
- National Quality Board (NQB) report in June 2016
- Planned Trust wide implementation in October 2016 of an updated version of the SCNT Live

In light of these developments it is recommended that the Trust maintains the current staffing establishments in inpatient wards. A further review should take place in the latter part of Q4 by

which time clarity should have been received in relation to the methodology to be used for the work recommended by the NQB. A review at this time will also fit in with business planning for 17/18.

This approach does not present a risk to the Trust in relation to patient safety. The Trust has in place robust arrangements to ensure the wards remain safely staffed and that staffing is monitored by the Board. These include

- Safe staffing compliance in real-time is undertaken throughout the day (minimum of two / day; however in areas where there are high levels of patient movement this has been increased to three).
- Staff may be reallocated, temporary staff requested or the Senior Sister / Charge Nurse or Matron works clinically in order to maintain patient safety and experience.
- There is a process in place for escalating staffing concerns up to, where necessary to the Director of Nursing and actions taken by the Clinical Site Practitioner team and/or manager on call.
- A safe staffing report is presented to Board every month

The maternity unit completes the Birthrate Plus® acuity tool for the obstetric delivery suite and the midwifery led unit four times a day. The national guidance for the safe staffing of maternity units is unlikely to move away from the recommended 1:29 midwife to mother ratio.

The review of maternity staffing has been completed and concluded that there is a **deficit of 5 wte midwifes**. The Women and Children's Directorate will present a business case to the Executive for these additional posts.

Harm to patients / patient safety

Pressure Ulcers

There have been 11 grade 2 pressure ulcers reported during October. Whilst the Trust reported zero grade 3 or 4 pressure ulcers we have previously noted the increase in the number of avoidable harm from pressure ulcers. In the period April to September 2016 the Trust reported 7 grade 2 & 3 pressure ulcers.

Pressure ulcers acquired in the Trust cause harm to patients and have a negative impact both physically and emotionally. Pressure ulcers also impose a substantial financial burden on the Trust

and wider healthcare sector as a whole. The cost of pressure ulcer iincidence in the Trust in 2015/2016 was estimated to be £541,641.

A review of pressure area care and management has been undertaken. The findings will be presented at the November Quality Assurance Committee.

Falls

During October 78 patients have fallen whilst in hospital. One patient on Gundolph ward sustained a fractured neck of femur as a result of a fall. One patient on Arethusa ward suffered a subdural haematoma after a fall which resulted in death of the patient. This is subject to ongoing investigation at the present time.

Infection Prevention & Control

Last month the Board was informed the Trust breached its Q2 trajectory for Clostridium Difficile (CDiff). In October the Trust reported 4 C Diff acquisitions which brings 16/17 total to 13 to date. The risk of breaching our 16/17 trajectory of 20 is high.

The Infection Prevention and Control team have a week of IPC activities planned for the week commencing 14 November. During this week they will be raising staff awareness of CDiff prevention.

The Trust submitted data for the national HCAI point prevalence survey. This survey is the fifth national point prevalence survey on healthcare-associated infections and the second national survey on antimicrobial use. Results will not be available before spring 2017.

Patient Experience

Mixed Sex Accommodation

The Trust reported 99 breaches across a number of areas. In relation to the significant increase in breaches there is a need to understand activity. The Trust is seeing around 1000 more ED attenders each month, a 12.5% increase on the same period last year. The Trust is also seeing about 150 more admissions each month with a 5-6% increase in ambulance attendances as well.

This increased demand has resulted in a much poorer flow of patients with ongoing delays in managing patients into community placement or their own home with support. As a result, the Trust is challenged to sustain effective and efficient bed management as capacity is never in line with

demand at any point. The decisions to breach MSA standards are made on the basis that patient safety has to supersede experience. This is not a decision the Trust takes easily but the safety of our patients is a priority.

Complaints

There were five complaints received by the Trust in October which related to nursing care issues only. In addition to this a one other complaint received also mentioned poor nursing attitude although this was the not the main subject of the complaint.

Analysis of the themes has been undertaken and corrective actions are incorporated into the transforming nursing care programme.

Transforming Nursing Care

Transforming Care is our quality improvement programme, designed by our nurses and led by our nurses to ensure we deliver high quality nursing care. It focuses very much on the fundamental and vital aspects of nursing care that are so important to our patients and their families.

The Transforming Care Programme successfully launched week commencing 26 September, through a number of awareness raising and launch events. These included a very positive 2 day open event in the Atrium which was attended by over 250 staff of all designations including Executive and Board members. Internal and external communication about the programme continues to ensure awareness across the community and its success. This includes:

- Presentation to the CCG Quality Committee
- Engagement with the Colleges for Nurse Training at both Kent and Canterbury
- Full day presentation at the FAB change day
- Presentation to the Patient Safety Committee
- Involvement with the Learning and Development Team to enhance the Project Skills of the Lead Matrons

The Programme Lead, Bev Critchlow – Associate Director of Nursing and Bob Finn, PMO has supported the Lead Matrons in developing realistic objectives to be achieved over the next year. Using PDSA methodology they are working with the Matrons and their action teams to implement these. At the present time all actions are on target to be achieved as planned. Some of the quick wins and achievement to date include:

- Detailed planning completed for all work streams and work commenced on delivery with appropriate KPIs
- Funding from Health Education England and appointment of 'Mouth Care Matters' specialist completed (one of only 6 Trusts to achieve this funding/resource)
- A number of baseline assessments commenced to identify gaps and key areas for focus including:
  - Promotion of Continence (Underway)
  - MUST nutritional Audits (Underway)
  - Privacy and Dignity Audits (Underway)
- Appointment of Nutritional Specialist to support the Food and Drink work stream completed
- Work started on standardisation of ward drug trolleys – rollout to commence beginning of November
- New thickened fluids for patients that have difficulty swallowing have been sourced and being presented for approval
- New improved Pureed diet identified and taster session has taken place and being presented for approval
- Relaunch of protected meal times and H2O fluid project
- Issue of yellow alert falls band completed to help and support the safety of patients on wards
- Completion of 'windows audit' for privacy and work has started on priority windows to be made opaque.
- A numbers of solutions identified to improve communication with patients and families, including communication boxes for all wards with materials to aid communication being purchased and implementation planned for next month.
- Criteria Led Discharge will be launch second week in November. Much of the education to improve discharge across the hospital is being directed through the Transforming Care Programme.

Recommendations

The Board of Directors is asked to note the information contained in this report and the actions that are in place.

Appendices

Appendix One-UNIFY data submission and Nursing, Midwifery and care Staff Return October 2016

Appendix 1

Unify report - October 2016

Fill rate indicator return
Staffing: Nursing, midwifery and care staff

Org: RPA   Medway NHS Foundation Trust
Period: October_2016-17

Please provide the URL to the page on your trust website where your staffing information is available
(Please can you ensure that the URL you attach to the spreadsheet is correct and links to the correct web page and include 'http://' in your URL)

Comments

Ward name	Specialty 1	Specialty 2	Day Reg planned	Day Reg actual	Day Care planned	Day Care actual	Night Reg planned	Night Reg actual	Night Care planned	Night Care actual	Day fill reg (%)	Day fill care (%)	Night fill reg (%)	Night fill care (%)	Cumulative count patients 23:59	CHPPD Reg	CHPPD Care	CHPPD Overall
Arethusa	110 - TRAUMA & ORTHOPAEDICS		1907.5	2,011	1,141	1,600	1,364	1,594	1,023	1,388	105.4%	140.2%	116.8%	135.7%	806	4.5	3.7	8.2
Bronte WARD	340 - RESPIRATORY MEDICINE		1453.5	1,345	1,112	1,082	1,093	1,104	729	740	92.5%	97.3%	101.0%	101.6%	540	4.5	3.4	7.9
Byron	430 - GERIATRIC MEDICINE		1392.216667	1,946	1,042	1,418	1,035	1,484	1,046	1,386	139.8%	136.1%	143.4%	132.5%	806	4.3	3.5	7.7
CCU	320 - CARDIOLOGY		716	716	-	-	713	690	-	12	100.0%		96.7%		118	11.9	0.1	12.0
Delivery	501 - OBSTETRICS		2967.483333	2,915	596	588	2,976	2,871	516	501	98.2%	98.7%	96.5%	97.1%	162	35.7	6.7	42.4
Dolphin (Paeds)	420 - PAEDIATRICS		3098.483333	3,168	728	811	2,415	2,394	288	391	102.3%	111.4%	99.1%	136.0%	413	13.5	2.9	16.4
Gundulph	300 - GENERAL MEDICINE		1322.75	2,116	1,150	1,136	1,342	1,689	1,023	1,166	160.0%	98.8%	125.8%	114.0%	728	5.2	3.2	8.4
Harvey	328-STROKE MEDICINE		1175.25	1,487	1,629	1,292	1,046	1,386	1,046	1,024	126.5%	79.3%	132.4%	97.8%	744	3.9	3.1	7.0
Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3589	3,322	-	-	3,139	2,983	-	-	92.6%		95.0%		250	25.2	0.0	25.2
Keats	301 - GASTROENTEROLOGY	307-DIABETIC MEDICINE	1555	2,638	1,158	1,221	1,012	2,265	1,023	1,056	169.6%	105.4%	223.8%	103.2%	802	6.1	2.8	9.0
Kent	501 - OBSTETRICS		1147.75	1,111	491	479	744	732	684	636	96.8%	97.6%	98.4%	93.0%	372	5.0	3.0	8.0
Kingfisher SAU	100 - GENERAL SURGERY		1914.75	1,750	1,591	1,449	1,352	1,419	682	715	91.4%	91.0%	105.0%	104.8%	680	4.7	3.2	7.8
Lawrence	823 - HAEMATOLOGY		1127.5	967	675	1,061	675	699	686	730	85.8%	157.3%	103.5%	106.4%	545	3.1	3.3	6.3
McCulloch	100 - GENERAL SURGERY		1506.5	2,172	1,110	1,538	979	1,734	990	1,254	144.2%	138.6%	177.1%	126.6%	874	4.5	3.2	7.7
Medical HDU	192 - CRITICAL CARE MEDICINE		1403	1,348	353	379	1,058	1,066	345	356	96.0%	107.4%	100.7%	103.2%	172	14.0	4.3	18.3
Milton	430 - GERIATRIC MEDICINE		1654.233333	1,631	1,278	1,461	1,035	1,508	1,046	1,160	98.6%	114.3%	145.7%	110.9%	806	3.9	3.3	7.1
Nelson	320 - CARDIOLOGY		1501.75	1,551	1,293	1,196	957	1,091	671	718	103.3%	92.5%	113.9%	106.9%	739	3.6	2.6	6.2
NICU	422- NEONATOLOGY		3579.966667	3,747	416	161	3,554	3,392	-	-	104.7%	38.7%	95.4%		872	8.2	0.2	8.4
Ocelot	502 - GYNAECOLOGY		883	857	526	523	744	744	384	420	97.1%	99.4%	100.0%	109.5%	305	5.2	3.1	8.3
Pearl	501 - OBSTETRICS		1116	1,197	677	623	1,116	1,106	372	349	107.2%	92.0%	99.1%	93.8%	394	5.8	2.5	8.3
Pembroke	110 - TRAUMA & ORTHOPAEDICS		1500	1,438	1,199	1,154	1,023	1,045	1,023	1,111	95.9%	96.2%	102.2%	108.6%	772	3.2	2.9	6.1
Phoenix	100 - GENERAL SURGERY		1818.033333	1,867	1,519	1,349	1,341	1,598	1,364	1,387	102.7%	88.8%	119.1%	101.6%	918	3.8	3.0	6.8
Sapphire Ward	300 - GENERAL MEDICINE		1608.5	2,211	2,276	1,912	1,012	1,887	1,362	1,332	137.4%	84.0%	186.5%	97.8%	868	4.7	3.7	8.5
SDCC	100 - GENERAL SURGERY		2064	1,954	1,630	1,109	682	987	682	690	94.7%	68.1%	144.7%	101.2%	644	4.6	2.8	7.4
Surgical HDU	192 - CRITICAL CARE MEDICINE		2109.5	2,121	381	342	1,705	1,643	-	-	100.6%	89.6%	96.4%		301	12.5	1.1	13.6
Tennyson	430 - GERIATRIC MEDICINE		1725.25	1,199	1,225	1,202	1,035	1,035	1,046	1,129	69.5%	98.1%	100.0%	107.9%	821	2.7	2.8	5.6
The Birth Place	501 - OBSTETRICS		1138.5	1,071	372	408	1,116	1,112	372	288	94.1%	109.7%	99.6%	77.4%	90	24.3	7.7	32.0
Victory	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1122.35	1,724	789	1,378	1,012	1,000	671	1,662	153.6%	174.8%	98.8%	247.7%	467	5.8	6.5	12.3
Wakeley	300 - GENERAL MEDICINE		1583.466667	1,787	1,132	1,328	1,046	1,363	1,035	1,339	112.9%	117.3%	130.3%	129.3%	720	4.4	3.7	8.1
Will Adams	301 - GASTROENTEROLOGY	307-DIABETIC MEDICINE	1508.25	1,554	1,112	1,220	1,023	1,333	1,023	1,287	103.0%	109.7%	130.3%	125.8%	800	3.6	3.1	6.7

All rows: Site code RPA02 — Hospital Site name: MEDWAY MARITIME HOSPITAL - RPA02

Medway NHS

NHS Foundation Trust

Nursing safe staffing return – October 2016

Fill rate indicator return

Staffing: nursing, midwifery and care staff

Nov-16

WARD	Beds	Day Registered Staff — Total monthly planned staff hours	Day Registered Staff — Total monthly actual staff hours	Day Care Staff — Total monthly planned staff hours	Day Care Staff — Total monthly actual staff hours	Night Registered Staff — Total monthly planned staff hours	Night Registered Staff — Total monthly actual staff hours	Night Care Staff — Total monthly planned staff hours	Night Care Staff — Total monthly actual staff hours	Day Avg fill rate - registered staff (%)	Day Avg fill rate - care staff (%)	Night Avg fill rate - registered staff (%)	Night Avg fill rate - care staff (%)	Number of escalations of nurse staffing	Number of hospital acquired Pressure Ulcers grade 2 and above	Number of Falls with moderate to severe harm	patient related medication errors - moderate to severe harm	Number of complaints relating to nursing care	DDON rag rating	Assurance statement	DDON signoff	Total Planned Hours (registered & care)	Total Actual Hours (registered & care)	Overall fill rate	Difference total Actual vs Planned hs	Difference total Actual vs Planned %	Cumulative count over the month of patients at 23:59 each day	Registered midwives / Nurses	Care Staff	Overall
Arethusa	27	1907.5	2,011	1141	1,600	1364	1,594	1023	1,388	105%	140%	117%	136%	3	0	1	0	0	(green)	Staff in Arethusa and Pembroke work flexibly across the units to ensure safe staffing.	SH	5,436	6,592	121%	1,156	21%	806	4.47	3.71	8.18
Bronte	18	1453.5	1,345	1111.5	1,082	1092.75	1,104	728.5	740	93%	97%	101%	102%	3	1	0	0	0	(orange)	Although there has been times where the 4th nurse has not been covered by bank, this ward has 18 patients and the ratio is 1:6. The ward is assessed daily on the acuity of the patients and mitigation is put in place if the skill set is not felt to be satisfactory to support the higher dependant patients. The workload of the specialist respiratory nurses is assessed and they support the ward when needed.	AG	4,386	4,271	97%	116	-3%	540	4.54	3.37	7.91
Byron	26	1392.217	1,946	1042	1,418	1035	1,484	1046.25	1,386	140%	136%	143%	132%	8	0	0	0	0	(green)		AG	4,515	6,234	138%	1,719	38%	806	4.26	3.48	7.73
CCU	4	716	716	0	-	713	690	0	12	100%	#DIV/0!	97%	#DIV/0!	0	0	0	0	0	(green)		AG	1,429	1,417	99%	12	-1%	118	11.91	0.10	12.01
Delivery	15	2967.483	2,915	596	588	2976	2,871	516	501	98%	99%	96%	97%	0	0	0	0	0	(green)	unit safely staffed	KM	7,055	6,875	97%	180	-3%	162	35.71	6.73	42.44
Dolphin (Paeds)	34	3098.483	3,168	727.5	811	2415	2,394	287.5	391	102%	111%	99%	136%	0	0	0	0	0	(green)	unit safely staffed	KM	6,528	6,764	104%	235	4%	413	13.47	2.91	16.38
Gundulph	25	1322.75	2,116	1150	1,136	1342	1,689	1023	1,166	160%	99%	126%	114%	0	1	1	0	0	(green)		AG	4,838	6,107	126%	1,269	26%	728	5.23	3.16	8.39
Harvey	24	1175.25	1,487	1629.4	1,292	1046.25	1,386	1046.25	1,024	127%	79%	132%	98%	10	0	0	0	0	(orange)	Harvey ward has had some short term sickness this month and are also reduced in band 6 cover. The Senior Sister has adjusted her hours to support the ward and the Matrons move staff to support. There were some occasions where there has not been enough staff through the directorate/Trust to enable cover to happen, in this case the matron for the area has supported.	AG	4,897	5,188	106%	291	6%	744	3.86	3.11	6.97
Intensive Care Unit	9	3589	3,322	0	-	3138.75	2,983	0	-	93%	#DIV/0!	95%	#DIV/0!	0	0	0	0	0	(green)	Staffing in critical care work flexibly across the three units to ensure straffing levels. Due to capacity issues on the wards a number of patients fit for ward care are unable to be transferred out of the unit. These...	SH	6,728	6,305	94%	423	-6%	250	25.22	0.00	25.22
Keats	27	1555	2,638	1158.333333	1,221	1012	2,265	1023	1,056	170%	105%	224%	103%	6	0	0	1	0	(orange)	The 4th nurse post is often not filled or there has been a need to move the 4th trained to an area that is at risk. The ward when there are 3 staff are working to a 1:8.6 ratio. The biggest risk is the lack of co ordinator for discharges	AG	4,748	7,180	151%	2,431	51%	802	6.11	2.84	8.95
Kent	24	1147.75	1,111	490.75	479	744	732	684	636	97%	98%	98%	93%	0	0	0	0	0	(green)	unit safely	KM	3,067	2,958	96%	109	-4%	372	4.95	3.00	7.95
Kingfisher SAU	14	1914.75	1,750	1591.483333	1,449	1352	1,419	682	715	91%	91%	105%	105%	1	0	0	1	0	(green)	Due to operational pressures The assessment unit trolley spaces can be bedded. This adjusts the staffing ratio required on the ward. Shortfall is filled with temporary staff or the Matron and Ward Sister work clinically in the numbers to maintain safe staffing levels.	SH	5,540	5,333	96%	207	-4%	680	4.66	3.18	7.84
Lawrence	19	1127.5	967	674.5	1,061	675	699	686.25	730	86%	157%	103%	106%	11	1	0	0	0	(red)	Lawrence ward struggle to cover via bank the upskilled staff to support the chemotherapy requirements on the ward. Establishment wise they do not have many vacancies, but the numbers of staff who are currently trained to deliver chemotherapy is reduced. The Senior Sister on the ward supports on a daily basis to mitigate risk and to ensure that patients treatment is given	AG	3,163	3,457	109%	293	9%	545	3.06	3.29	6.34
McCulloch	24	1506.5	2,172	1109.683333	1,538	979	1,734	990	1,254	144%	139%	177%	127%	0	0	0	0	1	(green)	A number of vulnerable patients are on the ward require specialist 1:1 nursing care and staffing levels are adjusted to meet this and maintain patient safety. Additionally the Ward Sister and Matron work clinically in the numbers when staffing levels fall below recommended numbers.	SH	4,585	6,698	146%	2,113	46%	874	4.47	3.19	7.66
Medical HDU	6	1403	1,348	353	379	1058	1,066	345	356	96%	107%	101%	103%	0	0	0	0	0	(green)	Staffing in critical care work flexibly across the three units to ensure safe staffing levels. Due to capacity issues on the wards a number of patients fit for ward care are unable to be transferred out of the unit. These patients do not require the same level of nursing support and...	SH	3,159	3,148	100%	11	0%	172	14.03	4.27	18.30
Milton	27	1654.233	1,631	1278	1,461	1035	1,508	1046.25	1,160	99%	114%	146%	111%	12	0	0	0	0	(green)		AG	5,013	5,760	115%	746	15%	806	3.89	3.25	7.15
Nelson	24	1501.75	1,551	1292.95	1,196	957	1,091	671	718	103%	92%	114%	107%	2	0	0	0	0	(green)		AG	4,423	4,555	103%	132	3%	739	3.57	2.59	6.16
NICU	25	3579.967	3,747	416	161	3553.5	3,392	0	-	105%	39%	95%	#DIV/0!	0	0	0	0	0	(green)	unit safely staffed	KM	7,549	7,299	97%	250	-3%	872	8.19	0.18	8.37
Ocelot	12	883	857	525.75	523	744	744	383.5	420	97%	99%	100%	110%	0	0	0	0	0	(green)	ward safely staffed	KM	2,536	2,544	100%	8	0%	305	5.25	3.09	8.34
Pearl	23	1116	1,197	676.75	623	1116	1,106	372	349	107%	92%	99%	94%	0	0	0	0	0	(green)	unit safely satffed	KM	3,281	3,274	100%	7	0%	394	5.84	2.47	8.31
Pembroke	27	1500	1,438	1199	1,154	1023	1,045	1023	1,111	96%	96%	102%	109%	0	1	0	0	1	(green)	Staff in Arethusa and Pembroke work flexibly across the units to ensure safe staffing.	SH	4,745	4,748	100%	3	0%	772	3.22	2.93	6.15
Phoenix	30	1818.033	1,867	1519.05	1,349	1341	1,598	1364	1,387	103%	89%	119%	102%	12	1	0	0	0	(green)	A number of vulnerable patients are on the ward require specialist 1:1 nursing care and staffing levels are adjusted to meet this and maintain patient safety. Additionally the Ward Sister and Matron work clinically in the...	SH	6,042	6,200	103%	158	3%	918	3.77	2.98	6.75
Sapphire Ward	28	1608.5	2,211	2276.25	1,912	1012	1,887	1362.016667	1,332	137%	84%	186%	98%	0	0	0	0	0	(green)		AG	6,259	7,341	117%	1,082	17%	868	4.72	3.74	8.46
SDCC	26	2064	1,954	1629.5	1,109	682	987	682	690	95%	68%	145%	101%	25	0	0	0	0	(green)	Due to operational pressures seven unfunded beds are open on the ward. When staffing is short the Matron and Ward Sister work clinically in the numbers to maintain safe staffing levels.	SH	5,058	4,740	94%	317	-6%	644	4.57	2.79	7.36
Surgical HDU	10	2109.5	2,121	381.25	342	1705	1,643	0	-	101%	90%	96%	#DIV/0!	0	0	0	0	0	(green)	Staffing in critical care work flexibly across the three units to ensure safe staffing levels. Due to capacity issues on the wards a number of patients fit for ward care are unable to be transferred out of the unit. These patients do not require the same level of nursing support and nurse:patient ratios may be adjusted.	SH	4,196	4,106	98%	90	-2%	301	12.51	1.14	13.64
Tennyson	27	1725.25	1,199	1225	1,202	1035	1,035	1046.25	1,129	69%	98%	100%	108%	9	1	0	0	0	(red)	risk mitigated by daily shift by shift review and redeployment of staff. The ward sister works clinically as required	AG	5,032	4,565	91%	467	-9%	821	2.72	2.84	5.56
The Birth Place	9	1138.5	1,071	372	408	1116	1,112	372	288	94%	110%	100%	77%	0	0	0	0	0	(green)	unit safely staffed	KM	2,999	2,879	96%	120	-4%	87	25.09	8.00	33.09
Victory	18	1122.35	1,724	788.55	1,378	1012	1,000	671	1,662	154%	175%	99%	248%	19	0	0	0	0	(green)	A number of vulnerable patients are on the ward require specialist 1:1 nursing care and staffing levels are adjusted to meet this and maintain patient safety. Additionally the Ward Sister and Matron work clinically in the numbers when staffing levels fall below recommended numbers.	SH	3,594	5,764	160%	2,171	60%	467	5.83	6.51	12.34
Wakeley	25	1583.467	1,787	1132	1,328	1046.25	1,363	1035	1,339	113%	117%	130%	129%	6	0	0	0	0	(green)		AG	4,797	5,817	121%	1,021	21%	720	4.38	3.70	8.08
Will Adams	26	1508.25	1,554	1112	1,220	1023	1,333	1023	1,287	103%	110%	130%	126%	0	1	0	0	0	(green)		AG	4,666	5,394	116%	728	16%	800	3.61	3.13	6.74
Trust total	633	51,189	54,921	28,599	29,417	39,344	44,949	21,132	24,226	107.3%	102.9%	114.2%	114.6%	127	7	2	2	2				140,264	153,512	109%	13248	9.4%	17526	5.70	3.06	8.76

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Report to the Board of Directors

Board Date: November 2016

Title of Report	Workforce Update
Presented by	James Devine, Executive Director of HR & OD
Lead Director	James Devine, Executive Director of HR & OD
Committees or Groups who have considered this report	n/a
Executive Summary	The purpose of this report is to advise on the activities relating to workforce. Key points are : • Activities undertaken to support the development of our staff and to address our resourcing gap • Update provided against recovery work streams
Resource Implications	None
Risk and Assurance	Safe staffing levels remain a significant risk and interventions are in place to mitigate this through 1. Improving the attractiveness of MFT as an employer 2. Generating nursing supply in Europe 3. Ensuring a robust temporary staffing service 4. Driving up the levels of mandatory training and appraisal 5. Staff engagement and focusing on the wellbeing of our staff 6. Creating opportunities for leadership and development
Legal Implications/Regulatory Requirements	Staffing levels, staff engagement, leadership and culture have been identified as areas of urgent improvement by the Trust and our regulators.
Recovery Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery of the Recovery plan.
Quality Impact Assessment	n/a
Recommendation	Information
	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Workforce Update - November 2016

1. EXECUTIVE SUMMARY

It has been another busy month in terms of workforce with a focus on resourcing activities, compliance with key people metrics, engagement for Staff Survey and Flu and the implementation and rollout of key systems being a priority.

The launch of the Recruitment campaign, an increased social media presence and a rolling programme of events now regularly in place is yielding improvements in terms of staff being offered jobs but it is recognised with a limited supply in key staff groups, alternative measures need to be considered.

Compliance with key people metrics continue to improve but additional interventions have been identified to speed up these improvements including the introduction of a mandatory training booklet, the expediting of the rollout of the new learning management system to all staff and a movement to electronic completion for local induction and agency induction.

The Staff Friends and Family results are published this month and although the benchmarking shows that the Trust is below average for the scores for both staff recommending the Trust as a place to work or to be treated, there is on-going improvement in terms of how staff rate the Trust on these measures. The national NHS Staff Survey is currently open to staff and the Trust has already had a response rate equivalent to last year with three weeks to go.

A permanent appointment was also made to an experienced Head of Resourcing Services. It is envisaged that the successful applicant will start at Medway at the end of November 2016.

2. STAFFING

This work stream focuses on ensuring sufficient numbers of suitably qualified, competent, skilled and experienced staff, working with Directorates to ensure that staffing quality is consistent with appropriate local induction and training.

Mandatory training/ Learning Management System

The mandatory training rate has remained static over the last few months and is currently 84.52%.

The new learning management system MOLLIE (Medway On Line & Interactive Education) went live on 25 October for mandatory topics in the Corporate directorates, excluding Estates and Facilities. The system is being rolled out across the organisation with a revised earlier completion by December 2016 and once embedded; it will improve compliance due to improved reporting and functionality.

In the meantime, a Level 1 mandatory training booklet that has been piloted in some administration areas has been distributed across the organisation to ensure that all staff have minimum levels of mandatory training compliance whilst actions are taken to address compliance.

Achievement Review

The achievement review rate has risen to 83.23%. A number of actions remain in place to improve performance across departments and individuals including directorate trajectories, long standing non-compliant individuals being identified and achievement reviews arranged. These are now reviewed weekly.

Local Induction

Compliance for local induction has increased to 52% from 46% last month. A number of actions remain in place as part of the review of onboarding including the launch of the new recruiting manager's information pack this month that places explicit emphasis on the importance of an effective local induction and its impact on improving staff retention. An online local induction confirmation form was launched on 7 November alongside the current paper version will aid accessibility and improvement in reporting.

Agency/ Bank Staff Local Induction

The recorded rate of local induction for agency workers has improved from 28% last month to 65%. The Temporary Staffing Team are undertaking ward walks every week to ensure that induction literature is distributed, relevant agency staff are targeted and also to collect any completed agency worker induction packs and record them on the HealthRoster system. In addition, the importance of the agency induction has been reiterated to the agencies we currently use, and the senior nursing staff on the wards/units. This is with the aim of bring consistency to the approach.

Furthermore, the Temporary Staffing Manager is now visiting all relevant Senior Sisters / Charge Nurses to provide management information and ensure inductions are undertaken swiftly.

The agency worked induction booklet is also being revised to be available in an electronic format which is being launched on 21 November.

SafeCare Live and e rostering

SafeCare Live was launched on 3rd October 2016. This has been rolled out through Acute and Continuing Care and the Coordinated Surgical Directorates. The Women and Children Directorate commenced roll out on 14 November and the project is on track to be completed by the end of November 2016. Initial feedback is positive with the nursing teams reported improvement in ease of moving staff and finalising shifts.

As part of the HealthRoster package, e-expenses portal is being rolled out with the benefits of all pay related elements being undertaken on one system. The rollout of e-expenses commences with community midwives with a rollout plan across nursing initially.

E- timesheets are also being launched on 30 November as part of the package to areas not currently rostered commencing with community school nursing. The rollout covers all areas of the Trust with a completion date of the end of June 2017.

3. RESOURCING

The Trust vacancy rate at Month 7 is 17%, with Nursing and Midwifery at 26%. There have been a number of resourcing interventions taking place in November 2016; this has included the launch of our new recruitment campaign; 'Put Yourself in the Picture'. The campaign has been developed in conjunction with operational and clinical feedback and involves promotional materials for events, train station billboards, bus banners, local billboards and social media (using our own staff).

In addition, the Trust has attended recruitment events in Kent and London, and there has been a review of the benefits package, the candidate pack and the retention incentives. A number of assessment centres for nursing and administrative & clerical have also taken place this month.

Recruitment activities

- *Assessment days*

There continue to be fortnightly Assessment Days for recruitment for substantive and bank for Nursing, CSW and Admin & Clerical. Other staff group assessment days are being arranged as necessary.

- *Events and open days*

The recruitment events undertaken this month include:
  o Christchurch University open day (Nursing)
  o MFT Open evening (Nursing)
  o Acute General Medicine event (Medical)
  o MFT NICU/ Paediatrics Open evening (Nursing)

- *EU recruitment*

A programme of Skype interviews is being undertaken to recruit the remainder of the commissioned 100 nurses. The HR team have been actively working with the agency and have:

- 17 nurses and 3 midwives in post from earlier recruitment
- 10 nurses to start 5 January
- 14 offered from 12/12 October Skype assessments
- 5 nurses offered from 26 October Skype assessments

- 7 nurses offered from 9 November Skype assessments

- *NICU recruitment*

Skype interviews have taken place for the international recruitment and 12 nurses have been offered roles from the Philippines. NICU also have an open evening in November.

- *Medical Training Initiative (Medical)*

The Trust has appointed 5 doctors as part of the MTI scheme. A further 5 interviews are taking place on 15 November and additional interviews are being arranged for the outstanding doctors. These placements will be used to address the vacancies at junior doctor level.

Temporary Staffing Service

Demand for nursing (registered and unregistered) remains at over 100,000 hours (approximately 642 WTE) with the majority of bookings to cover vacancies (63%), 'specialing' (17%) and sickness (10%). There has been a positive trend in qualified nursing bank hours, with the fill is now at the highest it has been in 12 months, although the % unfilled is at 15.7%. Unfilled shifts for all nursing staff dropped by nearly 6,000 hours and again is at a new low since the introduction of the in-house temporary staffing service.

The recent recruitment drives for Clinical Support Workers has had a positive impact on the demand trend for unqualified nursing staff and it is anticipated that this will continue to reduce in coming months as recruitment interventions continue, and those appointed start in post.

The *Doctors Bank* has been launched in the ED department and we have already had 7 Doctors who have registered with the service. This project will be rolled out to the wider Trust in December 2016.

The second Regional Temporary Staffing Forum was held at Kent & Medway Partnership Trust on 10th November to continue discussion around collaborative working. Key priority working areas were identified as agency and bank rate reviews and recruitment to bank practices.

Increased efficiencies within the Temporary Staffing Team for the coming months include maximising utilisation of electronic booking platforms and moving away from any manual processes to improve efficiency.

Retention

Turnover has increased slightly this month (from 9.01% to 9.2%) due to an increase in leavers in month. This remains below the same period last year (11.2%) but above the target of 8%.

We have a number of actions in place to improve retention including the *First and Lasting Impressions* events, feedback to staff through 'y*ou said, we did'* posters, targeting hotspot

areas of lower staff satisfaction and/or high turnover, and fortnightly *HR Ward Rounds* across all directorates to capture any staff issues or concerns.

A new online exit interview process will launch on 21 November 2016 to ensure that all leavers are captured and given the opportunity to have an exit interview.

4. STAFF ENGAGEMENT, DIVERSITY AND CULTURE CHANGE

This work stream is focussing on high impact activities to improve staff engagement and support diversity and culture change within the organisation.

<u>Fab Change Day</u>

NHS Fab Change Day took place in the staff restaurant on 19th October. The 64 ideas provided by staff have been reviewed and the Improving Working Lives group are leading on responding to the individuals and supporting these ideas to be addressed.

The success of the event was picked up by NHS Employers, who have invited the Trust to be part of the National review of the event.

<u>Raising Concerns and Every Person Counts</u>

The Raising Concerns campaign launched in November 2016. Posters, booklets and new policy route maps have been distributed to all staff areas. An event was held on 21 November to make our staff aware of the resources and support available to them in order to raise concerns (including bullying) and the teams to support staff including the Work place listeners, Freedom to Speak Up Guardians and the Occupational Health team.

<u>Flu campaign</u>

40.4% of front line staff have had their flu vaccination. This is an improvement from 16.1% last month. The target for front line staff is 75% by the end of December. Daily clinics are being held in occupational health, peer vaccinators are working on the wards and a bank nurse is supporting Trust walk-around to target areas. Vouchers are being given to encourage staff to have their vaccination.

<u>Equality and Diversity</u>

The Equality and Diversity Group met in November and a work plan to support the delivery of the Equality objectives is in place with allocated leads. The BME, LGBT and disabled Staff Forum leads have been identified and staff forums are taking place across November and December 2016.

Staff Friends and Family

The Q2 Trust Staff Friends and Family Survey took place between 15 August and 4 September 2016. The Trust had a response rate of 24% based on 1048 responses. The publication of the national results is planned for 24 November.

The table below shows the Trust against the Picker average for Quarter 2 and the national average for Q1.

Org Name	Work		Care	
	Percentage Recommended	Percentage Not Recommended	Percentage Recommended	Percentage Not Recommended
Medway Q2	**58%**	**23%**	**73%**	**9%**
Picker average Q2	65%	Not known	82%	Not known
England Q1	64%	18%	80%	6%

The graph below shows that there has been an improvement in the Trust results against the 'recommend as a place to work' question.
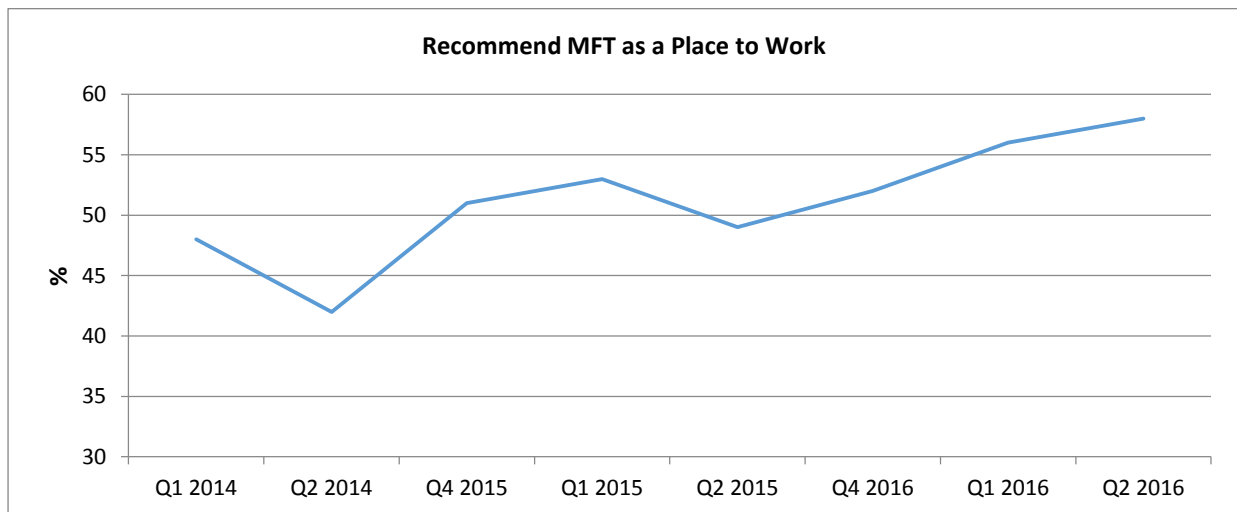
The graph below shows that there has been an overall improvement in the Trust results against the 'recommend as a place for care/ treatment' question although this has dropped by 1% this quarter.

Recommended MFT as a Place for Care or Treatment?
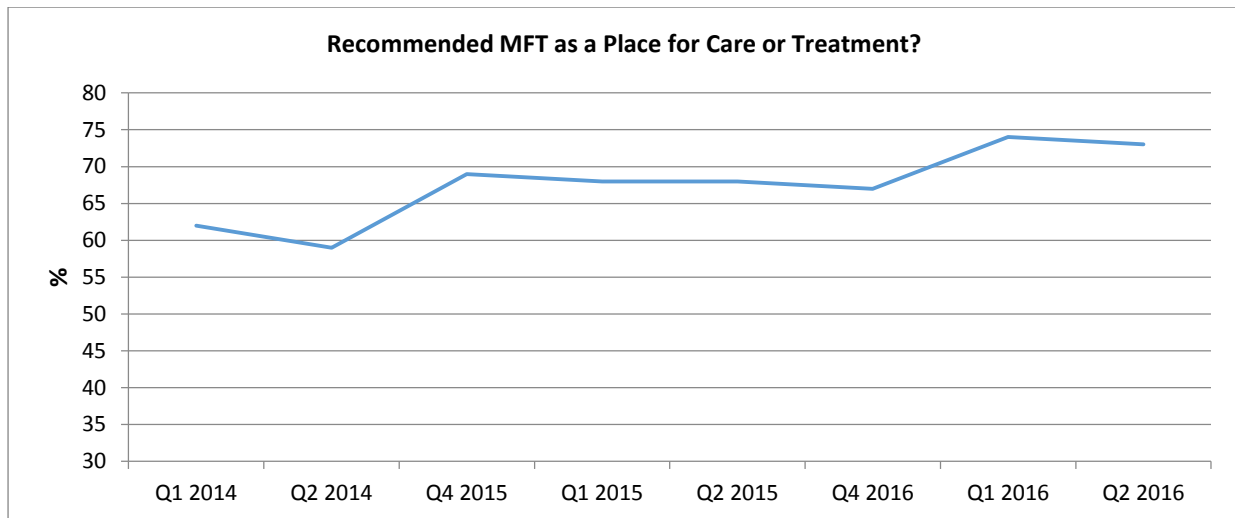
Directorates have been reviewing their results in line with current Directorate Staff Survey plans to ensure that any feedback and actions required are captured.

National NHS Staff Survey

The annual NHS Staff Survey commenced on 26 September and will run until 2 December. The Trust is aiming for a response rate of 55%, compared to the 2015 response rate of 38%. As at 11 November 2016, the response rate was 38.7%.

Final paper copies were distributed on 7 November and additional email chasers for online surveys are being undertaken each week in November. Additional actions include *You Said, We Did, We're Doing* Poster campaign for each Directorate, an incentive for teams who achieve a response rate of 60% or more, to go into a draw to win £500 for a team event of their choosing, regular weekly reminders via Global Communications and CEO updates, weekly response rate updates to Executive Directors, Directorate senior teams and HR Business Partners and targeted support for hotspot areas with low compliance.

5. LEADERSHIP AND DEVELOPMENT

The work stream will focus on developing our leaders and providing learning access to all staff.

Leadership development

Cohorts 4 of the Management Development Programme (MDP) completed this month with 5 participants. 28 participants have been trained so far.

The Bitesize programme continues to be popular with additional dates and topics being added on a regular basis. 147 members of staff have attended so far. A further 16 workshops covering a diverse range of topics are currently scheduled to March 2017.

The complete Leadership and Management programmes for 2017 are currently being planned.

The pan-Medway leadership programme continues to be a success, with the Trust invited to a senior partner event in November 2016 to discuss better collaboration across Medway for our future workforce.

- **END**

Report to the Board

Meeting Date: 24th November 2016

Title of Report	Report of the Director of Finance
Presented by	Darren Cattell, Director of Finance
Lead Director	Darren Cattell, Director of Finance
Committees or Groups who have considered this report	Executives
Executive Summary	**This report outlines;** 1. **Summary Trust financial performance for M7** 2. **Update on 2017-19 Contracting with Commissioners** 3. **Update on new requirement for Agency Improvement and reporting** 4. **Update on Corporate Services under STP** 5. **Update on Estates and Facilities progress** 6. **Update on progress on Procurement** 7. **Update on 2016-17 CCG contract** **1.Trust Financial Performance** Key points are: • The Trust has not achieved the plan for the first month of this year. The shortfall on the plan is £317k with the £600k swing in pay costs, this is predominantly due to the change in phasing of the CIP plan. This is being monitored by the Executive and is expected to be corrected through increased actual savings going forward. • The cumulative position is a £566k deficit better than the planned deficit of £25.5m. • The forecast for the end of the year remains on track to planned deficit due to a ramp up of CIPs, seasonal activity and a release of the remaining contingency. The clinical income position reported within the FOT is pending contract negotiation and therefore remains a risk. The key drivers are: • Overall the Trust continues to see and treat more patients than planned particularly through our Emergency Department (ED) with attendances running 19% above last Octobers ytd levels and a 12% above plan so far this

	• year. A Contract Performance Notice (CPN) on ED demand has been issued to the CCG.
	• Non Elective (NEL) admissions have also increased above last year's levels despite a fall in ED attendance conversion rate on total attendances from 25.7% to 21.3% over the same period.
	• The income plan was a high value in month, increasing by £600k over last month. The income actuals have increased in month by some £300k in line with activity however month on month we report a variance of £35ok adverse, this is a normal planning variation.
	• One of the impacts of the Medical Model is the reduction in Patient length of stay (average length of stay was 6.06 days YTD as at August 2015 vs 5.51 days over the same period in 2016) resulting in a reduction in excess bed day income of £1.3m YTD as at October 2016. This represents a 36% decrease from last year's excess bed day level of income however is mitigated by an increased volume of Patients seen in the Non Elective pathway.
	• Elective Inpatient and Day case activity continues to over perform against the planned levels by c5% due primarily to the increase in additional capacity available to the Trust following decisions taken by the Executive.
	• Workforce WTE are below plan substantively due to vacancies across clinical and corporate areas. We continue to use a high number of temporary staff to cover vacancies. Recruitment and retention actions to increase substantive staff numbers are outlined in the report of the HRD to the Board.
	• Pay expenditure is £700k adverse variance or a swing of £600k when compared to the previous month. The Executive is monitoring this in the lead up to CQC inspection as risk tolerance may change at local level. Only some of this additional cost is supported by additional activity and income (see above). Check and challenge actions have been agreed as part of the PRM process. This has in part been offset by non pay savings.
	• Non pay spend this month is largely on plan with savings released (this is an improvement) despite outsourcing of Patient activities (this activity is backed by higher than planned income levels).
	• Financial performance continues to be monitored at Directorate PRMs.
	• The Trust continues to rely on DH for cash support for ongoing operations
	• Capital programme expenditure remains currently below plan, we have started discussions with DH about the continued availability of capital in this year and we have received assurances that all investment projects remain on track to achieve the original year end plans.

2. Update on 2017-19 Contracting with Commissioners
- Initial offers received from Commissioners, in total some £18m less than this year's contract values. Little by way of detail.
- Trust counter offers issued 11-11-16 based on M6 activity projections, some £25m above this year's contract values.
- Negotiations about to start within a tightly regulated process (contracts expected to be signed by 23rd December) with arbitration waiting.
- Agreed involvement of Directorates.

3. Update on new requirement for Agency Improvement and reporting
- New NHSI requirements from 1st November, new reporting starts 1st December
- CEO to approve exceptions
- NHSI approval required for contractors over £750 pd
- Executive agreed programme to be added to Trust Recovery Plan (TRP), being scoped, governance and PID required
- Short term actions around controls environment

4. Update on Corporate Services under STP
- MTW leadership under STP
- Service leads matrix now completed
- Joint meeting between NHSI, Trusts, external Consultancy and potential provider to review service offering, no decisions made, data collection phase
- Corporate Services Governance board being set up to scope project

5. Update on Estates and Facilities progress
- The ED development was launched in the press
- P21+ construction stage training delivered to team
- Dickens Ward works now completed and Gundolph decanting from 14.11
- Minor works projects on schedule
- Estates Strategy work started and developing further
- Recruitment to Head of Facilities and LSMS roles on-going
- Updated Leases, licences and tenancy agreements database being developed for off-site premises
- New offsite premises being investigated for admin hub possibility.
- New offsite car parking facility being investigated

Housekeeping
- Recruitment into substantive posts continues with vacancy rate now less than 7%
- Ward schedules have been up-dated and are in the process of being displayed outside wards in notice

boards
- Audits now on schedule with any audit not meeting the indicative score being re-audited. Weekly updates to senior teams.
- HPV machinery now here and tested on Dickens ward prior to occupation.

Energy team
- About to roll out energy champions

Equipment
- Remote Drug Fridge Temperature monitoring project – system on order and implementation imminent.
- PTS service continuing well, complaints being investigated and regular meetings with G4S underway. Additional transport to be negotiated.

Waste and transport
- Internal recycling contract being progressed and costs developed to include all public areas as well as office space.
- All duty of care visits for the consortia now completed and acceptance audits in place

Security
- Body cameras have been ordered and delivery imminent
- No smoking support team working well.

Fire
- Strategy and policies updated – progress elsewhere on this agenda
- Recruitment of new in house fire team completed and appointed. Start date to be agreed.
- On-going meetings with KFRS working well.

Catering
- New catering manager in place, healthy options work started, with introduction of salads.

6. **Update on progress on Procurement**
- Head of Procurement in place, recruitment for additional senior buyer and procurement manager expected to be finalised by end of November. New procurement structure and Directorate points of contact in place from 3rd January 2017
- Nursing CIP from April to Oct shows £939k price benefit, Med locums saving being quantified
- New Medical Consumables savings report shows a minimum benefit of £320k from April to Oct
- Regional (STP level) opportunities for Category Management to be identified by Dec 2016
- Single Inventory Management option(s) being reviewed

regionally
- Procurement Transformation Plan submitted to NHSI in line with deadline
- Procurement Manual to be issued by end of December 2016
- Hybrid mail PQQ closed 10th November, evaluation starts on Monday 14th November
- Electronic Document management PQQ closed 10th November , evaluation starts on Monday 14th November

7. Update on 2016-17 CCG contract
- Trust and CCG have now entered formal arbitration whilst at the same time negotiations continue at a local level.

Resource Implications	As outlined
Risk and Assurance	- The high level of ED demand is creating multiple knock on adverse effects on the Trust's financial position such as the reliance on premium rate agency staff at short notice, the displacement of elective capacity by emergency patients, the increase in non-elective admissions which attract only a marginal tariff and additional unexpected demand pressures on achieving both our ED access and RTT targets. This is likely to lead to financial risk in achieving the Sustainability and Transformation Fund (STF) as well as a number of key quality standards. **The Board is asked to note that mitigating work continues with the CCGs to identify actions to reduce the demand impact. The Executive wait for a formal CCG response to the contract performance notice for ED Patient demand. A revised 4hour improvement trajectory is the expected outcome reducing the STF risk exposure. Executive Director Colleagues continue to manage the quality risks on a daily basis, this is reported elsewhere on this agenda.** - A number of Trust Directorates/Services are financially performing ahead of plan. A smaller number are not. The risk is currently mitigated by other areas where they are ahead of plan. **The Board is asked to note those areas behind plan have been agreed with Directorates as part of the PRM process and a rectification plan for each is being prepared.** - In Q3 and Q4 the financial risk associated with a lack of full CIP plans will rise. **The Board is asked to note that a new CIP policy has been developed. A CIP forecast has been produced and corrective actions expected. All CIP actions will be subject to a full Quality Impact**

Analysis (QIA) process. The monthly reforecast exercise will continue to highlight any CIP shortfall in the report to the Board.

- A current reputational and financial risk is the Agency cost above cap and outside of framework. Our current usage and cost is above expected levels.
  The Board is asked to note that mitigation includes close working with NHSI in the short term to agree improvement actions. The Executive Group has agreed that a further programme will be added to the Trust TRP, this is currently being scoped. Short term control and reporting actions will commence in short order. An update on the recruitment and retention actions is provided in the HRDs report. All actions will be subject to a full QIA process. This work is required for our Regulators but is also required to mitigate our potential trend increase in Agency pay costs.

- A rising risk to report is a lack of formal agreement to payment to all activity performed by the Trust due to a lack of contract agreement with the North Kent Commissioners. **The Board is asked to note that NHSI and NHSE have received joint papers submitted by the Trust and the CCGs.**

- 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/winter 2016.**

- Trust infrastructure and estate remains a risk due to age and condition. **The Board is asked to note that improvements have already commenced on both minor and major works, including ED. Operational staff are involved in these improvements, communications have been increased to outline timescales for the improvements. Risk assessments are now completed for areas and action plans are being developed.**

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.

Recovery Plan Implication	Financial Recovery is one of the nine programmes of Phase 2 Recovery.
Quality Impact Assessment	All actions will follow an appropriate QIA process
Recommendation	**The Board is asked to note the report**
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Finance Report

Month 7

2016/17

Finance Report for October 2016

1. Executive Summary
    a. Executive Summary

2. Liquidity
    a. Cash Flow
    b. Loan Conditions

3. Financial Performance
    a. Consolidated I&E
    b. Directorate Analysis
    c. Run Rate Analysis - Financial
    d. Clinical Activity
    e. Clinical Income
    f. Clinical Income-Directorate
    g. Workforce
    h. Run rate analysis Pay

4. Balance Sheet
    a. Balance Sheet
    b. Debtors
    c. Creditors

5. Capital
    a. Capital

1. Executive Summary

1a. Executive Summary (October 2016)

| Key Messages	Report Reference
Activity and Income Summary A&E attendances continue with high volumes month on month, seeing a 16% increase compared to October 2016 and 1,074 additional attendances compared to the previous month. Even though A&E conversion rate has reduced over the same period, non elective activity and income continues to be above plan YTD. Elective day cases are over in month by 187 spells (598 spells over YTD) while inpatients are under in month by 93 spells (31 spells YTD) resulting in an adverse income variance. The casemix of emergency patients remains more complex, while excess bed days continues to reduce as a result of the on going work in reducing the length of stay from the revised medical model. Overall, average length of stay has reduced from last year's level for both elective and non elective patients. High cost drugs income is favourable to plan in month and YTD due to increased activity. Contract negotiations are yet to be finalised with the CCGs.	Page 17/18/19
Workforce Summary Workforce wte are below plan substantively (the plan has been rebased on run rate including vacancies) due to vacancies across clinical and corporate areas. The use of temporary staff continues however not all shifts are covered, from a safety perspective, number of breaches on the 1:8 ratio is now stable.	Page 20/21
Expenditure Summary Pay: Pay expenditure is £0.7m adverse to plan in month mainly due to the CIP phasing. Agency expenditure is £1.7m higher YTD than prior year. The Trust is in the process of developing an agency improvement plan. Non Pay: Clinical supplies in month are below plan mainly due to CIP delivery and YTD is adverse to plan mainly due to external outsourcing to improve RTT performance and additional expenditure on supplies due to increased activity. Expenditure on drugs is adverse to plan mainly due to high cost drugs increased activity.	Page 9
Run Rate Analysis Overall: The clinical income run rate increases from the previous months reported position mainly relating to month 6 following updated coded activity. Pay: The pay run rate reduced mainly due to a reduction in agency expenditure for consultants and junior medics. Non Pay: The non pay run rate is £8.2m a £0.3m reduction from month 6 mainly due to CIP delivery.	Page 16

2. Liquidity

2a. Cash Flow

13 Week Forecast

£m	Actual						Forecast												
	w/e 07/10/16	w/e 14/10/16	w/e 21/10/16	w/e 28/10/16	w/e 04/11/16	w/e 11/11/16	w/e 18/11/16	w/e 25/11/16	w/e 02/12/16	w/e 09/12/16	w/e 16/12/16	w/e 23/12/16	w/e 30/12/16	w/e 06/01/17	w/e 13/01/17	w/e 20/01/17	w/e 27/01/17	w/e 03/02/17	w/e 10/02/17
BANK BALANCE BFWD	1.62	11.92	15.03	11.04	1.40	12.70	11.99	16.02	1.92	14.61	12.58	20.32	5.26	2.93	18.10	17.35	14.10	4.68	16.69
Receipts																			
NHS Contract Income	15.18	2.97	0.06	0.38	14.84	0.49	3.67	0.12	14.60	0.00	3.67	0.12	0.00	14.60	0.00	3.67	0.00	14.23	0.00
Other	0.26	2.99	2.15	0.57	0.59	0.88	0.30	0.25	0.65	0.82	0.34	0.25	0.55	3.40	2.09	0.34	0.25	0.65	0.25
Total receipts	15.45	5.96	2.22	0.95	15.43	1.37	3.97	0.37	15.25	0.82	4.01	0.37	0.55	18.00	2.09	4.01	0.25	14.88	0.25
Payments																			
Pay Expenditure (excl. Agency)	0.00	0.00	(5.85)	(7.91)	(0.02)	0.00	(2.22)	(11.37)	(0.03)	0.00	0.00	(13.59)	(0.03)	0.00	0.00	(5.77)	(7.82)	(0.03)	0.00
Non Pay Expenditure	(5.15)	(2.85)	(2.80)	(2.69)	(4.11)	(2.09)	(4.42)	(2.77)	(2.21)	(2.51)	(3.07)	(2.51)	(2.51)	(2.51)	(2.51)	(2.51)	(2.51)	(2.51)	(2.51)
Capital Expenditure	0.00	0.00	0.00	0.00	0.00	0.00	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)
Total payments	(5.15)	(2.85)	(8.64)	(10.60)	(4.13)	(2.09)	(6.97)	(14.47)	(2.57)	(2.84)	(3.40)	(16.43)	(2.87)	(2.84)	(2.84)	(8.61)	(10.66)	(2.87)	(2.84)
Net Receipts/ (Payments)	10.30	3.12	(6.43)	(9.64)	11.31	(0.72)	(3.00)	(14.10)	12.68	(2.02)	0.61	(16.07)	(2.32)	15.16	(0.75)	(4.60)	(10.41)	12.01	(2.59)
Funding Flows																			
FTFF/DOH (Incl Capital & STP Funding)	0.00	0.00	2.55	0.00	0.00	0.00	7.12	0.00	0.00	0.00	7.13	1.00	0.00	0.00	0.00	1.35	1.00	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	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	(0.12)	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding Flows	0.00	0.00	2.43	0.00	0.00	0.00	7.04	0.00	0.00	0.00	7.13	1.00	0.00	0.00	0.00	1.35	1.00	0.00	0.00
BANK BALANCE CFWD	11.92	15.03	11.04	1.40	12.70	11.99	16.02	1.92	14.61	12.58	20.32	5.26	2.93	18.10	17.35	14.10	4.68	16.69	14.10

Fig1. 13 week Cashflow Forecast

October 2016 Cashflow Performance & 13 week Cashflow Forecast
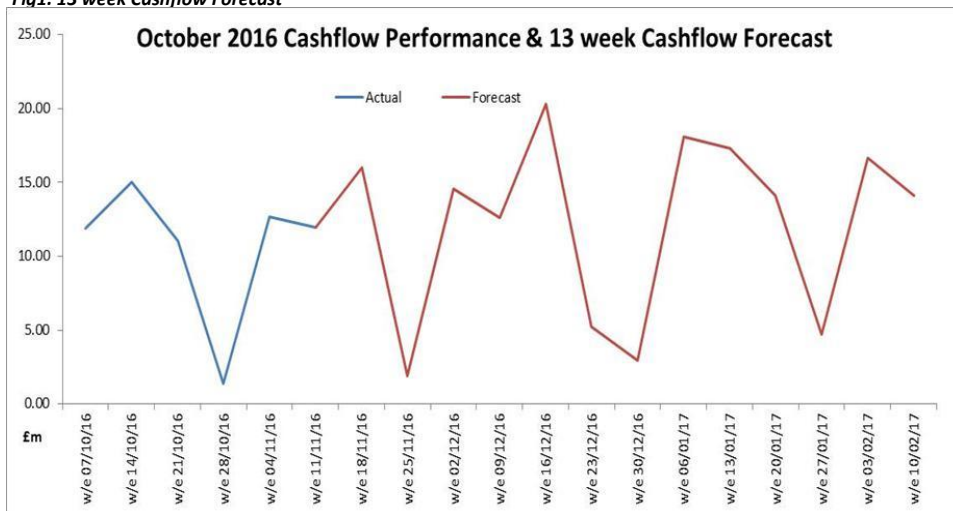
Commentary

This graph shows the actual cash profile for the Trust for October 2016; it also illustrates the Trust's forecasted cash profile up to the 10th February 2017. The Trust commenced October with £1.62m and ended the month with £1.67m. This balance complies with the minimum liquidity tramline required by DoH (£1.4m).

The Trust does not have a Revenue Loan facility in place for 2016/17 to cover the anticipated deficit; however the mitigation for this is included within the Finance Risk Register (see extract below).

Finance Risk Register - the 16/17 Operational plan clearly outlines revenue funding requirements. Discussions are ongoing with the DoH to confirm the final requirement. Business cases for key capital investments have been prepared with NHSI and DoH prior to approval of Board. The funding source will be secured prior to plans being finalised. Clarity of requirement for external funding has been signalled in the Operating Plan.

During October 2016 the Trust made further use of its £21.3m Working Capital Facility (WCF) and drew down £2.55m. It is also noted that the Trust has requested to draw down the remaining £2.05m in November 2016, which will fully utilise the Trust's current WCF.

Contrary to last month's commentary, the DoH amended its guidance and removed the option for the Trust to extend its WCF. NHSI subsequently issued guidance to suggest that cash support will be provided by an Uncommitted Loan Facility. Therefore a Board resolution was sought and approved for the Trust's anticipated remaining cash support for 2016/17. In practical terms this means that Trust will need to apply for a new Uncommitted Loan Facility each month - but this will be covered by a single Board Resolution.

It is anticipated that the Trust will also have access to the remaining £6.3m of Sustainability and Transformation Funding, however as the timings and profile of this receipt are currently uncertain and undetermined they are excluded from this forecast.

2b. 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 16/17	🟢	🟢	Trust is reporting an operating deficit within V3 of the plan
8 – 2	Agency nursing procured through approved frameworks and within maximum cap	Immediately	All agencies routinely used are compliant with frameworks. Following introduction of 1st April price cap compliance is stable but plans are being developed to put on a downward, improving trajectory.	🔴	🔴	The 1st April price cap resulted in an increase in the trajectory which needs to be managed
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 pre-approval.
8 – 4	Implementation of controls over VSMs and off-payroll workers	Immediately	In progress	🟡	🟡	Market Forces and compliance through Remuneration Committee
8 – 5	Review / benchmarking of Estates and Facilities costs	31st May 2016	Behind schedule.	🟡	🟡	New Interim Director of Facilities & Estates appointed and timing to be confirmed of benchmarking exercise
8 – 6	Produce an Estates strategy	Summer 2016	In progress	🟡	🟡	Estates strategy 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.	🟡	🟡	In relation to transactional services, SBS have now been engaged to undertake a review of processes and will be at the Trust during November 2016
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	Ongoing	🟢	🟢	

3. Financial Performance

3a. Consolidated Income & Expenditure

Consolidated I&E (October 2016)

	Current Month			Year to Date			Forecast	Annual	Variance
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Plan*	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical income	20,579	20,381	198	137,544	136,266	1,278	236,411	231,062	5,349
High Cost Drugs	1,794	1,782	12	12,394	12,117	277	20,809	20,785	24
Other Operating Income	2,049	1,983	66	14,160	13,820	340	23,947	23,729	218
Total Revenue	**24,421**	**24,146**	**275**	**164,097**	**162,203**	**1,894**	**281,167**	**275,576**	**5,591**
Expenditure									
Substantive	-13,560	-15,404	1,844	-95,266	-109,598	14,332	-164,682	-187,832	23,150
Bank	-553	-157	-396	-4,310	-2,402	-1,908	-7,768	-3,251	-4,518
Agency	-3,469	-1,314	-2,155	-21,899	-10,376	-11,523	-37,751	-17,061	-20,690
Total Pay	**-17,582**	**-16,876**	**-706**	**-121,475**	**-122,376**	**901**	**-210,201**	**-208,144**	**-2,058**
Clinical supplies	-2,836	-2,988	152	-22,679	-20,434	-2,245	-37,383	-34,706	-2,677
Drugs	-2,480	-2,391	-89	-18,682	-17,774	-908	-29,827	-29,891	64
Consultancy	-5	22	-27	-356	-907	551	-750	-939	189
Other non pay	-2,859	-2,862	3	-18,591	-18,841	250	-33,586	-32,715	-871
Total Non Pay	**-8,180**	**-8,219**	**39**	**-60,308**	**-57,957**	**-2,351**	**-101,546**	**-98,251**	**-3,295**
Total Expenditure	**-25,762**	**-25,095**	**-667**	**-181,783**	**-180,333**	**-1,450**	**-311,747**	**-306,394**	**-5,353**
EBITDA	**-1,341**	**-949**	**-392**	**-17,686**	**-18,130**	**444**	**-30,580**	**-30,819**	**238**
	0	*0*	*-1*	*0*	*0*	*0*			
Post EBITDA									
Depreciation	-817	-817	0	-5,639	-5,663	24	-9,693	-9,693	0
Interest	-175	-175	0	-984	-1,048	64	-2,021	-2,021	0
Dividend	-119	-109	-10	-813	-762	-51	-1,307	-1,307	0
Gain/(loss) on asset disposals	85	0	85	85	0	85	85	0	85
	-1,026	**-1,101**	**75**	**-7,351**	**-7,473**	**122**	**-12,935**	**-13,020**	**85**
Net (Deficit)	**-2,367**	**-2,050**	**-317**	**-25,037**	**-25,604**	**566**	**-43,516**	**-43,839**	**323**
Adjustments (donations/asset disposal)	*-63*	*13*	*-76*	*-231*	*90*	*-321*	*-170*	*153*	*-323*
Net (Deficit) Adjusted	***-2,430***	***-2,037***	***-393***	***-25,268***	***-25,514***	***245***	***-43,686***	***-43,686***	***0***

Please note, the adjusted deficit reflects the Trusts performance against the NHSi control totals.

Commentary

Net (Surplus) / Deficit and Forecast Outturn
The Trust reported a £2.4m deficit in month 7, adverse to plan by £0.3m. As at month 7 the Trust's annual planned deficit for the year is £43.84m (as outlined in V3 of the Operating Plan presented to the Board in June). A detailed forecast outturn (FOT) has been prepared and the Trust remains on target to achieve the planned deficit of £43.84m in the most likely case. Worse case FOT assuming CIP and STF is not achieved is £3.3m adverse to plan. Best case FOT is £3m favourable assuming an improved position is achieved on CIP delivery and recruitment takes place reducing agency expenditure.

Clinical Income
A&E attendances continue with high volumes month on month, seeing a 16% increase compared to October 2016 and 1,074 additional attendances compared to the previous month. Even though A&E conversion rate has reduced over the same period, non elective activity and income continues to be above plan YTD. Elective day cases are over in month by 187 spells (598 spells over YTD) while inpatients are under in month by 93 spells (31 spells YTD) resulting in an adverse income variance. The casemix of emergency patients remains more complex, while excess bed days continues to reduce as a result of the on going work in reducing the length of stay from the revised medical model. Overall, average length of stay has reduced from last year's level for both elective and non elective patients.
High cost drugs income is favourable to plan in month and YTD due to increased activity.
Contract negotiations are yet to be finalised with the CCGs.

Other Income
Other income in month is favourable to plan mainly due to increased activity in the A&CC Directorate.

Pay
Pay expenditure is £0.7m adverse to plan in month mainly due to the CIP phasing. Agency expenditure is £1.7m higher YTD than prior year. The Trust is in the process of developing an agency improvement plan.

Non Pay
Clinical supplies in month are below plan mainly due to CIP delivery and YTD is adverse to plan mainly due to external outsourcing to improve RTT performance and additional expenditure on supplies due to increased activity. Expenditure on drugs is adverse to plan mainly due to high cost drugs increased activity.

Directorate Reports
The income and expenditure position by Directorate is detailed later in the report.

Risks and Mitigations
A high level of CIP remains unidentified in the Surgical and Estates and Facilities Directorates and continues to be challenged at the PRM. This is mitigated by increased CIP delivery on drugs and clinical supplies.

Sustainability & Transformation funding will be contingent upon achievement of the agreed performance trajectories. The Trust is currently not meeting the agreed A&E improvement trajectory but as per the STF guidance the growth has been raised with the CCG.

The clinical income contract with the main Commissioners is yet to be finalised. Arbitration papers have been submitted to NHSi and the Trust awaits the outcome.

3b. Directorate Summary

Year to Date Performance (April to October)

	Income			Pay			Non Pay			Year To Date			Annual Plan			
	Actual	Plan	Var	Actual	Plan	Var	Actual	Plan	Var	Actual	Plan	Variance	Income	Pay	Non Pay	TOTAL
Acute & Continuing Care	-64.2	-62.4	-1.7	40.7	41.3	-0.6	25.9	23.7	2.2	2.5	2.6	-0.1	-105.9	69.0	41.0	4.1
Co-ordinated Surgical	-51.5	-51.6	0.1	39.3	39.2	0.1	17.0	16.8	0.3	4.8	4.3	0.5	-86.8	67.5	26.4	7.1
Women & Children	-33.6	-32.3	-1.3	19.7	19.6	0.1	2.9	2.7	0.2	-11.0	-10.0	-1.0	-56.1	33.8	4.6	-17.8
Other Clinical Income	-5.0	-6.2	1.1	0.0	0.0	0.0	0.0	0.0	0.0	-5.0	-6.2	1.1	-10.1	0.0	0.0	-10.1
Total Clinical Directorates	**-154.3**	**-152.4**	**-1.8**	**99.7**	**100.1**	**-0.4**	**45.8**	**43.2**	**2.6**	**-8.8**	**-9.2**	**0.4**	**-258.9**	**170.2**	**72.1**	**-16.6**
Corporate	-1.8	-1.8	0.0	13.2	13.6	-0.4	3.3	3.5	-0.2	14.8	15.3	-0.6	-3.1	23.3	6.4	26.5
Facilities & Estates	-3.3	-3.3	0.0	7.5	7.3	0.2	5.8	5.9	0.0	10.0	9.8	0.2	-5.7	11.5	10.2	16.1
Central	-4.7	-4.6	-0.1	0.8	0.6	0.1	3.4	3.4	0.0	-0.5	-0.6	0.1	-7.8	1.1	5.9	-0.9
TOTAL	**-164.1**	**-162.2**	**-1.9**	**121.2**	**121.6**	**-0.4**	**58.4**	**56.0**	**2.4**	**15.5**	**15.4**	**0.1**	**-275.6**	**206.1**	**94.5**	**25.1**
Non Operating expense							7.4	7.5	-0.1	7.4	7.5	-0.1			13.0	13.0
TOTAL Trust	**-164.1**	**-162.2**	**-1.9**	**121.2**	**121.6**	**-0.4**	**65.8**	**63.5**	**2.3**	**22.8**	**22.9**	**0.0**	**-275.6**	**206.1**	**107.6**	**38.1**
Reserves				0.3	0.8	-0.5	1.9	1.9	0.0	2.2	2.7	-0.5	0.0	2.0	3.7	5.7
TOTAL Trust including Reserves	**-164.1**	**-162.2**	**-1.9**	**121.5**	**122.4**	**-0.9**	**67.7**	**65.4**	**2.2**	**25.0**	**25.6**	**-0.6**	**-275.6**	**208.1**	**111.3**	**43.8**

3b. Directorate Analysis - Acute & Continuing Care

Income & Expenditure   (October 2016)

	Current Month			Year to Date (YTD)			Forecast	Annual	Variance
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Plan*	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical Income	-7,245	-7,117	-128	-50,959	-49,775	-1,184	-87,977	-83,910	-4,067
High Cost Drugs	-1,719	-1,619	-100	-11,988	-11,670	-318	-20,094	-20,219	125
Other Operating Income	-185	-167	-18	-1,211	-967	-244	-2,193	-1,803	-391
Total Revenue	**-9,149**	**-8,903**	**-245**	**-64,158**	**-62,412**	**-1,746**	**-110,264**	**-105,932**	**-4,333**
Expenditure									
Substantive	4,054	4,546	-493	28,392	33,757	-5,366	48,835	56,560	-7,725
Bank	199	195	4	1,255	1,367	-112	2,149	2,343	-194
Agency	1,871	788	1,083	11,053	6,156	4,897	19,478	10,096	9,383
Total Pay	**6,123**	**5,529**	**594**	**40,700**	**41,280**	**-580**	**70,462**	**68,999**	**1,463**
Clinical supplies	1,053	798	255	7,087	5,730	1,357	12,146	9,720	2,425
Drugs	2,257	1,934	324	15,209	14,668	541	25,533	25,658	-125
Consultancy	4	0	4	6	1	5	11	2	8
Other non pay	545	461	85	3,622	3,339	283	6,215	5,660	555
Total Non Pay	**3,860**	**3,193**	**667**	**25,924**	**23,738**	**2,186**	**43,905**	**41,041**	**2,864**
Total Expenditure	**9,984**	**8,722**	**1,261**	**66,624**	**65,018**	**1,606**	**114,367**	**110,041**	**4,327**
EBITDA	**835**	**-181**	**1,016**	**2,466**	**2,606**	**-140**	**4,103**	**4,109**	**-6**

CIP Performance:	*Actual*	*Plan*	*Variance*
	£'000	£'000	£'000
Delivery Year to Date	1,229	1,229	0
Annual Plan		4,598	
Identified		4,598	
Unidentified		0	

WTE:	*Actual*	*Plan*	*Variance*
Substantive	1,150	1,411	-261
Bank	74	0	74
Agency	316	0	316
Total WTE	**1,540**	**1,411**	**129**

Commentary

1. Overview
The Directorate is reporting a position in month adverse compared to plan by £1,016k mainly due to pay and non pay expenditure. YTD a favourable position is reported of £140k mainly due to clinical income and pay expenditure. The budget for HIV/GUM services has been removed from months 7 to 12 as the service is no longer commissioned from our Trust. FOT is reported as a small adverse variance of £47k.

2. Revenue
Clinical income is favourable to plan in month by £128k and YTD favourable by £1,184k. A&E attendances continue to overperform (£153k in month; £825k YTD). YTD outpatients are favourable to plan by £1,084k mainly due to increased activity in Medical Oncology and increased outsourcing in Dermatology. Non Elective income is above plan by £174k YTD due to increased activity, however Excess Bed Days are adverse to plan by £772k YTD due to the reduced length of stay from the implementation of the new medical model. Direct access is adverse to plan by £331k mainly due to reduced activity. High cost drugs in month and YTD are favourable to plan mainly due to increased activity. Other operating Income over recovery is mainly due to increased pathology tests for other providers (YTD £117K), consumables recharged to CCG's for insulin pumps (YTD £44k) and pharmacy services (previously not being captured) (YTD £68k).

3. Pay
Pay expenditure is £594k adverse in month and YTD is £580k favourable. Phasing of the CIP plan is the main reason for the movement in month (£400k). Pay run rate has remained similar to month 6, with a slight reduction in agency spend. Recruitment of staff to reduce agency spend remains high priority for the Directorate.

4. Non Pay
Non pay expenditure is £667k overspent in month and £2,186k overspent YTD. Clinical supplies adverse variance mainly relates to increased activity. Main variances are due to; outsourcing within Gastroenterology, Dermatology and Cardiology (YTD £605k) and medical & surgical supplies (YTD £640k). Main variances in medical and surgical supplies relate to; Respiratory £122k, Endoscopy £164k, external tests and additional laboratory costs in pathology YTD £283k and A&E £71k. Additional clinical income received partially funds the overspend. The drugs overspend is due to high cost drugs activity above plan and additional drugs for HIV/GUM services. HIV/GUM drugs costs in month 7 are due to be recharged to the new provider. The YTD other non pay adverse variance mainly relates to cellular pathology (YTD £182k) and endoscopy (YTD £44K) due to increased activity.

5. CIP
The Directorate has delivered the £1,229k CIP plan for month 7, mainly from the closure of Dickens ward, histopathology contracts, agency price saving and non recurrent pay underspends. Plans are due to be finalised for the drugs and procurement CIP.

6. Risks and Mitigations
The Directorate is in the process of reviewing its CIP programme in particular the closure of Beds which has been delayed due to increased activity and the on-going pressures of the bed base within the Trust. Review of workforce and schemes to retain existing staff are on-going. Action plans are being developed with budget holders reporting adverse variances.

3b. Directorate Analysis - Co-Ordinated Surgery

Income & Expenditure   (October 2016)

	Current Month			Year to Date (YTD)			Forecast	Annual	Variance
	Actual	Plan	Variance	Actual	Plan	Variance	Actual	Plan	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical Income	-7,341	-7,259	-82	-48,766	-48,888	122	-83,567	-82,172	-1,395
High Cost Drugs	-69	-35	-34	-320	-224	-96	-557	-393	-164
Other Operating Income	-341	-356	15	-2,413	-2,475	62	-4,159	-4,236	77
Total Revenue	**-7,750**	**-7,650**	**-100**	**-51,498**	**-51,587**	**89**	**-88,283**	**-86,801**	**-1,482**
Expenditure									
Substantive	4,607	5,395	-788	31,665	37,109	-5,445	54,673	64,071	-9,398
Bank	309	7	301	2,031	42	1,989	3,508	79	3,429
Agency	801	211	590	5,556	2,006	3,551	9,464	3,350	6,114
Total Pay	**5,716**	**5,612**	**104**	**39,252**	**39,157**	**95**	**67,644**	**67,499**	**145**
Clinical supplies	1,700	1,786	-86	12,649	12,687	-38	21,298	21,624	-327
Drugs	280	254	26	1,792	1,780	11	3,071	3,050	21
Consultancy	0	0	0	3	2	1	3	3	0
Other non pay	372	-127	499	2,585	2,286	299	4,407	1,712	2,695
Total Non Pay	**2,352**	**1,914**	**438**	**17,029**	**16,755**	**273**	**28,778**	**26,389**	**2,389**
Total Expenditure	**8,068**	**7,526**	**542**	**56,281**	**55,913**	**368**	**96,422**	**93,888**	**2,534**
EBITDA	**318**	**-124**	**442**	**4,783**	**4,326**	**457**	**8,139**	**7,087**	**1,052**

CIP Performance:	Actual	Plan	Variance
	£'000	£'000	£'000
Delivery Year to Date	178	581	-403
Annual Plan		3,483	
Identified		1,382	
Unidentified		2,101	

WTE:	Actual	Plan	Variance
Substantive	1,130	1,445	-315
Locum	0	0	0
Agency	158	0	158
Total WTE	**1,410**	**1,445**	**-35**

Commentary

1. Overview
The Directorate is reporting an in month adverse variance of £442k mainly relating to pay and non pay expenditure. YTD the Directorate is adverse to plan by £457k mainly due to income, pay and non pay expenditure. FOT is reported as an adverse variance of £1,052k.

2. Revenue
Clinical income is a favourable in month variance of £82k (£122k adverse YTD). The in month favourable variance includes £543k relating to month 6 activity following prior months completed and coded datasets. The main YTD favourable variances relate to: day case colorectal surgery £494k, elective colorectal surgery £349k, elective day case pain management £288k, direct access radiology £288k, non elective general surgery £198k, outpatients nuclear medicine £172k and non-elective ENT £125k. The main adverse YTD variances relate to T&O activity £1,523k, day case ENT £206k, elective vascular surgery £198k, and outpatients nuclear medicine £147k.
Other operating income YTD adverse variance mainly relates to; £41k provider to provider income (imaging service) and £29k organ donations.

3. Pay
Pay expenditure is adverse in month by £104k. The YTD adverse variance has improved by £76k mainly due to additional funding for agreed cost pressures and is now £95k adverse to plan. Substantive pay continues to be favourable to plan and partially funding the bank and agency costs. Despite some success with recruitment to qualified nursing vacancies, temporary staffing costs remain largely consistent to the previous month. This position should improve as the nurses complete their training period. The YTD adverse variances mainly relate to scientific therapeutic and technical staff £712k, medical staff £537k and healthcare assistants £245k offset by favourable to plan nursing budgets £1,102k and admin and clerical budgets £297k.

4. Non Pay
Non pay is adverse to plan in month by £438k mainly due to the CIP target not being achieved in full (CIP Plan Oct-16 £581k) and YTD £273k adverse. Within Clinical Supplies main variances relate to; outsourcing shows a favourable 'in-month' variance of £17k and a favourable YTD variance of £379k, YTD adverse variances within critical care and theatres mainly due to increased activity. The Directorate is also in the process of reviewing stock levels within Theatres. Other non pay is adverse mainly reflecting the non-delivery against the CIP target that was phased to realise from the second half of the year.

5. CIP
Delivered £178k of CIP schemes YTD against a plan of £687k; shortfall of £509k. Detailed plans for the remaining schemes are pending development and £826k remains unidentified.

6. Risks and Mitigations
The CIP delivery remains the main risk for the Directorate with a recovery plan pending submission to the PRM. Further work to identify additional opportunities continue and confirmation of Procurement and Income schemes are awaited. Sunderland Ward remains high risk due to emergency pressures. Risk of planned activity reducing due to the pressure of emergency flows during winter months. Recruitment of substantive staff remains a priority. The Directorate is in the process of reviewing the expenditure relating to medical outliers with a view to agreeing an accounting adjustment with the A&CC Directorate.

3b. Directorate Analysis - Women & Children

Income & Expenditure   **(October 2016)**

	Current Month			Year to Date (YTD)			Forecast	Annual	Variance
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Plan*	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical Income	-5,106	-4,412	-694	-32,787	-31,560	-1,227	-56,206	-54,908	-1,298
High Cost Drugs	-5	-16	11	-86	-102	16	-158	-178	20
Other Operating Income	-111	-87	-23	-680	-611	-68	-1,124	-1,063	-61
Total Revenue	**-5,222**	**-4,515**	**-707**	**-33,553**	**-32,273**	**-1,280**	**-57,488**	**-56,149**	**-1,339**
Expenditure									
Substantive	2,430	2,634	-204	18,100	19,522	-1,422	31,300	33,570	-2,270
Bank	73	0	73	449	0	449	692	0	692
Agency	215	14	201	1,159	113	1,046	1,717	181	1,536
Total Pay	**2,719**	**2,648**	**71**	**19,708**	**19,635**	**73**	**33,709**	**33,751**	**-42**
Clinical supplies	213	209	4	1,550	1,468	82	2,782	2,513	269
Drugs	87	100	-13	638	593	44	1,196	1,057	139
Consultancy	0	0	0	0	0	0	0	0	0
Other non pay	292	289	2	669	622	46	1,111	1,055	56
Total Non Pay	**592**	**599**	**-7**	**2,856**	**2,684**	**172**	**5,089**	**4,624**	**465**
Total Expenditure	**3,310**	**3,247**	**64**	**22,564**	**22,319**	**245**	**38,798**	**38,376**	**422**
EBITDA	**-1,911**	**-1,268**	**-643**	**-10,989**	**-9,954**	**-1,035**	**-18,690**	**-17,773**	**-917**

CIP Performance:	*Actual*	*Plan*	*Variance*
	£'000	£'000	£'000
Delivery Year to Date	787	848	-61
Annual Plan		1,349	
Identified		1,349	
Unidentified		0	

WTE:	*Actual*	*Plan*	*Variance*
Substantive	655	733	-78
Bank	25	0	25
Agency	26	0	26
Total WTE	**706**	**733**	**-27**

Commentary

1. Overview
The Directorate is reporting a position favourable to plan in month of £643k due to clinical income. FOT is reported as a favourable variance of £917k.

2. Revenue
Clinical income is £694k favourable in month (£1,227k favourable YTD).
Womens Programme is £635k favourable YTD (27% Gynae, 73% Obstetrics), Gynae Outpatients and Birth is favourable, Acute & Community Paediatrics is £43k adverse YTD, Diabetes, Surgery and Community Paediatric income are all adverse to plan but has been offset by favourable variance of c£500k in Acute services.

High cost drugs income is lower than expected, an underspend in drugs matches this.
Other Operating income is £23k favourable in month (£68k YTD), this relates to additional care package income and unexpected income from Medway Council in relation to the Family Nurse Co-ordinator post.

3. Pay
Pay expenditure is £71k adverse to plan in month. This mainly relates to nursing & midwifery agency costs in excess of vacancy slippage. High levels of agency are still being used in Maternity and Neonates.
Bank rates are being reviewed for Neonates and additional controls are being put in place around maternity agency.

4. Non Pay
Non pay expenditure is £7k favourable to plan in month. The plan assumes high cost drugs expenditure increases in October for NICU, this has not happened returning a £20k underspend in the month. Income will be lower than expected to offset this.

5.CIP
All schemes except one in relation to nurse led colposcopy clinics are delivering in month 7. A number of schemes due to start from November onwards are yet to be fully scoped, risk of non delivery for these schemes is £37k.

6. Risks and Mitigations
The financial risk to the Directorate CIP programme is £101k. Each scheme is under review to ensure progress with implementation & delivery. The Directorate is also actively pursing other cost efficiency schemes for 17/18 to replace non recurrent schemes.

The use of agency expenditure is the main material financial risk to the Directorate. Recruitment drives to increase substantive and bank staff is in progress to reduce this risk. Based upon current run rate a favourable budget position is still expected for the financial year.

3b. Directorate Analysis - Corporate

Income & Expenditure   (October 2016)

	Current Month			Year to Date (YTD)			Forecast	Annual	Variance
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Plan*	
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Other Operating Income	-319	-258	-61	-1,810	-1,816	6	-2,924	-3,108	184
Total Revenue	**-319**	**-258**	**-61**	**-1,810**	**-1,816**	**6**	**-2,924**	**-3,108**	**184**
Expenditure									
Substantive	1,442	1,704	-262	10,005	11,894	-1,889	17,421	20,436	-3,015
Bank	47	5	42	214	17	197	367	56	311
Agency	502	233	269	3,022	1,713	1,309	5,180	2,769	2,411
Total Pay	**1,991**	**1,942**	**49**	**13,241**	**13,624**	**-383**	**22,968**	**23,260**	**-293**
Clinical supplies	13	17	-4	154	120	34	263	205	58
Drugs	6	3	3	13	20	-7	23	35	-12
Consultancy	72	42	30	330	292	37	565	501	64
Other non pay	609	609	0	2,834	3,102	-269	5,573	5,650	-77
Total Non Pay	**699**	**670**	**29**	**3,330**	**3,535**	**-205**	**6,424**	**6,391**	**33**
Total Expenditure	**2,690**	**2,612**	**78**	**16,571**	**17,159**	**-588**	**29,392**	**29,651**	**-260**
EBITDA	**2,371**	**2,354**	**17**	**14,760**	**15,343**	**-583**	**26,468**	**26,544**	**-75**

CIP Performance:	*Actual*	*Plan*	*Variance*
	£'000	£'000	£'000
Delivery Year to Date	527	527	0
Annual Plan		878	
Identified		878	
Unidentified		0	

WTE:	*Actual*	*Plan*	*Variance*
Substantive	425	493	-68
Bank	22	1	21
Agency	38	14	24
Total WTE	**485**	**508**	**-23**

Commentary

1. Overview
The Corporate areas are reporting a position adverse compared to plan in month by £17k and YTD a favourable position is reported of £583k. The favourable variance mainly relates to pay and non pay expenditure. FOT is reported as a small underspend of £75k.

2. Revenue
The current plan assumes a level of Research & Development revenue that has not yet been agreed by the CRN funding panel due to unfunded posts within W&C. The Directorate is in discussion with the network to resolve this but currently the potential risk is approximately £90k for the year.

3. Pay
Pay is favourable in month due to 68wte vacancies in substantive, only partially covered by bank and agency. All establishments are being reviewed in conjunction with budget holders with many restructures & recruitment plans being developed and achieved.

4. Non Pay
Non pay is favourable to plan by £205k YTD mainly due to underspends within Workforce; higher spends are anticipated through the remainder of the year as recruitment continues.

5. CIP
The CIP target has been fully delivered in month and YTD.

6. Risks and Mitigations
A high number of posts across corporate areas remain unfilled and covered by interim staff with recruitment plans being developed as a priority.

3b. Directorate Analysis - Facilities & Estates

Income & Expenditure (October 2016)

| | Current Month | | | Year to Date (YTD) | | | Forecast | Annual | Variance |
	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	Variance £'000	Actual £'000	Plan £'000	£'000
Revenue									
Other Operating Income	-481	-473	-7	-3,314	-3,312	-2	-5,680	-5,678	-2
Total Revenue	**-481**	**-473**	**-7**	**-3,314**	**-3,312**	**-2**	**-5,680**	**-5,678**	**-2**
Expenditure									
Substantive	919	841	78	6,324	5,886	438	10,636	10,091	545
Bank	26	-50	76	161	976	-815	352	773	-421
Agency	115	55	59	1,008	388	620	1,380	666	714
Total Pay	**1,060**	**846**	**214**	**7,493**	**7,250**	**243**	**12,368**	**11,529**	**839**
Clinical supplies	31	34	-3	370	236	134	595	404	191
Drugs	0	0	0	4	0	4	4	0	4
Consultancy	4	8	-4	17	57	-40	22	97	-75
Other non pay	737	798	-61	5,458	5,589	-131	9,389	9,719	-331
Total Non Pay	**772**	**840**	**-68**	**5,848**	**5,881**	**-32**	**10,009**	**10,220**	**-211**
Total Expenditure	**1,832**	**1,686**	**146**	**13,341**	**13,131**	**211**	**22,377**	**21,750**	**627**
EBITDA	**1,351**	**1,213**	**138**	**10,027**	**9,819**	**208**	**16,697**	**16,072**	**625**

CIP Performance:	Actual £'000	Plan £'000	Variance £'000
Delivery Year to Date	41	179	-138
Annual Plan		1,074	
Identified		461	
Unidentified		613	

WTE:	Actual	Plan	Variance
Substantive	441	472	-31
Bank	14	15	-1
Agency	45	2	43
Total WTE	**501**	**489**	**12**

Commentary

1. Overview
The Directorate is reporting a position adverse compared to plan in month of £138k (£208K YTD) due to unidentified CIP phasing in from October. FOT is reported as an adverse variance of £625k.

2. Revenue
Revenue is favourable to plan in month by £7K.

3. Pay
Pay is adverse in month to plan by £214K (£243k YTD) This mainly relates to the unidentified CIP/currently unbudgeted enhancements in Housekeeping & Portering and the use of agency.

4. Non Pay
Non pay is favourable in month to plan by £68k. This mainly relates to a reduction in cleaning material costs and maintenance contract.

5. CIP
£179k CIP is phased into month 7, £41k has been achieved. £9k in relation to the waste contract, £32k other non pay.

6. Risks and Mitigations
The Directorate continues to develop its CIP programme.

3c. Run Rate Analysis - Financial

Anaylsis of 15 monthly performance - Financials

	Aug-15 £m	Sep-15 £m	Oct-15 £m	Nov-15 £m	Dec-15 £m	Jan-16 £m	Feb-16 £m	Mar-16 £m	Apr-16 £m	May-16 £m	Jun-16 £m	Jul-16 £m	Aug-16 £m	Sep-16 £m	Oct-16 £m
Revenue															
Clinical income	18.0	17.1	17.1	17.3	16.7	16.8	16.9	21.9	17.6	17.6	22.8	19.9	18.6	20.0	20.6
High Cost Drugs	1.5	1.6	1.7	1.6	1.7	1.7	1.7	1.7	1.8	1.6	1.8	1.7	1.6	2.0	1.8
Other Operating Income	1.9	1.9	2.0	2.0	1.9	1.9	2.4	2.0	1.9	2.1	2.3	2.1	2.0	2.2	2.0
Total Revenue	**21.4**	**20.5**	**20.8**	**20.8**	**20.3**	**20.4**	**20.9**	**25.6**	**21.4**	**21.4**	**26.8**	**23.8**	**22.2**	**24.2**	**24.4**
Expenditure															
Substantive	-12.8	-12.9	-12.8	-12.9	-12.8	-13.1	-13.1	-12.9	-13.5	-13.5	-13.7	-13.6	-13.7	-13.7	-13.6
Bank	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.6	-0.8	-0.6	-0.5	-0.6	-0.8	-0.7	-0.6	-0.6
Agency	-3.3	-2.9	-3.0	-2.4	-3.6	-2.7	-3.0	-2.8	-2.6	-2.8	-3.6	-2.8	-3.1	-3.6	-3.5
Total Pay	**-16.6**	**-16.4**	**-16.4**	**-15.8**	**-17.0**	**-16.3**	**-16.7**	**-16.3**	**-16.8**	**-16.8**	**-17.8**	**-17.2**	**-17.5**	**-17.8**	**-17.6**
Clinical supplies	-2.8	-2.8	-2.8	-2.9	-3.0	-2.7	-3.1	-3.6	-3.2	-3.4	-3.4	-3.4	-3.3	-3.2	-2.8
Drugs	-2.2	-2.3	-2.5	-2.4	-2.4	-2.4	-2.4	-2.6	-2.7	-2.9	-2.7	-2.5	-2.7	-2.8	-2.5
Consultancy	-0.2	-0.3	-0.1	-0.1	-0.1	-0.2	-0.2	-0.1	0.0	-0.1	0.0	-0.1	0.0	-0.1	0.0
Other non pay	-2.9	-2.8	-2.9	-2.5	-2.7	-2.9	-2.8	-2.7	-2.9	-2.4	-2.9	-2.6	-2.6	-2.4	-2.9
Total Non Pay	**-8.2**	**-8.1**	**-8.4**	**-7.9**	**-8.3**	**-8.1**	**-8.5**	**-9.1**	**-8.8**	**-8.8**	**-8.9**	**-8.5**	**-8.6**	**-8.5**	**-8.2**
Total Expenditure	**-24.7**	**-24.5**	**-24.8**	**-23.7**	**-25.3**	**-24.5**	**-25.2**	**-25.5**	**-25.6**	**-25.6**	**-26.7**	**-25.7**	**-26.1**	**-26.3**	**-25.8**
EBITDA	**-3.3**	**-4.0**	**-4.0**	**-2.9**	**-5.0**	**-4.0**	**-4.3**	**0.1**	**-4.3**	**-4.2**	**0.1**	**-2.0**	**-3.9**	**-2.1**	**-1.3**
Post EBITDA															
Depreciation	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.9	-0.3	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8
Interest	-0.1	-0.1	-0.1	-0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2
Dividend	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	-0.3	0.2	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Fixed Asset Impairment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Profit on sale of asset	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	-1.3	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**-1.3**	**0.0**	**-1.0**	**-1.0**	**-1.0**	**-1.1**	**-1.1**	**-1.1**	**-1.0**
Net Surplus / (Deficit)	**-4.6**	**-5.3**	**-5.3**	**-4.2**	**-6.3**	**-5.3**	**-5.6**	**0.1**	**-5.3**	**-5.3**	**-0.9**	**-3.1**	**-5.0**	**-3.1**	**-2.4**
Revaluation Gain	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Net Surplus / (Deficit)	**-4.6**	**-5.3**	**-5.3**	**-4.2**	**-6.3**	**-5.3**	**-5.6**	**0.4**	**-5.3**	**-5.3**	**-0.9**	**-3.1**	**-5.0**	**-3.1**	**-2.4**

3d. Clinical Activity

Clinical Activity by Point of Delivery (October 2016)

	Current Month			Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
PBR								
Elective Day Case	1,976	1,789	187	2,287	13,276	12,678	598	11,893
Elective Inpatient	582	675	-93	678	4,351	4,382	-31	3,866
Non Elective Inpatient	3,588	4,050	-462	3,538	27,228	26,912	316	23,857
Excess Bed Days	1,445	2,126	-681	1,794	9,707	14,989	-5,282	8,144
Outpatients	27,906	30,098	-2,192	29,580	205,620	202,390	3,230	175,548
A&E	7,610	6,582	1,028	6,536	52,062	46,427	5,635	43,411
Maternity Pathway	789	926	-137	882	6,221	6,300	-79	5,403
Direct Access Radiology	5,094	3,622	1,472	5,324	41,123	31,470	9,653	35,580
Adult Critical Care	998	965	33	721	5,810	5,847	-37	4,820
Chemotherapy	715	830	-115	1,225	6,836	5,787	1,049	6,196
Total PBR	**50,703**	**51,663**	**-960**	**52,565**	**372,234**	**357,182**	**15,052**	**318,718**
Non PBR								
Direct Access	203,515	200,269	3,246	183,543	1,435,355	1,291,484	143,871	1,199,072
Paediatric & Neonatal Critical Care	859	959	-100	729	6,885	6,864	21	5,695
Excluded Devices	101	56	45	74	653	477	176	502
Other cost per case	2,257	3,406	-1,149	2,285	17,686	20,150	-2,464	14,891
Total Non PBR	**206,732**	**204,690**	**2,043**	**186,631**	**1,460,579**	**1,318,975**	**141,605**	**1,220,160**

Commentary

A&E attendances continues with high volumes month on month, seeing a 16% increase compared to October 2016 and 1,074 additional attendances compared to the previous month. A contract performance letter has been issued to the CCG in relation to the high level of A&E .

Elective day cases are over in month by 187 spells (598 spells over YTD) while inpatients are under in month by 93 spells (31 spells YTD). Within Daycases, Colorectal Surgery (184 spells in month & 970 spells YTD) and Gastroenterology (234 spells in month & 384 YTD) remain the largest over performers. These are offset by underperformances in General Medicine (100 spells in month & 741 YTD), Rheumatology (42 spells in month & 239 spells YTD), T&O (64 spells in month & 186 YTD), Vascular(15 spells in month & 15 spells YTD), and Urology (41 spells in month 52 spells over YTD).

T&O remains the biggest under performers within the elective in-patients 47 spells in month (125 spells YTD).

Non elective activity remains higher than the corresponding period of the last financial year YTD . This increase is driven by the high level of A&E attendances currently being experienced.

Direct access pathology activity & pricing is yet to be confirmed in the contract with the CCG's, once this has been agreed prior periods will be retrospectively adjusted.

Excess bed days have continued to under perform against plan due to the impact of the medical model and the reduction of length of stay within the emergency Pathway.

Activity Performance against Plan

Elective & Day Cases

(Plan, Actual, Prior Yr — monthly Apr–Mar)

Non-Electives

(Plan, Actual, Prior Yr — monthly Apr–Mar)

Outpatients

(Plan, Actual, Prior Yr — monthly Apr–Mar)

A&E Attendances

(Actual, Plan & Prior Yr — monthly Apr–Mar)
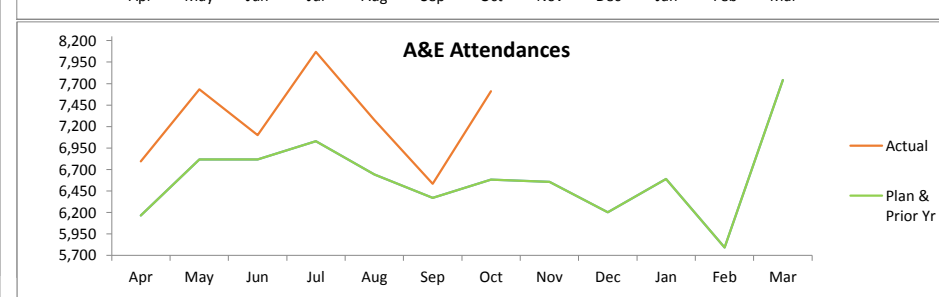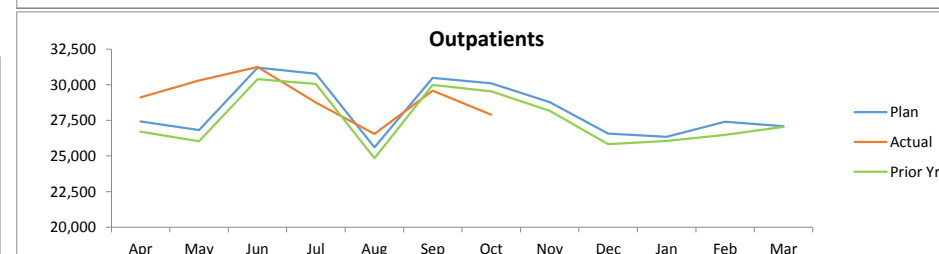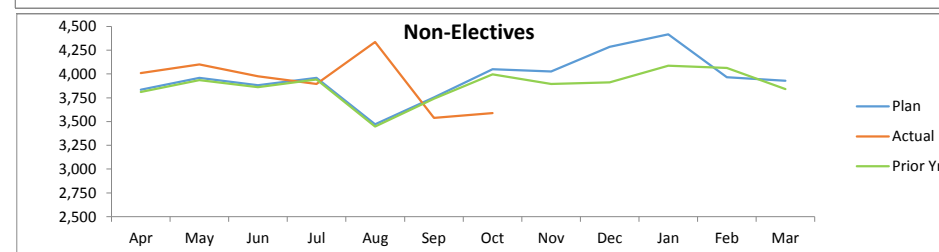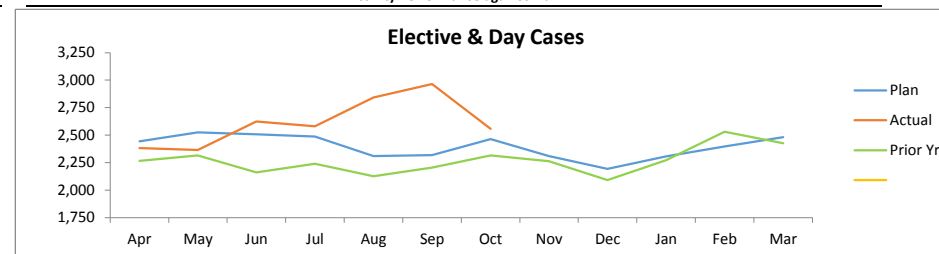
3e. Clinical Income

Clinical Income by Point of Delivery (October 2016)

	Current Month			Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
	£m	£m	£m	£m	£m	£m	£m	£m
PBR								
Elective Day Case	1.44	1.41	0.03	1.50	10.00	9.75	0.25	8.56
Elective Inpatient	1.62	1.81	-0.19	1.58	11.56	11.90	-0.34	9.88
Non Elective Inpatient	6.77	6.85	-0.08	6.53	46.34	45.13	1.21	39.45
Emergency Readmissions	-0.19	-0.19	0.00	-0.19	-1.35	-1.35	0.00	-1.16
Emergency Marginal rate	-0.27	-0.27	0.00	-0.22	-1.98	-1.86	-0.12	-2.08
Excess Bed Days	0.34	0.50	-0.16	0.31	2.27	3.59	-1.32	1.90
Outpatients	3.61	3.81	-0.20	3.67	25.53	25.47	0.06	22.06
A&E	0.99	0.84	0.15	0.97	6.81	5.99	0.82	5.79
Maternity Pathway	0.91	0.93	-0.02	0.84	6.35	6.28	0.07	5.31
Direct Access Radiology	0.20	0.15	0.05	0.21	1.59	1.29	0.30	0.99
Adult Critical Care	1.04	1.03	0.01	0.72	6.00	6.03	-0.03	4.96
Chemotherapy	0.10	0.12	-0.02	0.16	1.09	0.81	0.28	1.06
Total PBR	**16.56**	**16.99**	**-0.43**	**16.08**	**114.21**	**113.03**	**1.18**	**96.72**
Non PBR								
High Cost Drugs	1.79	1.89	-0.10	2.03	12.39	12.23	0.16	10.60
Direct Access	0.44	0.53	-0.09	0.46	3.17	3.49	-0.32	1.80
Paediatric & Neonatal Critical Care	0.71	0.75	-0.04	0.59	5.80	5.39	0.41	4.75
Excluded Devices	0.11	0.23	-0.12	0.22	1.25	1.34	-0.09	1.14
Other cost per case	0.25	0.30	-0.05	0.26	1.90	2.03	-0.13	2.94
Block contracts	0.75	0.77	-0.02	0.78	5.43	5.41	0.02	4.68
Outpatient efficiencies	-0.16	-0.23	0.07	-0.17	-1.21	-1.59	0.38	-0.84
Total Non PBR	**3.89**	**4.24**	**-0.35**	**4.17**	**28.73**	**28.30**	**0.43**	**25.07**
CQUIN	0.37	0.39	-0.02	0.37	2.52	2.60	-0.08	2.16
Contract Penalties	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Other Income Adjustments	0.81	-0.18	0.99	0.00	0.14	-0.17	0.31	0.00
Sustainability & transformation Funding	0.70	0.70	0.00	0.70	4.90	4.90	0.00	4.20
Other Non-Contracted Income	0.08	0.05	0.03	0.04	0.40	0.36	0.04	0.30
Provision	-0.23	-0.11	-0.12	-0.23	-1.62	-1.05	-0.57	-1.36 -
Prior Month Adjustments	0.00	0.00	0.00	0.90	0.00	0.00	0.00	
Others (RTA & Overseas)	0.19	0.08	0.11		0.66	0.41	0.25	
Total	**22.37**	**22.16**	**0.21**	**22.03**	**149.94**	**148.38**	**1.56**	**127.09**

Commentary

Non elective income is under plan in month but remains over plan YTD due to the rise in attendances in A&E even though the conversion rates from A&E have reduced from last year's level (25.8% in October 2015 vs 19.4% in October 2016). In addition, we are continuing to see a reduction in excess bed days (YTD 47% decrease as at October 2016) as a result of the reduction in average LOS for non elective patients due to the impact of the medical model.

The contract with the main commissioners remains pending agreement and arbitration papers have been submitted to NHSi and the Trust is awaiting the outcome.

Contract penalties have not been applied in line with the Trust's acceptance and sign up to the Sustainability & Transformation Fund, however future period Sustainability & Transformation funding will be contingent upon achievement of the agreed performance trajectories. Traditional contract penalties will not be applied in line with NHS Improvement guidance.

Income Performance against Plan

Elective & Day Cases

Non-Electives

Outpatients

A&E Attendances
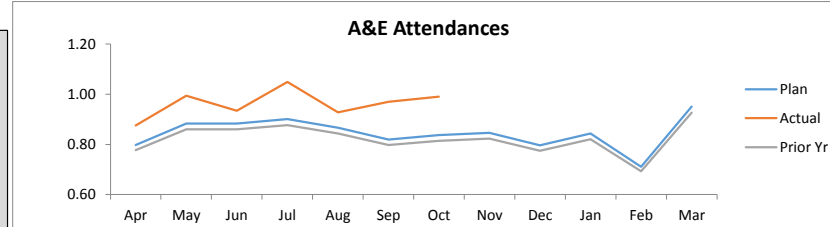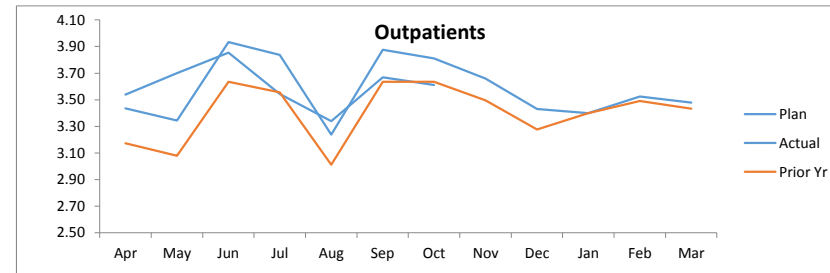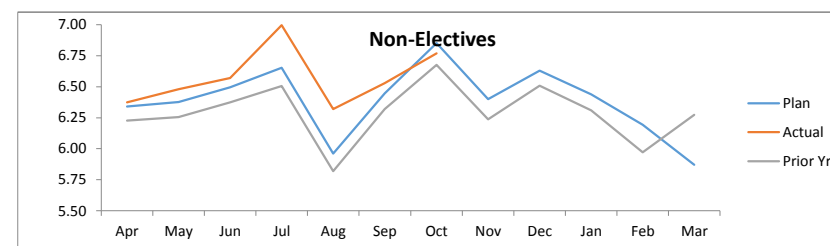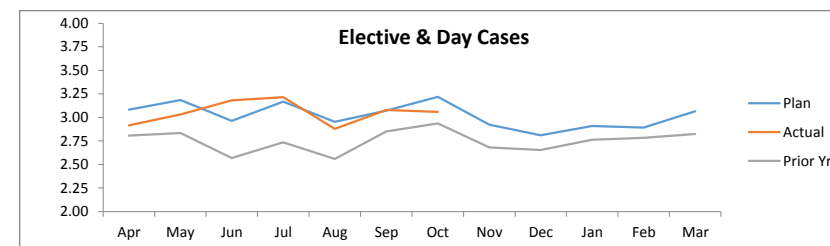
3f. Clinical Income Specialities

Clinical Income Top 3 Variances (underperformance YTD) at Point of Delivery & Specialty

Top 3 Elective for each Directorate (Combined Daycases & Inpatients)

		Current Month			Year to Date		
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*
Directorate	**Specialty**	£'000	£'000	£'000	£'000	£'000	£'000
Acute & Continuing Care	Cardiology	203	235	-32	1,354	1,378	-24
Acute & Continuing Care	General Medicine	20	64	-44	91	491	-400
Acute & Continuing Care	Rheumatology	42	65	-23	284	415	-131
Co-Ordinated Surgery	Trauma & Orthopaedics	787	978	-191	6,182	6,856	-674
Co-Ordinated Surgery	Vascular Surgery	97	140	-43	618	822	-204
Co-Ordinated Surgery	ENT	239	309	-70	1,731	1,847	-116
Women's & Children	Paediatric Surgery	31	45	-14	259	277	-18
Women's & Children	Paediatrics	2	17	-15	79	152	-73
	Total	**1,697**	**2,096**	**-399**	**12,299**	**13,927**	**-1,628**

Commentary

T&O is underperforming across all PODs .

Directorates have been requested to provide updates at the PRM on actions to improve the

Top 3 Non Elective for each Directorate

		Current Month			Year to Date		
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*
Directorate	**Specialty**	£'000	£'000	£'000	£'000	£'000	£'000
Acute & Continuing Care	Gastroenterology	105	155	-50	924	1,001	-77
Acute & Continuing Care	Endocrinology	42	64	-22	368	435	-67
Acute & Continuing Care	Respiratory Medicine	4	56	-52	118	357	-239
Co-Ordinated Surgery	General Surgery	922	665	257	4,953	4,755	198
Co-Ordinated Surgery	Trauma & Orthopaedics	463	534	-71	3,862	4,253	-391
Co-Ordinated Surgery	Urology	119	164	-45	930	967	-37
Women's & Children	Gynaecology	61	56	5	463	510	-47
	Total	**1,716**	**1,694**	**22**	**11,618**	**12,278**	**-660**

Top 3 Outpatients for each Directorate

		Current Month			Year to Date		
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*
Directorate	**Specialty**	£'000	£'000	£'000	£'000	£'000	£'000
Acute & Continuing Care	Respiratory Medicine	61	60	1	472	501	-29
Acute & Continuing Care	Gastroenterology	91	116	-25	726	796	-70
Acute & Continuing Care	Clinical Haematology	95	130	-35	809	861	-52
Co-Ordinated Surgery	Trauma & Orthopaedics	274	339	-65	2,168	2,378	-210
Co-Ordinated Surgery	ENT	324	340	-16	2,094	2,152	-58
Co-Ordinated Surgery	Urology	295	300	-5	2,029	2,070	-41
	Total	**1,140**	**1,285**	**-145**	**8,298**	**8,758**	**-460**

3f. 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	180	215	-35	2.48	2.70	-0.21	2.27	16.50	18.52	-2.02	15.99
	Junior Medical	328	368	-41	1.96	2.14	-0.18	1.74	13.38	14.61	-1.22	11.90
	Nurses & Midwives	1105	1485	-380	3.92	4.93	-1.02	3.69	27.57	34.90	-7.33	26.59
	Scientific, Therapeutic & Technical	442	505	-62	1.18	1.36	-0.18	1.36	9.65	10.50	-0.85	9.26
	Healthcare Assts, etc.	458	545	-86	0.94	1.09	-0.14	0.92	6.72	7.65	-0.93	6.60
	Executives	8	9	-1	2.03	2.54	-0.51	1.81	14.06	16.64	-2.58	12.72
	Chair & NEDs	6	7	-1	0.01	0.01	0.00	0.01	0.09	0.09	0.00	0.07
	Admin & Clerical	808	950	-142	0.10	0.14	-0.03	0.14	0.85	0.95	-0.10	0.94
	Other Non Clinical	464	491	-27	0.93	0.85	0.08	0.83	6.44	5.97	0.46	5.88
	Pay Reserves	0	0	0	0.00	-0.36	0.36	0.00	0.00	-0.23	0.23	0.01
	Substantive Total	**3801**	**4575**	**-775**	**13.56**	**15.40**	**-1.84**	**12.78**	**95.27**	**109.60**	**-14.33**	**89.96**
Agency	Consultants	20	0	20	0.31	0.09	0.22	0.26	2.31	0.69	1.6	1.45
	Junior Medical	68	0	68	0.57	0.44	0.14	0.68	4.07	3.08	1.0	4.82
	Nurses & Midwives	324	0	324	1.56	0.37	1.20	1.23	8.70	3.53	5.2	8.01
	Scientific, Therapeutic & Technical	35	0	35	0.24	0.08	0.16	0.36	1.79	0.75	1.0	2.46
	Healthcare Assts, etc.	49	0	49	0.12	0.00	0.12	0.04	0.70	0.00	0.7	0.25
	Admin & Clerical	22	16	6	0.56	0.31	0.25	0.31	3.42	2.11	1.3	2.23
	Other Non Clinical	44	0	44	0.10	0.03	0.07	0.14	0.91	0.20	0.7	0.98
	Agency Total	**562**	**16**	**546**	**3.47**	**1.31**	**2.15**	**3.02**	**21.90**	**10.38**	**11.52**	**20.20**
Bank	Nurses & Midwives	53	0	53	0.10	0.12	-0.02	0.17	1.38	0.86	0.5	1.37
	Scientific, Therapeutic & Technical	18	0	18	0.06	0.01	0.05	0.04	0.38	0.06	0.3	0.28
	Healthcare Assts, etc.	114	0	114	0.26	0.05	0.20	0.25	1.78	0.37	1.4	1.60
	Admin & Clerical	59	1	58	0.05	-0.07	0.11	0.11	0.63	0.86	-0.2	0.75
	Other Non Clinical	13	15	-2	0.09	0.04	0.05	0.03	0.15	0.25	-0.1	0.19
	Bank Total	**257**	**16**	**241**	**0.55**	**0.16**	**0.40**	**0.60**	**4.31**	**2.40**	**1.91**	**4.19**
	Workforce Total	**4619**	**4607**	**12**	**17.58**	**16.88**	**0.71**	**16.40**	**121.47**	**122.38**	**-0.90**	**114.36**

	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	200	215	-15	2.79	2.79	0.00	2.54	18.81	19.22	-0.41	17.44
Junior Medical	396	368	27	2.53	2.58	-0.05	2.42	17.45	17.69	-0.24	16.72
Nurses & Midwives	1,482	1,485	-3	5.58	5.43	0.16	5.09	37.65	39.29	-1.65	35.98
Scientific, Therapeutic & Technical	495	505	-10	1.48	1.45	0.03	1.75	11.82	11.31	0.51	12.01
Healthcare Assts, etc.	622	545	77	1.33	1.14	0.19	1.21	9.20	8.03	1.17	8.46
Executives	8	9	-1	2.03	2.54	-0.51	1.81	14.06	16.64	-2.58	12.72
Chair & NEDs	6	7	-1	0.01	0.01	0.00	0.01	0.09	0.09	0.00	0.07
Admin & Clerical	889	967	-78	0.71	0.38	0.33	0.56	4.90	3.92	0.98	3.92
Other Non Clinical	521	506	15	1.12	0.92	0.20	1.00	7.50	6.43	1.07	7.04
Pay Reserves	0	0	0	0.00	-0.36	0.36	0.00	0.00	-0.23	0.23	0.01
Workforce Total	**4,619**	**4,607**	**12**	**17.58**	**16.88**	**0.71**	**16.40**	**121.47**	**122.38**	**-0.90**	**114.36**

Commentary:

Pay expenditure is overspent compared to plan in month by £0.71m mainly due to CIP phased in. Increases on prior year in month expenditure are mainly due to increments, inflationary and national insurance increases of 3.3%.

Agency expenditure is £1.7m higher YTD than prior year. The Trust is in the process of developing an agency improvement plan.

Establishments have been set based on a run rate basis including vacancies and agreed opening budgets with Directorates. Further in year reviews are planned in all three clinical directorates to confirm required staffing levels following the demand and capacity analysis.

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.

3g. Run Rate Analysis - WTE / £

Anaylsis of 15 monthly performance - WTE

		Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	179	181	181	182	180	180	178	179	178	181	179	177	179	179	180
	Junior Medical	313	314	317	325	322	319	324	326	321	311	322	307	335	334	328
	Nurses & Midwives	1,064	1,076	1,075	1,088	1,076	1,066	1,077	1,102	1,110	1,107	1,105	1,089	1,084	1,097	1,105
	Scientific, Therapeutic & Technical	433	446	452	450	453	450	448	453	464	466	460	452	451	456	442
	Healthcare Assts, etc	485	473	468	465	472	465	466	477	471	465	457	461	450	457	458
	Executives	6	7	6	5	4	4	5	6	7	7	7	7	7	8	8
	Chair & NEDs	5	7	6	6	7	7	7	7	7	7	7	7	7	7	6
	Admin & Clerical	751	752	756	754	750	750	768	779	794	800	801	802	801	809	808
	Other Non Clinical	427	436	427	419	425	417	422	420	443	435	451	467	464	458	464
	Substantive Total	**3,663**	**3,692**	**3,689**	**3,694**	**3,689**	**3,658**	**3,695**	**3,749**	**3,795**	**3,779**	**3,789**	**3,768**	**3,756**	**3,805**	**3,801**
Agency	Consultants	10	14	13	11	10	8	11	14	10	13	14	16	19	25	20
	Junior Medical	62	57	53	64	54	59	51	59	50	52	51	54	59	65	68
	Nurses & Midwives	197	216	214	100	271	200	245	159	168	224	330	201	254	340	324
	Scientific, Therapeutic & Technical	57	52	56	54	54	52	55	49	44	52	61	55	61	28	35
	Healthcare Assts, etc	9	20	16	6	17	10	8	42	- 9	31	46	26	44	63	49
	Admin & Clerical	30	41	45	27	41	32	39	52	40	41	61	58	30	22	22
	Other Non Clinical	52	77	41	41	-	48	53	73	57	45	36	35	35	35	44
	Agency Total	**417**	**477**	**438**	**303**	**447**	**409**	**462**	**448**	**360**	**458**	**598**	**444**	**502**	**543**	**562**
Bank	Nurses & Midwives	42	46	45	43	41	47	49	92	58	58	46	51	47	44	53
	Scientific, Therapeutic & Technical	12	12	10	11	9	10	10	10	4	4	28	27	18	17	18
	Healthcare Assts, etc	119	104	120	113	105	118	108	91	91	91	153	120	117	108	114
	Admin & Clerical	41	46	46	49	47	48	50	42	36	36	19	62	106	51	59
	Other Non Clinical	12	12	11	12	13	9	11	10	3	3	1	4	9	3	13
	Bank Total	**226**	**220**	**233**	**228**	**215**	**232**	**228**	**245**	**192**	**192**	**247**	**264**	**297**	**223**	**257**
	Workforce Total	**4,307**	**4,389**	**4,359**	**4,225**	**4,351**	**4,299**	**4,385**	**4,442**	**4,347**	**4,429**	**4,634**	**4,476**	**4,577**	**4,571**	**4,619**

Anaylsis of 15 monthly performance - £

		Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.31	2.27	2.27	2.29	2.29	2.29	2.23	2.26	2.31	2.37	2.33	2.38	2.33	2.30	2.48
	Junior Medical	1.75	1.73	1.74	1.79	1.75	1.95	1.93	1.81	1.86	1.83	1.91	1.88	1.99	1.95	1.96
	Nurses & Midwives	3.68	3.78	3.69	3.71	3.74	3.74	3.77	3.73	3.97	3.95	4.00	3.89	3.91	3.92	3.92
	Scientific, Therapeutic & Technical	1.30	1.35	1.36	1.38	1.35	1.36	1.35	1.32	1.45	1.43	1.42	1.38	1.38	1.42	1.18
	Healthcare Assts, etc	0.93	0.94	0.92	0.92	0.93	0.95	0.95	0.94	0.99	0.95	0.97	0.96	0.94	0.97	0.94
	Executives	1.78	1.81	1.81	1.77	1.78	0.09	0.19	0.06	1.98	2.01	2.00	2.01	2.01	2.02	2.03
	Chair & NEDs	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01	0.01
	Admin & Clerical	0.10	0.14	0.14	0.13	0.13	1.82	1.83	1.91	0.11	0.11	0.13	0.15	0.12	0.13	0.10
	Other Non Clinical	0.84	0.88	0.83	0.83	0.83	0.83	0.84	0.82	0.91	0.87	0.91	0.93	0.96	0.94	0.93
	Substantive Total	**12.71**	**12.92**	**12.78**	**12.83**	**12.81**	**13.04**	**13.11**	**12.83**	**13.59**	**13.52**	**13.69**	**13.59**	**13.65**	**13.67**	**13.56**
Agency	Consultants	0.25	0.32	0.26	0.11	0.24	0.18	0.24	0.29	0.24	0.26	0.31	0.37	0.37	0.44	0.31
	Junior Medical	0.96	0.51	0.68	0.66	0.84	0.70	0.59	0.60	0.66	0.54	0.50	0.56	0.60	0.64	0.57
	Nurses & Midwives	1.21	1.26	1.23	0.88	1.66	0.94	1.34	0.80	0.72	0.96	1.68	1.01	1.18	1.58	1.56
	Scientific, Therapeutic & Technical	0.39	0.32	0.36	0.39	0.36	0.39	0.32	0.25	0.28	0.28	0.31	0.27	0.26	0.14	0.24
	Healthcare Assts, etc	0.03	0.06	0.04	0.03	0.05	0.02	0.02	0.06	0.04	0.08	0.12	0.06	0.11	0.16	0.12
	Admin & Clerical	0.31	0.27	0.31	0.20	0.34	0.31	0.34	0.55	0.53	0.50	0.50	0.40	0.52	0.42	0.56
	Other Non Clinical	0.13	0.18	0.14	0.13	0.14	0.14	0.14	0.20	0.15	0.14	0.13	0.14	0.09	0.17	0.10
	Agency Total	**3.28**	**2.92**	**3.02**	**2.39**	**3.63**	**2.68**	**3.01**	**2.76**	**2.63**	**2.76**	**3.55**	**2.81**	**3.13**	**3.55**	**3.47**
Bank	Nurses & Midwives	0.16	0.17	0.17	0.17	0.16	0.19	0.19	0.38	0.20	0.24	0.22	0.30	0.17	0.16	0.10
	Scientific, Therapeutic & Technical	0.05	0.04	0.04	0.04	0.03	0.03	0.04	0.04	0.00	0.01	0.10	0.08	0.06	0.06	0.06
	Healthcare Assts, etc	0.27	0.20	0.25	0.25	0.23	0.28	0.24	0.20	0.22	0.22	0.29	0.28	0.26	0.24	0.26
	Admin & Clerical	0.10	0.11	0.11	0.12	0.11	0.11	0.12	0.10	0.14	0.07	-0.05	0.13	0.21	0.09	0.05
	Other Non Clinical	0.03	0.03	0.03	0.03	0.04	0.02	0.03	0.02	0.03	0.01	0.00	-	0.02	0.01	0.09
	Bank Total	**0.60**	**0.56**	**0.60**	**0.60**	**0.58**	**0.63**	**0.62**	**0.75**	**0.59**	**0.54**	**0.56**	**0.79**	**0.72**	**0.57**	**0.55**
	Workforce Total	**16.58**	**16.40**	**16.40**	**15.82**	**17.02**	**16.35**	**16.74**	**16.34**	**16.81**	**16.82**	**17.80**	**17.19**	**17.50**	**17.79**	**17.58**

4. Balance Sheet

4a. Balance Sheet

	Last Month	Current Month		
	Actual	Actual	Plan	Variance
	£m	£m	£m	£m
Non current Assets				
Property, Plant and Equipment	169.0	170.0	166.5	3.5
Non NHS trade receivables	0.6	0.5	0.6	-0.1
Non current Assets Sub Total	**169.6**	**170.5**	**167.1**	**3.4**
Current Assets				
Inventories	6.6	6.8	6.4	0.4
Trade receivables	31.6	31.1	25.1	6.0
Other receivables	1.5	1.5	-1.3	2.8
Other current assets	3.5	3.8	2.3	1.6
Cash at bank	1.6	1.7	1.6	0.1
Current Assets Sub Total	**44.7**	**44.9**	**34.1**	**10.8**
Current Liabilities				
Trade payables	-18.8	-19.6	-17.2	-2.4
Other payables	-25.9	-25.9	-17.6	-8.3
Borrowings	-1.0	-1.0	-1.2	0.2
Provisions	-0.1	0.0	-0.1	0.1
Other liabilities	-16.4	-16.1	-13.9	-2.2
Sub Total Current Liabilities	**-62.1**	**-62.6**	**-50.0**	**-12.6**
Net Current Assets	**-17.4**	**-17.7**	**-16.0**	**-1.8**
Non Current Liabilities				
Borrowings	-102.0	-104.4	-89.8	-14.6
Provisions	-0.9	-0.9	-0.8	0.1
Other liabilities	0.3	-0.2	0.0	-0.2
Sub Total Non Current Liabilities	**-102.5**	**-105.5**	**-90.6**	**-14.7**
Net Assets Employed	**49.7**	**47.3**	**60.5**	**-13.2**
Taxpayers' and Others' Equity				
Public Dividend Capital	129.5	129.5	129.5	0.0
Retained Earnings	-112.1	-114.5	-101.3	-13.2
Revaluation Reserve	32.3	32.3	32.3	0.0
	49.7	**47.3**	**60.5**	**-13.2**

Commentary

For the commentary relating to the balance sheet please refer to section 5a for Capital, 2a for Cashflow, 4b for debtors and 4c for creditors.

4b. Debtors

Aged Debtors

	Total		Current	31 - 60 Days	61 - 90 Days	91- 180 Days	181 - 365 Days	12 - 18 Months	18 - 24 Months	2 - 3 Years	3 + Years
	£m		£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS											
Medway CCG	4.77		0.38	2.71	0.29	1.06	0.17	0.01	0.01	0.05	0.09
Swale CCG	2.27		0.10	1.07	0.13	0.35	0.58	0.00	0.01	0.02	0.00
Dartford & Gravesham CCG	1.50		0.21	0.40	0.00	0.37	0.18	0.22	0.05	0.06	0.00
Other CCGs	2.39		0.48	0.41	0.17	0.37	0.50	0.30	0.08	0.03	0.04
NHS England	0.04		0.00	0.01	0.00	0.00	0.00	0.01	0.02	0.00	0.00
Other	3.37		0.37	0.64	0.18	0.99	0.40	0.28	0.27	0.12	0.12
Partially Completed Spells and Overperformance	15.64		15.64	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total NHS	**29.98**		**17.20**	**5.24**	**0.76**	**3.15**	**1.84**	**0.82**	**0.45**	**0.28**	**0.24**
Non NHS											
Nursery	0.06		0.02	0.01	0.00	0.01	0.01	0.00	0.00	0.00	0.01
Payroll	0.13		0.00	(0.00)	0.00	0.00	0.01	0.04	0.02	0.01	0.06
Overseas patients	0.35		0.02	0.03	0.02	0.04	0.04	0.06	0.05	0.04	0.04
Medway Comm Healthcare	0.41		0.06	0.16	0.01	0.05	0.06	0.01	0.02	0.02	0.02
Other	1.10		0.16	0.25	0.03	0.25	0.30	0.03	0.03	0.03	0.02
Total Non NHS	**2.05**		**0.26**	**0.45**	**0.05**	**0.34**	**0.42**	**0.15**	**0.12**	**0.11**	**0.14**
Bad debt provision	**(0.90)**		**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.12)**	**(0.39)**	**(0.38)**
Total Debtors	**31.13**		**17.46**	**5.68**	**0.82**	**3.49**	**2.26**	**0.97**	**0.45**	**0.00**	**0.00**

Commentary

The gross trade receivables debt outstanding to the Trust as at 31 October 2016 is £32.03m (£31.13m Net). In accordance with Trust policy the Bad Debt provision is shown separately.

Overall NHS and non-NHS debtors decreased by a net £0.47m in the month. This includes a increase of £3.15m in the accrual for partially completed spells (PCS) and overperformance with Commissioners. Therefore debtors excluding PCS and overperformance decreased by £3.61m.

The previously reported overperformance debtors have shifted to the next ageing category and will continue to do so until negotiations and reconciliations are fully complete with the relevant CCG's.

During October the Trust has successfully concluded discussions with Carillion Plc who will shortly be settling £460k of their long overdue debt (dating back to Dec 15) debt. This represents 22% of the total Non-NHS Debt and the Trust anticipates receiving this cash in November 2016.

Fig.1 shows the value of debt outstanding by ageing category. Current debt (i.e. less than 30 days) stands at 55% of total receivables, with a further 31% of receivables for categories up to 6 months overdue; the remaining 14% of debt is over 6 months old.

Fig.2 and the below commentary illustrate the trends (& highlights) of each ageing category over the last 6 months.

Work continues with the income team and NHS suppliers to collect the overdue high cost drugs and clinical contract income debt. Resource has also been allocated to resolve some of the older NHS debts that make up the agreement of balances exercise.
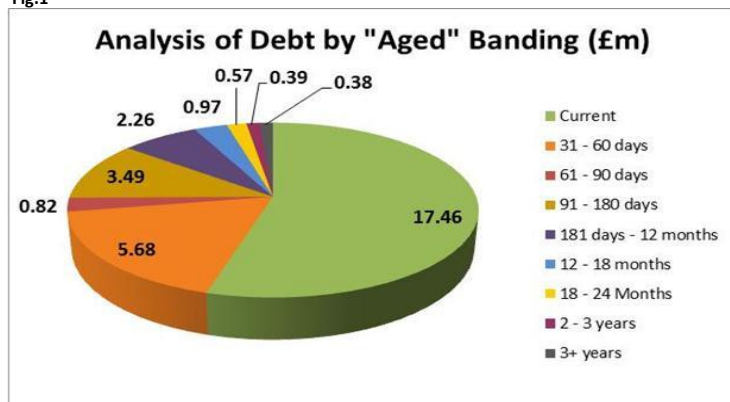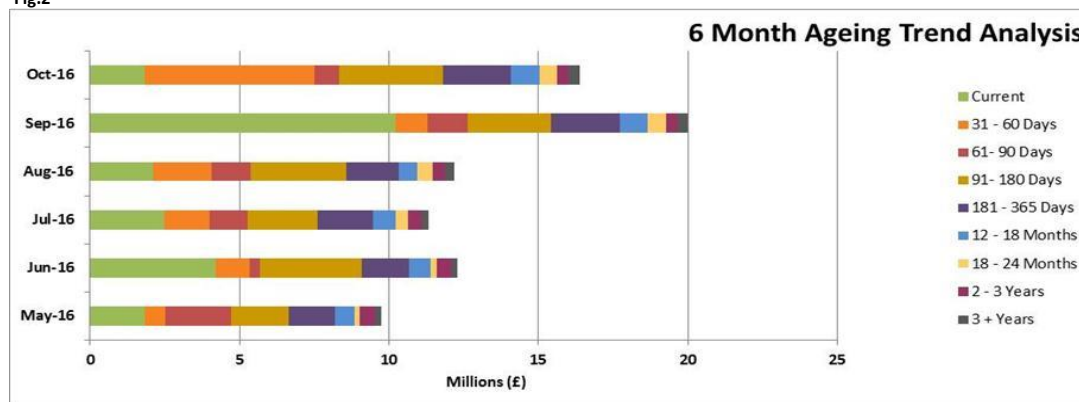
Fig.1

Analysis of Debt by "Aged" Banding (£m)

Fig.2

6 Month Ageing Trend Analysis

4c. Creditors

Aged Creditors

	Total £m	Current £m	31 to 60 Days £m	61 to 90 Days £m	91 - 180 Days £m	181 - 365 Days £m	1 Year + £m
NHS							
NHS Business Services Author	0.47	0.35	0.12	0.00	0.00	0.00	0.00
NHS Litigation Authority	(1.11)	(0.56)	(0.56)	0.00	0.00	0.00	0.00
Dartford and Gravesham	0.87	0.23	0.18	0.02	0.26	0.10	0.07
National Blood	0.13	0.12	0.01	0.00	0.00	0.00	0.00
Other	2.05	0.25	0.88	0.07	0.31	0.32	0.24
NHS Pension Scheme	2.22	2.22	0.00	0.00	0.00	0.00	0.00
Total NHS	4.62	2.60	0.62	0.09	0.57	0.42	0.32
Non NHS							
NHS Professionals	0.00	0.00	0.00	0.00	0.00	0.00	0.00
NHS Supply Chain	1.02	0.46	0.50	0.00	0.06	0.00	0.00
Johnson and Johnson	0.29	0.12	0.17	0.01	0.00	0.00	0.00
Other	13.62	6.38	4.31	0.79	1.65	0.39	0.11
Total Non NHS	14.93	6.96	4.97	0.79	1.71	0.39	0.11
Total Creditors	**19.55**	**9.56**	**5.59**	**0.88**	**2.28**	**0.81**	**0.43**

Commentary

The key NHS and Non NHS trade creditors are shown in the table to the left. Trade Creditors are now at £19.55m.

The Trust continues to maintain payments for all approved invoices between 45 and 60 days from the invoice date. The Trust continues to work through and resolve legacy issues and is actively working towards clearing the agency debt directly with suppliers.

Although the following totals include unapproved invoices - significant Creditors include NHS Supply Chain £958k, Siemens £907k, Dartford & Gravesham £869k, Maidstone & Tunbridge Wells NHS FT £661k, Medway Council £612k, Medicspro £458k, East Kent Hospitals NHS FT £449k, ID Medical £345k, Medtronic £338k, Kings College £334k, BMI Healthcare £300k, Medacs £299k & Johnson and Johnson £293k. There are a further 28 suppliers (both NHS & Non-NHS) with balances owing that are greater than £100k totalling £4.46m.

Fig. 1 Shows Aged Debt analysed by Ageing Category; Fig.2 Shows the 6 month Creditor Trend; & Fig.3 shows the number of outstanding invoices on the ledger at Month End.

Fig.1 - Aged Creditors Analysis
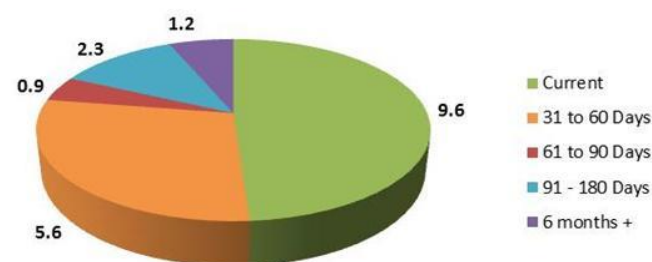
Fig.2 - Aged Creditor Monthly Profile
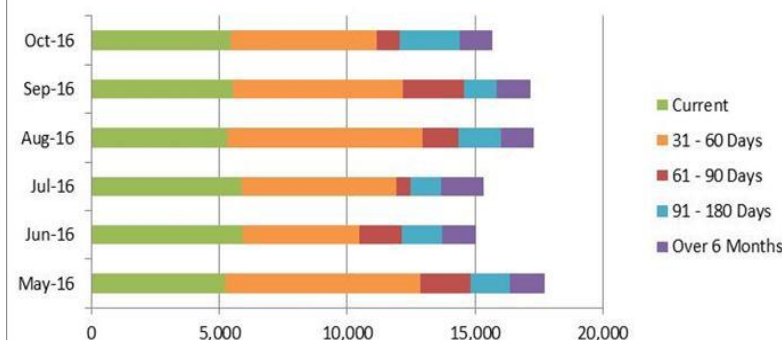
Fig.3 - Invoices on Ledger @ Month End
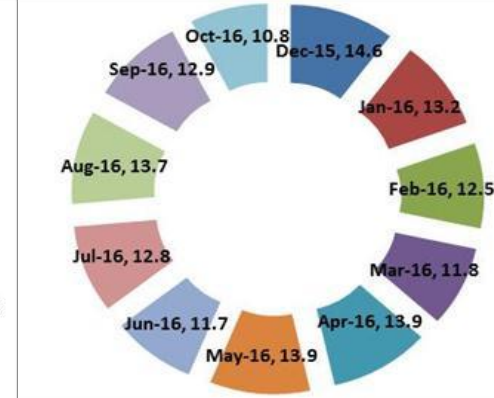
5. Capital

5a.Capital

Capital Programme Summary

	Current Month			Year to Date			Annual
	Actual	Plan	Variance	Actual	Plan	Variance	Plan
	£m	£m	£m	£m	£m	£m	£m
Expenditure							
Recurrent Estates & Site Infrastructure	0.63	0.62	0.01	2.71	2.88	-0.17	5.06
IM&T	0.38	0.67	-0.29	2.41	2.62	-0.21	5.90
Medical & Surgical Equipment	0.37	0.14	0.23	1.14	0.93	0.21	1.52
Specific Business Cases	0.52	0.55	-0.03	1.75	1.68	0.07	3.88
Transform Projects (ED/AAU)	0.38	1.06	-0.68	1.75	6.15	-4.40	11.84
Total	2.28	3.04	-0.76	9.76	14.26	-4.50	28.20

Commentary

As at Month 7 the capital programme is £0.77m below the plan for the year to date. This is principally due to the initial slippage against the plan for the ED refurbishment and it will be recalled that the original high level plan for this project was drafted before both the appointment of the current contractor and the completion of the re-design phase. This project is now underway following authorisation of the formal contract and the commencement of construction on site. The Trust has not yet drawn upon any of the 2016-17 external loan funding that has been approved and has therefore continued to match available funding against expenditure. It should also be noted that the overall investment plan of £28.2m for 2016-17 is dependant upon an additional loan of £4.4m which has not yet been formally agreed by the DH and the Trust should therefore retain some planning flexibility for the remainder of the year.

Capital Monthly Profile

Report to the Board of Directors

Board Date: 24 November 2016

Title of Report	Corporate Governance Report
Presented by	Lynne Stuart
Lead Director	Lynne Stuart
Committees or Groups who have considered this report	
Executive Summary	The report outlines current activity and issues in corporate governance.
Resource Implications	N/A
Risk and Assurance	The report outlines the progress of a number of Trust wide initiatives designed to improve corporate governance arrangements.
Legal Implications/Regulatory Requirements	N/A
Recovery Plan Implication	Continuing the work to improve our corporate and clinical governance, which will support both safe and high quality patient care and a productive working culture for staff.
Quality Impact Assessment	N/A
Recommendation	The Board are requested to note the report and the assurance and risks stated.
Purpose & Actions required by the Board :	Approval ☐ Assurance ✓ Discussion ☐ Noting ☐

Corporate Governance Report – November 2016

1. EXECUTIVE SUMMARY

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

2. CARE QUALITY COMMISSION

The corporate governance team are closely aligned with the PMO in preparing the Trust for the forthcoming inspection. Logistics are on track and nine additional data requests have been received so far – the main themes being detailed drill down on ward and role mix vacancies, turnover, sickness and appraisal rates. Details of the team of CQC inspectors have now been received.

3. RISK AND REGULATION QUALITY ASSURANCE

Non- CQC Regulators

The Medicines and Healthcare Products Regulatory Agency (MHRA) conducted a routine scheduled inspection of the Trust's Radiopharmacy "specials licence" under the Medicines Act and Good Manufacturing Practice (GMP), on 1 November 2016. There were two inspectors who gave very good feedback and described the staff as dedicated and conscientious with very good knowledge and competence with excellent organisation and detailed documentation.

The MHRA have three categories of deficiency:-

1. Critical – which is a failure leading to significant risk of releasing an unsafe product.
2. Major – a non-critical deficiency, which in itself is major, or a combination of other deficiencies of a similar nature.
3. Other – which is neither critical nor major but sited as a deficiency.

The Inspection resulted in no Critical or Major deficiencies and 13 points which will lead to 5 or 6 deficiencies in the category of "other" when the Inspectors have reviewed their notes. The Inspectors noted that to put the result in context, most Radiopharmacy MHRA Inspections result in at least 2 major deficiencies.

The Imaging department have received confirmation that they have retained their Imaging Services Accreditation Scheme (ISAS) Accreditation, following their second cycle of assessment. This is a great achievement. In 2012 the service was the 11th in the Country to achieve ISAS Accreditation, the scope was extended in 2014 to include Radionuclide Imaging (Nuclear Medicine), following a review of the ISAS standard to include this service. There are currently 25 Accredited Organisations across the country.

CQC Inspection Framework

The Head of Risk and Regulation Quality Assurance is a member of the CQC NHS Co-production group and attended a meeting in November. The main areas discussed were:

- In December 2016, all Trusts will be consulted on the proposed revised CQC Inspection Framework to be in place from April 2017. This is likely to include a yearly Provider Information Request (PIR) with a self-assessment, followed by a regulatory assessment meeting which will decide on the inspection regime for the Trust; this will always include an assessment under the Well Led domain.
- A revised reporting format is also likely with the reports being in two sections, a summary report with rating and rationale and an appendix report including a more detailed analysis and an evidence table.

4. EMERGENCY PLANNING, RESILIENCE AND RESPONSE

On 11 November Lynne Stuart attended the NHS England chaired Local Health Resilience Partnership meeting on behalf of the Trust. The Trust received favourable comment from NHS England, Medway CCG and their assurance partner on the robustness of its EPRR arrangements. Several areas of good practice were noted and the Trust was requested to share some resources to disseminate across Kent providers.

The Winter Plan has been finalised and is attached separately for Board approval.

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5. HEALTH AND SAFETY

The Corporate health and safety policy and strategy is attached separately for Board approval.

6. DOCUMENTATION MANAGEMENT

Work on streamlining policies continues. In respect of the refreshed Corporate policies requiring Board approval a status update is below.

Corporate Policy	Director Responsible	Status
Information governance	Director of Corporate Governance, Risk, Compliance and Legal	Approved by Board on 29 September 2016
Consent Policy	Director of Corporate Governance, Risk, Compliance and Legal	On November Board agenda
Complaints Policy	Director of Corporate Governance, Risk, Compliance and Legal	Still being drafted with supporting Standard Operating Procedures
Serious Incidents Policy	Chief Quality Officer	Approved by Board on 27 October 2016
Safeguarding Policy	Director of Nursing	TBC
Emergency Preparedness, Resilience and Response	Director of Corporate Governance, Risk, Compliance and Legal	Approved by Board on 29 September 2016
HR Policy	Acting Director of Workforce	Director of Workforce has confirmed that overarching approach is outlined in the Strategy and HR policies are approved by the Joint Staff Consultation

		Committee
Health and Safety Policy	Director of Corporate Governance, Risk, Compliance and Legal	On November Board agenda
Fire Safety Policy	Director of Finance	Approved by Board on 27 October 2016
Standards of Business Conduct	Company Secretary	January 2017
Medicines Management	Medical Director	TBC
Risk Management	Director of Corporate Governance, Risk, Compliance and Legal	Approved by Board on 29 September 2016
Violence, Aggression and Disruptive Behaviour	Director of Finance	On November Board agenda
Patient Care and Management	Director of Nursing	TBC
Estates, Facilities and Security	Director of Estates and Facilities	On November Board agenda
Duty of Candour	Chief Quality Officer	Approved by Board on 29 September 2016
Finance	Chief Finance Officer	On November Board agenda

Trust Board

Date: 24 November 2016

Title of Report	Emergency Preparedness, Resilience and Response – Winter Resilience Plan 2016.
Presented by	Lynne Stuart
Lead Director	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Exercise Vivaldi 1, 13 October 2016 (Winter Resilience Multi-agency Exercise) reporting to Emergency Preparedness, Resilience and Response (EPRR) Group 7 November 2016.
Executive Summary	Each May the Board agrees the EPRR Work Plan to ensure that the Trust are compliant with their duties under the Civil Contingences Act (2004) as defined below.

Yearly, each Autumn the Trust is required to contribute to the North Kent Clinical Commissioning Groups' Winter Resilience Plan which is ratified by the Local Accident and Emergency Delivery Boards.

In September 2016 the responsibility for Winter Resilience moved from the Acute and Continuing Care Directorate to the Corporate Governance Directorate and was integrated into the Trust EPRR Work Plan.

Surge and Escalation planning of the Trust's bed capacity and demand remains with the Acute and Continuing Care Directorate.

Exercise Vivaldi 1 (Multi-agency Table Top Exercise) was designed and carried out to validate the new Winter Resilience Plan and ensure that all associated Plans, Policies and Standard Operating Procedures are in place.

The attached Winter Resilience Plan reflects the outputs from the exercise and resulting amendments to the document. The draft plan was disseminated to North Kent CCGs on 21 October to fit in with the NHS England timescale for submission, notwithstanding that the Plan has not been formally approved. |
| Resource Implications | N/A |
| Risk and Assurance | Assurance is required against the NHS England Winter Assurance Programme.

Winter Resilience will be identified on the 2017/18 EPRR Work Plan.

A post Winter debrief is programmed for May 2017 prior to the |

	next annual planning cycle. Exercise Vivaldi 2 is programmed for September 2017.
Legal Implications/Regulatory Requirements	Winter Resilience is aligned to the Civil Contingencies Act (2004) There are six main duties to ensure that the Act is implemented, where the Trust provide assurance either collectively with all Category 1 Responders or locally: • risk assessment • develop emergency plans • develop business continuity plans • warning and informing • sharing information • co-operation with other local responders
Recovery Plan Implication	Continuing the work to improve our corporate and clinical governance, which will support both safe and high quality patient care and a productive working culture for staff.
Quality Impact Assessment	N/A
Recommendation	The Board are requested to approve the Winter Plan.
Purpose & Actions required by the Executive Group :	Approval ✓ Assurance ☐ Discussion ☐ Noting ☐

WINTER RESILIENCE PLAN

Author:	Jessica Scott, Emergency Planning and Business Continuity Manager
Document Owner:	Lynne Stuart, Director of Corporate Governance, Compliance, Risk and Legal
Revision No:	1
Document ID Number	OTCOM033
Approved By:	
Implementation Date:	3 November 2016
Date of Next Review:	May 2017

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Document Control / History	
Revision No	**Reason for change**
New	New document as Trust central repository for Winter Resilience. **Feedback from Exercise Vivaldi 1 (13/10/2016) to include:** Service Business Continuity Plan for Mortuary in relation to increasing capacity. Laundry Winter Resilience planning Use of Tannoy System for Norovirus Messaging. Communication cascade identified from EPRR Department to Directors where used as single point of contact from Met Office and Resilience Direct. To pre- identify Winter Resilience Debrief date in dairies on review of plan annually.

Consultation
Medway Clinical Commissioning Group
Swale Clinical Commissioning Group
Deputy Director of Infection, Prevention and Control
Acute and Continuing Care Directorate – Director of Operations, General Manager Emergency Programme, Matron Discharge, Chief Pharmacist, Chief Therapist
Facilities and Estates Directorate – Director, Head of Estates, Security and Car Parking Manager, Transport Manager
Women and Children's Directorate – Director of Operations, Matron Childrens.
Co-Ordinated Surgical Care Directorate – Director of Operations, General Manager for Perioperative & Critical Care Programmes
Director of Communications
South Coast Ambulance Service – Clinical Operations Manager (Medway)
IHSS Ltd – Decontamination Manager
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Table of Contents

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

1   Introduction

1.1   As one of North Kent Clinical Commissioning Group's Providers there is a duty on the Trust that we work collaboratively within the health economy to ensure that the system is as resilient as possible each Winter.

2   Purpose / Aim and Objective

2.1   The purpose of this plan is to act as a central repository for all the policy, standard operational procedures and key business continuity plans. The aim is that when used to mitigate against winter they will make the Trust more resilient and able to respond to variation in demand, capacity and weather

3   Definitions

3.1   North Kent Clinical Commissioning Groups (North Kent CCGs) - Comprise of 3 CCGs: Swale, Dartford, Gravesham and Swanley and Medway.

3.2   Surge – an unexpected increase in demand for a service that cannot be pre-identified.

3.3   SHREWD – Single Health Resilience Early Warning Database

3.4   SMEWS – Site Modified Early Warning Score

4   Roles & Responsibilities

The Director of Corporate Governance, Risk, Compliance and Legal.

4.1   Is the Executive lead for Winter Resilience

The Director of Nursing

4.2   Is the lead for the Staff Flu Campaign and will lead by example with the Executive Team.

Directors of Clinical Operations

4.3   All Directors of Clinical Operations are responsible for ensuring that Trust capacity is planned and managed with the mitigation of the Trust Surge and Escalation Plan to allow for any variation in capacity. OTCOM010 - Surge and Escalation Plan

4.4   All Directors of Operations will be cognisant of the day of the week that a Bank Holiday falls on and plan for an upturn in demand immediately following those dates.

4.5   All Directors of Clinical Operations will work collaboratively to plan for and implement, as necessary, the conversion of speciality beds to general medical beds.

4.6   All Directors of Clinical Operations will work with Partners to manage Winter without the requirement for any additional capacity in the Trust funded bed base.

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4.7 All Directors of Clinical Operations will review and agree their service's opening and closing times for the two festive weeks, for publication, by 1st October annually for inclusion at Appendix 3 of this Plan.

4.8 The Director of Clinical Operations for Co-ordinated Surgical Directorate will plan for a potential increase in Trauma and Orthopaedic caseload against Met Office Cold Weather Alerts issued via the EPRR Department that indicate ice/snow. – Appendix 5 OTCOM022 - Adverse Weather Plan. and ensure that the Sterile Service Provider Service Business Continuity Plan is valid OTCGR048 - IHSS Sterile Services - Business Continuity Plan

4.9 The Director of Clinical Operations Acute and Continuing Care will plan for an upturn in Respiratory and Cardiac caseload (Cold Weather Death Sequence – Appendix 3 OTCOM022 - Adverse Weather Plan)

4.10 The Director of Clinical Operations Women and Children will manage the expectation that Community Midwives will promote the uptake of the Flu Campaign within their own caseloads to aim for 70% compliance in the pregnant population.

The General Manager for the Emergency Medicine Programme

4.11 Will ensure that the Clinical Site Managers and Senior Managers on Call are proficient in application of the SMEWS, Trust Surge and Escalation Plan and upload to SHREWD where data is not automated.

4.12 Will ensure that issues between providers are resolved at the lowest level rather than waiting for a whole system teleconference.

4.13 Will ensure that the Trust Surge and Capacity Escalation Status is urgently communicated to the Communications Team and North Kent CCG Partners via email (using the agreed North Kent CCGs mailing list provided by the EPRR Department) on escalation or de-escalation.

4.14 Will manage the capacity and demand within the Emergency Department.

4.15 Will make themselves available for any Teleconference requested by North Kent CCGs in relation to Emergency Department flow and Trust Escalation.

4.16 Will ensure that the Clinical Site Manager maintains contact with the Patient Transport Service (4.35, 4.36 OTCOM022 - Adverse Weather Plan)

4.17 Will ensure that the Operational Plan for the Winter Bank Holiday period is issued to the Senior Manager on Call and Director on Call, from the Site Manager to cover from the Friday before Christmas to the Tuesday after New Year. This will cover:

4.17.1	SMOC Contacts
4.17.2	Director on Call Contacts
4.17.3	Site Manager Contacts
4.17.4	Predicted Discharges
4.17.5	Step List Down Lists
4.17.6	Director on call North Kent Pager

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4.17.7	Community Contact Information
4.17.8	IDT Key Contact Rota
4.17.9	Staff Bank Key Contact Rota
4.17.10	Agency Contacts
4.17.11	Medical Rota
4.17.12	Emergency Department Rota
4.17.13	Surgical Rota
4.17.14	Planned Elective Activity
4.17.15	Times of Planned Meetings and Conference Call dial in details.
4.17.16	Times of set Reports

The Director of Communications

4.18   Will ensure that the Public facing Trust Web Page contains links in respect of winter National Campaigns.

4.19   Will ensure that the revised Trust Surge and Capacity Escalation Status is highly visible across the Organisation.

4.20   Will ensure that Global Messages include any key lines for staff and promote the Seasonal Flu Campaign (Appendix 3 4.45, 4,47 OTCOM022 - Adverse Weather Plan)

Business Intelligence Analyst/Health Informatics

4.21   Will ensure that Winter Situation Reports (SITREPs) follow the nationally required daily frequency during the winter period.

4.22   Will ensure that weekly Flu Reports are captured to follow the nation reporting requirement from October annually.

The Director of Estates and Facilities

4.23   Will ensure that access and egress within the Hospital Estate is maintained SOP0158 - Trust Gritting and Snow Clearance

4.24   Will ensure that Service Business Continuity Plans are in place for all key services where there is a higher risk from Adverse Weather on deliveries to site.

4.25   Will ensure that the Laundry has sufficient resources funded and available, in stock for Winter Resilience.

4.26   And ensure that Operational Estates and Projects plan works to minimise operational functions with evidence of Business Impact Assessments having been undertaken SOP0153 - Business Impact Assessment for Estates Project Team and Operational Estates).

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The Emergency Planning, Resilience and Response Department

4.27   Will ensure that the Trust has a Significant Incident Plan in place which has a scale of incident Matrix OTCOM006 - Trust (Significant Incident) Business Continuity Plan

4.28   Will act as the Single point of contact for Met Office and Resilience Direct key reports to be disseminated to Directors.

4.29   Will assure that the version controlled Escalation Management Contact details from the North Kent Winter Resilience Plan are given for email communications and telephone contacts to the Trust on call staff in their Red on call Files and General Manager for the Emergency Medicine Programme.

4.30   Will ensure that plans are in place to manage staff Accommodation in Adverse Weather SOP0157 - Mitigation using Staff Accommodation

4.31   Will ensure that plans are in place to assess the requirement and access the 4X4 Owners Club SOP0159 - 4X4 Vehicle Mutual Aid

The Deputy Director of Infection Prevention and Control

4.32   Will request that the Pathology Department monitor any external source of Norovirus presented and escalate to the Director of Infection Prevention and Control of her Team, if it is a Nursing or Residential Home.

4.33   Will ensure that the Trust Outbreak Plan is in place POLCGR039 - Arrangement for the Control of an Outbreak of Infection - including Novovirus in Medway NHS Trust and patient information leaflets for NorovirusPIL00000089 - Norovirus

4.34   Will create a Tannoy Message for Warning and Informing the Public in relation to Norovirus.

4.35   Will confirm the use of the Switchboard system for public warning and informing in relation to Norovirus.

The General Manager for Haematology, Pathology and Cancer

4.36   Will ensure that a Service Business Continuity Plan is in place to mitigate capacity issues in the Mortuary. OTCGR184 - Mortuary - Business Continuity Plan

Trust Staff

4.37   Will ensure that they understand their commitment to patients, staff and their own families and take up the offer of a seasonal flu vaccination.

4.38   Will ensure that they are conversant with the expectations in relation to them planning for adverse weather and attending work (Section 4 Responsibilities of the Employee OTCOM022 - Adverse Weather Plan)

5 Capacity and Demand Planning

5.1 Each Directorate will review the following in their planning for capacity in relation to winter resilience

    5.1.1 Identification of predictive data tools

    5.1.2 Capacity identification

    5.1.3 Elective activity against emergency activity

    5.1.4 Identification of additional specialist staff

    5.1.5 Seven day services

    5.1.6 Improved responsiveness

    5.1.7 Consultant Led review within assessment units

    5.1.8 Proactive discharge planning

    5.1.9 Sate staffing levels in additional areas of capacity

Key points

Acute and Continuing Care Directorate

- Medicine has and uses predictive data for both elective and emergency flows.

- Monitoring of planned elective and emergency activity with re-scheduling in advance

- Utilise Clinical Nurse Specialists in periods of variability

- Consultant led Ward/Board Rounds seven days per week on the emergency pathway

- 7/7 Access to Ambulatory Assessment Unit and GP advice to support the emergency pathways and avoid admissions

- Internal professional standards in place for all specialities and departments

- Established criteria-led Discharge

- Support via Bank/Agency Staff to maintain a staff ratio of 1:8

Services

Pharmacy

- Extended hours into the evenings and weekends

- Seven day service (24 hour pharmacy on call service)

Pathology

- Bloods can be marked as 'DD' Discharge Dependant to give them priority

- Seven day services (24/7)

Physiotherapy

- Six day services with emergency service and a.m. Orthopaedic Service Sundays

Co-ordinated Surgical Directorate

- Surgery have and use predictive data for both elective and emergency flows.

- They plan to increase bed capacity for escalation from 14 to 26 beds in Sunderland Day Surgery Unit and cohort Medical Outliers.

- Monitoring of planned elective and emergency activity with re-scheduling in advance with Trauma and CEPOD taking priority

- Utilisation of Clinical Nurse Specialists in periods of variability and A&C staff to support non-clinical functions in clinical areas.

- Planned increase in Physiotherapy to Orthopaedic patients and increase of Bed Co-ordinators hours.

- Fast Track of the fractured neck of femur pathway

- Set internal professional standards onto SAU as per ED targets

- Early eDN completion, Nurse led Discharges

- Support via Bank Staff to maintain a staff ratio of 1:8

Services

Outpatients

- Additional clinics as requested by the Clinical Directorates for example fracture and frailty

- Additional evening and Saturday morning clinics as requested by the Clinical Directorates

General Imaging

- Seven day service (24/7)

CT

- Seven day service (24/7)

Ultrasound

- ED referrals and Discharges a priority, Seven day service with on call out of hours.

Orthotics, Plaster Theatre and Clinical Photography

- On special request patients may be seen at home for Orthotics and Clinical Photography on domiciliary visits.

Health Records/Patient Service Centre

- Running additional reports in line with demand and greater frequency of arrival of records

Women's and Children's Directorate

- Women's has and uses predictive data for both elective and emergency flows.
- They plan to closely manage the capacity have no identified escalation.
- Planned deviation in elective capacity by increasing sessions to increase flow in Emergency demand.
- Reallocation of staff resources from areas of less priority within the service or areas of planned reduction.
- Continue to provide a seven day service
- Guidance for hyperemesis as antenatal patient management.
- Early eDN completion, Nurse led discharge

- Children's has and use predictive data for both elective and emergency flows.
- They plan to closely manage the capacity have no identified escalation.
- The Majority of elective work is undertaken in Sunderland and may be moved to Directorate. The elective activity can be reduced.
- Reallocation of staff resources from areas of less priority within the service or areas of planned reduction.
- Continue to provide a seven day service
- Paediatric Emergency Department can be supported by PAU for illnesses not injuries.
- Registrar and SHO to support ED to discuss/expedite patient transfers to PAU.
- Early eDN completion, Average length of stay benchmarking

6 North Kent CCGs Monitoring Resilience via a Single Health Resilience Early Warning Database (SHREWD)

6.1 SHREWD, commissioned by Medway Clinical Commissioning Group, takes each provider's information from a health economy based on an agreed set of triggers for escalation The overview for our economy is with North Kent CCGs.

6.2 This when used to its full effect during Winter this gives the CCGs the advantage of being able to react tactically to even out pressure points where one organisation is at high demand and high capacity and the others are at low demand and low capacity.

6.3 Each organisation supplies a visible set of requested actions to the CCGs for publication within the North Kent Winter Resilience Plan at each trigger point from green through amber, red to black so all partners are sighted.

7 Key Contacts

7.1 The North Kent Operational and Escalation Contacts List is available via the Senior Manager on Call Rota and Executive on Call Rota within their Red on call files from October annually.

7.2 The rationale for not publishing them in this Plan is wholly related to version control which is maintained by North Kent CCGs.

7.3 North Kent CCGs will plan for teleconference dates and set these dates in advance, the frequency will be determined in line with the economy position. Therefore as a Trust staff will ensure that issues are resolved at the lowest level rather than waiting for a teleconference.

8 Senior Manager and Executive On Call Festive Period Rota

Date	19	20	21	22	23	24	25
Executive	Diana Hamilton-Fairley	Diana Hamilton-Fairley	Diana Hamilton-Fairley	Diana Hamilton-Fairley	Diana Hamilton-Fairley	Diana Hamilton-Fairley	Diana Hamilton-Fairley
SMOC	Rob Nicholls	Rob Nicholls	Rob Nicholls	Rob Nicholls	Steph Parrick	Steph Parrick	Paul White
Date	26	27	28	29	30	31	1
Executive	Margaret Dalziel	Margaret Dalziel	Karen Rule	Karen Rule	Lesley Dwyer	Lesley Dwyer	Lesley Dwyer
SMOC	Alistair Lindsay	Sam Chapman	Sam Chapman	Sam Chapman	Simon Weeks	James Lowell	James Lowell
Date	2	3	4	5	6	7	8
Executive	Margaret Dalziel	Margaret Dalziel	Margaret Dalziel	Margaret Dalziel	Karen McIntyre	Karen McIntyre	Karen McIntyre
SMOC	Ben Stevens	Ben Stevens	Ben Stevens	Ben Stevens	Dot Smith	Dot Smith	Dot Smith

9 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Plan review	First review in	Author	Emergency	Where gaps are

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
	one year and then every three years		Preparedness, Resilience and Response Group	recognised action plans will be put into place
Lessons identified	Annually Winter Resilience Debrief Meeting	Author	Emergency Preparedness, Resilience and Response Group	Where gaps are recognised action plans will be put into place

10 Training and Implementation

10.1 The Winter Resilience Plan will be launched annually on the back of a Table Top Exercise (Vivaldi) each September/October.

10.2 The Winter Resilience Plan will be documented within the Emergency Preparedness, Resilience and Response Training Needs Analysis for Executive, Directors, Deputy Directors, General Managers, Matrons, Site Managers and Communications Team.

11 Equality Impact Assessment Statement & Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide "evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]"; in effect to undertake equality impact assessments on all procedural documents and practices. Authors should use the Equality Impact Toolkit to assess the impact of the document.

In the first instance this will mean screening the document and, where the screening indicates, completing a full assessment. The Toolkit can be found on the Trust website http://www.medway.nhs.uk/our-foundation-trust/publications/equality-and-diversity/equality-impact-assessments/

A document will not be considered approved until the author has confirmed that the screening process has been carried out and where required a full impact assessment has been completed. Where a full assessment is completed this should be submitted along with the document for approval.

12 References

Document	Ref No
References:	
NHS England Surge and Escalation Framework 2016/17	
Cold Weather Plan 2016, Public Health England	

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Trust Associated Documents:

OTCOM006 - Trust (Significant Incident) Business Continuity Plan (1 attachment)	
OTCOM010 - Surge and Escalation Plan	
OTCOM022 - Adverse Weather Plan	
POLCGR039 - Arrangement for the Control of an Outbreak of Infection - including Novovirus in Medway NHS Trust	
OTCGR184 - Mortuary - Business Continuity Plan (1 attachment)	
SOP0159 - 4X4 Vehicle Mutual Aid	
SOP0157 - Mitigation using Staff Accommodation	
SOP0153 - Business Impact Assessment for Estates Project Team and Operational Estates).	
SOP0158 - Trust Gritting and Snow Clearance	
PIL00000089 - Norovirus	
OTCGR048 - IHSS Sterile Services -Business Continuity Plan	

Winter Resilience Risk Assessment - Appendix 1

Based on Kent Local Resilience Forum Community Risk Register 2016

Consequence Impact Likelihood	Insignificant 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Rare 1	1	2	3	4	5
Unlikely 2	2	4	6	8	10
Possible 3	3	6	9	12	15
Likely 4	4	8	12	16	20
Almost certain 5	5	10	15	20	25

Community Risk Register Risk and Potential Impact on Medway NHS Foundation Trust	Likelihood	Impact	Total Score	Considered in Place in this Plan
Low Temperatures and Heavy Snow	4	4	**16**	
Facilities Issues- Blocked Access				Yes
Increased number of Trauma and Orthopedic referrals				Yes
Disruption to Staff Travel Plans				Yes
Increased demand on Services				Yes
Reduced ability to discharge patients due to environmental conditions				Yes
Disruption to deliveries				Yes
Mortuary Capacity Issue				Yes

Community Risk Register Risk and Potential Impact on Medway NHS Foundation Trust	Likelihood	Impact	Total Score	Considered in Place in this Plan
Immerging infectious disease	3	3	**9**	
Norovirus				Yes
Seasonal Influenza				Yes

Changes to Opening and Closing Times of Departments – Festive Period – Appendix 2

Directorate of Estates and Facilities – Supporting Services
(If not listed assume closed Weekend and BHs but otherwise open as normal)

Date	Staff Residences	Waste Management	Transport Dept	Estates	EME	Equipment Library	Catering
19/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
20/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
21/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
22/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
23/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
24/12/16	No Service	Saturday Service	Saturday Service	Normal Service	Collection only/Lab closed	Normal Service	Normal Service
25/12/16	No Service	B/H Service	No Service	Normal Service	Collection only/Lab closed	Normal Service	Normal Service
26/12/16	No Service	B/H Service	No Service	Normal Service	Collection only/Lab closed	Normal Service	Normal Service
2712/16	No Service	B/H Service	No Service	Normal Service	Collection only/Lab closed	Normal Service	Normal Service
28/12/16	8.00 till 4.00pm	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
29/12/16	8.00 till 4.00pm	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
30/12/16	8.00 till 4.00pm	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
31/12/16	8.00 till 4.00pm	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
01/01/17	No Service	B/H Service	No Service	Normal Service	Collection only/Lab closed	Normal Service	Normal Service
02/01/17	No Service	B/H Service	No Service	Normal Service	Collection only/Lab closed	Normal Service	Normal Service
03/01/17	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service

Date	Laundry	Housekeeping	Security	Car Parking
19/12/16	Normal Service	Normal Service	Normal Service	Normal Service
20/12/16	Normal Service	Normal Service	Normal Service	Normal Service
21/12/16	Normal Service	Normal Service	Normal Service	Normal Service
22/12/16	Normal Service	Normal Service	Normal Service	Normal Service
23/12/16	Normal Service	Normal Service	Normal Service	Normal Service
24/12/16	Normal Service	Normal Service	Normal Service	Normal Service
25/12/16	Closed	Normal Service	Normal Service	Normal Service
26/12/16	Closed	Normal Service	Normal Service	Normal Service
2712/16	Closed	Normal Service	Normal Service	Normal Service
28/12/16	Normal Service	Normal Service	Normal Service	Normal Service
29/12/16	Normal Service	Normal Service	Normal Service	Normal Service

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30/12/16	Normal Service	Normal Service	Normal Service	Normal Service
31/12/16	Normal Service	Normal Service	Normal Service	Normal Service
01/01/17	Closed	Normal Service	Normal Service	Normal Service
02/01/17	Closed	Normal Service	Normal Service	Normal Service
03/01/17	Normal Service	Normal Service	Normal Service	Normal Service

Directorate of Corporate Governance, Risk, Compliance and Legal – Supporting Services

(If not listed assume closed Weekend and BHs but otherwise open as normal)

Date	EPRR
19/12/16	Normal Service
20/12/16	Normal Service
21/12/16	Normal Service
22/12/16	Normal Service
23/12/16	Normal Service
24/12/16	Contact in event of Emergency
25/12/16	Normal Service
26/12/16	Normal Service
2712/16	Normal Service
28/12/16	Normal Service
29/12/16	Normal Service
30/12/16	Normal Service
31/12/16	Normal Service
01/01/17	Normal Service
02/01/17	Normal Service
03/01/17	Normal Service

Directorate of Acute and Continuing Care – Supporting Services

(If not listed assume closed Weekend and BHs but otherwise open as normal)

Date	Pharmacy	Physiotherapy	Pathology Services	Phlebotomy Outpatients	Occupational therapy
19/12/16	**Normal Service**	Normal Service	Normal Service	Normal Service	Normal Service

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20/12/16	**Normal Service**	Normal Service	Normal Service	Normal Service	Normal Service
21/12/16	**Normal Service**	Normal Service	Normal Service	Normal Service	Normal Service
22/12/16	**Normal Service**	Normal Service	Normal Service	Normal Service	Normal Service
23/12/16	**Normal Service**	Normal Service	Normal Service	Normal Service	Normal Service
24/12/16	**10am – 3pm**	Normal Saturday service 08.00-16.00	Normal Saturday Service	Ward Service 7-12	CLOSED (Physio service in place)
25/12/16	**Closed**	Emergency & On-call service	Normal Sunday Service	No Service	CLOSED (Physio service in place)
26/12/16	**10am – 1:30pm**	Saturday level service 08.00 - 16.00	Normal Saturday Service	No Service	Limited service 08.00-16.00
2712/16	**10am – 1:30pm**	Saturday level service 08.00-16.00	Normal Saturday Service	No Service	Limited service 08.00-16.00
28/12/16	**Normal Service**	Normal Service	Normal Service	Normal Service	Normal Service
29/12/16	**Normal Service**	Normal Service	Normal Service	Normal Service	Normal Service
30/12/16	**Normal Service**	Normal Service	Normal Service	Normal Service	Normal Service
31/12/16	**10am – 3pm**	Normal Saturday service 08.00-16.00	Normal Saturday Service	Ward Service 7-12	CLOSED (Physio service in place)
01/01/17	**10am – 1:30pm**	Emergency & On-call service plus ortho ward service am	Normal Sunday Service	No Service	CLOSED (Physio service in place)
02/01/17	**10am – 1:30pm**	Saturday level service 08.00-16.00	Normal Saturday Service	No Service	Limited service 08.00-16.00
03/01/17	**Normal Service**	Normal Service	Normal Service	Normal Service	Normal Service

Co-Ordinated Surgical Directorate – Supporting Services

(If not listed assume closed Weekend and BHs but otherwise open as normal)

Date	CT	MRI	Ultrasound	Patient Service Centre and Sterling Park	Plaster Room
19/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
20/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service

Best of care
Best of people

WINTER RESILIENCE PLAN

21/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
22/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
23/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
24/12/16	Normal Service/one scanner till 4pm	07:15-18:00	On call(Cauda equina/MSCC)	Normal Service	Normal Service
25/12/16	On Call Service Only	08:00-18:00on-call only	On call(Cauda equina/MSCC)	Closed	Contact in event of Emergency
26/12/16	On Call Service only	07:15-20:15	only 1 scanner/scanner 2 to confirm	7am to 7pm Service	Contact in event of Emergency
2712/16	Normal Service	07:15-08:15	Both scanner	7am to 1pm Service	Contact in event of Emergency
28/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
29/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
30/12/16	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service
31/12/16	Normal Service	07:15-18:00	On call(Cauda equina/MSCC)	Normal Service	Adhoc based on Clinics
01/01/17	Normal Service	08:00-18:00on-call only	On call(Cauda equina/MSCC)	Closed	Contact in event of Emergency
d02/01/17	Normal Service	09:00-18:00	only 1 scanner/scanner 2 to confirm	7am to 7pm Service	Contact in event of Emergency
03/01/17	Normal Service	Normal Service	Normal Service	Normal Service	Normal Service

Key Contracted Partners and Allied Professionals

Date	G4S (Patient Transport)	IHSS (Sterile Services)	Integrated Discharge Team
19/12/16	Normal Service	Normal Service	Normal Service
20/12/16	Normal Service	Normal Service	Normal Service
21/12/16	Normal Service	Normal Service	Normal Service
22/12/16	Normal Service	Normal Service	Normal Service
23/12/16	Normal Service	Normal Service	Normal Service
24/12/16	Normal Saturday Service	On Call	8am-4pm
25/12/16	Normal Sunday Service – 1 vehicle	On Call	8am - 4pm
26/12/16	BH (Saturday	On Call	8am - 4pm

Best of care
Best of people

WINTER RESILIENCE PLAN

	Service)		
2712/16	BH (Saturday Service)	On Call	8am - 4pm
28/12/16	Normal Service	Normal Service	Normal Service
29/12/16	Normal Service	Normal Service	Normal Service
30/12/16	Normal Service	Normal Service	Normal Service
31/12/16	Normal Service	Normal Service	8am - 4pm
01/01/17	Normal Sunday Service – 1 vehicle	On Call	8am - 4pm
02/01/17	BH (Saturday Service)	On Call	8am - 4pm
03/01/17	Normal Service	Normal Service	Normal Service

END OF DOCUMENT

Report to the Board of Directors

Board Date: 24 November 2016

Title of Report	Corporate Policy: Consent
Presented by	Lynne Stuart
Lead Director	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Executive Group
Executive Summary	Further to discussions between the Chief Executive and the Executive Group, it was resolved to map all policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) under one of 14 overarching Policy Areas with a high level Board approved Corporate Policy covering each area. The Corporate Policy is intended to be a high level overview of the organisation's policy in the relevant area, with the detailed instructions / guidance being laid out in supporting documentation which is referenced in the Corporate Policy and therefore linked to the overarching policy document. The corporate policy areas are: • Information Governance • Consent • Complaints • Serious Incidents • Safeguarding • Emergency Planning, Resilience and Response • Human Resources/employee handbook • Health and Safety / Fire Safety • Standards of Business Conduct • Medicines Management • Risk Management • Patient Care and Management • Security and Estates • Duty of Candour • Finance Accordingly, the Corporate Policy for Consent has been drafted and is attached for Board approval.
Resource Implications	N/A
Risk and Assurance	Currently there is an excessive number of policies, SOPs and AGNs in place and linkage between associated documentation

	may lack clarity and purpose. The process of creating an overarching Corporate Policy for each area is supported by a review of background documentation and the culling of documents which are superfluous or out of date. The process will streamline document management processes across the Trust.
Legal Implications/Regulatory Requirements	Corporate Policies are being drafted to reflect legal and regulatory requirements.
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Executive Group have reviewed the policy and recommend that the Board approves the new Corporate Policy for Consent.
Purpose & Actions required by the Board :	Approval ✓ Assurance ☐ Discussion ☐ Noting ☐

Consent Policy

Author:	Head of Corporate Compliance and Resilience – Paul Mullane in conjunction with Brachers LLP
Document Owner:	Director of Corporate Governance, Risk, Compliance and Legal – Lynne Stuart
Revision No:	6
Document ID Number	POLCGR034
Approved By:	Executive Group
Implementation Date:	October 2016
Date of Next Review:	October 2017

Document Control / History	
Revision No	**Reason for change**
Updated	Alteration to reflect changes to legislation – Mental Capacity Act (2005) and Human Tissue Act (2004) and Department of Health: Reference guide to consent for examination or treatment 2nd Edition 2009
1	Amendment – change of contact details for IMCA – see 1.3.8.
2	Changes to Case Law and Legislation; inclusion of Monitoring Table and Equality Impact Assessment
3	Inclusion of consent for post mortems
4	To accommodate revisions to NHSLA risk management standards
5	Scheduled update – no changes to guidance
6	Policy updated and split into individual SOPs

Consultation
Director of Corporate Governance, Risk, Compliance and Legal – Lynne Stuart
Medical Director – Diana Hamilton-Fairley
Mortuary Manager - Lesley Timlin
Director of Nursing – Karen Rule
Head of Risk and Regulation Quality Assurance - Fiona Egan
Jeremy Davis
Paul Hayden
Robin Able
Dr V Gunesh
Mr Andrew Stradling

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Table of Contents

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

1   Introduction

1.1   This policy sets out the standards and procedures in this Trust, which aim to ensure that health professionals are able to comply with the guidance. While this document is primarily concerned with healthcare, social care colleagues should also be aware of their obligations to obtain consent before providing certain forms of social care, such as those that involve touching the patient or client.

1.2   Responsibility for ensuring the application of this policy lies with the Director of Clinical Operations for each Directorate. Adherence to this policy will be monitored by the Medical Director via the Clinical Effectiveness and Research Group.

2   Purpose / Aim and Objective

2.1   This Policy sets out the Trust arrangements for Consent and associated governance to ensure compliance with the regulatory framework.

2.1.1   Health professionals must all be aware of guidance on consent issued by their own regulatory bodies, e.g. the General Medical Council consent guidance "doctors and patients making decisions together" - see http://www.gmc-uk.org/guidance/ethical_guidance/consent_guidance_index.asp

2.1.2   The Department of Health (DoH) updated its guidance in 2009 after the Mental Capacity Act and Code of Practice came into effect in its Reference Guide to Consent for Examination or Treatment (2nd Edition). See https://www.gov.uk/government/publications/reference-guide-to-consent-for-examination-or-treatment-second-edition

2.1.3   The Human Tissue Authority Code of Practice 1, Consent (July 2014) at https://www.hta.gov.uk/guidance-professionals/codes-practice/code-practice-1-consent gives practical guidance and establishes standards on how consent should be sought and what information should be given in relation to the retention, storage and use of human tissue for various specified purposes, and concerning the removal of tissue from the deceased.

2.1.4   Royal College of Surgeons: Consent: Supported Decision Making – a good practice guide (November 2016) https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/consent-good-practice-guide/. The Trust Policy is that the consent process must be underpinned by the key principles set out in this good practice guide:

•   The aim of the discussion about consent is to give the patient the information they need to make a decision about what treatment or procedure (if any) they want.

- The discussion has to be tailored to the individual patient. This requires time to get to know the patient well enough to understand their views and values.

- All reasonable treatment options, along with their implications, should be explained to the patient.

- Material risks for each option should be discussed with the patient. The test of materiality is twofold: *whether, in the circumstances of the particular case, a reasonable person in the patient's position would be likely to attach significance to the risk, or the doctor is or should reasonably be aware that the particular patient would likely attach significance to it.*

- Consent should be written and recorded. If the patient has made a decision, the consent form should be signed at the end of the discussion. The signed form is part of the evidence that the discussion has taken place, but provides no meaningful information about the quality of the discussion.

- **In addition to the consent form, a record of the discussion (including contemporaneous documentation of the key points of the discussion, hard copies or web links of any further information provided to the patient, and the patient's decision) should be included in the patient's case notes**. This is important even if the patient chooses not to undergo treatment.

2.2 The principles set out in this Policy apply to treatment in an elective situation when the patient has time to consider their options. In an urgent or emergency situation where it is imperative to save life or limb, or prevent serious deterioration, the surgeon will have to proceed with limited discussion or even without consent (see Appendix 1 of the Royal College of Surgeons good practice guide referred to in 2.1.4 above) on acting in the patient's best interests).

3 Definitions

3.1 **Capacity**

3.1.1 The ability to carry out the processes involved to make and communicate a specific decision at a specific time (as set out in the Mental Capacity Act)

3.1.2   "Consent" is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

3.1.3   have capacity to take the particular decision;

3.1.4   have received sufficient information to take it; and

3.1.5   not be acting under duress.

3.2   A signature on a form is not consent; it is part of the consent process. It can be evidence of understanding and acceptance of information given during the consent process. Patients with capacity may withdraw consent at any time before or during an investigation or treatment taking place.

3.3   **Independent Medical Capacity Advocate (IMCA)**

3.3.1   This service helps the Trust to make decisions in the best interests of people who lack the capacity and who have no family or friends that it would be appropriate to consult about these decisions.

3.4   **Risk**

3.4.1   Any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications'

4	(Duties) Roles and Responsibilities

4.1   The health professional actually carrying out any procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is this health professional that will be held responsible in law if there is a challenge later.

4.2   Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional that is to carry out the procedure. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

4.3   Completing consent forms

4.3.1   The standard consent form provides space for a health professional to specify key information provided to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

4.3.2   The consent form will normally also be signed by the patient. However, if a patient is unable to do so (e.g. because of blindness, amputation, locked in syndrome), verbal consent can be witnessed and documented by a second member of staff after the whole form has been read out to the patient. If a patient completes the form in advance of a procedure (e.g. in out-patients or

at a pre-assessment clinic), a health professional involved in their care on the day of the procedure should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer any questions they cannot handle themselves.

4.4   Delegation of Consent

4.4.1   Any specialty that wishes to develop training for health professionals to enable them to seek informed consent for one or more specified procedures (which they are not able to perform themselves) must produce documentation specifying the knowledge and practical skills required before this is undertaken. They must also produce details of the competency assessment that will be undertaken before such a practitioner seeks consent for the procedure, specifying how often this will be reviewed or the person will be reassessed. This training and documentation must be approved by the specialty lead consultant (who must confirm in writing that it meets the requirements of the consent policy), and by the Clinical Management Board, before it is implemented.

4.4.2   Each specialty is responsible for keeping a list of those staff approved to obtain delegated consent, together with the date of this approval, and a note of each procedure for which the member of staff is now competent to obtain delegated consent.

4.4.3   The annual consent audit will include a process for checking that consent is being sought by staff who are competent to perform the procedure concerned, or who are documented as having successfully completed the relevant training showing they are competent to undertake this process.

4.4.4   Any member of staff who is asked a supplementary question by a patient, which is outside their immediate professional expertise to be able to answer, should not countersign the form unless or until they are satisfied that

- an appropriate professional has addressed any outstanding concerns of the patient; and

- the patient has received full information to enable him/her to make a decision on whether or not they wish the proposed procedure to go ahead.

4.5   Responsibility of health professionals

4.5.1   It is a health professional's own responsibility:

- to ensure that if a colleague seeks consent on their behalf they are confident that the colleague is competent to do so; and

- to work within their own competence and not to agree to perform tasks which exceed that competence.

4.5.2 If a health professional feels that they are being pressurised to seek consent when they do not feel competent to do so, they should contact one of the following for advice and support:

- a member of the Directorate management team,
- the specialty lead or principal lead consultant,
- the Medical Director

4.5.3 If the Trust has reason to believe (e.g. following an audit / investigation) that any trainee doctor has inappropriately sought consent for a medical procedure, or obtained consent without the authorisation to do so, this should be reported to the Medical Director, who will take it up if appropriate with the General Medical Council (GMC)

5 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	First review in one year and then every three years	Author	Clinical Effectiveness and Research Group	Policy will be updated and made available to staff.
Elective Surgical Consent process to include: Process for obtaining consent Process for recording consent Process for identifying staff authorised to take consent Process for delivery of procedure specific training on consent for those staff to whom consent training is delegated Generic training on consent	Annual audit of patient records, delegated consent directories, procedure specific and generic training records as required.	Medical Directors' Assistant	Medical Director	Where gaps are recognised action plans will be put into place

Consent Policy

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Trust – wide Consent Forms	Annual audit	Medical Directors' Assistant	Medical Director	Where gaps are recognised action plans will be put into place

6 Training and Implementation

6.1 Training on generic consent issues is available for all staff via the Trust e-learning programme. In addition, ad hoc training services are available at Directorate/departmental levels as required. Staff requiring general training on the Consent policy, procedure or best practice in obtaining consent in specific clinical settings should contact the Head of Corporate Compliance and Resilience on ext 3881.

6.2 Training and assessment for nurses or junior doctors obtaining consent, who do not themselves undertake the procedure(s) being consented for, should be developed locally by the senior clinicians. The Trust requires that each Directorate should identify which individual nurses or junior doctors are deemed competent to obtain consent for specific procedures (which are serious enough to usually warrant written consent) either by virtue of their existing skill base, or by virtue of having undertaken specific training in obtaining consent for that procedure. This procedure specific training should be provided by a person trained to perform the procedure or by a person with the required medico-legal skills. Training should relate to a specific procedure or groups of procedures and cover the knowledge and skills required to enable the nurse to advise the patients and respond to specific questions, especially in relation to the risks and benefits of the procedure in question and the risks and benefits of the alternatives to that procedure. Competence to perform the consent process for nurses or junior doctors not undertaking the clinical procedure must be documented on the individuals' training record and a note should be added to the procedure Directory held by the relevant Directorate. Directorates must also ensure that where nurses and junior doctors are involved in assessing continuance of consent, that ready access is available to appropriate colleagues where they are unable to answer personally any questions raised by the patient.

6.3 Any incident about the process of gaining consent or giving patients sufficient information on which to make a decision will be reported via the incident reporting system. In the event that a patient's consent is obtained by Trust personnel not considered appropriate to obtain such consent, the matter will be reported using the Trust's incident reporting system.

6.4 The effectiveness of the implementation of this policy will be subject to annual audit which will be led by the Medical Director's Assistant and the results of which will be considered at Directorate governance group meetings.

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7　　Equality Impact Assessment Statement and Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide "evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]"; in effect to undertake equality impact assessments on all procedural documents and practices. Authors should use the Equality Impact Toolkit to assess the impact of the document.

In the first instance this will mean screening the document and, where the screening indicates, completing a full assessment. The Toolkit can be found on the Trust website http://www.medway.nhs.uk/our-foundation-trust/publications/equality-and-diversity/equality-impact-assessments/

A document will not be considered approved until the author has confirmed that the screening process has been carried out and where required a full impact assessment has been completed. Where a full assessment is completed this should be submitted along with the document for approval.

8　　References

Document	Ref No
References:	
Care Quality Commission Fundamental Standard	Regulation 11
Human Tissue Act 2004	
Mental Capacity Act 2005	
Consent: Supported Decision Making – a good practice guide (Royal College of Surgeons November 2016)	
Good practice in consent implementation guide (Department of Health 2002)	
Trust Associated Documents:	
Consent Procedure	SOP0131
Consent - Tissue	SOP0134
Consent - Clinical photography and conventional or digital video recordings	SOP0135
Consent - Medway Elective Surgical Consent Pathway	OTCGR161
Consent - Consent Flow Chart for Children Under 16 Years of Age	OTCGR162
Consent - Form 1 - Patient agreement to investigation or treatment	OTCGR165
Consent - Form 2 - Parental agreement to investigation or treatment	OTCGR166
Consent - Form 3 - Patient-parental agreement to investigation or treatment -procedures where consciousness not impaired	OTCGR167
Consent - Form 4 - Form for adults who are unable to consent to investigation or treatment	OTCGR168
Consent - Form 6 - Supplementary Consent for Gifting of Tissue	OTCGR158
Consent - Form 7 - Consent to photography and conventional or digital video recordings	OTCGR159
Consent - Form 8 - Post Mortem Consent Form - Adult	OTCGR164

Consent - Form 9 - Post Mortem Consent Form - Baby	OTCGR163
Management and Publication of Written Patient Information Policy and Procedure	POLCGR019
Interpreter/Translator Policy	POLCGR023
Use of Unlicensed Products	POLCPCM034

END OF DOCUMENT

Report to the Board of Directors

Board Date: 24 November 2016

Title of Report	Corporate Policy: Health and Safety
Presented by	Lynne Stuart
Lead Director	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Executive Group
Executive Summary	Further to discussions between the Chief Executive and the Executive Group, it was resolved to map all policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) under one of 14 overarching Policy Areas with a high level Board approved Corporate Policy covering each area. The Corporate Policy is intended to be a high level overview of the organisation's policy in the relevant area, with the detailed instructions / guidance being laid out in supporting documentation which is referenced in the Corporate Policy and therefore linked to the overarching policy document. The corporate policy areas are: - Information Governance - Consent - Complaints - Serious Incidents - Safeguarding - Emergency Planning, Resilience and Response - Human Resources/employee handbook - Health and Safety / Fire Safety - Standards of Business Conduct - Medicines Management - Risk Management - Patient Care and Management - Security and Estates - Duty of Candour - Finance Accordingly, the Corporate Policy and Strategy for Health and Safety has been drafted and is attached for Board approval.
Resource Implications	N/A
Risk and Assurance	Currently there is an excessive number of policies, SOPs and AGNs in place and linkage between associated documentation

	may lack clarity and purpose. The process of creating an overarching Corporate Policy for each area is supported by a review of background documentation and the culling of documents which are superfluous or out of date. The process will streamline document management processes across the Trust.
Legal Implications/Regulatory Requirements	Corporate Policies are being drafted to reflect legal and regulatory requirements.
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Executive Group have reviewed the policy and recommend that the Board approves the new Corporate Policy and Strategy for Health and Safety.
Purpose & Actions required by the Board :	Approval ✓ Assurance ☐ Discussion ☐ Noting ☐

Medway NHS Foundation Trust

NHS Foundation Trust

Medway NHS Foundation Trust
Corporate Policy: Health and Safety

Author:	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal Paul Miles, Senior Health and Safety Adviser
Document Owner:	Lynne Stuart
Revision No:	7
Document ID Number	POLCS005
Approved By:	
Implementation Date:	December 2016
Date of Next Review:	December 2017

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Document Control / History	
Revision No	**Reason for change**
2	Review
3	Review and include reference to part time, flexibank and volunteer staff as required by the Health Care Commission.
4	Review, minor amendments only.
4.1	Occupational Health Service roles and responsibilities added.
4.2	Review of objectives. Amendments to organisational chart. Revision of Equality Impact Assessment.
4.3	Review subject to HSE inspection March 2012. Addition of risk assessment policy link, H&S Committee T.O.R and change in Executive Leadership.
5	Review and update
6	Review and update into new format
7	Corporate policy drafted for Board approval.

Consultation
Fire, Health and Safety Group members

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Corporate Health and Safety Policy

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

1   Introduction / Statement of Intent

1.1   It is the policy of Medway NHS Foundation Trust to comply with the Health and Safety at Work etc. Act 1974 and other relevant legislation as appropriate in order to ensure, so far as is reasonably practicable, the health, safety and welfare of its employees (while they are at work), patients and any other person who may be affected by its undertaking.

1.2   The responsibilities set out in this Policy and associated documents are intended to ensure that work will be carried out safely, consistent with good practice and in accordance with all relevant statutory provisions. It is the Trust policy to ensure that adequate resources will be made available to ensure that this objective is met.

1.3   The Health and Safety at Work etc. Act 1974 (HASAWA 1974) requires all employers and employees to comply with the regulations as set out in the legislation. Furthermore, the HASAWA 1974 imposes a legal duty on each and every employee to take reasonable care for their own safety and that of others, and to play their part in maintaining a safe working environment.

2   Purpose / Aim and Objective

2.1   To set out the organisational framework to outline how the Trust achieves compliance with the HASAWA 1974 and associated regulations as required by law.

2.2   To ensure all Trust staff are aware of their individual roles and responsibilities for health and safety within the organisation.

2.3   To ensure robust systems are in place to report and investigate health and safety incidents in order to identify learning points to support continuous improvement.

3   Definitions

3.1   The Health and Safety at Work Act 1974 (HASAWA 1974) provides a comprehensive and integrated system for dealing with workplace health and safety including the protection of the public, patients, delivery persons and contractors from workplace activities. This is achieved by placing duties on employers and employees.

3.2   Trust employee's includes all permanent, part time, flexi bank and volunteer staff.

3.3   The Health and Safety Executive (HSE) is the Government agency with responsibility for enforcing the law. Failure to comply with the requirements of the HASAWA 1974 and associated legislation can result in prosecution, fines and even imprisonment for certain offences.

4 Policy Framework

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

Arson - Prevention and Control
POLCS001 - Arson - Prevention and Control
This policy upholds the Firecode document 05-01: Managing Healthcare Fire Safety to fulfil its duties in respect of the prevention and control of arson in all premises owned by the Trust.
Asbestos Policy
POLCS022 - Asbestos Policy
This policy supports the "**The Control of Asbestos Regulations 2012**" which are enforced under the provisions of **The Health and Safety at Work Etc. Act 1974** specifically Regulation 4 of The Control of Asbestos Regulations (CAR) 2012.
Bomb Threats Policy & Procedures
POLCS002 - Bomb Threats Policy & Procedures
This policy aims to give clear guidance to Trust employees in the management of Bomb Threat/Suspect Package with the organisation.
Fire Safety Policy
STRCS001 - Fire Safety Policy
This policy ensures that the Fire Management Policies comply fully with both the requirements of law and NHS Firecode Documents.
Safe and Effective Use of Ionising Radiation
POLCGR096 - Safe and Effective Use of Ionising Radiation
This policy ensures all legislation governing the use of ionising radiation is upheld which includes: - The Ionising Radiations Regulations 1999 (IRR99)   - The Environmental Permitting Regulations (EPR)   - The Ionising Radiation (Medical Exposure) Regulations 2000 (IR(ME)R2000) and amendments   Including Implementation of IR(ME)R Schedule 1 Procedures.
Smoke-Free
POLCS011 - Smoke-Free Policy
This policy has been created to provide a smoke-free environment as smoking has a significant negative impact on people's health.

Water Safety Policy

POLCGR036 - Water Safety Policy

This policy provides a structured Procedure and Reporting Schedule, for the Management and Control of Legionellosis and Pseudomonas aeruginosa in compliance with current Guidelines (HTM's, HGN's, Model Engineering Specifications and Approved Codes of Practice), Legislation and Water Supply Regulations. As required by the Health and Safety Commissions (2000) Approved Code of Practice (L8).

Window Management Policy

POLCS018 - Window Management Policy

This policy ensure that precautions have been taken in respect of all windows, glass doors and/or any glass screens or partitions which are accessible to patients/residents/clients, to comply with the latest statutory requirements.

Display Screen Equipment Policy

POLCS019 - Display Screen Equipment Policy

This policy provides a practical strategy to meet the requirements of the Health and Safety (Display Screen Equipment) Regulations 1992.

Lone Worker Policy

POLCS007 - Lone Worker Policy

This policy ensures the Trust meets its obligations under the Health and Safety at Work Act (1974) and the Management of Health and Safety at Work Regulations (1999), for the health, safety and welfare at work for all its staff.

First Aid Policy

POLCS004 - First Aid Policy

This policy relates to the Health and Safety (First Aid) Regulations 1981 which place a duty on employers to provide and ensures that equipment, facilities and First Aid Personnel are adequate and appropriate.

COSHH HSE: A Brief Guide to the Regulations

OTCS025 - COSHH HSE: A Brief Guide to the Regulations

Provides guidance to meet specific duties under the Control of Substances Hazardous to Health Regulations 2002 (COSHH).

Moving & Handling Policy

POLCS008 - Moving & Handling Policy

The policy ensures the Trust meets its responsibilities in relation to the Health and Safety at Work etc. Act 1974, the Manual Handling Operations Regulations 1992.

5 (Duties) Roles & Responsibilities

5.1 **The Trust**, as the employing authority, is responsible for ensuring so far as is reasonably practicable, the health, safety and welfare of its staff, and for conducting the business of the Trust so as not to endanger the health and safety of others.

5.2 **Trust Board**

    5.2.1 Is responsible for approving the Trust's Corporate Policy for Health and Safety.

    5.2.2 Is responsible for understanding the statutory framework and assuring itself on the adequacy of the Trust arrangements for meeting requirements.

    5.2.3 Is responsible for leading and upholding a positive health and safety culture within the Trust by:

- Allocating appropriate resources to improve health and safety within the organisation, e.g. appropriate financial resources, health and safety advice, occupational health provision, fire safety and manual handling advice
- Adopting best practice in health and safety management in line with standards set by external bodies such as NHS Litigation Authority, Care Quality Commission, HSE.
- Regularly reviewing the Trust's performance against health and safety standards.
- Ensuring that learning from health and safety incidents is disseminated and systematically embedded across the Trust.
- Reviewing risks and making corporate decisions on those risks which the Board are prepared to accept based on the principles of absolute requirements, practicable to achieve and reasonably practicable.

5.3 **Chief Executive**

    5.3.1 The Chief Executive is the officer ultimately responsible within the Trust for health and safety. This includes the responsibility of ensuring that there is a health and safety framework which achieves the following:

- Provision and maintenance of plant, premises and systems of work so that they are safe and without unmanaged risk to health;

- Ensuring that whatever articles and substances are being used, handled, or stored there is minimum risk to safety and health to the individual;

- Maintaining all places of work in a safe condition and ensuring safe means of access and egress at all times;

- Provision and maintenance of a safe working environment with suitable and sufficient facilities and arrangements for the welfare of the Trust's employees;

- Ensuring that a written policy on health and safety is prepared and implemented within the Trust and to ensure that this information is available to all employees;

- Acknowledging the function and role of, and to co-operate with, safety representatives, and to provide the means for the establishment of a Health and Safety Group.

- The provision of suitable and sufficient information, instruction, supervision and training to enable all employees to carry out their duties as required in respect of health and safety.

5.4 **All Executive Directors, Directors of Clinical Operations, Clinical Directors** have responsibility for:

5.4.1 Ensuring all staff members are aware of the Trust Board's expectations for carrying out their health and safety responsibilities.

5.4.2 Oversight of the management of the risk assessment process within their areas of responsibility to ensure that a systematic approach is made to identify and control risks to an acceptable level.

5.4.3 Ensuring appropriate monitoring systems are in place to determine the effectiveness of risk reduction actions.

5.5 **Director of Corporate Governance, Risk, Compliance & Legal**

5.5.1 Is the Executive Director with lead responsibility for health and safety within the Trust. She/he will regularly report to the Board on relevant matters and will:

- Define resource requirements to enable the implementation of agreed safety plans and objectives

- Ensure integration of health and safety plans into strategic business planning processes

- Inform the Chief Executive of significant risks in relation to health and safety

5.5.2 Is the designated Chairperson of the Fire, Health and Safety Group with responsibility for monitoring the effectiveness of the Group, ensuring that it meets its agreed terms of reference.

5.5.3 Has responsibility for ensuring that that the Trust has an appropriate health and safety infrastructure and framework in place.

5.5.4 Has responsibility for ensuring the appropriate provision of health and safety training.

5.5.5 Advises the Trust Board on health and safety matters.

5.6 **Fire, Health and Safety Group** - is established on the authority of the Compliance and Risk Group to assist the Trust Board in fulfilling its responsibilities in relation to the Health and Safety at Work etc. Act. It will fulfil its purpose by having responsibility for oversight of the systems and controls governing fire, health and safety, reviewing

key performance indicators to assess their adequacy and identifying where improvements need to be made. Terms of Reference setting out the full responsibilities of the Group are available here: DOC35 - Fire Health and Safety Group - Terms of Reference (1 attachment)

5.7 **The Head of Corporate Compliance and Resilience** is accountable to the Director of Corporate Governance, Risk, Compliance & Legal Risk for:

5.7.1 Providing line management and oversight to the Senior Health and Safety Adviser and the Senior Moving and Handling Adviser.

5.7.2 Preparation of the annual plan for the Fire, Health and Safety Group

5.7.3 Preparation of a bi-annual report to the Board on the Trust's performance across fire, health and safety

5.8 **The Director of Estates and Facilities** is the designated Director with responsibility for fire safety across the Trust and the appointment and management of a Senior Fire Safety Adviser.

5.9 **The Director of Human Resources**

5.9.1 Is responsible for the provision of Occupational Health Services including health assessment, personal and environmental monitoring and health surveillance where required. He/she shall also ensure individuals' health and safety responsibilities, both statutory and job specific are contained in their written job description which is reviewed and amended as required.

5.10 **Senior Health & Safety Adviser**

5.10.1 Is the designated and appointed source of competent advice and assistance in the management of health and safety throughout the Trust with responsibility for advising the Trust, on compliance with health and safety legislation, assisting in the formulation, development and planning of targets, standards and priorities for health and safety.

5.10.2 Is responsible for investigating incidents and recommending suitable remedial actions to prevent recurrences.

5.10.3 Is responsible for monitoring procedures for the reporting, investigating, recording and analysing of health and safety information and to provide feedback on managers' submissions to aid continuous improvement and learning.

5.10.4 Is responsible for undertaking compliance audits to identify where improvements need to be made.

5.10.5 Assists in the provision of health and safety training.

5.10.6 Identifies risk trends from incident reporting and disseminates the learning across the Trust.

5.10.7 Acts as point of contact for liaising with outside bodies, where appropriate, inclusive of statutory notification of Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR).

5.11 **Occupational Health (OH) Service**

5.11.1 This service is intended to address the impact of work on health and health on work with responsibility for promoting the highest degree of physical and psychological health of all employees through prevention measures:

- The prevention of ill health caused or exacerbated by work, thereby reducing absenteeism in the workplace.

- Preventing staff from posing an infection risk to others including vulnerable patients by appropriate screening and immunisation programmes.

- Preventing work-related ill health among groups of employees who may be exposed to certain health risk by assessment and health surveillance programmes.

5.11.2 Timely Intervention measures

- Easy and early treatment of the main causes of sickness absence including access to counselling services and physiotherapy services as appropriate.

5.11.3 Rehabilitation intervention

- Early intervention by Occupational health to help staff stay at work or return to work after illness or injury.

5.11.4 Health assessments for work

- Supporting managers with issues such as attendance at work, retirement on the grounds of ill health and other related matters by offering reliable evidence based advice.

5.11.5 Promotion of health and wellbeing

- Improving health and wellbeing of staff by offering staff practical help and advice on improving lifestyle and overall health and wellbeing.

5.11.6 Teaching and training

- Promoting the health and wellbeing approach amongst staff and managers.

- Educating staff on the reduction of inoculation incidents.

- Educating staff and managers on issues such as work related stress.

5.12 **General Managers and Service Managers**

5.12.1 Are responsible for the overall management of health and safety within their departments and services. They shall also ensure individuals' health and safety responsibilities, both statutory and job specific, are contained in written job descriptions which are reviewed and amended as required

5.12.2 Are responsible for adherence to policy in line with the Trust's health and safety objectives to ensure compliance in all workplaces under their control.

5.12.3 Are responsible for monitoring and assessing the accountability of line management in their health and safety roles.

5.12.4 Are responsible for ensuring that all staff receive health and safety training appropriate to their responsibilities.

5.12.5 Are responsible for ensuring that risk assessments are carried out routinely including prior to the introduction of new, or changes in established, procedures, practices, equipment, machinery or substances.

5.12.6 Are responsible for ensuring that recommendations for remedial action are actioned as soon as is practicable.

5.12.7 Are responsible for implementing any health and safety recommendations.

5.13 **Site Practitioners**

5.13.1 Site Practitioners are responsible for managing health and safety incidents which occur outside of office hours and reporting them back directly to the responsible General Manager for investigation and corrective action.

5.14 **Department/Ward Managers**

5.14.1 Each Ward or Department Manager is responsible for the implementation of health and safety as an integral part of the service they manage.

5.14.2 Departmental/Ward Managers are responsible for the day to day implementation of Trust policy and are empowered to take all reasonable measures to ensure that all workplaces and work practices within their areas of responsibility are safe and healthy and meet legal requirements. This also extends to the undertaking of formal, written risk assessments and their ongoing maintenance.

5.14.3 To ensure risk assessment are reviewed regularly and follow the process laid out within the Risk Assessment Procedure - SOP0186.

5.14.4 Implementing any necessary controls and arrangements from the risk assessment to ensure the risks are eliminated or reduced to acceptable levels.

5.14.5 Are responsible for maintaining a departmental safety manual, which is reviewed at least annually by them, which clearly states individual responsibilities.

5.14.6 Are responsible for production and maintenance of safe systems of work and procedures for all activities within their department

5.14.7 Are responsible for ensuring that all staff receive adequate information, instruction, training and supervision in relation to health and safety and the maintenance of an up to date record of all training within each department. Such information must be accessible and readily available for inspection.

5.14.8 Are responsible for ensuring that staff are released from their normal duties to attend all mandatory health and safety training courses.

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5.14.9 Are responsible for ensuring that hazard data sheets are obtained, and suitable and sufficient assessments are carried out of all hazardous substances within the department in accordance with the Control of Substances Hazardous to Health Regulations 2002.

5.14.10 Are responsible for ensuring that all incidents and accidents are reported in a timely manner using Datix, and investigated.

5.14.11 Are responsible for identifying Health and Safety Keyworkers to help them fulfil their responsibilities and for allocating them time within working hours for them to be able to meet their responsibilities.

5.15 **Health and Safety Keyworkers**

5.15.1 Are appointed by ward/departmental managers to assist them in undertaking mandatory risk assessments.

5.15.2 Will be trained by the Safety department to undertake their departmental H&S risk assessments on behalf of their Line Manager. The Line manager will manage any findings and control measures of these assessments as a requirement under legislation.

5.15.3 All subsequent risks and hazards identified by the keyworker will remain the appropriate manager's responsibility to action.

5.15.4 Will assist their managers to close actions on workplace H&S audits.

5.15.5 Will be able to give "Low risk" health and safety advice to managers and staff.

5.15.6 Maintain the health and safety folder.

5.16 **Trust Employees**

5.16.1 All Trust employees, including part time, flexi bank and volunteer staff shall comply with any information, instruction, procedure or policy provided by the Trust (either directly or via the management structure) in pursuance of its statutory responsibilities including participation in relevant training programmes.

5.16.2 Every individual has a duty to behave in such a manner at work to take reasonable care for their own safety, and the safety of others.

5.16.3 Must take reasonable care for their own health and safety and that of other employees, patients, visitors and non-employees who may be affected by their acts or omissions.

5.16.4 Must co-operate fully with their managers, supervisors and other staff to ensure that Trust policies and guidelines are implemented and adhered to;

5.16.5 Must comply with safe systems of work and recognised procedures where these are in place;

5.16.6 Must not interfere with, misuse or intentionally disregard any equipment, article, or notice provided by the Trust in the interest of health and safety.

5.16.7 Must bring to the attention of their managers any shortcomings they are aware of in respect of health and safety policies, procedures, guidelines, training and supervision.

5.16.8 Must bring to the attention of their managers any shortcomings they are aware of in respect of the health and safety of the workplace and work practices.

5.16.9 Must participate fully in training programmes ensuring that mandatory training requirements are fulfilled.

5.17 **Contactors and Other Specialist Advisers inclusive of Construction and Design Management coordinators**

5.17.1 Contractors or Agency Staff working at premises under the control of the Trust shall comply with the same health and safety responsibilities as an employee of the Trust. Contractors shall provide any health and safety information to the Trust pertinent to the works being carried out.

5.17.2 Other specialist advisers are responsible for providing advice, assistance and support to facilitate the effective assessment and control of risk.

5.17.3 The CDM coordinator is responsible for ensuring that Sub contractors provide suitable pre contract risk assessments and method statements pertaining to the works to be carried out.

6 Monitoring and Review

6.1 This policy will be monitored and reviewed by the Trust Senior Health and Safety Adviser to take into account new legislation and working practices. Any changes will be taken through the Fire, Health and Safety Group for review before dissemination to staff.

6.2 Where no new legislation or working practices directly affect this policy it will then be reviewed bi-annually by the Senior Health and Safety Adviser.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	First review in one year and then every three years	Author	Fire, Health and Safety Group	Where gaps are recognised action plans will be put into place
Application of policy	Monthly Audit	Senior Health and Safety Adviser	Fire, Health and Safety Group	Corrective action with Managers/individuals

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Training Records	Monthly Via ESR/OLM	Senior Health and Safety Adviser	Senior Health and Safety Adviser Fire, Health and Safety Group	Where training has been identified by Trust managers, on the Training Needs Analysis, and no such training has been taken up; actions plans will be put into place with timescale for completion
A central record of Risk Assessments will be maintained.	Reviewed by Health and Safety Adviser Monthly	Senior Health and Safety Adviser	Senior Health and Safety Adviser Fire, Health and Safety Group	Where risks are recognised and no risk assessment has been documented actions plans will be put into place with timescale for completion
Risk assessments recorded on directorate Risk Registers if need be; reported onto the corporate risk register	Reviewed in the Directorate Governance Meetings monthly	Directorate Governance teams	Senior Health and Safety Advisor Fire, Health and Safety Group	Where risks are recognised actions plans will be put into place
Review of Risk Assessment including data from general risk assessment form	Ongoing/ updated daily via Risk Matrix Database through the Health and Safety Department	Senior Health and Safety Advisor	Fire, Health and Safety Group Directorate governance teams	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these
Fire, Health and Safety Group Report - this includes areas such as risk assessments, work related stress, training, and staff	Quarterly Report	Senior Health and Safety Advisor	Fire, Health and Safety Group	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
accident statistics.				

7 Training and Implementation

7.1 Trust mandatory training requirements are regularly updated and disseminated to staff.

7.2 Provide adequate training for those undertaking risk assessments, developing action plans from assessments or otherwise involved in the risk assessment process.

7.3 Risk assessment training will be repeated periodically, reviewed and revised as appropriate and a record of such training will be maintained.

8 References

Document	Ref No
References:	
Care Quality Commission Essential Standards of Quality & Safety;	Safe
Trust Associated Documents:	
POLCS001 - Arson - Prevention and Control	
POLCS022 - Asbestos Policy	
POLCS002 - Bomb Threats Policy & Procedures	
STRCS001 - Fire Safety Policy	
POLCGR096 - Safe and Effective Use of Ionising Radiation	
POLCS011 - Smoke-Free Policy	
POLCGR036 - Water Safety Policy	
POLCS018 - Window Management Policy	
POLCS019 - Display Screen Equipment Policy	
POLCS007 - Lone Worker Policy	
POLCS004 - First Aid Policy	
OTCS025 - COSHH HSE: A Brief Guide to the Regulations	
POLCS008 - Moving & Handling Policy	
POLCGR071 - Serious Incident Policy (SI) (1 attachment)	
Fire Safety Strategy	
Risk Assessment Standard Operating Procedure	
Relevant Statutory Provisions	
ACTS OF PARLIAMENT	
The Health and Safety at Work etc. Act 1974	
The Regulatory Reform (Fire Safety) Order 2005	

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The Corporate Manslaughter Act 2008	
REGULATIONS The Management of Health and Safety at Work Regulations 1999 The Control of Substances Hazardous to Health Regulations 2002 (C.O.S.H.H.) The Health and Safety (Display Screen Equipment) Regulations 1992 (D.S.E.) The Manual Handling Operations Regulations 1992 as amended 2002 The Workplace (Health, Safety and Welfare) Regulations 1992 The Personal Protective Equipment at Work Regulations 2002 (P.P.E.) The Provision and Use of Work Equipment Regulations 1998 (P.U.W.E.R.) The Lifting Operations and Lifting Equipment Regulations 1998 (L.O.L.E.R.) The Health and Safety (First Aid) Regulations 1981 The Confined Spaces Regulations 1997 The Construction (Design and Management) Regulations 2007 (C.D.M.) The Chemicals (Hazard Information and Packaging for Supply) Regulations 2002 (C.H.I.P.) The Control of Asbestos at Work Regulations 2006 The Health and Safety (Safety Signs and Signals) Regulations 1996 The Ionising Radiations Regulations 2000 The Noise at Work Regulations 2005 The Health and Safety (First Aid) Regulations 1981 The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 The Working at Height Regulations 2005 A link to all regulations can be found on http://www.hse.gov.uk/search/results.htm?q=regulations&cx=0158481783152 89032903%3Akous-jano68&sa=Search&cof=FORID%3A11#1061	

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Health and Safety Strategy

Author:	Paul Miles – Senior Health and Safety Advisor
Document Owner	Lynne Stuart - Director of Corporate Governance, Risk, Compliance & Legal
Revision No:	1
Document ID Number	STRCS015
Approved By:	
Implementation Date:	December 2016
Date of Next Review:	December 2017

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Health and Safety Strategy

Document Control / History	
Revision No	**Reason for change**
1	New strategy document created

Consultation
Chief Executive
Fire, Health & Safety Group Members

1   Table of Contents

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Health and Safety Strategy

1 Introduction

1.1 The overall aim of Medway NHS Foundation Trust health and safety strategy is to ensure the development and sustainability of high quality compliance services and systems that are associated with Fire, Health and Safety, Occupational Health, Human Resources and Estates and Facilities activities.

1.2 This strategy will be delivered in a timely, efficient, effective and affordable manner to ensure the organisation meets its legislative obligation to safeguard the health, safety and welfare of people/property. This will enable the Board to meet the statutory obligations placed upon the organisation to safeguard the health, safety and welfare of staff, patients and others who might otherwise be affected by the actions and/or the omissions of the Trust. This strategy will be reviewed on a yearly basis to give the Board assurance of compliance.

2 Current Position (where we are now)

2.1 Policy and Strategy

    2.1.1 Documents are reviewed annually or sooner to reflect any changes in legislation or working practices.

2.2 Training

    2.2.1 Board members and senior managers have attended the Institute of Occupational Safety and Health safety for Senior Executive course.

2.3 Training in risk assessments is available as part of Manager Awareness Sessions, which are mandatory every two years.

2.4 A range of training is available for all staff groups which includes general Health and Safety, Control of Substances Hazardous to Health (COSHH), Violence and Aggression (V&A)/Conflict Resolution, Display Screen Equipment (DSE) and Risk Assessment.

2.5 Corporate welcome is on a weekly basis which includes Health and Safety training for new starters.

2.6 Attendance of mandatory training is recorded via the ESR system, however not all staff attend and there appears to be no consequent action for non-attendance.

2.7 Risk assessment

    2.7.1 All areas of the trust have health and safety folders containing clinical risk assessment templates and ward/department risk assessments. Folders vary greatly in their content with regard to current clinical risk assessments; due to a Trust wide exercise carried out during September and October, all risk assessments for clinical areas have been completed.

2.7.2 Generic risk assessments are available to cover general work activities around the Trust. Medway NHS Foundation Trust Health and Safety Policy states that all Managers should attend this training. Uptake of this training is inconsistent and not all staff are familiar with the findings of health and safety risk assessments for which they may be responsible.

2.8 Health and Safety Keyworkers have limited availability to assist their Managers in the risk assessment process usually due to their clinical commitments.

2.9 Incident reporting

2.9.1 Datix incident reports are monitored, investigated and themes are reported on quarterly through the Fire, Health and Safety Group.

2.9.2 Investigations are carried out by Health and Safety, Fire and Moving and Handling Advisers.

2.9.3 Reporting of Injuries, Disease and Dangerous Occurrences Regulations (RIDDOR) reports are sent to the Health and Safety Executive (HSE) from the Safety department as and when they occur.

2.9.4 Department of Health safety alerts are received and acted on where necessary.

2.9.5 There is a variable commitment to health and safety across the Trust and this may be due to staffing levels, clinical and non-clinical, impacting on mangers having to prioritise their workloads to cover patient and business support requirements.

2.10 Currently Ward/Dept managers have responsibility for carrying out Trust-wide Risk Assessments but there needs to be clarification to these staff on their responsibilities in this area.

3 The Vision (where we want to be)

3.1 Risk assessment is the foundation of all health and safety so the quality of all health and safety risk assessments across the Trust will be regularly audited by the Health and Safety Department to ensure they are suitable, in-date, reflect current work practices of the department or ward where they are located and have been read and understood by all staff concerned. Evidence of the latter will also be audited.

3.2 A greater provision of all health and safety and moving and handling training including increased availability of venues and resources will show an increase in the recorded level of uptake and DNA's will be acted on by agreed parties.

3.3 Management commitment to health and safety will be actively encouraged and cascaded down to staff at all levels to embed a health and safety culture.

3.4 All Staff will be familiar with the risk assessments and associated safe systems of work with managers being responsible to relay relevant information from the findings.

3.5 Risks will be identified through the Trust risk reporting system and where necessary entered on the relevant directorate risk registers.

3.6 All accidents/incidents will be reported in a timely manner in conjunction with RIDDOR requirements. These will be monitored and any necessary risk reduction measures taken. Follow up reports from managers will be made available to all parties concerned.

3.7 All Staff will receive appropriate mandatory training in health and safety including associated equipment.

3.8 A commitment to a safer working environment will be demonstrated throughout the Trust through a reduction in accidents and incidents but with a higher number of near misses reported.

3.9 An annual Health and Safety communication plan is to be devised.

3.10 Compliance rates will be monitored and an improvement plan put in place.

3.11 There will be a shift in the focus of the health and safety function from its prevalent advisory role to one of proactively ensuring compliance across the Trust and identifying areas where greater support or escalation is required.

4 Sustainability (the do nothing gap)

4.1 Workplace health and safety needs to be a continually improving environment with lessons being learnt from past incidents, thus emphasising the need to be proactive as opposed to reactive.

4.2 To do nothing would stagnate health and safety, in a changing environment, leaving the Trust open to possible prosecutions from the Health and Safety Executive (HSE) and criticisms from agencies such as the CQC as well as Trust reputational damage.

5 Improving Quality and Outcomes (improvements)

5.1 In order to drive forward the acceptance of effective health and safety working arrangements as the daily operational norm, there needs to be an identifiable "Top down" commitment to health and safety.

5.2 To deliver these improvements the following actions will be implemented during the next 12 months with regular progress reports being provided to the Fire, Health and Safety Group:-

5.2.1 A Full Health & Safety audit of the existing management systems using the NHS Workplace health and safety standards tool (http://www.nhsemployers.org/~/media/Employers/Publications/workplace-health-safety-standards.pdf).

5.2.2 Full physical audit of the workplace environment in cooperation with staff-side to highlight any failings.

5.2.3 Full Health & Safety folder audit

5.2.4 Current 'suitable and sufficient' risk assessments available in all departments to be reviewed and updated in accordance with Trust policy.

5.2.5 Enhanced support to be given to keyworkers by managers to allow them the necessary time to devote themselves to their H&S role.

5.2.6 Accountability for non-attendance at H&S training and all other mandatory training.

5.2.7 A measurable trajectory will be established showing the improvements as a result of this increase in training provision, risk assessment and audit, however it may be that additional health and safety/moving and handling resource will be required to ensure full delivery.

6   Governance Overview (measuring & monitoring)

6.1 Datix data will be used to help measure and monitor the effectiveness of this strategy. Once implemented there should be a gradual fall in health and safety incidents involving staff, visitor and patients which will be recorded on the Fire, Health and Safety Group scorecard.

7   Values and Principles (values that underpin the system)

7.1 Core values are ensuring the health, safety and wellbeing of all staff, patients and visitors.

8   Financial Implications (cost)

8.1 It is intended that the Strategy can be delivered within existing resources for pay and non-pay. There may be opportunities for reducing spend on external training and recruiting further in-house resource instead.

9   References

Document	Ref No	
References:		
Trust Associated Documents:		
Health and Safety Policy	POLCS005	
Risk Assessment Procedure	SOP0186	

END OF DOCUMENT

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Report to the Board of Directors

Board Date: 24 November 2016

Title of Report	Corporate Policy: Violence, Aggression and Disruptive Behaviour Policy
Presented by	Darren Cattell, Director of Finance
Lead Director	Darren Cattell, Director of Finance. Claire Lowe, Director of Estates and Facilities
Committees or Groups who have considered this report	Executive Group
Executive Summary	Further to discussions between the Chief Executive and the Executive Group, it was resolved to map all policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) under one of 14 overarching Policy Areas with a high level Board approved Corporate Policy covering each area. The Corporate Policy is intended to be a high level overview of the organisation's policy in the relevant area, with the detailed instructions / guidance being laid out in supporting documentation which is referenced in the Corporate Policy and therefore linked to the overarching policy document. The corporate policy areas are: • Information Governance • Consent • Complaints • Serious Incidents • Safeguarding • Emergency Planning, Resilience and Response • Human Resources/employee handbook • Health and Safety / Fire Safety • Standards of Business Conduct • Medicines Management • Risk Management • Patient Care and Management • Estates and Facilities • Duty of Candour • Finance • Violence, Aggression and Disruptive Behaviour Accordingly, the Corporate Policy for Violence, Aggression and Disruptive Behaviour has been drafted, agreed by the Executive and is attached for Board approval.
Resource Implications	N/A

Risk and Assurance	Currently there is an excessive number of policies, SOPs and AGNs in place and linkage between associated documentation may lack clarity and purpose. The process of creating an overarching Corporate Policy for each area is supported by a review of background documentation and the culling of documents which are superfluous or out of date. The process will streamline document management processes across the Trust.
Legal Implications/Regulatory Requirements	Corporate Policies are being drafted to reflect legal and regulatory requirements.
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Executive Group have reviewed the policy and recommend that the Board approves the new Corporate Policy for Violence, Aggression and Disruptive Behaviour.
Purpose & Actions required by the Board :	Approval ☑ Assurance ☐ Discussion ☐ Noting ☐

Corporate Policy: Violence, Aggression and Disruptive Behaviour

Author:	Inge Damiaens - Security Management Specialist Manager
Document Owner:	Darren Cattell
Revision No:	5
Document ID Number	POLCS010
Approved By:	
Implementation Date:	2016
Date of Next Review:	2019

Document Control / History	
Revision No	**Reason for change**
1	General review and update into new format
2	General review
3	General review
4	General review – simplified process
5	Review and create SOPs for procedures.

Consultation
Director of Corporate Governance, Risk, Compliance and Legal
Head of Security
Urgent Care Staff
Director of Finance
Executive Group
Director of Estates and Facilities
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Violence, Aggression and Disruptive Behaviour Policy

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Violence, Aggression and Disruptive Behaviour Policy

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

1   Introduction

1.1   Medway NHS Trust has a duty to provide a safe and secure environment for patients, staff and visitors. Abusive or violent behaviour will not be tolerated and the Trust will actively support the prosecution of any person who assaults staff.

1.2   Trust staff will have access to training in how to reduce and manage abuse and violence in the workplace. As a general principle, the Trust will be prepared to seek the prosecution of any competent adult who physically assaults and/or verbally assaults a member of staff during the course of their duties. Staff will be generally within their rights to refuse to treat any competent adult who physically and/or verbally assaults them.

1.3   Where staff refuse to continue treatment in these circumstances, then the patient's Consultant (or the most senior member of the medical team on duty) and line manager must be informed immediately so that alternative necessary arrangements can be made.

1.4   Those patients who, in the expert judgement of the relevant clinician are not competent to take responsibility for their actions will not be subject to this procedure. In these circumstances the Trust will take all reasonable steps to ensure staff safety.

1.5   This policy defines what constitutes abusive and violent behaviour, describes the framework within which such assaults will be dealt with, and provides guidance on the practical actions to be taken to minimise and deal with incidents involving unacceptable behaviour.

1.6   Patients and visitors must be informed that they have the right to challenge any stage of this policy if applied to them through the Trust's formal complaints management process.

1.7   This policy has been developed in-line with the following:

1.7.1   Guidance from NHS Protect regarding Violence and Aggression in the NHS.

1.7.2   National Audit Office Report on Violence in the NHS

1.7.3   NHS Business Services Authority, Security Management Division – 'Prevention and Management of Violence where withdrawal of treatment is not an option' – 2007.

1.7.4   NHS Business Services Authority, Security Management Division - 'Meeting needs and reducing distress: Guidance for the prevention and management of clinically related challenging behaviour in NHS settings' - 2013

1.8   When following this policy, if there is any concern about an individual's level of understanding (e.g. if English is not their first language), the interpreting service should be contacted to interpret and offer help.

1.9   If an assault occurs to a patient, a member of staff or visitor, please follow the adult pathway, which should be used in conjunction with the relevant sections of this

policy. Support and guidance can be obtained from the Security Manager, Clinical Site Manager, or Local Security Management Specialist.

1.10   Any member of staff who has been subjected to any of the unacceptable behaviours listed in this policy by a patient/patient's visitor has the right to opt out of caring for the relevant patient in discussion/agreement with the Head of Nursing/Midwifery/Therapy Services or other appropriate senior manager/clinician as part of the individual's care management plan.

1.11   Where an individual's behaviour is unacceptable from the outset of their attendance at hospital and where, following appropriate clinical assessment, it is decided that urgent healthcare is not required, they can be asked to leave the premises with the assistance of the security service if necessary. This does not count as exclusion.

1.12   Where there is repetition of inappropriate or unacceptable behaviour, which does not warrant criminal or civil action, the Trust may pursue exclusion. Repetitive behaviour may be taken as a whole and the various stages of the procedure can be adhered to in this manner.

2   Purpose / Aim and Objective

2.1   Medway NHS Foundation Trust believes that everyone has a duty to behave in an acceptable and appropriate manner while on Trust premises. Staff have the right to work, visitors have the right to feel welcome and patients have the right to be cared for free from the fear of assault and abuse, in an environment that is safe and secure.

2.2   This policy has been developed to set out the Trust's position in the event of any behaviour perceived by the recipient as being offensive, intimidating or harmful resulting in damage either psychologically or physically. This includes verbal or physical aggression and abuse directed at any person for whatever reason.

2.3   This policy describes the behaviours which are unacceptable and the procedural documentation in place to enable Trust staff to effectively respond to incidents of violence, aggression and disruptive behaviour including a mechanism whereby patients who are extreme or persistent in their unacceptable behaviour can, as a last resort, be excluded from the Trust. (Persistent unacceptable behaviour refers to behaviour both within one admission and/or over a number of separate attendances within period of sanction.)

2.4   Where there are concerns regarding a patient or visitor it will be important for staff in other areas that may need to be involved in the patient's care to be made aware e.g. a referral from Emergency Department to Radiology/Fracture Clinic and similarly to alert the Trust's Security department.

2.5   This policy does not affect the rights of any individual to take independent action following abuse or an assault, e.g. by contacting the police.

2.6   The objectives of the Policy are:

    2.6.1   To create and maintain a safe working environment for all Trust staff to reduce the risks of intimidation and violence to staff and others whenever

possible and provide appropriate support if necessary and aftercare in the event of such incidents.

2.6.2 To ensure that provision is made within the organisation for informing those whose behaviour is considered unacceptable.

2.6.3 To make all staff and the public aware that intimidation and violence against NHS staff is unacceptable and that the Trust are determined to continually and proactively address this issue.

3   Definitions

3.1 **Physical Assault** – "the intentional application of force to the person or another, without lawful justification, resulting in physical injury or personal discomfort".

3.2 **Verbal assault** – "the use of inappropriate words or behaviour causing distress and/or constituting harassment"

3.3 **Unacceptable Behaviour**: In addition to behaviours explicit in 3.1 and 3.2 above the following are examples of behaviours that are not acceptable on Trust premises.

    3.3.1 Excessive noise, e.g. loud or intrusive conversation or shouting

    3.3.2 Malicious allegations relating to members of staff, other patients or visitors.

    3.3.3 Offensive sexual gestures or behaviours

    3.3.4 Drinking of alcohol

    3.3.5 Taking non prescribed drugs in hospital (all medically identified substance abuse problems will be treated appropriately)

    3.3.6 Dangerous driving

    3.3.7 Drug dealing

    3.3.8 Smoking

    3.3.9 Any criminal act to Trust property

    3.3.10 Theft

4   (Duties) Roles & Responsibilities

4.1 **Chief Executive**

    4.1.1 The Chief Executive is ultimately accountable for the implementation throughout the Trust of the Violence, Aggression and Disruptive Behaviour Policy and Procedures, and to ensure its effectiveness is continually reviewed.

4.2 **Director of Finance (in the role of Security Management Director)**

    4.2.1 Director of Finance is responsible for ensuring that, in the event of a physical assault on a member of staff, systems are in place so that police are contacted immediately, either by the person who has been assaulted or an appropriate manager or colleague, full co-operation is given to the police

in any investigation, the Local Security Management Specialist (LSMS) is informed of any incidents and is responsible for ensuring full co-operation is given to them in any investigation or subsequent action which is considered appropriate.

4.2.2 The Director of Finance has delegated this responsibility to the **Director of Estates and Facilities** in his role as Security Management Director (SMD).

4.3 Director of Human Resources

4.3.1 The Director of Human Resources is also responsible for organisation of the Corporate Induction Programme, ensuring that it covers Health, Safety and Security Management.

4.3.2 The Director of Human Resources is responsible for ensuring effective systems are in place to investigate any incidents of violence and aggression from staff towards staff, patients and/or visitors and that appropriate action (disciplinary, dismissal etc.) in accordance with Trust policies is followed through when appropriate.

4.4 Response Team

4.4.1 If the team dealing with a violent and/or aggressive patients or visitors is in distress, a response team can be contacted for assistance

4.4.2 The response team is composed of:

- Matrons and the security officers during office hours

- Site practitioners and the security officers out of hours

4.4.3 The response team is expected to respond within a timely manner to any incident being reported, and each have a specific task when attending an incident:

- Matrons and site practitioners provide clinical assistance to ensure any action taken will not put the assailant at risk

- The Security team will ensure, through appropriate methods, that physical security is offered where needed by staff

4.5 Local Security Management Specialists

4.5.1 Are responsible for liaising with the local police in the event of a physical or non-physical assault to assist with any investigation, undertaking an investigation where the police are unable to do so and where the Trust SMD requests the services of the LSMS.

4.5.2 The LSMS will also:

- feedback to the victim on the progress of any police or local investigations into physical or non-physical assault

- be responsible for the provision of security advice to the Trust at the request of the Director of Estates and Facilities or the SMD

- carry out risk assessments of selected sites where there is a suspected risk of Violence and Aggression or where lone workers are based.

- Report on compliance numbers regarding completion of Conflict Resolution training by individuals. Reporting is extracted as part of the Trust's performance management approach and is presented to the Fire, Health & Safety Group.

4.5.3 Is responsible for the organisation of Conflict Resolution Training and for conducting a Training Needs Analysis (TNA) which is robust and in line with the Trust's overall training matrix for mandatory subjects.

4.5.4 Included within the TNA will be any relevant issues and information from risk management, incident reporting and evaluation of training. Conflict Resolution Training comprises the following areas in line with national guidelines set by NHS Protect and includes the following areas:

- Causes of violence

- Recognition of warning signs

- Relevant interpersonal skills

- Details of working practices and control measures

- Incident Reporting

4.6 Occupational Health Department

4.6.1 Are responsible for providing support and counselling to any member of staff and for assessing their fitness to work.

4.7 Fire, Health & Safety Group

4.7.1 Has responsibility for providing assurance to the Board, via the Compliance and Risk Group, and the Executive Group, that the Trust executes its duties and responsibilities in the promotion of health & safety in the work place, as a requirement of The Health and Safety at Work Act 1974

4.7.2 Monitor and evaluate the effectiveness of existing systems and procedures designed to ensure health and safety in the workplace.

4.7.3 Review incident report statistics identifying trends and assessing remedial action that may be required.

4.8 Departmental and Ward managers

4.8.1 Under the above relevant legislation, the Trust has a legal duty to provide for the safety of its employees. A key requirement is for managers to carry out risk assessments to identify significant risks arising out of any work activity. Once the risks are identified and quantified, local protocols are required to plan, organise, control and monitor prevention and protective measures.

4.8.2 Managers are responsible for identifying the risk and required level of Conflict Resolution and/or Violence & Aggression training each member of staff requires within their team, in addition to agreeing their release to attend and any follow-up support required.

4.8.3 Managers should encourage their staff to report all incidents, no matter what the circumstances are.

4.8.4 Managers are responsible for ensuring staff that are affected by violence and aggression incidents get the support needed, through Occupational Health or other counselling services.

4.8.5 Managers are responsible for the investigation of incidents, although help can be sought from experts were deemed necessary.

4.9 Employees

4.9.1 All members of staff must take responsibility for their own essential training on Conflict Resolution and/or Violence & Aggression, as identified in the mandatory training matrix, or as identified through discussion and agreement during appraisal with their line manager.

4.9.2 Employees are responsible for reporting any incidents of violence and/or aggression through the Trust incident reporting system (Datix).

4.9.3 All Trust employees (including those on honorary contracts and those working primarily for other organisations but on Trust premises) have a duty to adhere to and to uphold this policy.

5 Procedures For the Prevention and Management of Violence, Aggression and Disruptive Behaviour

5.1 The supporting Standard Operating Procedures regarding Violence, Aggression and Disruptive Behaviour allow staff to have access to practical guidelines on how to deal with Violence, Aggression and Disruptive Behaviour in the Trust.

5.2 The following Procedures are available in separate documents for easy access:

5.2.1 First Response
SOP0106 - Violence Aggression and Disruptive Behaviour - First Response

5.2.2 Investigation
SOP0107 - Violence Aggression and Disruptive Behaviour - Investigation Procedure

5.2.3 Warning Escalation
SOP0147 - Violence Aggression and Disruptive Behaviour - Warning Escalation - Adults

6 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	First review in one year and then every three years	Author	Security Director	Where gaps are recognised action plans will be put into place
Incidents/Near Misses, Training Records, Policy Legislation & Guidance, Claims /Litigation	Through reports to the Fire, Health and Safety Group and an annual report to the Audit Committee (IAC) by the LSMS	The nominated security Management Director	Audit Committee	Action plans will be developed to support any deficiencies or gaps and will be monitored through interim reports to the Executive Group
CRT/Lone Worker Training Risk Assessments	Collated through individual Directorates and Health and Safety Department.	Directorate General Manager.	Fire, Health & Safety Group	Action plans will be developed to support any deficiencies or gaps and will be monitored through interim reports to the Fire, Health & Safety Group.

7 Training and Implementation

7.1 The Trust recognises that the approach to violence against NHS professionals is an important part of the Health & Safety Policy and that such training should be included in training courses where appropriate and in on-the-job training as a normal part of job instruction. The training requirements will be determined by the need of each professional group and specialist as identified in the training needs analysis, in line with the essential training.

7.2 Training available to Trust employees:

    7.2.1 Security Induction training as part of the Health & Safety Induction

    7.2.2 Conflict Resolution training is offered to all staff to enable them to deal with and possibly defuse a potentially violent situation before it gets worse. Conflict Resolution is available in three levels:

Violence, Aggression and Disruptive Behaviour Policy

- Induction Training
- Face to face conflict resolution training, plus break away training
- Restraint training

7.2.3 Managers are to ensure that appropriate staff attend initial training and updates in Conflict Resolution.

7.2.4 Induction for new employees will include a general outline of the legislation and attention will be drawn to the Violence, Aggression and Disruptive Behaviour policy and its Standing Operating Procedures. The procedure to be adopted in the event of an accident or near miss will also be covered as well as the procedure to be adopted if hazards are discovered.

7.2.5 Depending on team or individual requirements, further specialised training can be made available in order to ensure staff can ensure their safety and security in more challenging working environments.

7.2.6 It is the responsibility of the directorate or department to ensure that staff are aware of any new or newly revised policies.

8 Equality Impact Assessment Statement & Tool

8.1 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.

8.2 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 Policy was found to be compliant with this philosophy.

8.3 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.

8.4 Refer to appendix 1.

9 References

Document	Ref No
References:	
Care Quality Commission	
NHSLA Standard for Acute Trusts	
Secretary of State Directions (November 2004) Children Act 1989(1989) and 2004 (2004) United Nations Convention on the Rights of the Child Working Together to Safeguard Children (2006) London Child Protection Procedures (2003) Criminal Law – Offences against Persons Act (1861)	

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Data Protection Act (1998) Human Rights Act (1998) Health and Safety Act (1974) Child protection policy and procedure (2002) NHS 20/November/2003. National Audit Office Report on Violence in the NHS NHS Business Services Authority, Security Management Division – 'Prevention and Management of Violence where withdrawal of treatment is not an option' – 2007.	

Trust Associated Documents
POLCPCM023 - Missing Persons Policy and Workbook (1 attachment)
POLCS007 - Lone Worker Policy (1 attachment)
POLCPCM030 - Discharge Policy (1 attachment)
POLCPCM027 - Safeguarding and Protecting Children Policy (1 attachment)
POLCHR038 - Learning Education and Development Policy (1 attachment)
GUCPCM001 - Safeguarding Vulnerable Adults (1 attachment)
POLCGR101 - Restraint, Seclusion & Emergency Medication Policy (1 attachment)
OTCS060 - Violence Aggression and Disruptive Behaviour - Adult Pathway
SOP0106 - Violence Aggression and Disruptive Behaviour - First Response
OTCGR154 - Violence Aggression and Disruptive Behaviour - Information Card for Symphony and Oasis Alerts
SOP0107 - Violence Aggression and Disruptive Behaviour - Investigation Procedure
SOP0147 - Violence Aggression and Disruptive Behaviour - Warning Escalation - Adults
OTCS064 - Violence and Aggression - Emergency Clinical Care Risk Assessment
OTCS061 – ViolenceAggression and Disruptive Behaviour - Red and Amber Alert Leaflet

Violence, Aggression and Disruptive Behaviour Policy

10   Appendix 1

		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:	no	Policy does not apply to patients who are not competent to take responsibility for their actions
	▪ Age	no	
	▪ Disability	no	
	▪ Gender reassignment	no	
	▪ Marriage and civil partnership	no	
	▪ Pregnancy and maternity	no	
	▪ Race	no	
	▪ Religion or belief	no	
	▪ Sex	no	
	▪ Sexual orientation	no	
2	Is there any evidence that some groups are affected differently?	no	
3	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?		
4	Is the impact of the policy/guidance likely to be negative?		
5	If so can the impact be avoided?		
6	What alternatives are there to achieving the policy/guidance without the impact?		
7	Can we reduce the impact by taking different action?		

END OF DOCUMENT

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Report to the Board of Directors

Board Date: 24 November 2016

Title of Report	Corporate Policy: Medicines Management
Presented by	Diana Hamilton-Fairley
Lead Director	Diana Hamilton-Fairley
Committees or Groups who have considered this report	Medicines Management Committee Executive Group
Executive Summary	Further to discussions between the Chief Executive and the Executive Group, it was resolved to map all policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) under one of 14 overarching Policy Areas with a high level Board approved Corporate Policy covering each area. The Corporate Policy is intended to be a high level overview of the organisation's policy in the relevant area, with the detailed instructions / guidance being laid out in supporting documentation which is referenced in the Corporate Policy and therefore linked to the overarching policy document. The corporate policy areas are: • Information Governance • Consent • Complaints • Serious Incidents • Safeguarding • Emergency Planning, Resilience and Response • Human Resources/employee handbook • Health and Safety / Fire Safety • Standards of Business Conduct • Medicines Management • Risk Management • Patient Care and Management • Security and Estates • Duty of Candour • Finance Accordingly, the Corporate Policy for Medicines Management has been drafted and is attached for Board approval.
Resource Implications	N/A
Risk and Assurance	Currently there is an excessive number of policies, SOPs and AGNs in place and linkage between associated documentation

	may lack clarity and purpose. The process of creating an overarching Corporate Policy for each area is supported by a review of background documentation and the culling of documents which are superfluous or out of date. The process will streamline document management processes across the Trust.
Legal Implications/Regulatory Requirements	Corporate Policies are being drafted to reflect legal and regulatory requirements.
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Executive Group have reviewed the policy and recommend that the Board approves the new Corporate Policy for Medicines Management.
Purpose & Actions required by the Board :	Approval ✓ Assurance ☐ Discussion ☐ Noting ☐

Medicines Management Policy

Author:	Chief Pharmacist
Document Owner:	Medicines Management Committee
Revision No:	6
Document ID Number	POLCPCM033
Approved By:	Medicines Management Committee
Implementation Date:	September 2016
Date of Next Review:	September 2017

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MEDICINES MANAGEMENT POLICY

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

Consultation
Medicines Management Committee

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MEDICINES MANAGEMENT POLICY

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

1   Introduction

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

2   Aim

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

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

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

2.4   The key components of this policy include:

        2.4.1   Storage, security and ordering of medicines

        2.4.2   Prescribing (and other legal mechanisms for authorising supply/ administration of medicines)

        2.4.3   Administration of medicines

        2.4.4   Dispensing and issue of medicines

        2.4.5   Monitoring of medicines management processes

3   Roles & Responsibilities

3.1   Chief Executive Officer

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

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

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

3.2   Executive Directors

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

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

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

3.2.2.2 All managers are competent to discharge their medicines management responsibilities

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

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

3.3 Executive Lead for Medicines Management

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

3.4 Medicines Management Committee

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

3.4.2 See also MMC Terms of Reference.

3.5 Director of Nursing and Chief Pharmacist must:

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

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

3.6 Controlled Drugs Accountable Officer

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

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

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

MEDICINES MANAGEMENT POLICY

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

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

3.6.1.5   Ensure adequate destruction and disposal arrangements for controlled drugs.

3.6.1.6   Ensure relevant individuals receive appropriate training.

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

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

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

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

3.7   Chief Pharmacist is responsible for:

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

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

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

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

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

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

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

3.7.8   Developing a system to provide an audit trail of all medicines at points of transfer (e.g. on handover from Pharmacy to clinical area), with particular reference to

drugs which require special handling, notably Controlled Drugs (CDs) and drugs requiring refrigeration.

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

3.7.10   Auditing the implementation of medicines handling policies and systems.

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

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

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

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

3.8   Heads of Nursing are responsible for:

3.8.1   Ensuring operational implementation of this policy within clinical areas

3.9   Senior Sisters/ Senior Charge Nurses are responsible for:

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

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

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

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

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

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

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

3.10   Registered Nurses and Midwives:

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

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

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

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

3.11 Prescribers (doctors and non-medical prescribers):

3.11.1 Will prescribe appropriate medicines for patients in their care.

3.11.2 Will prescribe legally and legibly.

3.11.3 Will only prescribe within their sphere of competence.

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

3.12 Pharmacists:

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

3.13 Pharmacy Support Staff

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

3.14 All healthcare staff who handle, supply or administer medicines:

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

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

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

3.16 Medicines Management Committee

3.16.1 Will oversee all medicines management policies and procedures.

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

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

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

3.17   Directorate Management Teams

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

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

4   Definitions

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

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

5   Procurement of Medicines

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

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

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

5.4   All medicines will be procured by Pharmacy, with the exception of certain dressings and disinfectants which will be supplied via NHS Logistics. The Trust will have a formulary of

medicines and pharmacy will only procure non-formulary items in exceptional circumstances. Records will be kept of such purchases.

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

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

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

5.8 Pharmacy will ensure they procure medicines with safety in mind and will review the packaging of all new products to ensure they conform to necessary standards. They will report to the regional procurement specialist/ the Commercial Medicines Unit any identified problems.

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

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

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

6   Security of Medicines

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

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

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

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

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

6.6 The medicines keys are the responsibility of the nurse in charge although they may be held by any registered nurse or member of pharmacy staff. The key for the controlled drug cupboard must be separated from all other keys and be kept on the person of the nurse-in-charge of the ward when not being used by another registered nurse.   Clinical support workers or student nurses must not hold the keys at any time.

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

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

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

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

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

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

7 Prescribing of Medicines

7.1 Prescription Only Medicines (POMs) may be sold or supplied only in accordance with the written directions of an appropriate practitioner. An appropriate practitioner may be a doctor, dentist or non-medical prescriber. The written direction may be a patient-specific direction (PSD - e.g. an entry on the patient's drug chart) or an individual prescription.

Other methods of issuing and administering medication:

- Pharmacy-Only (P) and POM medication may also be supplied or administered using a Patient Group Direction (PGD), in accordance with the Trust's PGD policy and procedures.

- Certain groups of healthcare professionals may supply or administer medicines in the course of their professional practice, without the need for a individual prescription/ PSD/ PGD, if there is a specific exemption to medicines legislation to allow them to do this (e.g. midwife exemptions).

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

7.3 Prescribers are responsible for:

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

7.3.2 Monitoring the effects of the treatment

7.3.3 Reviewing the prescription for ongoing need

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

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

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

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

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

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

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

7.10 All prescribers must prescribe within the formulary. Prescribing recommendations made to primary care prescribers must also be on the formulary. Primary care clinicians should not

be asked to prescribe medicines not on the formulary. If a hospital prescriber initiates a non-formulary drug, the ongoing prescribing responsibility may need to remain with the secondary care prescriber.

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

8   Administration of Medicines

8.1   Responsibilities for drug administration.

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

8.1.1.1   A registered nurse or registered midwife

8.1.1.2   A radiographer

8.1.1.3   Operating Department Practitioners, NVQ Level 3

8.1.1.4   Registered Medical Officers

8.1.1.5   Pre-Registration Medical Officers

8.1.1.6   Student nurses or midwives under supervision.

8.1.1.7   Any other healthcare professional acting in accordance with a Trust-approved PatientGroup Direction.

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

8.1.3   It is recognised that there are situations where checks by a second person may be required and this need should be assessed by the registered nurse who is responsible for the administration. Such situations may be due to the status of the patient or where a drug dose needs calculation.

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

8.1.4.1   Controlled drugs (Schedule 2 or 3)

8.1.4.2   Where a calculation of dose is required

8.1.4.3   Administration to children under 12 years of age

8.1.4.4   Cytotoxic agents

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

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

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

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

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

8.1.7.1   Name of the drug

8.1.7.2   Date and time of preparation and date and time of expiry

8.1.7.3   Total amount of drug used

8.1.7.4   Name and total volume of diluent used

8.1.7.5   Final volume of preparation

8.1.7.6   Route of administration

8.1.7.7   Batch numbers of all ingredients

8.1.7.8   Names of persons preparing and checking the solution

8.1.7.9   Name of patient

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

8.2   Administration of cytotoxic drugs

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

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

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

8.3   Administration using Medicines Protocols

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

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

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

8.3.1.3 have been trained to use the protocol

8.3.1.4 deemed competent to use the protocol by their line manager

8.3.1.5 be authorised to use the protocol

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

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

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

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

8.4 Consent and covert administration

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

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

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

8.5 Non-administration of Medicines

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

8.5.2 It is important that the correct 'medicine not administered' code is recorded on the drug chart if a dose is omitted. A blank space in the medication administration

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section of the drug chart when a medication should have been administered is unacceptable practice. Such incidences should be treated as a drug error.

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

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

8.6 Self-administration of medicines

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

8.6.2 The Self Administration of Medicines policy should be referred to for full operational details; the Adult In-patient Diabetes Policy also provides additional guidance on self-administration of subcutaneous insulin.

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

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

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

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

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

9   Supply of Medicines

9.1 Dispensing, checking and supervision within Pharmacy

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

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

9.1.3 The supply of appropriate, accurately dispensed medicines is the responsibility of all those involved in the process, who must each accept responsibility for the quality of their own work. Accurate working and self-checking of dispensed items

are as important as the final check in ensuring that medicines are correctly dispensed.

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

9.2   Dispensing and checking outside pharmacy

9.2.1   *Unplanned absence/ hurriedly arranged discharges*: In the event that there is not time to have a discharge prescription dispensed by Pharmacy, or a patient decides to self-discharge without medical advice, the registered nurse/ midwife managing the discharge is responsible for supplying medicines, where this is in accordance with legal regulations, practical and safe. Medication that has already been supplied from Pharmacy to that patient, ready for discharge, (via one-stop dispensing), or pre-labelled 'To Take Out' (TTO) packs may be used to supply medication to a patient in these circumstances. In such cases, a discharge prescription (eDN) must still be written, and supplies may only be made in accordance with these written directions. Ward staff must ensure that the medicines on the eDN have been accurately transcribed from the inpatient chart, and that all the correct particulars are included on the label.

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

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

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

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

9.3   Issue of medicines to patients

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

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

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

9.3.2.2 The medicines being issued are those requested on the prescription

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

10 Risk Management

10.1 Managing errors or incidents in the use of medicines

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

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

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

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

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

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

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

10.2 Learning from incidents

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

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

10.3 Adverse Drug Reaction Reporting

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

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

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

10.4 Medicine Defect Reporting

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

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

10.5 Medication Safety Alerts and Drug Recalls

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

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

10.6 Control of substances Hazardous to Health Regulations (COSHH)

10.6.1 Some medicines are, by their nature, hazardous. COSHH regulations is the UK legislation on chemical hazards at work. The main legal duties of employers under COSHH are contained in regulations 6 -12, which cover risk assessment,

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prevention or control of exposure, use and maintenance of controls, monitoring exposure, health surveillance and provision of information and training.

11   Safe Disposal of Medicines

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

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

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

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

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

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

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

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

12   Medical Representatives and Standards of Business Conduct

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

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

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

12.4   It is accepted that liaison with pharmaceutical companies can sometimes be beneficial to the Trust and individual practitioners, but due probity must be observed. Staff must ensure they are not placed in a position which risks conflict between their private interests and their NHS

duties, or gives the appearance of such a conflict. It is an offence for a member of staff to corruptly accept gifts as an inducement. No purchase order may be issued for any item for which an offer of gifts or hospitality has been received from the person interested in supplying goods and services. Any offers of gifts, conference attendance or hospitality should be discussed by members of staff with their line manager (or the Medical Director for consultants), and if approved should be entered in the register of hospitality. Overt disclosure of any hospitality offered to a consultant, or to any member of the Drugs and Therapeutics Committee, from a pharmaceutical company in relation to a new product must be disclosed to the Drugs and Therapeutics Committee.

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

13   Training requirements for prescribing, administration and dispensing of medication

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

Table 1: Medical Staff

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

Table 2: Nursing Staff

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

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

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Table 3: Pharmacy staff

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

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

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

Table 4: Other Staff Groups

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

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

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

14   EQUALITY IMPACT ASSESSMENT STATEMENT

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

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

14.3   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.

14.4   Refer to appendix 1.

15   MONITORING & REVIEW

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

Medicines Management Policy

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

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

16   Relevant legislation

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

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

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

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

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

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

Medicines Management Policy

17	Equality Impact Assessment Tool – Appendix 1

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

END OF DOCUMENT

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Report to the Board of Directors

Board Date: 24 November 2016

Title of Report	Corporate Policy: Estates and Facilities Policy
Presented by	Darren Cattell, Director of Finance
Lead Director	Darren Cattell, Director of Finance. Claire Lowe, Director of Estates and Facilities
Committees or Groups who have considered this report	Executive Group
Executive Summary	Further to discussions between the Chief Executive and the Executive Group, it was resolved to map all policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) under one of 14 overarching Policy Areas with a high level Board approved Corporate Policy covering each area.

The Corporate Policy is intended to be a high level overview of the organisation's policy in the relevant area, with the detailed instructions / guidance being laid out in supporting documentation which is referenced in the Corporate Policy and therefore linked to the overarching policy document.

The corporate policy areas are:
- Information Governance
- Consent
- Complaints
- Serious Incidents
- Safeguarding
- Emergency Planning, Resilience and Response
- Human Resources/employee handbook
- Health and Safety / Fire Safety
- Standards of Business Conduct
- Medicines Management
- Risk Management
- Patient Care and Management
- Estates and Facilities
- Duty of Candour
- Finance

Accordingly, the Corporate Policy for Estates and Facilities has been drafted, agreed by the Executive and is attached for Board approval. |
| **Resource Implications** | N/A |
| **Risk and Assurance** | Currently there is an excessive number of policies, SOPs and |

	AGNs in place and linkage between associated documentation may lack clarity and purpose. The process of creating an overarching Corporate Policy for each area is supported by a review of background documentation and the culling of documents which are superfluous or out of date. The process will streamline document management processes across the Trust.
Legal Implications/Regulatory Requirements	Corporate Policies are being drafted to reflect legal and regulatory requirements.
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Executive Group have reviewed the policy and recommend that the Board approves the new Corporate Policy for Estates and Facilities.
Purpose & Actions required by the Board :	Approval ✓ Assurance ☐ Discussion ☐ Noting ☐

Estate and Facilities
Corporate Policy

Author:	Head of Capital and Estates Compliance
Document Owner:	Director of Estates and Facilities
Revision No:	2.0
Document ID Number	TBC
Approved By:	Trust Board
Implementation Date:	TBA
Date of Next Review:	Three years from publication

Document Control / History	
Revision No	**Reason for change**
1.0	New Corporate Policy – Draft sent to Estates and Facilities leads for consultation and input.
2.0	New Corporate Policy – Draft updated following department service lead input.

Consultation
Director of Estates and Facilities
Head of Estates
Head of Facilities
Head of Capital and Estates Compliance
Local Security Management Specialist (LSMS)
Equipment Services Manager

Table of Contents

Estates and Facilities Corporate Policy

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

1. Introduction

1.1 The Estates and Facilities directorate has a corporate responsibility to provide and maintain land, premises, equipment and all associated support facilities and services which are managed and operated efficiently and effectively, and which are safe, secure, clean, fit for purpose and appropriate to the delivery of clinical healthcare services.

1.2 The information within this overarching policy and all subsequent supporting Estates, Facilities and Security policies and procedures provides detail on how the above requirements and standards are to be met, on levels of accountability and responsibility, implementation of specific policies and procedures, benchmarking and measurement of performance, and reporting mechanisms, in order to provide assurance to the Trust Board.

2. Purpose / Aim and Objective

2.1 The purpose and aim of this document is to provide an overview of the three strands of Estates and Facilities and to identify through supporting policies and procedures the various regulatory frameworks to which the directorate is expected to work at the National level, and at Trust level.

The four strands of the Estates and Facilities Directorate are:

- Estates Services
- Facilities Services
- Medical Equipment Services
- Security Services

2.2 The objective of this document and all supporting policies and procedures is to identify, at high level and in detail, the relevant statutory regulations and standards which govern the provision of Estates and Facilities services, and to provide all Trust staff with detailed guidance, references and clarity on a range of topics relating directly to Estates and Facilities service provision in order to ensure that the principles of providing a safe, secure and clean healthcare environment are met.

3. Regulatory Frameworks

The following outlines the Regulatory frameworks which govern all Estates and Facilities activities within the Trust:

3.1 <u>National Frameworks and Regulations</u>

3.1.1 <u>Regulatory Requirements: Standards of Quality and Safety</u>

The Care Quality Commission (CQC) regulates all providers of regulated health and adult social care activities in England. The CQC's role is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

At the time of preparing this document, registration requirements are set out in the Care Quality Commission (Registration) Regulations 2009 (CQC Regulations) (Part 4) (as amended) and include requirements relating to:

- Safety and suitability of premises;

- Safety, availability and suitability of equipment; and

- Cleanliness and infection control.

The CQC is responsible for assessing whether providers are meeting the registration requirements. Failure to comply with the CQC Regulations is an offence and, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3), CQC has a wide range of enforcement powers that it can use if the provider is not compliant. The regulations stipulate that all premises and equipment used must be safe, clean, secure and suitable for the purpose for which they are being used, and properly used and maintained.

3.1.2 NHS Constitution

The NHS Constitution sets out the rights to which patients, public and staff are entitled to. It also outlines the pledges that the NHS is committed to achieve, together with responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All healthcare organisations are required by law to take account of this Constitution in their decisions and actions.

Healthcare organisations need to "ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice".

In order to deliver on this pledge, it specifically advises NHS organisations to take account of:

- National best-practice guidance for the design and operation of healthcare facilities.(HTM's and HBN's – see 3.2.1 & 3.2.2)

- The NHS Premises Assurance Model (NHS PAM).

3.1.3 Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations.

The DH have commissioned and published an independent report by Lord Carter of Coles into productivity and efficiency in non-specialist acute hospitals in England.

The report concluded that there is significant unwarranted variation across all main resource areas. The report notes that the unwarranted variations are worth £5bn in terms of efficiency opportunity and goes on to make 15 recommendations designed to tackle this variation and help trusts to improve their performance.

The recommendations (recommendation 6) relating to the hospital estate are summarised as follows:

- <u>Total estates and facilities running costs per area (£/m2)</u>

  Trusts are considered good if their metric is lower than £320. (The current variation is between £105 and £970)

- <u>Non clinical space (% of floor area)</u>

  Trusts are considered good if their metric is lower than 35% (The current variation is between 12% and 69%)

- <u>Unoccupied or under used space (% of floor area)</u>

  <u>Trusts are considered good if their metric is lower than 2.5%</u>

- <u>Trust are required to have in place, by April 2017 a strategic estates and facilities plan to deliver the above benchmarks by April 2020 so that estates and facilities resources are used in a cost effective manner.</u>

3.1.4 Health and Safety legislation

The Health & Safety Executive (HSE) is the national regulator for workplace health and safety.

The following primary and secondary legislation places legal duties on various duty holders:

The Health and Safety at Work etc. Act 1974
The Health and Safety (Display Screen Equipment) Regulations 1992
Management of Health and Safety at Work Regulations 1999
Manual Handling Operations Regulations 1992
Personal Protective Equipment at Work Regulations 1992
Workplace (Health, Safety and Welfare) Regulations 1992
Provision and Use of Work Equipment Regulations 1998

Other regulations specific to Estates and Facilities activity are expanded further in the supporting policy documentation relating to Estates, Facilities and Security.

3.1.5 Fire Safety Legislation

The Regulatory Reform (Fire Safety) Order 2005 covers general fire safety in healthcare premises. The body responsible for enforcing this fire safety legislation is the Kent Fire and Rescue Service (KFRS)

3.1.6 NHS Premises Assurance Model (PAM)

The NHS has developed, with the support of DH, the NHS Premises Assurance Model (NHS PAM), the remit of which is to provide assurance for the healthcare environment and to ensure patients, staff and visitors are protected against risks associated with hazards such as unsafe premises.

Primarily aimed at providing governance and assurance to Trust Boards, it allows organisations that provide NHS funded care and services to better understand the effectiveness, quality and safety with which they manage their estate and facilities services and how that links to patient experience and patient safety.

Key questions are underpinned by prompt questions which require the production of evidence. Healthcare organisations should prepare and access this evidence to support their assessment of the NHS PAM.

The model also includes reference to evidence and guidance as a helpful aide-memoir to assist in deciding the level of NHS PAM assurance applicable to a particular healthcare site or organisation.

NHS PAM is designed to be available as a universal model to apply across a range of estates and facilities management services.

3.2   Estates Related Frameworks and Regulations.

3.2.1   NHS Estate code (HBN 00-08) – Strategic Framework for the Efficient Management of Healthcare Estates and Facilities.

HBN 00-08 provides information primarily related to the provision of a compliant healthcare estate and the performance of the estate in terms of efficiencies. It specifically links with Regulations 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and with regard to the safety and suitability of premises used for the delivery of healthcare.

Regulation 12 - specifically deals with the protection of users against infection

Regulation 15 - specifically deals with the protection of users against risks of unsafe and unsuitable premises.

HBN 00-08 provides information, in two parts, to all Estates and facilities professionals in the NHS on ways in which efficiencies in the running of land and property can be achieved and on the active management of land and buildings used for healthcare services.

Parts A and B cover the strategic framework references and further detailed guidance in relation to the following areas:

- improvements to the efficient and effective running of the estate;

- improved efficiency, including value for money, in capital procurement and construction;

- adherence to best practice inland management, ensuring the optimum solutions are implemented, including the identification and disposal of surplus land.

3.2.2   Health Technical Memorandum (HTM 00)

HTMs are the main source of specific guidance for all healthcare estates and facilities professionals. They give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

HTM 00 is supported by the HTM suite of guidance. The aim of HTM 00 is to ensure that everyone concerned with the strategic and operational management, design, procurement and use of the healthcare facility understands the requirements (including regulatory) of the specialist, critical building and engineering technology involved. The core guidance (including professional support) is applicable to all building engineering services including those not covered by HTMs (for example, steam, gas and pressurised hot water services).

HTM 00 addresses the general principles, key policies and factors common to all engineering and building services within a healthcare organisation.

Key issues include:

- Compliance with policy and relevant legislation;

- Professional support and operational management policy;

- Design and installation;

- Maintenance;

- Training requirements.

3.2.3 Health Building Notes (HBN's) and Health Technical Memoranda (HTM's)

HBN's and HTM's are the main source of guidance to all healthcare estates and facilities professionals on the specific planning and design requirements for healthcare environments and settings.

Health Building Notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/ extension of existing facilities.

Health Technical Memoranda provide best practice guidance on the design, operation, commissioning and maintenance of a range of healthcare engineering systems and equipment.

3.2.4 Sustainability Regulatory Frameworks.

- UK Climate Change Act (2008)

- National Adaptation Programme (NAP)

- The Carbon Reduction Commitment Energy Efficiency Scheme (CRC)

- The Civil Contingencies Act (2004) (CCA)

3.3 Facilities related Frameworks and Regulations.

3.3.1 Catering Services

The catering department provides nutritional support, food and hydration for patients, staff and members of the public. The guidance and regulatory frameworks that the catering department are governed by are listed below:

- The Food Safety Act 1990

- The General Food Hygiene Regulations 2004

- Food Hygiene (England) Regulations 2006
- D.H.S.S. Guidelines For Cook/ Chill & Cook / Freeze Meals
- NHS Codes of Practice for the manufacture, distribution & Supply of Food, ingredients and related products
- Food Information for Consumers Regulation 2014 (Allergens)
- Local council Food premises registration

3.3.2 Housekeeping Services

The guidance and regulatory frameworks that the Housekeeping department are governed by are listed below:

- PAS 5748 (2014): Specification for the planning, measurement and review of cleanliness services in hospitals.
- The national specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes April 2007.

3.3.3 Waste & Transport Services

The Waste and Transport Department manages all domestic, clinical, confidential and recycling waste activities and all Trust owned and leased vehicles. The frameworks and guidance governing the waste and transport services are listed below:

Waste

- HTM 07-01 Management & disposal of healthcare waste
- The Environmental Protection Act 1990 (including the Duty of Care Regulations)
- The Hazardous Waste Directive 2011
- The Waste (England and Wales) Regulations 2011

Transport

- Road Traffic Act 1991
- EU drivers hours regulations(EC)561/2006

3.3.4 Portering Services

The Portering Services department manages the movement of patients, records, general and medical equipment.

The frame work and guidance governing the Portering service is shown below:

- HTM02-01 (Medical Gas Pipeline systems)
- Pressure Equipment Regulations of 1999

3.3.5 Laundry Services

The Laundry department provide linen services for the Trust.

The framework and guidance governing the Laundry Service is:

- HTM 01-04 (Decontamination of Linen for health and social care)

3.4 Medical Equipment Services related Frameworks and Regulations:

3.4.1 The framework and guidance governing the Equipment Services Department is shown below:

- SI 2002 (618): The Medical Devices Regulations 2002;

- MHRA Managing Medical Devices: Guidance for Health and Social Services Organisations April 2015;

- IEC62353 (Ed10) Medical Electrical Equipment: Recurrent test and test after repair of medical electrical equipment.

3.4.2 There are three principal policies relating to Medical Equipment and Devices which ensure that the Trust is compliant with regard to the requirements of the MHRA and CQC for managing Medical Devices:

- Management of Reusable Medical Devices and Equipment;

- Training of Staff with Medical Equipment;

- Management of Single Use and Single Patient Use Medical Devices.

3.5 Security related Frameworks and Regulations.

3.5.1. NHS PROTECT: NHS Protect is a division of the NHS Business Services Authority and has nationwide overall responsibility for all strategy, policy and operational matters related to the management of security within the delivery of NHS services in England. The aim of the NHS Protect is a simple one - to protect the NHS so that it can better protect the public's health.

NHS Protect publicises yearly Security Standards for Providers which serve as a framework for security arrangements at providers. Medway NHS FT aims to implement these standards in every aspect of the healthcare services provided.

3.5.2. There are three CQC Outcomes that relate to security management. They are both part of the core 16 quality and safety standards:

Outcome 7: Safeguarding people who use services from abuse. "Abuse", in relation to a service user, means—

- sexual abuse;

- physical or psychological ill-treatment;

- theft, misuse or misappropriation of money or property; or

- neglect and acts of omission which cause harm or place at risk of harm

Outcome 10: Safety and suitability of premises. Service users and others having access to premises are protected against the risks associated with unsafe or unsuitable premises, by means of

- suitable design and layout;
- appropriate measures in relation to the security of the premises
- adequate maintenance and, where applicable, the proper:
  - o operation of the premises, and
  - o use of any surrounding grounds

Outcome 15 (b): Premises and equipment. Security arrangements must make sure that people are safe while receiving care, including:

- Protecting personal safety, which includes restrictive protection
- Protecting personal property and/or money
- Providing appropriate access to and exit from protected or controlled areas
- Not inadvertently restricting people's movement
- Providing appropriate information about access and entry
- Using the appropriate level of security needed in relation to the services being delivered.

  In addition, if any form of surveillance is used for any purpose, the provider must make sure that this is done in the best interests of people using the service.

The CQC is a signatory to the joint information sharing protocol with NHS Protect.

3.5.3 Other security management components, such as Security Management, Lock Down Plan, CCTV, Violence, Aggression and Disruptive Behaviour, are covered in Trust policies where regulation and legislation is detailed further.

4.   (Duties) Roles & Responsibilities

4.1   Trust Board

4.1.1 Responsible for approving the Trust's Corporate Policy for Estates and Facilities.

4.1.2 Responsible for reviewing and approving the annual report to the Board on Estates and Facilities activity and performance.

4.1.3 Responsible for understanding the statutory frameworks governing the delivery of Estates and Facilities services and assuring itself on the adequacy of the Trust arrangements for meeting the requirements of these frameworks.

4.2 Chief Executive

4.2.1 Department of Health Guidance (HBN00-08 Part A: Strategic framework for the efficient management of healthcare estates and facilities) indicates that the Chief Executive, as an accountable officer, has a corporate responsibility to enact the principles set out in HBN00-08.

4.2.2 To support this arrangement an Executive is designated to take responsibility for Estates and Facilities on behalf of the organisation.

4.3 Director of Finance

4.3.1 Is the designated Executive for Estates and Facilities services with responsibility for ensuring that the Trust has resources, plans and policies in place to fulfil the requirements of the statutory frameworks.

4.3.2 Is the nominated Security Management Director, as registered with NHS Protect, and as such the responsible lead for security related issues within the Trust.

4.4 Director of Estates and Facilities

4.4.1 Has overarching responsibility for the effective and efficient management and delivery of all Estates, Facilities and Security services within the Trust and for development of policies and procedures in support of these functions.

4.5 Head of Estates

4.5.1 Is responsible for the management and delivery of all Estates Operational services in line with the Regulatory and NHS frameworks and specific standard operating procedures described within Estates policies.

4.6 Head of Capital and Estates Compliance

4.6.1 Is responsible for the management and delivery of the Trusts Capital, Estates and Facilities Compliance and Sustainability Programmes and for the development of programmes for capital schemes in line with the Trusts overarching strategies, clinical strategies and local and national healthcare regulatory frameworks and guidance.

4.7 Head of Facilities

4.7.1 Is responsible for the management and delivery of the catering, housekeeping, waste and transport, portering and laundry services in line with Trust policies and overarching procedures, and in line with governing regulations and regulatory/NHS frameworks described within this policy.

4.8 Equipment Services Manager

4.8.1 Is responsible for ensuring the delivery of the Medical Equipment Service in line with Regulatory and NHS Frameworks and specific and standard operating procedures described in this policy and covering Medical Devices Policies.

4.9   Head of Security

4.9.1 Is responsible for the provision of Trust wide operational support regarding the security of staff, assets and premises, in line with security related Trust, national security policies and standard operating procedures.

4.10   Local Security Management Specialist (LSMS)

4.10.1 Follows the NHS Protect framework of the Security Standards to provide an overarching security approach within the Trust.

5.   Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Every three years	Director of Estates and Facilities	Director of Finance	Where deficiencies are recognised - action plans will be put into place and reviewed regularly.
Estates and Facilities Directorate performance against Regulatory Frameworks and DH requirements.(DH Level)	Through annual review of PAMs/ERIC metrics Feedback from NHS Improvement & DH. Through ongoing review of metrics relating to Carter review recommendation 6.	Head of Capital and Estates Compliance	Director of Estates and Facilities	Where deficiencies are recognised - action plans will be put into place and reviewed regularly.
Estates and Facilities Directorate performance against Regulatory Frameworks and DH requirements.(Trust Level)	Through ongoing Estates & Facilities compliance forums and Senior Management Teams. Through annual PAMs review and Benchmarking through ERIC.	Head of Capital and Estates Compliance (in conjunction with Head of Estates)	Director of Estates and Facilities	Where deficiencies are recognised - action plans will be put into place and reviewed regularly

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What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Staff training and awareness	Through annual review of training statistics and review and update of training needs matrices.	All E+F Heads of Service	Director of Estates and Facilities	Where shortfalls in training completion are identified - actions will be taken to ensure that training requirements are fulfilled and monitored on a monthly basis until all training is up to date
Staff training and awareness	Through review of individual staff personal development plans at Achievement reviews.	All E+F Managers and Heads of Service	Director of Estates and Facilities	Where shortfalls in training completion are identified - actions will be taken to ensure that training requirements are fulfilled and monitored on a monthly basis until all training is up to date
Implementation and Monitoring/Review	Through sign off processes/collation of evidence on usage of policies (i.e. derogation schedules/design team minutes and specification content). Reviewed annually as part of Estates and Facilities compliance audit	Head of Capital and Estates Compliance	Director of Estates and Facilities	Where deficiencies are recognised - action plans will be put into place and reviewed regularly

6.   Training and Implementation

6.1   This policy and all subsequent subordinate estates and facilities policies will be implemented through directorate and service level forums such as Senior Management Team meetings, Project Team meetings and Design Team meetings, and also through group and individual training and awareness sessions.

6.2   All Estates and Facilities staff will receive formal training in all areas of expertise and competency required, and to ensure that the requirements of the regulatory framework are met in full.

6.3   Training needs analysis will take place through individual performance reviews and development plans, and through departmental analysis of the requirements for staff ratios and skill mix to ensure that suitably trained and competent staff are always available.

6.4   The Estates and Facilities directorate will undertake regular reviews of training requirements and will take steps to ensure that suitably trained staff will be in place where legislative requirements deem, where legislation changes over time and where new legislation is introduced.

6.5   In terms of the requirement to monitor and review effectiveness, the Estates and Facilities Directorate will undertake an annual audit of estates and facilities, security and equipment services compliance in order to identify gaps in compliance, to generate action plans and to provide assurance to the Trust that the requirements of the previously stated regulatory frameworks are met.

7. Equality Impact Assessment Statement & Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide "evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]"; in effect to undertake equality impact assessments on all procedural documents and practices. Authors should use the Equality Impact Toolkit to assess the impact of the document.

In the first instance this will mean screening the document and, where the screening indicates, completing a full assessment. The Toolkit can be found on the Trust website http://www.medway.nhs.uk/our-foundation-trust/publications/equality-and-diversity/equality-impact-assessments/

A document will not be considered approved until the author has confirmed that the screening process has been carried out and where required a full impact assessment has been completed. Where a full assessment is completed this should be submitted along with the document for approval.

8. References

Document	Ref No
References:	
Care Quality Commission (Registration) Regulations 2009 (CQC Regulations)	
The NHS Constitution	
Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations. (an independent report for the Department of Health by Lord Carter of Coles) (February 2016)	
The Health and Safety at Work etc. Act 1974	
Secondary Health and Safety related regulations (various)	
The Regulatory Reform (Fire Safety) Order 2005	
NHS Premises Assurance Model (PAM) (2016)	
NHS Estatecode (HBN 00-08) – Strategic Framework for the Efficient Management of Healthcare Estates and Facilities. (2014)	
UK Climate Change Act (2008)	

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National Adaptation Programme (NAP)	
The Carbon Reduction Commitment Energy Efficiency Scheme (CRC)	
The Civil Contingencies Act (2004) (CCA)	
The Food Safety Act 1990	
Food Information for Consumers Regulation 2014 (Allergens)	
Local council Food premises registration	
D.H.S.S. Guidelines For Cook/ Chill & Cook / Freeze Meals	
NHS Codes of Practice for the manufacture, distribution & Supply of Food, ingredients and related products	
The General Food Hygiene Regulations 2004	
Food Hygiene (England) Regulations 2006	
PAS 5748 (2014): Specification for the planning, measurement and review of cleanliness services in hospitals.	
The national specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes April 2007.	
HTM 07-01 Management & disposal of healthcare waste	
The Environmental Protection Act 1990 (including the Duty of Care Regulations)	
The Hazardous Waste Directive 2011	
The Waste (England and Wales) Regulations 2011	
Road Traffic Act 1991	
EU drivers hours regulations(EC)561/2006	
HTM02-01 (Medical Gas Pipeline systems)	
Pressure Equipment Regulations of 1999	
HTM 01-04 (Decontamination of Linen for health and social care)	
SI 2002 (618): The Medical Devices Regulations 2002	
MHRA Managing Medical Devices: Guidance for Health and Social Services Organisations April 2015	
IEC62353 (Ed10) Medical Electrical Equipment: Recurrent test and test after repair of medical electrical equipment	
Trust Associated Documents:	
Estates and Facilities Directorate - Operational Estates Policy	
Estates and Facilities Directorate - Operational Facilities Policy	
Estates and Facilities Directorate - Operational Security Policy	
Estates and Facilities Directorate - Operational Equipment Policy	

END OF DOCUMENT

Report to the Board of Directors

Board Date: 24 November 2016

Title of Report	Corporate Policy: Finance Policy
Presented by	Darren Cattell, Director of Finance
Lead Director	Darren Cattell, Director of Finance
Committees or Groups who have considered this report	Executive Group
Executive Summary	Further to discussions between the Chief Executive and the Executive Group, it was resolved to map all policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) under one of 14 overarching Policy Areas with a high level Board approved Corporate Policy covering each area. The Corporate Policy is intended to be a high level overview of the organisation's policy in the relevant area, with the detailed instructions / guidance being laid out in supporting documentation which is referenced in the Corporate Policy and therefore linked to the overarching policy document. The corporate policy areas are: • Information Governance • Consent • Complaints • Serious Incidents • Safeguarding • Emergency Planning, Resilience and Response • Human Resources/employee handbook • Health and Safety / Fire Safety • Standards of Business Conduct • Medicines Management • Risk Management • Patient Care and Management • Estates and Facilities • Duty of Candour • Finance Accordingly, the Corporate Policy for Finance has been drafted, agreed by the Executive and is attached for Board approval.
Resource Implications	N/A
Risk and Assurance	Currently there is an excessive number of policies, SOPs and AGNs in place and linkage between associated documentation

	may lack clarity and purpose. The process of creating an overarching Corporate Policy for each area is supported by a review of background documentation and the culling of documents which are superfluous or out of date. The process will streamline document management processes across the Trust.
Legal Implications/Regulatory Requirements	Corporate Policies are being drafted to reflect legal and regulatory requirements.
Recovery Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Executive Group have reviewed the policy and recommend that the Board approves the new Corporate Policy for Finance.
Purpose & Actions required by the Board :	Approval ✓ Assurance ☐ Discussion ☐ Noting ☐

Corporate Policy: Finance Policy

Author:	Daniel Thompson, Acting Financial Controller
Document Owner:	Darren Cattell , Interim Finance Director
Revision No:	1
Document ID Number	
Approved By:	
Implementation Date:	
Date of Next Review:	[one year from approval]

Document Control / History	
Edition No	**Reason for change**
1	New policy

Consultation
Executive Group

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Finance Policy

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

1	Introduction

1.1 All NHS-funded organisations must meet the requirements of the NHS Act 2006 which states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officers' Memorandum issued by the Independent Regulator.

2	Purpose / Aim and Objective

2.1 The Chief Executive as Accounting Officer has responsibility for the overall organisation, management and staffing of the Trust and for its procedures in financial and other matters. The Accounting Officer must ensure that:

    2.1.1 There is a high standard of financial management with the Trust as a whole;

    2.1.2 financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the NHS FT; and

    2.1.3 Financial considerations are fully taken into account in decisions on Trust policy proposals.

2.2 This should be read in conjunction with the Trust's Standing Financial Instructions (SFIs) which are issued for the regulation of the conduct of the Trust, its directors and officers in relation to all finance matters with which they are concerned, and in conjunction with all other finance policies and procedures as directed by the SFIs.

3	Definitions

3.1 Section not used

4	(Duties) Roles & Responsibilities

4.1 **The Trust Board**

    4.1.1 The Board exercises financial supervision and control by:

    (a) Formulating the financial strategy;

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

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

    (d) Defining specific responsibilities placed on members of the Board and employees as indicated in the Scheme of Delegation document.

4.2   **The Director of Finance**

   4.2.1   The Director of Finance is responsible for:

      (a)   The Standing Financial Instructions and for keeping them up to date;

      (b)   Implementing the Trust's financial policies and for coordinating any corrective action necessary to further these policies;

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

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

   4.2.2   And, without prejudice to any other functions of the Trust, and employees of the Trust, the duties of the Director of Finance include:

      (e)   The provision of financial advice to other members of the Board and employees;

      (f)   The design, implementation and supervision of systems of internal financial control;

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

4.3   **Board Members and Employees**

   4.3.1   All members of the Board and employees, severally and collectively, are responsible for:

      (a)   The security of the property of the Trust;

      (b)   Avoiding loss;

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

      (d)   Conforming to the requirements of Standing Orders, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation, Constitution and Terms of Authorisation.

4.4   **Contractors and their employees**

   4.4.1   Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall

be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

4.5   **Use of the policy**

4.5.1   This policy does not provide detailed procedural advice and should be read in conjunction with detailed departmental and financial procedure notes. All financial procedures must be approved by the Director of Finance.

4.5.2   The Integrated Audit Committee is responsible for approving all detailed financial policies. These detailed policies will be published and maintained on the Trusts intranet.

4.5.3   Should any difficulties arise regarding the interpretation or application of this policy or any other financial policy or procedure then the advice of the Director of Finance must be sought before acting. The user of this policy should also be familiar with and comply with the provisions of the Trust's constitution, standing orders and scheme of delegation.

Finance Policy

5   Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	First review in one year and then every three years	Author		Where gaps are recognised action plans will be put into place

6   Training and Implementation

6.1

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 strategy 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.

7.4   Refer to appendix 1.

8   References

Document	Ref No
References:	
NHS Foundation Trust Accounting Officers' Memorandum	
DH Group Accounting Manual	
Trust Associated Documents	
Trust Standing Financial Instructions	OTCGR037
Standing Orders	
Reservation of Powers to the Board and Delegation of Powers Including Detailed Scheme of Delegation	POLCF002
All Finance Policies and Procedures as available on the Trust Intranet	

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Appendix 1

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

END OF DOCUMENT

Report to the Trust Board of Directors

Date: 24 November 2016

Title of Report	**Risk Management and Assurance Framework**
Presented by	Lynne Stuart
Lead Director	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Executive Group 16.11.2016
Executive Summary	This report gives assurance on the on-going review of the Corporate Risk Register and Board Assurance Framework, as outputs to date from the Risk Management Improvement Project • The Board are requested to approve the Risk Appetite Statement (appendix 1). • The Board are requested to receive the Corporate Risk Register report generated from RiskAssure (appendix 2) noting the enhanced details of mitigating actions and controls amalgamated from the Trust wide related risks. • The Board Assurance Framework (appendix 3), is provided for discussion, with particular reference to the gaps and assurances detailed.
Resource Implications	N/A
Risk and Assurance	Set out in report.
Legal Implications/Regulatory Requirements	The Board is responsible for ensuring that the organisation has appropriate risk management processes in place to manage 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.
Recovery Plan Implication	Governance and Standards

Quality Impact Assessment	N/A
Recommendation	The Board are asked to:- • Approve the Risk Appetite Statement for 2016/2017 • Receive and note the Corporate Risk Register (CRR) • Receive and note the Board Assurance Framework (BAF)
Purpose & Actions required by the Board :	Approval ✓ Assurance ✓ Discussion ✓ Noting ☐

Risk Management and Assurance Framework – November 2016

1. EXECUTIVE SUMMARY

1.1.   The Corporate Risk (CRR) register has now been built on the RiskAssure system, with associated linked risks across the Trust.

1.2.   The CRR has been reviewed and revised by the Executive Group on 16 November as detailed below.

2. RISK APPETITE STATEMENT

2.1.   Following feedback and suggested changes to the Risk Appetite Statement in the quality and patient safety section from one board member at the September Board meeting, the Executive leads for quality and safety considered these with the Director of Corporate Governance. After due consideration the executive leads determined that the original submission to the Board made in September was preferable and accurate as it was felt that the proposed changes reduced the clarity in the original Statement. The Board are therefore requested to approve the Risk Appetite Statement at appendix 1.

3. CORPORATE RISK REGISTER (CRR)

3.1.   The CRR was reviewed by the Board in September 2016 and subsequently the information was formulated into a Corporate Risk Register on RiskAssure, with initial scoring as agreed by the Board and controls in place relative to the amalgamation of control in place across the Trust.

3.2.   The CRR report from RiskAssure is given at appendix 2. Following review by the Executive Group some changes have been made in terms of risk title and description and some current scores have been reduced as a result of Executive review of mitigation in place across the Trust; these are as follows:-

- **CRR-2016-007 Estates**, score reduced from 16 (C4xL4) to 12 (C4xL3). This is in recognition of the improvements made in the working of the Estates function, the progression of works and implementation of early warning systems.

- **CRR-2016-012 Deteriorating Patient**, score reduced from 12 (C4xL3) to 8 (C4xL2). This is reflective of the progression of the Deteriorating Patients programme work stream including: the recent launch of Professional Standards for recognising and responding to unwell patients to ensure clinicians are well equipped and trained to manage these patients; and the launch of a Treatment Escalation Plan, NEWS, Sepsi and AKI e-learning and intentional hospital rounding overnight.

- **CRR-2016-009 Patient Flow**, replaced with 2 separate risks to describe patient safety scoring [12 (C4xL3)] and regulatory intervention scoring [10 (C5xL2)] aspects of patient flow.

- **CRR-2016-002 Medical Staffing**, Update to risk description and actions in place to address.

- **CRR-2016-006 Medicines Management,** Update to risk description.

4. BOARD ASSURANCE FRAMEWORK (BAF)

4.1.   The Board Assurance Framework (appendix 3), is provided for discussion, with particular reference to the gaps and assurances detailed.

5. INTERNAL AUDIT

5.1.   The Trust Risk Management arrangements will be subject to internal audit by KPMG in early February 2017.

6. REGULAR REVIEW OF DIRECTORATE RISK REGISTERS

6.1.   Weekly scheduled risk register reports are generated automatically from RiskAssure and emailed to the Directorate Director and copied to the Risk Governance Lead within the Directorate. These reports are support the process of review, oversight and escalation within the Directorates.

6.2.   As the Risk Improvement processes are embedded across the Trust, the Risk Governance Team continue to support the Directorates in terms of risk management process and procedure and best practice in terms of risk description, mitigation and scoring.

7. APPENDICES

1. Risk Appetite Statement
2. Corporate Risk Register
3. Board assurance framework

Risk Appetite Statement

Author:	Director of Corporate Governance, Risk, Compliance & Legal – Lynne Stuart
Document Owner	Director of Corporate Governance, Risk, Compliance & Legal – Lynne Stuart
Revision No:	1
Document ID Number	OTCGR176
Approved By:	Trust Board
Implementation Date:	
Date of Next Review:	

Risk Appetite Statement

Document Control / History	
Revision No	**Reason for change**
1	New document created

Consultation
Executive Group

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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 currently in special measures with its regulators, the Trust Board has taken a cautious view regarding the risks that it is prepared to take in terms of risks to quality, patient safety, financial controls, reputation, compliance and regulation, workforce and external stakeholders, expressing a preference for safe delivery options that have a low degree of risk and which may only have a limited potential for reward.

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 significant regulatory scrutiny due to being rated "Inadequate" by the Care Quality Commission. Additionally the Trust is in breach of its licence conditions which are monitored by NHS Improvement. The Trust is keen to return to regulatory compliance as soon as practicable 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.

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.

Risk Appetite Statement

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 to good outcomes. The Trust therefore has a moderate appetite for risks that may cause reputation 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 but has greater tolerance for service delivery that may be sub-optimal in terms of quality and patient experience, but is still clinically safe. The Trust will avoid taking risks that will compromise patient safety.

Medway NHS Foundation Trust has long-standing quality and safety issues in some areas of its operation. The Board acknowledges that the Trust's risk appetite is likely to be exceeded in the short-term (a period of up to 12 months) whilst it is progressing sustainable improvements.

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 and, 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   Risk Appetite Summary Table

The diagram below summarises the Trust's risk appetite across these domains.

Domain	Appetite	Likelihood	Consequence	Score (trigger level)
Financial/Value for money	Moderate	3	2	6
Compliance and regulation	Moderate	2	2	4
Innovation	High	3	3	9
Reputation	Moderate	3	2	6
Quality and Patient Safety	Moderate	2	2	4
Workforce	Moderate	2	2	4
External Stakeholders	Moderate	3	2	6

Risk Appetite Statement

10   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 VfM).
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.

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Appendix 2 - Corporate Risk Register 18.11.2016

Corporate Risk Register

Corporate Risk Register

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-010	Performance	Failure to meet national performance standards results in delayed diagnosis and harm to patients, financial penalties and reputation damage.	Corporate _Quality / Audit	4	4	16	16 (4x4)	04 (2x2)	Potential moderate/serious harm events due to delayed diagnosis and subsequent treatment, poor patient experience with potential for complaints and claims. Financial penalties Reputational damage	Lesley Dwyer	Chief Executive	26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
In relation to the 18 week target, the Surgical Directorate has initiated outsourcing. Capacity and Demand models have been implemented and there is a new Lead in post to review and challenge performance. Cancer waiting times and performance - Weekly monitoring of Patient tracking list (PTL), agreed trajectory and breach reports. RCA's to interrogate reasons for delays and to implement remedial actions. Cancer remedial action and improvement plan in place. Mortality reviews are in place in all specialties within the Directorates and are taking place routinely. Trust Mortality Learning Coordinator in place and assisting with the quality of reviews and their outcomes. Mortality Data scrutinised at all levels of the Directorate Governance Structures.	PTL meetings and subsequent actions taken are impacting on the theatre lists. Trust Mortality performance is showing significant improvements, HSMR's are improving with the exception of 'acute and unspecified Renal Failure' which remains an outlier. AKI reporting app has been launched, Outreach team review and visit identified patients daily.	For oversight Executive further sub groups are in development, Performance Review Meetings are taking place. Reporting structure and templates have been developed and disseminated to Executives on 14.06.2016.	Lesley Dwyer	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-001	Nurse Staffing	Nursing staff shortages may lead to sub optimal care, impacting on patient safety processes and clinical outcomes	Corporate Staffing/ Competence	3	5	15	15 (3x5)	04 (2x2)	Potential patient harm events Potential complaints and claims Increased agency use and associated increased cost Potential regulatory action by CQC Potential increased staff stress and potential increased staff sickness	Karen Rule	Director of Nursing	26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Reviewing staff on a daily basis, shift by shift relocating staff to ensure safety. Vacant posts being filled by agency staff where possible and ensuring robust induction for these staff.		New advertising recruitment campaign for the region to be launched October – targeting nurses. Business Critical posts identified and extra recruitment resource and priority given. Streamlining recruitment process to make it easier/quicker for candidates to apply. Recruitment exhibition stands at both the BMJ and AGM Conferences in London October and November. Overseas recruitment for NICU nurses and EU nurses active.	Karen Rule	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-005	Emergency Department	Physical restrictions in the layout of ED leads to overcrowding which impacts on patient care. Resus and Trolleys area of the ED are not suitable for the service provided, or big enough to accommodate the potential number of people using the service at any one time.	Corporate _Service/Business Interruption	3	5	15	15 (3x5)	04 (2x2)	Potential patient harm events. Increased complaints and potential claims Inability to comply with statutory regulations and meet patient care targets, leading to adverse financial and reputational loss.	Margaret Dalziel	Director of Clinical Operations - ACC	26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Controls have been put in place as detailed in cohorting escalation policy. Patients in all ED are being frequently reviewed to ensure patient safety and prompt escalation where appropriate.	Latest audits show improvement in all clinical indicators associated with cohorting area.	ED new build project underway in staged process to ensure patient safety.	Margaret Dalziel	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-007	Estates	The combination of under investment in a dilapidated estate and the absence of a coherent strategic approach to the management of estates means that the infrastructure does not meet business needs and capital funding and resources may be insufficient to deliver what is required	Corporate _Service/Business Interruption	4	4	16	12 (4x3)	04 (2x2)	Service disruption due to estates issues may impact adversely on patient safety. Potential regulatory action due to non compliance with building regulations. Financial impact of remedial action leading to non compliance with financial restrictions placed on the Trust.	Claire Lowe	Director of Estates and Facilities	26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
New Director of Estates and Facilities in post prioritising work required. Estates Infrastructure Governance Group developed Estates business continuity plans in place.		Business Impact Assessment for Estates Project Team and Operational Estates procedure in place since August 2016. Various business cases underway across the Trust in relation to Estate improvements required.	Claire Lowe	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-008	Equipment Failure	Significant high value equipment that is out of date and past its replacement date may not be reliable or fit for purpose impacting on service delivery and income	Corporate _Service/Business Interruption	4	3	12	12 (4x3)	04 (2x2)	Potential for service disruption with adverse impact on patient care. Inability to meet the demands of the service with potential for delayed diagnosis and or treatment. Increased maintenance costs with associated financial impact.	Darren Cattell	Director of Finance	26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Risk based Medical Devices replacement Programme in place for up to 150k replacement , annual replacement Programme but 10% of overarching allocated budget retained as contingency for ongoing urgent replacement. Business case as required over 150k replacement.	All reported controls being applied	Consideration of alternative funding arrangements, such as managed equipment services to provide advance budgeting of equipment within services.	Darren Cattell	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-009A	Patient Flow - Patient Safety Risk	Due to failure to meet operational performance standards and maintain effective patient flow there is a risk of delayed diagnosis, treatment and/or discharge of patients.	Corporate _Patient Safety	4	3	12	12 (4x3)	04 (2x2)	Potential avoidable moderate / serious harm to patients Potential regulatory intervention	Karen Rule	Director of Nursing	17/11/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Implementation of improvement Programmes (as part of the Trust Recovery Programme), including in relation to: a) Reducing delays to the diagnosis and treatment of patients (e.g. Medical model, Planned Care and Outpatients) b) Identifying risks to patients and preventing them from crystallising (deteriorating patients, transforming nursing care, governance and standards); and c) Ensuring we have appropriate numbers of sufficiently skilled staff (workforce)	Improved performance against key safety and operational performance indicators (KPIs).	Delivery of Recovery programme remains in progress; regulatory standards are not yet consistently achieved (in some cases with much still to be done). Contractual operational performance improvement trajectories are not being achieved.	Karen Rule	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-015	Finance	Failure to achieve planned financial control total through Cost Improvement Plans and Carter Review efficiencies across the Trust affects the financial sustainability and Going Concern assessment of the Trust.	Corporate _Finance	4	3	12	12 (4x3)	06 (2x3)	Potential for further licence conditions and regulatory action Increased pressure on staff to meet efficiency targets whilst maintaining quality of patient care. Insufficient funding for on-going service commitments in staff and suppliers; investment in Estates, IT and equipment. Services provided are sub-optimal and open to criticism from Regulators under an inspection regime.	Darren Cattell	Director of Finance	26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Directorates have been engaged in budget setting & all budgets formally signed off. Monthly reporting of actual vs. budget performance reviewed at Performance Review Meetings (PRMs) and presented to the Board. The Cost Improvement Programs(CIPs) process has been amended to include a gateway from Idea to CIP; to RAG rate the schemes with a monthly review process. The target for 2016/2017 is 4% (£12.6m) but with a contingency of £1.8m. Review of all income opportunities by specialist external resource working with the Trust team. Income analysis by specialty now reported in monthly Finance Reports. Liquidity: Operational plan clearly outlines revenue funding requirements. On-going discussion with DH to confirm requirements. Business cases for key capital investments prepared with NHSi and DH prior to approval of Board. Funding source secured prior to plans being finalised. Clarity of requirement for external funding signaled in Operational Plan. Development of financial recovery plan.	All reported controls being applied.	Plans to implement Patient Level Costing (PLICS) and Service Line Reporting (SLR) 2016/2017, Key enabler for Trust deficit reduction. A Programme Management Office (PMO) Director has been appointed and is working with Finance to develop an assurance and governance regime and to monitor and control the delivery of CIPs to target. Finalisation and agreement of financial recovery plan, subsequent implementation. Engagement with the Sustainability & Transformation Plan (STP)	Darren Cattell	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-002	**Medical staffing**	Inability to recruit sufficient numbers of suitably qualifies medical staff, may lead to sub optimal care, impacting on patient safety processes and clinical outcomes	Corporate Staffing/ Competence	3	4	12	12 (3x4)	04 (2x2)	Potential patient harm incidents. Potential complaints and claims. Increased locum use and associated increased cost Potential regulatory action by CQC	Diana Hamilton-Fairley	Medical Director	26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Medical model and patient surveillance e.g. NEWS in place to prioritise patient safety. Use of regular agency staff to ensure consistency. Recruitment of locum consultants while substantive appointments are made.		Consultants: Targeted recruitment strategy. Out to advert for approved posts Further Business Cases for Consultant posts being completed and submitted Junior Doctors: Negotiations with Deanery, recruitment of non-training rotations doctors, MIT roles. Physician associates and other roles to support medical teams.	Diana Hamilton-Fairley	19/12/2016

Allocate Software

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-003	Reduced capacity and capability in non-nursing and medical staff groups	Reduced capacity and capability across the organisation impacts on delivery of operational objectives and may compromise patient care	Corporate Staffing/Competence	3	4	12	12 (3x4)	04 (2x2)	Potential patient harm events, reputational impact, increased stress on existing staff and potential recruitment and retention issues. May impact on Trust ability to meet statutory requirements.	James Devine		26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
In house bank introduced in March 2016. Fill rates increased. Regular Locum and agency staff where possible to improve consistency, with rolling recruitment adverts in many areas. Emphasis on local induction and training to enhance capability.		Service reviews and staff recruitment where required underway in many areas.	James Devine	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-009B	Patient Flow - Regulatory Intervention	There is a risk that failure to meet regulatory quality, operational performance and financial standards could result in further regulatory intervention.	Corp_ Compliance/Audit/Governance	5	2	10	10 (5x2)	04 (2x2)	Potential restrictions on the Trust's healthcare licences, up to an including service closures. Potential imposition of Trust Special Administrator and/or removal of Trust Board and Council of Governors members. Increased regulatory oversight, diverting management resources from core activities	Lesley Dwyer	Chief Executive	17/11/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Development of Trust Recovery Programme (work streams relate to quality, operational performance and financial improvement) Improved governance and reporting processes Improved working relationship with CQC and NHS Improvement	Improved performance against key safety, operational performance and financial indicators (KPIs).	Delivery of Recovery Programme remains in progress; regulatory standards are not yet consistently achieved (in some cases with much still to be done). Contractual operational performance improvement trajectories are not being achieved.	Lesley Dwyer	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-004	Safeguarding	Failure to protect vulnerable children and adults may cause harm and potential reputation damage due to inadequacies in meeting statutory responsibilities	Corporate _Patient Safety	3	3	9	09 (3x3)	04 (2x2)	Potential failure to protect vulnerable adults & children leading to patient harm events. Failure to meet statutory requirements may lead to regulatory action. Financial impact due to potential penalties and claims. Adverse reputational impact.	Karen Rule	Director of Nursing	26/09/2016	

Risk Mitigation/Controls		Update on Control Effectiveness		Action Required & Gaps in Control				Control Owner		Review Date
Safeguarding team resource increased & Safeguarding team visible in clinical areas to support staff. Content of mandatory training reviewed. Additional training session in place. Resources to support staff understanding & management of safeguarding - policies, protocols, quick guide manuals on all wards, generic e-mail for safeguarding team, safeguarding page on intranet				Interim staff employed until substantive appointments made. Review of safeguarding activity & resource required.				Karen Rule		19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-006	Medicines management	Pharmacy support and resourcing does not meet Trust requirements impacting on patient care and outcomes. Inability to recruit sufficient suitably qualified pharmacists and other staff to adequately meet the needs of all Trust services results in a risk to prescribing management and storage of medicines across the Trust.	Corporate _Staffing /Competence	3	3	9	09 (3x3)	04 (2x2)	Potential for medication errors and omissions due to lack of pharmacy support, leading to potential patient harm events. Increased stress on existing staff with an adverse impact on recruitment and retention.	Margaret Dalziel	Director of Clinical Operations - ACC	26/09/2016	

Risk Mitigation/Controls		Update on Control Effectiveness		Action Required & Gaps in Control		Control Owner	Review Date
Drug charts are reviewed on ward round. Double checking of prescription charts by nurses. Use of locum staff were possible with emphasis on local induction. Drug charts sent to pharmacy to review and validate, wards can contact pharmacy with queries.				Ongoing recruitment is in place, Prescribing audit required to find where pharmacist is most needed, along with skill mix review. Critical Care - Business Case being developed by Pharmacy with the input of the Clinical Director to request additional pharmacy support. Ambient temperature monitoring project pharmacy are working with estates and equipment services to identify a trust-wide room temperature monitoring system.		Margaret Dalziel	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-011	Compliance	The Trust may not be compliant with key statutory and mandatory requirements. This may lead to patient harm, regulator interventions and reputation damage	Corporate _Quality / Audit	3	3	9	09 (3x3)	04 (2x2)	Patient safety may be adversely affected. Potential for regulatory action and financial penalties. Reputational damage with potential for adversely affecting staff recruitment and retention.	Lynne Stuart	Dir. of Corp. Governance, Risk, Compliance & Legal	26/09/2016	

Risk Mitigation/Controls		Update on Control Effectiveness		Action Required & Gaps in Control		Control Owner	Review Date
Patient safety controls in place as described in relation to Corporate Patient safety risks e.g. Nurse and Medical Staffing. CQC Registration: - Governance Standards work Programme within the Programme Management Office Implementation of CQCAssure to provide automated process for self-assessment and collection and overview of results. NHS Provider Licence Standard Conditions:- Regular meetings and reporting and submissions to NHS Improvement; submission of self-assessment templates to NHS Improvement (NHSI) in accordance with the Risk Assessment Framework.				CQC Self-assessments incomplete; September 2016, evidence variable and gaps being addressed through dialogue with directorates.		Lynne Stuart	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-013	Training and appraisal rates	Poor training and appraisal rates may result in an inability to retain a high quality, trained workforce, impacting detrimentally on quality and safety of care to patients	Corporate _Organisational Development	3	3	9	09 (3x3)	04 (2x2)	Potential for patient harm events with increased complaints and claims, associated financial and reputational loss. Staff not able to perform effectively in their roles, adverse impact on staff recruitment and retention.	James Devine		26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control		Control Owner	Review Date
Mandatory Training:- Trust wide Development and implementation of action plan. Data provided weekly to Directorates & HR Business Partners (HRBPs). Information Governance (IG) All staff required to undertake annual (IG) training. New IG Manager appointed 01.06.16; Programme of work and identification of specific problem areas is being developed Moving & Handling:-Review of training availability and accessibility has identified more workplace based training is required. A recovery trajectory plan is now in place. Mental Capacity Act & Deprivation of Liberty (MCA & Dols): Content of mandatory training reviewed. Additional training session in place. Safeguarding team resource increased. Safeguarding team visible in clinical areas to support staff. Appraisal:- Directorates agreeing trajectories of compliance with HR Business Partners (HRBP). New achievement review replaced appraisal Sept 16, simplifies process.				Rebecca Bradd	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-012	Deteriorating patient	Tools and skills in recognising and escalating deterioration in patients is not embedded successfully in the Trust leading to poor outcomes for patients	Corporate _Patient Safety	4	3	12	08 (4x2)	04 (2x2)	Potential patient harm events, potential for increased complaints and claims with associated adverse financial impact and reputational damage.	Diana Hamilton-Fairley	Medical Director	26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
National Early Warning Score (NEWS) training for substantive and agency staff. NEWS training for all nursing staff now mandatory and compliance is being monitored. Outreach Team and Site team supporting nurses. Matrons and Senior Sisters working clinical shifts on a regular basis to monitor and supervise care. Audit of NEWS and other aspects of care. Block booking of agency. Review of staffing levels on a day by day, shift by shift basis.		Acute & Continuing Care Directorate Business case to be submitted for practice development nurses on wards.	Diana Hamilton-Fairley	19/12/2016

Risk Ref:	Risk Title / Controls	Description of Risk / Update on Control	Risk Type	Consequence	Likelihood	Initial Risk	Current Risk Score	Target Risk Score	Impact of Risk:	Risk Owner	Ultimate Accountable Owner	Date Risk Raised	Date Risk Closed
CRR-2016-014	Learning from incidents, complaints and claims and application of Duty of Candour	Learning from incidents, complaints and claims is not structured and formalised across the Trust meaning that learning opportunities are not adequately disseminated and further patient harm may result from repeat incidents.	Corporate _Quality / Audit	2	4	8	08 (2x4)	04 (2x2)	Dissatisfaction of users and commissioners of the service, potential increased complaints and claims. Reputational damage Increased burden on staff time to investigate repeated events.	Trisha Bain	Chief Quality Officer	26/09/2016	

Risk Mitigation/Controls	Update on Control Effectiveness	Action Required & Gaps in Control	Control Owner	Review Date
Learning events are being rolled out across the Trust. Learning from serious incidents is included in the F1/F2 doctors training sessions, grand rounds, Nursing and Quality Forum. Feedback from serious incident investigations facilitated by the Patient Safety Team relating to the teams and trends. Action plan monitoring undertaken in the SI monitoring group. Deep dives into the actions will be undertaken regularly to provide assurance. Newsletter is being published. 07/09/16 - first swarm event took place looking at SI's. Trajectory has been set to reduce the Serious Incident investigation breach rate and is being monitored monthly. Directorates are identifying investigators, investigation tracker is in place and an escalation framework . Developed closer working arrangements between Patient Safety Team and Legal Services. Weekly meetings held. Developing process for reporting and triangulation of claims and inquest data with other patient safety metrics.		Deep dives into the actions will be undertaken regularly to provide assurance. Newsletter is being published. Complaints process reviewed Sept 16 and improved methodology being implemented. Complaints backlog being addressed.	Trisha Bain	19/12/2016

Strategic Objective	Strategic Blueprint	Strategic Risks	Indicators	Corporate Risk Register	Con	L'hood	Total Risk Score	Gaps	First Line (Business management)	Second Line (Corporate Oversight)	Third Line (Independent)
Our People: We will enable our people to give their best and achieve their best	We will have effective and appreciative leadership throughout the organisation, creating a high performance environment where staff have clarity about what is expected of them, receive regular feedback and understand that poor performance will be addressed. Our employees will be engaged, committed to continuous improvement and embrace change. We will be an employer of choice.	The Trust is unable to attract, recruit and retain high quality staff impacting on a continued dependency on temporary staff and safe staffing levels, affecting quality of care, and financial costs.	Vacancy rates	Staff shortages may lead to sub optimal care, impacting on patient safety processes and clinical outcomes. Reduced capacity and capability across the organisation impacts on delivery of operational objectives and may compromise patient care. Pharmacy support and resourcing does not meet Trust requirements impacting on patient care and outcomes. The combination of under investment in a dilapidated estate and the absence of a coherent strategic approach to the management of estates means that the infrastructure does not meet business needs and capital funding and resources may be insufficient to deliver what is required, as a result staff may not be sufficiently supported in their roles and retention of staff is a challenge.	5	3	15	Recruitment activity and resourcing initiatives are in place but are not filling the resourcing gap. Director of Nursing provides a report on nursing staff gaps but there is not a comparable equivalent from other professional leads/functions. Therefore, whilst there is an organisational view of nursing staff this does not provide a complete picture and there may be gaps in workforce that the Board are not aware of Recognition and escalation of deteriorating patients is not embedded successfully in the Trust leading to poor outcomes for patients	The Director of Nursing provides a monthly report to the Board which details the previous month's Unify data, areas of risk, mitigations in place and plans going forward.	Performance against the Key Performance Indicators (KPIs) agreed within the Trust Recovery Plan which is reviewed and monitored at the weekly Executive Recovery Committee which reports direct to the Board, but with oversight by the Clinical Council on a monthly basis. Workforce Report to the Board by Director of Human Resources; Workforce Strategy and PID developed Performance Review meetings with Directorates / ToR and framework Monitoring of quality and safety indicators via clinical governance framework: Quality Improvement Group; Quality Assurance Committee; Patient Safety Group (with upward reporting from Resuscitation and Acute Deterioration Group, Transfusions and Thrombosis Group, Serious Incident Monitoring Group, Harm Free Care Group); Patient Experience Group (with upward reporting from EOL Care Group, Clinical Environement and Food Quality Group); Clinical Effectiveness and Research Group (with upward reporting from Clinical Guidelines, Clinical Audit, NICE and Compliance Group, Mortality and Morbidity and Clinical Outcomes Group, Research Governance Group) ; Medicines Management Group (with upward reporting from Non-Medical Prescribing Group, Drugs and Therapeutics Group, Safe Sedation Group); Safeguarding Assurance Group (with upward reporting from Children and Adult Safeguarding Group); Infection Prevention and Control Group (with upward reporting from Water Safety Group, Anti Microbial Stewardship Group, Decontamination Group) Strategic Workforce Group established as a sub-group of the Executive Group	Monthly Quality Oversight Committee with NHSI, CQC, CCGs Weekly reporting on KPIs via a conference call with the CCG, NHSI and the CQC Published monthly Unify data Board/Executive visits to ward areas Trust Wide (CQC) and Service Specific regulatory bodies review service outputs as an assesment of staffing levels, these include evidence of staff meetings, manatory training percentages, appraisal rates, responsiveness to incident reporting and follow up investigations and actions complete, audit performance and non conformarnance management, training and competency records, equipment maintenance logs, staff feedback mechanisms and the results of these.
		Workforce diversity is not achieved due to a lack of strategic focus and oversight on statutory and contractual equality and diversity obligations.	Workforce Race Equality Standards (WRES) Equality Delivery System (EDS2) outputs	Failure to protect vulnerable children and adults may cause harm and potential reputation damage due to inadequacies in meeting statutory responsibilities.	3	3	9	EDS2 process has not commenced Board champion not identified Lack of Board understanding/focus on the requirements due to absence of board development or induction in this area	Director of Workforce is the Executive lead for E&D	Equality and Diversity Annual Report to Board Equality and Diversity Group Terms of Reference and onward reporting to Executive Group	Reporting to Commissioners on WRES outputs
		Trust may not have stable and effective leadership and well trained, competent staff at all levels	Appraisal rates Induction rates Mandatory training rates Leadership development programme Management development programme	The Trust may not be compliant with key statutory and mandatory requirements. This may lead to patient harm, regulator interventions and reputation damage. Poor training and appraisal rates may result in an inability to retain a high quality, trained workforce, impacting detrimentally on quality and safety of care to patients. Learning from incidents, complaints and claims is not structured and formalised across the Trust meaning that learning opportunities are not adequately disseminated and further patient harm may result from repeat incidents. Recognition and escalation of deteriorating patients is not embedded successfully in the Trust leading to poor outcomes for patients	3	3	9	Formal development plans for middle and frontline staff Training needs analysis has not been undertaken/formalised in a way that gives organisational oversight and enables a planned approach to addressing training needs or areas of risk Mandatory training and appraisal rates are insufficient in some areas Organisational development planning has not mapped out a culture change programme; diagnostic around prevailing culture has not been undertaken Structured succession planning and talent management approach is not in place	Weekly reporting to Directors of Clinical Operations and Executives provides data on recruitment, appraisal, induction, mandatory training rates (from w/c 12.09.2016) Directorate Management Board and Programme Board structure and upward reporting to Quality Improvement Group and Performance Review meetings	Monthly reporting to the Board	Local Supervising Authority Audit Report (Supervision of Midwives)
		Staff are unable to participate in learning and development opportunities due to staffing shortages.	Mandatory training rates Learning and development programme and take-up Appraisal rates Induction rates		2	4	8	Migrating data from learning system to another.	Director of Workforce reporting	Directorate Management Board and Programme Board structure and upward reporting to Quality Improvement Group and Performance Review meetings	
Innovation: We will embrace innovation and digital technology to support the best of care	We will protect people from harm, giving them treatments that work and ensuring that they have a good experience of care. We will create an open and sharing environment where research and innovation can flourish achieving dual aims of enhancing the quality of patient care and contributing to the financial sustainability of the organisation. We will have a culture where staff are given the opportunity, training and resources to research and innovate. We will proactively develop partnerships with other organisations, underpinned by robust governance arrangements, to enable execution and exploitation of innovation projects to benefit the population that we serve. We will do this by increasing the availability of modern technology and quality information systems. We will take a whole systems approach to implementing a digital strategy that will result in providing real time access to patient information across all providers of healthcare in Kent and Medway.	The Trust remains behind peers in the implementation of technology and is reliant on outmoded systems. The Trust does not have the requisite financial resources to introduce all technical innovations that are needed. Although the Trust has made progress in implementing technology it is still reliant on multiple outmoded systems and multiple interfaces. Whilst capital funding may be allocated, financial resources required to accelerate implementation may not be available.	Business Case submissions to Executive Group for approval						Health Informatics Risk Register maintenance and review process Health Informatics Progamme Management Office	Reporting to Trust wide PMO / Executive Recovery Group updates and oversight Chief Quality Officer's portfolio report to Board Corporate Informatics Group (CIG) Terms of Reference and onward reporting to Executive Group Data Quality Group Terms of Reference and onward reporting to CIG	
		Developing and aligning a digital strategy to meet Sustainability and Transformation Plan (STP) aspirations could mean that local improvements that have been developed or already approved do not then get implemented as the STP changes the direction of travel from the original concept. This may cause delays in implementing local improvements and cause developments designed to improve patient care to stagnate if STP partners are not aligned around the digital strategy.	Digital Strategy in place Health Informatics Project Management plans implementation reporting (% outstanding)					STP governance is not developed Resources are not aligned to STP requirements; staff are internally focussed dealing with Trust issues	Chief Executive's integration into STP process	Chief Executive's reporting to Board on wider STP developments	External review of STPs and monitoring of health economy progress in development and implementation
		A culture and environment for innovation where staff are encouraged to innovate or feel confident with modern technology requires development and time commitment and creating the conditions for innovation is difficult when staff are focussing on dealing with fundamental issues such as staff shortages and preparing for regulatory inspections. This may impede progress and support for innovation, impacting detrimentally on sustainability improvements designed to improve patient care.	Research income Successful project implementation outcomes					Research governance - lacks clarity or reporting to Executive / Board on research and innovation initiatives R&D team are unclear about routes for approval; Research governance is unclear and there is a lack of clarity about where initiatives can be approved Limited capacity and capability in Business Intelligence function: seeking sharing opportunities with other Kent acute trusts.	Speciality/Programme Board and upward reporting in the Directorate governance structure	Research Group reporting upwards to Clinical Effectiveness and Research Group Project Change Advisory Board and upward reporting to Corporate Informatics Group and Executive Group Medical Devices & Equipment Group and upward reporting to Compliance and Risk Group / Escalation to Executive Group	

Strategic Objective	Strategic aim	Risk / cause	Controls / assurance (1)	Risk description	L	C	Rating	Gaps in controls	Controls	Assurance	Gaps in assurance
Integrated Health Care : We will work collaboratively with our local partners to provide the best of care and the best patient experience	Working strategically, as a trusted partner in the Sustainability and Transformation Plan we will work with partner organisations and the public to transform out-of-hospital care through the integration of primary, community and social care and re-orientate elements of traditional acute hospital care into the community. We will work collaboratively and progressively, ensuring that protecting our local Trust interests does not stand in the way of achieving benefits for the wider health economy and public.	Partners do not work strategically for the greater good and are not willing to sacrifice local interests. Delivery of transformation remains an aspiration rather than a reality; Other providers interests' may not be aligned and there may be resistance to change from within the organisation or the local authority Confidence and trust in the leadership is undermined by negative inspection reports and CQC "Inadequate" ratings; failing to exit Special Measures in Nov 2016 may lead to a decline in the reputation of the Trust amongst stakeholders	Representation and contribution to key strategic groups/meetings Clinical engagement with wider health economy (via Clinical Council)	Physical restrictions in the layout of ED may lead to overcrowding within the department which may impact on patient care. Resus and Trolleys area of the ED are not suitable for the service provided, or big enough to accommodate the potential number of people using the service at any one time. Significant high cost equipment that is out of date and past its replacement date may not be reliable or fit for purpose impacting on service delivery and income Poor patient flow throughout the hospital impacts on performance, results in sub-optimal care for patients and discharge delays Failure to meet national performance standards results in delayed diagnosis and harm to patients, financial penalties and reputation damage	3	5	15	MOU needed to cover developing governance arrangements	Chief Executive's monthly report to Board	Board approved STP EPRR Group and Local Health Resilience Partnership representation - onward reporting to the Board	Medway Council Overview and Scrutiny Committee Medway Health and Wellbeing Board Monthly Quality Oversight Committee with NHSI, CQC, CCGs NHS England Assurance Process (EPRR) External regulatory standards require accredited and regulated services to asses the quality of services they commission by the review of service level agreements and quality outputs of the serice, e.g result trunaround times, participation in external quality assurance schemes etc. e.g a Clinical Pathology Accreditation (CPA) accreditation requirments.
Financial Stability: We will deliver financial sustainability and create value in all that we do	We will maximise efficiency in service delivery and operational management. We will be outward looking, actively working in partnership with the wider health economy through the Kent and Medway Sustainability and Transformation Plan to maximise efficiency opportunities in workforce, back-office functions, digital strategy and estates utilisation.	The Trust's Going Concern assessment is threatened by: failure to achieve its planned deficit reduction and budget for 2016/17 resulting in further licence conditions and potential regulatory action; failure to deliver financial recovery plans and Carter Review efficiencies, threatening long term sustainability; inability to operate without central funding (loans) which restricts the financial operation of the organisation and its autonomy which may impact on its ability to bring about required organisational changes; failure to work with local partners to develop a financially sustainable organisation/system and develop genuine changes in patient experience and health outcomes, for the longer term; failure to receive all the income for activity due to validation issues with the Commissioner or stretched commissioning budgets.	Cost Improvement Plans (CIPs) achievement Use of contingency / reserves Carter benchmark data and performance against targets Signed contracts with Commissioners	Failure to achieve planned deficit reduction through Cost Improvement Plans and Carter Review efficiencies across the Trust affects the financial sustainability and Going Concern assessment of the Trust.	4	3	12	Do not have a functional Finance and Performance Committee to test assurances Terms of Reference for Board assurance committees are not up to date or current (no annual review) (Audit Committee, Investments & Contracts Committee, Finance and Performance Committee)	Scheme of Delegation and authorisation levels Business planning process Financial Recovery Plan Interim Director of Finance appointed Budgetary Control Framework in place from April 2016 ensuring that budget holders have clear responsibilities and accountability and they are supported by training alongside robust budgets. National agency caps; monitoring by procurement team of contracts for agency workers Investments and Contracts Committee Finance and Performance Committee (if and when established) Cost Improvement Plans	Estates and Capital Group Integrated Audit Committee oversight of financial governance systems Monthly Finance Report to Board includes status report on compliance with Loan Terms from DH Finance Report to Board	External audit of financial accounts and core financial systems Regular submissions to NHSI - NHS Improvement's monitoring of adherence to loan conditions Internal audit reports

Report to the Board of Directors

Board Date : 24 November 2016

Title of Report	Communications report
Presented by	Glynis Alexander
Lead Director	Director of Communications
Committees or Groups who have considered this report	Not applicable
Executive Summary	The purpose of this report is to summarise the communications highlights of the last month. Key points are : • Improved staff engagement through communications campaigns and engagement opportunities • Strong relationships with stakeholders and the media • Collaboration with partners to engage staff and public in emerging transformation plans.
Resource Implications	None
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA
Recovery Plan Implication	The Communications Team's work is aligned with the recovery plan.
Quality Impact Assessment	NA
Recommendation	For noting by the Board
Purpose & Actions required by the Board :	Approval ☐　　Assurance ☐　　Discussion ☐　　Noting [x]

COMMUNICATIONS REPORT: NOVEMBER 2016

EXECUTIVE SUMMARY

During the second phase of our improvement journey, we are concentrating on engaging colleagues and people in our community on how we can raise the quality of care for our patients still further.

Meanwhile, as the development of the Sustainability and Transformation Plan continues, we are also working with our partners in health and social care, both locally and across Kent and Medway.

Our communications are aligned with the five key CQC domains, so we are reflecting the ways in which the Trust is delivering services that are safe, responsive, caring, effective and well-led.

ENGAGING COLLEAGUES

Since the beginning of October we have been producing daily messages for staff, under umbrella Themes of the Week, featuring priority areas for staff awareness, such as infection prevention, medicines management, and End of Life care. We deployed a range of tactics to ensure the messages reach all staff, even if they do not regularly access emails. We have used traditional methods such as discussion at team meetings, screen savers and posters in staff areas, as well as WhatsApp for targeted staff groups, such as junior doctors. Feedback has been positive with many staff confirming that they receive and respond to the messages.

We are also continuing to produce the Aiming for Best newsletter which highlights progress on the Trust's improvement plan.

Earlier in the month we launched a communications campaign around respecting each other, under the heading Every Person Counts. Staff have been provided with a booklet with information on how to raise any concerns, including details of our Freedom to Speak Up Guardians, and Guardian of Safe Working for junior doctors. There is also information on dealing with bullying and contact details for the Trust's Workplace Listeners. Posters have been printed and postcards produced with easy to follow instructions on how to raise concerns or deal with bullying.

At the beginning of November we held a staff briefing in the hospital restaurant so that staff could see and hear what the Chief Executive, Lesley Dwyer, will be presenting to the CQC inspection team at the end of the month. Around 400 staff attended the meeting making it the best attended briefing for several years. Following the presentation there was a question and answer session, when a number of staff shared their views about recent improvements and spoke positively of recent developments. This is the first of these meetings at which there has been active and enthusiastic feedback from people in the audience, which shows the strides we have made in boosting employee engagement.

MEDIA

The Trust has a good relationship with the media, developed by being responsive to enquiries and proactive in communicating good news. As a result we are now seeing balanced coverage across print, radio and television.

We have been pleased to see excellent media coverage in some of the most exciting developments at the Trust recently, such as the start of work on the next phase of improvements to the Emergency Department, and the official opening of the beautiful bereavement suite, Abigail's Place.

We have also engendered considerable media interest in programmes of work across the Trust, including a six-month trial to help improve the survival rates of elderly patients who are admitted with a fractured hip and Books for Babies scheme, which is being piloted on the Oliver Fisher Neonatal Unit. The Oliver Fisher Special Care Baby Trust and The Book Trust are working in partnership to provide the parents of every premature baby with a book for them to read to their child, within 48 hours of arriving on the unit. Both of these initiatives were covered by ITV Meridian.

The appointment of Dr Peter Carter OBE as our Interim Chair has been positively reported in the media, locally and in the health press, as well as on social media.

Local papers have included details of how local residents can share their thoughts about the Trust with the Care Quality Commission ahead of the forthcoming inspection.

Across the county there has been interest in the Sustainability and Transformation Plan for Kent and Medway which is about to be published.

Meanwhile, the latest edition of News@Medway, our newsletter for staff and patients, has been published and is available throughout the site and from council hubs and libraries in Medway. We also distribute it electronically to a large stakeholder database.

DIGITAL COMMUNICATIONS AND SOCIAL MEDIA

Over the past 30 days we have engaged with 42,500 people on Twitter and 35,712 people on Facebook. We have gained 60 new followers on Twitter and 50 on our Facebook account, taking our total number of followers to 2,324 and 3,682 respectively. Key topics over the last month were our recruitment open days, Starfish (a film raising awareness of sepsis) and our Fab Change Day on 19 October. We continue to build relations with local and national health organisations and stakeholders with our posts retweeted/shared by a number of followers, including HealthWatch Medway, A Better Medway and local politicians.

Work has been continuing on our new website, which is now nearing completion.

COMMUNITY ENGAGEMENT

We have recently established good links with sectors of the community, for example through Medway Youth Parliament, the Active Retirement Association, and with faith groups. This gives us the beginnings of a foundation to engage more meaningfully on our services and, importantly, to ensure the voice of patients is fed into future improvements. We are also in discussion with Medway Healthwatch about how we can access their best practice to reach further into the community.

Over the coming weeks we will be holding a stand in the main entrance to encourage people to get involved, and in particular, to become a Member of the Trust.

WORKING WITH PARTNERS

The Trust is working with other health and social care partners and public health across Kent and Medway, to plan how we will transform health and social care services to meet the changing needs of local people. Messages about the Sustainability and Transformation Plan have been sent to all staff, and also externally. There has been some media coverage. The main aim at this stage is to raise awareness on the evolving plan, and to encourage people to complete an online survey highlighting what is important to them.

POLITICAL ENGAGEMENT

Our local MPs and council representatives provide a vital link with patients and public, and we recognise the importance of keeping them updated on our improvement plans, as well as hearing the insight they gain from meeting with constituents. In recent weeks the Chief Executive has held discussions with two of our MPs, Rehman Chishti and Kelly Tolhurst. Accompanied by the Director of Finance, Darren Cattell, she also presented an update on the Trust's progress and performance to the Medway Health and Adult Social Care Overview and Scrutiny Committee.

Report to the Board of Directors

Board Date : 24 November 2016

Title of Report	Quality Improvement and Oversight Committee report
Presented by	Lesley Dwyer
Lead Director	Lesley Dwyer
Committees or Groups who have considered this report	n/a
Executive Summary	The purpose of this report is to provide a high level summary of the outcomes of the Quality Oversight and Improvement Committee (QOIC) meeting held on 11 November 2016. The QOIC is chaired by NHS Improvement
Resource Implications	n/a
Risk and Assurance	The purpose of the QOIC is for the Trust to provide assurance to key external stakeholders over the sufficiency of actions (taken and proposed) to enable the Trust to exit Special Measures.
Legal Implications/Regulatory Requirements	The establishment of the QOIC was requested by NHS Improvement in May 2016 (the first meeting was held in June 2016). This is now standard practice for trusts in Special Measures.
Recovery Plan Implication	Exit from Special Measures is a key milestone of the Trust's Recovery Plan
Quality Impact Assessment	n/a
Recommendation	n/a
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Report of the Medway Quality Oversight and Improvement Committee

11 November 2016

1. **Purpose of the Medway Quality Oversight and Improvement Committee (QOIC)**

The QOIC was established in May 2016, on request of NHS Improvement, as an assurance forum specifically in relation to the actions taken to address CQC's concerns and enable the Trust to exit Special Measures.

So that NHS Improvement to obtain assurance over actions taken by the health system – and not solely by the Trust – local CCGs and NHS England (South East) are also members of the QOIC.

2. **Key outcomes**

Constructive feedback was received from all members in relation to the Trust Chief Executive's CQC presentation; this has been incorporated, where appropriate.

The Trust presented an update on implementation of its urgent care flow improvement programmes. The actions which had limited the impact of sustained significant increases in attendances on performance against the 4 hour waiting time standard were highlighted; these actions primarily related to ED streaming.

Assurance was provided to members that the Trust's actions are aligned with the specific recommendations made by NHS Improvements' Emergency Care Improvement Programme (ECIP) and the national improvement initiatives mandated by NHS Improvement and NHS England.

It was noted by the Trust that further action was required in relation to patient flow and discharges; recent actions taken by the Trust had prioritised progress against to these improvement initiatives.

NHS Improvement and NHS England re-affirmed that it was the role of the Local A&E Delivery Board to ensure that sufficient progress was made by all system partners in relation to addressing urgent care flow challenges.

The next QOIC meeting is scheduled for 9 December 2016.

Best of care
Best of people

Report to the Board of Directors

Board Date : 24 November 2016

Title of Report	Local A&E Delivery Board report
Presented by	Lesley Dwyer
Lead Director	Lesley Dwyer
Committees or Groups who have considered this report	n/a
Executive Summary	The purpose of this report is to provide a high level summary of the outcomes of the Local A&E Delivery Board (LAEDB) meeting held on 3 November 2016. The LAEDB is chaired by the Trust.
Resource Implications	n/a
Risk and Assurance	Assurance is obtained through the LAEDB that actions proposed and taken by the Trust are considered to be appropriate by partner organisations. This process complements and supports the Trust's internal assurance processes.
Legal Implications/Regulatory Requirements	The establishment of the LAEDB was required by NHS England and NHS Improvement in August 2016 of all local health systems (the first meeting was held in September 2016).
Recovery Plan Implication	Sustained achievement of national A&E performance standards is a key component of the Trust's recovery plan. LAEDB priority actions have been aligned to the Trust's priority actions
Quality Impact Assessment	n/a
Recommendation	n/a
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Report of the Local A&E Delivery Board meeting

3 November 2016

1. Purpose and establishment of the Local A&E Delivery Board (LAEDB)

The Kent and Medway LAEDB was established in September 2016, in response to instructions from NHS Improvement and NHS England that existing System Resilience Groups (SRG) should be "transformed" into LAEDBs.

The purpose of the LAEDB is to act as a single system-wide accountability and assurance forum, particularly in relation to delivery of the five improvement initiatives which have been mandated by NHS Improvement and NHS England[1].

2. Key messages

The LAEDB's winter resilience plans, which were submitted to NHS England and NHS Improvement earlier in the month, were ratified by members – this was in line with the approach agreed at the previous LAEDB. A detailed review of the plans had been undertaken by the LAEDB senior operational group (SOG) the day before submission.

Progress was reported in relation to 6 of the 9 NHS England "statements of good practice" which had been identified as priority improvement areas by the LAEDB (see appendix). Further improvements were expected against 3 of these statements by December 2016.

In order to enable the LAEDB to obtain assurance over progress, it was agreed that monitoring of progress against all 29 statements of good practice would be undertaken by the SOG in future. The Trust's new NHS Improvement Emergency Care Improvement Programme (ECIP) has been invited to attend the SOG in November 2016.

The next meeting of the LAEDB is scheduled for 1 December 2016.

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[1] The five mandated initiatives are:
1) developing primary care streams to manage patients presenting with minor illnesses and/or chronic conditions during peak demand periods;
2) progress implementation of the national Ambulance Response Programme;
3) increase levels of clinical input into current 111 providers;
4) enhance patient flow and reduce hospital bed occupancy; and
5) improve discharge from hospital

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Best of people

Appendix – Priority Statement of Good Practice

1. **Developing primary care streams to manage patients presenting with minor illnesses and/or chronic conditions during peak demand periods**
   - Patients presenting with mental health illness are assessed, managed, discharged or admitted within the ED standard
   - Community and intermediate care services respond to requests for patient support within 2 hours

2. **Progress implementation of the national Ambulance Response Programme**
   - There are alternative services which can accept NHS Pathways outcomes for conditions that can be managed oustide A&E E.g. limb injuries, bites, stings, plaster cast problems, suspected DVT, falls

3. **Increase levels of clinical input into current 111 providers;**
   - The A&E Delivery Board has established local mechanisms for increasing clinical input into green ambulance dispositions particularly at times of peak demand
   - The A&E Delivery Board has agreed workforce and service plans in place to deliver an increase in 'Hear and Treat' and 'See and Treat'

4. **Enhance patient flow and reduce hospital bed occupancy**
   - No LAEDB priority actions [all statements of good practice are Trust internal action priorities]

5. **Improve discharge from hospital**
   - A 'home first: discharge to assess' pathway is in operation across all appropriate hospital wards (pathways 1-3)
   - Trusted assessor arrangements are in place with social care and independent care sector providers
   - At least 90% of continuing healthcare screenings and assessments are conducted outside of acute settings
   - A standard operating procedure for supporting patients' choice at discharge is in use, which reflects the new national guidance

Minutes

of the Quality Assurance Committee held on Thursday, 20 October 2016 at 0930 hrs in the Trust Boardroom.

Members

Name:	Job Title:	Initial
Ewan Carmichael	Non-Executive Director (Chairman)	EC
Diana Hamilton-Fairley	Acting Chief Executive	DHF
Karen Rule	Director of Nursing	KR
Jan Stephens	Non-Executive Director	JS
Vivien Bouttell	Patient Governor Representative	VB

In attendance:

Name:	Job Title:	Initial
Michael Cunningham	Deputy Director of Estates & Facilities (Interim)	MC
Ngaio Goll	Note taker	NG
Jocelyn Hargan	Matron, representing Director of Co-ordinated Surgical Directorate & Deputy Director of Nursing	JC
VL	Patient's Relative	VL
Claire Lowe	Director of Estates & Facilities	CL
James Lowell	Director of Clinical Operations, Women's & Children's Directorate	JL
Karen McIntyre	Deputy Director of Nursing, Womens' & Children, Clinical Counsel Representative	KMc
Kirtida Mukherjee	Acting Medical Director	KMu
Martin Nagler	Public Representative	MN
Bridget Fordham	Head of Safeguarding	BF
Katy White	Head of Integrated Governance	KW

Apologies:

Name:	Job Title:	Initial
Busola Ade-Ojo	Interim Chief Pharmacist	BA
Trisha Bain	Chief Quality Officer	TB
Margaret Dalziel	Director of Clinical Operations – Acute & Continuing Care	MD
Lesley Dwyer	Chief Executive	LD
Simone Hay	Deputy Director of Nursing, Co-ordinated Surgical Directorate	SH
Dr. Ghada Ramadan	Consultant Neonatologist/Associate Medical Director – Quality & Safety	GR
David Rice	Company Secretary	DR
Ben Stevens	Director of Clinical Operations, Co-ordinated Surgical Directorate	BS
Zita Varga	General Manager, Co-ordinated Surgical Directorate	ZV
Shena Winning	Trust Chairman	SW

1. Chairman's Welcome, Apologies and Introductions

The Chairman welcomed members and their deputies to the meeting. Martin Nagler was welcomed in his new role as Public Representative. Apologies were noted as referred to above. Due to the Trust being in black escalation a number of attendees were absent, however, the Chairman noted that representation should have been made for each directorate. The Chairman expressed his condolences for the death of Staff Governor Rosemary Toye, and the fathers of the Trisha Bain and David Rice. The Chairman advised that a patient's story would be presented by a relative to the Committee at the meeting, and on arrival the agenda would be adjusted accordingly.

2. Quorum

The meeting was quorate

3.   Minutes of previous meetings

It was agreed that the minutes of the June meeting were approved as a correct record of the matters discussed. The minutes of the September meeting were approved subject to the following amendment;

The Patient Governor Representative be noted in the attendance list as a member, not an attendee.

4.   Matters Arising/Action Log

The Committee Action Log was reviewed and updated accordingly.

5.   Internal Review of QAC Effectiveness

5.1   The Chairman advised the Committee's Terms of Reference required the members to review the effectiveness of the QAC, and therefore required each member to complete a Committee Evaluation Form by 31 October for discussion at the next meeting.

6.   Directorate Assurance Report – Women and Children

6.1   The Committee noted that it needed to be provided with assurance from the directorate report and therefore a standardized template was needed which should include the pressures, challenges, the directorate scorecard and exceptions. The Committee agreed to include this on the agenda in November.

6.2   JL reported on the main successes and challenges faced by the three programme management boards in the directorate.

6.3   In the Women's programme;

Gynae assessment unit (GAU) has extended its opening times to 24/7 with a plan to explore further improvements. A workshop looking at processes and flow between ED and GAU with the multi-disciplinary clinical team has been held and will underpin further development.

The Trust STOMP (3rd and 4th degree tear rate), was presented to the RCOG project team who are leading the national OASI prevention bundle as a quality improvement project which will inform the implementation of the national bundle. The HOM has submitted STOMP for an RCM award for Excellence in Maternity Care.

There have been 2 post natal maternal deaths and investigations are being completed in conjunction with an external review. Both formed part of a SWARM event for learning.

Following the recent CQC challenge the directorate had received a green rating across the board and some outstanding scores. An overarching action plan which is monitored on a monthly basis has been pulled together.

6.4   The Neo-Natal Programme has been challenged around capacity and staffing, with the overseas recruitment plan being the priority. Interviews have been scheduled by Skype for the 28 October. Capacity is not on the risk register, however a capacity review is planned. JL informed that refurbishment was completed on the Transitional Care Unit.

6.5   The deteriorating patient continues to be the focus of the Paediatric Programme

7.   Patient Story

7.1   The Chairman introduced the patients relative VL and summarized the role of the Committee which is to provide assurance to the Trust Board of the quality of its service. VL thanked the Chairman for the invitation and proceeded to share the experiences of a close relative who had been a patient at the Trust. Consent had been granted to disclose the information.

7.2   KR thanked VL for the account and offered a personal apology and sincere regrets on behalf of the Trust for the failings to the patient and family. KR accepted that it is the expectation for patients to feel safe, receive quality care, and for families to feel confident that this is the case. KR assured VL that a number of the issues raised had been reviewed since, with new policies and practices in place to provide an improved, quality of service. VL accepted an open invitation to share the experience with a wider team of clinicians.

7.3   DHF apologised on behalf of the Chief Executive for the poor standards of care and dismissiveness.

7.4   The Chairman suggested that it would be beneficial to have a patient story periodically on the agenda.

8.   Deep Dive: Mental Capacity Act (MCA)/Deprivation of Liberty statutory (DoLs)

8.1   The Chairman advised the Committee that BF had been asked to present a Safeguarding item because although Safeguarding Annual Report had been discussed at the September meeting, the meeting was not quorate. Meanwhile, the report had been presented at the Trust Board.

8.2   BF highlighted the main points of the presentation on 'Meeting the Mental Capacity Act (MCA) and Deprivation of Liberty statutory (DoLs) requirements';

- Risks identified by the Care Quality Commission (CQC)
- These were identified by the CQC following an inspection in August/September 2015 and a list of Must Dos was mandated in the CQC report.
- BF noted that mental capacity must be assumed in the first instance, and that there was a need to embed the correct understanding of how to assess mental capacity. The Standards of Practice were due to be accessible on the intranet on the 21 October 2016. A six-part film commissioned by GSTT which includes the MCA, DoLs and Consent; entitled Barbara's Story will be delivered at team meetings.
- Risks raised from the Remedial Action Plan (RAP) by the Clinical Commissioning Groups (CCG)
- BF elaborated on the Contract Performance Notice which the CCG served on the Trust on 16 March 2016 and the various actions agreed to achieve the terms of the Notice.
- Risks identified by the Safeguarding team
- The Committee was informed of the updated Safeguarding Risk Register, and the Trust's past and present risks.
- A Trust-wide action plan and RAP, and the capacity of the Safeguarding team had been developed.

The Chairman thanked BF and the Safeguarding team on behalf of the Committee for their commitment to the improvement of Safeguarding adults at the Trust. BF was commended for turning theory into reality.

9 Estates & Facilities: 2016/17 annual cleaning plan and monitoring regime

9.1 CL introduced the interim Deputy Director of Estates and Facilities who jointly delivered the presentation.

CL reported that clear objectives have been set together with regular audits to ensure that the housekeeping team maintains National Standards of cleanliness. Two new auditors were recruited to implement a comprehensive action plan, and will report audit results to Infection Prevention and Control by 15 November 2016. Weekly audit results will also be submitted to the Director of Estates, with escalations to the Executive. 37 additional full time staff are due to be recruited.

CL advised that a new Head of Capital and Compliance will be responsible to ensure that national standards are complied with. Yellow folders with audit results will be placed in every ward.

In respect to the Environmental audits for the Women's and Children's directorate; the action plan is held by the senior sister and copies are sent to the Estates and facilities department for any issues that are relevant to them.

MC advised that the window cleaning contract and pest control are the responsibility of the new auditors.

MC accepted an invitation to attend the Nursing and Midwifery Steering Group to discuss cleaning schedules and the Service Level Agreement.

Action:

MC to liaise with Catering Manager regarding standardizing stock list for the pantries	MC/ Peter Reeson

The Chairman extended his appreciation on behalf of the Committee to; CL, MC and their team and acknowledged that their work was valued.

10. Radiology – Deep Dive Process for discussion

10.1 The Chairman recommended that this agenda item be postponed to the November meeting in the absence of TB. JL informed the Committee that a re-assessment of the imaging services provided by Medway NHS Foundation Trust was carried out to assess on-going conformity to the ISAS standard v2.1 in September. The feedback report provides evidence for the CQC inspection. It was agreed that the deep dive would provide assurance that the CQC serials had been addressed.

11. Reports for QIG:

The Key Issues Report was taken as read. The QIG minutes will be circulated on completion by NG

11.1 It was noted that the CCG had raised concerns about delayed reporting of Serious Incidences (SIs) and increasing breaches. The CCG would be meeting with TB, KR and DHF to discuss.

Infection Prevention & Control reported 9 C.Diff breaches in Qtr2, however, the Trust may remain within the total trajectory of 20 by the end of the year. One case of MRSA Bacteraemia was also reported. A Root cause analysis was taken across all cases.

11.2 Quality Risk Register was taken as read.

11.3 The IQPR was taken as read. KR informed the Committee that the CCG had questioned the lateness in reporting of SIs. KR explained that triangulating evidence at the Harm Free meetings was identifying more SIs, and also patient numbers had increased. JL advised that the new SI monitoring process should reduce the risk of SIs being reported late. It was noted that a never event had been reported.

12.   Any Other Business

Following discussion on the next three months work plan, it was decided that the following items would feature on the Agenda of the November meeting;

- Update on Tissue Viability & Pressure Ulcers
- Infection Prevention Control
- Directorate Feedback Reports
- Radiology

13.   Date and Time of Next Meeting

The next meeting will be held on Thursday, 17 November 2016, 9.30 – 12.00 hrs in the Trust Boardroom

Signed by Chair:

Ewan Carmichael

Date: ……………

Draft minutes - Quality Assurance Item 14 - Draft QAC Minutes 20.10.2016

Quality Assurance Committee (QAC) Chair's Report
17 November 2016

Once again this was a valuable meeting of the QAC, where the committee examined fresh, but important, topics.

Internal Evaluation of QAC Effectiveness. The Quality Assurance Committee (QAC) has commenced an annual evaluation of its effectiveness. Thus far we have a 75% return.
Overall the 'Must Do's' are viewed as complied with.
The committee does, however, have some issues where it could do better:
- The majority of members believe that papers are not circulated in good enough time for consideration, and that the minutes are not produced promptly enough.
- It hasn't produced an annual report for consideration by the Board (although it does report monthly).
- It could improve at providing relevant training for those new to the committee.
It is the Chair's intention to summarise the QAC's activities since September 2015, and to do so by the end of November 2016. On training, it has set an hour prior to its next meeting to undergo training on the Trust approach to risk. Additionally, a training session on quality and standards has been arranged in December for the Public Representative.

Directorate Report – Coordinated Surgical Care. The committee heard the quarterly report from the Coordinated Surgical Care Directorate. The report was comprehensive and covered a broad spectrum, including a small number of incidents where harm has been done. The committee was informed that dialogue with the CCG was encouraging with regard to the improving quality of reporting. Duty of candour is also progressing, with increased evidence being recorded. However, we could improve still further with more evidence of closure of loops after incidents. The Directorate's backlog of complaints is reducing. The complaints process has also improved, particularly through encouragement for early engagement with complainants. RTT, returning to reporting and the level of risk to be presented to the committee were discussed.

Deep Dive – Radiology. The deep dive on radiology had been postponed from October. However the committee was able to hear that the CQC 'Must/Should Do's' have all been addressed and, significantly, that the Trust is one of only 24 to successfully defend its Imaging Services Accreditation Scheme qualification. A second CT scanner has been ordered and should be installed by the end of March 2017.

Deep Dive - Pressure Ulcers. The deep dive on pressure ulcers took place on World Stop Pressure Ulcers Day. This is an area where the Trust is underperforming with regard to avoidable harm episodes. Tissue viability requires an interdisciplinary approach, with all involved in care playing their appropriate part. The value of the committee hearing this report was to emphasise that we must do better and to highlight that matters such as equipment procurement should be reprioritized within the programme. (afternote – the Chair was informed that Canterbury Christ Church University has removed the topic from the nursing syllabus, and that it has also been given low priority for post-graduate training). The uptake of training on this subject within the Trust could be improved.

Deep Dive – Infection Prevention and Control. The deep dive on infection had to be postponed because of bereavement. This re-emphasizes the need for resilience and depth within teams.

Quality Improvement Group (QIG). There was no meeting of QIG in November. However, the committee examined the refreshed version of the Integrated Quality Performance Dashboard/Report (IQPD). The refreshed version is more user-friendly and the month's 'story' is

useful. It is most helpful when a denominator is provided, giving an indication of trends in improvement or worsening.

Deep Dive Format. It was agreed that the QA will adopt the Good Governance Institute's approach to future deep dives.

Looking Ahead. QAC will not meet in December, but out of committee it will review the programme of work, taking into account early feedback from CQC. In January's QAC it will also require to hear the Infection Prevention & Control report postponed from the November meeting.

E B Carmichael
Non-Executive Director; Chair, Quality Assurance Committee
18 November 2016