PUBLIC MEETING OF THE TRUST BOARD
THURSDAY 27 OCTOBER 2016, 1.30pm – 4.00pm
BOARDROOM, POST GRADUATE CENTRE, MEDWAY MARITIME HOSPITAL

Time	Item	Subject	Presenter	Format	Action
1.30pm		Quality Insight - Trust's Energy and Carbon Emission Research Project	Edyta McCallum Tony Emeakaroha	Presentation	For Noting
OPENING OF THE MEETING					
2.00pm	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 29 September 2016	Chairman	Paper	For Approval
	5.	Matters Arising Action Log	Chairman	Paper	For Noting
MAIN BUSINESS					
2.15pm	6.	Chair's Report	Chairman	Verbal	For Noting
2.20pm	7.	Chief Executive's Report	Chief Executive	Paper	For Noting
2.30pm	8.	Trust Recovery Plan	Kevin Tallett	Paper	For Noting

2.40pm	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
			Margaret Dalziel
			Chief Quality Officer
			Medical Director
			Director of Nursing
			Acting Director of Workforce
			
			Director of Finance
			Director of Corporate Governance, Risk Compliance & Legal
				Paper	For Noting

3.05pm	10	Risk & Corporate Governance:
		For Assurance
		   a) Emergency Preparedness, Resilience and Response Assurance Report
		For Approval
		   b) NHSI Quarterly Submission
		   c) SI Policy
		   d) Access Policy
		   e) Fire Safety Policy
		   f) Procurement Transformation Plan
			Director of Corporate Governance, Risk Compliance & Legal
			
			Director of Finance
			Chief Quality Officer
			Chief Quality Officer
			Director of Finance
			Director of Finance
				Paper	

3.20pm	11	Health Informatics Reports : a) QGAF Biannual Assessment	Chief Quality Officer	Paper	For noting
3.30pm	12	Communications Report	Director of Communications	Paper	For Noting
FURTHER INFORMATION ITEMS					
3.35pm	13	Single Quality Oversight Committee	Chief Executive	Verbal	For Noting

3.40pm	14	Quality Assurance Committee Report including Minutes : Quality Assurance Committee 15/09/16	QAC Chair	Paper	For Noting
AOB					
3.45pm	15	AOB	Chairman	Verbal	For Noting
	16	Questions from members of the public relating to the Agenda	Chairman		
CLOSE OF MEETING					
		Date of next meeting: Thursday 24 November 2016, 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

Present:

Mrs. S Winning, Chairman
Mrs. L Dwyer, Chief Executive
Mrs. G Alexander, Director of Communications
Mr. E Carmichael, Non-Executive Director
Mr. D Cattell, Interim Finance Director
Mr. S Clark, Non-Executive Director
Dr. D Hamilton-Fairley, Medical Director
Mr. T Moore, Non-Executive Director
Mrs. J Palmer, Non-Executive Director
Mrs. N Prince, (representing the Acting Director of Workforce)
Mrs. K Rule, Director of Nursing
Ms. J Stephens, Non-Executive Director

In attendance:

Mrs. B Fordham, Head of Safeguarding (Presentation only)
Mrs. C Lowe, Director of Estates (item 10 only)
Mr. J Lowell, Director of Clinical Operations, Women & Childrens Directorate
Mr. P Lehmann, Director of Communications
Mr. B Stevens, Director of Clinical Operations, Co-ordinated Surgical Directorate
Mrs. L Stuart, Director of Corporate Governance, Risk, Compliance & Legal
Mr. K Tallett, Director of Programme Management Office (item 8 only)
Mr. D Rice, Trust Secretary

Apologies:

Dr. T Bain, Chief Quality Officer
Ms B Bradd, Acting Director of Workforce
Mr. M Jamieson, Non-Executive Director

Observers:

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

QUALITY INSIGHT –   SAFEGUARDING

The Director of Nursing and the Head of Safeguarding gave a presentation on Safeguarding which focussed on a video named "Barbara's Story" which was played to the Board. The story of Barbara had been developed into a number of episodes which would be played to all staff over the course of the coming months.   The lessons from the series of videos would be endorsed by the Transforming Care Programme.

The Board agreed that the video was a powerful reminder of the patient's experience and how behaviours by staff can be perceived. JS asked whether it could be included in the general induction session on Monday mornings for new staff. It was agreed that it was being considered how staff would be able to access the series.

Following a suggestion from Mrs King, it was agreed that all volunteers and Governors should be shown the video.

The Chairman thanked the Director of Nursing and the Head of Safeguarding for their presentation and the Board supported the initiative to ensure that it was widely disseminated across all staff, Governors and volunteers.

16/09-01   WELCOME AND APOLOGIES FOR ABSENCE

1.1   The Chairman welcomed everyone to the meeting. Apologies had been received from Martin Jamieson, Trisha Bain and Rebecca Bradd.

16/09-02   QUORUM

2.1   The Chairman confirmed that a quorum was present.

16/09-03   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.

16/09-04   MINUTES OF THE PREVIOUS MEETING

4.1   The minutes of the meeting held on 28 September 2016 were APPROVED for signature as a true and accurate account of the meeting subject to minor amendments.

16/09-05   MATTERS ARISING – ACTION LOG   OUTSTANDING FOR UPDATING

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

16/09-06   CHAIRMAN'S REPORT

6.1   The Chairman noted the following:

- In August the Public meeting had been cancelled and the Board had participated in a workshop which had featured a presentation from Peter Wyman, Chair of the CQC, a discussion on the Sustainability and Transformation Plan, the Trust's financial situation and the preparations for the next CQC inspection in November.
- NHSE and NHSI were introducing a joint approach to the accountability and oversight of the operational plan together with performance delivery for providers and CCGs in the South East to ensure consistency by all trusts regarding finance and performance.
- Philip Dunne, the newly appointed Health Minister had visited the Trust on 15 September.
- The Organ Donation art installation had been unveiled by the Deputy Lieutenant of Kent and the event was attended by recipients of organs and a moving letter had been read out from a recipient of a lung donation.
- The Annual Members Meeting had been held on 27 September with an attendance of over 80 governors, members, the general public and a representative from the Medway Youth Parliament who wanted to establish closer links with the Trust.

16/09-07   CHIEF EXECUTIVE'S REPORT

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

- The Trust was preparing for the November inspection which would run for two days rather than four as had been previously reported.
- The planned industrial action planned by doctors withdrawing labour for five days between October and December had been cancelled and in the following week the first doctors would be starting on the new contract.
- Following the joint NHS England and NHSI joint reviews the CCG and the Trust would be held to account via a quarterly performance meeting, whilst the Single Oversight Quality Committee would continue to meet on a monthly basis to focus on the Trust's Recovery Programme.
- The Trust was reviewing issues faced by other trusts across the country including Brighton & Sussex University Hospitals NHS Trust which was placed in special measures after inspectors deemed it unsafe and poorly-led.
- Progress continued to be made to the "Going Smoke Free" which would go-live on 17 October and PL and JS were thanked for their work over the last eight months in ensuring that the policy would be implemented on time.
- Recruitment of substantive members of staff had taken place with Karen Rule as Director of Nursing and James Devine Director of Workforce which would provide further stability for the organisation.
- LD noted that she would be away from the Trust during October and Diana Hamilton-Fairley would be acting Chief Executive in LD's absence.

16/09-08   TRUST RECOVERY PLAN

8.1   The Board noted the paper from Kevin Tallett, Director of the PMO. KT noted that the PMO were making good progress and had better control of the various programmes which had been established and welcomed questions from the Board.

8.2   The Chairman asked about the programme for transforming outpatients. BS responded that initiatives were being discussed and that for example there would be new processes whereby no patient would leave an appointment at the Trust without knowing the date and time of the next appointment or having been officially discharged. BS also explained the work of MASCOE (the Medway & Swale Centre of Excellence) whereby the CCG had engaged Helo, who had set up a similar scheme in Salford, to reduce the number of face-to-face meetings by those attending the Trust.

8.3   The Chairman thanked KT for his report noting that the PMO added structure and discipline for the organisation which enabled the staff to perform more effectively. It was noted that the continuation of the PMO to 31 March 2017 had been approved at the private Board meeting held earlier that day.

16/09-09   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   BS gave an overview of the performance in the following areas:

- RTT – 0.1% deterioration to 77.7%
- Diagnostics – 3.9% deterioration to 91.2%, a mobile scanner would help
- ED Performance – 2.12% improvement to 81.49%
- Cancer performance – 2.31% deterioration in 62 day target to 72.17%, additional capacity with locums would assist
- Site and Flow – it was intended that fewer beds would be used which would improve the level of safe staffing

9.3   TM queried when a part of the hospital was struggling to maintain a target, how responsive was the Trust to be able to implement a plan to bring it back on track. BS responded that for an area like ED there was an immediate reactive process, whilst with RTT, for example, a review was taken on a monthly basis to see if it could be assisted by either in or out sourcing.

9.4   There was a discussion regarding the prioritisation of patient appointments. BS confirmed that the initial classification was made by GPs. The Trust used a weekly Patient Tracking List ("PTL") list to review the specific details of the patient to ensure that they were seen within appropriate timescales. It was noted that the backlog in cardiology was a current priority.

9.5   EC noted that the Trust was seven weeks ahead of a CQC inspection and whilst he was aware of the improvements taking place, he was concerned at the set-backs along the way. LD noted his concerns specifically in relation to PTL where there were changing referral patterns which led to more patients being added to the list whilst the number of diagnoses remained stable. This problem was compounded with the increase in numbers arriving at ED which then impacted on the amount of elective surgery that could be performed. BS noted that the Trust was more agile than it had been previously and could cope more easily with fluctuations in demand as had been seen by the maintenance of trajectories.

9.6   There was a discussion generally about the problem of reduced capacity, however, this was a multifactoral problem with no one specific solution.

9.7   In the absence of the Chief Quality Officer the Quality and Health Informatics reports were presented by the Medical Director which were noted by the Board.

9.8   The Board noted the report on the Serious Incident Process Review (including Never Events). Following failings of the previous system, a new process had been proposed which would provide clarity and involvement from the directorates at the initial decision making stage, improved learning and to ensure proper accountability. The new processes and structures were unanimously approved at the Quality Improvement Group on 8th September. The Board APPROVED the new Serious Incident Process Review.

9.9   The Chairman queried the current status of the G-RIS system and the impact of the recent service problems. BS explained that G-RIS had provided imaging IT support to the Trust and the service had been unavailable for ten days during August this year across Kent. Whilst the problem had been

resolved this had created a backlog which would be cleared in the next 2-3 weeks and urgent cases were being reviewed as a priority.

9.10   DH-F emphasized that no patient came to harm as a result of the disruption to the G-RIS system. The Trust had coped with the lack of service but this had resulted in the incorrect sequencing of images. JS queried at what point an external investigation would be launched and DHF confirmed that a decision had been taken internally by the Executive with advice from the appropriate speciality.

9.11   LD queried whether an external review would be carried out on the risk rating of such an event and DHF confirmed that this was done if the Trust needed to learn from the incident.

9.12   EC noted that during August there had been an increase in mixed-sex breaches. The Director of Nursing confirmed that there 28 mixed sex breaches and these had been mainly within the surgical directorate but acknowledged that it was a multifactorial issue.

9.13   EC commented that he was pleased that the Trust had not had any "never events" but that it should be rigorously monitored. DHF confirmed that Datix had been reviewed thoroughly and the Trust was confident that no "never events" had occurred over the period of the review.

9.14   The Medical Director noted the following from her report:

- An evaluation of the Medical Model had been carried out and the majority of staff responding considered that the quality of care and safety had improved since implementation, however, admission wards were seen as slightly less successful than the ambulatory unit and further work was required.
- Five new junior doctors would be joining the Trust shortly and, whilst there had been no specific guidance, they would be asked to sign the new junior doctors contract.
- The Clinical Excellence Awards for 2015-2106 had been completed with 53 applications being made for outstanding work and there would be a distribution of 27 points among consultants of the Trust.
- A workshop for consultants had been held on 22 September to enable Trust values to be translated into an agreed set of behavioural competencies for the medical staff at Medway.

9.15   The Chairman queried when ambulatory care would move to a consistent seven day service. DHF confirmed that this was in process although the weekend service could not be guaranteed until the Medical Model was embedded.

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

- The Trust continued with a high level of activity and in August there were more leavers than starters so addressing nursing and midwifery retention was a priority.
- The Transforming Care programme, launched at the Midwifery Forum, aimed to ensure that the Trust delivered a high quality of nursing care and assistance had been requested from the PMO.

- On the Infection Prevention and Control Annual report, the Trust had met the target for C difficile, reporting 20 against a trajectory of 20 and 6 MRSA cases were attributed to the Trust against a target of zero for 2015/16.
- The Safeguarding Annual Report was noted and this highlighted that there was a now a Learning Disability nurse in post and the Trust had a Safeguarding Improvement Plan which also addressed the concerns of the CCG.

9.17   EC noted the improvement in hand cleansing, stressing that this should be maintained.

9.18   There was a discussion on the recent gap analysis and confirmation that Infection Control was the remit of the Director of Nursing and Environmental cleanliness was the responsibility of Claire Lowe, the Director of Estates whilst Ben Stevens was the Executive lead for Decontamination issues.

9.19   JP was very supportive of the Transforming Care Project, noting that the members of staff involved were enthusiastic which was inspiring for staff.

9.20   NP who was representing the Acting Director of Workforce noted the following from her report:

- The appraisal rate for the end of August was 63% against a target of 95% and a number of actions were in place to improve the performance level;
- The staff survey had been made available from 26 September until 2 December 2016.

9.21   The Chairman queried how more members of staff could be encouraged to complete the survey. LD noted that there were a limited number of paper copies of the survey for staff who did not have access to the electronic version. Staff should be encouraged by their managers to complete the survey so that they could feedback their opinions. It was noted that the CQC would not provide feedback to the Trust about the inspection in November until the results of the staff survey had been published.

9.22   JS noted that there were areas of the hospital where the survey was not completed due to the belief that the answers were not provided anonymously. JS also asked whether the Trust could develop the idea of providing more evidence to the staff to demonstrate the improvements that had been made so that they could provide more informed answers to the survey questions.

9.23   The Medical Director noted the following from the IQPR:

- The majority of CQUINs were in target.
- The current HSMR was 101.73 for the rolling 12 period (June 2015-May 2016);
- Other indicators for example, sepsis and mortality rates were showing signs of improvement in medical HDU.
- Generally the IQPR had an improving level of areas at "green" and data quality too was improving.
- Areas of continued concern involved the continued number of falls to fracture, the two Grade 4 pressure ulcers showed that improvement was needed together with the increase in two week waits for dermatology.

9.24   There was a concern that GP's were aware of how to circumvent the waiting lists for dermatology which would have a seriously detrimental impact on those who needed a referral within the two week period. Following a question from JP, DHF agreed noting that a process needed to be agreed whereby those jumping the queue should be forced to wait the required time. JP suggested that an analysis could be carried out of the worst offending GPs so that this practice could be stopped. TM noted that the Trust should be paid a premium from the CCG for patients seen without having to wait for two weeks.

9.25   TM commented that the improved HSMR was a powerful message to be conveyed to the CQC as part of the inspection and asked that the Trust Board be provided with background information to understand how this had come about. DHF agreed noting that a report could be provided by the mortality team which would show the impact of the Medical Model.

ACTION: Report on HSMR from the mortality team once figures available to show the impact of the Medical Model.

9.26   JS noted that the performance was deteriorating on emergency re-admissions and that elective readmissions performance was above target. LD confirmed that the statistics for representations in ED for the same matter was under review. DHF noted that the rate of elective surgical readmissions within 28 days had a target of 0% which appeared optimistic.

ACTION: The elective surgical readmissions within 28 days target of 0% to be investigated.

9.27   JP queried when there should be a reversal of the trend for re-admissions and LD confirmed that the first step was for stabilisation. The Chairman stressed that it was important to review the overall trend rather than simply comparing month on month statistics. The Director of Nursing noted that a comprehensive review was being carried out which would provide quarterly clinical indicators in future.

16/09-10   FINANCE & ESTATES

10.1   The Board noted the report and the Director of Finance highlighted the following points:

- The Trust continued to see and treat more patients than are planned for, particularly in ED, where attendances are 10% above last year's level.
- The Trust's substantive workforce was below plan across all clinical and corporate areas so there was continued dependency on agency staff.
- The Trust's capital programme expenditure was currently below plan, however, the slippage in IT and ED would move forward and all investment projects were forecast to achieve the original year end plan.
- The Contract with the North Kent CCGs was still not agreed and the discussions between NHSI and NHSE in mediation had been completed and the Board would be kept aware of any developments.

10.2   TM queries if there was one main issue that needed to be resolved regarding the CCG contract. DC confirmed that there was no recognition by the CCG of the fact that costs were increasing due to the higher turnover of

patients. This was a consequence of the introduction of the Medical Model which had reduced the average length of stay and increased the number of patients being seen by the Trust. There was a discussion about how this could be accounted for within the Cost Improvement Plan.

10.3   Following a question from JS there was a discussion about the deadlines for submission of a financial plan which was required under the NHS Contracting Guidelines. DC noted that the plan for the next two financial years was in draft, however, there was a risk that the CCG contract would not be agreed before submission of the two year plan was required. In that event, a view would be taken on the status of the plan and caveats added where there were any remaining uncertainties at the time of submission.

10.4   The Chairman requested that a budget forecast be submitted for the next Board meeting in October which should include how the CIPs were going to be managed given that their achievement was directed towards the second half of the financial year.

ACTION : DC to prepare a budget forecast for the October board meeting.

10.5   The Director of Estates introduced the **Fire Safety report** which was noted by the Board. CL summarised the following points from the report which provided an update on the current situation regarding compliance with fire safety requirements and the improvements which were needed:

- Kent Fire and Rescue Service (KFRS), the authorising body responsible for the Trust's properties, had carried out a review of the Trust in July 2016 which outlined a number of serious Fire Safety concerns, many of which required immediate action.
- Bill Scott was appointed by the Trust as a Fire Safety Advisor whereupon ATC resigned from providing their fire safety service.
- A 3-5 year plan was agreed with KFRS which included carrying out fire risk assessments, making staff aware of evacuation procedures as they applied to specific areas, changing the training package at staff induction so that it included more on-line training and recruiting a fire training team for the Trust.
- The Board would be trained in fire safety at a board meeting later in the year.

10.6   The Director of Corporate Governance, Compliance, Risk and Legal noted that the deficiencies surrounding fire safety had been highlighted by the Health and Safety Committee and it was intended that a half-yearly update would be provided to the Board in future.

10.7   The Director of Estates introduced a summary of issues arising from the **Annual Report for PLACE**. CL explained that key points were as follows:

- A new catering manager had been appointed and there would be an initiative to improve the standard of food provided at the Trust, to encourage healthier eating and to have more food prepared on site rather than buying prepared food for patients which was heated up before serving.

- To conduct a dementia and disability friendly audit identifying areas of improvement with an action plan to rectify any issues identified and ensure the Trust was DDA compliant.
- Improve on the standard of cleanliness.

10.8   DK offered the services of the Governors to act as assessors with regard to the review of food and standards of cleanliness which was duly noted.

The Chairman thanked CL for her reports and congratulated her on the improvements she was making within her remit at the Trust.

16/09-11 CORPORATE GOVERNANCE REPORT

11.1   The Director of Corporate Governance, Compliance, Risk and Legal gave a summary of the following points from the Corporate Governance Report:

- Stage 2 of the Provider Information Request (PIR) was required to be returned to the CQC by 6 October 2016.
- A new approach had been approved by the Executive Group covering 14 main Policy Areas which will be board approved policies with a number of other policies or Standard Operating Procedures sitting under each policy with the aim of generally improving clarity on corporate governance.
- The relevant executives would be working on drafting the relevant corporate policies for their respective areas with the aim of them all being approved by the end of October.

11.2   There was a discussion, following a question from JP, regarding the ownership of the respective policies and it was clarified that the process would be broken down as far as possible so that that specific individuals were accountable for dedicated areas.

11.3   JS queried where there had been information governance breaches, were there processes to ensure that lessons could be learnt to ensure that this could not occur again? LS noted that the Trust had historically a poor information governance culture and that the intention was to re-educate staff with bespoke face-to-face training where it was deemed appropriate. There was no evidence of information being deliberately withheld but there could have been better levels of data being captured had there been more focused leadership.

16/09-12 CORPORATE POLICIES

Risk Management Strategy & Policy

12.1   The policy was taken as read by the Board. LS explained that this was a high level policy and the intention was that there would be a focus on strategy within the next six months and that the overall policy would be subject to further review in twelve months' time.

12.2   There was approval for the policy with SC noting that this provided the Trust with a much improved corporate governance threshold and that any further amendments could be made in due course. He added that it was the intention of the Audit Committee to monitor the effectiveness of the policy.

12.3 The Board APPROVED the Corporate Policy and Strategy for Risk Management.

Emergency Planning, Resilience and Response Policy

12.4 The policy was taken as read by the Board. As with the other policies this would be subject to review in twelve months' time.

12.5 The Board APPROVED the Emergency Planning, Resilience and Response Policy.

Duty of Candour

12.6 The policy was taken as read by the Board. There had been a policy for the Duty of Candour but there was a need for this to be updated with clearer lines of accountability and responsibility.

12.7 It was noted that the Duty of Candour was a part of the Serious Incidents investigation process and should be reviewed by QAC before being presented to the Board.

12.8 TM noted that there needed to be cultural honesty and that the Duty of Candour was a vital part of that process.

12.9 The Board APPROVED the Duty of Candour.

ACTION: The Board to be provided with a review of how the policy was working in practice.

Information Governance

13.0 The policy was taken as read by the Board. LS explained that this policy would ensure compliance with the Information Governance toolkit which included Informatics and central information resources.

13.1 JS commented that this policy was helpful as it pulled Information Governance together with other linked policies.

13.2 The Board APPROVED the Information Governance policy.

Health & Safety Report

13.3 The Health and Safety half yearly report was taken as read. LS explained that the over the last six months the terms of reference for the Fire & Safety Group had been refined and the standards of reporting improved in order that meaningful data was presented. There would be further refinements in due course.

13.4 There had been a backlog of actions which had now been addressed. There were concerns regarding issues of aggression and this would be subject of further review together with local security management. The recent mock-inspections had shown that risk assessments were out of date but this was now subject to a regular audit and would be closely monitored.

13.15 EC noted the reference to 20 incidents of staff on staff aggression and it was noted that this would be reviewed by the Fire and Safety Group and followed up by the Executive and reported to the Board. JS noted that the Board had previously been advised that the Acting Director of Workforce was addressing staff on staff aggression as a part of the strategy on eliminating bulling.

13.16 The Board noted the report and the assurance it provided.

Senior Information Risk Owner Report

13.7 The Senior Information Risk Owner half yearly report was taken as read. LS explained that there were poor information governance standards practiced by staff including the inadequate storage and maintenance of patient records and a failure to achieve the 95% target for mandatory training on the IG Toolkit. There was a plan to address the deficiencies and to ensure compliance with Data Protection legislation.

13.8 The Board noted the report and the assurance it provided.

Risk Management and Assurance Framework Report

13.9 The Risk Management and Assurance Framework Report and associated papers were taken as read by the Board. In particular the Board discussed the Risk Appetite Statement and the Standard Operating Procedure for the Board Assurance Framework (BAF). LS noted that the directorates had built robust governance structures which would underpin the governance framework. This would enhance the reporting of risk at future meetings and that the improved structure would support the work on the Annual Governance statement included in the Annual Report and Accounts.

13.10 SC reported that the Integrated Audit Committee supported the considerable work that had been carried out on risk and recommended that the Board approve the Risk Appetite Statement and Operating Procedure for the BAF noting that refinements could be made in the future where they were deemed necessary.

13.11 LD noted that she considered there needed to be further consideration of the matter at the Integrated Audit Committee on the tolerances to be applied to the BAF framework.

13.12 It was agreed that the BAF be APPROVED subject to further analysis of the appendices by the Integrated Audit Committee.

ACTION: The Integrated Audit Committee to review the appendices of the BAF.

13.13 It was agreed that the risk appetite framework used was appropriate. However, concern was expressed about scoring a medium risk for delivering a sub optimal service in terms of quality and patient experience albeit still clinically safe. After discussion it was agreed that it would be reviewed outside of the meeting

ACTION : To review a scoring of medium risk for delivery of a sub optimal service in terms of quality and patient experience.

13.14   It was agreed that the risk appetite statement required more discussion and consultation with the Board.

ACTION : The Risk Appetite Statement to be discussed further in consultation with the Board.

13.15   The Board noted the Corporate Risk Register which included all the risks with individual scorings. LS explained that future reporting will be enhanced with details of mitigating actions and controls once the report is generated from Risk Assure.

13.16   The Standard Operating Procedures for Risk Management were noted by the Board. LD noted that the top risks at the Directorate level fed up into the Standard Operating Procedures and these risks were reviewed at the Executive's 90 Day Forum.

16/09-14   COMMUNICATIONS REPORTS

14.1   The Board took the Communications report as read. Mrs Alexander updated the Board on the following recent developments.

- Over the past two months there had been a concentrated effort on building staff awareness and reminding staff about the CQC's five domains of safe, responsive, caring, effective and well-led.
- There had been an encouraging take up of the flu vaccination amongst staff.
- There were continued efforts on the no-smoking initiative which would go live on 17 October.
- David Ward from Abigail's Footsteps had been interviewed on BBC Radio Kent and BBC South East and had spoken supportively of improvements in maternity at the Trust.
- A session had been held with the Governors about how to engage with certain groups with whom the Trust has had limited contact in the past.

16/09-15 AOB

15.1   The Chairman noted that the final contract for the ED redevelopment had been signed off at the private meeting of the Board held earlier that day.

16/09-16 QUESTIONS FROM THE GOVERNOR REPRESENTATIVE

16.1   Mrs King queried if correspondence from the Trust to GPs had been improved. BS confirmed that this was undergoing an improvement review.

16.2   Mrs King sought clarification that following treatment that confidential information was being sent to the correct person at the right address. BS responded that the data on the Trust's IT systems was being thoroughly reviewed.

16.3   Mrs King queried the status of the Trust's winter planning. LD confirmed that winter planning was on track with internal planning focusing on flu vaccinations and the preparation of rotas up to the end of the year.

16/09-17 QUESTIONS FROM THE PUBLIC

17.1   A question was raised by Mrs Coussens regarding the Trust's state of preparedness for the CQC inspection in November. LD explained that at the private meeting held earlier that day, the Board had been given sight of a 'burn down list' of items that needed to be addressed before the inspection. This would require gathering evidence to support the improvements at the Trust.

17.2   Mrs Boutell raised the topic of mothers smoking during pregnancy. JL noted that this was an issue with which Medway Public Health were assisting the Trust. The Trust's figures of mothers smoking during pregnancy had fallen from 17% to 15% but this was still above the 11% national average.

17.3   There was a question regarding the services provided for Mental Health patients in the Minor Injuries department. It was confirmed that there were now improved pathways to ensure that Mental Health patients were not kept waiting in the Trust for longer than necessary although more beds for these patients were required when they had to be admitted.

17.4   There was a comment that the service provided in Children's A&E had improved.

17.5   There was a further comment that Pharmacy needed to be improved which would assist in the discharge of patients.

17.6   Further to a question regarding preventative health measures the Chief Executive expressed a desire to reduce attendances by 30% through the development of hospital avoidance measures.

17.7   The Lead Governor was concerned that she had seen a patient wheeling a drip outside the hospital. The Chief Executive noted the concern and although it was allowed by certain members of staff it was not encouraged.

17.8   A question was asked by Glyn Allen as to whether the mock-inspections held in September followed the CQC style that would take place in November. The Chief Executive responded that the inspections had followed key lines of enquiry and the inspectors were from the CCGs, GSTT and NSHI. The mock-inspections had enabled the Trust to focus on key areas for improvement before the November inspection.

16/09-18 DATE OF NEXT MEETING

The next meeting of the Trust Board will be held on Thursday 27 October 2016 in the Trust Boardroom, Medway Maritime Hospital.

The meeting closed at 5:30pm

Martin Jamieson   Date:
Chair

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB-0316	26/10/15	14.5	To present the plans for implementing electronic patient records to a future Trust Board meeting.	Chief Quality Officer/ Director of Health Informatics	23/09/16 Aiming to present to a future Board meeting	Open (red)
PUB-0346	25/02/16	11.2	The Digital Road Map would be brought to the August Board Meeting	Chief Quality Officer/ Director of Health Informatics	23/09/16 - To be presented at a future Board meeting	Open (red)
PUB-0360	26/05/16	11.8	For the Finance Report to include a run-rate analysis for a 15 month rather than a 12 month period	Finance Director	23/09/16 Finance Director to address	Open (red)
PUB-0361	28/07/16	10.11	Executive to investigate utilisation of resources for MRI, given MRI backlog	Director of Clinical Operations	23/09/16 – to be confirmed	Open (red)
PUB-0363	28/07/16	11.1	DC and RB to look a way of encompassing the staffing expenditure into the finance report	Director of Workforce/ Director of Finance	23/09/16 – Finance Director to address	Open (Red)
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, board meeting to be confirmed.	Open (red)
PUB-0365	29/09/16	9.25	IQPR – mortality – provide new HSMR following impact of the Medical Model	Medical Director	24/01/16 – HSMR report to be circulated at a future date	Open (red)
PUB-0366	29/09/16	9.26	IQPR – Clinical best practice – elective surgery readmissions within 28 days – target of 0% to be investigated	Medical Director / Ben Stevens	24/10/16 – Verbal update to be provided at October Board	Open (red)
PUB-0367	29/09/16	10.4	DC to prepare a budget forecast	Finance Director	24/10/16 - To be brought back to a future Board meeting	Open (red)
PUB-0368	29/09/16	12.9	Risk & Corporate Governance – Duty of Candour – update on how the policy is working in practice.	Chief Quality Officer	24/10/16 - To be brought back to a future Board meeting.	Open (red)
PUB-0369	29/09/16	13.11	Appendices of BAF – to return to the Board following a review by the Audit Committee	Trust Secretary	24/10/16- To be brought back to a future Board meeting	Open (red)
PUB—0370	29/09/16	13.13	Risk Appetite - To review a scoring of medium risk for delivery of a sub optimal service in terms of quality and patient experience.	Director of Corporate Governance, Risk, Compliance &	24/10/16 – To be reviewed	Open (red)

				Legal		
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)

Report to the Board of Directors

Board Date : 27 October 2016

Title of Report	Acting Chief Executive's Report
Presented by	Diana Hamilton-Fairley
Lead Director	Diana Hamilton-Fairley
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 are : • Performance • National and Regional Issues • Going Smoke Free
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 ☒

Acting Chief Executive's Report – October 2016

1. EXECUTIVE SUMMARY

1.1 As Lesley Dwyer is currently on annual leave, the author of this month's Chief Executive's report is Diana Hamilton-Fairley, Acting Chief Executive.

1.2 The Acting Chief Executive's report provides the Board with an update on key issues since the last meeting of the Board that are not covered elsewhere on the agenda. It will also provide an overview of national and regional issues.

2. PERFORMANCE

2.1 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.

2.2 Key improvements which have been achieved following the September Quality Oversight Improvement Committee include:

- The "ED Corridor" has been closed by the Trust, with patients awaiting an ED cubicle now located in the former CDU site. Clinical oversight remains the same as was previously the case.
  o Impact: improved environment, dignity and privacy.
- Additional mental health liaison support provided by Kent & Medway NHS and Social Care Partnership (KMPT), with improved 'pull' from off-site liaison services.
  o Impact: improved access and patient experience; supports improved ED flow and management of ED resources.
- Joint 2 week wait cancer plan agreed between the Trust and commissioners.

- Continued delivery of the Trust's Referral To Treatment (RTT) and 62 day cancer improvement trajectories and above-peer benchmark achievement of ambulance handover times

2.3 Key challenges which require further action from all stakeholders include:

- Ensuring that effective and efficient urgent care flow is maintained out of hours:
    o Alternative service options for key patient groups (e.g. frail elderly) remain under-developed, resulting in continued high levels of unplanned attendances (see agenda item 6);
    o Patients continue to be admitted to outlying areas, impacting on both urgent and planned care flows in-hours. NHS Improvement (NHSI) is supporting improvements to the Trust's escalation policies to support clinical and management decision making.

2.4 Discharges are not effected on a timely basis, with high concern over access to nursing and care home beds at weekends.

2.5 The Trust went into external black escalation on 20 September 2016. A verbal update will be given at Board.

3. CARE QUALITY COMMISSION (CQC)

3.1 The Trust continues to prepare for the inspection in November. Since my last report we have submitted 796 documents to the CQC in response to their Provider Information Request. The CQC will in turn analyse this information and turn this into a Trust data pack for the inspection team, which we will have the opportunity to check for factual accuracy first.

3.2 On the first day of the inspection the CQC has requested that there should be ten presentations running concurrently; one from the

Executive team, one from each of the eight core services that will be formally rated and one by the Estates and Facilities team. These presentations will all cover the following, as set by the CQC

- 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   Key risk areas will be covered in Item 8.

4.   JUNIOR DOCTORS' INDUSTRIAL ACTION

4.1   The Government has recommended that trusts in England begin using the Terms and Conditions for NHS Doctors and Dentists in Training (England) 2016 as published in July to employ junior doctors from October 2016, starting a process of a phased transition with obstetrics and gynaecology Specialist Trainee Year3+ trainees. The BMA does not accept this contract and has written to each Trust to ask them to reconsider their implementation timetable. The Trust has replied to the BMA that it is satisfied that it complies with the non-negotiable contractual requirements that need to be in place before the contract can be used and that it is the intention of the Trust to implement the new contract in a safe and fair manner.

4.2   As part of the new contract a Junior Doctors Forum will be set up and meet quarterly. These meetings will be arranged shortly. Meanwhile the Trust has calculated the options under the new doctors' contract for each doctor and we await their decision to draw up the contract.

5. NATIONAL AND REGIONAL ISSUES

5.1 Submission of updated draft Sustainability and Transformation Plans (STPs)

Updated STPs were submitted to NHS England and NHS Improvement by the 44 national Sustainability and Transformation Footprints on 21 October 2016. The majority of STPs remain work in progress, reflecting the amount of work that is required to develop transformative proposals across a wide range of health and social care providers, commissioners and statutory bodies. Much further work is therefore expected across all footprints after October to ensure that robust proposals are developed and subsequently implemented.

In line with guidance from NHS England, summaries of the 44 STPs are expected to be published in late 2016.

5.2 Expansion of Financial Special Measures

NHS Improvement placed three further trusts into Financial Special Measures on 17 October 2016, taking the total to eight providers. The trusts are:

- East Sussex Healthcare Trust;
- Brighton and Sussex University Hospitals Trust; and
- Gloucestershire Hospitals Foundation Trust

All three of the trusts are in the South of England; two are in the South East. Maidstone and Tunbridge Wells NHS Trust was placed into financial Special Measures in July 2015.

Two of the trusts – East Sussex Healthcare Trust and Brighton and Sussex University Hospitals Trust – are also in Special Measures due to quality concerns (Nb. Barts Health NHS Trust have been in special measures for both quality and finances since July 2015).

Significant shortfalls against agreed financial plans for all three providers appears to be the main factor behind NHS Improvement's decision; however, it should also be noted that significant financial governance concerns were also identified at Gloucestershire Hospitals Foundation Trust.

The number of CCGs in financial special measures remains at nine.

5.3   Taking further action to reduce agency spending in the NHS

NHS Improvement has identified a 20% reduction in agency spending in the 12 months following the introduction of the agency rules in October 2016; this amounts to savings of £600m across the NHS.

In October 2016 NHS Improvement informed providers of a number of additional actions which were now being introduced to achieve further reductions, including:

- A greater and clearer role for STPs to ensure that agency controls are consistently implemented;
- Publishing of trust-level data on agency expenditure (in NHS Improvement's quarterly finance report). This is likely to include the best and worst performing trusts against agreed agency ceilings and relative to workforce costs;
- Submission to NHS Improvement, by 30 November 2016, of Board-level assurance trusts are taking all appropriate actions on agency spending;
- The requirement for trusts to secure approval from NHS Improvement for new and/or extended contracts with agency senior managers on a day rate over £750/day; and
- Additional reporting on breaches of the agency caps

6. HORIZON SCANNING

Recent issues concerning the NHS, which have been reported on by national and regional media, are listed below:

6.1 Safer maternity care

New measures to make giving birth safer, including maternity safety funding and publishing maternity ratings, have been announced by Health Secretary Jeremy Hunt.

Safer Maternity Care is an action plan setting out a vision for making NHS maternity services some of the safest in the world, by achieving a national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030.

Announced on 17 October, the measures will provide resources for trusts to improve their approach to maternity safety, including funding for multi-disciplinary training. They also will make sure lessons are learned from mistakes and shared openly and transparently across the NHS.

6.2 Hospitals and social care

It has been reported that some NHS hospitals are opening their own nursing homes and employing their own home help to deal with a crisis in the elderly care system. In spite of the costs involved, it is suggested that it could be cheaper than seeing wards full and emergency departments congested because of delays getting people out of hospital. Some hospitals have taken on full responsibility for the social care systems from councils in an attempt to join up services more effectively.

6.3   CQC State of Care report

The Care Quality Commission released figures showing more than half of accident and emergency and general medicine services are inadequate or require improvement, and said it had particular concern about these services.

The State of Care report showed that as of July 2016, nine per cent of A&E services were rated inadequate – almost double the rate of trusts judged inadequate overall (five per cent). A further 48 per cent of emergency departments require improvement. In addition, more than half (56 per cent) of all medical services also require improvement (52 per cent) or are inadequate (four per cent).

7.   GOING SMOKE-FREE

7.1   On 17 October 2016, after eight months of planning, we went fully smoke-free as a Trust. We marked the day with a celebratory event in the main entrance featuring the choir of Robert Napier School in Gillingham singing a song which drew an enthusiastic crowd from passers-by. At the time of writing (the first day of the new policy), compliance has been good with hardly any smokers spotted.

7.2   There was a significant amount of activity in the few days leading up to go live. The Council's stop smoking advisers did extensive training for frontline staff on how to handle patients who smoke and provide them with nicotine replacement therapy. In the weekend before 17th, the smoking shelters were removed, new tannoys installed and a new message broadcast, advising hospital users that smoking is now prohibited. On launch day, new signs went up across the Trust, as well as posters and banners. Also, the three new smoking officers, whose role is to patrol the site and move smokers on, started work, having undergone training the week before.

7.3   The smoke-free committee which has been steering the project over the past few months, will continue to meet to review how the new policy is working in practice. We will also be liaising closely with the local councillors and residents to ensure there is no adverse impact on them.

8.   ORGANISATIONAL STRUCTURE

The Trust welcomes James Devine, Director of Human Resources & Organisational Development, who commences with us on 31 October 2016. The Trust received the resignation, with immediate effect, of the Chairman, Shena Winning, on 14 October 2016. The executive would like to thank Shena for her significant achievement as Chair of the Trust. With her determination to ensure the delivery of a quality service to the patients and the local community, she has seen us through a stormy period and we are grateful to her and thank her for her total commitment

Report to the Board of Directors

Board Date : 27th October 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 – October 2016

1. EXECUTIVE SUMMARY

The Trust Recovery Programme has continued to make good progress during October. The PMO has developed its processes and started to carry out a range of assurance activities. 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 working well and we are tackling the one remaining red item from the must do/should do actions.

2. The Planned Care is now getting underway with a new lead from GSTT.

3. The Deteriorating Patient programme has launched a number of initiatives this month and one of the hubs of the hospital – The Trust Operations centre – is undergoing a makeover

4. The Unplanned Care programme has implemented a new set of internal professional standards and launched the Trust Concept of Operations helping to manage patient care and flow.

5. The Workforce programme is delivering on a number of initiatives around recruitment, systems and induction.

6. Transforming Outpatients is now beginning to gain momentum in its conceptual phase.

7. The Financial Recovery programme has moved from its conceptual phase to delivery and implementation.

8. The Transforming Care programme successfully launched this month too with over 250 staff attending the event.

In summary, we are more robust and better prepared than before 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

Governance & Standards has begun its' final phase of delivery. A plan has been developed detailing the actions, tasks and arrangements required ahead of the inspection teams' arrival on 29th November. The plan includes deadlines for evidence submission; logistics (including room booking and catering); presentation preparation; stakeholder communication, VIP care and 'Burndown Chart' actions.

The Burndown Chart is a prioritised subset of actions from September's Mock Inspection as agreed by the Executive Team. It borrows from 'Agile' project management techniques to maintain focus and speed. Actions are displayed in a cascade format and are 'burnt-down' once they are completed. The process will occur over the next 7 weeks and is managed by a 'Scrum Master' a senior executive able to make decisions, approve actions and remove blockages. Additional clinically focused actions that are not included in the Burn Down chart are being tackled by the Nursing and Medical teams separately.

During the first two weeks the Trust is making good progress with the actions on the Burn Down chart and all the deadlines have been met for suppling evidence to the CQC. The organisation has also made steady progress in completing the actions on the Must Do Should Do list. For the first time since January more Green rated actions are listed than Amber and only 1 red action remains. Plans are in place to turn the remaining Red and Amber actions Green.

Over the next few weeks further work will be done to support and prepare the Board members and Governors for the inspection with handbooks for them and the visiting inspectors. Both the Board and Governors will participate in a series of 'Cold- Eye' reviews with matrons to monitor the embedding of actions coming out of the plan.

2. PLANNED CARE PROGRAMME

The GSTT Programme Lead is now in place and work is underway to define and sign off the scope of the three work streams – Pre Theatre, Peri-operative and Post-Operative. Key deliverables for this month include:

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- Initial Planned Care Programme Board meeting held
- Work stream Leads in place
- Work stream members and Clinical Leads defined
- Terms of reference for all groups defined
- Work stream 3 pathway mapping commenced
- Quick wins for Work streams defined and implementation commenced
- RAID log developed
- Reporting tools developed
- Diagnostics commenced

3. DETERIORATING PATIENT

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

- Launch of the Improving Safety campaign commenced week of 17 October. The week long campaign included a presence in the main reception, staff restaurant with a particular focus on engaging with clinical staff on the wards. This key campaign messages have been coordinated with the message of the day which has come out of the Chief Executive and Director of Nursing's office.
- Awareness ribbons have been handed out to reiterate the 3 key components of the programme: recognising, responding and reporting unwell patients.
- The DPP Board convened and saw progress reported against the National Safety Alert for deteriorating patients and children.
- The Trust Operation Centre refurbishment has commenced and is due for completion week commencing 24 October. On completion, the TOC will co-locate both the Clinical Site Practitioner and the Acute Response Team.
- The Improving Safety briefing was published and cascaded into clinical areas. This included the publication of the avoidable harm analysis and information on the DPP.

4. UNPLANNED CARE PROGRAMME

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

The highlights for this month include;

- Preparation for launch of Internal Professional Standards and Concept of Operations completed and implemented across the Trust w/c 17th October
- GSTT Geriatrician resource continuing to support Frailty Flow Pilot on Byron and Milton wards
- Emergency Department have stopped use of the corridor. This function is now being undertaken in the area formerly designated as the Clinical Decision Unit
- Criteria led discharge policy ratified at Nursing and Midwifery Strategy Group
- Choice policy approved and awaiting confirmation on funding decision
- Medical Model Stakeholder event finalised for October
- New high level management performance dashboards being piloted

5. WORKFORCE PROGRAMME

Significant progress has been made in many areas within Workforce, with particular focus on recruitment and retention. In the run up to the CQC inspection, Workforce have agreed all Burndown priorities and submitted evidence in readiness for the review. Key highlights include;

Recruitment

The Emergency Department (ED) has achieved a substantial reduction in its nursing vacancy rate. The vacancy rate stood at 65% last November, yet now stands in the region of 24%. As part of the new recruitment and retention programme, newly-qualified nurses straight out of university will begin an 18-month preceptorship programme within the Emergency Department, designed to offer essential grounding and experience in emergency nursing.

The Workforce Recruitment Team have collaborated with Circus, a Brand Strategy Consultancy and created a powerful recruitment campaign. The images used in the campaign are those of Trust staff members who volunteered to take part in a well-publicised and choreographed photo shoot on 23 September. The bill board posters and banners will be displayed in a 3 month staggered campaign across the region, and will also be visible on public transport. The launch date for the campaign is 21 October at the British Medical Journal (BMJ) event, for which there will be a campaign stand and podium and the distribution of pens, flyers, contact cards etc. to help promote the campaign. The Recruitment Team will also be attending the Acute General Medicine

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(AGM) conference in October and have arranged a Trust Nursing Open Day for 9 November and an additional Open Day at Canterbury Christ Church University.

Overseas Staffing

The Business Case for Overseas Staffing was approved in August to proceed with the recruitment of 10 Neonatal Intensive Care Unit (NICU) nurses from the Philippines; this recruitment exercise is now underway with 24 nurses being interviewed on 28th October. The recruitment agency is managing this process and has advised that the new recruits are expected to be in post by August 2017.

EU Staffing

The continuation of the Medacs EU recruitment contract continues with ongoing weekly Skype interviews taking place. Two full days of interviews took place on 12th and 13th October and so far, 14 EU nurses have been recruited to commence employment with the Trust. The aim is to recruit 70 nurses in total from the EU.

GSTT Buddying Agreement

GSTT have completed their full review of the Temporary Staffing Service (TSS) and submitted their initial findings and recommendations to the Acting Director of Workforce, actions will be picked up fed into either the programme or business as usual.

On Boarding Review

A full internal review has been carried out on how the Trust inducts new staff and is designed to:

- Review and redesign of local induction checklist for substantive staff
- Create a 'New Manager' on boarding checklist
- Create a 'New Manager' training pack
- Create a new starter welcome pack for new Managers
- Create a new starter welcome pack for new Starters
- Review of medical staffing and medical education on boarding and induction
- Manage impact of the group work in relation to the new recruitment policy/procedures
- Creation of an effective Communication Plan

The review is due to be completed by the end of the month, with findings from the report implemented in November.

Workforce Systems

The Workforce Team have been rolling out Health Roster and SafeCare Live since 5 September which will be significant enablers in improving safer staffing through matching staffing hours more accurately to staffing requirement, based on real time patient acuity assessment. SafeCare Live and Health Roster will improve visibility of staffing levels on every shift in real time.

The new Learning Management System (LMS) is currently being rolled out and will replace OLM and Wired. The new system is called MOLLIE (**M**edway **O**n Line **L**earning & **I**nteractive **E**ducation). 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 PROGRAMME

The key principles for the Outpatients programme have been agreed and the project initiation document is being developed. Engagement workshops are planned in October to identify the work stream leadership and to further develop the project plan. The programme will improve responsiveness, patient experience, use of the estate, enable realisation of commercial opportunities and embrace the use of digital technology for patients and GP's.

7. FINANCIAL RECOVERY PROGRAMME

The project initiation document was approved on 12th October 2016, together with sign off on the Milestones, Level 1 plan, Communications Plan, Draft Data Pack format, Terms of Reference and structure of the Financial Recovery Board. The initial meeting for the Board is on the 24th October.

The 2016/17 elements of the Financial Recovery Plan are continuing to develop. CIPs are undergoing a full governance review. The YTD delivery of CIPs is £2.2m the identified CIPs are £15.9m although delivery of this will be over 2016/17 and 2017/18. Two key areas of CIP delivery that will release significant savings once benefits realisation is validated, over the next month, are Price reductions in drugs and procurement. A full analysis of the data from Pharmacy will give all drug issues and prices over two years will demonstrate price reduction savings (anticipated to be approximately £1m). Procurement benefits realisation has requested a report to be written that can extract full details of orders and prices by Directorate year on year. With this analysis a full year benefit on Agency cap reductions of £2.5m is expected to be released in Month 7.

The next immediate phases of the Programme are communication with Directorates, production of data packs and the sharing of those with Service focus groups to start the detailed reviews. There is an ongoing issue with the updating of 15/16 reference cost data by NHSI but the decision has been made to progress with the current data available and develop this further as NHSI publish amendments

8. HEALTH INFORMATICS PROGRAMME

See update in health informatics programme

9. TRANSFORMING CARE PROGRAMME

The Programme has successfully launched with work starting on the delivery of a number of key products:

The highlights for this month include:

- Programme launched with over 250 staff attending the display in the Atrium and high levels of engagement achieved across the trust
- Funding from Health Education England and appointment of 'Mouth Care Matters' specialist completed
- A number of baseline assessments commenced to identify gaps and key areas for focus
- Appointment of Nutritional Specialist to support the Food and Drink work stream completed
- Work started on standardisation of ward drug trollies
- Detailed planning completed for all work streams and work has commenced on delivery

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 Transforming Care campaign was launched at the end of September with substantial communications support in the form of a leaflet; posters and a series of banner stands for each of the eight work streams displaying their lead Matrons. The programme received additional support through the regular internal communications channels.

Communications also supported the Safeguarding Team's workshops in celebration of Adult Safeguarding Awareness Week, 3-7 October.

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 will be a further handbook for the CQC inspectors and the 'Board Book' providing information for Executive and Non-Executive Directors, Governors and Senior Managers.

For much of October and early November, communications focus will be primarily 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 are using a layered approach to minimise risk based around the burn down activities, clinical & nurse led reviews and cold eye reviews with Board members and Governors.
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 is now entering Phase 2 of its Recovery Plan with the proposed programmes for recovery being presented to the May Trust Board. The Trust will then ensure the programmes are adequately resourced and any issues escalated to the Executive Recovery Group

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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 implemented to compliment the recovery activities

Integrated Quality and Performance Report

October 2016

Integrated Quality and Performance Report

October *2016*

Contents and Key

Medway **NHS**
NHS Foundation Trust

Section	Content
Overview	Trust overview

Domain scorecards	1. Safe
	2. Effective
	3. Caring
	4. Responsive
	5. Well-led
	7. Enablers

Key to scorecard coding

Trust overview

Status	
Outlook	
Update	Expected to improve over next reporting period
Stable	Not expected to change over next reporting period
Escalate	Expected to deteriorate over next reporting period

Status	
Priority this/last month	
Yes	Larger/significant new risks to be/being managed in month
No	Smaller/maintainance risks to be/being managed in month

Scorecards

RAG	
Status	
G	Achieving target with good margin in month
A	Achieving target with small margin in month
R	Not achieving target in month

Executive Summary

Safe

Legend ● Compliant with target ● Breaching target

● **Total Serious Incidents 1.1.3** – There were 5 serious incidents reported in September, with 29 SIs breaching (including 11 historical cases from 15/16). A trajectory has been set to achieve zero breaches by the end of October. 25 investigations have been completed and reports finalised for CCG closure, 1 has been requested for downgrade, 2 investigation reports will be completed by the 14th October and 1 complex case by end of October.
SWARM events for falls and pressure ulcers are planned to identify immediate learning, actions and themes, continuing with the programme of learning in place back to the floor.

Proportion of Harm Free Care 1.2.1 – The trust was below target at 88.93% for harm free care, however for new harms the trust was at 98.36%. Most harms were due to Catheters and UTIs, and new VTEs.

● **HSMR & SHMI 1.4.1 & 1.4.2** – The Hospital Standardised Mortality Ratio (HSMR) continues to demonstrate a downward trend, and is now 100.19 the rolling 12 months to June 16 – this is within the expected range, demonstrating the Trust's continued focus on this area.
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 the period Jan 15 – Dec 15, but is still a reduction on previous periods, and the lowest value for the Trust in this indicator for over two years. 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. The next SHMI value for the period July 2016 – June 2016 will be published on the 15th December 2016.

Septicaemia SMR, Pneumonia SMR & Congestive Cardiac Failure SMR 1.4.13, 1.4.15 & 1.4.18 - The SMR for Septicaemia continues to show a steady downward trend and Pneumonia has remained below the benchmark for the three most recent updates. COPD remains higher than the national benchmark and the latest figure is an increase on the previous update. Aspiration Pneumonia has started to slowly decrease and now falls within the expected range. A new Quality Improvement project is being launched and will be led by Rob Nicholls, the HAP bundle will also be re-launched and may be part of a pilot on one or some of the COE wards.

Effective

CQUIN – A CQUIN update will be available in time for this month's board.

Nice - NICE Guidelines (TAs)
Total for Apr – Sep 2016 - 30 published, 28 relevant
- 17.9% (5) currently for 2016-17 of the applicable TAs have been reviewed within the 90 day time frame.
- The remaining 82.1% (23) are under review, and are being escalated to Specialty, Program, Directorate and Board level on a monthly basis.

NICE Quality Standards
Total for Apr – Sep 2016 - 17 published, all relevant
- 29.4% (5) current response rate for 2016-17

Caring

● **MSA** - The 33 breaches which were recorded in SAU this month have been reviewed and validated. This was due to increased site activity and the need to open emergency beds.

Responsive

● **RTT 4.1.1, 4.1.2, 4.1.3 & 4.1.4** – On a monthly basis there has been a general upward trend which shows steady improvement since March , and we are meeting the monthly trajectory. Additional capacity to be secured in Cardiology and ENT through an in source provider. The business cases for Cardiology and ENT have been approved with implementation scheduled for October.

There were 18 patients reported RTT waits over 52 weeks for incomplete pathways at the end of August. A process has been put into place to complete clinical harm reviews for any patient that exceeds 52 weeks wait for definitive treatment or discharge implemented.

A&E

● - **12 Hour Trolley Wait 4.2.1** – There was one 12 hour DTA trolley wait in September. Site team to be provided with tablets to access the Symphony system in order to have more timely and consistent review of attenders within ED.

Better management of flow according to the improvement plan through the site team so that beds are available as and when needed on the appropriate wards.

● - **4 Hour Performance and Flow 4.2.2 & 4.2.3** - Month on month performance remained constant in September. At the same time calendar year to date attendance volumes have increased 13% in 2016 against 2015. September attendance volumes increased +3% against August. 4 hour performance for admitted patients was 35% (down from 37% in August), whilst non admitted performance was 90% (down from 91% in August), this was against plans to get non admitted attenders to 98% through improved clerking and assessment of patients (by end Sep). Interventions have been put into place:
- 'Immediate Action' phase commenced aimed at expediting current improvement plans.
- 'Adopt a Ward' where every senior manager and matron within medicine is based on 1 ward allocated to them until 10am, facilitating board rounds and actions required to progress patients progress.
- Strengthen and put discipline into site meetings to achieve continuity of communication and actions with further clarification of roles and responsibilities.

Cancer

● - **2 Week Wait - 4.3.1 & 4.3.2** – The Trust has failed to achieve the 2 week wait and symptomatic breast standards. 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 an improvement trajectory is being developed. The Trust failed to achieve the symptomatic breast standard. Breaches were as a result of patient cancellations, patient choice and Consultant availability which is being actively addressed within the Coordinated Surgical Directorate.

- **31D Waits – 4.3.3 & 4.3.4 & 4.3.5** - The Trust failed to achieve the first definitive treatment & subsequent drug treatment standards but maintained compliance with the surgical subsequent treatment standard.
Breaches were due to patient choice, patient cancellations, with Urology breaches also including a delay in offering treatment date, complex pathway and theatre availability which is being actively addressed within the Coordinated Surgical Directorate.

- **62D Waits – 4.3.7 & 4.3.8 & 4.3.9** - The Trust achieved the GP referral standard but failed to meet the screening standard in Lower GI with 4 breaches due to a complex pathways and theatre availability. The Coordinated Surgical Directorate is progressing a Cancer Action Plan to address performance across all the Directorate's tumour sites. Workshops are being planned to review breach reports for the challenged tumour sites of Urology & Lower GI to identify issues, themes and remedial actions. Delays in pathways due to patient choice are being reviewed to ensure all appropriate adjustments are being recorded.

Well Led

HR Commentary not received.

Enablers

Data Quality - The DQ team is currently recruiting to a substantive structure from an agency team. The team once recruited will align staff to work closely with Directorates to improve and prioritise DQ issues, based on clinical need and financial loss.

Currently the top 5 issues priorities by the team are: RTT, E- referral system errors, Patients potentially omitted from waiting lists, Dynamic outcome form implementation into clinic to aid pathway decision making, and improving the cash up reporting process to mitigate potential loss of Trust income.

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

Estates - That key issues relating to Estates services are being maintained to the correct statutory and mandatory levels and where they are not being achieved an action plan is in place to achieve the necessary level. In relation to Water Safety there has been a marked improvement in compliance that the Authorised Engineer's audit from 68% to 81%. In relation to Fire Safety an action plan with approved funding by the Trust is in place and the work is being carried out.
In relation to Electricity at Work an Authorised Engineers report was recently carried out and an action plan is being developed.

Integrated Quality and Performance Report

October 2016

Domain 1: Safe

Medway **NHS**
NHS Foundation Trust

Theme		Ref	Indicator	RAG Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	YTD avg	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2	Quality Account
		1.1.1	Total patient safety incidents (patient related)		*N/A*	811	656			645						
		1.1.3	Numbers of SIs reported to STEIS	G	5	6	8	5		6.2						
		1.1.3.1	Number of SIs declared			5	4	5		4.7						
		1.1.3.2	Potential under-reporting of patient safety incidents										✓			
		1.1.3.3	No. of Serious Incidents relating to Learning Disability			Data being collected from October							✓			
		1.1.3.4	No. of Serious Incidents relating to Mental Health Patients										✓			
		1.1.21	Number of SI's breaching	R	0	12	17	29		17.7						
		1.1.4	Never events	G	0	0	0	0		0.0			✓			✓
		1.1.4.1	Never Events - Incidence Rate		*0.00%*	0.00%	0.00%	0.00%		0.0						
		1.1.5	Incidents resulting in death (1 month in arrears)	G	7	6	4			4.6						✓
		1.1.6	Incidents resulting in severe harm (per 1000 bed days) (1 month in arrears)	R	0.11	0.33	0.27			0.23						✓
		1.1.7	Incidents resulting in moderate harm (per 1000 bed days) (1 month in arrears)	R	1.87	2.7	2.0			1.8						✓
		1.1.8	Incidents resulting in low harm (per 1000 bed days) (1 month in arrears)	G	7.77	24.9	23.7			20.8						✓
		1.1.9	Incidents resulting in no harm (per 1000 bed days) (1 month in arrears)	G	18.2	37.8	31.3			31.4						✓
1.1 Patient safety - incident reporting		1.1.10	Incidents with moderate or severe harm with duty of candour response (1 month in arrears)	G	1.00	0.13	0.13			0.1						✓
		1.1.11	Safeguarding alerts reported (Children and Midwifery)		-	13	7	12		14.0						
		1.1.12	Safeguarding alerts reported (Adults)		-	24	14	11		11.8						
		1.1.13	Deprivation of Liberty - Applications Made and Accepted		*N/A*	18	14	22		18.2						
		1.1.14	Pressure ulcers (grade 2) attributable to trust	G	10	12	3	9		9.2						✓
		1.1.15	Pressure ulcers (grade 3&4)	R	0	1	2	2		1.2						✓
		1.1.16a	Administration or supply of a medicine from a clinical area		*tbc*	0.3	2.5	2.7								✓
		1.1.16b	Medication error during the prescription process		*tbc*	0.1	0.5	1.0								
		1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	R	0.2	0.1	0.2	0.3		0.1						
		1.1.18	Falls per 1000 bed days	G	6.63	4.00	4.80	4.21		4.8						
		1.1.19	Number of falls to fracture (per 1000 bed days)	R	0.2	0.2	0.2	0.3		0.1						
		1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	G	0	0.0	0.0	0.0		0.0			✓			
		1.1.20	Transfer of Care Concerns (TOCC) relating to pressure ulcers (reported 1 month in arrears)	G	3	4	2			1.5						

Theme	Ref	Indicator	RAG Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	YTD avg	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2	Quality Account
	1.2.1	Proportion of Harm Free Care - point prevalence in month	R	95.0%	92.15%	94.37%	88.93%		92.73%				✓		
1.2 NHS Patient safety - safety thermometer	1.2.2	New VTEs - point prevalence in month	R	0.4%	0.9%	0.2%	0.6%		0.7%			✓			
	1.2.3	CAUTIs - point prevalence in month	R	0.3%	1.3%	0.8%	1.4%		1.4%						
	1.2.4	New harms - point prevalence in month	G	2.2%	2.6%	0.8%	1.6%		1.8%						
	1.2.5	New Pressure ulcers - point prevalence in month	G	0.9%	0.9%	0.2%	0.4%		0.5%						

Theme		Ref	Indicator	RAG Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	YTD avg	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2	Quality Account
1.3 Infection control and cleanliness		1.3.1	MRSA screening of admissions	R	*95%*	93%	94%	89%		94%						✓
		1.3.2	MRSA bacteraemia (trust – attributable)	R	*0*	0	0	1		1			✓			
		1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	G	*2*	1	2	0		1			✓			✓
		1.3.4	Hand Hygiene compliance	G	*95%*	95%	99%	98%		96%						
		1.3.5	Number of MSSA cases post 48 hours	G	*10*	4	3	1		2						
		1.3.6	Number of E-coli cases post 48 hours		*N/A*	3	7	3		5						
		1.3.7	Surgical Site Infection - Hip Replacement (reported 1 quarter in arrears)	G	*1.1%*		0.0%									
		1.3.8	Surgical Site Infection - Knee Replacement (reported 1 quarter in arrears)	R	*1.6%*		2.9%									
		1.3.9	Surgical Site Infection - Repair of neck of femur (reported 1 quarter in arrears)	G	*1.5%*		0.0%									
1.4 Mortality		1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	G	*100*		100.19			102.8			✓			✓
		1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	R	*100*		106.18						✓			
		1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	R	*100*		112.74			115			✓	✓		✓
		1.4.3	Number of Deaths in low risk diagnosis groups **(Apr-Jun 16)**	R	*0.65*	2	1	2		1.5						
		1.4.4	Crude Mortality **(Apr-Jun 16)**		N/A	118	129	110		116						
		1.4.4.1	No. of unexpected deaths relating to Learning Disabilities			Data being collected from October										
		1.4.4.2	No. of unexpected deaths relating to Mental Health													
		1.4.5	Mortality after 120 days	G		3.9%	6.9%	0.0%								
1.4 Mortality		1.4.13	Septicaemia SMR (Rolling 12 Month)	G	*100*		81.31									
		1.4.15	Pneumonia SMR (Rolling 12 Month)	G	*100*		95.87									
		1.4.18	Congestive Cardiac Failure SMR (Rolling 12 Month)	G	*100*		78.59									
1.5 Safe Staffing		1.5.1	Safe Staffing – ratio of actual to planned nursing hours		*TBC*	101%	103%	106%		103%						

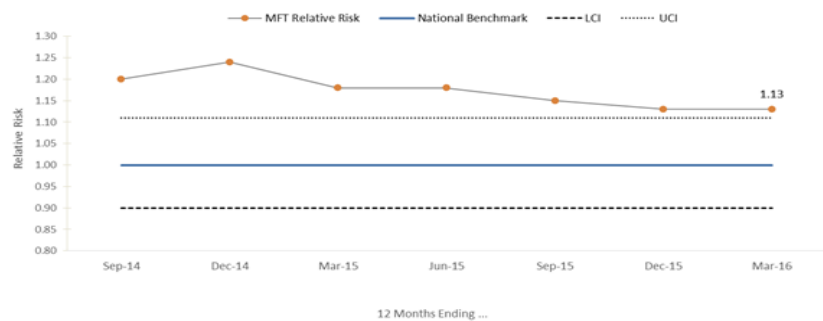## 1.4 Safe - Mortality

HSMR BY PROVIDER (All acute non-specialist) for all admissions
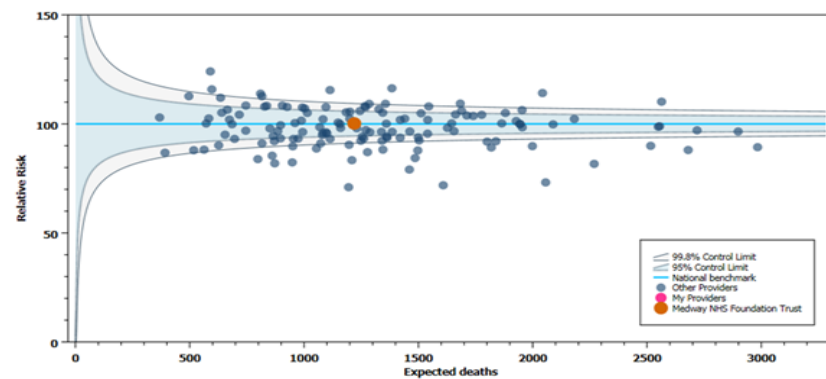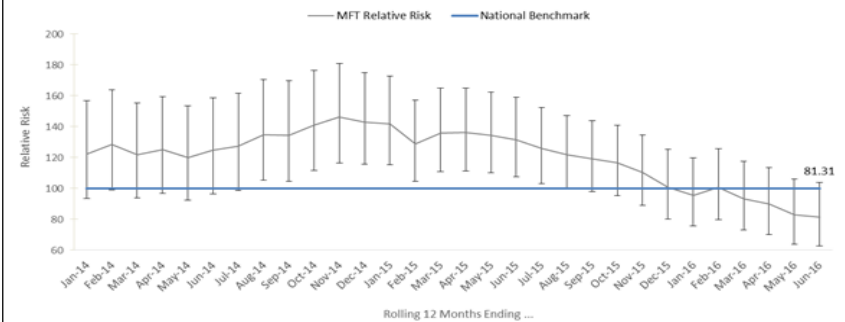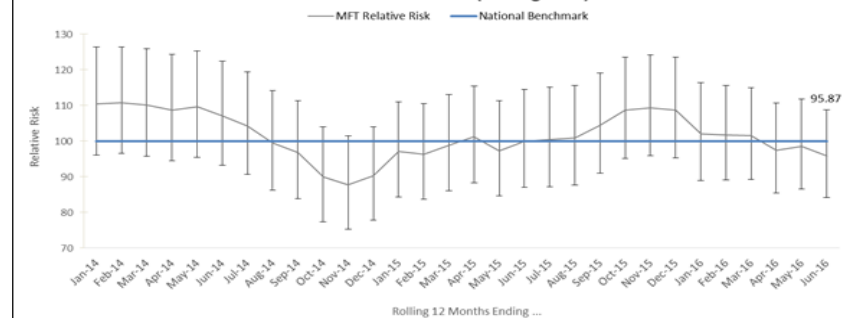

HSMR (Rolling Year)
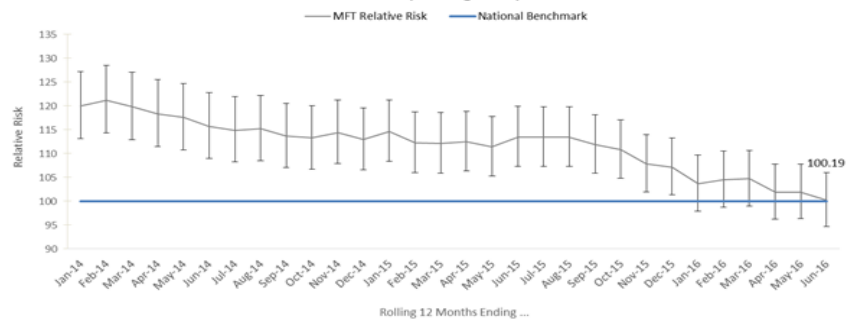
SHMI

Septicaemia SMR (Rolling Year)

Aspiration Pneumonia SMR (Rolling Year)

Pneumonia SMR (Rolling Year)

Domain 2: Effective

Medway **NHS**
NHS Foundation Trust

Theme	Ref	Indicator	Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2
			Status			**Trend**						**Alignment**	
2.1. CQUINs – national	2.1.1	NHS Staff and Wellbeing - Staff Survey	G	TBC									
	2.1.2	NHS Staff and Wellbeing - Healthy Food	A	TBC		Awaiting Update							
	2.1.3	NHS Staff and Wellbeing - Flu Vaccinations	A	TBC									
	2.1.4	Identification and Early Treatment of Sepsis - Treatment in ED	R	65%	53.0%								
	2.1.5	Identification and Early Treatment of Sepsis - Treatment in acute inpatient settings	R	65%	63.0%	Awaiting Update							
	2.1.6	Antimicrobial Resistance - Reduction in Antibiotic Consumption	A	TBC									
	2.1.7	Antimicrobial Resistance - Empiric Review of Antibiotic Consumption	A	TBC		Awaiting Update							
2.2. CQUINs – local	2.2.1	Reduction in Community Acquired Pressure Ulcers	G	TBC									
	2.2.2	Formulary adherence – Percentage reduction in the number of hospital FP10 prescriptions issued by the Trust.	G	TBC									
	2.2.3	Discharges before midday	G	TBC									
	2.2.4	Medication Safety Thermometer	G	TBC		*Awaiting Update*							
	2.2.5	Effective review of patients on Oral Nutritional Supplements (ONS) in the hospital prior to discharge.	G	TBC									
	2.2.6	Paediatric outpatient referral management system	A	TBC									
	2.2.7	Development of electronic clinical communications to GPs, including a standard template for the Electronic Discharge Note	G	TBC									
	2.2.8	Paediatric asthma and wheeze pathway	A	TBC									
2.3. CQUINs – NHS England	2.3.1	Optimal Device - (ICD's)	R	TBC		Awaiting Update							
	2.3.2	Adult Critical Care Timely Discharge	R	TBC									

Theme	Ref	Indicator	Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2
2.4. CQUINs – NHS England (Public Health)	2.4.0	Increase Take Up of School Immunisations			Awaiting Update								
2.5. Nice Compliance	2.4.1	NICE Technology Appraisals implemented			2	0	5						
	2.4.4	NICE Quality Standards escalated			7	53	50						
2.6. Clinical best practice	2.5.3	Emergency readmissions within 7 days	G	4.6%	5.1%	7.7%	4.1%						
	2.5.4	Emergency readmissions within 28 days	R	4.9%	10.5%	12.4%	8.4%				✓		
	2.5.5	Elective surgical readmissions within 28 days	R	0%	4.3%	3.7%	3.7%						
	2.6.9	VTE screening (Quarter Behind)	G	95%		97.0%							
2.7. Best practice tarriff	2.6.0	FNOF: Time to surgery within 36 hours from arrival (1 month in arrears)			90.0%	72.7%	56.0%						

2. Effective - CQUINs

Indicator	Commentary
NHS Staff and Wellbeing Physical, Mental & Physio	Baseline Wellbeing Survey completed. Meeting to be held with CCG to analyse results and agree the required level of improvement for the outcome of the second survey which will be run towards the end of the financial year. A strategy will be written, with an operational plan compiled from staff feedback from the Survey, the Wellbeing Event and gap analysis from the Wellbeing Charter. A further Event is planned for the New Year. Gemma Nauman is CQUIN project lead with effect from 12th October 2016.
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	Vaccines : delivered. Peer vaccinators: trained but uptake disappointing. Monthly draws: to be facilitated by OH - first draw beginning of Nov Statistical analysis: OH working on this together with resourcing of DoH Imms requirements. Additional resources: OH recruiting a Bank Nurse for clinics outside office hours. Food vouchers: not produced by deadline so task taken on by OH who will produce and distribute Comms: robust comms plan in place. Gemma Nauman is CQUIN project lead with effect from 12th October 2016.
Sepsis 2a	There is a large amount of audits which are required for this CQUIN, and so in order to support nursing staff
Sepsis 2b	who are completing the audits, a business case for additional support is with Execs. Audits have been
Antimicrobial Resistance 5a - reduction	On target to deliver - However further clarification required from Commissioners regarding the baseline
Antimicrobial Resistance 5b - review	On target to deliver - However further clarification required from Commissioners regarding the baseline
Joint Formulary	Action plan agreed with CCG
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 Q2 is 25%, MFT achieved 12%. Amanda and Vanessa are meeting CCG on 14/10/16 to review action plan and trajectory.
Paediatric outpatient referral management system	On target to deliver. Database is in place but we haven't received many e-referrals. GPs are not referring electronically. It is the CCGs responsibility to communicate the e-referral system to the GPs. We continue to receive paper referrals, and we are logging all paper referrals in the same way that we would for e-referrals.
Development of Electronic Discharge Note	Monthly meeting with the CCG on 5th October 2016. CCG were really impressed with how we are managing the delivery of the CQUIN and the progress we are making. It is to be reported that we have met the Q1 and Q2 milestones.
Paediatric asthma and wheeze pathway	We have identified a cohort of children and we are completing assessments. Training is also being delivered. We have worked with ED to resolve the issues of communication. There is a risk as nursing backfill has not been authorised, and we only have nursing staff until the end of December 2016.
Optimal Device	Awaiting update
Adult Critical Care Timely Discharge	Baseline agreed to be 30% reduction from 14/15 ICNARC data, of those delayed > 24 hours. Currently, 46% (n292) of delayed discharges from critical care are delayed > 24 hours
Increase take up of School Immunisation	On target to deliver. Action plan has been prepared. No identified risks.

Theme	Ref	Indicator	Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	YTD avg	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2	Quality Account
3.1 Admitted	3.1.1	Friends and Family Test response rate	G	25%	21.5%	24.9%	25.3%		24%			✓			
	3.1.2	Friends and Family Test % extremely likely/likely to recommend	R	83%	88.5%	85.2%	82.3%		85%			✓	✓		
	3.1.3	Mixed Sex Accommodation breaches	R	15	16	28	33		13.5			✓			
	3.1.6	Dementia screening (% of patients over 75) (Reported 1 month in arrears)	G	90%	96.2%	95.4%			95%						
3.2 A&E	3.2.1	Friends and Family Test response rate	R	18%	14.8%	15.5%	14.6%		15%			✓			
	3.2.2	Friends and Family Test % extremely likely/likely to recommend	G	65%	71.1%	74.7%	74.4%		75%			✓			
3.3 Maternity	3.3.1	Friends and family test response rate	G	25%	25.4%	38.6%	58.9%		50%			✓			
	3.3.2	Friends and family test % extremely likely/likely to recommend	G	79%	99.1%	97.9%	99.0%		99%			✓			
3.4 General Patients and Carers	3.4.1	Number of Complaints	R	45	30	44	59		44			✓	✓		
	3.4.3	Number of complaint returners	R	↑	7.0	7.0	8.0		7.5			✓			

FFT A&E and maternity response rate targets are taken from the overall England Average score for 2014/15

Theme	Ref	Indicator	Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	YTD avg	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2	Quality Account
4.1 Elective Treatment (reported 1 month in arrears)	4.1.1	RTT – Incomplete pathways (overall)	R	92%	77.78%	77.71%		~	76.30%	G		✓			
	4.1.2	RTT – Treatments over 52 weeks	R	0	16	18		~	16						
	4.1.3	RTT – Total complete pathways (non admitted)	R	95%	75.80%	77.30%		~	75.74%			✓			
	4.1.4	RTT –Total complete pathways (admitted)	R	90%	59.50%	59.71%		~	55.66%			✓			
4.2 A&E	4.2.1	Trolley wait >12 hours	R	0	0	0	1	~	0.67	G					
	4.2.2	Overall Time in A&E (95th percentile overall time in A&E Dept)	R	04:00	09:37:00	09:25:57	09:00:06	~	09:15:22						
	4.2.3	A&E 4 hour target	R	95%	79.58%	81.49%	81.13%	~	80.61%		✓	✓			
	4.2.7	Ambulance handover time - within 15 minutes	R	70%	51.2%	62.2%	55.1%	~	55.9%						
	4.2.6	Patients left without being seen	G	5%	4.24%	3.35%	3.22%	~	3.52%						
4.3 Cancer (reported 1 month in arrears)	4.3.1	Cancer – 2 week wait	R	93%	76.39%	80.23%		~	84%	G		✓			
	4.3.2	Cancer – symptomatic breast	R	93%	82.61%	82.41%		~	87%						
	4.3.3	Cancer – 31 day first treatments	R	96%	92.31%	94.78%		~	93%						
	4.3.4	Cancer – 31 day subsequent treatments – surgical	R	94%	100.00%	92.86%		~	96%						
	4.3.5	Cancer – anti cancer drug treatment <31 days	G	98%	100.00%	100.00%		~	99%						
	4.3.7	Cancer – 62 day urgent GP referrals	G	85%	72.17%	88.97%		~	78%			✓			
	4.3.8	Cancer – internal 62 day referrals		N/A	74.29%	75.76%		~	85%						
	4.3.9	Cancer – 62 day screening	R	90%	57.14%	72.73%		~	80%			✓			
4.4 Diagnostics (reported 1 month in arrears)	4.4.1	Diagnostic waits - under 6 weeks	R	99%	95.09%	91.18%		~	92%	orange		✓			
	4.4.2	Diagnostic referral levels		N/A	6553	6148		~	6636						

Domain 4: Responsive

Medway **NHS**
NHS Foundation Trust

| Theme	Ref	Indicator	Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	YTD avg	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2	Quality Account
					Jan-16	**Feb-16**	**Mar-16**	For Stroke Only							
4.5 Stroke services *(one quarter in arrears)*	4.5.1	Stroke patients scanned within one hour of arrival	G	50%	49%	56%	61%		52%						
	4.5.2	Stroke patients scanned within twelve hours of arrival	G	95%	95%	100%	96%		97%						
	4.5.3	Patients admitted to a stroke unit within 4 hours of adm	R	90%	53%	42%	46%		42%						
	4.5.4	Patients with at least 90% of their stay on a stroke unit	G	90%	81%	77%	94%		79%						
	4.5.5	Patients receiving thrombolysis (RCP criteria)	R	90%	100%	100%	83%		91%						
	4.5.6	Patients that receive thrombolysis within one hour	R	55%	20%	25%	40%		13%						
	4.5.7	Patients seen by a stroke nurse within 24 hours	R	95%	87%	84%	93%		88%						
	4.5.8	Patients seen by a stroke consultant within 24 hours	R	95%	54%	60%	50%		55%						
4.6 Bed capacity and management	4.6.1	Average elective Length of Stay	G	<5	2.4	2.29	2.29		2.3						
	4.6.2	Average non-elective Length of Stay	R	<5	6.0	5.70	6.34		3.7						
	4.6.3	Average non-elective Length of Stay (Age 0 - 65)	G	<5	3.7	3.80	3.76		1.3						
	4.6.4	Average non-elective Length of Stay (Age > 65)	R	<5	9.3	10.67	11.86		3.1						
	4.6.5	Discharges before noon	R	20%	16%	14%	16%		15%						
	4.6.6	Average occupancy	G	90%	93%	92%	94%		92%						
4.7 Outpatient Management	4.7.1	Did Not Attend rate	G	10%	9.1%	9.6%	9.3%		9%						

4.1 Responsive - RTT

Please see below the Tripartite trajectories for RTT, 52 waiters, Diagnostics and Cancer, with our current performance highlighted.
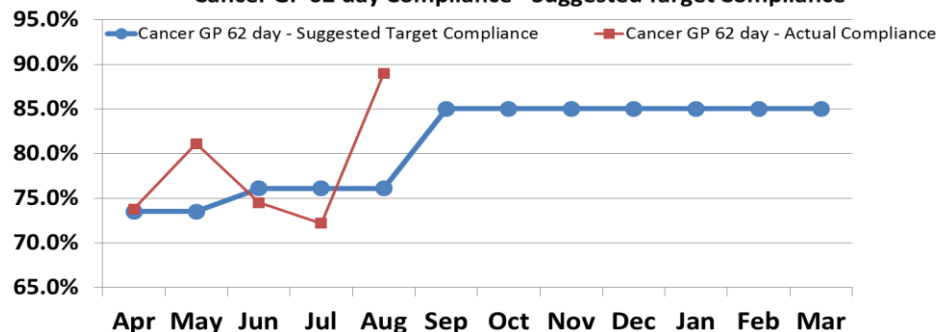

RTT Incomplete Compliance - Suggested Target Compliance
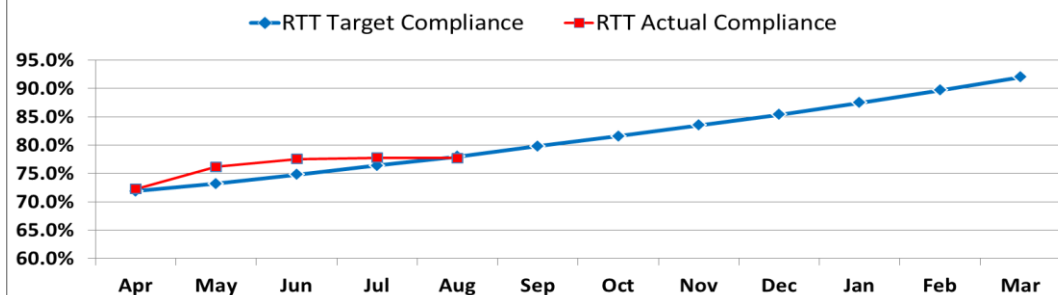
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
RTT Target Total PTL	28,653	25,753	22,852	22,377	21,902	21,427	20,953	20,478	20,003	19,528	19,053	18,578
RTT Target Backlog PTL	8,040	6,900	5,760	5,285	4,810	4,335	3,861	3,386	2,911	2,436	1,961	1,486
RTT Target Compliance	71.9%	73.2%	74.8%	76.4%	78.0%	79.8%	81.6%	83.5%	85.4%	87.5%	89.7%	92.0%
RTT Actual Compliance	72.3%	76.2%	77.5%	77.78%	77.71%							

RTT 52 Weeks - Suggested Target Breaches >52 Weeks
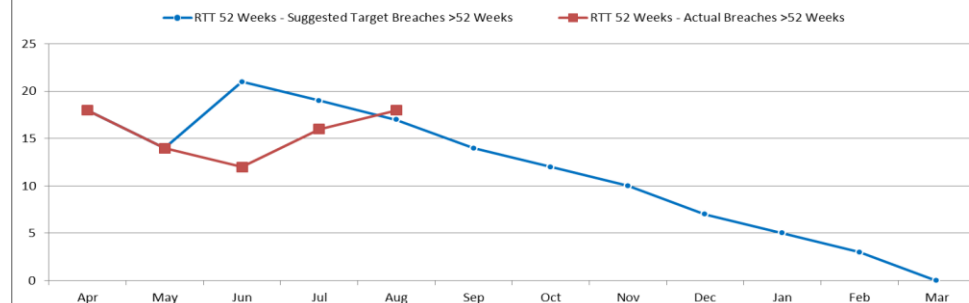
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
RTT 52 Weeks - Suggested Target Breaches >52 Weeks	18	14	21	19	17	14	12	10	7	5	3	0
RTT 52 Weeks - Actual Breaches >52 Weeks	18	14	12	16	18							

Cancer GP 62 day Compliance - Suggested Target Compliance

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Cancer GP 62 day - Suggested Target Activity	70	70	70	70	70	70	70	70	70	70	70	70
Cancer GP 62 day - Suggested Target Breaches	18	18	17	17	17	10	10	10	10	10	10	10
Cancer GP 62 day - Suggested Target Compliance	73.5%	73.5%	76.1%	76.1%	76.1%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Cancer GP 62 day - Actual Compliance	73.8%	81.1%	74.5%	72%	89%							

Diagnostic 6-week Target - Suggested Target Compliance
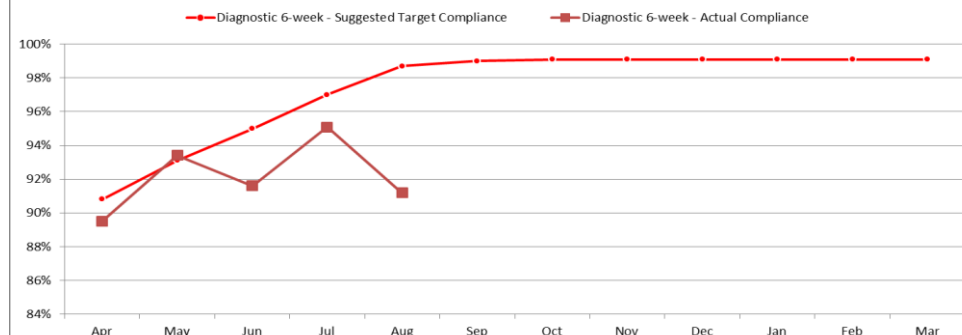
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Diagnostic 6-week - Suggested Target Activity	8100	7905	7751	7602	7484	7467	7447	7447	7447	7447	7447	7447
Diagnostic 6-week - Suggested Target Activity >6 weeks	747	546	385	227	101	74	67	67	67	67	67	67
Diagnostic 6-week - Suggested Target Compliance	90.8%	93.1%	95.0%	97.0%	98.7%	99.0%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%
Diagnostic 6-week - Actual Compliance	89.5%	93.4%	91.6%	95.1%	91.2%							

4.2 Responsive - A&E	Trends
Please see below the Tripartite trajectory for A&E, with our current performance shown.	
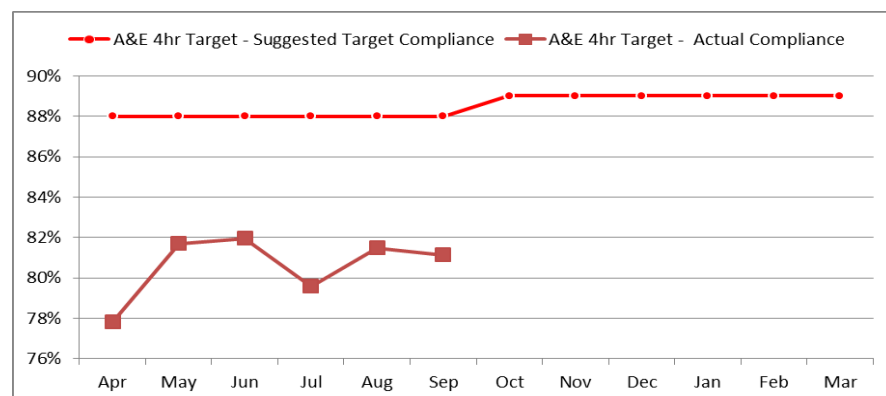
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
A&E 4hr Target - Suggested Target Attendances	9170	9237	9304	9371	9438	9505	9572	9639	9706	9706	9706	9907
A&E 4hr Target - Suggested Target Attendances >4 hrs	1100	1108	1116	1125	1133	1141	1053	1060	1068	1068	1068	1090
A&E 4hr Target - Suggested Target Compliance	88.0%	88.0%	88.0%	88.0%	88.0%	88.0%	89.0%	89.0%	89.0%	89.0%	89.0%	89.0%
A&E 4hr Target - Actual Compliance	77.8%	81.7%	82.0%	79.6%	81.5%	81.1%						

4.3 Responsive - Cancer Waits

2 week wait standard - 93%

Tumour Site	Patients seen	Seen within 2 weeks	Breaches	Performance
Leukaemia	1	1	0	100.00%
Brain	6	6	0	100.00%
Breast	205	183	22	89.27%
Children	17	9	8	52.94%
Gynaecology	76	75	1	98.68%
Haematology	3	3	0	100.00%
Head & Neck	134	131	3	97.76%
Lower GI	146	143	3	97.95%
Lung	19	17	2	89.47%
Other	0	0	0	No patients
Sarcoma	0	0	0	No patients
Skin	678	432	246	63.72%
Testicular	17	17	0	100.00%
Thyroid	0	0	0	No patients
Upper GI	73	68	5	93.15%
Urology	102	100	2	98.04%
TOTAL	**1477**	**1185**	**292**	**80.23%**

2-WEEK WAIT (SYMPTOMATIC BREAST) - Target: 93%

31-DAY FIRST DEFINITIVE TREATMENT - Target: 96%

Tumour Site	Patients treated	Treated within 31 days	Breaches	Performance
Breast	26	25	1	96.15%
Gynaecology	4	4	0	100%
Haematology	8	8	0	100.00%
Head & Neck	0	0	0	No patients
Lower GI	19	19	0	100.00%
Lung	4	4	0	100.00%
Other	0	0	0	No patients
Sarcoma	0	0	0	No patients
Skin	42	40	2	95.24%
Testicular	0	0	0	No patients
Thyroid	0	0	0	No patients
Upper GI	0	0	0	No patients
Urology	31	27	4	87.10%
TOTAL	**134**	**127**	**7**	**94.78%**

31-DAY SUBSEQUENT TREATMENT - SURGERY - Target: 94%

Tumour Site	Patients treated	Treated within 31 days	Breaches	Performance
Breast	7	7	0	100.00%
Gynaecology	0	0	0	No patients
Head & Neck	0	0	0	No patients
Lower GI	3	3	0	100.00%
Other	0	0	0	No patients
Skin	8	7	1	87.50%
Thyroid	0	0	0	No patients
Upper GI	0	0	0	No patients
Urology	10	9	1	90.00%
TOTAL	**28**	**26**	**2**	**92.86%**

31-Day Subsequent Treatment - Drug Treatment - Target: 98%

Tumour Site	Patients treated	Treated within 31 days	Breaches	Performance
Breast	2	2	0	100%
Haematology	9	9	0	100%
Lower GI	0	0	0	No patients
Lung	4	4	0	100%
Urology	8	8	0	100%
TOTAL	**23**	**23**	**0**	**100.00%**

62-DAY STANDARD FROM GP REFERRAL - Target: 85%

Tumour Site	Patients treated	Treated within 62 days	Breaches	Performance
Breast	11	11	0	100.0%
Gynaecology	3	2.5	0.5	83.3%
Haematology	1	1	0	100.0%
Head & Neck	0.5	0.5	0	100.0%
Lower GI	3.5	2.5	1	71.4%
Lung	0.5	0	0.5	0.0%
Other	0	0	0	No patients
Sarcoma	0.5	0.5	0	100.0%
Skin	36.5	34	2.5	93.2%
Thyroid	0	0	0	No patients
Upper GI	0	0	0	No patients
Urology	11.5	8.5	3	73.9%
TOTAL	**68**	**60.5**	**7.5**	**88.97%**

62-DAY SCREENING SERVICES - Target: 90%

Tumour Site	Patients treated	Treated within 62 days	Breaches	Performance
Breast	11	10	1	90.9%
Gynaecology	0.5	0.5	0	100.0%
Lower GI	5	2	3	40.0%
TOTAL	**17**	**13**	**4**	**75.76%**

62-Day Consultant Upgrade

Tumour Site	Patients treated	Treated within 62 days	Breaches	Performance
Gynaecology	0	0	0	No patients
Haematology	0	0	0	No patients
Head & Neck	0	0	0	No patients
Lower GI	0	0	0	No patients
Lung	5.5	4	1.5	72.73%
Skin	0	0	0	No patients
Thyroid	0	0	0	No patients
Upper GI	0	0	0	No patients
TOTAL	**5.5**	**4.0**	**2**	**72.72%**

4 - Responsive - STF Dashboard

Medway **NHS**
NHS Foundation Trust

STF KPIs And Trajectories   **Reporting Month :   Sep-16**

Best of care
Best of people

		Jun-16	Jul-16	Aug-16	Sep-16	Four Month AVG	R/G			Jun-16	Jul-16	Aug-16	Sep-16	Four Month AVG	R/G
Percentage of service users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from referral **(One month in arrears)**	Actual	77.50%	77.78%	**77.71%**		77.66%	▲	All handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 30 minutes	Actual	13.27%	15.49%	16.33%	**9.20%**	15.03%	
	Trajectory	74.80%	76.40%	**78.00%**		76.40%			Trajectory						
Percentage of service users waiting less than six weeks from referral for a diagnostic test **(One month in arrears)**	Actual	91.60%	95.09%	**91.18%**		92.62%	▼	All handovers between ambulance and A&E must take place within 15 minutes with none waiting more than 60 minutes	Actual	2.63%	2.98%	2.56%	**1.70%**	2.72%	
	Trajectory	95.00%	97.00%	**98.70%**		96.90%			Trajectory			TBC			
Percentage of A&E attendances where the service user was admitted, transferred or discharged within four hours of their arrival at an A&E department	Actual	81.94%	79.58%	**81.49%**		81.00%	▼	Following handover between ambulance and A&E, ambulance crew should be ready to accept new calls within 15 minutes and no longer than 30 minutes	Actual	4.56%	5.75%	5.80%	**5.19%**	5.37%	
	Trajectory	88.00%	88.00%	**88.00%**		88.00%			Trajectory			TBC			
Percentage of service users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer **(One month in arrears)**	Actual	74.48%	72.17%	**88.97%**		78.54%	▼	Following handover between ambulance and A&E, ambulance crew should be ready to accept new calls within 15 minutes and no longer than 60 minutes.	Actual	0.45%	0.06%	0.47%	**0.00%**	0.32%	
	Trajectory	76.10%	76.10%	**76.10%**		76.10%			Trajectory			TBC			
Zero tolerance RTT waits over 52 weeks for incomplete pathways **(One month in arrears)**	Actual	12	16	**18**		15.33	▲								
	Trajectory	0	0	**0**											
Trolley waits in A&E longer than 12 hours	Actual	1	2	0	**1**	1	▼								
	Trajectory	0	0	0	**0**	0									

Commentary

Below are the caveats provided on submission of these trajectories

RTT - The RTT trajectory is being revised at the request of NHS E and the CCG, to meet the prescribed compliance plan of March 2017. The calculated trajectory provides a straight line projection from the Trust current position to compliance achievement at the end of Q4 2016/17. This will be exceptionally challenging to deliver and success will be predicated on robust whole system involvement in delivery of the plan. The Trust is revising the trajectory with the following caveats:
1. A whole system approach to the development of the delivery plan is required
2. CCG demand management plans need to be developed with detailed implementation plans and impact analyses.
3. A joint approach between commissioners and Medway will be required to source alternative outpatient capacity.
4. The expected impact of items 1-3 and a jointly owned delivery plan will be developed by the end of June 2016.
5. A review of the trajectory with the delivery plan , using the Trust forecast modelling tool, will be completed in July 2016.
6. The Trust will seek to conduct a telephone validation of the current waiting list.
7. The Trust will expect that any adverse movement of the new to follow up ratio, due to additional activity being undertaken, will not incur any financial penalty.

Cancer - Following discussion with the CCG, the cancer trajectory is being revised to deliver 62 day compliance in September 2016. The revised trajectory is submitted with the following caveats:
1. Clarity needs to be sought regarding the breach allocation, in particular where delays are due to non-Medway surgeon capacity.
2. Demand management reviews will be undertaken for 2WW referrals.

ED - Following discussion with the CCG and NHSE, the ED trajectory is being revised to deliver 89% performance in Q4 2016/17. This trajectory will be the same as that submitted by the CCG and remains different to that suggested by NHSE. The Trust retains the underlying assumption that there is the likely potential of a demand increase over winter (along with longer Length of Stay) affecting flow . The revised trajectory is submitted with the following caveat:
1. The CCG will develop robust demand management schemes.
2. The impact of demand management schemes will be reviewed in September and performance monitored against expected impact and the revised trajectory.

DM01 - The trajectory submitted for the DM01 meets the expectation of compliance by September 2016 and has been generated in discussion with the CCG. This is predicted on the basis of successful insourcing of endoscopy capacity.

						Status	Trend							Alignment				
Numbering formulae			Theme	Ref	Indicator	Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	YTD avg	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2	Quality Account
5.1	1 5.1.1		**5.1 External assessments**	5.1.1	Monitor governance rating	R	3	2	2	2	•••	1						
				5.1.2	CQC rating	R	Good	Inadequate										
5.1	2 5.1.2 5.3			5.1.3	CQC Inpatient / MH and Community Survey	R		Awaiting Data										
5.2	1 5.2.1		**5.2 Staff experience (Figures for Q2)**	5.2.1	Staff Friends and Family – Recommend as place to work	R	62%	48.8%							✓			
5.2	2 5.2.2 5.3			5.2.2	Staff Friends and Family – Recommend for care or treatment	R	79%	67.5%							✓			
5.3	1 5.3.1			5.3.1	Vacancy rate - Medical (unfilled % of budgeted WTE)	R	8%	16.0%	9.0%	9.3%		12%						
5.3	2 5.3.2			5.3.2	Vacancy rate - Nursing (unfilled % of budgeted WTE)	R	8%	25.0%	26.0%	26.4%		25%						
5.3	3 5.3.3			5.3.3	Vacancy rate - Others (unfilled % of budgeted WTE)	R	8%	14.3%	13.4%	13.4%		13%						
5.3	4 5.3.4			5.3.4	Appraisals completed (% all staff)	R	95%	66.2%	70.4%	70.7%		70%						
5.3	5 5.3.5			5.3.5	% of medical staff completing revalidation who were due to be re-validated within the month	G	100%	100%	N/A	N/A	To be validated							
5.3	6 5.3.6			5.3.6	Mandatory training compliance	G	80%	84.6%	83.2%	83.7%		84%						
5.3	7 5.3.7		**5.3 Workforce indicators**	5.3.7	Rolling annual turnover rate	R	8%	9.4%	9.1%	9.1%		9%			✓			
				5.3.7.1	Executive Team Turnover Rate		TBA	0.0%	0.0%	0.0%		0%			✓			
5.3	8 5.3.8			5.3.8	Overall Sickness rate	G	4.0%	3.7%	3.9%	3.9%		3.9%				✓		
5.3	9 5.3.9			5.3.9	Sickness rate – Short term	R	2.0%	3.5%	2.7%	2.7%		2.8%			✓			
5.3	10 5.3.10			5.3.10	Sickness rate – Long term	R	1.0%	0.3%	1.3%	1.3%		1.1%			✓			
5.3	11 5.3.11			5.3.11	Temporary staff % of pay bill		15%	21.9%	23.9%			23%			✓			
5.3				5.3.13	Local Induction % Compliance	R	80%	36.14%	37.95%	45.97%		44.14%						
5.3				5.3.14	Starters		N/A	85	129	89		86.8						
5.3				5.3.15	Leavers		N/A	53	154	51		66.2						

Theme	Ref	Indicator	Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	YTD avg	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2	Quality Account
7.2 Clinical coding, information and IT* (1 month in arrears)	7.2.1	APC – NHS number completeness (1 month in arrears)	R	99%	99.2%	98.8%			98.8%					✓	✓
	7.2.2	APC – Primary diagnosis (1 month in arrears)	G	96%	96.5%	99.7%			98.5%					✓	✓
	7.2.3	APC – HRG4 (1 month in arrears)	G	96%	96.0%	99.7%			96.5%					✓	✓
	7.2.4	OP – NHS number completeness (1 month in arrears)	G	99%	99.4%	99.4%			99.4%					✓	✓
	7.2.5	OP – Primary procedure (1 month in arrears)	G	99%	99.8%	100.0%			100.0%					✓	✓
	7.2.6	OP – HRG 4 (1 month in arrears)	G	98%	98.5%	100.0%			99.7%					✓	✓
	7.2.7	A&E – NHS number completeness (1 month in arrears)	G	95%	96.4%	96.3%			96.0%					✓	✓
	7.2.8	A&E – Attendance disposal (1 month in arrears)	R	99%	97.7%	96.0%			96.2%					✓	✓
	7.2.9	A&E – HRG4 (1 month in arrears)	G	97%	95.8%	100.0%			99.2%					✓	✓
7.3 Data quality improvement	7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	R	0	49	88			52.6		✓			✓	✓
	7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	R	0	0.1%	0.0%			0.1%		✓			✓	✓
	7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	R	0	401	393			447.0		✓			✓	✓
	7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	R	0	1.50%	1.49%			1.7%		✓			✓	✓
	7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	R	0	406	421			470.6		✓			✓	✓
	7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	R	0	0	1			4.6		✓			✓	✓
	7.3.12a	A&E No. missing left department times	G	0	0	0	0		0.0		✓			✓	✓
	7.3.12b	A&E % missing left department times	G	0	0%	0%	0%		0.0%		✓			✓	✓
	7.3.13a	A&E No. missing breach reason on breached attendances	R	0	937	1768	1806		978.3		✓			✓	✓
	7.3.13b	A&E % missing breach reason on breached attendances	R	0	55.5%	100.0%	100.0%		79.1%		✓			✓	✓
	7.3.16	Cancer 2ww missing NHS number	G	0	0	0	0		0.0		✓			✓	✓
	7.3.17	Cancer 2ww invalid NHS Number	G	0	3	5	0		6.0		✓			✓	✓
	7.3.18	Cancer 2ww missing referral received date	G	0	0	0	0		0.0		✓			✓	✓
	7.3.19	Cancer 2ww missing urgent referral type	G	0	1	0	0		0.3		✓			✓	✓
	7.3.20	Cancer 2ww missing org code first seen	G	0	0	0	0		0.0		✓			✓	✓
	7.3.21	Cancer 2ww missing breach reason	R	0	70	39	8		30.5		✓			✓	✓
	7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex	R	0	0.52%	0.71%	0.01%		4%		✓			✓	✓

Theme		Ref	Indicator	Status	Monthly target	Jul-16	Aug-16	Sep-16	12m Trend	YTD avg	Data Quality	Carter	SOF	Recovery Phase 1	Recovery Phase 2	Quality Account
		7.3.23	Cancer 31 day missing NHS number	G	0	0	0	0		0.0		✓			✓	✓
		7.3.24	Cancer 31 day invalid NHS number	G	0	0	0	0		0.0		✓			✓	✓
		7.3.25	Cancer 31 day missing primary diagnosis	R	0	9	11	3		10.3		✓			✓	✓
		7.3.26	Cancer 31 day missing tumour laterality	G	0	9	0	0		8.0		✓			✓	✓
		7.3.27	Cancer 31 day missing decision to treat date	G	0	0	0	0		0.0		✓			✓	✓
		7.3.28	Cancer 31 day missing org code for treatment	G	0	0	0	0		0.0		✓			✓	✓
		7.3.29	Cancer 31 day missing breach reason	R	0	4	4	3		3.8		✓			✓	✓
		7.3.30	Cancer 62 day missing NHS number	G	0	0	0	0		0.0		✓			✓	✓
		7.3.31	Cancer 62 day invalid NHS number	G	0	0	0	0		0.0		✓			✓	✓
		7.3.32	Cancer 62 day missing primary diagnosis	G	0	7	5	0		5.7		✓			✓	✓
		7.3.33	Cancer 62 day missing tumour laterality	G	0	7	0	0		4.8		✓			✓	✓
		7.3.34	Cancer 62 day missing decision to treat date	G	0	0	0	0		0.0		✓			✓	✓
		7.3.35	Cancer 62 day missing org code for treatment	G	0	0	0	0		0.0		✓			✓	✓
		7.3.36	Cancer 62 day missing breach reason	R	0	15	5	2		7.2		✓			✓	✓
		7.3.37	Cancer 62 day missing consultant upgrade	G	0	0	0	0		12.2		✓			✓	✓

Enablers

Estates Summary

Medway NHS
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What assurances have we received?	That key issues relating to Estates services are being maintained to the correct statutory and mandatory levels and where they are not being achieved an action plan is in place to achieve the necessary level. The primary elements requiring action have been highlighted, which are; Water Safety, Fire Safety and Electricity at work; In relation to Water Safety there has been a marked improvement in compliance that the Authorised Engineer's audit from 68% to 81%. In relation to Fire Safety an action plan with approved funding by the Trust is in place and the work is being carried out. In relation to Electricity at Work an Authorised Engineers report was recently carried out and an action plan is being developed.
Which messages or risks need to be escalated?	Need to improved Planned preventative maintenance items noted within the Water Risk Assessment 2013 as outstanding. Need for decant ward to enable completion of the Electricity at work items which are outstanding.
What actions have we agreed to undertake?	Recruitment of staff to necessary levels and complete necessary PPM as indicated on Water Safety Plan. Deliver Fire Safety action plan Continue campaign for decant ward to enable Electricity at Works items to be completed (this needs to continue until bed pressures reach an appropriate level).
What outcomes would we like to see as a result?	Zero harm in relation to Water Safety, Fire Safety and Electricity at work.

Reporting Period: **Sep-16**

Performance Review Scorecard - Clinical Directorates Summary

Ref	Indicator	Units	Target	R/G *	All areas Overall Clinical	Acute & Continuing Care Current Reporting Period	Acute & Continuing Care Previous Reporting Period	Acute & Continuing Care Trend	Co-ordinated Surgical Current Reporting Period	Co-ordinated Surgical Previous Reporting Period	Co-ordinated Surgical Trend	Womens and Children Current Reporting Period	Womens and Children Previous Reporting Period	Womens and Children Trend
Safe														
1.1.3	Total Serious Incidents	Number	5	green	5	3	6		1	0		1	2	
1.1.4	Never Events	Number	0		0	0			0	0		0	0	
1.2.1a	Proportion of harm free care - Point prevalence in month - all harms	Monthly %	95%	red	88.93%	85.61%	92.52%		91.57%	95.65%		100.00%	100.00%	
1.2.1b	Proportion of harm free care - Point prevalence in month - new harms	Monthly %	95%	green	98.36%	97.05%	98.98%		100.00%	99.28%		100.00%	100.00%	
1.2.3	Pressure ulcers (grade 3&4)	Number	0		2	1	2		1	0		0	0	
1.2.5	Patient falls with moderate or severe harm	Cases	0	red	4	4	3		0	0		0	0	
1.3.1	MRSA screening of admissions	Monthly %	95%		89%	94.85%	93.85%		90.20%	87.14%		72.00%	93.75%	
1.3.3	C-Diff acquisitions (Trust-attributable)	Number	0		6	5	2		1	0		0	0	
1.4.1	Hospital Standardised Mortality Ratio (HSMR) - Weekend	Number	100		106.2	100.86	98.8		139.61	132.48		160.07	164.07	
1.4.4	Hospital Standardised Mortality Ratio (HSMR) (All days)	Number	100		101.72	99.02	100.71		112.54	109.81		68.45	70.29	
1.4.4	Deaths in Hospital	Number	N/A		92	70	88		20	11		2	1	
1.5.1	Safe staffing – ratio of actual to planned nursing hours	Ratio	0.93	green	1.06	1.11	1.05		1.07	1.05		0.95	0.95	
Effective														
2.2.1	Non elective Length of Stay	Cum ALOS	N/A		6.34	7.23	9.62		4.76	5.94		1.61	2.63	
2.2.4	Complaints	Number	N/A		59	30	24		22	12		7	7	
2.5.2	Number of day cases (Quality Account)	Number	N/A		1722	605	558		945	839		173	176	
2.5.3	Emergency readmissions within 7 days	Monthly %	N/A		5.15%	4.78%	5.12%		3.58%	3.68%		4.73%	3.07%	
2.5.4	Emergency readmissions within 28 days	Monthly %	10%	red	10.36%	10.74%	11.50%		7.18%	5.94%		7.60%	8.05%	
Caring														
3.1.3	Mixed sex accommodation breaches	Cases	15	red	33	0	0		33	28		0	0	
3.1.4	No. Patients cancelled on day of Surgery	Number			38	1	5		32	29		5	4	
3.1.5	Patients cancelled and not admitted within 28 days	Number	0		2	0	0		2	0		0	0	
3.1.6	Friends and Family Test response rate (Admitted)	Monthly %	25%	green	25.30%	21.40%	23.10%		29.90%	23.67%		24.70%	36.44%	
3.1.7	Friends and Family Test % recommend (Admitted)	Monthly %	83%	red	82.30%	79.50%	78.30%		80.50%	79.60%		86.90%	87.50%	
Responsive														
4.1.1	RTT – Incomplete pathways (overall) (1 month in arrears)	Monthly %	92%	red	77.71%	73.64%	73.44%		77.11%	77.12%		97.15%	98.08%	
4.1.2	RTT – Treatments over 52 weeks (1 month in arrears)	Number	0		18	2	5		16	11		0	0	
4.1.3	RTT – Total complete pathways (non admitted) (1 month in arrears)	Monthly %	95%	red	77.28%	72.37%	68.76%		74.89%	75.00%		96.52%	97.84%	
4.1.4	RTT –Total complete pathways (admitted) (1 month in arrears)	Monthly %	90%	red	59.71%	40.91%	57.14%		52.13%	51.32%		85.31%	87.17%	
4.3.1	Cancer – 2 week wait (1 month in arrears)	Monthly %	93%	red	80.23%	67.56%	59.45%		95.03%	95.59%		98.68%	95.89%	
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	Monthly %	94%		92.86%	87.50%	100.00%		95.00%	100.00%		No pts	No pts	
4.3.5	Cancer – secondary chemotherapy <31 days (1 month in arrears)	Monthly %	98%	green	100.00%	100.00%	100.00%		100.00%	100.00%		No pts	No pts	
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	Monthly %	85%		88.97%	92.21%	82.22%		84.91%	66.67%		83.33%	57.14%	
4.3.9	Cancer – 62 day screening (1 month in arrears)	Monthly %	90%	red	75.76%	No pts	No pts		75.00%	76.47%		100.00%	0.00%	
4.6.1	Average elective length of stay	Cum ALOS	<5	green	2.29	3.54	3.79		2.23	2.79		2.29	1.92	
4.6.3	Discharges before noon	Monthly %	25%		15.67%	13.90%	13.73%		17.33%	13.93%		16.83%	25.93%	
4.7.2	Follow-up to new ratio	Ratio			1.98	2.67	2.45		1.81	1.91		1.27	1.35	
4.7.3	Did not attend rate	Monthly %	10%	green	9.20%	8.20%	8.69%		9.60%	9.93%		10.60%	10.96%	
Well-Led														
5.3.4	Appraisals completed (% all staff)	Monthly %	95%			68.65%	62.00%		62.24%	66.00%		83.22%	81.00%	
5.3.5	Local Induction Compliance	Monthly %		red		43.39%	33.45%		34.52%	29.57%		45.86%	29.92%	
5.3.6	Mandatory training compliance	Monthly %	85%	red		81.22%	80.00%		83.70%	82.00%		88.42%	88.00%	
5.3.7	Rolling annual turnover rate	Monthly %	8%	red		12.28%	12.00%		9.60%	10.00%		9.08%	6.00%	
5.3.8	Overall Sickness rate	Monthly %	3%	red		3.54%	3.50%		4.19%	4.21%		3.56%	3.63%	
5.3.10	Temporary staff % of pay bill	Monthly %	15%				31.00%			22.51%			8.96%	
5.3.11	Vacancy Rate %	Monthly %	8%	red		17.24%	16.29%		21.99%	22.19%		11.29%	12.63%	
Enablers														
6.4.1	NHS number completeness (Inpatients and Outpatients)	Monthly %	N/A		99.32%									
6.4.2	Primary Diagnosis (Inpatients)	Monthly %	N/A		99.70%									
6.4.5	Primary Procedure (Inpatients and Outpatients) **Under Review**		N/A											
560	Clinical Income variance to Plan	Mthly £ var	£0	green	0		-289			52			-92	
606T	Expenditure budget variance to plan	Mthly £ var	£0	green	0		343			-75			53	
Income	CIP Performance variance to plan	Mthly £ var	£0	green	0		0			0			0	
102	% of CIP plans fully developed	Monthly %	100%	red	0.00%		73.27%			76.28%			100.00%	

Report to the Board of Directors

Board Date: 27th October 2016

Title of Report	Monthly Operations Report
Reporting Officer	Margaret Dalziel, Director of Clinical Operations A&CC
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: 77.8% (Incomplete) – target 92% - Diagnostics: 91% - target 99% - ED performance: Actual 81.12% - target 89% (national 95%) - Cancer performance: improvement in all targets except 31D subsequent treatment surgery where 92.86% (target 100%)
Risk and Assurance	Performance against the access standards for Emergency and RTT pathways do not meet the national targets. Improvements continue to be made and action plans remain in place to support the maintenance of the improvement trajectory. Improvements can be seen against most measures.
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.
Purpose & Actions required by the Board : **Assistance** **Approval** **Decision** **Information**	The board are asked to note the contents of the report for information.
Recommendation	The report is provided for information only.

Operations Update: September 2016

- ED
- Emergency Pathway
- Medical Model
- Cancer
- Referral to Treatment (RTT)
- Imaging/Diagnostic

Report to Trust Board October 2016

Margaret Dalziel

Ben Stevens

James Lowell

ED Update

Summary

- Total ED attenders: 9649 - 16% increase on September 2015.

- Ambulance attendances: 3200 - 11% increase on September 2015. Remain top performer in the region with 55.1% of handovers within 15 minutes compared to last September when 7th in the region with 41.8% managed within 15 minutes.

- Monthly performance against the 4 hour standard : 81.12%

This year to date, MFT has seen a 12.5% increase in total attenders and an almost 6% increase in ambulance attendances.

Performance against the 4 hour standard
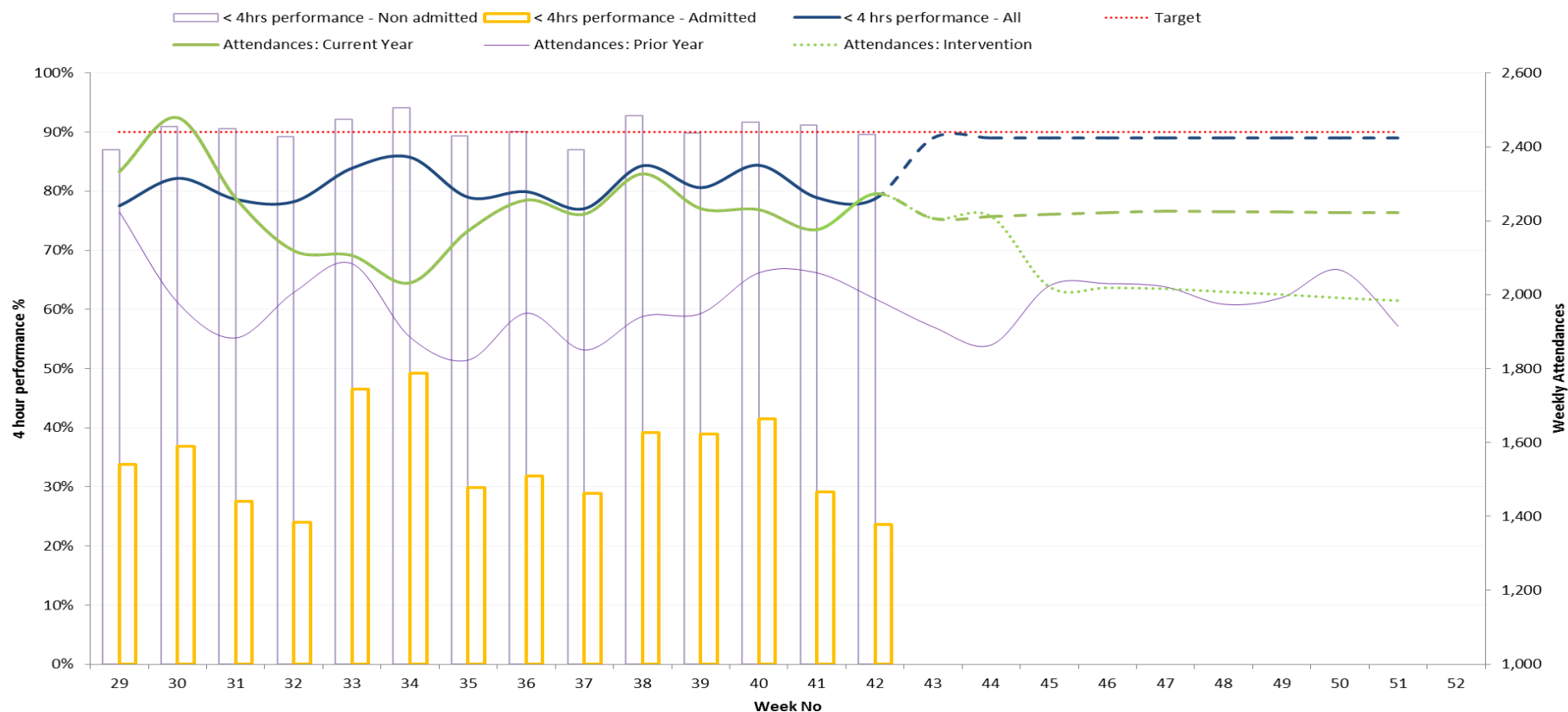
Unplanned Care - September

Admissions	Flow	Discharge

Medical Model

4 hour performance

	Target	Aug-16	Sep-16	
All	90%	81%	81%	🟠
Admitted	50%	37%	35%	🔴
Non Admitted	95%	91%	90%	🔴

Hospital

Total Attendances

YTD

2015	2016
76,101	85,636

+13%

Month

Aug-16	Sep-16
9,422	9,691
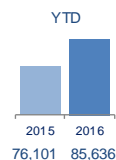
+3%

Emergency Admissions

Month

Aug-16	Sep-16
1,641	1,590

17%   16%

Admissions via A&E

Age Range	Sep-15	Sep-16	
<65	645	561	-13%
65-79	331	367	11%
80+	352	390	11%

Admissions via A&E

Ward	Sep-15	Sep-16	
Gundulph	56	269	⬆
Wakely	51	240	

Average LOS

	Sep-15	Sep-16	
Gundulph	6.0	2.3	⬇
Wakely	5.7	2.8	

% LOS reduction

Age Range	Sep-15	Sep-16	% Change
<65	3.7	3.0	-19%
65-79	7.3	6.6	-10%
80+	12.5	9.3	-25%
Average	6.7	5.6	-16%

Discharges from Medical Ward

	Weekly Average		
LoS Range	Jan-16	Sep-16	% Change
Zero LoS	92	115	25%
7+ LOS	97	79	-18%

Prenoon discharges from an Acute Ward

Jan-16	Sep-16
11.8%	12.3%

Milestone Actions

1. Enhanced Triage / RAP
2. Primary Care Streaming Pathway
3. Mental Health Pathway
4. ED Rapid Response Pathway
5. Emergency Surgical Pathway
6. Emergency Gynae Pathway

1. Internal Professional Standards
2. Trust Concept of Operations
3. Board Rounds / Ward Rounds
4. Medical Model Transition

1. EDN
2. Criteria Led Discharge
3. Supporting Early Discharge
4. Choice Policy
5. Frailty Flow

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Admissions

Medical Emergency admissions via A&E

Admission by Speciality code in Oasis PAS
To be reconciled with Symphony ward distribution

Bars: All Ages Admissions under Medical

Lines: Age Range of Admitted under Medical and via A&E

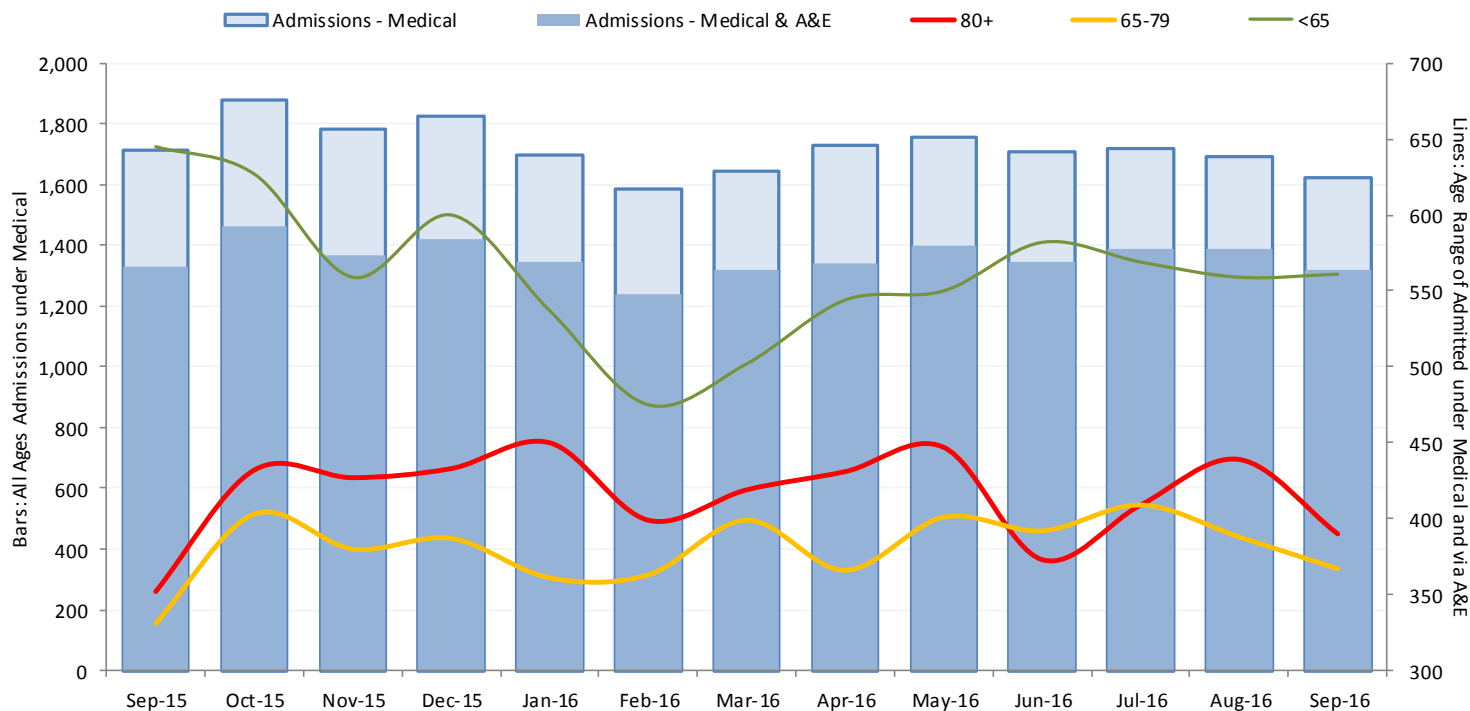Legend: Admissions - Medical | Admissions - Medical & A&E | 80+ | 65-79 | <65

	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	
Admissions - Medical	1,715	1,880	1,783	1,827	1,696	1,583	1,646	1,729	1,757	1,709	1,718	1,694	1,621	-5%
Admissions - Medical & A&E	1,328	1,462	1,366	1,420	1,348	1,237	1,320	1,341	1,398	1,347	1,387	1,386	1,318	-1%
	77%	78%	77%	78%	79%	78%	80%	78%	80%	79%	81%	82%	81%	
Age Range														
<65	645	627	559	600	537	475	502	544	550	582	569	559	561	-13%
65-79	331	403	380	387	361	363	399	366	401	392	409	388	367	11%
80+	352	432	427	433	450	399	419	431	447	373	409	439	390	11%
<65	49%	43%	41%	42%	40%	38%	38%	41%	39%	43%	41%	40%	43%	
65-79	25%	28%	28%	27%	27%	29%	30%	27%	29%	29%	29%	28%	28%	
80+	27%	30%	31%	30%	33%	32%	32%	32%	32%	28%	29%	32%	30%	

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Flow / Medical Model

Discharge/ Medical Model

Average LoS

Legend: 80+ (red), 65-79 (yellow), <65 (green), Total Average (blue dashed)

Medical Model Implemented

Age Range	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	Sep-15 to Sep-16	Mar-16 to Sep-16
														% LOS reduction	
<65	3.7	3.0	3.1	2.7	3.4	3.4	3.4	3.2	3.1	3.4	2.8	3.0	3.0	-19%	-12%
65-79	7.3	8.0	6.3	7.9	6.9	6.9	7.7	6.2	6.3	6.4	6.1	6.3	6.6	-10%	-15%
80+	12.5	10.3	9.9	9.8	10.3	10.8	11.1	9.1	7.6	7.7	9.9	8.1	9.3	-25%	-16%
Total Average	6.7	6.2	5.7	6.1	6.3	6.4	6.7	5.7	5.2	5.3	5.6	5.3	5.6	-16%	-17%

Best of care
Best of people

Medway
NHS Foundation Trust

Discharge/ Medical Model

Discharges from Medical Wards

—— Zero LoS   —— 7 LOS

	Weekly Average		% increase/
LoS Range	Jan-16	Sep-16	reduction
Zero LoS	92	115	25%
7 LOS	97	79	-18%

	Weekly Average		% increase/
	Mar-16	Sep-16	reduction
	97	126	30%
	103	74	-28%

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Cancer Update

Summary of validated July Open Exeter position

There has been a general improvement in performance against the cancer waiting time standards, most notably 31 day first treatment and the 62 day GP referral which has exceeded both trajectory and the standard. The Trust has maintained 31 day subsequent treatment drug but just fallen short on maintaining 31 day subsequent treatment surgery. The 2 week wait has improved but is still non-compliant predominantly due to lack of Dermatology capacity.

2WW – Trust has failed the 2 week wait and symptomatic breast standards.

- 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 an improvement trajectory is being developed.

- The Trust failed to achieve the symptomatic breast standard. Breaches were as a result of patient cancellations, patient choice and Consultant availability which is being actively addressed within the Coordinated Surgical Directorate.

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

- Breaches were due to patient choice, patient cancellations, with Urology breaches also including a delay in offering treatment date, complex pathway and theatre availability which is being actively addressed within the Coordinated Surgical Directorate.

62D – The Trust achieved the GP referral standard but failed to meet the screening standard in Lower GI with 4 breaches due to a complex pathways and theatre availability.

- The Coordinated Surgical Directorate is progressing a Cancer Action Plan to address performance across all the Directorate's tumour sites.

- Workshops are being planned to review breach reports for the challenged tumour sites of Urology & Lower GI to identify issues, themes and remedial actions.

- Delays in pathways due to patient choice are being reviewed to ensure all appropriate adjustments are being recorded.

Cancer Waiting Time Summary Performance (one month in arrears)

Target		Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16
93%	2WW cancer	85.23%	87.43%	95.77%	96.42%	94.06%	93.40%	92.57%	75.44%	76.39%	80.23%
	Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
93%	2WW symptomatic breast	83.70%	90.40%	88.24%	92.31%	81.42%	89.81%	86.00%	91.87%	82.61%	82.41%
	Target	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%	93.00%
96%	31D first treatment	92.20%	94.12%	90.84%	93.38%	89.31%	95.61%	94.39%	87.50%	92.31%	94.78%
	Target	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%	96.00%
94%	31D sub treatment surgery	94.44%	87.50%	85.00%	83.33%	82.86%	94.29%	97.14%	96.88%	100.00%	92.86%
	Target	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%	94.00%
98%	31D sub treatment drug	100.00%	88.24%	92.00%	100.00%	100.00%	100.00%	95.83%	100.00%	100.00%	100.00%
	Target	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%	98.00%
85%	62D GP referral	87.73%	83.33%	65.41%	75.40%	83.02%	73.77%	81.10%	74.48%	72.17%	88.97%
	Target	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%	85.00%
90%	62D screening	87.50%	90.63%	92.86%	96.15%	72.73%	84.85%	86.67%	100.00%	74.29%	75.76%
	Target	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%	90.00%
n/a	62D consultant upgrade	100.00%	64.29%	71.43%	78.95%	71.43%	100.00%	75.00%	100.00%	57.14%	72.73%

Cancer Remedial Action Plan
The outstanding Cancer Remedial Plan actions and evidence are being reviewed and closed in regular meetings with commissioners.
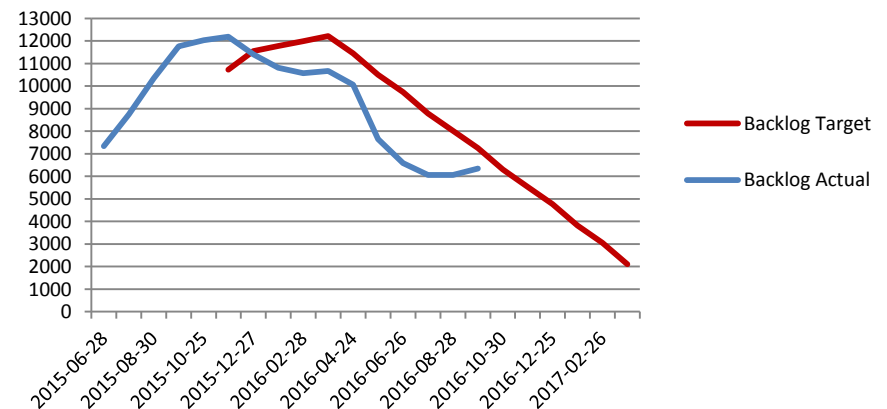
RTT Update

Summary

- The Trust is not currently reporting externally for RTT. The draft report has been received from the intensive support team following the visit in September 2016. The final report is expected at the end of October. The trust was scored 3 points higher than the self-assessment and some areas of good practice were highlighted. Once the IST send out the final report a summit will be convened by NHSi with the local health economy partners to agree the next step actions for recovery.

- The total incomplete waiting list size increased by approximately 15 patients across the month of September. Additional Capacity is being arranged which will support further waiting list reduction.

- Incomplete performance for September is 77.8% which is slightly behind the trajectory. Actions are in place to recover this position.

- The current backlog size increased in September however 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 is currently worse than trajectory.

- Specialities that give cause for concern are ENT, Orthopaedics, Cardiology and Respiratory.
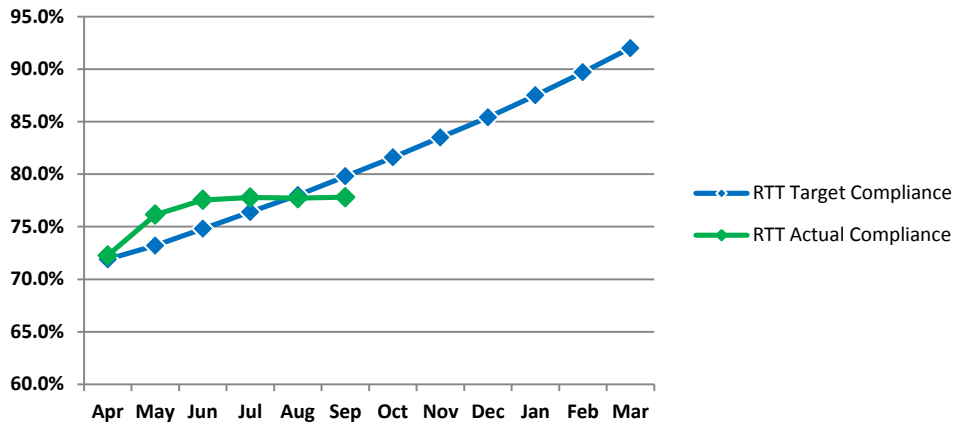
Total Waiting List Size
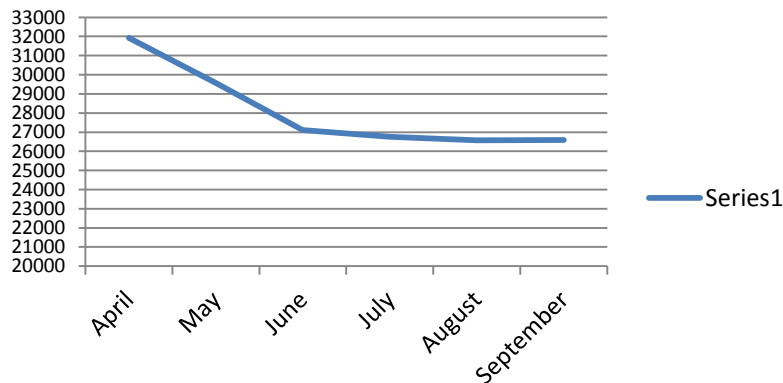
Backlog Actual vsTrajectory

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
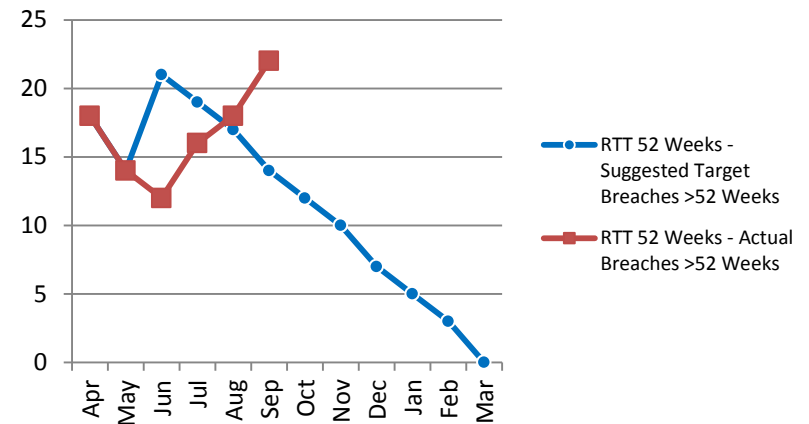
18 week RTT Sustainability Plan

 The final Intensive Support Team diagnostic report will be received in early October an action plan based on the draft report is being developed and will form part of the overall RTT recovery plan.

The outsourcing of orthopaedic activity to Ashford one is now in progress.

Cardiology, Respiratory and ENT in-sourcing will be commencing in October and will contribute to backlog clearance and waiting list reduction.

The planned care programme work streams have now launched.

A process to complete clinical harm reviews for any patient that exceeds 52 weeks wait for definitive treatment or discharge is under way.

Diagnostic Update – September 2016 Position

Summary

- Trust performance against the 6 week diagnostic target has deteriorated for September 2016.
- MRI scanning has seen deterioration.
- 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

Legend:
- Diagnostic 6-week - Suggested Target Compliance
- Diagnostic 6-week - Actual Compliance
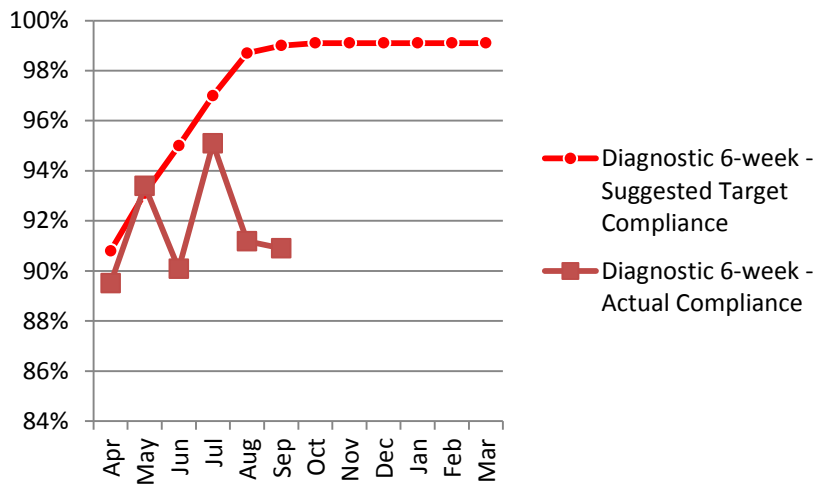
Diagnostic Performance by Modality

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
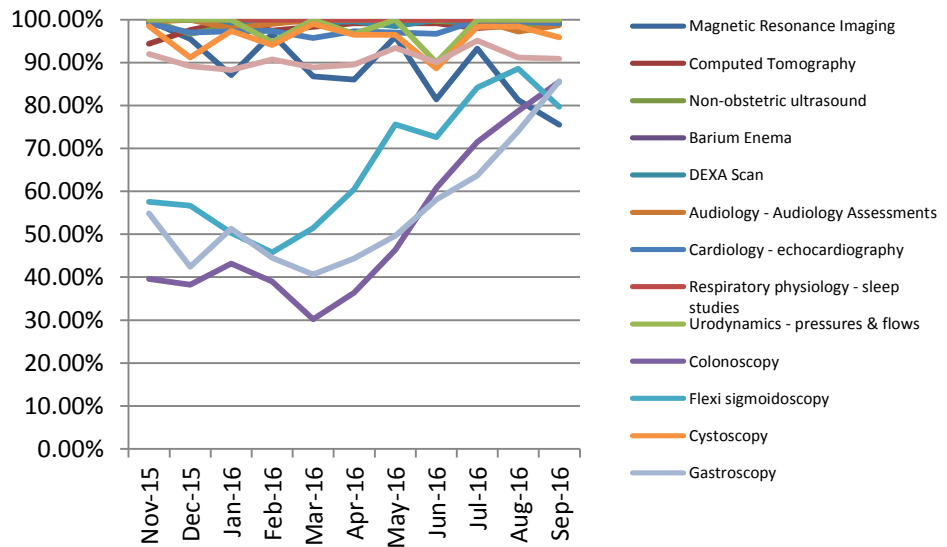
Diagnostic Sustainability Plan

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.

A strategic review of all areas within imaging is planned for completion by the end of 2016.

Report to the Board of Directors

Board Date : 27th October 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 :

- The report outlines the current status in relation to serious incidents. The number of Sis was raised as a concern at QIG, ten reported during September . We have a higher number of Sis related to last year, with an increase in Sis relating to treatment delay, which reflect patients waiting over 52 weeks associated with RTT waiting times, fewer relating to maternity closures with an increase in pressure ulcer related SIs.

- We have reported 1 Never Event this month, the incident 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 harm the patient. However consultation with NHSI confirmed it met the criteria for a Never Event.

- The numbers also reflect more robust identification of serious incidents via complaints and mortality reviews. However the delay in reporting Sis reflects weaknesses in the directorate governance processes. A message has been disseminated to all directorates to ensure that when a RED complaint is received then it is immediately raised as a potential SI and that all mortality and morbidity meeting minutes are scrutinised to ensure that any potential SI are escalated to the executive team for decision making immediately.

- Swarm events have been arranged for pressure ulcer incidents, with falls and nutrition identified as topics for the next 2 events. Treatment delays are being address via the focus on waiting times and increased clinical engagement in

	assessing and prioritising patients on waiting lists. A quarterly communication is being developed to disseminate lessons learned and focused visits are currently being completed to ward that were identified in CQC mock reviews who reported limited learning from incidents. • A meeting has been arranged with the CCG to discuss the situation. • Duty of Candour patient leaflets have been circulated and an e-learning module for staff developed. Focused visits to wards that identified a limited understanding of DoC during the CQC review have and are being conducted to share information. Datix system continues to be monitored for completion of DoC letters. • **Health informatics –** the majority of programmes are on target to be delivered. The PAS upgrade will be completed on 1st November, bed management will be rolled out to 2 wards (Gundolph and Wakley – medical model wards) in November and December with full roll-out across the Trust from January 2017 onwards. • The Trust will inform NHSI that we can commence RTT formal reporting in November (October data) following completion of the 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 and Health Informatics Update

1. EXECUTIVE SUMMARY

1.1 The report outlines the current status in relation to serious incidents. The number of Sis was raised as a concern at QIG, ten reported during September .

1.2 We have reported 1 Never Event this month, the incident 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 harm the patient. However consultation with NHSI confirmed it met the criteria for a Never Event.

1.3 We have a higher number of Sis related to last year, with an increase in Sis relating to treatment delay, which reflect patients waiting over 52 weeks associated with waiting times, fewer relating to maternity closures with an increase in pressure ulcer related Sis.

1.4 The numbers also reflect more robust identification of serious incidents via complaints and mortality reviews. However the delay in reporting Sis reflects weaknesses in the directorate governance processes. A message has been disseminated to all directorates to ensure that when a RED complaint is received then it is immediately raised as a potential SI and that all mortality and morbidity meeting minutes are scrutinised to ensure that any potential SI are escalated to the executive team for decision making immediately.

1.5 Swarm events have been arranged for pressure ulcer incidents, with falls and nutrition identified as topics for the next 2 events. Treatment delays are being address via the focus on waiting times and increased clinical engagement in assessing and prioritising patients on waiting lists. A quarterly communication is being developed to disseminate lessons learned and focused visits are currently being completed to ward that were identified in CQC mock reviews who reported limited learning from incidents.

1.6 A meeting has been arranged with the CCG to discuss the situation.

1.7 Duty of Candour patient leaflets have been circulated and an e-learning module for staff developed. Focused visits to wards that identified a limited understanding of DoC during the CQC review have and are being conducted to share information. Datix system continues to be monitored for completion of DoC letters.

1.8 **Health informatics –** the majority of programmes are on target to be delivered. The PAS upgrade will be completed on 1st November, bed management will be rolled out to 2 wards (Gundolph and Wakeley – medical model wards) in November and December with full roll-out across the Trust from January 2017 onwards.

1.9 The Trust will inform NHSI that we can commence RTT formal reporting in November (October data) following completion of the PAS upgrade.

1. SERIOUS INCIDENTS UPDATE

1.1 Currently the Trust have 59 open cases, 32 SI reports breaching – 14 of which are with the CCG for closure, the remaining 18 include 3 historic incidents. Twelve of the 18 reports have been completed and are awaiting sign off be executive or directorates.

1.2 We have reported 1 Never Event this month, the incident 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 harm the patient. However consultation with NHSI confirmed it met the criteria for a Never Event.

1.3 Ten incidents were reported this month, the table below sets out when the incidents occurred and the identification source.

	Steis	Incident date	Uploaded on Steis	Identified
1	2016 25847	16/05/2016	03/10/2016	Inquest
2	2016 26487	21/08/2016	11/10/2016	Complaint
3	2016 26483	21/09/2016	11/10/2016	Complaint
4	2016 26559	02/10/2016	11/10/2016	Incident
5	2016 26554	27/09/2016	11/10/2016	Incident
6	2016 26549	26/02/2016	11/10/2016	Mortality review
7	2016 26477	14/09/2016	11/10/2016	Incident
8	2016 26455	13/09/2016	10/10/2016	Incident
9	2016 26449	13/09/2016	10/10/2016	Incident
10	2016 26464	27/09/2016	10/10/2016	Incident

1.4 The numbers reflect more robust identification of serious incidents via complaints and mortality reviews. However the delay in reporting Sis reflects weaknesses in the directorate governance processes. A message has been disseminated to all directorates to ensure that when a RED complaint is received then it is immediately raised as a potential SI and that all mortality and morbidity meeting minutes are scrutinised to ensure that any potential SI are escalated to the executive team for decision making immediately.

1.5 Swarm events have been arranged for pressure ulcer incidents, with falls and nutrition identified as topics for the next 2 events. A quarterly communication is being developed to disseminate lessons learned and focused visits are currently being completed to ward that were identified in CQC mock reviews who reported limited learning from incidents.

1.6 A meeting has been arranged with the CCG to discuss the situation.

1.7 Duty of Candour patient leaflets have been circulated and an e-learning module for staff developed. Focused visits to wards that identified a limited understanding of DoC during the CQC review have and are being conducted to share information. Datix system continues to be monitored for completion of DoC letters.

2. QUALITY TEAM UPDATE

2.1 The Trust's position within the published mortality indicator the Hospital Standardised Mortality Ratio (HSMR) continues to demonstrate a downward trend and is 100.19 for the latest period (July 2015 – June 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 (April 2015 – March 2016) remains higher than expected 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.

2.2 The Quality Team held a stand at the recent Trust AGM on 27th September 2016 to showcase the work that has been undertaken within the Sign up to Safety and Safe to Care Programmes, with a particular focus on the importance of the early recognition and treatment of Septicaemia and Acute Kidney Injury. This was extremely well received and as such the team has also been asked to hold a stand at the NHS Fab Change Day on 19th October 2016.

2.3 The Trust has been nominated by the Sepsis Trust to show an advance screening of the educational film 'Starfish' on Wednesday 26th October 2016. The film, which will be released in cinemas nationwide on 28th October 2016 has been produced in conjunction with the Sepsis Trust and aims to raise awareness of Septicaemia and the importance of early recognition and treatment. All staff are invited to attend the screening and the Trust will be able to use the film internally following its release to support with staff training.

2.4 The National Sepsis CQUIN continues to prove challenging, particularly given the volume of audits involved. A business case to provide additional resources for the CQUIN has recently been approved and it is hoped that this along with the increased focus on Sepsis as part of the Deteriorating Patient Programme (DPP) launching on the 17th October 2016, will result in improved performance within the CQUIN elements.

2.5 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. 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

A decision was made by the Trust Executive Group on Wednesday 21st September not to interface the DART OCM system to the Medway Pathology system ahead of an ultimate connection to the Dartford Pathology system. The Project Team will now only interface the system to the Dartford Pathology system, which will mean a potential Go Live of the solution will not be possible now until mid-quarter one of the 17/18 Financial Year (as opposed to early Q4 of this financial year).
The project team continue to work with the supplier on configuration for the solution and this is progressing well.
The PAS / RIS interface work that was originally planned for October is not now going ahead. We are working with GE, the supplier, to re-schedule this element.

3.2 Bed Management and Electronic Observations

Device workshops have been scheduled with clinical colleagues to test and select hand held mobile devices (tablets and phone sized) with the staff groups, to ensure that the most appropriate device is procured for each staff group in the process.
The project team have also agreed a location plan with the Clinical Divisions and Wards and the Estates Team, for the positioning of the 42inch Electronic Whiteboards. It is anticipated that these will be ordered during late October.
There is a key dependency on interfacing delivered by the PAS upgrade project as to the planned time lines for go-live, however the project team are currently planning to have 2 wards activated and live, utilising the Bed Management solution and large screens during November and December.

3.3 Electronic Document Management (EDM)

This has now moved into procurement phase with Pre-Qualification Questions being issued during w/c 10th October – this will narrow the number of suppliers that move to the next Phase. At present it is planned that the formal tender process, including results review, will close at the end of December 2016.

3.4 E-Referral

The E-Referral project board has agreed that further investigation and a recommendation paper needs to be presented to agree, operationally, whether the scope of the project remains or whether the more appropriate approach is to move to partial bookings.

3.5 Mobile Interoperability Gateway (MIG)

MIG Web viewer has been successfully deployed to Lister Ward this month, and has been very well received. The team are now planning next phases of deployment of the 100 licences that the Medway CCG has funded for the Trust.

3.6 Child Protection Information Standards (CP-IS)

Work on this has been paused until November due to delays in the local authority partners progressing with their system input and compliance. Deployment and interfaces are scheduled to be completed by end November 2016, subject to the local authorities achieving their pre-requisites.

3.7 Oasis PAS upgrade to version 2016.1

The PAS software version upgrade is now being planned for overnight on Tuesday 1st November – the 2week delay to the original planned date is as a consequence of several technical issues detected during testing that Allscripts were unable to resolve within the planned resolution timeframe, prior to the subsequent testing iteration.
The Project Team are in close communication and liaison with operational services to ensure that cutover and business continuity planning is robust and that departments are ready for the planned downtime overnight on 1st November.
There will be an additional requirement to deploy a final software patch, to complete the full functionality upgrade, during mid-November, but this will only require a small amount of downtime (90 minutes to 2 hours).

3.8 Maternity Solution

HI PMO have been working closely with the W & C Team over the last couple of months to gather requirements, scope a programme and prepare a business case,

to move to a fully paperless maternity solution, which would include the removal of paper notes for the expectant mums, as well as within the midwifery team. This business case should be presented to the Executive Group in late October and then to Trust Board in November. The ambition is to procure a solution during Q4 of this financial year and commence deployment in Q 1 of 2017/18, with an aimed completion of December 2017.

Other Programmes

Integration Programme – interfacing work continues to support many of the other HI Programmes (including those mentioned above).

Chemotherapy ePrescribing – Is progressing to revised plan, of rollout by March 2017 with Paeds following in September 2017.

E-Prescribing – HI PMO and Pharmacy are working collaboratively to plan the scope and commence preparing the business case for this programme.

Upgrades – HI PMO is currently managing several software upgrades, which include Galaxy (theatres), Endovault (endoscopy), as well as supporting ED in the scoping and planning of their business case to upgrade Symphony.

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 have facilitated a workshop with the Directors of Clinical Operations for Outpatients and Surgery and Women and Children's, and their supporting teams, to investigate the solution and the potential beneficial opportunity the solution can deliver in the reduction of DNA rates and increased Clinic Utilisation.

Following the workshop, the HI PMO team have been asked to work with the supplier to prepare a business case to enable the Executive Group to make an informed decision as to whether this solution is a good strategic fit for the Trust and one that should be taken forwards.

Serious Incident Summary

October 2016

Number of Open SIs

October 2016
59

Average Number of Breach Days

October 2015	October 2016
116.34 Days	47.59 Days

59% ↓

Serious Incident Breaches by Status
October 2016
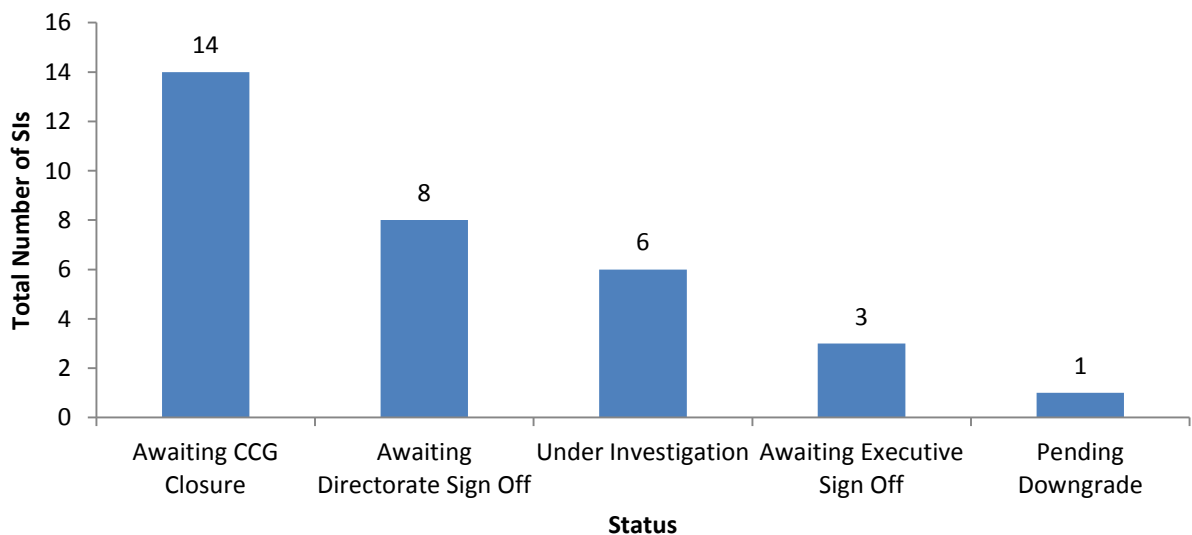
As of October 2016 there are 59 open Serious Incidents; 32 cases are breaching, the status of which is as follows:

- **Awaiting CCG Closure** – 14
- **Awaiting Directorate Sign Off** – 8
- **Awaiting Executive Sign Off** – 3
- **Pending Downgrade** – 1
- **Under Investigation** – 6

The remaining 27 are in date

The average number of breach days has decreased by 59% when compared with the October 2015 position.

Serious Incident (Month Incident Reported)

Serious Incidents April - October 2015/16 in Comparison with April - October 2016/17
(Month Incident Occured)
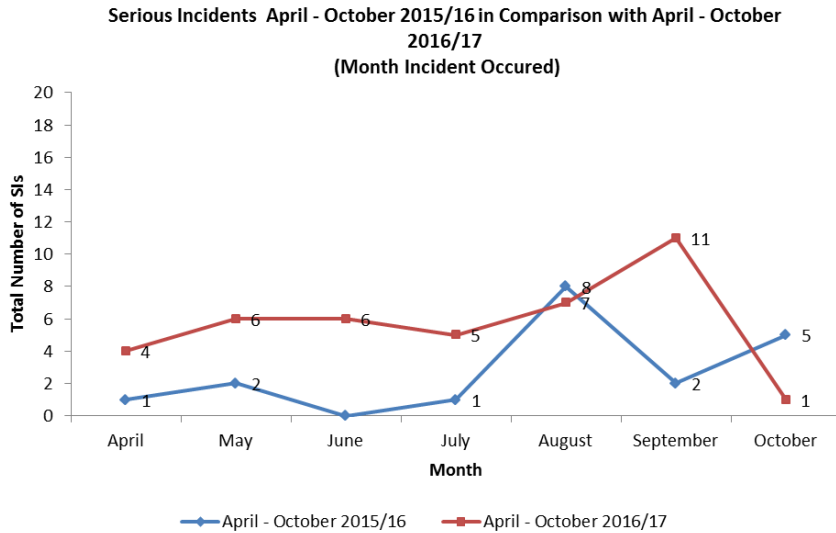
Overall the number of incidents (by month incident reported) have increased in 2016/17. This is as a result of improved reporting following the developed Serious Incident Process.

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.

Treatment Delay Meeting SI Criteria

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

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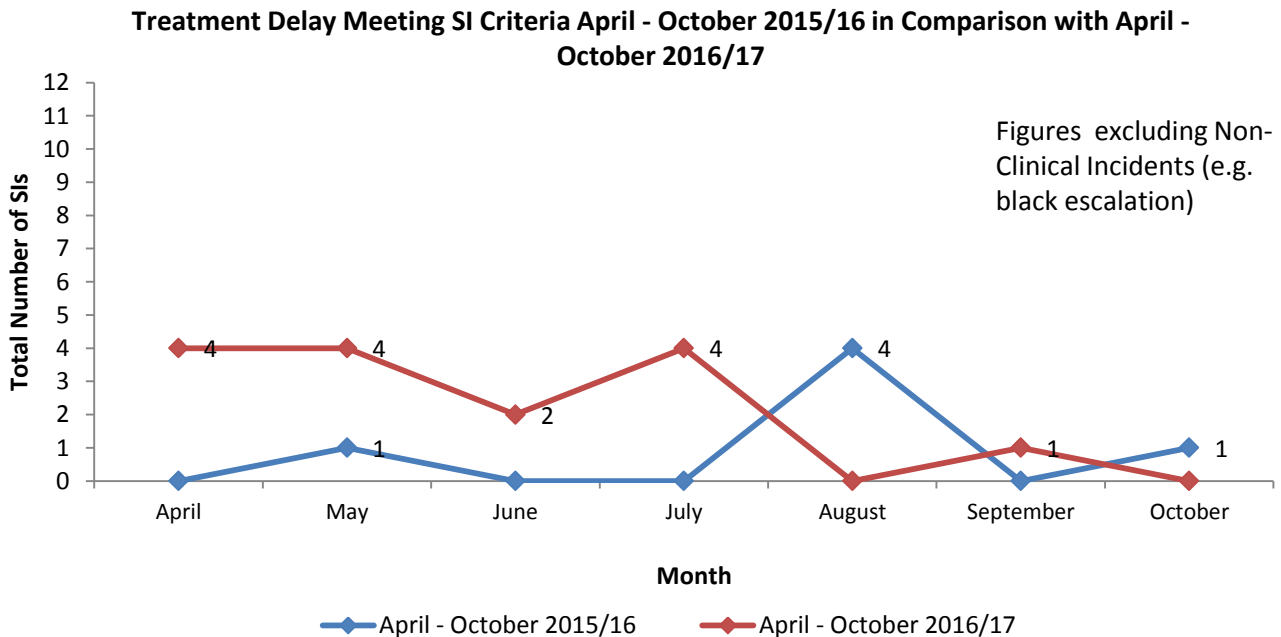
There has been an increase in clinical Serious Incidents relating to Treatment delay, in 2016/17 60% of these have occurred with ED. In addition to the clinical Serious Incidents there have also been a number of non-clinical Serious Incidents relating to this category, i.e. black escalation and 12 hour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

Slips, Trips and Falls Meeting SI Criteria

Slips/Trips/Falls Meeting SI Criteria
April -October 2015/16 in Comparison April - October 2016/17
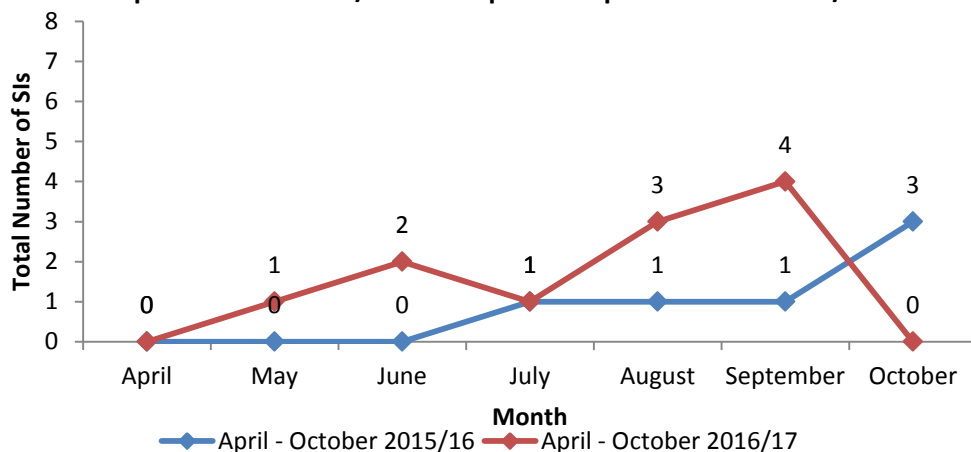
A SWARM event for Falls to Fracture is being held to identify immediate actions that can be taken in response to the increased numbers being seen in 2016/17. In addition the Trust has obtained agreement with the CCG to complete an aggregated SI for the 4 most recent Fall to Fracture SIs raised.

Complaints, Inquests and Mortality Reviews

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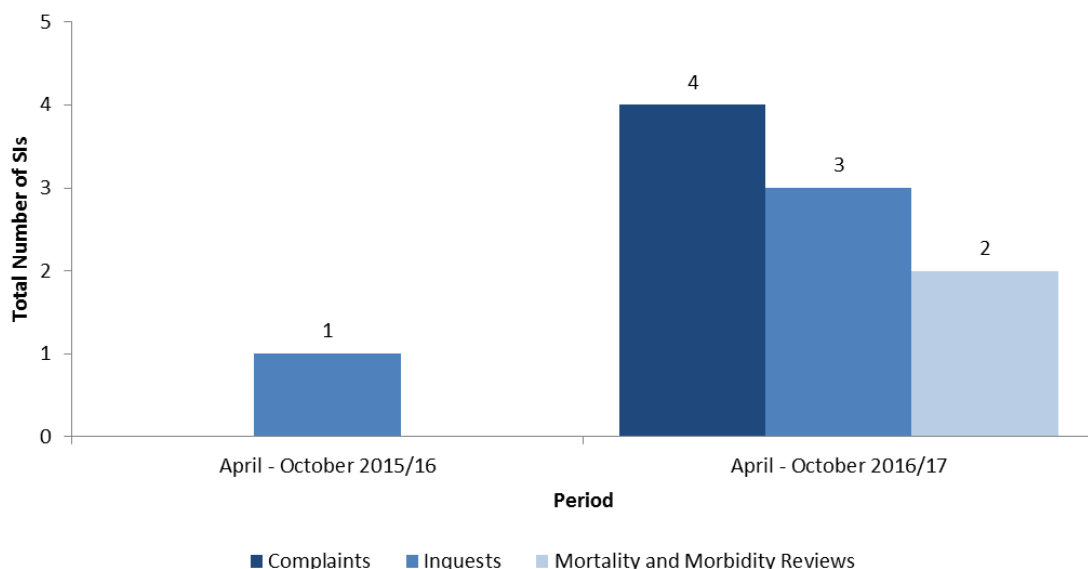
The Trust is triangulating patient safety concerns and linking information from Complaints, Inquests and the Trust Mortality and Morbidity reviews via the weekly Harm Free meeting. The chart above shows how many SIs have been identified in this way in 2016/17, an increase upon the position in 2015/16.

Report to the Board of Directors

Board Date : October 2016

Title of Report	MD report for October 2016
Presented by	Dr Kirti Mukherjee
Lead Director	Dr Kirti Mukherjee
Committees or Groups who have considered this report	None
Executive Summary	The purpose of this report is : Key points are : • Update on Safe Working Hours • Green Book formally approved • Patient Safety Update • Coroners visit report • Appraisal and Revalidation update • Research & Development news • Medical Education progress • Clinical Excellence Awards confirmation
Resource Implications	None
Risk and Assurance	Not applicable
Legal Implications/Regulatory Requirements	Not applicable
Recovery Plan Implication	Patient Safety progress
Quality Impact Assessment	Not Applicable
Recommendation	Note contents
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Medical Director's – October 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.

2. GUARDIAN OF SAFE WORKING HOURS

2.1.   The Guardian of Safe Working Hours report is attached in appendix 1.

2.2.   The role at this stage is focusing on ensuring there is clarity about how we can effectively monitor and respond to working hours issues as increasing numbers of doctor's sign up to the new contract.

3. GREEN BOOK

3.1. The Clinical Council formally approved the first edition of the Medway NHS Foundation Trust Green Book.

3.2. The Green Book is a set of Algorithms for the Management of Acute Clinical Emergencies and has been created by a small team of junior doctors: Dr Oliver Sohan (FY2), Dr David Jonathan Jones (FY1), Dr Claire Henderson (FY1) and Dr Dheeraj Khiatani (FY2).

3.3. 'The Green Book' is intended as a reference tool for junior doctors when on call and faced with an acute clinical situation. It is based on the author's own clinical experiences where they identified the need to present information in a succinct, accurate and accessible format. This book has been written with the full support of the Chief Executive and senior hospital leadership (managerial and clinical).

4. PATIENT SAFETY UPDATE

4.1   On Monday 17 October, the Trust launched the Improving Safety campaign. The purpose is to highlight the various components of the Deteriorating Patient Programme (DPP) and offer staff the opportunity to learn more about the changes that have been implemented so far.

This process is key in highlighting the importance and focus on safety and provide further impetus in embedding a safety culture across the Trust.

4.2   The Hospital Standardised Mortality continues to demonstrate a downward trend and the Summary Hospital Level Mortality Indicator has remained steady for the latest reporting periods.

5. CORONER VISIT

5.1.   The Coroner, Patricia Harding, addressed the Clinical Council on October 12th to help increase understanding of how our medical staff can improve the way they interact and support the coroner's service.

5.2.   Key messages the coroner emphasised included the importance of Consultants ensuring they are involved in the completion of Death Certificates to ensure accurate and reliable information is provided.

5.3.   The key messages will be shared with all medical staff. Further opportunities for reinforcing the messages are being implemented including inviting the Coroner to Grand Rounds and encouraging medical staff to attend the range of legal workshops being provided by the legal department at Medway.

6. MEDICAL APPRAISALS

6.1   The appraisal and revalidation team are entering the peak season for appraisals with the majority of the medical workforce appraised between September and February. All appraisals should be completed before the 31st March 2017.

6.2   To support the appraisal process we have recruited and trained 15 new appraisers and in addition commissioned MIAD (external experts in medical revalidation) to provide appraisal updates for our established appraisers with a further 40 doctors attending these updates. Using MIAD has enabled us to ensure that we ensure we are using the best practice approach to appraising and revalidating our medical staff.

7. RESEARCH & DEVELOPMENT

7.1   There continues to be a high level of new research and innovation projects applications received by the R&D Department. All are reviewed and Trust approvals granted where appropriate. The projects are of high benefit to patients and the Trust.

7.2 One such study that deserves particular mention is Furlong Evolution® Hip Trial. The primary intention of the trial is to assess the function and survival of the new Evolution® hip replacement implant, which was CE marked in October 2011. The implant is so successful that patients ask themselves to be put on the Trial and there were more applicants than available spaces. The Principal Investigators are Mr Sunil Jain and Mr Anand Joshi.

7.3 The Quarter 2 financial returns has been submitted to the Clinical Research Network Kent Surrey and Sussex (CRN KSS). We are £94,233K over the predicted budget for 2016/2017. The reasons are historic and the Director of Finance is looking into addressing these.

7.4 The survey for the research strategy has been drafted and as per advice from the Communication Department we will distribute these once the staff survey has finished.

7.5 Currently the biggest challenge faced by the R&D Department is adoption of the new systems compliant with Health Research Authority (HRA). Since 31st March 2016 HRA is the only route for all project-based research to commence in the NHS in England and incorporates the Ethical Approval.

8. POSTGRADUATE MEDICAL EDUCATION

8.1 The GMC National Trainee Survey highlighted some areas of exceptional practice (green flags). Highlights included clinical supervision, handover and local teaching in Paediatrics, handover in Obstetrics and Gynaecology responses and induction and handover for core medical trainees. We have now submitted action plans regarding areas of concern (red flags) including workload in Emergency Department, clinical supervision and satisfaction in F1 trainees in medicine, and satisfaction, experience and supportive environment for GP trainees in paediatrics. Issues had been identified by training leads with ongoing work already in place to improve the training environment.

8.2 The GMC Trainer Survey (not mandatory to complete) had a good response from trainers within the Trust with 100% response in radiology and emergency medicine. There was good report around time for trainers (green flags in anaesthetics and ED) and support for trainers (green flag in paediatrics). Supervisor training brought a green flag from anaesthetics and this is an area that PGME is improving at present for all educational supervisors.

9. CLINICAL EXCELLENCE AWARDS

Best of care
Best of people

9.1   53 applications were made for Clinical Excellence Awards and out of these 22 consultants were successful. The high number of applications made meant that there was a strong and competitive field. The successful applications demonstrated a high level of excellence across the 5 markable domains of

- Delivering a high quality service
- Developing a high quality service
- Leadership and managing a high quality service
- Contributing to the NHS through Research and Innovation
- Contributing to the NHS through Teaching and Training

APPENDIX 1

14th October 2016

GUARDIAN OF SAFEWORKING HOURS - REPORT

by Miss Delilah Hassanally

Background

Following discussions on the junior doctor's contract this year, the government requested the appointment of a 'Guardian of Safe working hours' in every NHS hospital. The remit is as follows:

"The guardian is responsible for protecting the safeguards outlined in the 2016 terms and conditions of service (TCS) for Doctors and Dentists in Training. The guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and /or employer, as appropriate; and will provide assurance to the Trust Board that doctors' working hours are safe."

PROGRESS

- Attended workshop in London, 26th Sept – National event - Guardian training day -The structure of the role was discussed and shared with other NHS trusts in the South East.

   -A review of 2 software programmes was given, to illustrate the use of these in logging non-compliance events, and reporting of the same

- Attended training day in London on DRS4 rota programme – currently in use at Medway, to look at how the rota is constructed, and how this can be used by junior doctors to record their hours. This programme is still being revised, and aims to generate a report of breached hours. Junior doctors will be given their own personal log-in which will enable them to enter their details and reports. The Guardian will also have a log in to see these reports. This is expected to be available at the end of November.
- Identifying rota gaps with medical staffing. The impact of these is varies across specialties but it leads to ongoing use of NHS locums or agency locums.
- Engaging with the Medilead group, a leadership forum involving Junior Doctors, to both explain the role of Guardian and express support for the Junior Doctors at Medway.

Best of care
Best of people

Next Steps

- Explore promoting the Guardian role at induction to engage and support the Junior Doctor workforce.
- Developing a web presence via the intranet and dedicated email address for Junior Doctors to raise working hour's issues.
- Discussions are set to discuss administrative support as their needs to be an efficient management of information and data to ensure compliance with safe working hours.

Report to the Board of Directors

Board Date: 27 October 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	
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. **Patient safety** The Trust breached its CDiff trajectory for Q2, reporting 9 cases. **Patient experience** The Trust reported 33 Mixed Sex Accommodation (MSA) breaches in September, all in SAU and related to the requirement to open escalation beds.
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.
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.
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

Safe Staffing

The safe staffing report for September 2016 is attached as Appendix 1. The report provides the Board with an overview of the nursing and midwifery workforce and highlights any workforce issues identified across the inpatient ward areas during the month of September 2016.

Key Points:

- 24.5% of all requested shifts remained unfilled. This is an increase of 1.6% on August figures. However the actual number of nursing hours worked was higher than the nursing hours planned on the nursing roster system by 5.9%.This is an increase of 3.2% on August figures. This is reflective of the need for extra staff to maintain patient safety with 1:1 specialing and additional beds which were opened in line with escalation, as well as the increase in the fill rates of temporary staff.
- The use of agency continues to be higher, with 51.8% of shifts filled by agency against 25.3% filled by bank staff.
- NICCU recorded a deficit of more than 10% actual hours then had been planned. The staffing escalation procedure was followed and actions taken to maintain safety.
- 44 reports relating to staffing issues were recorded via Datix. These mainly relate to shifts where there are less than minimal staffing levels per shift.
- **New starters** - In September 2016 28.0 WTE registered nurses and midwives commenced employment. This increase in new starters is reflective of the qualification date when students nurse and midwives gain their professional registration with the Nursing and Midwifery Council.
- **EU Nurses** – Skype interviews have now commenced weekly to recruit further EU nurses.
- **Revalidation –** Six months after the introduction of Revalidation for nurse and midwives 223 members of staff have successfully submitted revalidation applications.
- The Trust continues with a high level of activity and acuity demands, requiring high levels of nursing hours to deliver safe effective patient care. Stabilising and retaining the nursing and midwifery workforce in clinical areas is a priority as we move through 2016/2017.

Harm to patients / patient safety

Pressure Ulcer

- There have been 19 pressure ulcers of grade 2 and above reported during September. A patient on Gundolph acquired a grade 3 and a palliative care patient on Phoenix, acquired a grade 4 pressure ulcer. Both of these incidents are currently subject to RCA investigations.
- A deep dive review of pressure area care is scheduled to be presented to the Quality Assurance Committee in November.

Falls

- During September three patients sustained fractures as a result of a fall. The RCA investigations have yet to take place for two of the incidents, one on Harvey ward which resulted in a fractured shoulder and on Nelson ward where the patient sustained a fractured neck of femur. A patient on Wakeley was diagnosed with a fractured ankle, investigation found that this was sustained whilst absent from the ward but was not diagnosed until the patient attended the emergency department after discharge with continuing ankle pain and an x-r ay revealed a fracture.
- One patient on Wakeley ward sustained a serious harm post fall and subsequently died. This is subject to ongoing investigation at the present time.

Safety Thermometer

- The Trust was below target at 88.93% for harm free care however for new harms the Trust was at 98.36%.
- Analysis of the CAUTI data indicates that staff continue to have a poor understanding of the data collection criteria and its application. This is being addressed through the Infection Control Link Nurse network.
- The Trust is participating in the national HCAI point prevalence study commencing in October. Data from this study along with an evaluation of the HOUDINI protocol will enable the Trust to put in place appropriate targeted actions to improve performance.

Infection Prevention & Control

- The Trust breached its CDiff trajectory for Q2, reporting 9 cases. Post infection reviews did not identify any common themes. The Trust had a spike in reporting last year in Q1 and retrieved performance to meet its trajectory. However the winter months and the significant increase in inpatient activity will put considerable challenge on the Trust to meet its 2016/2017 trajectory of no more than 20 cases.

Patient Experience

- **MSA** - The Trust reported 33 Mixed Sex Accommodation (MSA) breaches in September, all occurring in Surgical Assessment Unit. These breaches were due to increased site activity and the need to open escalation beds.

- **Complaints** - There were 14 complaints received by the Trust during September which related to nursing care issues only. In addition to this a further seven complaints received also referred to Nursing care although this was the not the main subject of the complaint. The concerns raised relate to the fundamentals of care. The Transforming Care Programme has actions to address the common themes.

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 – Safe Staffing Report September 2016

TRUST BOARD MEETING (PUBLIC)

A paper prepared by Laurel Neame Senior Matron Workforce and Education and presented by Ms Karen Rule, Director of Nursing

September 2016

1. **Introduction**

    The purpose of this paper is to:
    - Provide an overview of the nursing and midwifery staffing levels within and to highlight any workforce issues identified across the inpatient ward areas during the month of September 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.

2. **Monthly Data / Safe Staffing Levels**

    2.1 Planned versus actual hours
    - The actual hours of planned versus actual hours was 5.9% above the planned hours. The underlying reason behind this increase is the continuing high levels of activity across the trust necessitating the use of extra beds in line with 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.

    - During September ten wards utilised 10% or more actual hours then had been planned .The wards were Byron, Milton and Sapphire (all elderly care wards) McCulloch and Phoenix (surgical wards), Arethusa (orthopaedic ward), Victory (cohort MRSA ward), Will Adams (medical Ward), Gundolph and Wakeley (short stay medical wards) These wards are reflective of the above indicators in which there was an increase in the need to support complex patients who need constant supervision.

- One ward had less than 10% of their planned hours NICCU; however throughout this period safe staffing was maintained in this area.
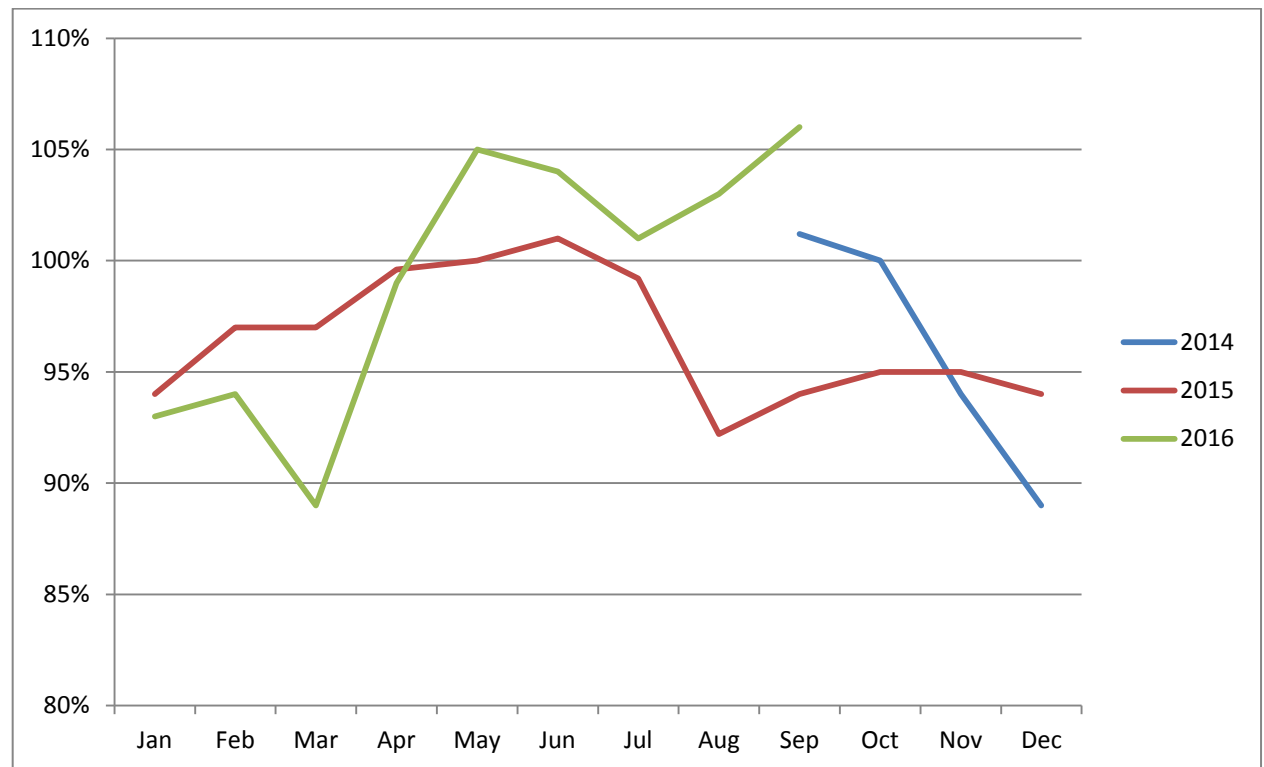
Figure 1 Overall fill Rate September 2014- September 2016

2.2 Temporary Staffing

- There continues to be a high demand on the resources of temporary staffing. In September requests to temporary staffing totalled 103302.4hours, with 77.1 % of these hours filled. Most of these shifts continue to be filled by Agency staff (51.8%) whilst the Trust temporary staffing service filled 25.3 %.

- The majority of the requests made were to cover vacancies which accounts for 64% of all requests. The other main reasons for requests were 1:1 specialing for our vulnerable patients (16%), provision of escalation beds due to operational pressures (9%) and staff sickness (8%). This is in line with previous months.

2.3 Staff Starters and leavers

- In September 24.0 WTE registered nurses commenced employment, alongside 4.0 WTE registered midwives and 12.3 WTE Clinical Support Workers. The increase in registered nurse starters is reflective of the qualification date when students nurse and midwives gain their professional registration with the Nursing and Midwifery Council and are able to commence employment following completion of their training. In the same period 6.51 WTE Nurses, 4.44 WTE Midwives and 3.0WTE Clinical Support Workers left the organisation.

2.4 CHPPD data

- In response to the Carter review all trusts are now required to submit care hours per patient day (CHPDD). The overall figure for September is 8.44. Although the figures vary widely across the wards and departments, with the critical care areas and the birth place recording higher care hour's analysis over the last three 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
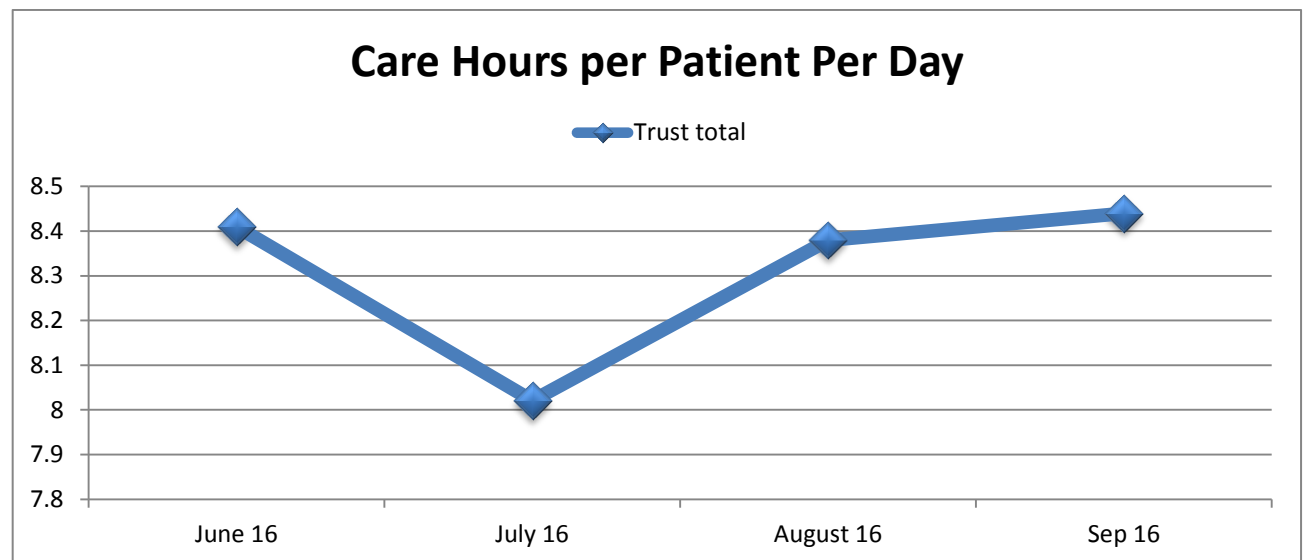
Figure 2 Overall Trust Score for Care hours per patient per day

2.5 Staff Escalation

- Incidents relating to staffing issues reported via Datix showed an increase from the previous month to 44 and these mainly relate to shifts where there are less than minimal staffing levels per shift.

3. Update

3.1 Recruitment

- Recruitment and retention of nurses remains a priority for the trust. A nurse recruitment open evening is taking place on 9 November 2016. Links have been established with both partner universities and the Trust now has the opportunities to attend their open days and careers event. Links with the local schools are being developed.

3.2 EU nurses

- Recruitment of EU nurse continues with weekly skype interviews throughout September resulting in conditional offers of employment to 10 nurses. These nurses are due to commence with the Trust in December 2016. Skype interviews are continuing throughout October with successful candidates likely to commence employment in early 2017.

3.3 Revalidation

- Six months after the introduction of Revalidation for nurse and midwives 223 members of staff have successfully submitted revalidation applications. To date no member of staff has failed to submit their application.

3.4 Escalation Standard Operating Procedure

- The escalation SOP is being reviewed to ensure which will give a standardised approached to reporting and managing escalation concerns across the Trust for all nurse and midwives.

4. Recommendations

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

5. Appendices:

6.1 Appendix One – UNIFY data –September 2016

6.2 Appendix Two – Nursing, Midwifery and Care Staff Return – September 2016

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

Org: RPA Medway NHS Foundation Trust

Period: August_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

Validation alerts (see control panel)

Site code	Hospital Site name	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	Avg fill reg - Day (%)	Avg fill care - Day (%)	Avg fill reg - Night (%)	Avg fill care - Night (%)	Cumulative count	CHPPD Reg	CHPPD Care	CHPPD Overall
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Arethusa	110 - TRAUMA & ORTHOPAEDICS		1837	1,905	1,113	1,453	1,320	1,463	990	1,337	103.7%	130.5%	110.8%	135.1%	763	4.4	3.7	8.1
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Bronte WARD	340 - RESPIRATORY MEDICINE		1459	1,254	1,100	1,010	1,058	1,022	705	729	85.9%	91.8%	96.7%	103.3%	534	4.3	3.3	7.5
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Byron	430 - GERIATRIC MEDICINE		1299.5	1,447	1,025	1,193	1,001	1,372	979	1,364	111.4%	116.5%	137.0%	139.4%	806	3.5	3.2	6.7
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	CCU	320 - CARDIOLOGY		687.5	686	-	25	690	667	-	35	99.7%		96.7%		109	12.4	0.5	12.9
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Delivery	501 - OBSTETRICS		2876.483333	2,814	552	552	2,880	2,857	528	403	97.8%	100.0%	99.2%	76.2%	178	31.9	5.4	37.2
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Dolphin (Paeds)	420 - PAEDIATRICS		3066	3,184	811	755	2,346	2,392	299	368	103.9%	93.0%	102.0%	123.1%	398	14.0	2.8	16.8
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Gundulph	300 - GENERAL MEDICINE		1511	1,586	1,221	1,104	1,156	1,495	1,028	1,291	104.9%	90.5%	129.3%	125.6%	735	4.2	3.3	7.4
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Harvey	328-STROKE MEDICINE		1156.25	1,106	1,583	1,136	999	1,039	1,013	1,091	95.6%	71.8%	104.0%	107.7%	706	3.0	3.2	6.2
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Intensive Care Unit	192 - CRITICAL CARE MEDICINE		3569.333333	3,102	-	-	3,038	2,882	-	-	86.9%		94.9%		242	24.7	0.0	24.7
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Keats	301 - GASTROENTEROLOGY	307-DIABETIC MEDICINE	1642.75	1,498	1,247	1,135	990	1,223	990	1,033	91.2%	91.0%	123.5%	104.3%	763	3.6	2.8	6.4
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Kent	501 - OBSTETRICS		1049.75	1,092	426	397	720	697	672	634	104.0%	93.1%	96.7%	94.3%	462	3.9	2.2	6.1
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Kingfisher SAU	100 - GENERAL SURGERY		1820.5	1,649	1,546	1,288	1,320	1,342	660	660	90.6%	83.3%	101.6%	100.0%	619	4.8	3.1	8.0
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Lawrence	823 - HAEMATOLOGY		1091.25	998	720	870	619	720	675	730	91.5%	120.9%	116.4%	108.1%	526	3.3	3.0	6.3
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	McCulloch	100 - GENERAL SURGERY		1432.083333	1,813	1,144	1,347	1,013	1,765	1,001	1,001	126.6%	117.7%	174.3%	100.0%	847	4.2	2.8	7.0
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Medical HDU	192 - CRITICAL CARE MEDICINE		1382	1,388	314	381	1,035	1,022	345	345	100.4%	121.5%	98.7%	100.0%	164	14.7	4.4	19.1
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Milton	430 - GERIATRIC MEDICINE		1432.08	1,813	1,144	1,347	1,013	1,765	1,001	1,001	126.6%	117.7%	174.3%	100.0%	810	4.4	2.9	7.3
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Nelson	320 - CARDIOLOGY		1544.98	1,394	1,209	1,177	990	1,046	660	770	90.3%	97.3%	105.7%	116.7%	859	2.8	2.3	5.1
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	NICU	422- NEONATOLOGY		3627.5	3,163	412	127	3,439	3,141	-	-	87.2%	30.9%	91.3%		711	8.9	0.2	9.0
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Ocelot	502 - GYNAECOLOGY		882	826	525	525	720	661	348	360	93.6%	100.0%	91.9%	103.4%	281	5.3	3.1	8.4
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Pearl	501 - OBSTETRICS		1083	1,248	759	450	1,080	1,083	360	301	115.2%	59.3%	100.3%	83.5%	395	5.9	1.9	7.8
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Pembroke	110 - TRAUMA & ORTHOPAEDICS		1441	1,399	1,249	929	990	990	990	968	97.1%	74.4%	100.0%	97.8%	747	3.2	2.5	5.7
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Phoenix	100 - GENERAL SURGERY		1781.6	2,117	1,512	1,305	1,309	1,951	1,320	1,397	118.8%	86.3%	149.1%	105.8%	864	4.7	3.1	7.8
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Sapphire Ward	300 - GENERAL MEDICINE		1637	2,804	2,330	1,897	968	2,742	1,320	1,265	171.3%	81.4%	283.3%	95.8%	840	6.6	3.8	10.4
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	SDCC	100 - GENERAL SURGERY		2056.566667	1,865	1,568	970	660	956	660	660	90.7%	61.8%	144.8%	100.0%	619	4.6	2.6	7.2
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Surgical HDU	192 - CRITICAL CARE MEDICINE		2057.25	2,104	421	219	1,606	1,632	-	4	102.3%	52.1%	101.6%		290	12.9	0.8	13.7
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Tennyson	430 - GERIATRIC MEDICINE		1436.25	1,237	1,164	972	1,013	1,128	1,013	1,034	86.1%	83.5%	111.4%	102.1%	800	3.0	2.5	5.5
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	The Birth Place	501 - OBSTETRICS		1090.5	1,046	360	354	1,072	1,040	360	313	95.9%	98.3%	96.9%	86.8%	100	20.9	6.7	27.5
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Victory	100 - GENERAL SURGERY	300 - GENERAL MEDICINE	1086.5	1,951	764	1,030	968	967	360	1,805	179.5%	134.7%	99.9%	273.4%	483	6.0	5.9	11.9
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Wakeley	300 - GENERAL MEDICINE		1525	1,614	1,062	1,380	1,013	1,218	1,013	1,319	105.8%	130.0%	120.3%	130.2%	740	3.8	3.6	7.5
RPA02	MEDWAY MARITIME HOSPITAL - RPA02	Will Adams	301 - GASTROENTEROLOGY	307-DIABETIC MEDICINE	1360.75	1,228	1,088	1,213	990	1,254	990	1,287	90.2%	111.5%	126.7%	130.0%	779	3.2	3.2	6.4

Nursing, Midwifery and Care Staff - Planned Vs Actual Hours - September 2016

Fill rate indicator return

Staffing: nursing, midwifery and care staff

Sep-16

WARD	Beds	Day Registered Staff Planned	Day Registered Staff Actual	Day Care Staff Planned	Day Care Staff Actual	Night Registered Staff Planned	Night Registered Staff Actual	Night Care Staff Planned	Night Care Staff Actual	Day Avg fill rate reg (%)	Day Avg fill rate care (%)	Night Avg fill rate reg (%)	Night Avg fill rate care (%)	No. escalations of nurse staffing	No. hospital acquired Pressure Ulcers grade 2+	No. Falls mod-severe harm	No. patient related medication errors mod-severe harm	No. complaints relating to nursing care	DDON rag rating	Assurance statement	DDON signoff	Total Planned Hours	Total Actual Hours	Overall fill rate	Diff Actual vs Planned hrs	Diff Actual vs Planned %	Cumulative count patients 23:59	CHPPD Reg midwives/Nurses	CHPPD Care Staff	CHPPD Overall
Arethusa	27	1837	1,905	1113.48333	1,453	1320	1,463	990	1,337	104%	130%	111%	135%	4	1	0	0	0		Staff in Arethusa and Pembroke work flexibly across the units to ensure safe staffing.	SH	5,260	6,157	117%	897	17%	763	4.41	3.66	8.07
Bronte	18	1459	1,254	1099.5	1,010	1057.5	1,022	705	729	86%	92%	97%	103%	4	0	0	0	0		this is due to unfill bank and agency shift and nurses being redeployed to other areas to maintain safe staffing. Safe staffing is reviewed each shift	RN	4,321	4,014	93%	- 307	-7%	534	4.26	3.25	7.52
Byron	26	1299.5	1,447	1024.5	1,193	1001.25	1,372	978.75	1,364	111%	116%	137%	139%	9	1	0	0	1		Safe staffing is reviewed each shift	RN	4,304	5,376	125%	1,072	25%	806	3.50	3.17	6.67
CCU	4	687.5	686	0	25	690	667	0	35	100%	#DIV/0!	97%	#DIV/0!	0	0	0	0	0			RN	1,378	1,412	102%	34	2%	109	12.41	0.54	12.95
Delivery	15	2876.483	2,814	552	552	2880	2,857	528	403	98%	100%	99%	76%	0	0	0	0	0		Safe staffing maintained in the unit	KM	6,836	6,625	97%	- 212	-3%	178	31.86	5.36	37.22
Dolphin (Paeds)	34	3066	3,184	811	755	2346	2,392	299	368	104%	93%	102%	123%	0	0	0	0	0		ward safely staffed	KM	6,522	6,699	103%	177	3%	398	14.01	2.82	16.83
Gundulph	25	1511	1,586	1220.5	1,104	1156	1,495	1027.75	1,291	105%	90%	129%	126%	0	2	0	0	2			RN	4,915	5,475	111%	560	11%	735	4.19	3.26	7.45
Harvey	24	1156.25	1,106	1583.25	1,136	999	1,039	1012.5	1,091	96%	72%	104%	108%	13	0	1	0	1		There were short term sickness in addition to vacancies. Staffing is reviewed each shift by matrons who redeploy staff as required. An RMN provided 121 supervision for a patient and the senior sister worked clinically as required	RN	4,751	4,372	92%	- 379	-8%	706	3.04	3.15	6.19
Intensive Care Unit	9	3569.333	3,102	0	-	3037.5	2,882	0	-	87%	#DIV/0!	95%	#DIV/0!	0	0	0	0	0		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	6,607	5,984	91%	- 623	-9%	242	24.73	0.00	24.73
Keats	27	1642.75	1,498	1246.75	1,135	990	1,223	990	1,033	91%	91%	124%	104%	7	0	0	1	0		Shifts are reviewed daily by matrons and staff deployed to mitigate clinical risk	RN	4,870	4,888	100%	19	0%	763	3.57	2.84	6.41
Kent	24	1049.75	1,092	426	397	720	697	672	634	104%	93%	97%	94%	0	0	0	0	0		ward safely staffed	KM	2,868	2,819	98%	- 49	-2%	462	3.87	2.23	6.10
Kingfisher SAU	14	1820.5	1,649	1546	1,288	1320	1,342	660	660	91%	83%	102%	100%	0	0	0	2	0		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	5,347	4,938	92%	- 409	-8%	619	4.83	3.15	7.98
Lawrence	19	1091.25	998	719.5	870	618.75	720	675	730	91%	121%	116%	108%	9	0	0	0	0			RN	3,105	3,318	107%	214	7%	526	3.27	3.04	6.31
McCulloch	24	1432.083	1,813	1144	1,347	1012.5	1,765	1001.25	1,001	127%	118%	174%	100%	9	0	0	0	2		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	4,590	5,926	129%	1,336	29%	847	4.22	2.77	7.00
Medical HDU	6	1382	1,388	314	381	1035	1,022	345	345	100%	122%	99%	100%	0	2	0	0	0		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	SH	3,076	3,136	102%	60	2%	164	14.69	4.43	19.12
Milton	27	1432.08	1,813	1144	1,347	1012.5	1,765	1001.25	1,001	127%	118%	174%	100%	15	0	0	0	0			RN	4,590	5,926	129%	1,336	29%	810	4.42	2.90	7.32
Nelson	24	1,544.98	1,394	1,209.43	1,177	990	1,046	660	770	90%	97%	106%	117%	6	0	1	0	0		Senior ward sister worked clinically to ensure safe delivery of care. The ward has recruited 3 newly qualified nurses to commence in September 2016	RN	4,404	4,387	100%	17	0%	859	2.84	2.27	5.11
NICU	25	3627.5	3,163	412.25	127	3438.5	3,141	0	-	87%	31%	91%	#DIV/0!	0	0	0	0	0		unit safely staffed	KM	7,478	6,431	86%	- 1,047	-14%	711	8.87	0.18	9.05
Ocelot	12	882	826	525	525	719.5	661	348	360	94%	100%	92%	103%	1	0	0	0	0		ward safely staffed	KM	2,475	2,372	96%	- 102	-4%	281	5.29	3.15	8.44
Pearl	23	1083	1,248	758.5	450	1080	1,083	360	301	115%	59%	100%	83%	0	0	0	0	0		unit safely staffed	KM	3,282	3,082	94%	- 200	-6%	395	5.90	1.90	7.80
Pembroke	27	1441	1,399	1248.5	929	990	990	990	968	97%	74%	100%	98%	0	0	0	0	0		Staff in Arethusa and Pembroke work flexibly across the units to ensure safe staffing.	SH	4,670	4,286	92%	- 384	-8%	747	3.20	2.54	5.74
Phoenix	30	1781.6	2,117	1512.25	1,305	1309	1,951	1320	1,397	119%	86%	149%	106%	3	2	0	0	0		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	KM	5,923	6,770	114%	848	14%	864	4.71	3.13	7.84
Sapphire Ward	28	1637	2,804	2329.5	1,897	968	2,742	1320	1,265	171%	81%	283%	96%	0	0	0	0	1			RN	6,255	8,707	139%	2,453	39%	840	6.60	3.76	10.37
SDCC	26	2056.567	1,865	1568	970	660	956	660	660	91%	62%	145%	100%	26	0	0	0	1		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	4,945	4,450	90%	- 494	-10%	619	4.56	2.63	7.19
Surgical HDU	10	2057.25	2,104	420.5	219	1606	1,632	0	4	102%	52%	102%	#DIV/0!	0	1	0	0	0		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	SH	4,084	3,960	97%	- 124	-3%	290	12.88	0.77	13.65
Tennyson	27	1436.25	1,237	1163.5	972	1012.5	1,128	1012.5	1,034	86%	84%	111%	102%	6	0	0	0	1		risk mitigated by daily shift review and redeployment of staff. The ward sister works clinically as required	RN	4,625	4,371	95%	- 254	-5%	800	2.96	2.51	5.46
The Birth Place	9	1090.5	1,046	360	354	1072.25	1,040	360	313	96%	98%	97%	87%	0	0	0	0	0		unit safely staffed	KM	2,883	2,752	95%	- 131	-5%	100	20.86	6.67	27.52
Victory	18	1086.5	1,951	764.02	1,030	968	967	660	1,805	180%	135%	100%	273%	11	0	0	0	0		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	3,479	5,751	165%	2,273	65%	483	6.04	5.87	11.91
Wakeley	25	1525	1,614	1061.5	1,380	1012.5	1,218	1012.5	1,319	106%	130%	120%	130%	4	0	2	0	1			RN	4,612	5,531	120%	919	20%	740	3.83	3.65	7.47
Will Adams	26	1360.75	1,228	1087.5	1,213	990	1,254	990	1,287	90%	111%	127%	130%	16	2	0	0	1			RN	4,428	4,981	112%	553	12%	779	3.19	3.21	6.39
Trust total	633	49,922	51,327	28,365	26,537	38,012	43,530	20,579	23,500	102.8%	93.6%	114.5%	114.2%	134	11	4	3	11				136,878	144,894	106%	8016	5.9%				

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September 2016

Report to the Board of Directors

Board Date: October 2016

Title of Report	Workforce Update
Presented by	Rebecca Bradd, Acting Director of Workforce
Lead Director	Rebecca Bradd, Acting Director of Workforce
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 : • Number of activities undertaken to support the development of our staff and to address our staffing gap since February • 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
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Best of care
Best of people

Workforce Update – October 2016

1. EXECUTIVE SUMMARY

Our workforce are critical in the delivery of our Vision of *Best of Care, Best of People*. James Devine, our new Director of HR & OD will be joining the Trust on 31 October and will be building on the foundations of work undertaken over the last nine months.

A number of attainments have been delivered since my commencement in post in February 2016 and as this is my final report I would like to reflect on the changes that have been made to support and develop our workforce including:

- Introduction of the in house *Temporary Staffing Service* in March. The Multi-disciplinary *Leadership forum* was also launched in March developed in conjunction with the MD's office.

- The launch of the Trust *Vision and Values* in April. The *Every Person Counts (Respect)* campaign was launched including an external confidential staff support line and internal *Workplace Listeners* to support colleagues who feel they are being bullied. *Corporate Welcome*, a refreshed Trust induction was also launched.

- Refreshed recruitment materials aligned to values and *First and Lasting Impressions* sessions were launched in May for new starters to feedback on their experiences and address turnover under 1 year.

- The *Leadership development* programme and a programme of *Bite size learning* sessions for staff launched in June.

- The *Achievement review* was launched in August, a new approach to feedback to staff and appraisal linking our behaviours (aligned to our Values) and performance

- In September we had our first *Health and Wellbeing Day* attended by over 600 staff, having worked in collaboration with Medway Council and Public Health on our health and wellbeing plans. The first Equality and Diversity Group and Strategic Workforce Group also took place. Appointment was made to *Freedom to Speak Up Guardians*.

- *You're the Best* staff recognition cards aligned to our Values and *Positively trees* (from a great idea by our NICU team) were launched at *Fab Change Day* on 19 October. Also in October two systems are commencing rollout; *SafeCare Live* (to

provide real time ward staffing data) and *MOLLIE*, our new Learning Management System.

- In November we are launching our new multimedia recruitment advertising campaign *'Put Yourself in the Picture'* having engaged with our staff and leaders. Our first BME forum is due to take place with other Staff forums being arranged for our LGBT and disabled staff.

Work also continues as part of the Recovery Plan work streams and an update in provided in this report.

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 current rate of 84% compliance for mandatory training and continues to be closely monitored. Staff who have been non-compliant for the longest period of time are being targeted to improve the overall compliance rate.

Weekly updates continue to be provided to directorates to support targeted improvement by department, individuals and topics. There is particular focus on areas where compliance is under 75%. In addition, regular contact with subject matter experts aims to ensure that any capacity issues are resolved and there is targeted training activity on the wards and within departments to improve compliance within "hotspot" areas.

A new learning management system called MOLLIE (Medway On Line & Interactive Education) went live on 25 October for mandatory topics in the Corporate directorates, excluding Estates and Facilities. With a phased launch to minimise risk, the system will be implemented one directorate at a time with completion in January 2017.

The benefits of the new system include employee self-service thus saving time and resources related to identifying training needs, bookings and having up-to-date, reliable and accurate information. User acceptance testing is underway with a variety of users involved, and the project remains on target subject to data integration and systems interface targets being met.

Achievement Review

The achievement review rate has risen to 77%. 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. DCOs are meeting or have plans to meet managers and challenge any outstanding achievement reviews and agree completion dates, including targeting long standing non-compliant individuals. Weekly data updates to demonstrate progress are circulated to the Executive.

Regular Achievement Review training continues to be undertaken which is well attended. Two open workshops ran in September with 35 attendees and 4 requested sessions were run for ward teams locally.

Local Induction

The recording of local induction continues to be challenging with a current recorded rate of 45.24%. This rate is improving and continues to be monitored and pursued closely. To address the low compliance and in response to feedback from our new starters a review of the entire onboarding process has been undertaken and actions are being taken to improve the experience of our new starters including the development of a new starter welcome pack that helps to focus on local induction. Alongside this is the introduction of a recruiting manager's information pack that places explicit emphasis on the importance of an effective local induction and its impact on improving staff retention. The introduction of on-line confirmation alongside the current paper version will aid accessibility and improvement in reporting.

SafeCare Live

SafeCare Live launched on 3rd October 2016 to the 4 early adopter wards in Acute and Continuing Care Directorate (Gundulph, Wakeley, Nelson and Bronte Wards), the implementation covered a two week period which enabled IT hardware and software to be installed, HealthRoster system configuration and training to required staff and Matrons to review and interrogate the data. The remaining wards in Acute and Continuing Care Directorate will begin implementation on 17th October which will cover a two week period with Co-ordinated Surgical Directorate and Women and Children's Directorates to follow.

Agency/ Bank Staff Local Induction

The recorded rate of local induction for agency workers is currently 28%; this is 10% increase from September. 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.

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

3. RESOURCING

The Trust vacancy rate at Month 6 is 17% (792 wte vacancies), with Nursing and Midwifery an outlier at 26%.There are a number of activities being undertaken to address resourcing gaps in the Resourcing Plan including recruitment promotion and advertising, recruitment activities and events, attraction and benefits, retention, temporary staffing, recruitment efficiency and training and future workforce.

Recruitment promotion and advertising

The HR team have engaged with a local advertising company to develop and deliver a initial three month *'Put yourself in the picture'* recruitment campaign which launches in November. 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.

As part of developing an ongoing social media presence, the Trust has a @MedwayNHSJobs Twitter account and is also currently promoting our Nursing Open Day on facebook and Linkedin.

Recruitment activities

- *Assessment days*

There are fortnightly Nursing Assessment Day (next on 28/10) which includes recruitment for substantive and bank. 8 nurses were offered at the last assessment day on 13 October.

There were weekly assessment days for temporary staffing for Admin & Clerical in October, moving to fortnightly in November and monthly from January to build the bank with the aim of removing agency workers for Band 1- 4. Current bank demand for admin and clerical staff is over 12,000 hours.

There are fortnightly CSW Assessment Days (next on 28/10) which includes recruitment for substantive and bank.

Assessment days for other staff groups are in the process of being arranged.

- *Events and open days*

The Trust has not actively engaged in attendance at recruitment fairs or at events previously. As part of the resourcing plan there are a number of events that are planned over the next few months including:
  - 21-22 October   BMJ event (Medical)
  - 8 November   Christchurch University open day (Nursing)
  - 9 November   MFT Open evening (Nursing)
  - 22-23 November   Acute General Medicine event (Medical)
  - 23 November   MFT Open evening (Nursing)
  - 26 January   Paediatrics/ NICU open day (Nursing)
  - 16 February   MFT Open day (Nursing)

Further events are being reviewed and open days planned for 2017.

- *CSW recruitment*

19 CSWs were appointed from 17/9 assessment day; 6 of which have started. There is a rolling programme of CSW adverts and assessment days with the next taking place on 28/10.

- *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
- 3 days of Skype assessments in October (12/ 13/ 26 October)
- Further Skype interviews planned for November (2 and 9 November confirmed)

- *NICU recruitment*

It was agreed that international recruitment would be piloted with appointment of 10 NICU nurses. The contract is now in place and skype interviews are taking place on 28 October. 24 are shortlisted for interview.

- *Medical Staffing*

The first doctors in Obstetrics and Gynaecology have joined the Trust on 5 October under the new Terms and Conditions. The October intake of HEKSS/London Trainees had a good fill rate, currently only advertising for a LAS in Cardiology. However there remains hotspots for recruitment for Specialty Doctor in ED and Trust SHO posts in HDU, Neonates and Orthopaedics which are currently being advertised.

The Trust is currently advertising for a number of Consultant posts including Neurology, Acute Medicine, Dermatology and Gastroenterology

- *Medical Training Initiative (Medical)*

The Trust approved 10-16 wte MTI placements to address the vacancies at junior doctor level. Skype interviews are being arranged for November with 16 currently shortlisted for the first interviews.

Temporary Staffing Service

In March our Temporary Staffing Service went live. The aim of the service was to improve the quality of temporary staffing and staffing levels, improve the visibility of staffing demands and control cost. The service has been in place now for six months and the demand for the service has increased and the resulting cost due to staffing demands.

Demand for nursing (registered and unregistered) was at over 100,000 hours (approximately 650 WTE) with the majority of bookings for qualified nursing staff to cover vacancies (67%). There has been an increase in demand and a resulting increase in agency usage, whilst bank staff bookings have remained static (Table 1). Recruitment to bank staff and streamlined fast processes remain a priority for the bank.

Table 1 Nursing requests and fill

Month	Demand	Hours Filled	% Hours Filled	Hour Filled Bank	% Hours Filled Bank	Hour Filled Agency	% Hours Filled Agency	Unfilled Hours	% Unfilled Hours
September	103302.4	79672.1	77.1%	26130.9	25.3%	53521.81	51.8%	23649.64	22.9%
August	104752.3	79071.4	75.5%	27971.0	26.7%	51100.4	48.8%	25680.9	24.5%
July	96145.5	74296.7	77.3%	28079.9	29.2%	46216.8	48.1%	21848.8	22.7%
June	90521.7	72266.2	79.8%	26041.0	28.8%	46225.2	51.1%	18255.5	20.2%
May	88696.2	71556.0	80.7%	25537.6	28.8%	46018.4	51.9%	17140.2	19.3%
April	80713.8	62007.0	76.8%	23244.6	28.8%	38762.4	48.0%	18706.8	23.2%
March	80460.8	60592.3	75.3%	24197.3	30.1%	36395.1	45.2%	19868.5	24.7%
February	91938.4	73020.5	79.4%	27329.6	29.7%	45690.8	49.7%	18918.0	20.6%
January	85929.0	69477.0	80.9%	28669.0	33.4%	40808.0	47.5%	16452.0	19.1%
December	81677.0	64330.0	78.8%	25638.0	31.4%	38692.0	47.4%	17347.0	21.2%
November	79442.0	65363.0	82.3%	27148.0	34.2%	38215.0	48.1%	14079.0	17.7%

The *Doctors Bank* will be launched in November, starting with the Emergency Department, aiming to reduce on locum expenditure, improve quality and improve locum visibility.

On 19 October Medway hosted the first regional temporary staffing meeting to discuss how the Kent and Medway region can benefit from joint working in the future including the use of technology, policies and the possibility of regional rates.

There have been significant improvements to the service since March but it is recognised that there are still a way to go to have an established service that supports all temporary staffing requirements for all staff groups. A service review has been undertaken by GSTT to support the team with focussed improvements and will be used to support the next phase of the development of the service.

Retention

Turnover has reduced and in September is 9.07% compared to 11.15% for the same period last year and against a 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 *You said, we did* posters, targeting hotspot areas of lower staff satisfaction and/or high turnover, fortnightly HR Ward Rounds across all directorates to capture any staff issues or concerns and a refreshed process has been implemented within the Employee Relations team 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. As part of the day we had a live twitter feed for social media sharing of pledges advocated by the national NHS Fab Change campaign.   We created a hub in the restaurant to showcase current improvements and successes, with a call to action for everyone to engage in continuous improvement with 64 ideas provided by staff. An ED simulation exercise was also undertaken. Volunteers were also out in the Trust encouraging staff to visit or complete "I will.." cards. *You're the Best* staff recognition cards and *positivity trees* were also launched.

Ideas were captured on our Fab Change Day wall in the restaurant.

<u>Health and Wellbeing</u>

A further wellbeing event is to be arranged for early 2017. A Health and wellbeing Coordinator has been appointed to work with Occupational Health department until March 2017 to support the promotion of Health and Wellbeing.   Analysis of the wellbeing questionnaire that was carried out in September (307 responses received) is being undertaken. 8 champions have come forward from the survey. A further meeting with the CCG to review our progress against the CQUIN targets will take place in November.

Best of care
Best of people

The annual flu campaign is now underway and we have a bank nurse to assist with vaccinations. Daily clinics are being held in OH and peer vaccinators are working on the wards. Vouchers are being given as prizes via a monthly draw to encourage staff to have their vaccination. Weekly statistics are being produced with 16.1% of all front line staff having had the vaccination at 16 October.

Equality and Diversity

The newly formed Equality and Diversity Group met in September. The group will be focusing on the delivery of the Equality objectives as presented to Board in July. Two groups have been set up for BME and LGBT staff. A further group for disabled staff is being arranged.

Staff Friends and Family and Staff Survey

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 final results will be published on 28 November 2016. Interim analysis is currently taking place and will be presented to Board next month.

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 14 Oct the response rate is 28%, which is currently the highest response rate for acute Trusts in the country undertaken by the Picker Institute.

We have changed the approach this year so that staff working in the hospital have had paper copies of the survey delivered to them, whilst the Corporate Directorates (excluding Estates and Facilities) are completing the survey online.

Additionally, the following actions are supporting the survey -
- *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.

5. LEADERSHIP AND DEVELOPMENT

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

30 minutes in the Zone

We have launched an initial series of 30 minute skills sessions that can be included in existing meetings in the Trust. The first uptake on this offer is for the Transforming Care team on 13 October covering basic improvement tools and project management skills.

Leadership development

Cohorts 1 and 2 of the Management Development Programme (MDP) are complete and evaluation of both the programme and applied learning is ongoing. Emphasis is placed on practical application of the learning. Cohorts 3 and 4 attracted 5 participants each, giving a total of 27 people out of a possible 60, trained so far. A further 4 cohorts are scheduled at present, with more being planned for 2017. There are currently 38 participants with confirmed places. Numbers of applications continue to be disappointing despite a potential target audience of approximately 500 staff who would benefit from the programme and a concerted marketing campaign.

The Bitesize programme continues to be popular with additional dates and topics being added on a regular basis. 140 members of staff have attended so far. A further 16 workshops covering a diverse range of topics are currently scheduled to March 2017 with 40 seats per session available and a total of 203 seats booked at this stage.

The complete Leadership and Management programme for 2017 is currently being planned, and the brochure for autumn/winter 2016/17 is now available.

Report to the Trust Board

Board Date: 27th October 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	Executive Group, 19th October 2016
Executive Summary	**This report outlines;** 1. Trust financial performance for M6. 2. Estates and Facilities update 3. The Procurement Transformation Plan is reported elsewhere on this agenda **Trust Financial Performance** Key points are: • The Trust has outperformed the plan for the sixth month in a row, this month by £290k. • The cumulative position is a £880k deficit better than the planned deficit of £23.55m. • The major reason for this is income is higher than planned levels, pay is below planned levels and non-pay is above planned levels but not over and above the gains in the other two categories. 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 Septembers level and a 10% above plan so far this year. A Contract Performance Notice (CPN) on ED demand has been issued to the CCG. • Non Elective (NEL) admissions are increasing (5% YTD over plan as at September 2016) despite a fall in ED attendance conversion rate on total attendances from 25.7% to 21.3% over the same period. • 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 £850k YTD as at September 2016. This

represents a 35% 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 c8% 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 this Board.
- Pay expenditure is £120k or 0.001% variance adverse to plan in month. This is a change from M5. Agency spend has increased in M6 and we watch for an emerging trend in the lead up to CQC inspection as risk tolerance may change at local level. Check and challenge actions have been agreed as part of the PRM process.
- Clinical supplies expenditure in month and cumulatively to M6 is adverse to plan resulting from higher than originally planned 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, however we have received assurances that all investment projects remain on track to achieve the original year end plans.
- The Contract with North Kent CCGs is still not agreed. Discussions are ongoing between NHSI and NHSE in mediation.

Estates and Facilities Update
General
- The ED redevelopment stage 4 contract has been signed by the CEO as agreed at the September Board. The Contractor has started preliminary work.
- Ward refurbishment has started
- Minor works budget approved and work started
- Initial Estates Strategy work started
- Continued recruitment to senior and operational teams

Housekeeping
- Housekeeping Operating plan reviewed and updated
- Recruitment into substantive posts continues apace
- New machinery purchased including steam cleaners and deep cleans started
- New uniforms being phased in, improving staff morale
- Ward schedules have been up-dated and are in the process of being displayed outside wards in notice boards

	- Audits now on a schedule with any audit not meeting the indicative score being re-audited. Audit tool being downloaded and should be ready to use - All COSHH up-dates completed and ready in new folders to be issued early November - List of cleaning responsibilities has now been agreed with Head of Nursing and Infection Control **Energy team** - About to roll out energy champions - Engineering collaboration in place with Greenwich University – presentation on agenda today **Equipment** - Remote Drug Fridge Temperature monitoring project – system on order and implementation imminent. **Waste and transport** - All transport checks now in place - New SRCL contract in place - Internal recycling contract being progressed - PTS service continuing well, complaints being investigated and regular meetings with G4S underway. Additional transport to be negotiated. **Security** - Body cameras in place as a trial - Stakeholder relationship meeting with District Commander Police - No smoking support **Fire** - Strategy and policies updated – progress elsewhere on this agenda **Catering** - New catering manager in place, healthy options work started
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 manage the quality risks on a daily basis.

- 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 highlighted to Directorates as part of the PRM process and a rectification plan for each is expected.**

- 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 reforecast exercise will 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 previously agreed to develop internal Agency improvement plan together with the longer term impact of a recruitment and retention programme led by HR. An update on the recruitment and retention actions if provided in the HRDs report. All actions will be subject to a full QIA process.

- 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 agreed to mediate but no final decision has yet been communicated.**

- 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 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, 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 6

2016/17

Best of care
Best of people

Medway **NHS**
NHS Foundation Trust

Finance Report for September 2016

1. Executive Summary
    a. Executive Summary

2. Liquidity
    a. Cash Flow
    b. Loan Conditions

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

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

5. Capital
    a. Capital

1. Executive Summary

1a. Executive Summary (September 2016)

Key Messages	Report Reference
Activity and Income Summary The Trust is experiencing a high level of A&E demand which currently stands at 19% higher that than last year's level as at M6. Even though A&E conversion rate has reduced over the same period, non elective activity and income continues to be above plan in month and YTD. 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 11
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 12/13
Expenditure Summary Pay: Pay expenditure is £0.12m adverse to plan in month mainly due to increased nursing agency expenditure. The Directorates are reviewing usage and providing an update at the PRM. Non Pay: Clinical supplies in month 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. Other non pay is favourable to plan in month mainly due to reduced costs in the estates and finance department.	Page 9
Run Rate Analysis Overall: The clinical income run rate increases from the previous months reported position mainly due to increased planned activity. Pay: The pay run rate increased mainly due to increased nursing agency expenditure. The average pay run rate has increased from c£17.5m (month 5) to c£17.8m (month 6). Non Pay: The non pay run rate is £8.5m a £0.1m reduction from month 5 mainly due to reduced costs in the estates and finance departments.	Page 10

2. Liquidity

2a. Cash Flow

14 Week Forecast

£m	Actual					Forecast													
	w/e 02/09/16	w/e 09/09/16	w/e 16/09/16	w/e 23/09/16	w/e 30/09/16	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
BANK BALANCE BFWD	7.40	18.61	16.10	18.96	2.41	1.62	11.92	14.67	9.87	2.28	11.52	8.76	15.36	1.41	13.56	11.05	18.79	3.73	1.41
Receipts																			
NHS Contract Income	13.93	0.03	4.02	0.38	0.12	15.18	3.57	0.67	0.12	14.60	0.00	3.67	0.12	14.60	0.00	3.67	0.12	0.00	14.60
Other	0.35	0.68	0.53	0.78	0.17	0.26	2.58	0.25	0.25	0.70	0.32	1.96	0.25	0.65	0.32	0.34	0.25	0.55	3.40
Total receipts	14.29	0.70	4.55	1.17	0.29	15.45	6.15	0.92	0.37	15.30	0.32	5.63	0.37	15.25	0.32	4.01	0.37	0.55	18.00
Payments																			
Pay Expenditure (excl. Agency)	(0.02)	0.00	0.00	(13.71)	(0.02)	0.00	0.00	(5.77)	(7.82)	(0.03)	0.00	(2.22)	(11.37)	(0.03)	0.00	0.00	(13.59)	(0.03)	0.00
Non Pay Expenditure	(3.05)	(3.22)	(3.62)	(2.96)	(1.06)	(5.15)	(3.40)	(2.17)	(0.14)	(5.37)	(2.75)	(3.60)	(2.62)	(2.72)	(2.51)	(3.07)	(2.51)	(2.51)	(2.51)
Capital Expenditure	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.33)	0.00	(0.66)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)	(0.33)
Total payments	(3.07)	(3.22)	(3.62)	(16.67)	(1.08)	(5.15)	(3.40)	(8.28)	(7.96)	(6.06)	(3.08)	(6.15)	(14.32)	(3.09)	(2.84)	(3.40)	(16.43)	(2.87)	(2.84)
Net Receipts/ (Payments)	11.21	(2.52)	0.93	(15.50)	(0.79)	10.30	2.76	(7.35)	(7.59)	9.24	(2.76)	(0.52)	(13.95)	12.17	(2.52)	0.61	(16.06)	(2.32)	15.17
Funding Flows																			
FTFF/DOH	0.00	0.00	1.95	0.00	0.00	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
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)	(1.05)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.02)	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.10	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	1.93	(1.05)	0.00	0.00	0.00	2.55	0.00	0.00	0.00	7.12	0.00	(0.02)	0.00	7.13	1.00	0.00	0.00
BANK BALANCE CFWD	18.61	16.10	18.96	2.41	1.62	11.92	14.67	9.87	2.28	11.52	8.76	15.36	1.41	13.56	11.05	18.79	3.73	1.41	16.58

September 2016 Cashflow Performance & 14 week Cashflow Forecast
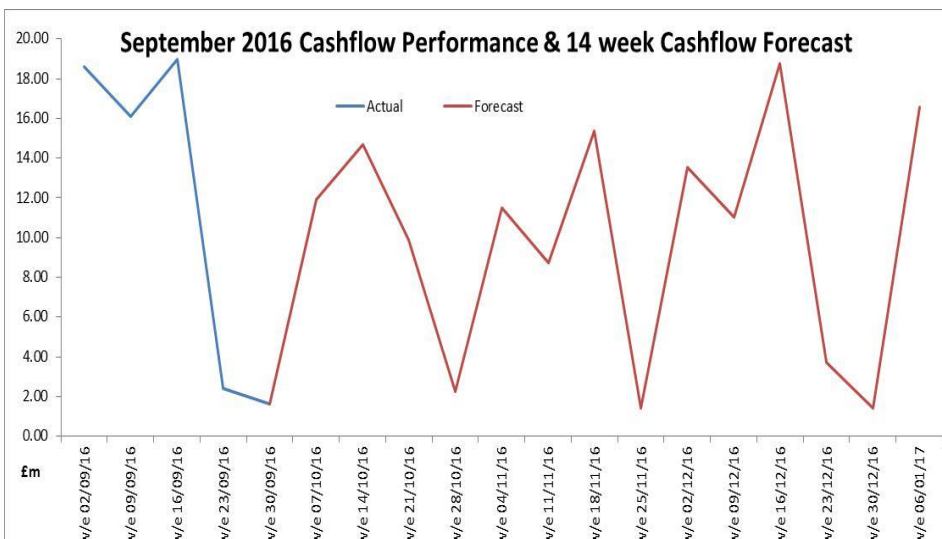
Commentary

The graph shows the actual cash profile for the Trust for September 2016; it also illustrates the Trust's forecasted cash profile up to the 6th January 2017. The Trust commenced September with £7.13m and ended the month with £1.62m. This balance complies with the minimum liquidity tramline required by DoH (£1.4m).

The Trust does not currently 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 September 2016 the Trust made further use of its £21.3m Working Capital Facility (WCF) and drew down £1.95m. It is also noted that the Trust has requested to draw down a further £2.55m in October 2016, which will bring the Trusts's total YTD drawdown to £19.25m - leaving £2.05m available to draw upon.

The Trust is currently working with NHSI to understand the available funding mechanisms to ensure that sufficient funds are available for the remainder of the financial year.

Capex spend remains slow, however this spend is expected to pick up with the redevelopment of the Ambulance Parking / Drop Off area as part of the wider Emergency Department Project.

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	(Green)	(Green)	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.	(Red)	(Red)	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.	(Green)	(Green)	No new contracts introduced without pre-approval.
8 – 4	Implementation of controls over VSMs and off-payroll workers	Immediately	In progress	(Amber)	(Amber)	Market Forces and compliance through Remuneration Committee
8 – 5	Review / benchmarking of Estates and Facilities costs	31st May 2016	Behind schedule.	(Amber)	(Amber)	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	(Amber)	(Amber)	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.	(Green)	(Green)	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.	(Amber)	(Amber)	In relation to transactional services, SBS have been provided with Trust data; they have reviewed and we have worked with them to ensure they understand our submisison. Final confirmation to be given on their notes by us and then they will submit their proposal
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.	(Green)	(Green)	
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.	(Green)	(Green)	
8 – 11	Test savings opportunities in use of CCS framework	9th May 2016	CCS framework used	(Green)	(Green)	
8 – 12	Become a member of the EEA portal and report relevant activity	Not specified	Member since 2010, activity is reported.	(Green)	(Green)	
8 – 13	Provide access to relevant authorised individuals to allow monitoring of progress on above conditions	Immediately	Ongoing	(Green)	(Green)	

3. Financial Performance

3a. Consolidated Income & Expenditure

Consolidated I&E (September 2016)

	Current Month			Year to Date			Annual
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Plan*
	£m	£m	£m	£m	£m	£m	£m
Revenue							
Clinical income	20.01	19.82	0.19	116.49	115.55	0.94	230.71
High Cost Drugs	2.03	1.74	0.30	10.60	10.33	0.27	21.45
Other Operating Income	2.15	2.01	0.13	12.58	12.17	0.41	24.33
Total Revenue	**24.19**	**23.57**	**0.62**	**139.68**	**138.06**	**1.62**	**276.48**
Expenditure							
Substantive	-13.67	-16.81	3.15	-81.70	-94.19	12.48	-187.86
Bank	-0.57	-0.18	-0.39	-3.76	-2.75	-1.01	-3.25
Agency	-3.55	-0.68	-2.87	-18.43	-8.56	-9.87	-17.92
Total Pay	**-17.79**	**-17.67**	**-0.12**	**-103.89**	**-105.50**	**1.61**	**-209.03**
Clinical supplies	-3.16	-2.85	-0.31	-19.84	-17.45	-2.40	-34.61
Drugs	-2.77	-2.48	-0.29	-16.20	-15.38	-0.82	-30.55
Consultancy	-0.14	-0.18	0.03	-0.35	-0.93	0.58	-0.94
Other non pay	-2.39	-2.74	0.35	-15.73	-15.98	0.25	-32.17
Total Non Pay	**-8.46**	**-8.25**	**-0.21**	**-52.13**	**-49.74**	**-2.39**	**-98.27**
Total Expenditure	**-26.25**	**-25.92**	**-0.33**	**-156.02**	**-155.24**	**-0.78**	**-307.30**
EBITDA	**-2.06**	**-2.35**	**0.29**	**-16.34**	**-17.18**	**0.73**	**-30.82**
	-9%	*-10%*	*0%*	*-12%*	*-12%*	*0%*	*-15%*
Post EBITDA							
Depreciation	-0.80	-0.81	0.01	-4.82	-4.85	0.02	-9.69
Interest	-0.16	-0.17	0.01	-0.81	-0.87	0.06	-2.02
Dividend	-0.12	-0.11	-0.01	-0.69	-0.65	-0.04	-1.31
	-1.09	**-1.09**	**0.00**	**-6.33**	**-6.37**	**0.05**	**-13.02**
Net (Deficit) / Surplus	**-3.14**	**-3.43**	**0.29**	**-22.67**	**-23.55**	**0.88**	**-43.84**

Commentary

Net (Surplus) / Deficit and Plan Figure

The Trust reported a £3.14m deficit in month 6, favourable to plan by £0.29m. As at month 6 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 has been prepared (seperate item on the Agenda) and the Trust remains on target to achieve the planned deficit of £43.84m.

Clinical Income

The Trust is experiencing a high level of A&E demand which currently stands at 19% higher that than last year's level as at M6. Even though A&E conversion rate has reduced over the same period, non elective activity and income continues to be above plan in month and YTD. 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 largely on plan.

Pay

Pay expenditure is £0.12m adverse to plan in month mainly due to increased nursing agency expenditure. The Directorates are reviewing usage and providing an update at the PRM.

Non Pay

Clinical supplies in month 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. Other non pay is favourable to plan in month mainly due to reduced costs in the estates and finance department.

Directorate Reports

The income and expenditure position by Directorate is detailed later in the report. Detailed forecasts have been prepared and are a seperate item on the agenda.

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 cancer target was met in August and September. The RTT target was not met in August and September but this has been raised with the CCG due to increased emergency attendances. The Directorates have been requested to review this and report to the PRM. The clinical income contract with the main Commissioners is yet to be finalised. An arbitration process may need to be followed to ensure resolution.

3b. Run Rate Analysis - Financial

Anaylsis of 15 monthly performance - Financials

	Jul-15	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
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue															
Clinical income	18.1	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
High Cost Drugs	1.8	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
Other Operating Income	2.2	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
Total Revenue	**22.1**	**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**
Expenditure															
Substantive	-12.7	-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
Bank	-0.6	-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
Agency	-3.2	-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
Total Pay	**-16.4**	**-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**
Clinical supplies	-2.7	-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
Drugs	-2.5	-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
Consultancy	-0.2	-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
Other non pay	-2.8	-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
Total Non Pay	**-8.1**	**-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**
Total Expenditure	**-24.5**	**-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**
EBITDA	**-2.4**	**-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**
Post EBITDA															
Depreciation	-0.9	-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
Interest	-0.1	-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
Dividend	-0.3	-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
Fixed Asset Impairment	0.0	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
	-1.3	**-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**
Net Surplus / (Deficit)	**-3.7**	**-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**
Revaluation Gain	0.0	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
Net Surplus / (Deficit)	**-3.7**	**-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**

3c. Clinical Activity

Clinical Activity by Point of Delivery (September 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	2,287	1,685	601	1,635	11,893	10,889	1,004	9,777
Elective Inpatient	678	634	44	589	3,866	3,707	159	3,511
Non Elective Inpatient	3,538	3,632	-94	3,630	23,857	22,739	1,118	22,095
Excess Bed Days	1,794	2,333	-539	1,831	8,144	12,863	-4,719	12,478
Outpatients	29,580	28,964	616	24,345	175,548	170,780	4,768	158,207
A&E	6,536	6,372	164	6,155	43,411	39,845	3,566	39,845
Maternity Pathway	882	972	-90	848	5,403	5,374	29	5,589
Direct Access Radiology	5,324	3,599	1,725	871	35,580	27,848	7,732	10,624
Adult Critical Care	721	859	-138	892	4,820	4,882	-62	4,912
Chemotherapy	1,225	840	385	846	6,196	4,957	1,239	4,954
Total PBR	**52,565**	**49,890**	**2,675**	**41,642**	**318,718**	**303,884**	**14,834**	**271,992**
Non PBR								
Direct Access	183,543	174,459	9,084	104,472	1,199,072	1,070,812	128,260	600,235
Paediatric & Neonatal Critical Care	729	0	5,866	951	5,695	4,927	5,905	5,591
Excluded Devices	74	76	-2	93	502	421	81	469
Other cost per case	2,285	1,764	521	6,299	14,891	15,799	-908	35,743
Total Non PBR	**186,631**	**176,299**	**15,469**	**111,815**	**1,220,160**	**1,091,959**	**133,338**	**642,038**

Activity Performance against Plan

Commentary

A&E attendances continues with high volumes month on month, seeing a 19% increase compared to September 2015. A contract performance letter has been issued to the CCG in relation to the high level of A&E .

Elective Day cases & Inpatients continue to over perform in month, 645 spells, resulting in a YTD over performance to 1163 spells. Main areas of over performance are Colorectal Surgery (956 spells), Medical Oncology (341 spells) and Urology (124 spells). However, this over performance is partially offset by underperformances in T&O (171 spells) and Gastroenterology (202 spells).

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.

3d. Workforce

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual WTE	*Plan* WTE	*Variance* WTE	*Actual* £m	*Plan* £m	*Variance* £m	*Actual* £m	*Actual* £m	*Plan* £m	*Variance* £m	*Actual* £m
Substantive	Consultants	179	222	-43	2.30	2.71	-0.41	2.27	14.02	15.83	-1.82	13.72
	Junior Medical	334	369	-35	1.95	2.20	-0.25	1.73	11.42	12.47	-1.06	10.15
	Nurses & Midwives	1097	1491	-394	3.92	5.63	-1.71	3.78	23.65	29.96	-6.32	22.90
	Scientific, Therapeutic & Technical	456	521	-65	1.42	1.57	-0.15	1.35	8.48	9.14	-0.67	7.90
	Healthcare Assts, etc.	457	550	-93	0.97	1.22	-0.25	0.94	5.78	6.56	-0.78	5.68
	Executives	8	9	-1	2.02	2.43	-0.41	1.81	12.03	14.10	-2.07	10.91
	Chair & NEDs	7	7	0	0.01	0.01	0.00	0.01	0.08	0.08	0.00	0.06
	Admin & Clerical	809	945	-136	0.13	0.14	-0.01	0.14	0.75	0.81	-0.06	0.80
	Other Non Clinical	458	491	-33	0.94	0.86	0.08	0.88	5.51	5.12	0.39	5.05
	Pay Reserves	0	0	0	0.00	0.04	-0.04	0.00	0.00	0.12	-0.12	0.01
	Substantive Total	**3805**	**4605**	**-800**	**13.67**	**16.81**	**-3.14**	**12.92**	**81.70**	**94.20 #**	**-12.50**	**77.18**
Agency	Consultants	25	0	25	0.44	0.09	0.35	0.32	2.00	0.61	1.4	1.19
	Junior Medical	65	0	65	0.64	0.44	0.20	0.51	3.50	2.64	0.9	4.14
	Nurses & Midwives	340	0	340	1.58	-0.12	1.70	1.26	7.13	3.16	4.0	6.78
	Scientific, Therapeutic & Technical	28	0	28	0.14	0.10	0.05	0.32	1.55	0.67	0.9	2.11
	Healthcare Assts, etc.	63	0	63	0.16	0.00	0.16	0.06	0.57	0.00	0.6	0.21
	Admin & Clerical	22	13	9	0.42	0.15	0.27	0.27	2.87	1.80	1.1	1.92
	Other Non Clinical	0	0	0	0.17	0.03	0.14	0.18	0.81	0.17	0.6	0.84
	Agency Total	**543**	**13**	**530**	**3.55**	**0.68**	**2.87**	**2.92**	**18.43**	**9.06**	**9.37**	**17.18**
Bank	Nurses & Midwives	44	0	44	0.16	0.04	0.12	0.17	1.28	0.74	0.5	1.20
	Scientific, Therapeutic & Technical	17	0	17	0.06	0.01	0.05	0.04	0.32	0.05	0.3	0.24
	Healthcare Assts, etc.	108	0	108	0.24	0.01	0.23	0.20	1.52	0.32	1.2	1.35
	Admin & Clerical	51	1	50	0.09	0.09	0.00	0.11	0.58	0.93	-0.4	0.63
	Other Non Clinical	3	15	-12	0.01	0.04	-0.03	0.03	0.06	0.21	-0.2	0.16
	Bank Total	**223**	**16**	**207**	**0.57**	**0.18**	**0.39**	**0.56**	**3.76**	**2.25**	**1.51**	**3.59**
	Workforce Total	**4571**	**4634**	**-63**	**17.79**	**17.67**	**0.12**	**16.40**	**103.89**	**105.51 #**	**-1.62**	**97.95**

	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	204	222	-18	2.74	2.80	-0.06	2.59	16.02	16.44	-0.43	14.91
Junior Medical	399	369	30	2.59	2.64	-0.05	2.24	14.92	15.11	-0.20	14.29
Nurses & Midwives	1,481	1,491	-10	5.67	5.55	0.12	5.21	32.06	33.86	-1.81	30.88
Scientific, Therapeutic & Technical	501	521	-20	1.62	1.68	-0.05	1.71	10.35	9.86	0.48	10.25
Healthcare Assts, etc.	628	550	78	1.37	1.23	0.14	1.20	7.87	6.88	0.99	7.24
Executives	8	9	-1	2.02	2.43	-0.41	1.81	12.03	14.10	-2.07	10.91
Chair & NEDs	7	7	0	0.01	0.01	0.00	0.01	0.08	0.08	0.00	0.06
Admin & Clerical	882	959	-77	0.64	0.38	0.27	0.52	4.20	3.54	0.66	3.35
Other Non Clinical	461	506	-45	1.12	0.93	0.20	1.09	6.38	5.50	0.88	6.05
Pay Reserves	0	0	0	0.00	0.04	-0.04	0.00	0.00	0.12	-0.12	0.01
Workforce Total	**4,571**	**4,634**	**-63**	**17.79**	**17.67**	**0.12**	**16.40**	**103.89**	**105.51**	**-1.62**	**97.95**

Commentary:

Pay expenditure is overspent compared to plan in month by £0.12m mainly due to increased agency expenditure. Increases on prior year in month expenditure are mainly due to increments, inflationary and national insurance increases of 3.3%.

There has been a substantial increase in agency expenditure in September mainly due to nursing 1 to 1 cover being reviewed by Directorates at the PRM.

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.

3e. Run Rate Analysis - WTE / £

Anaylsis of 15 monthly performance - WTE

		Jul-15	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
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	178	179	181	181	182	180	180	178	179	178	181	179	177	179	179
	Junior Medical	296	313	314	317	325	322	319	324	326	321	311	322	307	335	334
	Nurses & Midwives	1,091	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
	Scientific, Therapeutic & Technical	416	433	446	452	450	453	450	448	453	464	466	460	452	451	456
	Healthcare Assts, etc	477	485	473	468	465	472	465	466	477	471	465	457	461	450	457
	Executives	8	6	7	6	5	4	4	5	6	7	7	7	7	7	8
	Chair & NEDs	5	5	7	6	6	7	7	7	7	7	7	7	7	7	7
	Admin & Clerical	747	751	752	756	754	750	750	768	779	794	800	801	802	801	809
	Other Non Clinical	426	427	436	427	419	425	417	422	420	443	435	451	467	464	458
	Substantive Total	**3,643**	**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**
Agency	Consultants	9	10	14	13	11	10	8	11	14	10	13	14	16	19	25
	Junior Medical	70	62	57	53	64	54	59	51	59	50	52	51	54	59	65
	Nurses & Midwives	220	197	216	214	100	271	200	245	159	168	224	330	201	254	340
	Scientific, Therapeutic & Technical	62	57	52	56	54	54	52	55	49	44	52	61	55	61	28
	Healthcare Assts, etc	8	9	20	16	6	17	10	8	42 -	9	31	46	26	44	63
	Admin & Clerical	43	30	41	45	27	61	32	39	52	40	41	61	58	30	22
	Other Non Clinical	62	52	77	41	41	-	48	53	73	57	45	36	35	35	-
	Agency Total	**473**	**417**	**477**	**438**	**303**	**447**	**409**	**462**	**448**	**360**	**458**	**598**	**444**	**502**	**543**
Bank	Nurses & Midwives	48	42	46	45	43	41	47	49	92	58	58	46	51	47	44
	Scientific, Therapeutic & Technical	10	12	12	10	11	9	10	10	10	4	4	28	27	18	17
	Healthcare Assts, etc	107	119	104	120	113	105	118	108	91	91	91	153	120	117	108
	Admin & Clerical	49	41	46	46	49	47	48	50	42	36	36	19	62	106	51
	Other Non Clinical	14	12	12	11	12	13	9	11	10	3	3	1	4	9	3
	Bank Total	**228**	**226**	**220**	**233**	**228**	**215**	**232**	**228**	**245**	**192**	**192**	**247**	**264**	**297**	**223**
	Workforce Total	**4,344**	**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**

Anaylsis of 15 monthly performance - £

		Jul-15	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
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	WTE
Substantive	Consultants	2.25	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
	Junior Medical	1.62	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
	Nurses & Midwives	3.72	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
	Scientific, Therapeutic & Technical	1.31	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
	Healthcare Assts, etc	0.92	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
	Executives	1.84	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
	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	0.15	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
	Other Non Clinical	0.81	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
	Substantive Total	**12.63**	**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**
Agency	Consultants	0.17	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
	Junior Medical	0.79	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
	Nurses & Midwives	1.30	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
	Scientific, Therapeutic & Technical	0.46	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
	Healthcare Assts, etc	0.02	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
	Admin & Clerical	0.27	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
	Other Non Clinical	0.15	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
	Agency Total	**3.16**	**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**
Bank	Nurses & Midwives	0.17	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
	Scientific, Therapeutic & Technical	0.04	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
	Healthcare Assts, etc	0.23	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
	Admin & Clerical	0.11	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
	Other Non Clinical	0.03	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
	Bank Total	**0.58**	**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**
	Workforce Total	**16.37**	**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**

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	168.5	169.0	166.5	2.5
Non NHS trade receivables	0.5	0.6	0.5	0.1
Non current Assets Sub Total	**169.1**	**169.6**	**167.1**	**2.5**
Current Assets				
Inventories	6.7	6.6	6.4	0.2
Trade receivables	24.2	31.6	25.1	6.5
Other receivables	1.7	1.5	-1.3	2.8
Other current assets	6.8	3.5	2.3	1.2
Cash at bank	7.1	1.6	1.6	0.0
Current Assets Sub Total	**46.4**	**44.7**	**34.1**	**10.7**
Current Liabilities				
Trade payables	-19.7	-18.8	-17.2	-1.6
Other payables	-24.1	-25.9	-17.6	-8.3
Borrowings	-1.0	-1.0	-1.2	0.2
Provisions	-0.1	-0.1	-0.1	0.1
Other liabilities	-16.4	-16.4	-13.9	-2.5
Sub Total Current Liabilities	**-61.2**	**-62.1**	**-50.0**	**-12.2**
Net Current Assets	**-14.8**	**-17.4**	**-16.0**	**-1.5**
Non Current Liabilities				
Borrowings	-100.5	-102.0	-89.8	-12.2
Provisions	-0.9	-0.9	-0.8	0.0
Other liabilities	-0.1	0.3	0.0	0.3
Sub Total Non Current Liabilities	**-101.4**	**-102.5**	**-90.6**	**-11.9**
Net Assets Employed	**52.9**	**49.7**	**60.5**	**-10.8**
Taxpayers' and Others' Equity				
Public Dividend Capital	129.5	129.5	129.5	0.0
Retained Earnings	-108.9	-112.1	-101.3	-10.8
Revaluation Reserve	32.3	32.3	32.3	0.0
	52.9	**49.7**	**60.5**	**-10.8**

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	4.40	2.71	0.29	0.31	0.76	0.17	0.01	0.01	0.05	0.08
Swale CCG	2.27	1.09	0.10	0.03	0.43	0.58	0.00	0.03	0.00	0.00
Dartford & Gravesham CCG	1.34	0.40	0.00	0.13	0.30	0.19	0.21	0.05	0.06	0.00
Other CCGs	2.32	0.70	0.18	0.28	0.27	0.42	0.27	0.12	0.03	0.04
NHS England	0.24	0.01	0.00	0.21	0.00	0.00	0.01	0.02	0.00	0.00
Other	7.05	4.38	0.36	0.25	0.74	0.54	0.27	0.28	0.11	0.11
Partially Completed Spells and Overperformance	12.49	12.49	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total NHS	**30.11**	**21.79**	**0.94**	**1.20**	**2.50**	**1.91**	**0.76**	**0.51**	**0.25**	**0.23**
Non NHS										
Nursery	0.06	0.01	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	0.33	0.03	0.02	0.01	0.02	0.05	0.07	0.04	0.04	0.03
Medway Comm Healthcare	0.38	0.17	0.00	0.04	0.03	0.06	0.01	0.02	0.02	0.02
Other	1.49	0.69	0.12	0.08	0.22	0.25	0.04	0.03	0.03	0.02
Total Non NHS	**2.39**	**0.90**	**0.16**	**0.14**	**0.29**	**0.38**	**0.16**	**0.12**	**0.11**	**0.14**
Bad debt provision	**(0.90)**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.16)**	**(0.36)**	**(0.37)**
Total Debtors	**31.60**	**22.70**	**1.09**	**1.34**	**2.79**	**2.29**	**0.92**	**0.46**	**0.00**	**0.00**

Commentary

The gross trade receivables debt outstanding to the Trust as at 30 September 2016 is £32.49m (£31.60m Net). In accordance with Trust policy the Bad Debt provision is shown separately.

Overall NHS and non-NHS debtors increased by a net £7.37m in the month. This includes a decrease of £0.45m in unbilled activity. Therefore debtors excluding PCS increased by £7.82m.

This increase is contained within Current Debtors and includes £7m of Invoices raised on the 30 September. It includes 3.43m to NHS England for Q2 & Q3 Training Invoices; £2.64m of Invoices to Medway CCG (£2.26m Q1 Overperformance & £0.33m High Cost Drugs); & £0.94m of Invoices to Swale CCG (Q1 Overperformance). There has been a £0.2m decrease in all other debt ageing categories.

Fig.1 shows the value of debt outstanding by ageing category. Current debt (i.e. less than 30 days) is 70% of total receivables, with a further 16% 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.
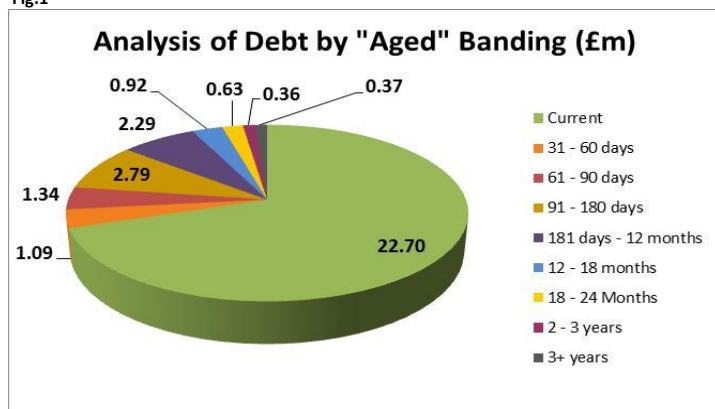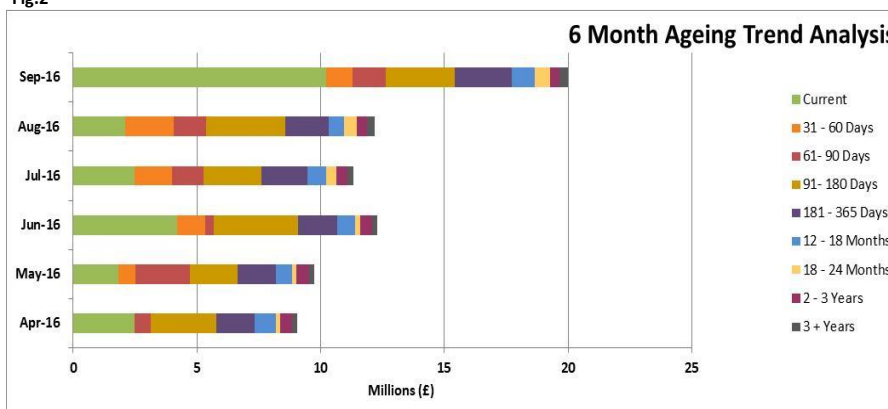
Fig.1

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

Fig.2

6 Month Ageing Trend Analysis

4c. Creditors

Aged Creditors

	Total	Current	31 to 60	61 to 90	91 - 180	181 - 365	12 - 18 Months	18 - 24 Months	2 - 3 Years	3 Years +
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
NHS										
NHS Business Services Authori	0.60	0.37	0.12	0.11	0.00	0.00	0.00	0.00	0.00	0.00
NHS Litigation Authority	(0.55)	(0.56)	0.00	0.00	0.01	0.00	0.00	0.00	0.00	0.00
Dartford and Gravesham	0.76	0.18	0.23	0.04	0.13	0.10	0.01	0.02	0.00	0.05
National Blood	0.13	0.13	(0.00)	(0.00)	0.00	0.00	0.00	0.00	0.00	0.00
Other	2.46	0.98	0.22	0.18	0.39	0.41	0.04	0.17	0.06	0.00
NHS Pension Scheme	2.18	2.18	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total NHS	5.58	3.27	0.57	0.33	0.53	0.52	0.05	0.19	0.06	0.05
Non NHS										
NHS Professionals	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
NHS Supply Chain	1.06	0.59	0.49	(0.01)	0.00	0.00	0.00	0.00	0.00	0.00
Johnson and Johnson	0.28	0.13	0.13	0.03	0.00	0.00	(0.01)	0.00	0.00	0.00
Other	11.83	3.40	5.28	1.98	0.75	0.27	0.10	0.06	(0.05)	0.05
Total Non NHS	13.18	4.12	5.89	2.00	0.75	0.27	0.09	0.06	(0.05)	0.05
Total Creditors	**18.75**	**7.39**	**6.46**	**2.33**	**1.28**	**0.79**	**0.14**	**0.25**	**0.01**	**0.10**

Fig.1 - Aged Creditors Analysis
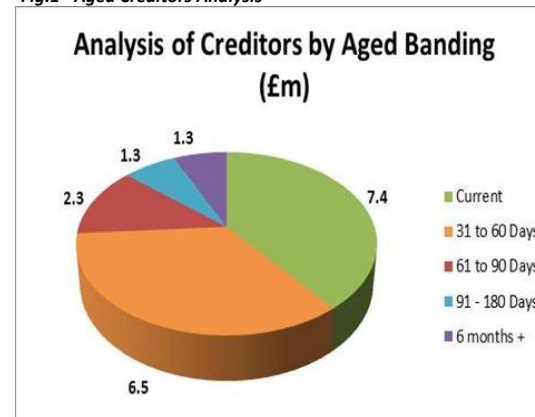
Commentary

The key NHS and Non NHS trade creditors are shown in the table to the left. Trade Creditors are now at £18.75m.

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.

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.
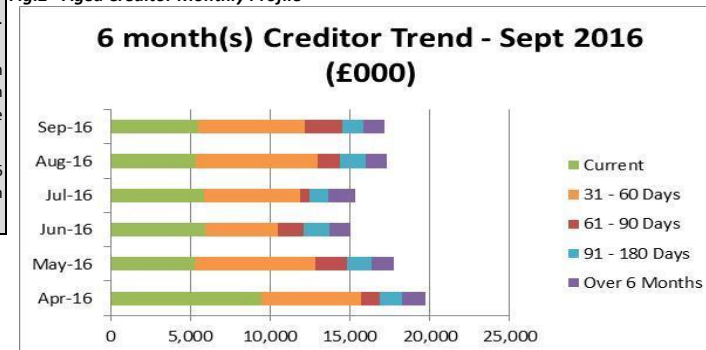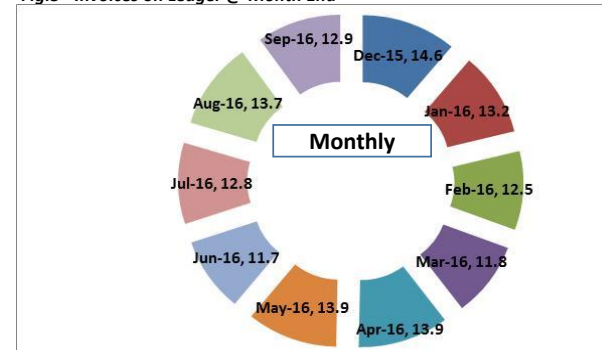
Fig.2 - Aged Creditor Monthly Profile

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	0.47	0.54	-0.07	2.08	2.26	-0.18	5.06
IM&T	0.72	0.43	0.29	2.03	1.95	0.08	5.90
Medical & Surgical Equipment	0.20	0.16	0.04	0.77	0.80	-0.03	1.52
Specific Business Cases	0.17	0.40	-0.23	1.23	1.13	0.10	3.88
Transform Projects (ED/AAU)	-0.25	1.63	-1.88	1.38	5.09	-3.71	11.84
Total	**1.31**	**3.16**	**-1.85**	**7.49**	**11.23**	**-3.74**	**28.20**

Commentary

As at Month 6 the capital programme is £3.74m below plan 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 2nd half of the financial year.

Capital Monthly Profile
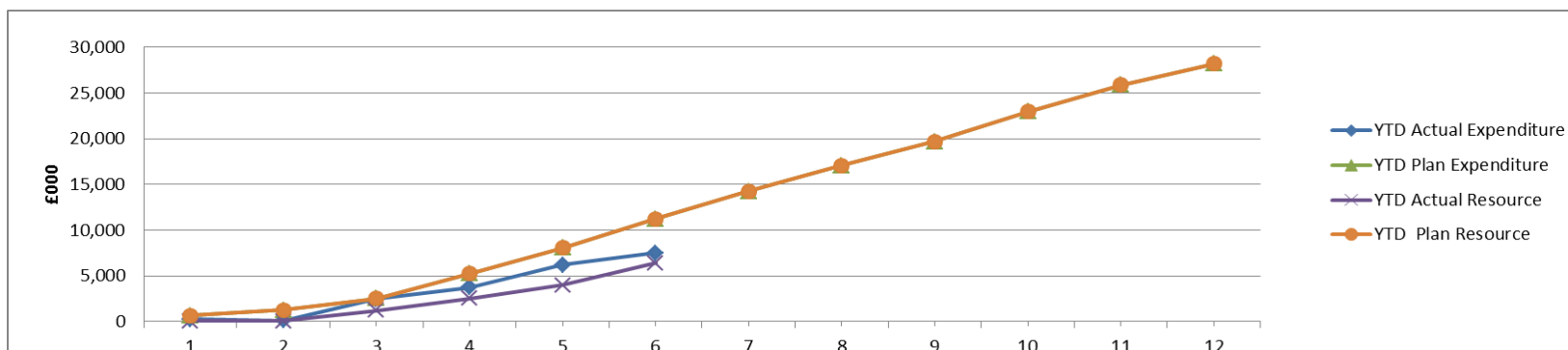
Report to the Board of Directors

Board Date: 27 October 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 – October 2016

1. EXECUTIVE SUMMARY

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

2. CARE QUALITY COMMISSION

2.1. On 6 October the CQC stage 2 Provider Information Request was submitted. This involved responding to 464 requests and the submission of 796 supporting documents. The corporate governance team continue to work closely with the PMO in planning the logistics for the on-site focus group meetings on 22 November and the inspection on 29 and 30 November.

2.2. Overall the quality and consistency in the style of the documents submitted has improved since 2015 - although training needs for minute taking and presentation of documents have been identified; the responsiveness in getting documents returned was quicker and the director level sign-off ensured appropriate scrutiny.

2.3. The Governance Team are preparing for the next set of data requests which are anticipated towards the end of October/early November.

3. RISK AND REGULATION QUALITY ASSURANCE

3.1. A database of non-CQC regulations has been compiled. A report on the methodology and database went to the Executive Group on 5 October and was recognised as providing a holistic overview of non-CQC regulatory status. A bi-monthly report will be sent to the Executives and Directors of Clinical Operations from November onwards to ensuring continuing oversight and selected reports can be generated as required, e.g. by Directorate and / or Programme level.

3.2. The Imaging department have been accredited under the Imaging Services Accreditation Scheme (ISAS) since December 2012. Accreditation is in a 4 year

cycle and the service has undergone a 2 day on site full accreditation maintenance visit on 28-29 September 2016. The Assessment Manager was pleased to recommend maintenance of accreditation subject to clearance of a small number of findings within the 4 week timeframe allotted. There were also some recommendations for improvement which were well received and will be acted upon. The service received some very complimentary comments, e.g. the Radiologist assessor described the general impression as "excellent", and the service was thanked for their open and helpful approach.

3.3. The Radiopharmacy Service has received notice that the Medicines and Healthcare Products Regulatory Agency (MHRA) intend to carry out a routine Inspection of the service on 1 November 2016. The service is under a 2 year Inspection cycle; however the last Inspection took place in August 2013. The department hold a "Specials Licence" under the Medicines Act and are assessed against the Good Manufacturing Practice (GMP) standards.

4. EMERGENCY PLANNING, RESILIENCE AND RESPONSE

4.1. The Trust responded as a receiving hospital to a major incident on Medway City Estate, declared by South East Coast Ambulance Service on Friday 30 September at 22:41. The Ambulance Service stood the Trust down from being a receiving Hospital at 23:06, but the hospital received casualties from the incident as priority calls x 4. This was managed within business as usual arrangements. A debrief report sharing learning from the incident will be reviewed by the EPRR Group and Executive Group in November.

4.2. Executive responsibility for winter planning has 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 an exercise and challenge session on 13 October. This was attended by representatives from various functions, SECAMB and Swale and Medway CCGs. Urgent care and clinicians were not well represented and this will be fed back together with the learning from the exercise. A full list of representation is attached at appendix 1.

4.3. A separate report on NHS England core standards is included in the Board papers.

5. HEALTH AND SAFETY

5.1. An audit of H&S folders across the Trust has been completed. This showed that H&S responsibilities for risk assessments are not being fulfilled adequately or consistently across the Trust. Immediate rectification work is underway and the

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wider work required will be outlined in the Health and Safety Strategy and Policy that will be presented to the Board for approval in November. Immediate issues arising from the risk assessment process will be fed back to the Directorate concerned.

6. DOCUMENTATION MANAGEMENT

6.1. 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
Complaints Policy	Director of Corporate Governance, Risk, Compliance and Legal	Planned for submission to November Board
Serious Incidents Policy	Chief Quality Officer	On October Board agenda
Safeguarding Policy	Director of Nursing	Unknown – verbal update 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	Planned for submission to November Board

Fire Safety Policy	Director of Finance	On October Board agenda
Standards of Business Conduct	Company Secretary	Unknown – verbal update TBC
Medicines Management	Medical Director	Unknown – verbal update TBC
Risk Management	Director of Corporate Governance, Risk, Compliance and Legal	Approved by Board on 29 September 2016
Patient Care and Management	Director of Nursing	Unknown – verbal update TBC
Estates, Facilities and Security	Director of Estates and Facilities	Planned for submission to November Board
Fire Safety	Director of Estates and Facilities	On October Board agenda
Duty of Candour	Chief Quality Officer	Approved by Board on 29 September 2016
Finance	Chief Finance Officer	Planned for submission to November Board

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APPENDIX 1 – WINTER RESILIENCE EXERCISE

	Number of staff, Invited	Attended	Number of Staff, Attended
Corporate	3	Yes	3
Facilities and Estates	5	Yes	4
IHSS (Sterile Services)	1	Yes	1
Co-ordinated Surgical	3	Yes	1
Women and Children	3	Yes	1
Acute and Continuing Care – Discharge	1	Yes	1
Acute and Continuing Care – Pharmacy	1	Yes	1
Acute and Continuing Care – Therapies	1	Yes	1
Acute and Continuing Care – ED/Site	2	No	0
SECAmb	1	Yes	1
Swale CCG	1	Yes	1
Medway CCG	1	Yes	2
MCH – IDT	1	No	0
Transforming Systems Ltd	1	Yes	1
Communications Team	4	Yes	1
Total	29		19

Report to the Trust Board

Date: 27 October 2016

Title of Report	Emergency Preparedness, Resilience and Response
Presented by	Lynne Stuart
Lead Director	Lynne Stuart, Director of Corporate Governance, Risk, Compliance and Legal
Committees or Groups who have considered this report	Emergency Preparedness, Resilience and Response (EPRR) Group
Executive Summary	Each May the Board agrees the EPRR Work Plan to ensure that the Trust is compliant with its duties under the Civil Contingences Act (2004) as defined below. Annually the Trust is required to undertake a self-assessment against the NHS England Core Standards for EPRR. (The assurance process is detailed in appendix 2). MFT self-assessed as compliant in all aspects. For the past two consecutive years the Kent and Medway Local Health Resilience Partnership have requested an audit of the self-assessment for each provider and this was undertaken by South-East Coast Commissioning Support Unit on 2 September on behalf of the Kent and Medway CCGs. Following the audit the Trust Annual Assurance Statement for 2016/17 has been assessed as fully compliant. The Audit Report is attached as appendix 1.
Resource Implications	N/A
Risk and Assurance	The self-assessment template is pre-set by NHS England and adheres to current threats, risks and hazards identified within the National Risk Register (Cabinet Office, 2015) for which this organisation must be able to respond and recover as a Category 1 Responder (Civil Contingencies Act, 2004) Assurance is required against the listed legal and regulatory requirements.
Legal Implications/Regulatory Requirements	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

	NHS England, EPRR Core Standards (2015)
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	Note the EPRR Assurance Audit Report as evidence and confirmation that the EPRR Work Plan previously approved by the Board has given the required level of assurance.
Purpose & Actions required by the Board :	Approval ☐ Assurance ✔ Discussion ☐ Noting ☐

MEDWAY FOUNDATION TRUST

EPRR Assurance Audit Report

September 2016

Date	Version	Author	Notes
5.9.16	V1	Samantha Proctor	
21.9.16	V2	Samantha Proctor	Updated results chart NHSE do not wish the deep dive ratings included into final compliance score

Assurance Visit

South East CSU Business Resilience team visited Medway Foundation Trust to conduct an audit of their Emergency Planning Response and Recovery [EPRR] preparedness against the NHS England EPRR Core Standards.

The purpose of the visit was to enable Medway Foundation Trust to provide assurance to their commissioners as to their level of preparedness.

Audit Details	
Date of audit	2nd September 2016
Locations of audit	Medway Foundation Trust
Auditors	Samantha Proctor [SECSU] and John Morrissey [SECSU] on behalf of Medway CCG
Provider Representatives	Jess Scott, Head of EPRR, MFT Paul Mullane, Head of Corporate Compliance and Resilience, MFT

Areas Investigated

The audit looked for evidence against the core standards identified by NHS England as being required to be in place by an acute trust provider. The investigated areas were:

- EPRR Core Standards

- Deep Dive – Business Continuity

- HazMat/ CBRN Core Standards

Audit Results

MFT were able to provide evidence to demonstrate the following rates of compliance

	Green [full compliance]	Amber [plans to address gaps on annual work programme]	Red [significant gaps with no plan to address]
EPRR Core Standards	34/34	0/34	0/34
Deep Dive – Business Continuity **[not counted into the final compliance level calculation]**	6/6	0/6	0/6
HazMat/CBRN Standards	14/14	0/14	0/14

Full audit results are appended to this report.

Based on the NHS England levels of assurance below we conclude that Medway Foundation Trust meets the requirements for Full Compliance

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

SOUTH EAST/CSU

Audit Narrative

Medway Foundation Trust have continued to work to a consistently high standard to achieve full compliance against the NHS England EPRR Assurance Framework Standards.

The commissioners of this provider can be assured that the trust has in place the required measures to respond to both internal disruptions and external major incidents.

Examples of good practice

During the audit a number of examples of good practice were identified that it is was felt were worthy of highlight.

- Risk assessment processes – the process in place at the trust was found to be extremely thorough and ensured that the trust is cognisant of risks which could impact upon the trust. The process allows for ongoing awareness and assessment of risks and for the development of suitable mitigating actions to be put in place

- Relocation of CBRN equipment store – due to planned building works the CBRN equipment store is required to be relocated. Extensive and detailed planning has been put in place regarding the relocation of this equipment. This has been done in conjunction with key internal MFT staff and outside partners – KFRS in particular. A detailed programme of training/testing and exercising has been developed and implemented to ensure that the equipment if required can be utilised effectively in its new location.

  Once building works are completed in approximately 18 months' time the storage will be relocated again and plans are already in place for this to occur. Again this has been done in conjunction with key partners and is supported by a robust training /testing/exercise programme.

- Fuel Crisis Plan – it was noted that during the development of this plan, legal advice had been sought to ensure that the trust plan was not open to fraudulent activity. The plan contains detailed actions to reduce the risk of fraud.

Appendix 1

Core-standards-eprr
Self Assessment 2016

Tim Young
Interim Director of NHS Operations and Delivery
NHS England
Skipton House
80 London Road
London SE1 6LH

10th June 2016

To: Accountable Emergency Officers of NHS funded services
      NHS England Regional Directors
      NHS England Regional Directors of Assurance and Delivery
      NHS England Directors of Commissioning Operations
      NHS England LHRP Co-chairs
      CCG Clinical Leads and CCG Accountable Officers

Cc: NHS England Heads of EPRR
      NHS England Business Continuity team
      CSU Managing Directors
      Karen Wheeler, Director, Transformation and Corporate Operations, NHS England
      Dr Felicity Harvey CBE, Director General – Public Health, Department of Health
      Helen Shirley-Quirk CB, Director Health Protection and Emergency Response, Department of Health
      Kathy McLean, Executive Medical Director, NHS Improvement
      Dr Ruth May, Executive Director of Nursing, NHS Improvement

Dear colleague

Process for 2016-17 emergency preparedness, resilience and response (EPRR) assurance.

The annual EPRR Assurance process is upon us again and this letter sets out the expectations for NHS organisations. As in previous years NHS England will lead the process via Local Health Resilience Partnerships in order to seek assurance that both the NHS in England and NHS England are prepared to respond to emergencies, and are resilient in relation to continuing to provide safe patient care. The format and process this year will follow that of 2015-16.

The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards which remain unchanged for this year.

The EPRR Core Standards are available on the NHS England internet site
http://www.england.nhs.uk/ourwork/eprr/

Local Health Resilience Partnerships continue to play an integral part of the process and constituent members are asked to support NHS England in conducting the process.

The NHS EPRR assurance process will be completed via a submission to the NHS England Board by April 2017.

Once this has been accepted by the Board, NHS England will be in a position to provide national EPRR assurance for 2016-17 to the Department of Health and the Secretary of State.

1.   Timeframes

The timelines for this year's process will be in line with those for the 2015/16 process.

All organisations should commence their self-assessment immediately so as to give suitable time to undertake this in a measured and calculated manner.

| EPRR Core Standards self-assessment. Work planning and Board presentation | LHRP confirm and challenge process. LHRP documentation submission to Regional team | Regional confirm and challenge meetings with LHRP co-chairs. Document submission to the central team by **31 December 2016** | National confirm and challenge meetings with Regions by **28 February 2107** | NHS England Board submission by **1 April 2017** |

Once organisations have taken their self-assessments to their Boards/Governing Bodies there will be an LHRP self-assessment process.

Following this LHRP Co-Chairs will submit their reports to the NHS Regional Teams where there will be a regional calibration process via confirm and challenge meetings.

By the 31 December 2016 Regional Teams will submit their consolidated data to the Central Team where a national calibration process will take place. This will be complete by 28 February so that the national report can be prepared and considered by the NHS England Board by 1 April 2017.

2.   Actions

2.1   Providers of NHS funded care

The following organisations are required to undertake the 2016-17 EPRR assurance process:
- Acute hospital service providers
- Ambulance service providers (including patient transport organisations)
- Community service providers (this includes NHS Trusts, Foundation Trusts and social enterprises)
- Mental health service providers
- NHS111 providers

Primary care (including out-of-hours primary care) will not be included in this year's assurance process. Discussions continue regarding this matter and it is hoped that we can incorporate primary care in future years.

Local Health Resilience Partnerships (LHRPs) may wish to include other organisations not mentioned above, at their discretion.

Provider organisations are asked to undertake a self-assessment against the relevant individual core standards and rate their compliance. These individual ratings will then inform the overall organisational rating of compliance and preparedness. In order to achieve a greater level of national consistency, the definitions of the overall organisational rating have tightened up. This can be found in section 4 of this letter.

Once this process has taken place organisations are expected to take a statement of compliance to their Boards. This Board report along with the Core Standards assurance ratings and rectification plan should then form the submission to the Clinical Commissioning Group and Local Health Resilience Partnership. The LHRP will undertake a formal calibration process via a confirm and challenge meeting.

Organisations which operate across LHRP borders should present their self-assessment and supporting evidence to their lead CCGs LHRP. This documentation should also be shared with other relevant LHRPs/stakeholders as necessary.

It is considered best practice for provider organisations to publish their level of EPRR assurance as part of their annual report.

2.2 Commissioners of NHS funded care

The following organisations are required to undertake the 2016-17 EPRR assurance process:
- Clinical commissioning groups
- NHS England regional and central teams.

Commissioning organisations (including NHS England) are asked to undertake a self-assessment against the relevant individual core standards and rate their compliance. These individual ratings will then inform the overall organisational/team rating of compliance and preparedness. In order to achieve a greater level of national consistency the definitions of the overall organisational rating have tightened up. This can be found in section 4 of this letter.

Once this process has taken place commissioners are expected to take a statement of compliance to their Governing Bodies/Senior Management Teams. This report along with the Core Standards assurance ratings and rectification plan should then form the submission to the Local Health Resilience Partnership. The LHRP will undertake a formal calibration process via a confirm and challenge meeting.

Commissioners which operate across LHRP borders should present their self-assessment and supporting evidence to their regular host LHRP. This documentation should also be shared with other relevant LHRPs/stakeholders as necessary.

2.3 Local Health Resilience Partnerships (LHRPs)

It is expected that LHRPs will review and consider all relevant organisations self-assessments, Board or Governing Body papers (or equivalent) and work plans and provide a mechanism to calibrate across the geography and facilitate per confirm and challenge.

LHRPs are expected to:
- Ensure that commissioners of services are actively involved
- Seek further evidence where an organisation considers itself non-compliant.
- Conduct a 'deep dive' into Business Continuity planning in all organisations included in the assurance process
- Provide to the NHS England Regional Director of Assurance and Delivery a report on the preparedness of all organisations
- Actively monitor progress of those organisations reporting an overall rating of non-compliant until the partnership is content that the organisation has attained an agreed level of compliance
- Consider the local engagement of NHS Improvement to support this process

Records should be kept of the reviews undertaken and include any evidence requested.

2.4 NHS England Regional Teams

NHS Regional Teams will coordinate a submission to evidence their level of assurance and to help inform the national assurance assessment. Regional Teams will be asked to complete template(s) which will follow this letter and:

- Request any evidence of the work completed and/or plans put in place that they feel is necessary to support and/or challenge organisation(s)
- Be able to distinguish between the preparedness of NHS England and the preparedness of other organisations.
- Demonstrate where improvement is needed and the mitigation in hand at individual organisational/team level.
- Be able to identify and set out instances of good practice against the core standards so that this can be shared across regions to improve the overall preparedness and resilience of NHS England and the NHS in England.
- Consider the local engagement of NHS Improvement to support this process

Records should be kept of the reviews undertaken and include any evidence requested.
It is expected that all actions in section 2 above will be completed by 31st December 2016.

2.5 NHS England Business Continuity Assurance

NHS England business continuity assurance will be undertaken once and in conjunction with the NHS England Business Continuity Team, via the NHS EPRR Core Standards template.

The NHS England Business Continuity Team will liaise directly with NHS England Regional Teams alongside the NHS England central EPRR team to gain assurance of NHS England arrangements.

The NHS England Business Continuity Team will liaise directly with each CSU to gain their business continuity assurance, which will then be incorporated into the NHS England Board paper.

3. Assurance Deep dive

This year's EPRR assurance deep dive topic is Business/Service continuity with an emphasis on fuel (NEP(F)). A significant amount of work has been undertaken across the NHS recently with regard to Business Continuity and it is a good time to take stock. The fuel emphasis this year is designed to support a national cross government initiative which is occurring across a number of other local services and including LRF's.

Following on from the CBRN 'deep-dive' carried out during the 2014-15 the HAZMAT/ CBRN assessment remains incorporated into the NHS EPRR Core Standards.

Acute hospitals should expect ambulance service providers to work with them to assess and challenge their level of HAZMAT/CBRN preparedness (using the NHS EPRR Core Standards). NHS England continues to fund ambulance service providers, via the National Ambulance Resilience Unit (NARU), to undertake this. In addition to this assessment ambulance service providers are funded to provide training to support the acute hospital response.

Specialist, community and mental health service providers should note that some HAZMAT/ CBRN core standards are relevant and pertinent to their organisations, and they also have a duty of care towards self-presenting patients who have been exposed to a HAZMAT or CBRN incident.

4. Organisational Assurance Ratings

Organisations will be expected to state an overall assurance rating as to whether they are fully, substantially, partially or non-compliant with the NHS EPRR Core Standards. The definitions of these ratings have been amended for the 2016/17 process and are detailed below:

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place that appropriately addresses all the core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however they do not appropriately address one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place, however they do not appropriately address six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant*	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

* Should an organisation be non-compliant the LHRP will regularly monitor progress throughout the year until it is has attained an agreed level of compliance.

5. Summary:

In summary, please can you:

1. Note that all organisations will undertake a self-assessment against the NHS EPRR Core Standards.
2. Note the approach to the 2016-17 EPRR assurance process that is expected to be followed by NHS England and LHRPs.
3. Note the timeframes for the delivery of the 2016-17 assurance process.
4. Liaise with local partners and stakeholders to achieve the outcomes required.

Senior managers are asked to bring the contents of this letter to the attention of their emergency preparedness, resilience and response staff and disseminate to other organisations as applicable.

For further information, please see the NHS England EPRR web-page[1] or if you have any further queries, please contact Stephen Groves (National Head of EPRR) at stephengroves@nhs.net.

Yours sincerely,

Tim Young
Interim Director of NHS Operations and Delivery

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[1] http://www.england.nhs.uk/ourwork/eprr/

Report to the Board of Directors

Board Date : 27th October 2016

Title of Report	Monthly In Year Governance Reporting Return Q2 - 30 Sep 2016
Presented by	Kelly Campbell-Goodall – Financial Accounting & Controls Manager
Lead Director	Darren Cattell – Interim Director of Finance
Committees or Groups who have considered this report	
Executive Summary	To inform the Board of the Monthly In Year Governance Reporting Return for Q2 - 30 Sep 2016.

The specific financial returns are, as always, not included within this Governance return but are included in the 'Monthly In Year Financial Reporting Return 30 Sep 2016.' These result from the Finance Board report elsewhere on this agenda.

The Board is asked to note there is no requirement to report the Q2 Governance Reporting Return. Below is the extract from a guidance note from NHSI.

New Q2 governance return

As we are launching the new single oversight framework (SOF), we will not be collecting the Q2 governance returns this month.

If we were required to report (for continuity) the proposed governance statements to report to NHSI are:

- "Not confirmed" for maintaining a financial sustainability risk rating of at least 3 over the next 12 months. This is due to our liquidity and trading deficit.
- "Confirmed" for the capital expenditure for the remainder of the financial year not materially differing from the amended forecast in the financial return.
- "Not Confirmed" for ongoing compliance with all existing targets. This is due to our performance position in relation to ED and RTT primarily.
- "Confirmed" that there are no matters arising in the quarter requiring an exception report to NHS Improvement (per the Risk Assessment Framework, Table 3) which have not already been reported. |

Resource Implications	
Risk and Assurance	The risk remains as was. This may change under the new Single Oversight Framework however a briefing on that will be provided in due course.
Legal Implications/Regulatory Requirements	We will be required to submit the new return to NHSI.
Recovery Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	The Board notes there is no requirement to submit the In Year Governance Reporting Return Q2 - 30 Sept 2016.
Purpose & Actions required by the Board :	Approval ☐ Assurance ☐ Discussion ☐ Noting ☒

Serious Incident (SI) Policy

Author:	Head of Patient Safety/ Chief Quality Officer - Debbie Brown / Trisha Bain
Document Owner:	Medical Director - Diana Hamilton-Fairley
Revision No:	5
Document ID Number	POLCGR071
Approved By:	Patient Safety Committee
Implementation Date:	
Date of Next Review:	

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Document Control / History	
Revision No	**Reason for change**
3.	To incorporate the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation produced by the National Patient Safety Agency 2010
3.1	To incorporate the Human Tissue Authority guidance on reporting and investigating Serious Incidents and Serious Adverse Reactions 2011
4.	Review and update to include Duty of Candour
4.1	Update job titles and SHA & PCT references
5	Serious Incident Management Process – split into policy and see separate SI procedures and reviewed the NHS Serious Incident framework 2015 and related document published in 2016 as well as the Mazar recommendations.

Consultation
Director of Nursing
Chief Executive Officer
Medical Director
Chair of Quality Improvement Committee
Chair of Patient Safety Committee
SI Monitoring Group
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To be read in conjunction with any policies listed in Trust Associated Documents and Standard Operating Plans (SOP) associated with this policy.

1   Introduction

1.1   Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

1.2   The Trust intends to recognise the potential for harm and undertake timely interventions to minimise the impact of the harm or to reduce the possibility of an incident from the same source occurring in the future, where this is possible. Serious incidents are, therefore, subject to thorough investigation in an attempt to identify what factors contributed to the incident. Serious incidents can be isolated incidents or multiple linked, or unlinked, events.

1.3   Responding appropriately when things go wrong in the care and treatment of patients is a key part of the way that the Trust will continually improve the safety of the services that it provides.

1.4   Patient safety is the responsibility of all staff in Medway Foundation Trust. The Executive Team, Directorate leaders and ward/ department managers will model the behaviours expected by a fair and just culture and will set clear expectations around multi-disciplinary involvement with the Serious Incident pathway.

1.5   Responding appropriately to incidents or circumstances that have caused or may cause harm to staff, including contracted staff, or visitors is key to the Trust maintaining the safety and wellbeing of staff and visitors.

1.6   An incident reporting, management and investigation process is a prerequisite to the serious incidents process. This process facilitates the recognition, management and investigation of incidents and enables learning and the minimisation of future harm or loss.

1.7   When an incident has caused significant harm or loss to patients and/or staff, the Trust will respond to and investigate these following this policy which is aligned with the national Serious Incident Framework- supporting and learning to prevent recurrence (NHS England March 2015), as well as the updated, related question and answer document published in 2016.

1.8   This policy identifies the principles of being open and the legal Duty of Candour (see the Trust's Being Open and Duty of Candour Policy and Procedure). The needs of those affected by the incident will be the primary concern of those I involved in the response to the investigation of an incident.

1.9   When things go wrong, it is the responsibility of the organisation to ensure that there is significant learning from each one to prevent recurrences. The Trust will provide resources to ensure that lessons are learned from each incident. Learning programmes are designed in a variety of formats that are best suited to the information to be shared and the audiences involved.

2   Purpose , Aims and Objectives

2.1   This policy is in place to facilitate staff understanding of what constitutes a serious incident, including an Information Governance, Mental Health Act or Pressure Ulcer serious incident.   This policy will assist staff in applying a consistent approach to the management of serious incidents in a timely and open manner so that immediate action can be taken to protect patients and staff, where necessary.

2.2   This document will focus on the identification and management of these incidents, using root cause analysis methodology and facilitating organisational learning from such incidents. This approach aims to reduce the likelihood of the same incidents occurring again or reduce their impact should they occur. This policy will identify the commitment to learning from each incident in a non-judgemental way, so that their recurrence is minimised and to ensure any changes to systems and processes recommended during the root cause analysis are implemented, mechanisms in place to monitor/implement and any necessary changes are made.

2.3   It will set out mechanisms and processes to ensure effective communication with patients, relatives, staff, media and other agencies is maintained at all times and appropriate information is conveyed. This document will set out the reporting arrangements for a Serious Incident to the Trust Board, lead clinical commissioning group (CCG), NHS England, Monitor, the and Care Quality Commission and other external agencies, where necessary, to meet the requirements of external stakeholders.

2.4   The Trust will ensure the process of investigation is open, fair and just, with the primary focus of any Root Cause Analysis based on the investigation of systems and processes, rather than focussing on an individual who may happen to be at the end of a series of faulty processes.

2.5   The identification of lessons to be learned is of the utmost importance to prevent recurrence of similar incidents. The Trust will support learning activities through the use of Grand Rounds, Schwarz rounds, Directorate learning activities , pop up events and swarm events that are tailored to the learning needs of the audience.

3   Scope

3.1   This policy applies to all permanent, locum, agency, bank and voluntary staff of Medway NHS Foundation Trust.

4   Definitions

Incident Definitions

4.1   A Serious incident (SI) is an accident or incident when a patient, member of staff or a member of the public suffers serious injury, unexpected or avoidable serious harm or death in hospital or other premises where NHS care is provided. Serious Incidents include acts or omissions in care that result in unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm which is either permanent (severe) or temporary (moderate) - including those incidents where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

The declaration of a Serious Incident should err on the side of caution. The Trust should not wait for the outcome of a full investigation before reporting to the CCG. If it subsequently emerges that an incident does not meet the criteria for a Serious Incident, the commissioner should be approached to downgrade the incident and remove it from STEIS.

4.2   Serious incidents may be identified through various routes, including, but not limited to:

- Incidents identified during the provision of healthcare
- complaints
- claims
- whistle blowing
- Serious Case Reviews
- safeguarding children and adults reviews/ enquiries
- prevention of Future Deaths Reports issued by the Coroner

4.3   This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.

- a Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.

- major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

- an incident (or series of incidents) that prevents, or threatens to prevent, an organisation"s ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

  o failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues

  o property damage;

  o security breach / concern;

  o incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;

  o inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS); The Department of Health have updated their guidance on investigations and the application of Article 2 of the European Convention on Human Rights. This should be read in conjunction with the NHS England Serious Incident Framework;

  o the placement of children or young people, under the age of 18 years, on an adult psychiatric ward;

  o unauthorised absences of a person detained, or liable to be detained, under the Mental Health Act 1983 in relation to low, medium or high security levels (applicable to Bowman Ward).

  o significant healthcare associated infections i.e. an outbreak of infection that closes a ward/unit, failure in decontamination or infected healthcare worker.

  o maternity, infant and child incidents as described in the NPSA National Framework for Reporting and Learning from Serious Incidents Requiring Investigation.

  o death of a patient, or a person using the service, who is detained, or liable to be detained, under the Mental Health Act 1983.

  o Ionising Radiation incidents

  o systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or

  o activation of Major Incident Plan (by provider, commissioner or relevant agency)

4.4 If staff have concerns about unsafe practice, poor staffing, issues of professional misconduct or institutional neglect, they can report these in the first instance

through a line manager, by following the Whistleblowing Policy or by seeking advice from the Trust's Safeguarding Team.

4.5   Incidents are graded according to the level of harm or whether they have been identified as a Never Event. Incidents that may be classed as Serious Incidents are those where there has been moderate or severe harm, unexpected death or a Never Event. Definitions of each of these categories are found below and this list is not exhaustive.

4.6   **Incident –** any unexpected or unintended event or circumstance that leads to, or could have led to, harm, loss or damage to people, property or reputation. They may be clinical or non-clinical; e.g. suspected suicide, missing person, fire, theft, violence.

4.7   **Incident Decision Tree**- developed as an aid to improve the consistency of decision making about whether human error or systems failures contributed to an incident. It can be used by those who have the authority to exclude a member of staff from work following a patient safety incident (including medical and nursing directors, chief executives and human resources staff).

4.8   **Investigation-** A process by which an incident is examined to allow the organisation to consider if actions can be put in place to stop the incident occurring, or reduce the impact, should the incident recur.

4.9   **Patient safety incidents –** any unexpected or unintended event or circumstance that results in, or could result in, harm to a patient.

4.10   **Non-patient safety incidents -** any unexpected or unintended event or circumstance that results in, or could result in, harm to a member of staff (including contractors) or a visitor or loss/damage to the Trust, including financial, asset or reputational loss/damage.

4.11   **Notifiable safety incident** for health service bodies (CQC) – any *unintended or unexpected incident* that occurred in respect of a patient's care that, in the reasonable opinion of a healthcare professional, could result in, or appears to have resulted in:

- the patient's unexpected death

- severe harm

- moderate harm

- prolonged psychological harm for a continuous period of least 28 days

Identifying an issue as a notifiable safety incident does not automatically imply error, negligence or poor quality care. It indicates that an unexpected and undesirable clinical outcome that resulted from some aspect of the patient's care, rather than their underlying condition and that Medway Foundation Trust has a responsibility to investigate to identify why the incident occurred and to take active steps to correct any

All notifiable safety incidents trigger the statutory Duty of Candour (please refer to the Being Open and Duty of Candour Policy and Procedure).

4.12 **Automatically declared Serious Incidents**
Incidents that are automatically declared as SIs include:

- Never Events (whether or not there was patient harm)

- falls to harm

- maternal death within a year of the birth of an infant

- hospital-acquired pressure ulcers Grades 3, 4 and unstageable

- hospital-acquired MRSA bacteremia, C. dificile

- incidents involving patients being held under the Mental Capacity Act/ DOLS or Mental Health Act

4.13 **Serious Incident Reports**

- **Concise**: concise reports are internal initial fact gathering reports that are gathered by a senior member of the area where the incident occurred within 24 hours of the incident occurring to assist in making a determination of a Serious Incident.

- **72 hour report:** a report containing all known facts of the incident that is presented to the CCG within 72 hours of the incident being declared.

- **Level 1 report:** an internal investigation of a less complex Serious Incident using the RCA technique at local level. This was previously named Level 2 –Red report. The completed report is expected to be delivered to the Patient Safety Team within 45 working days. It will be internally reviewed, approved and lessons learned in the same way as for Level 2 reports.

- **Level 2 report**: a comprehensive report of a declared Serious Incident that is presented to the CCG or any other external partner. This report is expected to be delivered to the CCG/ external partner within 60 working days.

- **Level 3** Independent Investigation: this is required where the findings are   likely to be challenged or where it will be difficult for the organisation to conduct an objective investigation. Level 3 investigations must be completed within six months of the incident being declared.

4.14 **Apology-** a sincere expression of regret that forms the foundation of the Duty of Candour and is expected to be applied in every Serious Incident.

4.15 **Datix -** the electronic incident reporting system used by the Trust. Every incident that is considered to be a potential Serious Incident must have a Datix report.

4.16 **Expected death-** The death of a patient that is expected as a natural course of their disease or condition and where there is no active intervention to prolong life.

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As an example, cancer patients who are on an End of Life pathway who die would be included as an expected death. Expected deaths are not considered to be Serious Incidents.

4.17 **External agencies (this list is not exhaustive):**

- NHS England
- Medway CCG/ other relevant CCGs
- Care Quality Commission
- Medicines and Healthcare Regulatory Agency (MHRA)
- HM Coroner
- Police
- Serious Hazards of Transfusion (SHOT)
- Human Tissue Authority
- Adult and Children Safeguarding Boards

4.18 **Moderate harm**

- temporary, significant harm which is defined as the lessening of bodily, sensory,
- motor, physiologic or intellectual functions that is directly related to the incident and not to the natural course of the patient's illness or underlying condition and moderate increase in treatment, such as an unplanned return to surgery, an unplanned readmission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment or transfer to another treatment area (such as intensive care, HDU).

4.19 **Near miss/prevented incident –** any incident that had the potential to cause harm but was prevented, resulting in no harm. Not every near miss needs to be reported as a Serious Incident but the potential for severity of harm should be a prime consideration.

4.20 **Never Event -** a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented (see Appendix 6 Never Events). These are automatically declared as Serious Incidents. There does not necessarily have to be patient harm in order for an incident to considered a Never Event. These are considered to be automatically declared Serious Incidents.

4.21 **Open, fair and just culture –** Incident reporting, investigation and learning will not be effective in an organisation that does not respond to incidents using the principles and practices of a Just Culture.

Traditionally healthcare's culture has held individuals accountable and culpable for all errors or mishaps that befall patients under their care (often referred to as the

'blame & shame' culture). This 'person centered' approach resulted in investigations that failed to identify effective organisational learning. The outcome of these investigations was to unjustly punish the staff involved but ignore the situation in which the incident occurred. Therefore, incidents were repeated.

In complete opposite to this a Just Culture which :
• recognises that individual practitioners should not be held accountable for system failings over which they have no control
• recognises that many errors represent predictable interactions between human operators and systems in which they work
• recognises that competent professionals make mistakes: human error (1)
• acknowledges that even competent professionals will develop unhealthy norms e.g. Shortcuts and 'routine rule violations' at risk behaviour (2)
• as a zero tolerance for reckless behaviour (3)

1. Human error – inadvertently doing other than what should have been done; slip, lapse or mistake. The response to an error will be to console and learn.

2. At-risk behaviour - behavioural choice that increases risk where risk is not recognised or is mistakenly believed to be justified. The response to risky behaviour will be to coach and learn.

3. Reckless behaviour - behavioural choice to consciously disregard a substantial and unjustifiable risk. The response to reckless behaviour will be punishment

4.22 **Prolonged psychological harm** - **psychological** harm which a patient has experienced or is likely to experience, for a continuous period of at least 28 days.

4.23 **Root Cause Analysis –** a **systems** approach to investigating an incident to understand how and why it happened and to identify effective actions to prevent the incident from occurring again

4.24 **Severe harm** - a permanent lessening of bodily, sensory, motor, physiologic or intellectual functions, including removal of the wrong limb, or organ or brain damage, which is directly related to the incident and not to the natural course of the patient's illness or underlying condition.

4.25 **STEIS (Strategic Executive Information System)** – a Department of Health management information system used to collect information about NHS organisations, including Serious Incidents**.**

4.26 **SWARM:** a multi-disciplinary investigation methodology where involved parties do an intensive review of all available information.

4.27 **Unexpected death-** The death of a patient following a harm-related incident that is not related to the natural course of their disease**.** Unexpected deaths must be verified and certified by a medical practitioner and reported to the Coroner.

5   (Duties) Roles and Responsibilities

5.1   **All staff**

- All staff have a responsibility to read and understand this policy.

- All staff have a duty to report any incident, including serious incidents and to take immediate steps to protect individuals, information or the environment.

- All members of Medway Maritime Foundation Trust staff – whether permanent ,   locum, agency or contractors- whatever occupation or seniority- are required to co-operate with all investigations as requested.

- Staff are entitled to be accompanied by a member of a Trade Union or other staff side representative when giving statements or when being interviewed in the course of an incident investigation.

- Arrangements for staff support following a Serious Incident will be provided by the Directorate Management Team who may also make a referral to the Occupational Health Team as required.

5.2   **The Trust Board will:-**

- be made aware of Serious Incidents via Chief Quality Officer report and IQPR

- receive assurance regarding effective incident management and implementation of incident management policies and procedures from relevant Committees

- be made aware of any particular concerns and issues in relation to trends or peaks in incidents and of the actions the Trust is taking to address these

5.3   **The Chief Executive**

- The Chief Executive has overall responsibility for the system of internal control and for protecting the health, safety and welfare of all who come into contact with the organisation and is ultimately accountable for the implementation of an organisational wide process associated with the investigation, analysis, learning and subsequent implementation of actions arising from incidents, complaints, contacts and claims. The Chief Executive will ensure that robust processes exist in order to implement the requirements of this policy.

5.4   **Executive Leads**

- In the event of a potential serious clinical incident, the Chief Quality Officer, Medical Director or the Director of Nursing will be designated as the lead executives to oversee the investigation process.

- The Chief Executive, Chief Quality Officer, Medical Director, Director of Nursing and other Executive Directors have a collective responsibility to ensure that this policy and procedure is effectively implemented. This includes ensuring that:

  - the required resources are available to facilitate the implementation of this policy,

  - nominate a Lead Investigator

  - the principles of open, fair and just culture are supported and maintained throughout the life of an incident (from reporting through to completion of the report and implementation of the action plan)

  - Chair the Harm Free Committee on a rotational basis

  - Authorise the declaration of Serious Incidents for reporting to the CCG or other appropriate external bodies

  - Sign off all Serious Incident reports for onward transmission to the CCG or other external body as appropriate.

- In the event of a serious non-clinical incident or serious Information Governance Incident, the Executive Director for Operations will be the lead executive to oversee the investigation

- Ensure there is a robust process in place and followed for monitoring the implementation of action plans arising from incidents causing significant harm and

- The lead executive retains overall responsibility and accountability for the investigation. Holds Directorate teams to account for the management of the Serious Incident pathway.

- Upon receipt of the final report, the lead executive is responsible for signing off the report and for ensuring an associated action plan is developed and implemented based on the recommendations contained within the report.

5.5 Head of Integrated Governance

- Responsible for notifying the Care Quality Commission of notifiable safety incidents.

5.6 Patient Safety Team

- The Patient Safety Team will provide advice, support and facilitation throughout the entire Serious Incident process, working primarily with the Directorates to undertake the investigation.

- The Patient Safety Team will provide administration support to liaise with the CCG to report declared Serious Incidents and to provide final copies of reports to the appropriate external bodies

5.7 **Lead Investigator will:-**

- conduct a thorough and impartial investigation, using the RCA technique. They may call upon any additional resources or personnel e.g. the health and safety advisor, clinical experts, Human Resources, managerial or technical staff may be required to provide specialist advice.

- hold panel meetings or SWARM events as required and will assist in the taking of statements as necessary.

- produce a report as directed by the Executive Teams

- attend the CCG closure meeting

5.8 **Directorate Responsibilities**

- Each Directorate will ensure that all permanent and temporary staff (including bank, agency and locum staff) receive information during induction on incident reporting and the use of the DATIX web and their responsibilities under the legal Duty of Candour process.

- Each Directorate will ensure timely investigation of incidents within the required time frame. It will ensure that there are sufficient numbers of staff trained in RCA methodology.

- Directorate leads will support the investigation process by ensuring that there is sufficient time and resources to conduct the investigation and that staff are able to attend interviews as necessary.

- Action plans arising from investigations are the responsibility of the Directorate Management and each department within each directorate is responsible for implementing changes where appropriate. The Directorate management team are responsible for ensuring that all actions are implemented and assurance given to the SI Monitoring Group.

- Directorate Leads are responsible for ensuring that there is a clear plan for sharing lessons learned from each Serious Incident, in collaboration with the Patient Safety Team.

6 Committee and Oversight Responsibilities

6.1 **Directorate Incident Review/ Governance Committees** meet weekly as a multi-disciplinary team to discuss all incidents that have been reported in the Directorate in the past week. The members make a consensus decision on which incidents are reported to the Harm Free Group and provide a concise report for the information of Harm Free Group members.

6.2 **Harm Free Group**- the Harm Free Group meets weekly to review incidents that **have** been reviewed at Directorate level as being moderate or severe harm incidents or unexpected deaths. They will be provided with a concise report on each presented incident in order to have all factual information to inform decision-making.

Serious Incident Policy

This group is chaired by the Chief Quality Officer, the Director of Nursing or Medical Director on a rotational basis. The Chair is responsible for declaring Serious Incidents that will uploaded to STEIS to notify the CCG.

6.3 **Serious Incident Monitoring Group-** meets monthly to monitor action plans from each Serious Incident Investigation (Level 1, Level 2, Level 2 Red as currently exist). Executive leads, Directorate leads and Patient Safety Team members are members of this group.

6.4 **Morbidity and Mortality Group** (M&M) – the M&M for each speciality meets monthly to review all deaths and to make a determination whether deaths were expected or unexpected.

6.5 **Executive Sign Off-** two of the three Executive Leads must sign off a declaration of a Serious Incident for reporting to the CCG or other body. The Executive Leads also sign off completed investigation reports prior to submission to the CCG.

7   Duty of Candour

7.1 The Trust recognises the importance of full, open and honest communication in feeding back to patients or their nominated representative. There is a duty to give a genuine apology and an explanation of the facts as they are known at the time of the first discussion.

7.2 The most responsible senior clinician will lead this discussion and invite the patient or their representative to identify any questions that they may have to be answered by the investigation committee. They will be informed of investigation timelines and will be invited to meet to discuss the outcome of the investigations.

7.3 The Duty of Candour Policy and Procedure provide full details.

8   Learning Lessons

8.1 Serious incident investigation reports should identify specific recommendations for improvement. These recommendations are supported by actions for completion by an identified lead within a defined timescale. The Directorate Management Team is responsible for following up and reporting on compliance with agreed actions and confirming that embedded learning has been achieved.

8.2 The Trust is committed to ensuring robust investigations are conducted which result in the organisation learning from SIs to minimise the risk of the incident occurring in the future, or to reduce the potential harm, and, as such, expects any actions to result in "embedded learning".

8.3 Embedded learning is defined as a change of behaviour at individual, team or organisational level. If appropriate, the serious incident investigation executive summary, or report, can be shared. The executive summary includes a précis of the incident and investigation and is fully anonymised to preserve confidentiality of the people involved. This will enable the executive summary to be widely shared. Learning can be shared from individual investigations or as an aggregate of similarly

themed incidents. Learning programmes can take a variety of forms and the information can be tailored to suit the audience.

9   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	Head of Patient Safety	Patient Safety Committee, Quality Improvement Group	This policy will be reviewed in conjunction with any legislation changes and Trust objectives A revised Policy will be published via the Trust Intranet System for global access.
Numbers of Serious Incidents by Directorate by category	SIs will be reported monthly	Head of Patient Safety	Trust Board (monthly), Patient Safety Committee (monthly) and the Quality Improvement Group (bimonthly)	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these Agreement from Patient Safety Committee
Trends and Themes reviews	Quarterly thematic reports	Head of Patient Safety	Trust Board, Patient Safety Committee	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these Agreement from Patient Safety Committee
Audit	Yearly	Head of Patient Safety	Patient Safety Committee	Any gaps/deficiencies will be reviewed and necessary action taken to resolve these

10   Training and Implementation

10.1   The Trust shall provide training and support to managers and their delegated representatives to enable them to fulfil their responsibilities in the local investigation of incidents.

10.2   The Trust will train Lead Investigators in Root Cause Analysis investigation techniques. Those who have been trained will undertake the investigation of Serious Incidents as directed by the Director of Nursing or Medical Director/Chief Quality Officer.

10.3   Over time, a pool of individuals nominated to lead on investigations will be developed. The scope of this training will be :

- Incident reporting procedure and reasons for reporting and investigation

- Principles of investigation and Root Cause Analysis. (National Patient Safety Agency (NPSA) Model and internal model)

- Record keeping

- Identification and implementation or remedial action to prevent recurrence.

- Risk evaluation/Risk grading

- Serious Incident investigation will be conducted using the University College Hospital (UCH) investigation protocol 1999 (Appendix 2) and the pro forma for the written reports (Appendix 2).

- The root cause analysis toolkit is available for all staff from http://www.npsa.nhs.uk/nrls/improvingpatientsafety/patient-safety-tools-and-guidance/rootcauseanalysis/rca-investigation-report-tools/

11   References

Document	Ref No
References	
NHS England Serious Incidents Framework (March 2015)_ found via website on 08 August 2016: https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2016/03/serious-incdnt-framwrk-faqs-mar16.pdf	Guidance
NHS England Serious Incidents Framework (2016) https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf	Guidance
Cornwall Partnership NHS Foundation Trust Serious Incident Policy 2015	Policy
[3]Marks David, Patient Safety & the 'Just Culture': A Primer for	

Health Care Executives, 2001	
Reason James Managing the Risks of Organisational Accidents in 1997 (and subsequent work)	
Trust Associated Documents	
Risk Management Strategy	POLCS017
Slips, Trips and Falls	POLCGR057
Duty of Candour	POLCGR064
Medicine Management Policy	POLCPCM033
Safeguarding Vulnerable Adults	GUC PCM 002
Child Protection Policy and Procedure	POLCPCM027
Infection Control Policies	
Business Continuity Policy	OTCOM006
Tissue Viability Policy	POLCNM001
Supporting Staff Involved in Complaints, Claims and Incident Policy	POLCGR102
Resuscitation Policy	POLCPCM032
Serious Incident Pathway	OTCGR145
Serious Incident SI Procedure	SOP0039
Serious Incident SI - Death Process	SOP0080
Serious Incident SI - Reporting to Clinical Commissioning Group - CCG	SOP0075
Serious Incident SI - Serious Incidents Definitions - OTCGR146	OTCGR146
Serious Incident SI Investigation - Establish a Hotline Procedure	SOP0040
TEMLATE - Serious Incident SI - Level 1 Investigation Form	
TEMPLATE - Serious Incident SI - Level 2 Investigation Report	
TEMPLATE - Serious Incident SI - 72 hour report	
TEMPLATE - Serious Incident SI - Concise Review	
TEMPLATE - Serious Incident SI - CCG Downgrade Request Form	
SI Resource Pack	

Hyperlinks to be added

END OF DOCUMENT

Medway **NHS**
NHS Foundation Trust

Standard Operating Procedure
Serious Incident SI – Death Process

Relevant to:

SI Investigators

Purpose of Guidance:

This procedure sets out the arrangements when a patient has died.

Process to Follow

Role of the Coroner

The coroner is an independent judicial officer, and is responsible for investigating the circumstances and causes of death in certain cases

The coroner with jurisdiction for this Trust is Ms Patricia Harding, Kent - Mid Kent and Medway District, The Archbishop's Palace Mill Street Maidstone Kent ME14 1XX, 01622 701927

For out of hours only - mobile 07808 844614

The coroner's officers for Medway Foundation Trust can be contacted on Telephone: 03000 41 05 02
Email: mkmcoroner@kent.gov.uk   Fax: 01622 663690

The coroner is required by law to hold an inquest in certain circumstances where initial enquiries give reasonable cause to suspect that the death:

- Was violent or unnatural

- Was a sudden death of unknown cause

- Occurred in prison/DOL/MH Act

- Child death process

- Safeguarding child /adult

The coroner may, in some cases, ask the police to investigate the circumstances of a death.

Purpose of the inquest

The purpose of the inquest is to determine:

- Who the deceased was

- When, where and how the deceased came by their death

- In some cases the wider circumstances in which the deceased came by their death (see paragraph 6.45)

Standard Operating Procedure
Serious Incident SI – Death Process

Statements / Reports

1) Once it has been determined that an inquest must be held, the coroner's officer will contact the Trust Legal Department, who will inform the Patient Safety Team, who will in turn request statements / reports be obtained from the relevant staff involved with the care and treatment of the deceased patient, whether immediately prior to their death, or at any other relevant period in time.

2) Occasionally, the coroner's officer may request a statement / report directly from the medical staff involved. If this happens, staff are asked to return the statement / report via the Patient Safety Team.

3) Statements / reports must be provided to the Patient Safety Team within 14 days. If there is likely to be any delay in doing so, staff are asked to advise the Patient Safety Team of the reasons for the delay and to agree a revised deadline for providing the statement or report. This will assist the Patient Safety Team in providing a realistic timescale to the coroner's office.

4) If you are asked to provide a statement, this does not always mean that you will be called to give evidence at the inquest. Some statements are simply read out in court. There is therefore a strong case for providing a detailed and well written statement in the first place.

5) Detailed guidance on writing a statement is attached at Appendix 2.

Resuming the inquest

6) The Patient Safety Team / Legal Team will investigate all patient deaths which are the subject of an inquest, with the Directorate and provide a report for the Coroner. The report will detail events leading up to the patient's death and highlight any changes in practice that have been implemented. Once the Coroner is satisfied that he or she has all necessary evidence, a date for the inquest will be fixed. The coroner will provide the Patient Safety Team with a list of Trust witnesses to be called to give evidence. The Patient Safety Team will liaise with members of staff regarding their attendance at the inquest.

7) The Coroner has the power to call anyone as a witness if they may be able to provide any information that could assist in establishing how the deceased died.

8) Witnesses will be advised by the Patient Safety Team in good time, of the date and place of the inquest.

9) If a witness is unable to attend on the designated day they must inform the Patient Safety Team immediately and provide a reason why. The Patient Safety Team will liaise with the coroner's office regarding an alternative date. However, although the coroner may agree to reschedule the inquest, he or she does have the power to insist on a witness's presence regardless of any other commitments they might have, including illness.

10) If the inquest is likely to be complex, or if the deceased's family are being legally represented, the Trust may decide to instruct solicitors to act on our behalf. In these

Standard Operating Procedure

Serious Incident SI – Death Process

circumstances, witnesses will be given an opportunity to meet with the Trust's legal representative before the inquest.

11) In most cases there will be no need for individual members of staff to have independent legal representation. However, if a conflict of interest arises between a member of staff and the Trust, they may be asked to obtain their own legal representation.

12) The Trust realises the prospect of giving evidence at an inquest can be stressful. Support for staff before, during, and after the inquest is available from line management, workplace Occupational Health the Patient Safety Team. Further information can be found in the Supporting Staff Involved in Complaints, Claims and Incident Policy POLCGR102. A copy of the policy is available on the intranet.

National Definitions:

A Serious incident (SI) is an accident or incident when a patient, member of staff or a member of the public suffers serious injury, unexpected or avoidable serious harm or death in hospital or other premises where NHS care is provided.

If there is any doubts that an SI has occurred, discuss with the Head of Patient Safety and refer to the SI process.

Implications of not following procedure

Useful Contacts:

Chief Quality Officer

Fairley – Medical Director

Director of Nursing

Head of Patient Safety

Patient Safety Manager

Monitoring the Process:

See Monitoring & Review table in the Serious Incident Policy

Reference Material:

Serious Incident Policy	POLCGR071
Serious Incident Pathway	OTCGR145
Serious Incident SI Procedure	SOP0039
Serious Incident SI - Death Process	SOP0080
Serious Incident SI - Reporting to Clinical Commissioning Group - CCG	SOP0075
Serious Incident SI - Serious Incidents Definitions - OTCGR146	OTCGR146

Serious Incident SI Investigation - Establish a Hotline Procedure	SOP0040
TEMLATE - Serious Incident SI - Level 1 Investigation Form	
TEMPLATE - Serious Incident SI - Level 2 Investigation Report	
TEMPLATE - Serious Incident SI - 72 hour report	
TEMPLATE - Serious Incident SI - Concise Review	
TEMPLATE - Serious Incident SI - CCG Downgrade Request Form	
SI Resource Pack	

Approval Signatures:

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Produced by:	**Trish Bain – Chief Quality Officer** **Debbie Brown – Patient Safety Manager**		
Distribution:	**Intranet**		
Date Approved:			
Approved by:			
	n/a		
Date last reviewed:	**2017**		
Review date:	**Diana Hamilton Fairley – Medical Director**		
Person responsible for review:	**Trish Bain – Chief Quality Officer** **Debbie Brown – Patient Safety Manager**		

Serious Incident – SI – Definitions for Serious Incidents/Never Events

LINK TO APROPRIATE POLICY

Abuse of Adults:

1) Death or injury to a vulnerable adult where abuse or neglect is a suspected factor or where a vulnerable adult has suffered harm.

2) See Safeguarding policy GUCPCM001 - Safeguarding Vulnerable Adults

Blood Transfusion:

3) Any serious adverse reaction or serious adverse event that occurs at any point during the transfusion cycle i.e.: from the collection of blood through to the transfusion of blood or blood products.

4) Microbiological contamination of the transfusion resulting in major morbidity or death.

5) Transfusion of an incorrect blood component leading to serious injury or death.

6) See policy and SOP's POLCPCM001 - Blood Transfusion Policy

Children:

7) Significant harm to a child where reported under the local child protection procedures e.g.

   a) A child death where abuse or neglect is a suspected factor in the death

   b) When a child has suffered significant injuries suspected to be as a result of child abuse

   c) Where a child has suffered further harm as a result of a health care worker failing to follow procedures

   d) Unexplained child death in a health care setting

   e) Unexplained death of more than one sibling

   f) When a serious case review is to be undertaken

   g) Children and adults with complex health needs failing to obtain their assessed and agreed packages of health care, thus putting their health at serious risk

   h) Multiple attendances at A&E for a single child or more than one sibling;

   i) The death of a child on the child protection register

8) See policy POLCPCM027 - Safeguarding and Protecting Children Policy

Unexpected Death, Serious Harm or Injury, Other Mortality, Morbidity, Other Care Incidents and Clusters of Lesser Harm Events:

9) Patients, individuals or groups of individuals suffering serious or catastrophic harm or unexpected death whilst in receipt of health services, including screening and immunisation/radiation errors and equipment failures

10) Serious injury or unexpected death of any individual to whom the organisation owes a duty of care including staff, visitor, contractor or any other person.

11) Clusters of unexpected or unexplained deaths.

12) Where the death results in adverse comments from a coroner.

13) Maternal deaths, neonatal deaths and unexpected stillbirths.

14) The suicide of any person currently in receipt of NHS services on or off NHS premises, or who has been discharged within the last twelve months. Suicide is defined as death:-

   a) where there is obvious evidence or strong suspicion of self harm

   b) where the above does not apply initially but emerges later from a clinical review of the case, or discussion at the incident monitoring group

   c) where the Coroner's verdict is suicide (or open verdict)

15) Death or injury where foul play is suspected.

16) Situations when a patient requires additional intervention(s) as a result of failures in the assessment or diagnosis process.

17) The accidental death of, or serious harm to, a patient, a member of staff, or visitor on NHS or primary care premises, or involving NHS or primary care staff or equipment.

18) Out of county critical care transfers or any other transfer that could have resulted in a serious incident.

19) Abuse that has been perpetrated within the remit of the organisation; this may be abuse by a member of staff, visitor or member of the public.

20) Grade 3 and above pressure sores.

21) See policies

   a) Coroners and Inquests - Guide for NHS Trust Clinicians and Nursing Staff - GUCGR024

   b) Serious Incident SI - Death Process - SOP0080

   c) POLCNM001 - Tissue Viability

   d) POLCHR002 - Respect Countering Bullying in the Workplace - Policy & Procedure

Health Protection:

25) Major outbreaks, serious incidents of communicable disease or exposure to environmental hazards caused by healthcare failures or other NHS system failures that have put patients/staff at harm/risk of harm or restrict service delivery e.g.

   a) Outbreaks of infection that involve presumed transmission within healthcare settings (acute, community) e.g. norovirus, Clostridium difficile, Panton-Valentine Leukociden (PVL) positive, Methicillin resistant staphylococcus aureus (MRSA)

   b) Cases/outbreaks of infection with an NHS-attributable food, water or environmental source e.g. nosocomial legionnaires' disease, salmonella outbreak

   c) Case of blood borne virus (hepatitis B, C, HIV), TB etc. infection in a healthcare worker that necessitates consideration of a look-back exercise

   d) Case of infection in a patient to whom others have been exposed that necessitates consideration of a look-back exercise

   e) Failed vaccination cold chain

   f) Failed sterilisation of instruments

   g) An outbreak e.g. of viral gastroenteritis, necessitating ward closures to new patients and resulting in significant restrictions of hospital activity

   h) A confirmed death of a patient due to hospital acquired infection including MRSA and C. difficile

   i) Exposure to chemical agents or radiation caused by failures in healthcare settings

   j) An outbreak/health protection incident that is poorly managed, resulting in harm

NB: From February 2007, the Department of Health has required mandatory reporting by Acute Trusts of each case of Methicillin-Resistant Staphylococcus Aureus (MRSA) bacteraemia as a serious incident. The mechanism for this is separate from STEIS and requires the completion of an e-mail reporting pro forma to the NHS England.

26) See policy

   a) POLCGR067 - Management of Risks Associated with Infection, Prevention and Control

Never Events

27) Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. These are defined as:

   a) Wrong site surgery

   b) Wrong implant/prosthesis

   c) Retained foreign object post- procedure

   d) Mis-selection of a strong potassium containing solution

   e) Wrong route administration of medication

f) Overdose of Insulin due to abbreviations or incorrect device

g) Overdose of methotrexate for non-cancer treatment

h) Mis-selection of high strength midazolam during conscious sedation

i) Failure to install functional collapsible shower or curtain rails

j) Falls from poorly restricted windows

k) Chest or neck entrapment in bedrails

l) Transfusion or transplantation of ABO-incompatible blood

m) Components or organs

n) Misplaced naso-or gastric tubes

o) Scalding of patient

Medical Devices

28) Any serious harm to staff or patients involving medical equipment whether due to human error or to equipment which is suspected of or found to be faulty or to have failed.

29) Where there is suspicion of malicious activity, such as tampering with equipment.

30) See policies

a) POLCGR105 - Management of Single Use and Single Patient Use Medical Devices

b) POLCGR020 - Management of Reusable Medical Devices & Equipment

Radiology

31) Any severe equipment failure which leads to harm or death.

33) See policy

a) POLLGR008 - Implementation of IR(ME)R Schedule 1 Procedures

Medicines and Serious Drug Reactions

34) Suspected or actual serious side effects or adverse drug reactions or serious adverse events from –

a) Prescription medicines (including clinical trial drugs)

b) Herbal remedies

c) Over the counter medicines

d) Counterfeit medicines causing harm or potential harm

35) See policies

a) POLCPCM033 - Medicines Management Policy

b) [POLCMM007 - Medicines Management Sub-Policy 1 – Safe and Secure Handling of Medicines](#)

c) [POLCMM008 - Medicines Management Sub-Policy 2 – Prescription Writing](#)

d) [POLCMM009 - Medicines Management Sub-Policy 3 - Controlled Drugs Procedure](#)

Mental Health, Substance Misuse, Learning Difficulties or Has Reduced Mental Capacity

36) Any of the following incidents that may occur involving patients with mental health problems or who have substance misuse problems or have learning difficulties:

37) A serious offence, including homicide, committed by an individual in receipt of mental health/or learning disability services

38) Where a patient assaults a member of staff and causes serious harm or death, puts their life in jeopardy or abuses the member of staff.

39) Patients detained under the Mental Health Act 1983 who are absent without leave from health services and who present a risk to themselves or others and where there is serious cause for concern.

40) An inpatient who is missing and is considered a serious threat to themselves or is vulnerable due to reduced mental capacity or learning difficulties

42) See policies

a) [POLCGR095 - Deprivation of Liberty](#)

b) [POLCGR099 - Mental Capacity Act Policy](#)

Screening Programmes

43) A failure of the screening service that has consequences to the patients. The screening programmes are:

a) Breast cancer

b) Cervical screening

c) Bowel cancer

d) Diabetic retinopathy

e) Abdominal aortic aneurysm

f) Foetal anomaly

g) Infectious disease in pregnancy

h) Sickle cell and thalassaemia

i) New-born blood spot

j) Newborn hearing

k) Newborn and Infant Physical Examination

Professional Misconduct

44) Allegations of serious professional misconduct (decision on whether an individual case becomes a SIs is to be made by the Director of Human Resources).

45) See policies

a) OTCGR004 - Code of Conduct For Staff in Respect of Confidentiality

b) PROCHR002 - Disciplinary Policy, Rules and Procedure

Emergency Plan Invoked

46) Major incidents that results in the activation of the Emergency Plan

47) Adverse incident that would invoke the Business Continuity Plan including multiple ward closure due to infection, serious damage to occupied NHS property through fire, flood or criminal damage, significant loss of electrical power, IT failure leading to serious outcomes or data loss resulting in a severe breach of confidentiality)

48) Extensive wilful damage to property, destruction and vandalism.

49) See policies

a) POLCS006 - Major Incident Plan

b) POLCOM015 - Paediatric Major Incident Arrangements

Information Governance

50) Major breaches of confidentiality such as loss or theft of personal identifiable records or information

51) An incident involving the actual or potential loss of personal identifiable information that could lead to identity fraud or have an other significant impact on an individual

52) (to be investigated in line with the Checklist for Reporting, Managing and Investigating Information Governance Serious Incidents; Gateway ref: 13177)

53) See policies

a) POLCGR017 - Information Governance Strategy and Policy

b) POLCGR007 - Data Protection Policy

Medico-Legal Incidents/Litigation

54) Suspicion of large scale theft or any incident that may give rise to serious criminal charges

55) Potential legal claims against the Trust regarding a serious incident

56) Potential legal claims against the Trust or Department of Health that may affect national policy.

57) Impending court hearing or out of court settlement in cases of large scale litigation, including negligence claims (as defined by the NHS Litigation Authority [NHSLA], large scale claims are considered to be over £250,000)

58) See policy POLCGR003 - Claims Policy & Procedure (Clinical Negligence Personal Injury and Property)

Media Issues

59) Matters likely to attract negative interest from local, regional or national newspapers, TV or radio

60) All incidents reported to or involving the police that are considered serious or may have adverse media interest

61) Any Health and Safety Improvement Notices or convictions being served upon the Trust

62) Matters involving any patients likely to attract negative media interest

63) Cancellation of surgery for a patient on more than three occasions

64) Serious fraud or security related media matter

65) Serious breach of Research Governance

66) See policy POLCGR106 - Media Handling Policy & Guidance for Staff

Human Tissue Authority

67) The Human Tissue Authority (HTA) is the Government Regulator that supports public confidence by licensing organisations that store and use human tissue for purposes such as research, patient treatment, post-mortem examination, teaching, and public exhibitions. They also give approval for organ and bone marrow donations from living people.

68) The HTA have issued very clear and specific guidance as to what constitutes an HTA Reportable Incident (HTARI), details of these can be found at

http://www.hta.gov.uk/_db/_documents/Guidance_for_reporting_HTARIs.pdf

69) From May 1st 2010 all establishments in the post mortem sector possessing a HTA licence are required to report any HTARI, (the term HTARI includes near misses), to the HTA within five working days of the incident occurring. This is a condition of the establishment's HTA licence.

70) For any incident or near miss (incident which could have led to a HTARI had it not   been detected) a Trust DATIX report must be completed.

71) The HTA are informed by submission of HTARI notification via the web portal.   The web Portal is available at the following web address:

https://portal.hta.gov.uk/.

72) The HTA Portal will allow authorised users to securely submit HTARI notifications from 1 April 2013. Only the DI and Persons Designated (PDs) are able to raise a HTARI notification.

73) Any HTARIs must be reported to the Trust Designated Individual (DI), Head of Pathology and Mortuary Manager, in order to ensure timely reporting via the HTA portal by designated staff under the HTA Licence.

Standard Operating Procedure
Serious Incident SI Investigation – Establish a "Hot line"

Relevant to:

Director of Nursing /Medical Director/Chief Quality Officer

Purpose of Guidance:

To set up a hotline in an event of a serious clinical incident

Process to Follow:

ESTABLISHING A "HOT LINE"

1. In the event that a serious clinical incident has occurred requiring the establishment of a hot line, the following process should be followed.

2. This process will be initiated by the Director of Nursing /Medical Director

3. The Director of Nursing /Medical Director/Chief Quality Officer will immediately establish a Hot Line Co-ordinating Group comprising:

    a. Director of Nursing/Medical Director/Chief Quality Officer

    b. Hot line Co-ordinator (to be nominated)

    c. Lead Consultant (clinical specialty involved)

    d. Deputy Director of Estates & Facilities (or nominated deputy)

    e. Switchboard Manager

    f. Communications Office

    g. Occupational Health Manager

    h. General Manager on-call

4. The Director of Nursing /Medical Director will determine :-

    a. Staff to operate the hot line

    b. The information to be provided via the hot line

    c. Determine the duration of the operation for the hot line including formal stand down

    d. Report to the Chief Executive and Trust Board

    e. Briefing of staff who will be operating the hot line

5. The Director of Nursing /Medical Director will brief the lead clinical commissioning group (CCG) and the NHS England.

6. The hot line will be established in room ECO 91, Post Graduate Centre

7. The lead Consultant for the specialty involved will be responsible for providing:-

    a. Clinical support and advice to the Director of Nursing /Medical Director and hot line staff.

8. The Hot Line Co-ordinator will be responsible for :

    a. Preparation of the hot line centre (room ECO 91)

    b. Provision of documentation to be used by hot line staff to record calls received and information given ([" Hot line" documentation pro forma](#))

    c. Establishing shift rotas to ensure the hot line is fully operational

    d. Maintenance and security of records

    e. Provision of update reports and subsequent final report including details of effectiveness and lessons learned for future improvement.

9. The Switchboard Manager will be responsible for:-

    a. Triggering the process with BT for provision of extra telephone lines and extra switchboard consoles.

    b. Ensuring that installation is carried out and running smoothly.

    c. Ensuring shutdown of hot lines and removal of telecom equipment.

10. The Head of Communications will be responsible for :-

    a. Dealing with Press enquires

    b. Supporting the hot line

11. The Occupational Health Manager will be responsible for :-

    a. Supporting hot line staff

    b. Providing debriefing/counselling opportunities

12. The Deputy Director of Estates & Facilities will be responsible for :-

    a. Providing refreshments for hot line staff

    b. Ensuring the security of the hot line room, rest and counselling rooms, and security of site, if required.

    c. Ensuring appropriate postal arrangements/facilities are in place should they be required.

13. The Information Technology Manager (IT) will be responsible for:

    a. Supporting the Switchboard Manager, ensuring that external telephone lines are in place.

    b. Determine the IT support required for the "hot line "

    c. Providing and installing computer equipment and links

    d. Ensure that technical advice and support is available for the duration of the "hot line" and is dismantled when the "hot line" is closed down.

    e. Ensure that all data is erased from the computers before they are returned to normal use.

Standard Operating Procedure
Serious Incident SI Investigation – Establish a "Hot line"

"Hot line" documentation pro forma

INCIDENT TYPE	REF NO

DATE:	TIME:

NAME OF CALLER:

ADDRESS:

TEL NO.

G.P. NAME:
ADDRESS:

INFORMATION RECEIVED FROM CALLER:

Best of care
Best of people

Please turn over

ADVICE/INFORMATION GIVEN TO CALLER:-

Standard Operating Procedure
Serious Incident SI Investigation – Establish a "Hot line"

SIGNATURE OF HOT LINE STAFF MEMBER:

PLEASE PRINT NAME:

DATE :

Best of care
Best of people

Standard Operating Procedure
Serious Incident SI Investigation – Establish a "Hot line"

Implications of not following procedure

Useful Contacts:

Chief Quality Officer

Medical Director

Director of Nursing

Head of Patient Safety

Patient Safety Manager

Monitoring the Process:

See Monitoring & Review table in the Serious Incident Policy

National Definitions:

Reference Material:

Serious Incident Policy	POLCGR071
Serious Incident Pathway	OTCGR145
Serious Incident SI Procedure	SOP0039
Serious Incident SI - Death Process	SOP0080
Serious Incident SI - Reporting to Clinical Commissioning Group - CCG	SOP0075
Serious Incident SI - Serious Incidents Definitions - OTCGR146	OTCGR146
Serious Incident SI Investigation - Establish a Hotline Procedure	SOP0040
TEMLATE - Serious Incident SI - Level 1 Investigation Form	
TEMPLATE - Serious Incident SI - Level 2 Investigation Report	
TEMPLATE - Serious Incident SI - 72 hour report	
TEMPLATE - Serious Incident SI - Concise Review	
TEMPLATE - Serious Incident SI - CCG Downgrade Request Form	
SI Resource Pack	

Approval Signatures:

Edition No:	1	SOP No:	SOP0040

Best of care
Best of people

Standard Operating Procedure
Serious Incident SI Investigation – Establish a "Hot line"

Produced by:	Trish Bain – Chief Quality Officer Debbie Brown – Patient Safety Manager
Distribution:	Intranet
Date Approved:	
Approved by:	
Date last reviewed:	n/a
Review date:	2017
Person responsible for review:	Diana Hamilton Fairley – Medical Director

Serious Incident Process : Reporting and Investigation

Purpose: For the escalation and management of moderate and severe incidents in the Trust

Identification of Incident

Entry Points for Identification of Potential SIs:
Directorates
Patient Safety Team
Harm Free Care Meeting
CCG
Complaints Team
SafeguardingTeam
Legal Team
External Providers

Identification of potential SI communicated to PST

Clear SI

Unclear SI

Scrutiny of Incident by PST

Level 1 Investigation Directorate level governance and monitoring with feedback to PST

Is it an SI? SI Declaration Panel

Is it an SI?

Potential SI

If no or low harm, incident managed through Directorate Level incident management process

Yes – Level 2 Serious Investigation

No

No – Level 2 Red Internal Investigation. See notes for timescales

Investigation

Completed 72 Hour Report to be sent to PST email within 48 hours

Multi-Disciplinary Team RCA within 10 Days of Incident Identification

Confirm formal Duty of Candour Actions

Draft Report to be sent to PST email within 30 days of Incident Identification

Governance and sign off

Completed draft final report and action plan within 40 days of Incident Identification

SI Assurance Meeting/Report Review Panel

Executive Sign Off/ Amendments

Closure

CCG Closure Meeting

Completed Duty of Candour regarding Investigation findings

Close case. All associated documentation to be sent to PST for audit purposes

Lessons Learned and Assurance

Staff De-brief and Internal PS Alerts

Directorate Level Learning Event and Monitoring

Corporate Learning Events (Quarterly)

Duty of Candour – Final closure and feedback

Standard Operating Procedure
Serious Incident SI Procedure

Relevant to:

This procedure applies to all permanent, locums, agency, bank and voluntary staff of Medway NHS Foundation Trust whilst acknowledging that for staff other than those directly employed by the Trust the appropriate line management or chain of command will be taken into account. Whilst the procedure outlines how the Trust will report, manage, analyse and learn from all SI's and serious untoward near misses, implementation does not replace the personal responsibilities of staff with regard to issues of professional accountability for governance.

Purpose of SOP:

This procedure sets out the reporting arrangements and actions to be taken, and by whom, in the event of a SI and ensures that the lessons learned inform future practice.

Procedure to Follow:

IDENTIFICATION

1. Identification of incident – responsibility of the Patient Safety Team (PST), Executive team and Directorate. See Serious Incident - SI - Definitions for Serious Incidents-Never Events OTCGR146

2. An incident has been identified as a potential SI.

3. The initial facts need to be collated with a concise review and timeline of the events –this is the responsibility of the directorate and has to be completed within the first 24 hours to present to the SI declaration panel.

4. Patient records will seized and photocopied by the PST.

5. The SI declaration panel is called within 48 hours of the identification of the incident and the exec team are notified of the declaration panel by the PST and are expected to attend.

6. At the panel the initial facts and timeline are presented.

7. The risk is identified and scored.

8. The checklist is completed.

9. A decision is made as to whether a "hot-line" is required – see Serious Incident SI Investigation - Establish a Hotline Procedure - SOP0040

10. A decision is made as to whether it meets the criteria for an SI -decision making and rationale for declaration of an SI is documented and signed off.

11. If it is declared an SI the investigator is identified by the directorate representation at the panel, the type of investigation required is determined and if legal input is required.

12. Actions are to be identified to support staff involved in the incident and directorate have a responsibility to ensure these are carried forward.

13. Actions are to be identified regarding Duty of Candour and these are the responsibility of the directorate to ensure compliance with legislation. See POLCGR064 - Duty of Candour Policy (Being Open).

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Standard Operating Procedure
Serious Incident SI Procedure

14. Immediate actions required to minimise the risk of another incident will be identified and enacted upon.

15. If the incident does not meet the criteria for an SI the level of investigation with a clear rationale is to be agreed and signed off.

16. Formal declaration to the CCG is completed with the upload onto steis by the PST. See Serious Incident SI - Reporting to Clinical Commissioning Group - CCG - SOP0075

17. The outcome of the SI declaration panel will be cascade by the PST via a notification email stating a declared SI with the steis number, timeline for the investigation and the identified investigator or in the event it is not an SI the level of investigation required which will be a level 1 or level 2 red.

18. PST will provide the investigator with a copy of patient records, time line, resource information and 72 hour and Level 2 Investigation report - TEMPLATE 72 hour report and - Serious Incident SI - Level 2 Investigation Report).

19. If it is unclear the incident is an SI and further investigation is required the directorates have a responsibility to undertake a level 1 investigation – TEMPLATE – Level 1 Investigation Report.

20. If the findings from the level 1 investigation indicate it is a potential SI the above actions are taken.

INVESTIGATION

Directorate responsibility and accountability

1. A 72 hour report is required to be completed by the directorate which detail the immediate actions and learning to ensure future risks are mitigated.

2. The report is returned to the PST within 48 hours of the incident being declared

3. The 72 hour report is sent to the CCG via the PST

MDT within 10 days

4. A Multi-Disciplinary Team Root Cause Analysis (MDT RCA) meeting is arranged by the directorate within 10 days of the SI being declared and all relevant staff will be notified to attend and the patient will be invited.

5. MDT responsibility is to confirm Duty of Candour compliance and staff support, identify further learning / actions to mitigate future risks.

RCA process and Investigation Case Management Approach

6. The PST will be responsible for providing support, mentoring, advice and guidance to the investigator throughout the investigation process.

7. The directorate and investigator are responsible for ensuring the patient, if they want to be, are involved in the investigation process and updated.

Standard Operating Procedure
Serious Incident SI Procedure

8. The investigator has to have the investigation, report and action plan is completed within 35 days and goes to the Directorate Governance meeting for sign off.

21. Directorate is responsible for feeding back to the staff / team involved following the agreed signed off investigation.

22. If the investigation highlights HR issues please refer to the relevant Trust Workforce policies.

23. If the investigation findings evidence the incident does not met the SI criteria the report and action plan needs to be presented to the Exec team who will review and if agree will document a request for downgrade, with a clear rationale.

24. The PST will complete the CCG downgrade request form, in line with their policy and forward the report and action plan.

25. The CCG are responsible for the final decision as to whether an SI is to be downgraded. If agreed the CCG has the responsibility to remove from STEIS.

GOVERNANCE AND SIGN OFF

SI Monitoring Group / report review – 30-40 days

26. Completed report is to be sent to PST one week before the SI Monitoring meeting / report review.

27. Investigator and directorate representative to attend the SI Monitoring meeting / report review and present the report, action plan and provide evidence of duty of candour has been complied with and how the patient has received the feedback.

28. The report will be quality assured and signed off.

29. If the report requires further amendments these need to be completed within 72 hours of the meeting and sent back for virtual closure.

30. Action plan monitoring will be within the directorate governance structure.

31. SI Monitoring meeting will sample and deep dive into action plans 3 months after the SI has been closed to provide corporate assurance.

CLOSURE

32. The report and action plan signed off at the SI Monitoring Group will be submitted to the CCG for closure.

33. CCG closure meeting PST and directorate representation is required.

34. PST to notify the directorates of the outcome from the CCG closure meeting

| **Standard Operating Procedure** |
| **Serious Incident SI Procedure** |

LESSONS LEARNED AND ASSURANCE

Learning

35. Directorates are responsible for documenting how they have feedback the investigation findings to the patient to comply with duty of candour and sharing the investigation findings. Refer to Duty of Candour Policy

36. Directorates are responsible for sharing the learning from the SI investigation and feeding back to the staff.

37. Directorates are responsible for monitoring action plans and assuring through identified metrics learning has been embedded.

38. Corporate PST responsibility to have quarterly Learning events with key themes across the Trust.

39. Patient safety internal alerts will be cascaded via the PST with key learning for information / action.

40. Patient involvement in learning events and stories to be coordinated with the directorate's and PST team.

41. Staff involved in the SI to be provided with feedback on the investigation and offered a debrief session to be agreed.

PROCESS DELIVERY TIMELINE

Click link to view

Serious Incident SI -
Process Delivery Time

Implications of not following procedure

Patient safety risk, financial risk, non compliance with national guidance and contract performance and reputation.

Useful Contacts:

Chief Quality Officer

Medical Director

Director of Nursing

Head of Patient Safety

Patient Safety Manager

Standard Operating Procedure
Serious Incident SI Procedure

Monitoring the Process:

See Monitoring & Review table in the Serious Incident Policy

National Definitions:

Reference Material & Associated Documents:

Serious Incident Policy	POLCGR071
Serious Incident Pathway	OTCGR145
Serious Incident SI Procedure	SOP0039
Serious Incident SI - Death Process	SOP0080
Serious Incident SI - Reporting to Clinical Commissioning Group - CCG	SOP0075
Serious Incident SI - Serious Incidents Definitions - OTCGR146	OTCGR146
Serious Incident SI Investigation - Establish a Hotline Procedure	SOP0040
TEMLATE - Serious Incident SI - Level 1 Investigation Form	
TEMPLATE - Serious Incident SI - Level 2 Investigation Report	
TEMPLATE - Serious Incident SI - 72 hour report	
TEMPLATE - Serious Incident SI - Concise Review	
TEMPLATE - Serious Incident SI - CCG Downgrade Request Form	
SI Resource Pack	

Approval Signatures:

Revision No:	1	ID No:	SOP0039
Distribution:	Intranet		
Date Approved:			
Approved By:	Patient Safety Committee		
Review date:			
Author:	Trish Bain – Chief Quality Officer Debbie Brown – Patient Safety Manager		

Standard Operating Procedure
Serious Incident SI Procedure

Document Owner:	Trish Bain – Chief Quality Officer

SI Process Delivery Timeline

Within 24 Hours

Alert Key People:

Directorate Leads, Exec, PST, Clinical Staff

Directorate Responsibility and Accountability

Draft Report 1 week prior

TOUCH POINT

Within 48 Hours

Day 3   within   **10 Days**

30-40 Days   **60 Days**

Investigation

Learning

CLOSURE

Initial Review

SI Declaration Panel

Serious Incident Decision

Risk Identification

Checklist Completed

Timeline

Identification of Investigator, type of investigation required and legal input

Identify Staff Support

Actions Regarding Duty of Candour

Formal declaration to CCG

Executive Sign-off

72 Hour Report from Initial Review

MDT RCA

Directorate

Patient Involvement

Key People

Confirm Formal Duty of Candour Response

Staff Support

Further Risk Mitigation

RCA Process

Investigation Case Management Approach

Support, Mentoring, Advice for Investigation Team

Directorate Governance Process

Investigation Sign-off within 35 days

Patient Involvement

Patient feedback

Staff/Team Feedback

SI Assurance Meeting / Report Review Panel

Executive Sign-off/Amendments

Report to CCG following SI Panel Meeting

Action Plan Monitoring—Directorate Level

Corporate Team Assurance Role

CCG Deadline

Directorate Level Learning Event and Monitoring

Corporate Quarterly Learning Events with Key Themes

Patient Safety Internal Alerts

Key Issues, Actions and Learning

Duty of Candour Feedback

Patient Involvement Stories

Staff De-brief

Standard Operating Procedure
Serious Incident SI – Reporting to Clinical Commissioning Group CCG

Relevant to:

Investigators

Purpose of SOP:

Provide guidance on when and how to report an SI to CCG

Procedure to Follow:

1) In the event of a serious incident, the Head of Patient Safety (or designated deputy) will report this to the lead (CCG)-as soon as the incident is designated as a serious incident; this is currently NHS Medway. NHS England will be kept informed using the information contained on the STEIS database and through reports via the CCG. The CCG and NHS England will make a judgement about whether the incident should be escalated within the organisation or to the Department of Health. The commissioning CCG and NHS England will inform the organisation if an SI is escalated to the briefing unit at the Department of Health.

2) The STEIS database should be accessed and used by the Trust,(CCG) and the NHS England to record all correspondence, communications and actions relating to each incident.

3) In the interests of confidentiality, all reports should contain anonymised information   and should not contain the names of practitioners or patients. If the SI merits the   necessity of identifying the individual(s) concerned, the lead Commissioning or NHS England will contact the named serious incident lead in the Trust to discuss   the incident and ascertain more detailed information.

4) The initial Trust report of an incident on STEIS should include:

    a) Date/time/site of incident

    b) Who did it affect? Patients, staff, visitors, other – and how many? (personal identifiable data of those involved should not be included)

    c) Brief description of what happened

    d) Brief description of immediate action taken

    e) Media interest (actual or potential).

5) The first point of contact with the lead CCG is by e mail to the Chief Quality Officer and Governance Manager giving a summary of the incident and providing the STEIS reference number. This will be provided by the person reporting the incident onto STEIS (usually the Head of Patient Safety or designated deputy).

6) Full and contemporaneous records of events must be kept from first notification of incident through to the investigation and final outcome reporting process.

7) If required, the Director of Nursing /Medical Director/Chief Quality Officer will nominate a Hot Line Co-ordinator to set up a Trust "hot line" in liaison with the Switchboard Manager, who will trigger the procedure for obtaining additional external telephone lines to be

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brought in. Refer to the Serious Incident SI Investigation - Establish a Hotline Procedure - SOP0040.

8) In the event of the need to establish an external independent inquiry into any type of very serious incident within the NHS England boundary, guidelines issued by the NHS England should be followed, i.e. acute service incidents, primary and community care incidents and mental health incidents. There is specific guidance for the independent investigation of adverse events in mental health services. This guidance replaces paragraphs 33 -36 in HSG (94) 27, (LASSL (94)4), concerning the conduct of independent inquiries into mental health services.

9) The commissioning CCG will decide when the SI is formally closed on the STEIS database. This is after the incident investigation is complete, the Trust has confirmed an action plan has been developed and a summary of this and key lessons learnt have been recorded on the STEIS database.

10) Decisions to request an external review of any service will be subject to confirmation by the Chief Executive.

Implications of not following procedure

A contractual breech will occur.

Useful Contacts:

Chief Quality Officer

Medical Director

Director of Nursing

Head of Patient Safety Manager

Patient Safety Manager

Monitoring the Process:

See Monitoring & Review table in the Serious Incident Policy

National Definitions:

Reference Material & Associated Documents:

Serious Incident Policy	POLCGR071
Serious Incident Pathway	OTCGR145
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Standard Operating Procedure
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TEMPLATE - Serious Incident SI - CCG Downgrade Request Form	
SI Resource Pack	

Approval Signatures:

Revision No:	**1**	**ID No:**	**SOP0075**
Distribution:	**Intranet**		
Date Approved:			
Approved By:			
Review date:			
Author:	**Trish Bain – Chief Quality Officer** **Debbie Brown – Patient Safety Manager**		
Document Owner:	**Diana Hamilton Fairley – Medical Director** **Trish Bain – Chief Quality Officer** **Debbie Brown – Patient Safety Manager**		

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Serious Incident
Level 1 Investigation

Incident Details

Datix ID	
Date	
Injury sustained	
Directorate	
Lead Investigator/s & job title	
Other specialities/services involved	
Service Provider (Ward & brief description of the service)	
Staffing Ratio?	

Summary of Patient & Incident

Background and context

Pre-investigation scoring of the incident:			Post investigation scoring of the incident:		
A Likelihood of recurrence at actual harm (1-5)	B Consequence (1-5)	C Risk Rating (C = A x B)	A Likelihood of recurrence at actual harm (1-5)	B Consequence (1-5)	C Risk Rating (C = A x B)

Chronology/Timeline of Events				
Date & Time	**Source of information**	**Event –** *what actually happened?*	**Solution –** *what should have happened?*	**Comments Actions Required**

Terms of Reference of the investigation (please tick on completion)	
To establish what happened	
To see there were failings in care or treatment	
To look for improvements rather than blame	
To identify the root causes	
To make recommendations and develop an action plan to reduce or eliminate recurrence	
To provide a report as a record of the investigation process	
To identify ways to share learning from the incident	

Process & Methods used (please tick relevant boxes)	
Account of events from Staff/patient	
Policy/procedure/usual practice	
Identifying things that contributed to the incident	
Incident mapping/timeline	
Identify Care and service delivery issues	
Identifying the root cause/s of the incident (if any)	
Other	

Involvement & Support of Patients & Relatives	
Duty of Candour	
Explanation & Apology Given (Date, time & details)	
Invite to meet (Date, time & details)	
Documented in patients notes (Date, time & details)	
How the outcome of the investigation & report will be shared	

Patient Details	
Date of Admission	
Length of Stay	
Reason for Admission	
Past Medical History	
Patient Background (lives alone? Nursing home? Independent?)	

Patient Risk Factors (tick those that apply)

Delirium		History of Fall/s Admitted with a fall		Collapse, syncope or dizziness		Acutely Unwell/ Septic	
Dementia		Is the patient on the Frailty Pathway		Prescribed at risk medications		Pain	
Cognitive Impairment		Is the Patient on DOLs		Hearing or visual impairment		CVA / Parkinson's	
Confusion		Unsteady, unsafe &/or getting up unaided		Bladder of bowel symptoms?		Other: (please list) e.g. anaemic, vac pump on foot, drips, drains, catheters	
Agitation/Restless/ Drowsy		Increase/reduced mobility		Dehydrated/ malnourished			
Under the influence or withdrawing from alcohol?		Low Blood Pressure/ Postural Drops		Post op/ post op analgesia			

Current Condition of the Patient (Current Status of the patient- how is the patient following the investigation?)

Good Practice Points

1	
2	
3	

Contributory Factors (Note the relevant contributory factors)

Root Cause(s)

1	
2	
3	

Lessons & arrangements for shared learning

1	
2	
3	

Contribution & Support of staff involved in the incident

Please return to PST seriousincident@medway.nhs.uk

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Recommendations	Specific Actions (SMART)	Outcome for patient when implemented	CQC Domain (S,C,R,E,W)	Due date	Responsible person	Update / date Completed	RAG

Key: CQC domains: S= safe, C=caring, R = Responsive, E = Effective, W= Well-led
RAG: Red = outstanding.   Amber = work in progress.   Green = completed

Assurance	
Outcome metrics (impact on KPI's)	
Evidence of implementation against CQC domains	
Impact of outcomes on corporate objectives (to deliver safe high quality care and an excellent patient experience)	

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Governance arrangements	
Are these actions included in the Directorate action plan? (if no continue to next box)	
Will these actions be added to the Directorate Action plan? (if not specify how they will be monitored)	
Date signed off at Directorate Governance	
Date learning has been shared with the Team involved	
Date of action plan closure	
Date shared with PST	
Date & Signature	

Stage 2 Serious Incident
72 hr report

DATIX number: **STEIS Identification Number:**	
Date/Time/Location of Incident including hospital / ward / team level information	
Incident type	
Description of incident including reason for admission and diagnosis (for mental health please include Mental Health Act status and date of referral and last contact)	
Details of any police or media involvement/interest	
Details of contact with or planned contact patient/family or carers	
Immediate actions taken including actions to mitigate any further risk	
Details of other organisations/individuals notified	
Lead Commissioner	
Report completed by	
Designation	
Date / time report completed	

SERIOUS INCIDENT DOWNGRADE REQUEST FORM

Some SI's may be reported based on limited information which, on further investigation, do not meet the criteria for an SI and will require downgrade/removal from STEIS. In such cases, the Downgrade Request Form must be completed. On receipt of the completed form, North Kent CCGs will review the request and inform the provider organisation of the decision made.

SECTION 1 – Provider Organisation to complete			
Provider		**STEIS Reference**	
Requester		**Date Reported**	
Contact Details		**Date of Request**	
Incident Description			
Reason for Downgrade			

SECTION 2 – CCG to complete			
Date of Review		**Outcome**	YES / NO
Reviewer(s)			
Additional Notes			

Please return the completed form by e-mail to SWCCG.sui@nhs.net

Directorate: Click here to enter text.

Concise Investigation

Datix WEB number	
Incident date	
Patient Name	
PAS Number	
Reviewer	
Date of review	

Speciality	
Ward/Department	
Detection of incident	
Brief incident description	
Actual effect on patient	
Actual severity of incident	

Care and service delivery problems	
Contributory factors	
Root causes	

Recommendations	

Simple timeline of events

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Date and time	

Clinical Risk and Incident Review Group	
Does this incident require further investigation?	
Level of harm agreed	
Duty of Candour to be applied	
Date of CRIG meeting	

Action plan		
Action	Implementation lead	Target date for implementation

Date and forums shared	

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Serious Incident
Level 2 Investigation Report

Status	*Draft /final*
Version Number	
Author	
STEIS Number	
Datix Number	WEB
Complaint Reference	
Adult Protection Alert	
Speciality involved	
Acknowledgements	
Executive sign off (name, title, date)	
Circulation	Chief Quality Officer Director of Nursing Medical Director Director of Clinical Operations Serious Incident Group CCG SI Group
Action Plan Owner	Directorate
Document Storage	Patient Safety Department

TYPE, PROCESS, METHODS USED (ALL APPROPRIATE) PLEASE '✓'			
Review of clinical records		Review of clinical guidelines	
Staff factual accounts (written evidence)		Multidisciplinary review	
Tabular timeline		Five whys	
Narrative chronology		Staff interviews	
Incident decision tree		Policies, handover processes , Royal Marsden	

Document Tracking

Version	Status	Date	Issued to	Summary of changes
0.1	Draft			

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1. Terms of Reference of the investigation (please tick on completion) ✓

To establish what happened	
To see there were failings in care or treatment	
To look for improvements rather than blame	
To identify the root causes	
To make recommendations and develop an action plan to reduce or eliminate recurrence	
To provide a report as a record of the investigation process	
To identify ways to share learning from the incident	

2. Brief Incident Description

3. Background information

Date of admission	
Length of stay	
Reason for admission	
Past medical history	
Patient background (lives alone? nursing home? independent?)	

Service provider details

Other specialties / services involved?	
Service provider (ward & brief description of the service)	
Staffing ratio	

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4. Incident *(narrative chronology) full details on supporting chronology* **& Analysis**	
5. STEIS Incident Type / Category	
6. Detection of Incident	
7. Effect on Patient and/or Service	
8. Duty of Candour	
9. Staff Support	
10. Safeguarding	

11. Contributory Factors (consider the following taken from NPSA classification framework):	
Patient	
Individual	
Task	
Communication	
Team and Social	
Education and Training	

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Equipment and Resource	
Working Conditions	
Organisational and Strategic	

12. Root Causes

13. Conclusion

14.Recommendations

15.Outcomes for future patients

16. Pre and post risk grading

Pre-investigation scoring of the incident:		
A Likelihood or recurrence of actual harm(1-5)	B Consequence (1-5)	C Risk rating (C = A x B)

Post-investigation scoring of the incident:		
A Likelihood or recurrence of actual harm(1-5)	B Consequence (1-5)	C Risk rating (C = A x B)

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17. Arrangements for Shared Learning
Head of Service to feedback to team
Present findings to the Quality Improvement Committee
Report will be shared with the CCG SI Group
Trust wide sharing at learning events

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Timeline

Chronology/Timeline of Events				
Date & Time	**Source of information**	**Event** – *what actually happened?*	**Solution** – *what should have happened?*	**Comments Actions Required**

Action plan

Problem	Recommendations	Specific Actions (SMART)	Outcome for patient when implemented	CQC Domain (S,E,C,R,W)	Due date	Responsible person	Update / date Completed

Key: CQC domains: S= safe, E = Effective, C=caring, R = Responsive, W= Well-led
RAG: Red = outstanding.   Amber = work in progress.   Green = completed

Assurance	
Outcome metrics (impact on KPI's)	
Evidence of implementation against CQC domains	
Impact of outcomes on corporate objectives (to deliver safe high quality care and an excellent patient experience)	

Governance arrangements	
Are these actions included in the Directorate action plan? (if no continue to next box)	
Will these actions be added to the Directorate Action plan? (if not specify how they will be monitored)	
Date signed off at Directorate Governance	
Date learning has been shared with the Team involved	
Date of action plan closure	

Date shared with PST	
Date & Signature	

Previous SIs Grids

a) Has the ward / Directorate had previous SIs of the same type? (e.g. pressure ulcer, fall, medication etc.)
(Contact PST/Governance for advice)
Yes/No
If yes, please complete table below

b) Please give details of previous SIs	SI reference	Date of SI	What date was the action plan due to be completed by?	Was the action plan completed?	Were themes/actions the same /similar in the previous SIs as those in this RCA?

ELECTIVE ACCESS POLICY

Edition No:	11.9.4	**ID Number:**	POLCOM018
Dated:	October 2016	**Review Date:**	October 2018

Document ID:	Policy	**Document Type**	Corporate
Directorate:	Operations	**Category:**	Operational Management
Department(s):	Operations		

Name of Author/Reviewer:	James Clary	**Name of Sponsor:**	Ben Stevens
Job Title	RTT Programme Lead	**Job Title**	Director of Clinical Operations, Co-ordinated Surgical Care Directorate

Policy Dissemination
Intranet

Policy Consultation
General Managers
Trust Board
CCG
Patient Representative Group

Approval & Ratification		
Name of Board	Coordinated Surgical Care Directorate Governance & Management Board	Date: 22/07/2016
Name of Committee	CCG Commissioning Committee	Date: 19/10/2016

Document Control / History	
Edition No	**Reason for change**
6	18 Week Access Policy to support achievement of 18 weeks Referral to Treatment
7	Updated as per revised SEC SHA guidance. Amendment on 6.11.
8	NHS Constitution , NHS Operating Framework 2010/11
9	Complete rewrite of policy
10	Update to include Looked after Children DNA protocol
11	Change to reflect NHSI recommendations, new NHS England RTT Rules and guidance published 01 October 2015

Document	**Ref No**
References:	
Referral to treatment consultant-led waiting times Rules Suite (October 2015)	

Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care (01 October 2015)	04113
Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care: Frequently asked questions (May 2016) Version 1.0	04112
Cancer Waiting Times: A Guide (Version 9.0)	Version 9.0
NHS Constitution (July 2015)	
NHS Standard Contract 2016/17 Technical Guidance	04977
See Appendix 3	
Trust Associated Documents:	

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Table of Contents

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

1 Introduction

1.1 The Medway NHS Foundation Trust (MFT) Access Policy is intended to ensure that all patients that are referred and treated within the Trust receive high quality care, fair and equitable access and services in line with 18 week Referral to Treatment. The Cancer Waiting Time Standards, and the NHS Constitution.

1.2 The NHS Constitution brings together in one place for the first time in the history of the NHS, what staff, patients and public can expect from the NHS. As well as capturing the purpose, principles and values of the NHS, The Constitution brings together a number of rights, pledges and responsibilities for staff and patients alike. These rights and responsibilities are the result of extensive discussions and consultations with staff, patients and public and it reflects what matters to them.

1.3 This policy will provide the Trust with a coherent approach to the management of waiting lists, scheduling and booking across the organisation. Ensuring that patients are treated in line with local and National Policies regarding Vulnerable Adults, Patients with Learning Disabilities, Safeguarding Children Policies and War Veteran Guidance. The Trust is committed to the delivery of Same Sex Accommodation preserving and protecting patient and client privacy and dignity whilst in Hospital, through the provision of segregated facilities for men and women.

1.4 It is essential that all staff involved in the management of patients waiting elective treatment have a clear understanding of their roles and responsibilities in this process. This includes clinical, managerial and administrative staff. Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and will be open to inspection, monitoring and audit. The Trust will give priority to clinically urgent patients and treat everyone else in turn and will share correspondence that is sent between clinicians with patients regarding their care.

1.5 This policy will be regularly reviewed reflecting any changes in light of patient feedback, the commissioning intentions of the local CCG's and NHS Constitutional rights and pledges.

1.6 This Policy details how patients will be managed administratively at all points of contact with Medway NHS Foundation Trust, and should be implemented by staff in conjunction with any supporting SOPs.

2 Scope

2.1 This Policy will reflect the overall expectations of the Trust and local Commissioners on the management of referrals and admissions into and within the organisation, and defines the principles on which the Policy is based.

2.2   The policy reflects the key access targets for Outpatient, Inpatient, Diagnostic and Planned Waiting List Management, National Referral to Treatment (RTT), and Cancer Waiting Time (CWT) Standards, in line with the NHS Constitution.

2.3   Patients on a Cancer Pathway are managed according to the Trusts separate Cancer Waiting Times Standard Operation Process (SOP)

2.4   This Policy is intended to be of interest to and used by all those individuals within Medway NHS Foundation Trust, who are responsible for referring patients, managing referrals, adding to, and maintaining waiting lists for the purpose of organising patient access to hospital treatment. The principals of the Policy apply to both medical and administrative waiting list management.

3   Definitions

3.1   Active Monitoring   (Also known as 'watchful waiting')

An 18 week clock may be stopped where it is clinically appropriate to start a period of monitoring in secondary care without clinical intervention or diagnostic procedures.

A new 18 week clock would start when a decision to treat is made following a period of active monitoring.

3.2   Active Waiting List

Patients awaiting elective admission for treatment and are currently available to be called for admission.

3.3   Cancellation (Patient initiated)

A cancellation is when a patient gives any advance notice. A cancellation is a cancellation even if notice is very short. By cancelling an appointment a patient has shown a willingness to engage with the NHS.

3.4   Clinical decision

A decision taken by a clinician or other qualified care professional, in consultation with the patient, and with reference to local access policies and commissioning arrangements.

3.5   Date Referral Received (DRR)

The date on which a hospital receives a referral letter from a GP. The waiting time for outpatients should be calculated from this date. For NHS e-Referral Service (Choose and Book) referrals, this will be the date that the patient converts their UBRN (Unique Booking Reference Number)

3.6   Day cases

3.7 A Patient admitted electively during the course of a day with the intention of receiving care who does not require the use of a Hospital Bed overnight and who returns home as scheduled. Decision to Admit date (DTA)

The date on which a consultant decides a patient needs to be admitted for an operation. This date should be recorded in the case-notes and used to calculate the total waiting time.

3.8 Did Not Attend (DNA)

Patients who have been informed of their date of admission or pre-assessment (inpatients/day cases), appointment date (outpatients, diagnostic appointment), and who without notifying the hospital did not attend for admission/ pre-assessment or OP appointment.

3.9 e-Referral

A national electronic referral service that gives patients a choice of place, date and time for their first consultant outpatient appointment in a hospital or clinic.

3.10 First Definitive Treatment

An intervention intended to manage a patient's disease, condition or injury and avoid further invention. What constitutes First Definitive Treatment is a matter for clinical judgement, in consultation with others as appropriate, including the patient.

3.11 Inpatients

Patients who require admission to hospital for treatment and are intended to remain in hospital for at least one night.

3.12 Pause (18 week pathway)

From 1 October 2015, there is no provision to pause or suspend an RTT waiting time clock (18 Week) under any circumstances. Patients are entitled to delay their treatment beyond 18 weeks for personal or social reasons (see 5.11)

3.13 Patient Tracking List (PTL)

The PTL is a list of patients (both inpatients and outpatients) whose waiting time is approaching the guarantee date, who should be offered an admission/appointment before the guarantee date is reached.

3.14 Reasonable offer

A reasonable offer is one for a time and date three or more weeks from the time that the offer was made. It is good practice to offer patients at least two reasonable offers.

3.15 Referral to Treatment (RTT)

An RTT period is the time between a person's referral to a consultant-led service, which initiates a clock start, and the point at which the clock stops for any of the reasons set out in the RTT national clock rules, for example the start of first definitive

treatment or a decision that treatment is not appropriate.

3.16   TCI (To Come In) date

The offer of admission, or TCI date, is a formal offer in writing of a date of admission. A telephone offer of admission should not normally be recorded as a formal offer. Usually telephoned offers are confirmed by a formal written offer.

3.17   UBRN (Unique Booking Reference Number)

The reference number that a patient receives on their appointment request letter when generated by the referrer through the NHS e-Referral Service. The UBRN is used in conjunction with the patient password to make or change an appointment.

4   Responsibilities

4.1   Whilst responsibility for achieving targets lies with the Directorates, accuracy of the referral and waiting list information is the responsibility of all staff that have access to and responsibility for the upkeep of systems that hold referral and waiting list information, during the course of their work.

4.2   The General Manager is accountable for implementing the 18 week target, the Elective Access Policy, monitoring waiting list management and ensuring compliance with the Policy.

4.3   The Service Managers are accountable to the General Manager for ensuring that the waiting times targets are monitored and delivered and that the policy is being implemented in full.

4.4   Waiting list administrators, clinic staff, secretaries, pathway coordinators and booking clerks, are responsible to the Service Managers with regard to compliance of all aspects of the Trusts Elective Access Policy.

4.5   Service Managers are responsible for the day-to-day management of their lists and are supported in this function by the operational managers or team leaders who are also responsible for achieving access targets.

4.6   General Managers through the Operational Director are responsible for ensuring the data is accurate and the policy is complied with.

4.7   The IT department are accountable for the maintenance of the trusts Patient Administration System (PAS) and other reporting systems on which all waiting lists are held.

4.8   The General Manager is accountable for the operational management of data once it has been entered onto the PAS and on other reporting systems on which all waiting lists are held.

4.9 The Performance Manager is responsible for the reporting of information to the Directors, monitoring performance against locally or nationally agreed targets and ensuring this is fed into appropriate operational and performance forums.

4.10 The Head of Information is responsible for providing regular data quality audits of standards of data collection and recording the submission of central returns produced by the Information Department. Informing Directorates of new or changed performance targets.

4.11 GPs play a pivotal role in ensuring patients are made aware during their consultation of the likely waiting times for a new outpatient consultation and of the need for patients to be contactable and available when referred.

4.12 All clinical staff are responsible through their Clinical Director to the Medical Director for ensuring they comply with their responsibilities as outlined in this Policy.

4.13 Any staff not following this Policy may have this reported to their line manager and this may result in action under the Trusts disciplinary policies.

4.14 Staff involved in managing patient pathways for elective care must not carry out any action about which they feel uncertain or that might contradict this Policy.

5 Key Principles

5.1 This Policy covers the way in which Medway NHS Foundation Trust (MFT) will manage patients who are waiting for treatment on admitted, non-admitted or diagnostic pathways. It covers the management of patients at all sites where MFT operates, including outreach clinics.

5.2 Every process in the management of patients who are waiting for treatment must be clear and transparent to the patients and to partner organisations and must be open to inspection, monitoring and audit.

5.3 The Trust will give priority to clinically urgent patients and treat everyone else in turn. War veterans and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

5.4 The Trust will work to meet and improve on the maximum waiting times set by the Department of Health for all groups of patients.

5.5 The Trust will, whenever possible, honour booked appointments and negotiate appointments and admission dates and times with patients.

5.6 The Trust will work to ensure fair and equal access to services for all patients.

5.7 In accordance with a regular training needs analysis, staff involved in the implementation of this Policy, both clinical and clerical, will undertake training provided by the Trust and regular annual updates. Policy adherence will be part of the staff appraisal process.

5.8 The Trust will ensure that management information on all waiting lists and activity is recorded on an appropriate Trust system. This must be the trusts PAS or other approved reporting systems authorised by the director of operations e.g. Radiology

Information System (RIS), Dental Electronic Referral Service (DERS), Galaxy etc. All approved reporting systems form part of the Trusts electronic patient record (EPR). Stand-alone or paper based systems must not be used in isolation.

5.9 The Trust will monitor the Referral to Treatment (RTT) pathway by using Patient Tracking Lists (PTL) measuring the patients length of wait from referral to new outpatient appointment, diagnostic test, elective admission and open pathway follow-up appointments.

5.10 It is the responsibility of all members of staff to understand the RTT principles and definitions.

5.11 Patients who chose to delay treatment

From 1 October 2015, there is no provision to pause or suspend an RTT waiting time clock under any circumstances. Patients are entitled to wait longer for their treatment if they wish. Patients must be allowed to plan their treatment around their personal circumstances.

5.12 Reasonable offer of appointment or TCI

An offer is reasonable where:

- the offer of an out-patient appointment or an offer of admission is for a time and date three or more weeks from the time that the offer was made
  or
- the patient accepts the offer

All offers made to the patient should be recorded on the Trusts PAS.

5.12.1 Two reasonable offers should be made and the offers should be on different days and both dates offered should be recorded on PAS.

Where a patient declines a second reasonable offer, the patients request should be discussed with the patients consultant to confirm how long the patient can defer treatment without clinical review.

5.12.2 If the clinician is not satisfied that the proposed delay is appropriate then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date agreed.

5.12.3 If the patient refuses to accept the advice of the clinician then the responsible clinician must act in the best interest of the patient. If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing then this must be made clear to the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account.

This should be communicated to the patient in all appointment letters, as the patient may not be aware of the clinical implications of choosing to wait longer.

5.13   Patients who Do Not Attend (DNA) **First Appointment / Activity** Following Initial Referral (with the exception of paediatrics, urgent, Two Week Wait (2WW) and vulnerable adults)

If a patient DNA's their first appointment / activity following the initial referral which started their referral to treatment pathway, the patient will be discharged back to the GP / Referrer and their RTT clock must be nullified, provided that:

5.13.1 The Trust can demonstrate that the appointment was clearly communicated to the patient.

5.13.2 Discharging the patient is not contrary to their best clinical interests, which must be determined by a clinician.

Should the patient be offered another date, a new pathway will start on the date the patient mutually agrees their appointment (not the date of the future appointment).

5.14   Patients who DNA any Subsequent Activity – Outpatient Appointment, Diagnostic, or Admission along a Patients Pathway (with the exception of paediatrics, urgent, 2WW and vulnerable adults)

Patient DNA's at any other point on the RTT pathway will not stop the RTT clock unless the patient is being discharged back to the care of their GP. This will stop the clock provided that the Trust can demonstrate that the appointment was clearly communicated to the patient, otherwise the RTT clock will still tick. All appointments offered must be recorded on PAS.

If a patient does DNA any subsequent activity, a clinical review must take place and the patient will be either:

Discharged back to the GP's care, provided that discharging the patient is not contrary to their best clinical interest. The RTT clock will stop on the date the patient DNA's appointment / TCI. A DNA letter must be sent to the GP and the patient (copy filed in case notes).

OR

The clinician will request the patient is offered another appointment / TCI, in this instance the RTT clock will continue to tick.

5.15   Cancellation - Patient initiated cancellations
A cancellation is when a patient gives any advance notice. A cancellation is a cancellation even if notice is very short. By cancelling an appointment a patient has shown a willingness to engage with the NHS.

If it is not possible to see a patient who arrived on time for their appointment due to the clinic running late, staff shortages etc. and the patient has to leave before they

have been seen, this is a cancellation.

If the patient has previously agreed to a reasonable offer of appointment or TCI (i.e. three weeks' notice and a choice of two dates, or the patient has accepted a short notice date) which they subsequently wish to change, the patient can make two cancellations anywhere in their RTT pathway and the RTT clock will continue to tick (on-going).

Upon a third cancellation the patient may be discharged back to their GP/referrers care. A clinical review must take place before this decision is made.

5.16   Hospital initiated cancellations

If the hospital cancels an appointment or TCI anywhere on an RTT pathway, the clock continues to tick. The patient should be re-dated within the existing RTT standards and departmental RTT milestones.

5.16.1 Clinic cancellation

Where possible patients should not be cancelled more than once by hospital.

A minimum of six weeks notice of annual or study leave is required for clinic cancellation or reductions. Clinic cancellation with less than six weeks notice can only be authorised by the appropriate General Manager or Clinical Lead.

5.16.2 Patient unfit

If an operation needs to be cancelled because the patient is unfit for surgery for less than 2 weeks, for example for a minor cough / cold, the RTT clock should continue to tick unless it is deemed not be clinically appropriate to keep the patient on an active RTT pathway. The patient will be offered a re-scheduled date within the RTT standards while adhering to the reasonable offer guidelines.

In the event of long term periods of the patient being medically unfit (i.e. over 2 weeks) the responsible clinician can decide to refer the patient back to their GP for the management of the condition rendering the patient unfit for the required surgical procedure.

The letter to the GP will state the optimisation required and the need for re-referral when the patient is fit to proceed. A copy of the letter will be sent to the patient and copy filed in the patient's case notes. Once the patient has been informed the RTT pathway can then be stopped upon referring back to the GP's care. A new pathway will start upon receipt of re-referral from the patients GP.

5.16.3 Cancelled Operations on the Day of Admission

In the event the Trust has to cancel a patient's elective procedure on the day of admission or day of surgery for a non-clinical reason, the patient must be offered another TCI date within 28 days of the cancelled procedure date

5.17 HMP Patients

Patients who are in the custody of Her Majesty's Prisons (HMP) are entitled to the same access to NHS services as members of the public. When HMP Patients attendance to MFT will be outside of the expected 18 week waiting period due to repeated DNA or cancellations (see section 5.12 – 5.15) by the prison facility, the patient will be discharged back to the care and responsibility of that referring HMP facility's Medical Officer.

5.18 Appointment booking methods

It is good practice for a provider to mutually agree all appointments and admission dates with the patient. This will help to reduce patient cancellations, DNA rates and to improve the patient experience.

5.18.1 Full booking
In a full booking system, the patient is given the opportunity to agree a mutually convenient new appointment date, or when a patient agrees a mutually convenient follow-up appointment directly after a clinic attendance, or agrees a mutually convenient admission date after a decision to admit.

5.18.2 Partial booking
A letter is sent to the patient, requesting the patient telephones the Trust to agree a mutually convenient appointment date or the patient is given a date by letter but given the opportunity to ring in and change the appointment. Where patients are sent letters to contact the Trust, they must respond to the Trust within 21 calendar days from date of letter, or they will be discharged back to their GP and their 18w clock stopped. If a GP then contacts the Trust for another appointment, this should be treated as a new referral as per date of telephone call/letter.

5.18.3 No booking choice
An appointment (new or follow-up) or TCI date is booked and sent to the patient, without any negotiation with the patient. This process is not recommended and should only be used as a last resort.

5.19 Short Notice offer of appointment or TCI
If a patient is offered a short notice appointment, diagnostic procedure or admission and they are happy to accept the date offered, this becomes a reasonable offer. If a patient accepts a short notice offer but then cancels or DNA's the activity, they have still agreed the appointment and therefore this will be treated as a reasonable offer. This must be made clear to the patient at the time of the short notice offer.

6   Management of New and Follow-up Outpatient Appointments

6.1   Named Referrals

6.1.1 The trust will receive named referrals, however referrals will be managed by the consultants within a specialty. e-Referral will allow referrals to be booked to a named clinician but the patient may be booked to another consultant if they are deemed as the most appropriate clinician to see the patient.

6.1.2 Where possible referrals should be made to a service rather than to a named clinician as this allows MFT to proportion the work out to the team more effectively.

6.2 Outpatient Referrals

6.3 The following principles will be adhered to:

6.3.1 Paper referrals will be registered onto the Trust PAS and scanned within 24 hours of receipt

6.3.2 Referrals sent in via E-Referral must be reviewed by the clinician team within three working days.

6.3.3 Clinical review will take place within three working days of receipt of paper referral.

6.3.4 Patient contact, where possible will be made within four days of receipt of triaged paper referral.

6.3.5 Where patients cannot be contacted within 28 days of registration they will be discharged to their GP as no contact made.

6.4 Consultant to Consultant Referrals – This provider

6.4.1 Referrals for the same condition; every effort should be made to ensure the patient is seen in the correct clinic at the outset of the 18 week pathway, however, if following the consultation a decision is made that the patient should be seen by another specialist the clock will continue to tick from the original referral date.

6.4.2 The appointment for the 2nd Consultant must be offered following the original consultation. Directorates must ensure the referral letter to the 2nd Consultant and the completed Minimum Data Set (MDS) form is available in time for the new appointment.

6.4.3 Referrals for a different, unrelated condition to the original referral (excluding urgent or cancer referrals) must be discharged and referred back to the GP to enable patient choice.

6.5 Consultant to Consultant Referrals – Other Provider

6.5.1 For patients referred to other providers responsibility for the care of those patients is transferred to the receiving Trust once the referral is accepted.

6.5.2 A completed Inter-provider Administrative Minimum Data Set (IPTAMDS) form must be sent with all inter-provider transfers. This applies to patients being transferred into or out of the Trust.

6.6   Patients transferring from the independent sector to MFT as an NHS patient

    6.6.1   Patients wishing to transfer from the independent sector to the NHS must be referred via their GP in line with section 6.1.

    6.6.2   Patients who start an 18 week clock in NHS outpatients, who choose to pay for their procedure in the independent sector and then choose to return to the NHS for follow-up care must be re-referred by their GP and cannot be referred directly by the independent sector to MFT.

6.7   Patients transferring from the NHS to the independent sector at their Own Request

    6.7.1   NHS patients already on an NHS waiting list who opt to have a procedure in the independent sector must be removed from the NHS waiting list and their RTT clock stopped. The RTT pathway should be stopped on the date the patient informs the Trust they no longer require treatment and the referral should be discharged.

6.8   NHS patients who receive part of their treatment in the independent sector as part of their NHS pathway are not effected by either 8.6 or 8.7

6.9   Referrals from the Clinical Assessment Service (CAS)

    6.9.1   CAS will ensure that patients are referred using appropriate clinical guidelines and that patients understand their responsibilities, potential steps in the pathway and timescales from the point of referral.

    6.9.2   CAS will ensure that patients are not referred for a condition/procedure which does not comply with the Kent and Medway CCG's Referral and Treatment Criteria (RaTC).

    6.9.3   Patients will be given clear verbal information by CAS about the need to attend appointments and reminded of the consequences if they fail to attend appointments.

    6.9.4   CAS will inform MFT of any Patient cancellations within the CAS pathway and actively manage and monitor the 18 week pathway,

    6.9.5   CAS will ensure that all demographic and referral information is provided including day time contact and mobile phone numbers.

    6.9.6   CAS will ensure that referrals are clearly marked with the 18 week clock start date indicating distinctly if the patient has received treatment by the CAS.

    6.9.7   If the patient has received treatment by the CAS Medway Foundation Trust will record the 18 week clock start date from the referral received in the Trust date.

    6.9.8   If the Patient has not received treatment by the CAS Medway Foundation Trust will record the original 18 week clock start date from the GP referral received date in CAS or in the case of an E-Referral, from the conversion of the URBN.

6.9.9 In the case of E-Referral referrals into CAS the clock start date for patients not receiving treatment will be the conversion of the URBN into CAS.

6.9.10 The CAS will aim to achieve a maximum 3 week turnaround time for patients who need a face to face consultation but do not require imaging. Patients that do require imaging will be managed in line with 18 weeks, allowing the Trust adequate time for treatment requirements within the 18 week pathway.

6.10 Patients requiring Commissioner Approval (Prior Approval)
No referral for a procedure listed in the Kent and Medway CCG's Referral and Treatment Criteria (RaTC) that requires prior approval should be accepted by MFT without an CCG approved Individual Funding Request (IFR) submission form supplied by a patient's GP with the referral.

6.11 General Principles for Booking

6.11.1 All patients must be seen in order of clinical priority and length of wait.

6.11.2 Patients are able to negotiate their appointment time and date.

6.11.3 No patient waiting for an outpatient appointment can be suspended or paused.

6.11.4 No patient waiting for a diagnostic appointment can be suspended or paused.

6.11.5 A decision to add to an outpatient, diagnostic or elective waiting list must be recorded on the trusts PAS within one working day.

6.12 Reasonable Offer

6.12.1 A 'reasonable' offer for routine referrals is at least three weeks from the time of the offer being made

6.12.2 For patients referred under the 2WW pathway, OPD and diagnostic appointment dates will be offered to patients within the 14 day period and at short notice. For in-patient treatment, dates will be offered within the national cancer target period.

6.12.3 Two reasonable offers should be made and the offers should be on different days and both dates offered should be recorded on PAS.

6.12.4 Where possible appointments will be agreed with the patient by phone but can be confirmed to the patient via post.

6.13 Suspected Cancer (2WW) and Rapid Access Chest Pain

6.13.1 All patients with suspected cancer or new exertional chest pain must be seen in outpatients within 14 days of receipt of the GP referral.

6.14 Choice of Consultant

6.14.1 Patients referred to a named consultant can be offered appointments with a different consultant, however unless the change of consultant is due to ill health, retirement or is not clinically appropriate the refusal of this offer does not affect the patients breach date.

6.15 Overseas Visitors

6.15.1 Patients who are identified as overseas visitors must be referred to the Overseas Patients Officer for clarification of status regarding entitlement to NHS treatment before registration takes place. (See Overseas Patients Policy).

6.16 Hospital initiated Clinic Cancellation

Where possible patients should not be cancelled more than once by the hospital.

A minimum of six weeks notice of annual or study leave is required for clinic cancellation or reductions.

Clinic cancellation with less than six weeks notice can only be authorised by the appropriate General Manager or Clinical Director.

6.17 Patient initiated cancellation

6.17.1 If a patient cancels, rearranges or postpones their appointment, this has no effect on the RTT clock, which should continue to tick. Patients should not be discharged back to their GP simply because they have cancelled or rearranged appointments; referral back to the GP should always be a clinical decision, based on the individual patient's best clinical interest through clinical review.

If the patient has previously agreed to a reasonable offer of appointment (i.e. three weeks' notice and a choice of two dates, or the patient has accepted a short notice date) which they subsequently wish to change, the patient can make **two cancellations anywhere in their RTT pathway** and the RTT clock will continue to tick (on-going). Upon a third cancellation the patient may be discharged back to their GP/referrers care. A clinical review must take place before the decision to discharge is made. This applies to all patients (routine, paediatric, urgent and suspected cancer).

6.18 Patients who Do Not Attend (DNA) First Appointment / Activity Following Initial Referral (with the exception of paediatrics, urgent, 2WW and vulnerable adults)

If a patient DNA's their first appointment / activity following the initial referral which started their referral to treatment pathway, the patient will be discharged back to the GP / Referrer and their RTT clock must be nullified, provided that:

6.18.1 The Trust can demonstrate that the appointment was clearly communicated to the patient.

6.18.2 Discharging the patient is not contrary to their best clinical interests, which must be determined by a clinician.

Should the patient be offered another date, a new pathway will start on the date the patient mutually agrees their appointment (not the date of the future appointment).

6.19   Patients who DNA any Subsequent Activity – Outpatient Appointment, Diagnostic, or Admission along a Patients Pathway (with the exception of paediatrics, urgent, cancer and vulnerable adults)

Patient DNA's at any other point on the RTT pathway will not stop the RTT clock unless the patient is being discharged back to the care of their GP. This will stop the clock provided that the Trust can demonstrate that the appointment was clearly communicated to the patient, otherwise the RTT clock will still tick. All appointments offered must be recorded on PAS.

If a patient does DNA any subsequent activity, a clinical review must take place and the patient will be either:

Discharged back to the GP's care, provided that discharging the patient is not contrary to their best clinical interest. The RTT clock will stop on the date the patient DNA's appointment / TCI. A DNA letter must be sent to the GP and the patient (copy filed in case notes).

OR

The clinician will request the patient is offered another appointment / TCI, in this instance the RTT clock will continue to tick.

6.20   Paediatric New Appointment DNA

6.20.1   If a paediatric patient DNA's their appointment following a new referral, the clinician should discharge back to the GP unless there are special circumstances described in the referral letter, or if the child is known to clinician (e.g. Child in need, Child Protection concern, parents with learning disabilities or mental health problems or a Looked After Child [LAC]).

6.20.2   A standard letter should be sent to the GP and referrer (if not the GP) with a copy to the parents and social worker (if involved) and LAC Health Team if involved. For pre-school children, a copy of the letter should be sent to the Health Visitor.

6.21   Paediatric Follow Up appointment DNA

6.21.1   First DNA – a standard letter including a list of diagnoses should be sent to the GP informing that the patient has been discharged, unless the child has chronic or significant medical conditions, or there are safeguarding concerns or Looked After Child. In these cases a second appointment will be sent. A copy of either the discharge letter or the second appointment letter should be sent to the parents and social worker (if involved) and a copy to the LAC Health Team if appropriate, and Health Visitor if a pre-school child.

6.21.2 Second DNA in succession – The clinician will make the decision regarding discharge or further appointment if a second DNA in succession occurs in a child with chronic or significant medical conditions, safeguarding concerns or Looked After Child. If the patient is discharged a standard letter should be sent to the GP with copy to HV, SW or other health care professionals involved in the child's care which includes a list of diagnoses, medications and any monitoring required by the GP.

6.22 Patient Did Not Attend (DNA) on a suspected cancer pathway

6.22.1 If a patient DNA's their **first appointment** they should be offered another appointment.

6.22.2 If a patient does DNA any **subsequent activity (2 or more DNA's)**, a clinical review must take place and the patient may discharged back to their GP, provided that discharging the patient is not contrary to their best clinical interest

or

the clinician will request the patient is offered another appointment.

7 Diagnostic Appointments

7.1 Patients Referred on for Diagnostics

7.1.1 The Trust is responsible for informing patients of the likely waiting time for diagnostic appointments.

7.1.2 18 week pathways - Diagnostic appointments for patients on an 18 week pathways must been seen and reported in accordance with the patients clock.

7.1.3 There is a national maximum wait time for Diagnostics to be undertaken and reported on of six weeks the start time is taken from decision to undertake the diagnostic.

7.1.4 However the 18 week clock for the patient must be recognised as the time available to undertake the diagnostic may need to be shorter than 6 weeks.

7.1.5 Where treatment has not been given, subsequent appointments must be given with in the RTT breach date.

7.2 Diagnostic Referrals

7.2.1 All Access Policy rules apply equally to diagnostics.

7.3 Bowel Screening

7.3.1 The NHS Bowel Cancer Screening Programme has now been rolled out nationally and achieved nationwide coverage by 2009. Programme hubs operate a national call and recall system to send out faecal occult blood

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(FOB) test kits, analyse samples and despatch results. Each hub is responsible for coordinating the programme in their area and works with up to 20 local screening centres. The screening centres provide Endoscopy Services and specialist screening nurse clinics for people receiving an abnormal result. Screening centres are also responsible for referring those requiring treatment to their local hospital multidisciplinary team (MDT).

7.4 Arranging Diagnostic Appointments

7.4.1 For diagnostic appointments the patient must be offered a minimum of two appointment dates on different days, with a minimum three weeks' notice. For waiting list diagnostic procedure dates a 'reasonable offer' is considered to be a date with at least three weeks notice.

7.4.2 Rapid access patients may be offered an earlier appointment inside of the three week reasonable offer period. If a patient does not accept this date however you cannot count it as a reasonable offer for a reset of the clock on the diagnostic national maximum waiting time.

7.4.3 Should a patient be unable to accept a date within two weeks, at least one date with at least three weeks notice will be offered.

7.4.4 If patients are unable to be booked within the requisite timeframes they will be escalated to the relevant service manager for that diagnostic speciality.

7.4.5 Where a date and time cannot be agreed with the patient, they will be discharged back to the referring clinician, and the clinician must make a decision regarding rebooking.

8 Results reporting

8.1 Reporting of results must be made available in time to allow progress through all likely stages of the RTT pathway.

8.2 Patients on an 18 week pathway should be reported on promptly to allow for the patient to continue treatment within their 18 period. Penalties apply to patients not treated within 18 weeks

9 Management of Elective Admissions

9.1 Adding Patients to an Inpatient Waiting List

9.1.1 The decision to add patients to the waiting list must be made by the consultant or designate.

9.1.2 The patient must have accepted the clinician's advice on elective treatment prior to be added to the waiting list.

9.1.3 Add to waiting list forms must be completed at time of decision to admit and be signed by the consultant managing the patients care within two working days.

9.1.4 Additions to the waiting list on the Trusts PAS must be within two working days of receipt of a signed add to waiting list form.

9.1.5 Patients must not be added if:

They are unfit for procedure (unless short-term illness i.e. two weeks or less)

Further investigations are required first

Not ready for the surgical phase of treatment

9.2 Use of Planned Waiting List

9.2.1 Patients should only be included on planned waiting lists if there are clinical reasons why the patient cannot have the procedure or treatment until a specified time.

9.2.2 Patients added to a planned waiting list must be added with a indicative treatment date

9.2.3 Planned waiting lists should be used for patients that have regular surveillance or require specific treatment i.e. Endoscopy or removal of metal work following a previous operation

9.2.4 When patients on planned lists are clinically ready for their care to commence and reach the date for their planned appointment, they should either receive that appointment or be transferred to an active waiting list and a new RTT clock should start (and be reported in the relevant waiting time return).

9.3 Selecting Patients for Admission

9.3.1 Clinically urgent patients will be prioritised according to need.

9.3.2 All routine elective patients must be managed chronologically.

9.3.3 War Veterans and service personnel injured in conflict must receive priority treatment if the condition is directly attributable to injuries sustained in conflict.

9.4 Contacting Patients to Arrange a Date for Elective Admission

9.4.1 Patients will be contacted by telephone to arrange their admission date and this date confirmed in writing.

9.4.2 Patients that MFT have been unable to contact will be sent a contact letter and may be followed up with a further phone call.

9.4.3 Where patients cannot be contacted over a three week period this will be escalated to the treating consultant for clinical review. The patient may be discharged back to their GP.

9.5 Patients who chose to delay treatment

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From 1 October 2015, there is no provision to pause or suspend an RTT waiting time clock under any circumstances. Patients are entitled to wait longer for their treatment if they wish.

9.5.1   The same principles apply as outlined for reasonable offer.

9.5.2   Where a patient declines a second reasonable offer the patients request should be discussed with the patients consultant to confirm how long the patient can defer treatment without clinical review.

9.5.3   If the clinician is not satisfied that the proposed delay is appropriate then the clinical risks should be clearly communicated to the patient and a clinically appropriate TCI date agreed.

9.5.4   If the patient refuses to accept the advice of the clinician then the responsible clinician must act in the best interest of the patient. If the clinician feels that it is in the best clinical interest of the patient to discharge the patient back to the care of their GP and inform them that treatment is not progressing then this must be made clear to the patient. This must be a clinical decision, taking the healthcare needs of each individual patient into account.

9.5.5   Did Not Attend (DNA)

9.5.5.1   Patients (with the exception of paediatrics, urgent, 2WW and vulnerable adults) who do not attend their date for elective admission or pre-assessment appointment, may be discharged back to the referrer. This must be a clinical decision based on clinical review.

9.5.5.2   Clinically urgent patients can be offered one further admission date following discussion with clinician.

9.5.6   Hospital Cancellations on Day of Surgery

9.5.6.1   Following a "last minute cancellation" (on the day of surgery, day of admission or following admission), patients have a right to be offered a new date for treatment that is both within 28 calendar days of the cancellation and within their RTT breach date.

9.5.6.2   Where a patient cannot be re-booked with 28-days following a cancellation by the Trust, they will be entitled to choose if clinically appropriate to have their procedure in the private sector paid for by Medway NHS Foundation Trust.

10   Access Policy training and implementation

10.1   RTT training is available to all staff who manage or facilitate any part of an a patient's 18 week pathway, to ensure accurate & timely data collection, recording to enable the Trust to meet the waiting time standards and more importantly to ensure that patients are treated in a timely way.

10.2 Each year all relevant staff will undergo compulsory refresher elective access training. It is the responsibility of the Administration and Operational Managers to ensure all staff are fully compliant.

10.3 Any changes to the elective access policy will be communicated to all Trust staff through the Trust communication team and Directorate management teams.

10.4 The only authorised version of the policy will that made available on the Trusts online publication platform – Q-Pulse

11 EQUALITY IMPACT ASSESSMENT STATEMENT

11.1 All public bodies have a statutory duty under the Equality Act 2010. To have due regard to the elimination of discrimination, harassment, victimisation and any other conduct prohibited by the Act

11.2 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 is placed at a disadvantage over others. This document was found to be compliant with this philosophy.

11.3 Equality Impact Assessments will ensure discrimination does not occur also on the grounds of any of the protected characteristics covered by the Equality Act 2010.

11.4 Refer to appendix 3.

12 MONITORING & REVIEW

What will be monitored	Measure / Tool	How/Method/ Frequency	Lead	Reporting to	Deficiencies / gaps Recommendations and actions	Changes to practice and lessons learned
Policy		First review in one year and then every two years	Author	Policy and Procedures Committee	Review, amend and replace edition on intranet.	
18 week & 52 week PTL		Weekly	Service Team	General Manager	No Automation on Non admitted PTL/Tracker	
KHO7		Weekly				
QMO8		Weekly	Service Team			
Non QMO8		Weekly	Service Team			

What will be monitored	Measure / Tool	How/Method/ Frequency	Lead	Reporting to	Deficiencies / gaps Recommen dations and actions	Changes to practice and lessons learned
Diagnostic PTL		Weekly	Service Team			
Planned PTL		Weekly	Service Team			
92% data		Weekly				
		Monthly				

13   Overview of RTT Rules – Appendix 1

In England, under the NHS Constitution, patients 'have the right to access certain services commissioned by NHS bodies within maximum waiting times (126 days or 18 weeks), or for the NHS to take all reasonable steps to offer a range of suitable alternative providers if this is not possible'.

This right is a legal entitlement protected by law, and applies to the NHS in England. The maximum waiting times are described in the Handbook to the NHS Constitution.

In simple terms, a patients' 18 week 'clock' starts ticking on the day that the hospital (or referral management/triage centre) receives the referral letter (the original hospital in the case of tertiary referrals) or on the day that the patient converts their UBRN number via the NHS e-Referral Service and then the 'clock' stops ticking on the day that the patient is treated or for the non-treatment reasons as shown below.

13.1 Clock Starts

A waiting time clock starts when any care professional or service permitted by an English NHS commissioner to make such referrals, refers to:

a) a consultant led service, regardless of setting, with the intention that the patient will be assessed and, if appropriate, treated before responsibility is transferred back to the referring health professional or general practitioner;

b) an interface or referral management or assessment service, which may result in an onward referral to a consultant led service before responsibility is transferred back to the referring health professional or general practitioner.

c) a self-referral by a patient into a consultant led service for pre-agreed services agreed locally by commissioners and providers.

13.2   Subsequent Clock Starts

Upon completion of a consultant-led referral to treatment period, a new waiting time clock only starts:

a) When a patient becomes fit and ready for the second of a consultant-led bilateral procedure. A bilateral procedure is that which is performed on both sides of the body at matching anatomical sites.

b) Upon the decision to start a substantively new or different treatment that does not already form part of that patient's agreed care plan;

c) Upon a patient being re-referred in to a consultant-led; interface; or referral management or assessment service as a new referral;

d) When a decision to treat is made following a period of active monitoring;

e) When a patient rebooks their appointment following a first appointment DNA that stopped and nullified their earlier clock.

13.3   Clock Stops for Treatment

A Clock stops for treatment when:

a) First definitive treatment starts. This could be:

i) Treatment provided by an interface service;

ii) Treatment provided by a consultant-led service;

iii) Therapy or healthcare science intervention provided in secondary care or at an interface service, if this is what the consultant-led or interface service decides is the best way to manage the patient's disease, condition or injury and avoid further interventions;

b) A clinical decision is made and has been communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay, to add a patient to a transplant list.

13.4   Clock Stops for Non-Treatment

A Clock stops for 'non-treatment' when:

A waiting time clock stops when it is communicated to the patient, and subsequently their GP and/or other referring practitioner without undue delay that:

a) It is clinically appropriate to return the patient to primary care for any non-consultant-led treatment in primary care;

b) A clinical decision is made to start a period of active monitoring;

c) A patient declines treatment having been offered it;

d) A clinical decision is made not to treat;

e) A patient DNAs (does not attend) their first appointment following the initial referral that started their waiting time clock, provided that the Trust can demonstrate that the appointment was clearly communicated to the patient. The patients RTT clock should then be nullified (i.e. removed from the numerator and denominator for RTT measurement purposes).

f) A patient DNAs any other appointment and is subsequently discharged back to the care of their GP, provided that:

i) The Trust can demonstrate that the appointment was clearly communicated to the patient.

ii) Discharging the patient is not contrary to their best clinical interests.

From 1st October 2015, there is no provision to 'pause' or 'suspend' an RTT waiting time clock under any circumstances. All clocks will continue to tick unless there is a reason to stop the clock for treatment or non-treatment as above.

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14   National Standards - Appendix 2

The table below details the national elective care standards with effect from 1 October 2016

Referral to Treatment – 18 weeks	
Incomplete Pathways	92% of patients on an incomplete non-emergency pathway (i.e. still waiting for treatment) to be waiting no more than 18 weeks (126 days)
Diagnostics	
Diagnostic Investigations	99% of patients to undergo the relevant diagnostic investigation within 6 weeks from the date of decision to refer to appointment date
Cancer (Patients on a Cancer Pathway are managed according to the Trusts Cancer Waiting Times SOP	
Two Week Waits	93% of patients to be seen within two weeks of an urgent GP referral for suspected Cancer 93% of patients with breast symptoms to be seen within two weeks of a GP referral
Decision to Treat to Treatment (31 day)	96% of patients to receive their first definitive treatment for cancer within 31 days of the decision to treat 94% of patients to receive a subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second or subsequent treatment, where that treatment is surgery, or a course of radiotherapy 98% of patients to receive subsequent treatment for cancer within 31 days of the decision to treat/earliest clinically appropriate date to start a second of subsequent treatment where that treatment is an anti-cancer drug regime. - Maximum wait of 31 days from urgent GP referral to first treatment for childrens cancer, testicular cancer and acute leukaemia – monitoring as part of the 62 day wait for first treatment.
Referral to Treatment (62 Day)	85% of patients to receive their first definitive treatment for cancer within 62 days of an urgent GP referral for suspected Cancer. 90% of patients to receive their first definitive treatment for cancer within 62 days of referral from an NHS Cancer Screening Service (breast, bowel, cervical) - Maximum wait of 62 days for patients to receive their first

| | definitive treatment for cancer where their consultant has upgraded their referral to urgent |
| | Patients will also be monitored against the 18 week standard |

14.1   Clinical exceptions
All of the standards within the table above are set at less than 100% to allow for tolerances which apply in the following scenarios:

a) Clinical Exceptions – applicable to RTT pathways where it is in the patients best clinical interest to extend treatment beyond 18 weeks.
b) Choice – applicable where patients chose to extend their pathways by rescheduling previously agreed appointments or admission offers
c) Co-operation – applicable where patients do not attend previously agreed appointments or admission dates and clinicians deem it is appropriate to retain clinical responsibility for the patient; e.g. the patient will be complying with a prescribed sequence of treatments.

15	**Equality Impact Assessment Statement & Tool – Appendix 3**		
		Yes/No	Comments
1	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	▪ 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?		
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?		

All public bodies have a statutory duty under the Equality Act 2010. To have due regard to the elimination of discrimination, harassment, victimisation and any other conduct prohibited by the Act
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 is placed at a disadvantage over others. This document was found to be compliant with this philosophy.

Equality Impact Assessments will ensure discrimination does not occur also on the grounds of any of the protected characteristics covered by the Equality Act 2010.
END OF DOCUMENT

16

Report to the Board of Directors

Board Date: 27 October 2016

Title of Report	Corporate Policy: Fire Safety
Presented by	Darren Cattell
Lead Director	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 • 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 Fire 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 for Fire Safety.
Purpose & Actions required by the Board :	Approval ✓ Assurance ☐ Discussion ☐ Noting ☐

Fire Safety Policy

Author:	Fire Safety Advisor - Harry W Scott
Document Owner:	Director of Estates & Facilities – Claire Lowe
Revision No:	5
Document ID Number	POLCS024
Approved By:	
Implementation Date:	2016
Date of Next Review:	2017

Document Control / History	
Revision No	**Reason for change**
3	Reviewed and updated into new format
4	Reviewed and updated
5	Reviewed and updated in accordance with requirements imposed upon the Trust by the Kent Fire & Rescue Service; changes in Fire Safety Law; changes in technical requirements.

Consultation
Fire, Health and Safety Group
Executive Group

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Fire Safety Policy

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

1	Policy Statement / Purpose

1.1 The Trust will ensure, as far as reasonably practicable, that the risk from fire will be managed in compliance with relevant legislation and guidance.

1.2 The Chief Executive, Board, Directors and Heads of Service accept on behalf of the Trust, as the Body Corporate, the responsibility to ensure the safety of staff, visitors, patients and any other persons present on the premises in the event of fire and to that end will ensure that the following policy is implemented and adhered to the best of their ability, at all material times.

2	Introduction

2.1 Fire is a potential hazard in any premise; however hospitals, clinics, health centres, and nursing homes also incorporate high life risks and high fire risk areas.

2.2 Medway NHS Foundation Trust Managers must become familiar with their duties and responsibilities and ensure that the fire management policies and protocols comply fully with both the requirements of law and NHS Firecode Documents.

2.3 Fire Safety within Medway NHS Foundation Trust premises can be broken down into two distinct factors, human and physical.

2.4 **Human factors are much influenced by:**

2.4.1 Having effective local management and organisation;

2.4.2 The implementation of appropriate fire safety policies, and local fire evacuation plans and procedures;

2.4.3 The programmes of training and refresher training as appropriate to role and responsibility and being provided at a frequency adequate to meet statutory requirements.

2.5 **Physical factors involve:**

2.5.1 careful building design, construction and ongoing maintenance conforming with approved regulations and Codes;

2.5.2 the regular maintenance and testing of all fire safety installations, including lighting, water supplies and distribution, electrical distribution and emergency supplies including generators and UPS systems;

2.5.3 selection of the appropriate automatic fire alarms and detection systems with proper installation and lifetime maintenance;

2.5.4 a suitable choice of fire fighting equipment with proper installation and lifetime maintenance;

2.5.5   provision and upkeep of fire retardant furnishings, textiles, fixtures and fittings;

2.5.6   a review of fire precautions following alterations in use, layout, or construction.

3   (Duties) Roles & Responsibilities

3.1   Medway NHS Foundation Trust

3.1.1   The Trust Board has overall accountability for the activities of the organisation. The board should ensure they have appropriate assurance that the requirements of current legislation are met and, where appropriate, that the objectives of Firecode are met.

3.2   The Chief Executive

3.2.1   The Chief Executive is responsible for ensuring that current fire legislation is met and that, where appropriate, Firecode guidance is implemented in all premises owned or occupied by the Trust. The Chief Executive is required to have appropriate fire safety policies and programmes of work in place in order to improve and maintain fire precautions within the organisation's premises.

3.2.2   The Chief Executive shall delegate a Board level Director who is responsible for championing fire safety issues at board level; this to include proposing programmes of work relating to fire safety for consideration as part of the Annual Business Plan. The **Director of Finance** has been delegated with this responsibility.

3.2.3   **The Director of Estates and Facilities** is designated as the 'Fire Safety Manager' in accordance with the Department of Health, Firecode 05–01 'Managing healthcare fire safety', and 05-03-Operational Provisions

3.2.4   The Director of Estates and Facilities shall appoint the Specialist Fire Safety Adviser, and other fire safety specialist staff as to ensure the Trust meets its statutory obligations in the most effective manner.

3.3   The Fire Safety Manager

3.3.1   The Fire Safety Manager must be sufficiently empowered and have access to adequate resources to enable them to perform their duties effectively.

3.3.2   It will be necessary for the Fire Safety Manager to have a number of staff as deputies to act as Fire Controllers, to ensure that there is always a key decision-maker available when Trust premises are occupied.

3.3.3 The Fire Safety Manager has responsibilities including but not limited to the following:

- an awareness of all fire safety features and their purpose;

- fire safety risks particular to the organisation;

- requirements for disabled staff and patients (related to fire procedures);

- ensuring appropriate levels of management are always available to ensure decisions can be made regardless of the time of day;

- compliance with legislation;

- development and implementation of the organisation's fire safety policy;

- development and implementation of the organisation's fire safety strategy;

- development of an effective training programme;

- cooperation between other employers where two or more share the premises;

- the reporting of fire incidents in accordance with current practice;

- monitoring and mitigation of unwanted fire incidents;

- liaison with enforcing authorities;

- liaison with other managers;

- monitoring of inspection and maintenance of fire safety systems;

- arrange and organise Fire Drills

3.3.4 Supervising the effective day to day upkeep of the fire safety policy

3.3.5 Ensuring that site fire plans are in place and available for the emergency services upon their arrival.

3.3.6 Ensuring that in conjunction with department directors and heads of service that all staff are provided with the time to participate in the mandatory fire safety training and that they practice fire evacuation procedures and that a record of their undertaking of such is maintained for audit purposes. This should also take account of Bank, Temporary, contractors' staff and volunteers.

3.3.7 Ensuring that sufficient Deputy Fire Safety Managers are in place and properly trained and that at least one appointed deputy is always available to assume the relevant duties in the absence of the Fire Safety Manager.

3.3.8 Ensuring that a suitable and sufficient Fire Response Team is in place and that its members are appropriately trained. This to include site managers, porters, maintenance staff and assigned evacuation officers for admin

buildings or areas within the main Hospital such as Pathology, Pharmacy, Physiotherapy where staff and visitors leave the premise.

3.3.9 Ensuring that departmental Fire Wardens are appointed and properly trained to undertake the weekly checks of their work areas, and alongside local management to act as departmental evacuation officers in an emergency situation.

3.3.10 Ensuring that suitable departmental evacuation plans are in place and tested as to their efficacy.

3.3.11 Attending all Fire incidents where patients are being evacuated or the fire risk to the Hospital is of sufficient severity or duration as to warrant their attendance.

3.3.12 Attending major fire evacuation exercises.

3.3.13 The co-ordination and direction of staff actions during a fire in accordance with the emergency plan and in a position to be able to take command until the Fire Brigade arrives and to act as a focus for liaison purposes thereafter.

3.3.14 Ensuring that fire reports are completed and to inform the Chief Executive Officer of their contents and arrange for them to be acted upon in accordance with the fire reporting procedures.

3.3.15 Ensuring that the fire safety risk assessments are both carried out and reviewed as necessary for each assessable area.

6.2 **The Deputy Fire Safety Manager**

6.2.1 The Deputy Fire Safety Manager shall be responsible to the Fire Safety Manager. These persons should be of sufficient seniority and proficiency to enable them to carry out the whole range of their duties effectively and take command in emergencies and would generally be Service Directors or Heads of Department.

3.4 **Fire Controller**

3.4.1 All Fire Controllers are responsible to the Fire Safety Manager. He/she should have sufficient training as to be responsible for the following:

- the co-ordination and direction of all staff actions in the event of a fire;

- Informing the Fire Safety Manager of any serious incident;

- keeping the location of any serious incident protected until investigated by the Senior Fire Safety Adviser, Kent Fire and Rescue Service, or Kent Police;

- arranging after an incident to make good any damage, unless the area is under investigation;

- Submitting Incident reports of all fire incidents

3.4.2 The prime concern of the site manager is the safety of staff and the patients and in particular emphasis on those higher risk areas where patients and staff do not immediately evacuate the Hospital in an emergency.

3.4.3 To act as liaison to the attending Senior Fire Authority Officer on risk, and the Trust requirements for patient care and protection, and as necessary their movement to further places of safety.

6.2.2 All designated Fire Controllers, including Service Managers, should ensure that they attend an initial training course for Fire Safety Managers and a refresher course every three years; they should also keep their annual attendance at fire lectures up to date between these times.

3.5 Senior Fire Safety Adviser

3.5.1 The Senior Fire Safety Adviser's role is to provide technical expertise to the Fire Safety Manager to enable them to fulfil their duties effectively. The Senior Fire Safety Adviser should be responsible for the following:

- providing expert advice on the application and interpretation of fire legislation and fire safety guidance, including Firecode;

- advising on the content of the organisation's fire safety policy;

- assisting with the development of the organisation's fire strategy;

- helping with the development of a suitable training programme;

- liaising with enforcing authorities on technical issues;

- liaising with managers and staff on fire safety issues;

- liaising with the Authorising Engineer (Fire);

- managing the Hospital Heliport and Fire Fighters

- undertaking fire risks assessments and providing training as necessary for all staff

- assisting in the development and implementation of location specific fire evacuation procedures

3.6 Fire Safety Adviser

3.6.1 The Fire Safety Adviser is responsible to the Senior Fire Safety Adviser and should be responsible for the following:

- assisting the Senior Fire Safety Adviser in all fire related duties;

- assisting with the development of the organisation's fire strategy;

- assisting with the development of a suitable training programme;

- presenting role specific training for all staff who are involved in the fire safety management of the site during a fire incident

- assisting in the development and implementation of location specific fire evacuation procedures assist in preparing and participating in annual fire drills

- assisting in the management of the Hospital Heliport and training of the Fire Fighters

- Undertaking fire risks assessments and providing training as necessary for all staff

3.7 Authorising Engineer (Fire)

3.7.1 The Trust is not required to appoint an Authorising Engineer (Fire) in a permanent capacity. It is recommended that a fire engineer be engaged if a specific fire-engineered solution has been identified or is proposed, and the in-house resources indicate they have insufficient knowledge of the proposed engineered solution.

3.7.2 Fire engineering is the application of scientific and engineering principles, codes and expert judgement, based on an understanding of the phenomena and effects of fire, and the reaction and behaviour of people to fire; it is not normally within the remit of risk and training specialists who provide that service within the NHS.

3.8 Managers / Heads of Departments

3.8.1 All Managers/Heads of Departments are responsible for:

- assisting the Fire Safety Manager in the development and implementation of the organisation's Fire Safety Policy;

- assisting the Fire Safety Manager in the development and implementation of the organisation's Fire Safety Strategy;

- developing local fire evacuation plans and procedures detailing the action to be taken on discovering a fire, or hearing the fire alarm, and agreeing them with the senior fire safety adviser;

- ensuring provision is made for all their staff to participate in Fire Safety Training according to their role and responsibility at a period agreed with the senior fire safety adviser,

- organising fire drills at a period agreed with the senior fire safety adviser,

- maintaining local training records of all staff,

- ensuring that the senior fire adviser is consulted on all fire safety issues relating to any change of activity, use or occupancy of their work areas.

- maintaining the fire log book containing details of local training, local fire procedures, local risks, local fire drawings, names of responsible

persons at local level, including fire wardens, coordinators, fire advisers, their contact number and any other relevant information regarding staff and patient safety(see appendix 5)

3.9   **All Staff**

3.9.1   All staff are responsible for:

- ensure that they attend fire safety training on a regular basis as outlined within mandatory training requirements

- are aware of the fire procedures and evacuation plans specific to their work locations

- as is necessary ensuring that the fire safety standards are maintained in their work location.

- That if they as an individual require assistance in any way, either permanently or on a temporary basis, to evacuate their work location during an emergency that they alert their line manager, Health & Safety Officer and Fire Safety Adviser so that an effective (Personal Emergency Evacuation Plan can be put into place.

4   All Medway NHS Trust Premises - Basic Principles of the Physical Fire Precautions

4.1   **The basic principles of the physical fire precautions are that**:

4.1.1   a safe means of escape in case of fire is to be maintained at all times

4.1.2   the fire is extinguished as quickly as possible

4.1.3   the development and spread of any fire is delayed and contained as long as possible by structural and other means;

4.1.4   endangered areas are evacuated quickly to a pre-arranged and rehearsed procedure

4.1.5   these principles have fundamental implications for the design of buildings, their mechanical and electrical systems, and for equipment within them, including furniture, textiles, fixtures and fittings

4.1.6   any fires that may occur are rapidly detected, an alarm is given and the Fire and Rescue Service is called immediately

4.2   **Plans of Premises**

4.2.1   Detailed plans and drawings are to be provided for all premises and / or departments showing the fire risk assessment arrangements indicating escape routes, fire compartmentation and other fire-resistant construction. The respective plans should be held in all premises and / or departments within a location Fire Log Book, to comply with Regulatory Reform (Fire Safety) Order 2005, and Firecode Documents

4.2.2   The Fire Safety Manager will be responsible to ensure that all active fire precaution measures shall be prepared and maintained for all sites owned or used by the Medway NHS Trust

4.2.3   The Head of Estates will be responsible for the maintenance of these site plans, copies of the Medway Maritime site will be kept in the Security Base adjacent to the main entrance doors. The Kent Fire & Rescue Service will also require site plan/information, to be kept on local fire appliances

4.3   New Premises or Alterations to Existing Premises

4.3.1   The Head of Estates will ensure that:

- new buildings or alterations to existing buildings comply with current Building Regulations, Regulatory reform (Fire Safety) Order 2005 and Firecode

- all plans for building or alteration will be submitted to the Senior Fire Safety Adviser for comment and certification that they conform to current regulations. All approved schemes will be signed and returned before any works are undertaken

4.4   Furniture and Fittings

4.4.1   It is a requirement that the contents of premises comprising of furniture, textiles, fixtures and fittings, including mechanical and electrical equipment, receive careful consideration and selection. Flame retardant products should be purchased in accordance with HTM05-03 part C all parts as necessary any guidance should be sought from the Senior Fire Safety Adviser

4.5   Fire Fighting Equipment

4.5.1   The Fire Safety Manager, with advice from The Senior Fire Safety Adviser will ensure that the correct type and number of fire extinguishers and other fire fighting equipment are available in all premises as per the guidance of BS5306 & BS9999. The Estates Maintenance Department will manage a contract of service with an approved contractor who will service any spent extinguishers and will ensure that there is in place an annual maintenance programme

4.6   Emergency Lighting Equipment

4.7   The Fire Safety Manager with advice from the Senior Fire Safety Adviser, will ensure that an adequate level of emergency lighting is provided in all premises according to the use, occupancy and risk involved; this in accordance with BS5266 guidance. The Estates Maintenance Department will ensure continuing service and maintenance of all units as required and will ensure that there is in place a programme of replacement of defective units accordingly.

5 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Author	Director of Estates and facilities, Fire, Health & Safety Group	
Provide a review of compliance of fire safety standards for submission to the Board	Annually	The Fire Safety Manager	CE & Board	
Provide an annual report on the Trust's fire safety performance	Annually	The Director of Estates and Facilities	CE & Board	
All Fire Training	All fire safety training will be monitored and recorded by the Education and Learning Department	Education and Learning Manager	Fire, Health & Safety Group	Reported to the Board Director responsible for Fire safety
Risk Assessments	Completed by The Senior Fire Safety Adviser or deputy	The Senior Fire Safety Adviser	Director of Estates and facilities	Reported to the Board Director responsible for Fire safety, CEO & Board
Fire Evacuation Exercises	Undertaken by the Fire Safety Advisers, Heads of Departments, local management	Heads of Service, Senior Fire Safety Adviser	Board Director responsible for Fire Safety	Reported to the Board Director responsible for Fire safety, the CEO & Board

6   Training and Implementation

6.1   Fire safety training appropriate to role and responsibility is essential for all staff and is a legal requirement under the Health and Safety at Work Act 1974, the Management of **Health** and Safety at Work Regulations 1999 and the Regulatory Reform (Fire Safety) Order 2005 and with the Firecode suite of documents

6.2   Staff must have an understanding of fire risks and know what to do in the event of alarm activation or fire so that fire procedures can be applied effectively. It is therefore imperative that the **Trust** provide appropriate levels of fire safety training. This applies to all staff without exception. Senior management and senior medical staff should lead by example

6.3   **Initial Fire Training**

   6.3.1   On their first day of work every new member of staff, including voluntary and agency workers, should be given fire safety instructions relating to their own workplace, and signing to confirm that they have received this training, by one of the following: -

- Head of Department
- Ward Manager
- Line Manager
- Local Fire Coordinator

They should be made aware of the following

- location of Fire Action notices
- fire alarm system, the different sounds and what they mean,
- the fire procedures relevant to their work location(s), including places of safety

   during any evacuation

- any responsibilities towards patient or visitor evacuation
- control and management of piped and bottled gases, chemicals and other risks within their location
- location of fire alarm call points and how to operate
- fire exit routes
- firefighting equipment
- fire assembly points
- emergency telephone numbers

6.4   **Induction Fire Safety Training**

6.4.1 Every new member of staff, including voluntary and agency workers, shall attend the Trust Induction Program, within the first month of employment. This will be in accordance with HTM, RRO & H&S standards as to provision of information, instruction and training:

- basic fire safety

- actions to be taken in the event of a fire or on hearing the fire alarm (see appendix 1 & appendix 2)

- good housekeeping

- fire hazards

- practical use of fire equipment

- evacuation procedures

- specialist roles (fire controller, switchboard, estates, security and porters)

6.5 Refresher Fire Training

6.5.1 Managers are responsible for ensuring that their staff are scheduled to attend fire safety lectures / training at a frequency of not less than annually and not more than every two years, and that the training is relevant to location, role and responsibility

6.5.2 All patient facing staff are required to attend face to face training not less than once in each 12 month period. Those staff working within high dependency patient care locations additionally to participate in practical or desktop evacuation training at least once in each 12 month period, all other staff should participate in exercises every 24 months.

6.6 E-Learning

6.6.1 Currently computer-based training is not available on the Trust intranet site; when installed it should mirror the Trust fire safety practice and procedures and only be used when a member of staff is unable to attend a regular training session delivered by the Fire Safety Adviser. Once accepted the e-learning module can be used once within any two year training cycle and should not be used in isolation for induction or any other form of training as outlined in the HTM 05-03 Document – Operational Provisions.

6.7 Fire Drills

6.7.1 The effectiveness of plans for dealing with a fire outbreak and of various aspects of the fire safety training should be tested by practical fire drills, both during the day and at night. It is advised that evacuation exercises take place within each 24 month period in each department / premises. A fire drill will not be carried out in a department where it could cause distress or harm to patients, however desktop exercises within these and high dependency locations shall take place as to ensure all staff participate once in each 12 month period; Fire drills will be organised by local management and the Fire

Safety Manager, and Fire Safety Advisers, in consultation with Matrons and other Clinical staff as necessary and with the assistance of the estates department in regard to alarm management.

6.8 Informal Visits

6.8.1 The Senior Fire Safety Adviser or their deputy will carry out visits to Wards and Departments, to discuss fire safety procedures with staff. Special attention will be given to high-risk areas, e.g., intensive/critical care areas, long stay patients, kitchen, laboratories and staff residential areas. These visits will take place at any time day or night and may not be prearranged

6.9 Recording of Fire Training

6.9.1 Each Head of Department, Ward Manager or Line Manager, together with HR are responsible for the accurate recording of staff attendance at all fire safety training, including staff who are based in other premises.

6.10 Staff Working in other NHS premises

6.10.1 Medway NHS Foundation Trust employees working on sites or premises, which do not belong to the Trust must be instructed by the approved local fire safety instructor and made aware of the local fire safety arrangements for the premises.

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:	
The Regulatory Reform (Fire Safety) Order 2005 Firecode 05 Documents – Fire Safety in the NHS The Health and Safety (Safety Signs and Signals) Regulations 1996 & BS5499 BS9999 BS5839, BS5266 BS8214 HBN15-03 Disability Discrimination Act 1995 Local Building Acts and Building Regulations Approved Document B.(all parts) CDM Regulations 2007 (and amendments) The Health and Safety at Work Act 1974 The Management of Health and Safety at Work Regulations 1999 The Workplace (Health, Safety & Welfare) Regulations 1992 The Dangerous Substances & Explosive Atmospheres Regulations The Housing Act 1985 Houses of Multiple Occupation Regulations 1990 The Petroleum Consolidation Act 1928 The Highly Flammable Liquid Regulations 1972 Local Government (Miscellaneous Provisions) Act 1992	
Trust Associated Documents:	
Fire Safety Strategy	STRCS001
Fire Safety - Completing of Fire Log Book	GUCS005
Fire Safety - Constructing your Fire Evacuation Plan	GUCS006
Fire Safety - Site Fire Management Procedure	SOP0144
Fire Safety - Fire Action Notices	OTCS058
Fire Safety - Fire Log Book	OTCS059

END OF DOCUMENT

Report to the Board of Directors

Board Date : 27th October 2016

Title of Report	Procurement Transformation Plan
Presented by	Dan Small
Lead Director	Darren Cattell
Committees or Groups who have considered this report	Execs – 19th October 2016
Executive Summary	The purpose of this report is : In July 2016, NHSI wrote to all Trusts asking them to develop a Procurement Transformation Plan (PTP) to transform their procurement services in order to achieve Trust's Carter procurement recommendations and targets. They requested that the PTP be approved by the Board and submitted to NHSI by the end of October 2016. MFT's procurement transformation plan is attached and the key points are: • PTP focuses on People, Systems, Policies and Procedures and Partnerships within the Trusts Procurement Department <u>and</u> where relevant, its regional partners • Metrics shown on page 3 have been set by NHSI and are the metrics required for reporting within the Carter review. • Progress against the PTP and the metrics will be reviewed regularly by NHSI at performance meetings with the Trust • The department is currently in year 2 of a 5 year procurement strategy that was implemented in August 2014 focusing on cost improvement, becoming the best and organisational development for procurement. • The PTP enhances this strategy and aims to future proof the department to meet the needs of an ever changing internal and external environment • The PTP's of our regional partners will include the same collaborative actions and targets. <u>People</u> • Restructuring of the Procurement function to offer flexible approach to workload and enable the department to give Directorate focal points whilst retaining category management principles

	- Standardisation of job descriptions across the region - Training and upskilling of procurement staff to offset difficulties in recruiting procurement professionals across the region. 50% of procurement staff to be qualified or working towards the professional procurement qualification by October 2018 - Procurement training to be provided to wider organisation to promote the correct procurement process and timescales. Provided through the Trusts bitesize training program by February 2017 - Procurement communications to further promote the department and work we do. Systems, Policies and Procedures - There is a requirement for the department to be score 1 against the NHS standards of procurement by September 2017 - The department currently scores 0.69 and the PTP sets out a plan to achieve a self-assessed score of 1 by March 2017, with a peer review by June 2017 - An inventory management system will be fully implemented within the 18-24 months giving the Trust greater control over stock holdings and stock turns and reducing wastage. - A procurement manual will be created detailing the correct procurement processes, procedures and policies. This will support the Trusts SFI's. - Agreed procurement KPI's to be presented at Board Collaboration - Collaborate, share workplans and prioritise activity within the region - Expect 50% of spend to be through collaborative arrangements by December 2017 - Support STP principles and recommendations including a centralised regional Procurement function if agreed - Regionally manage the market and hold joint supplier events
Resource Implications	The plan highlights a restructure in the Procurement Department but due to vacancies the WTE will stay at 23.92. The new Procurement structure has been agreed with the DOF
Risk and Assurance	Collaboration of partners proceeds at a different pace to MFT expectation. This will be mitigated through STP governance and programme management.
Legal Implications/Regulatory Requirements	NHSI require a Board approved PTP to be submitted to them by the end of October 2016.

Recovery Plan Implication	The plan will assist in the delivery of the Carter Metrics and as such will assist in the Recovery Plan
Quality Impact Assessment	Nil at this stage of development
Recommendation	It is recommended that 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 Trusts Carter recommendations and targets
Purpose & Actions required by the Board :	Approval [x] Assurance [ ] Discussion [ ] Noting [ ]

Procurement Transformation Plan (PTP) for Medway NHS Foundation Trust

1. Executive Summary

The role of the Procurement Function within an NHS organisation is fundamentally changing. The Department is becoming more visible within MFT and is being seen as key enabler to delivering the recommendations within Lord Carters report and operational efficiency and financial performance improvement.

The department is at the forefront of the Corporate Services review (back office) under the STP footprint.

The department is a customer focused service delivery department and part of this role will be communicating regularly with the wider organisation. There will be a Procurement Representative at all relevant Directorate meetings who is able to update the senior management team.

The department are developing a communication strategy enabling communications to the wider organisation bi-directionally.

Strategy

The current Procurement structure and strategy within Medway NHS Foundation Trust was implemented in August 2014.The strategy covers a period of 5 years and focuses on 3 areas: cost improvement, organisation and becoming the best.

Cost Improvement
- Strategic CIP Savings Plan 3-5 years
- Relationship Management
- Spend Analysis
- Opportunity Assessment

Becoming the Best
- Process re-engineering
- Use of Technology
- Transparency
- Total Spend Influence
- Compliance
- Performance Monitoring
- Contract Management
- Use of partners

Organisation
- Structure
- Training / Development
- Procedures
- Policies

Procurement Transformation Plan (PTP) for Medway NHS Foundation Trust

The department is currently split into strategic and operational core areas. The strategic team is made up of the Equipment and Services team and the Medical Consumables team and is responsible for large scale (spend >£30k) planned sourcing activity .The operational area is made up of the Systems and Services team and the Materials Team. The Systems and Services team are responsible for all aspects of transactional procurement and the management and maintenance of all procurement related technology. The Materials team are responsible for the operational aspects of Procurement including receipt, distribution and inventory management throughout the Trust.

The procurement department's future strategy follows four key deliverables:

- To support the Trust in the Delivery of all Carter metrics
- To support the Trust in its delivery against the Procurement Transformation Plan (PTP)
- To support the directorates in their management of non-pay
- To support The Trust, Regional and National policies with regards to the Future Operating Model and the STP requirements.

Procurement Transformation Plan (PTP) for Medway NHS Foundation Trust

2. Procurement Targets against Carter (RAG rating against Carter targets[1])

	MEASURES	PERFORMANCE			COMMENTARY
		CURRENT MONTH 16	TARGET 2017	TARGET 2018	
1	Monthly cost of clinical and general supplies per 'WAU'	£	£	£	Waiting updated information from Model Hospital website
2	Total % purchase order lines through a catalogue (target 80%)	60%	90%	98%	
3a	Total % of expenditure through an electronic purchase order (target 80%) up to and including PO issue	80%	90%	98%	
3b	Total % of transactions through an electronic purchase order (target 80%) up to and including PO issue	93%	95%	98%	
3c	Total % of expenditure through an electronic purchase order (target 80%) from requisition through to and including payment	0%	%	%	The target for September 17 and 18 can be set once the evaluation of NHS SBS's solution is complete
3d	Total % of transactions through an electronic purchase order (target 80%) from requisition through to and including payment	0%	%	%	The target for September 17 and 18 can be set once the evaluation of NHS SBS's solution is complete
4	% of spend on a contract (target 90%)	78%	90%	98%	Agency Suppliers to be added to contract/catalogue as well as utilising the Future operating model.
5a	Inventory Stock Turns-static	4.01 Days	3.0 Days	1.5 Days	
5b	Inventory Stock Turns-dynamic	N/A	N/A	N/A	Do not have a dynamic stock system
6	NHS Standards Self-Assessment Score (average total score out of max 3)	0.69	1.34	2.48	Target date for level 1 completion – March 2017
7	Purchase Price Benchmarking Tool Performance	TBC	TBC	TBC	NHSI Advised to be provided once the index is in operation

[1] RAG Rating Definitions:
Green = better than the Lord Carter or Trust target
Amber = Up to 10% less than Carter target
Red = More than 10% below Carter target

Best of care
Best of people

Procurement Transformation Plan (PTP) for Medway NHS Foundation Trust

3. Procurement Targets against Procurement Transformation Plan (PTP)

Procurement Strand	Procurement Objective	Action	Timescale
People and Organisation	Meeting the Trusts current and future needs	Restructure Department and create Strategic Services team	December 2016
People and Organisation	Meeting the Trusts current and future needs	Adopt Directorate accountability and Category Management	January 2017
People and Organisation	Meeting the Trusts current and future needs	Review Job Descriptions and standardise across the region	January 2017
People and Organisation	Workforce Development	Develop individual Training plans and identify courses to assist in personal and professional development. (MCIPS, PSD, Apprenticeships, etc)	January 2017
People and Organisation	Workforce Development	50% of Procurement Staff to be qualified or working towards MCIPs	October 2018
People and Organisation	Workforce Development	All members of Procurement team to have at least 2 pieces of training per year relevant to the current role or future development	October 2017 and then yearly thereafter.
People and Organisation	Communication Strategy	Develop Regular communications from the Procurement function to the wider Organisation	Commence January 2017
People and Organisation	Provide Training to wider organisation	Develop "understanding the Procurement and Tendering Process" for the Trusts bitesize training Program	Feb 2017
Processes, Policies and Systems	Meet level 1 of NHS Procurement Standards	Complete outstanding actions and Arrange Peer review for	March 2017

Procurement Transformation Plan (PTP) for Medway NHS Foundation Trust

		assessment	
Processes, Policies and Systems	Reporting of Procurement Metrics at Board Level	Agree scope and frequency of presentation of Procurement KPI's to Trust Board	November 2016
Processes, Policies and Systems	Reporting of Directorate KPI's	Create directorate level operational KPI's	January 2017
Processes, Policies and Systems	Inventory Management	Source and Implement an Inventory Management System	Full implementation by October 2018
Processes, Policies and Systems	Processes and Procedures	Create the Procurement manual which will encompass all relevant Procurement SFI, Policy and Procedure information	February 2017
Partnership	Collaborative Procurement	Share work plans and agree priorities and category teams and leaders	April 2017
Partnership	Collaborative Spend Management	50% of expenditure on goods and services to be channelled through collaborative arrangements	Dec 2017
Partnership	Collaborative Spend Management	60% of expenditure on goods and services to be channelled through collaborative arrangements	April 2019
Partnership	Collaborative Market Management	2 regional supplier events held per year	Started September 2016

Best of care
Best of people

4. Risks and issues

Key risks identified are:

| Risk	Mitigation
Staffing and recruitment	Develop a department recruitment and retention policy in line with the Trusts Policy
Availability of Investment	Develop robust business cases for investment which clearly show the benefits of any investment required
Culture of the team	Promotion of the team to the wider organisation and share successes to show the value of the department

Procurement Transformation Plan (PTP) for Medway NHS Foundation Trust

## People & Organisation

Procurement Organisation

To be able to manage resource and workforce effectively the Strategic team and the Systems and Services team will merge to form The Strategic Services team. This change will mean adding a Senior Buyer into the team and the move away from transactional procurement by adding more line items to the catalogue will allow additional Procurement support through the Buyer/Trainers and the Assistant Buyer.

By making the organisational change the strategic element of the strategic services team will adopt a directorate support and category management structure (as demonstrated in the diagram below). This will give the directorates a single point of contact within the Department and allow category management to take place across the Trust and the Region delivering value for money through aggregated demand. Category Management will be linked to the supply Towers of the future operating model once they are known.
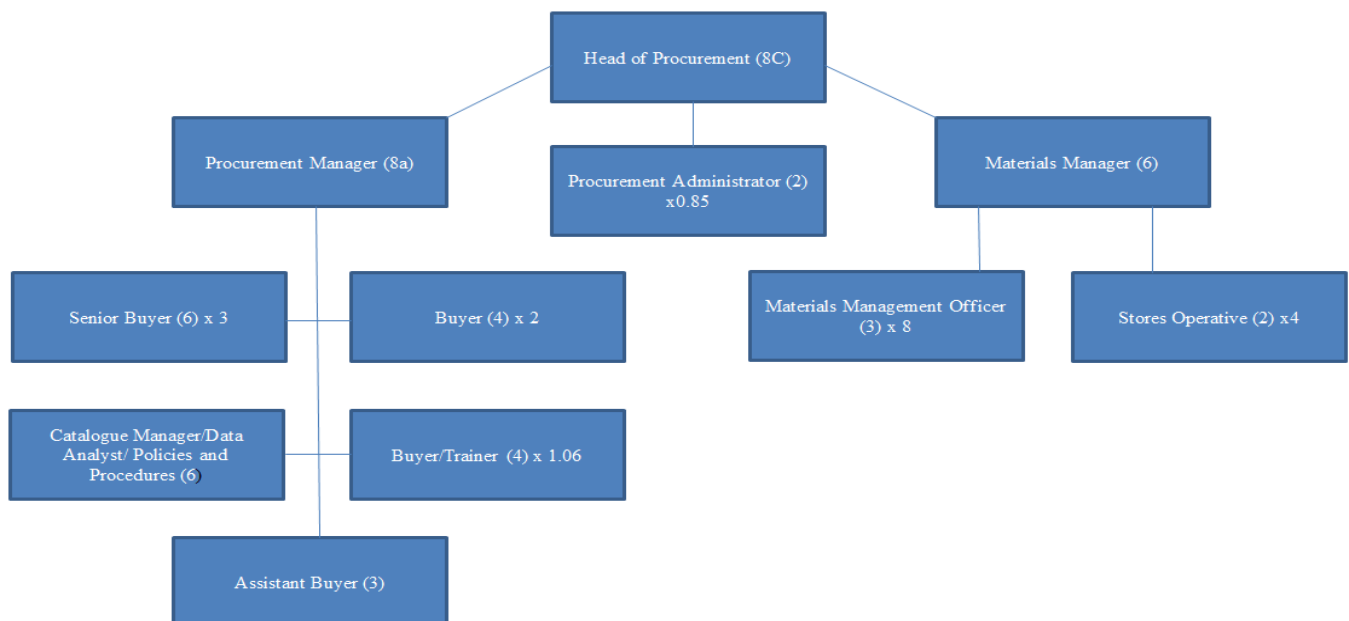
Revised procurement structure

Procurement Transformation Plan (PTP) for Medway NHS Foundation Trust
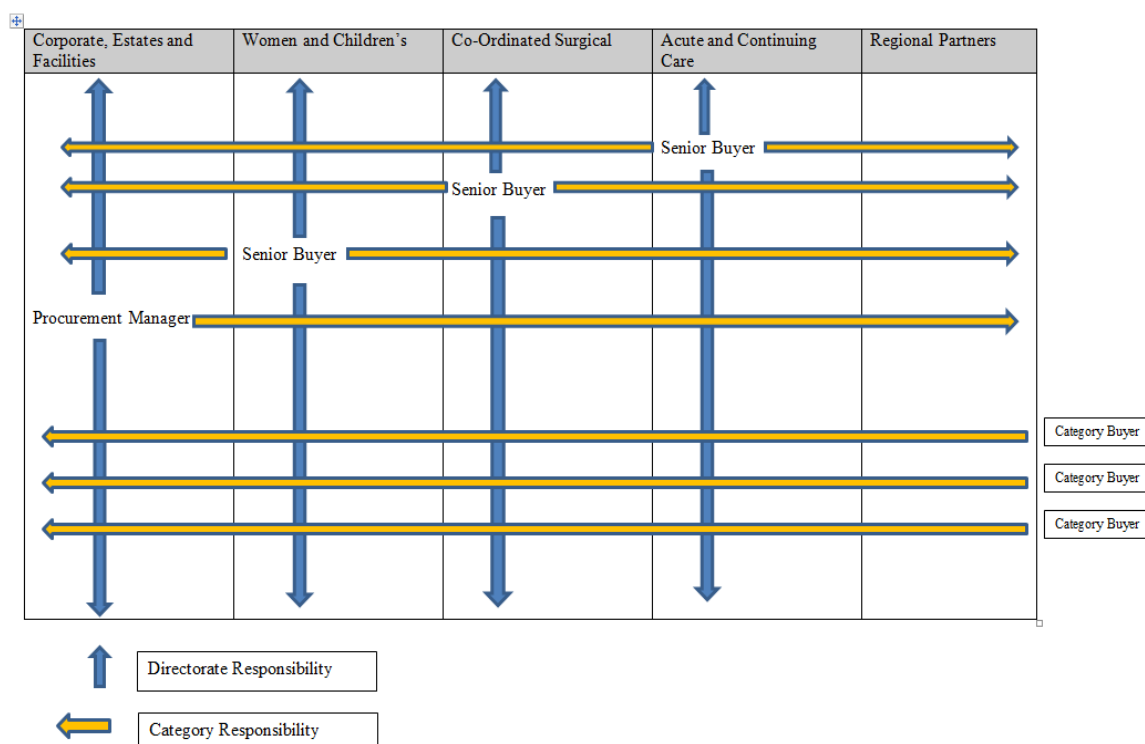
Directorate support and category management matrix

Training

The department has 2 people who are full members of the Chartered Institute of Purchasing and Supply and 3 people who are studying towards the qualification. Over the next 2 years the Procurement Department will aim to have at least 50% of the department qualified or working towards the MCIPs qualification.

The Procurement Skills Development network offers access to other Training courses which are beneficial to procurement professionals. Procurement have 16 members of staff signed up to the network. The remaining 8 members of staff will be encouraged to sign up by December 2016.

The Department's staff will be able to sign up to apprenticeships under a new national scheme that is being launched. This will allow access to funds to undertake NVQ type training enhancing skills in such areas as business administration and warehousing and storage up to chartered management degrees. The scheme launches in April 2017 and suitability of courses will be assessed thereafter.

All members of the Procurement Department have a personal training record with courses completed and identified training opportunities which will be updated through the achievement review process. The department targets that by October 2017 and yearly thereafter that all members of the team have had a minimum of 2 pieces of personal development relevant to their job or future development.

Procurement Transformation Plan (PTP) for Medway NHS Foundation Trust

Processes, Policies & Systems

<u>NHS Standards of Procurement</u>

Having undertaken a self-assessment of the NHS Standards of Procurement the score is 0.69. In order to get to the required level of 1 by March 2017 the Department needs to complete the following actions with evidenced documentation:

- Embed the Procurement Strategy and have clear accountability for it at Executive Level
- Develop Procurement Coms and Training for the wider organisation
- Develop a Contract and supplier management program
- Implement a Procurement Risk register which interfaces with the Directorate and Trust registers
- Document Category Strategies considering all options
- Develop a PPIB strategy and use results to develop action plans
- Clear Reporting of Procurement KPI's including Carter Metrics to Trust Board
- Strategy for increasing catalogue usage to 80% by September 2017
- Implementation and reporting of No PO No Pay Policy
- Publish a Procurement Manual
- Evidence all aspects of Corporate Social Responsibility are considered during the procurement process (Have a CSR policy)

<u>Key Performance Indicators</u>

The department produces monthly KPI's these are being developed to take into account of the metrics required by the Model Hospital, the Carter Metrics included in this PTP and any beneficial output of the PPIB tool.

As well as issuing trust level KPI's the department will be issuing a subset of KPI's to the directorates which will focus on specific operational metrics agreed with each team to allow the directorates to focus in on the key spend areas such as top ten by spend and volume and changes in volume compared to previous months/years

<u>Systems</u>

The Procurement system currently used at Medway NHS Foundation Trust is Integra provided by IB Solutions (this is the same system that is used at MFT and DVH, EKHUFT use Agresso). The collaborative partners have agreed that should any new procurement system be required at one site there will be a joint review to explore the opportunity of all Trusts being on the same systems, be that an existing system or a new one.

A business case is being developed for an inventory management system to be sourced and fully implemented within the next 24 months. This system will enable the Procurement

department to implement a cradle to grave system which will start with setting relevant levels of stock holding, track the usage of product to a patient and once consumed will trigger the automatic replenishment of the product to the agreed level. It will monitor stock turns and control wastage through identifying product which is due to go out of shelf life. The Inventory Management system will be supportive of the GS1 and Peppol. When evaluating an Inventory Management system consideration will be given to solutions that are used within our collaborative partners to see if there is any benefit to the region.

The Procurement Manual

The Department is creating a revised Procurement Manual which will hold all correct and relevant policy and procedure information. The manual will also hold all the Procurement information that is currently held within the Trusts SFI's. The manual will be held centrally on a the Intranet and/or within other relevant databases and will be reviewed and updated on a six month basis to ensure that it remains relevant. Anything that is not in the Procurement Manual will not be applicable to the Trust.

Partnerships

Medway NHS Foundation Trust is part of the Kent and Medway STP and as such the Procurement Function is part of the corporate review. The Procurement function will support any recommendations that are derived from the STP, which may include the formation of a centralised regional Procurement department over the next 3-5 years

The Trust is currently a member of the London Procurement Partnership and NHS Commercial Solutions for Pharmaceutical requirements including but not limited to medical gases. (Maidstone and Tonbridge Wells NHS trust and Dartford and Gravesham NHS Trust are both members of LPP whilst East Kent Hospitals University NHS Trust is members of NHS Commercial Solutions).

With the emergence of the Future Operating Model the trust, along with its regional partners, will be reviewing these memberships over the next 12-18 months to ensure that we are aligned with best practice and achieving value for money.

The Trust has recently stated its commitment to support the national procurement of selected products contracted through NHS Supply Chain, beginning with the first 12 products at the time of availability, this will continue as further products are identified and rolled out.

To facilitate future strategic reviews the regional Procurement Departments of Medway NHS Foundation Trust, Maidstone and Tunbridge Wells NHS Trust, East Kent Hospital University NHS Foundation Trust and Dartford and Gravesham NHS Trust have instigated monthly Heads of Procurement meetings to identify how we can work together to achieve best results. Information has openly been shared in the forum which has allowed a regional strategy to be developed. This will then be presented to the Trust board for approval and the strategy will be implemented and monitored.

Procurement Transformation Plan (PTP) for Medway NHS Foundation Trust

It is expected that 50% of expenditure on goods and services will be channelled through collaborative arrangements by 2017 rising to 60% by 2019.

The region will work together to engage and manage the market by holding 2 joint supplier events per year. It is anticipated that these events will be themed and will be linked to the categories that will be identified from the joint work plans.

Communication Strategy

The role of the Procurement Function within an NHS organisation is fundamentally changing. The Department is becoming more visible within an organisation and is being seen as key enabler to delivering the recommendations within Lord Carters report.

The Procurement department is a customer focused service delivery department and part of this role should be communicating regularly with the wider organisation. There will be a Procurement Representative at all relevant Directorate meetings who is able to update the senior management team. The department are developing a communication strategy enabling communications to the wider organisation bi-directionally.

A "Procurement and Tendering Process" training course is being developed which will be part of the Trusts bitesize training program. This is will go live in February 2017

Report to the Board

Meeting Date : 27th October 2016

Title of Report	
	Quality Improvement and Assurance Framework (QIAF) revised 2016 Quality Governance Assurance Framework assessment
Reporting Officer	Dr P Bain Chief Quality Officer
Lead Director	Medical Director, DoN, CQO
Responsible Sub-Committee	Quality Improvement Group/Quality Assurance Group
Executive Summary	The 2015-17 QIAF has been revised to include the changes in the directorate structure since 2015. In addition the document reflects the trusts quality aims , included in the quality account and the recovery Phase 2 programmes managed within the PMO for 2016/17 (Section 4.1 and 4.2).

Amendments have also been made to director responsibilities following changes in personnel (Section 4.7)

The bi-annual QAGF that supports this document is also attached. An assessment has been made on current evidence against the framework and the view of the executive leads responsible for the relevant sections and QAC members. Additional review was provided by the Medical Director and Chief Executive prior to submission to CQC. |
Risk and Assurance	Assurance in relation to both documents is provided via the performance management framework and evidence on health /CQC Assure.
Legal Implications/Regulatory Requirements	It is a requirement for the Trust to undertake a QAGF assessment annually. An independent assessment will be undertaken by NHSI in January 2017.
Recovery Plan Implication	All documents and activities related to recovery plan programmes.
Quality Impact Assessment	n/a

Purpose & Actions required by the Board : • **Assistance** • **Approval** • **Decision** • **Information**	Approval of both the revisions to the quality framework and the QAGF assessment.
Recommendation	Approve both the revisions to framework and status for QAGF.

Quality Improvement and Assurance Framework 2015-17
(Revised August 2016)

FINAL VERISON AUGUST 2016

Contents

Medway NHS Foundation Trust, Quality Improvement and Assurance Framework.

1. Foreword

This framework sets out to describe the system of Quality Improvement and Assurance operated within Medway NHS Foundation Trust (MFT). It is designed to ensure the delivery of high quality patient centred care that is well managed, cost effective and has a well trained and motivated work force.

As part of the Trust's approach to improving Quality, the Trust is committed to working in partnership with its key stakeholders so that a consistent high quality and equitable service is provided to people. It is also recognised that the Trust is a significant employer within the local communities of Medway and Swale. The Trust is adopting a Quality Governance approach to its systems, processes and behaviours so that it directs and controls its functions to achieve organisational objectives, safety and quality of service that relate to patients and carers, the wider community and partner organisations.

The NHS Outcomes Framework focuses on five domains and is used by the Secretary of State to hold NHS England, which is responsible for commissioning services, to account for securing improvements in outcomes for those who use NHS Services. The NHS Outcomes Framework underpins the Trust's Quality Improvement and Assurance Framework and is shown in Appendix A.

The National Institute for Health and Care (NICE) produces Quality Standards which are used by NHS England to hold NHS organisations to account for the delivery of care and the outcomes they achieve. The Care Quality Commission is the Regulator for the quality of services.

NHS England publish an annual Commissioning Outcomes Framework which will be used to hold Clinical Commissioning Groups (CCGs) to account for the outcomes they achieve for their local population through effective commissioning of services. All commissioning and provider organisations have a duty of quality and will be held to account by Parliament. Provider payment mechanisms will be used to incentivise improvements in quality and provide penalties where quality falls below nationally agreed standards (CQUINs) . The commissioning and contracting arrangements for specialist and primary care services are undertaken by NHS England and not the CCGs.

The Trust will be held to account for the quality of care provided not only by those who use the services, but also a range of organisations that have specific responsibility for regulating and commissioning health services.

Additionally, the Trust will demonstrate publicly improvements in quality through the publication of an annual Quality Account and Quality Report which will be reviewed by the commissioners, Health Overview & Scrutiny Committee (HOSC) and partner local authority organisations.

The framework provides the overarching principles and processes required to drive quality throughout the Trust describing ways in which to achieve consistently high quality of care which is equitable for users of the service and employees. The Quality Improvement Programme is the Trust's plan to improve quality which was determined from CQC inspections, internal information and risk assessments, agreed system wide improvement programmes and is led by the Chief Quality

Officer, Medical Director and Director of Nursing, PMO Director as the designated Executive Leads for Quality and improvement, by the Board.

2. Trust's Aim and Objectives for 2016/17

It is important for everyone to understand that working together in everything we do, with our patients and users, our commissioners and other stakeholders and with each other, will enable the Trust to achieve its aims and objectives. The culture of the Trust will need to change to ensure the quality of patient care will come before other considerations in the leadership and conduct of the Trust and that pursuing the continual improvement of safety will permeate every action and level within the Trust. The Trust needs to deliver consistent high quality care that is equitable. This has to be the Medway way. **The Vision will be** achieved through the Trust's **Key Values** and the corporate objectives: Best of Care , Best of People.

Approach to quality: The first priority in everything we do is to work together to ensure the delivery of consistent safe, high quality care, which encompasses safety, effectiveness and experience, meeting the needs of everyone and is therefore equitable in its approach. A clear thread of accountability must permeate through the organisation from frontline staff to senior management. This will be achieved via the Performance Management Framework . The Trust also has to further develop its quality governance frameworks.

Key developments: In 2016/17, the Trust will need to develop its quality strategies and several services within the context of the Sustaining and Transforming care Programme (STP) and the Trusts Recovery Programme. In the medium to long term, the key development will be working in partnership with local NHS Trusts and other stakeholders to provide additional opportunities to develop current and new specialist services and to ensure on-going clinical sustainability.

Productivity and efficiency: The cost improvement plans, based on continuous improvement have been developed and need to be delivered. Partnership work with local Clinical Commissioning Groups (CCGs) is in place to deliver a health system wide redesign of services with the support of the Haleo improvement team.

3. Scope of the Quality Assurance Framework

3.1.   Approach to quality

The first priority in everything we do is to work together to provide the delivery of consistently safe high quality care and excellent patient experience that is equitable in its approach. The Darzi Review, 2008, identified three key components associated with quality which are; patient safety (avoiding harm from the care that is intended to help), effectiveness/performance (aligning care with science and ensuring efficiency), and patient experience (including patient-centeredness, timeliness and equity). Berwick 2013, indicated that many modern industries define "quality" as "the degree to which a system of production meets (or exceeds) the needs and desires of the people it serves". An effective quality management system

includes *quality control* (to keep sound processes reliable on a daily basis), *quality improvement* (to decrease variation within and among NHS organisations so that the best becomes the norm) and *quality planning* (especially fostering innovative care models that can deliver better outcomes at lower cost). These principles will be adopted by the Trust in developing dashboards at Directorate and Board levels in order to provide a seamless approach to quality management from Board to Ward to ensure initiatives are performance managed, monitored, reviewed and outcomes measured. The Trust has introduced a performance model whereby each Directorate reports monthly to Executives using a performance dashboard which includes outcome measures which relate to safety, effectiveness, patient experience, workforce and finance. This way of performance management is a means to ensure quality is owned by front line staff and therefore embedded in daily practice.

3.1   Quality Governance Arrangements

A self-assessment in 2016, using Monitor's Quality Governance Framework has determined the key elements of the Quality Assurance Strategy.   The self-assessment is based on a review of the following domains and is rag rated to provide a focus on areas for improvement. An independent assessment of the Quality Assurance Framework by NHSI is planned for early 2017.

1.Strategy	1A, Does quality drive the Trust strategy? 1B, Is the Board sufficiently aware of potential risks to quality?
2. Capabilities and Culture	2A Does the Board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda? 2B, Does the Board promote a quality focused culture throughout the Trust?
3. Processes and structure	3A, Are there clear roles and accountabilities in relation to quality governance? 3B, Are there clearly defined, well understood processes for escalating and resolving issues and managing quality performance? 3C, Does the Board actively engage patients, staff and other key stakeholders on quality
4. Measurement	4A Is appropriate quality information being analysed and challenged? 4B Is the Board assured of the robustness of the quality information? 4C, Is quality information used effectively?

This framework will be supported by robust evidence and regular monitoring via the operational (QIG) and the Quality Assurance Committee (QAC) . Following re-structuring of divisions into 3 directorates, the Trust has also reviewed the directorate teams driving the quality agenda to support the Directors of Clinical Operations. Each of the clinical directorates have governance meetings that follow a standard agenda, Terms of reference and ensure they are escalating and reporting issues/success via the performance meetings, the appropriate use of risk registers and via reporting mechanisms to relevant groups/committees.

4. Key Drivers to improve Quality Standards: Patient Safety, Effectiveness / Performance and Patient Experience

The key drivers to improve quality standards are described under the three dimensions of Quality, Patient Safety, Effectiveness/ Performance and the Patient Experience.

4.1. Quality Improvement Programmes (PMO)

Our quality improvement strategies for 2016/17 are set out in the annual quality report and form part of the Phase 2 recovery programme managed within the Programme Management Office. The aims are set out in Appendix B and in Section 4.2 below. In addition the recovery phase 2 programme includes:

- Continuing to embed the medical model patient pathway from attendance in the ED department to discharge
- Develop and implement the surgical pathway for patients to ensure they are provide timely and high quality care
- Continued focus on mortality in relation to the deteriorating patient programme
- Reviewing the management of outpatient functions and referrals
- Ensuring we have a workforce that is fit for purpose and provides safe , high quality care
- Ensuring we have robust and comprehensive clinical governance structures and processes that can provide assurance on assessment by the CQC.

4.2 Quality Accounts

The Trust will demonstrate publicly improvements in quality through the publication of an annual Quality Account and Quality Report, which will be reviewed by the commissioners, HOSC and partner local authority organisations.
The priorities for improvement for 2016/17 are:

Patient Safety:	- Continuing to improve mortality rates in sepsis - Reduce Harm: Pressure Ulcers, medication safety, MRSA and C.Diff infections - Improve learning form serious incidents
Patient Experience:	- Improve the assessment of vunerable adults with mental capacity issues - Improve responses to complaints - Ensure patents have timely access to services - Improve Friends & Family `likely to recommend scores

Quality Improvement & Assurance Framework revised AUGUST 2016

Clinical Effectiveness:	• Increase the number of patients appropriately discharged before noon • Reduce Length of Stay for patients over 65 years old • Reduce non-elective readmissions • Increase % of utilisation of Day Case Surgery

4.3 Effectiveness / Performance

The Trust has introduced a scorecard approach to managing performance at Directorate level. It is important that the Trust seeks out any variation within the hospital at a local level to improve outcomes. There is a danger that if Information is aggregated, it can camouflage variation in information. A new analytical tool has been introduced (Methods Analytics) that will be used as the monthly meetings to discuss performance and take appropriate action from directorate to individual clinical level. This is also a mechanism for sharing best practice across the organisation and using the information to benchmark with external organisations.

4.4 Commissioning for Quality and Innovation (CQUINs).

A proportion of MFT's income in 2016/17 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with, for the provision of NHS services through the Commissioning for Quality and Innovation payment framework.

The CQUIN framework has been the foundation of discussions about quality of service between the Trust commissioners. A number of CQUIN targets are determined nationally and are as a response to known areas requiring improvement within Patient Safety and Patient Experience. The CQUIN targets are also composed of regional and local targets. CQUINs for 2016/17 are set out below:

National CQUINs : Improvements in: NHS Staff Wellbeing, Sepsis, Antimicrobial resistance
Local CQUINS: Medicines management, Nutrition, Pressure Ulcer Collaborative, Discharge before mid-day and improved electronic discharge information, paediatric referrals, management of children with asthma.

Research as a driver for improving the quality of care and patient experience

Active participation in research contributes to successful patient outcomes, allowing clinicians to stay abreast of the latest treatment possibilities. The Trust remains committed to improving the quality of care for patients and wider healthcare services through active participation in clinical research. It has continued to demonstrate a strong commitment to clinical research supported by the National Institute for Health Research (NIHR) by setting annual NIHR recruitment targets to improve year-on-year patient involvement in clinical trials.

Continual growth in research activity indicates commitment to work in successful partnership to provide flexible, first class heath care to local people and the desire to improve patient outcomes and experience across the NHS. The Trust has exceeded recruitment Targets set by the NIHR for three consecutive years.

Audit

The Trust participates in national, regional and local audits. Each Directorate has a nominated Clinical Audit Lead with designated times allocated to present and discuss audit findings. There is a comprehensive Nursing and Midwifery audit programme which reports on clinical audits monthly by directorate. The clinical audit findings are published in the Trusts Quality Account and annual report. Annual Learning events share the outcomes of the annual audit plan. Non clinical audit is undertaken by Internal Auditors in accordance to an annual plan determined by Executive Leads in conjunction with Directorates.

4.5 Patient Experience and Engagement

Patient experience and engagement is a significant part of the quality agenda. It is essential for the Trust to provide high quality services to all patients and that is it person centred.

The Trust launched the Friends and Family Test in April 2013 and more recently the A&E Family and Friends test. The survey includes the question *"How likely are you to recommend us to a relative of friend?"* This question is being encouraged to be used on a daily basis and to identify if staff needed to undertake any further action to improve a patient's stay whilst they are in hospital.

The Patient Advisory Liaison Service (PALS) provides independent advice to patients and troubleshoots informal concerns. Formal Complaints are managed in accordance with national guidance and information is available to patients and users who wish to complain and the process they need to follow. Complaints, informal and formal are taken very seriously and investigated by staff involved with the care of the patient. Learning from compliments, concerns raised and complaints forms an important aspect of the Trust's work to ensure staff get things right, first time, every time. The Trust ensures it is open and honest when mistakes are made and patients are informed promptly when treatments do not go according to plan.

The Trust will encourage patients to use NHS Choices and Patient Opinion and will ensure mechanisms are in place to respond to positive and negative information provided by patients. Patient information will be available readily, up-to-date and will meet agreed standards.

The Trust works with external organisations, patient groups and other stakeholders to develop local priorities, policies and action plans. Experience based co-design will provide the Trust with a well tested framework for involving patients and their carers in the design of services. There will be a focus to increase the number of patients involved in supporting the work to deliver sustainable quality improvements.

The Patient Experience Group, reporting to the Quality Improvement Group, is the conduit used to improve the patient experience across the Trust.

4.6 People and Organisational Development

A Leadership and Management Framework has been developed which is aligned to the Trusts overall vision, values and strategic objectives. This framework underpins the the need to change the culture of the Trust so that the pace of change and employing a first class workforce is achieved to ensure high quality standards are provided to patients at all times in a consistent manner. The Framework outlines the roles and responsibilities of individuals and teams and will guide the development of roles, recruitment, induction, appraisal, development and training, reward and succession planning. Working together in teams and being held to account for care is the thread and is re-enforced by this framework.

4.7 Roles and Responsibilities for Quality Governance

Members of the Board are accountable jointly for the delivery of high quality services for the Trust. A designated Non-Executive Director is the lead for Quality and chairs the Quality Assurance Committee which is sub- committee of the Trust Board. The Chief Quality Officer, Medical Director and Chief Nurse are the Executive Leads with joint responsibility for Quality and Quality Assurance across the Trust.

Position	Lead for Board Objective
Chief Executive	• Accountable Officer
Medical Director	• Professional leadership – Medical workforce • Clinical Quality, strategy and development • Caldecott Guardian • Patient Safety • Mortality review • Research and Education & Training • Re-validation • Clinical audit and effectiveness strategy Clinical Engagement/GP relationships • Medical / legal matters/dealing with concerns • Medicines Management- Controlled Drugs
Chief Quality Officer	• Quality Accounts • Serious Incidents (SI) • Quality Governance Framework • CQUINS • Management of quality team to support Quality agenda • Health Informatics : clinical systems development, Business Intelligence, Coding
Director of Nursing	• Professional Leadership – Nursing and Midwifery • Patient Experience strategy and development • Infection prevention and control • Safeguarding adults and children • Safe Staffing • Nurse and Midwifery re-validation • Complaints • Patient experience / involvement • CQUINS • Patient Advisory Liaison Service (PALS) • Volunteers • Chaplaincy – spiritual care
Director of Finance	• Financial Management • Financial performance • Accounting • Audit and counter fraud • Invoicing and billing processes • Business improvement • CIPs • Fire Safety

Position	Lead for Board Objective
	• Estates Management/Security
Director of Corporate Governance, Risk and Legal services	• Corporate Governance • Corporate Strategy • Risk Management • BAF • CQC registration and compliance • Monitor Licence requirements • SIRO • Legal Services
Director of Human Resources	• Human Resources • Employment law • Personal Performance management • Disciplinary issues • Equality and diversity • Staff involvement • Mandatory training • Training and development • Organisational and Leadership Development • Payroll • Communications/media • Stakeholder engagement
Company Secretary	• Board meeting governance • Governors involvement and training

5 Committee Structure to Meet Quality Governance Standards

The Chief Executive is the Accountable Officer responsible for Quality with delegated responsibility for quality and quality Assurance held by the Director of Nursing, Chief Quality Officer and Medical Director. The Committee structure was revised following the self-assessment of the Good Governance as set out in the Governance Framework (May 2015). The Quality Assurance Committee is a sub-committee of the Board, chaired by a Non-Executive Director .

- **Accountability of Governors** - The governors, to whom the Trust is accountable, have an established Governors' Quality Working Group, which meets quarterly. The non-executive chair of the Quality Committee and executive directors, as appropriate, attend each of the meetings.
- **Medway, the host CCG,** schedules monthly Clinical Quality Review Group meeting chaired by the Lead GP for quality. This group scrutinises the quality performance of the Trust.
- **Academic Health Science Network (AHSN)** across Kent, Surrey and Sussex has been established. The Trust is an active leader in the Enhancing Quality and Recovery Programmes.

The corporate committee structure is supported by Directors of Clinical Operations who are responsible for Governance, Audit and Safety and report through their individual Directorate Governance Meetings

6 Arrangements for Partnership Working

The Trust engages with its staff, patients, stakeholders and the wider community in helping shape the healthcare services that it provides. It has made a commitment to:

- Balance meeting the demands of delivering safe, modern services with that of being responsive to the needs of patients.

- Work together to develop innovative solutions to provide high quality care to the local population.
- Strengthen relationships with Clinical Commissioning Groups, NHS England and other major stakeholders
- Forge closer links and better understanding with the Trust's Council of Governors, the Trust's Membership, patient support groups and the voluntary sector as well as harder to reach and less often heard minority groups within the community.

The Trust's Stakeholder Engagement Plan will be reviewed and updated regularly to ensure continued involvement as the plan evolves and is refreshed each year.

7   Monitoring and Reporting Process

The Board monitors the delivery of this framework primarily through the work of the Quality Assurance Committee, Quality Improvement Group and Executive Team Meetings, Performance Review Meetings, supplemented by reports brought directly to the Board.

The Quality Committees (QAC, QIG) receive regular monitoring information as set out in the Sub-Committee structures. This covers all principal strands of quality assurance with a particular focus on patient safety. ETM is the management Committee chaired by the Chief Executive. It is responsible for maintaining and improving the operational and clinical performance across the Trust.

The Trust submits an annual report to Monitor, which includes the annual Quality Report. The Quality Account is subject to consultation with external stakeholders and the local community and is submitted to Monitor. National, regional and local CQUINs are determined in collaboration with the Host Commissioner, Medway CCG, which also monitors the Trust's quality performance at the Clinical Quality Review Group (CQRG).

The Quality Assurance Framework will be subject to a formal annual review and bi-annually at QIG and QAC.

1.1

APPENDIX A   The NHS Outcomes Framework/CQC Domains

The NHS Outcomes Framework (used by the Secretary of State and NHS England) are used for commissioning services, to account for securing improvements in outcomes for those who use NHS Services. The Care Quality Commission is the Regulator for the quality of services via CQC five domains (Safe, Caring, Effective, Responsive, Well Led)

The National Institute for Health and Care (NICE) will produce Quality Standards which will be used by NHS England to hold NHS organisations to account for the delivery of care and the outcomes they achieve..

 NHS England publish an annual Commissioning Outcomes Framework which will be used to hold Clinical Commissioning Groups (CCGs) to account for the outcomes they achieve for their local population through effective commissioning of services. All commissioning and provider organisations have a duty of quality and will be held to account by Parliament.

Commissioning Guidance is published to support CCGs. Provider payment mechanisms will be used to incentivise improvements in quality and provide penalties where quality falls below nationally agreed standards. The commissioning and contracting arrangements for specialist and primary care services will be undertaken by NHS England and not the CCGs.

APPENDIX B   Quality Aims 2016/17

Zero harm

- Improve our medication safety standards
- Reduce avoidable community acquired pressure ulcers by 40%
- Improve communication with GPs when a patient is discharged from our care
- Zero 'Never events'
- Zero MRSA & C.Diff infections
- Reduce the number of in-hospital cardiac arrests
- Improve our learning from incidents and reduce the number of serious incidents

Excellent care

- Improve the assessment of vulnerable patients with mental capacity issues
- Improve our responses to complaints
- Improve the treatment of patients with sepsis
- Ensure all patients have access to services in a timely manner
- Improve Friend and Family 'likely to recommend' scores to 83% by April 2017

Best standards

- Increase the number of patients discharged before noon
- Reduce the length of stay for patients over 65 years old
- Reduce the number of non-elective readmissions within 28 days
- Improve paediatric outpatient referral management and asthma pathways
- Reducing SHMI to within benchmarked limits by April 2017
- Reduce mortality to <100 HSMR by April 2017
- Reduce avoidable mortality by septicaemia

Supporting staff

- Reducing vacancy rates and improving retention
- Commit to ensure our vision and values are followed by all
- Increasing training and development opportunities
- Improving safety culture from ward to board
- Providing the best technology
- Provide business partners to all divisions
- Share and support staff in learning from incidents

Patient Safety

Patient Experience

Clinically Effective

Our Staff

APPENDIX C   Definitions of Governance

Integrated Governance

Integrated Governance is defined as systems, processes and behaviours, by which trusts lead, direct and control their functions in order to achieve organisational objectives, safety and quality of service and in which they relate to patients and carers, the wider community and partner organisations'

Corporate Governance

The term used by the NHS to mean the system by which an organisation is directed and controlled, at its most senior levels, to achieve its objectives and meet the necessary standards of accountability, probity and openness. Corporate governance is therefore about achieving objectives and about good business conduct in accordance with the Cadbury report.

Clinical Governance

A framework through which healthcare organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical governance is the mechanism for understanding and learning to develop the fundamental components required to facilitate the delivery of quality care – no blame, questioning, learning culture, excellent leadership, and an ethos where staff are valued and supported to deliver high quality care to patients.

The Role of the Board

The Board will promote and demonstrate the values and behaviours which underpin Integrated Governance. It will ensure a balanced focus on all aspects of the business, (Quality, Performance, Finance and Workforce) and will adopt a systematic process of patient, staff and public involvement.

Further:
- The Quality Strategy will ensure the Board and its subsidiary committees related to quality are structured effectively and properly constituted.
- Through the implementation of the Quality Strategy, the Board will ensure it promotes a culture where patient safety is paramount and staff learn from experience and innovation.
- The Board will be responsive to new legislation and relevant healthcare policies.
- The Board will comply with the Care Quality Commission's Fundamental Standards of Quality and Safety.
- The Board will comply with Royal College Accreditation in line with the College's policy on accreditation for a given specialism and the assurance that the professional involved is adequately accredited for the practice that he or she carries out regularly. The trust will be aware of the role of the General Medical Council (GMC) Nursing and Midwifery Council (NMC) and other professional bodies.
- The Board will work with the NHS Litigation Authority and its risk management standards and report annually as required.
- The Board will ensure that any risks relating to system validation are identified within the Trust's Information Governance Assurance Framework.

Board Assurance Framework (BAF)

The Board Assurance Framework provides the Trust with a simple but comprehensive method for the effective and focused management of the principal risks to meeting its corporate objectives. It sets out the controls to mitigate the risk, the sources of assurance which can be provided to the

Board to validate their effectiveness and action plans to further reduce the risk or manage it to an acceptable level.

The Board Assurance Framework is a dynamic Board assurance tool, underpinned by the Risk Management Policy and the risk register. The Framework will also enable the Board to gain a deeper level of assurance into the specific areas of quality governance, organisational strategy and values and financial governance, as required. The Trust's internal business planning and performance monitoring process will be linked to the strategic objectives. This will ensure a holistic approach to Board Assurance, risk management and performance management frameworks are achieved throughout the organisation.

Corporate Risk Register (CRR)

The Corporate Risk Register is a compilation of high risks across the Trust that has been populated from Directorate risk registers. It represents risks associated with operational management and clinical issues.

Quality Governance

The Quality Strategy determines how the Trust will provide a quality service evidenced through its governance and assurance frameworks to demonstrate its compliance with the necessary quality and safety standards. This will include compliance to: Monitor's License requirements, CQC Registration Regulations (Health Act 2008); Quality Accounts national framework; NHS Litigation Authority (NHSLA) Risk Management standards; Information Governance ISO Standards; GMC, NMC and other regulatory bodies Codes of Professional Conduct and national and local Key Performance Indicators. Patient safety will be a golden thread that runs throughout the Trust's business as a priority.

Organisational Development and Training

The Trust will promote its vision and values further as part of a re-branding exercise across the Trust. Staff development will be integral to the Trusts revised appraisal process. It will ensure the principles of good clinical and corporate governance are embedded throughout the organisation. The focus of all training will be the needs of patients together with corporate and statutory obligations and that clinical quality standards are up-to-date. Staff will be assisted to understand their specific roles and be accountable for the service they provide in relation to Patient Safety, Effectiveness and Patient Experience.

Financial Governance

Financial governance relating to financial business decisions, risk, reporting, investment and operational performance is assured by internal and external Auditors.

Information Governance

The Trust has appropriate information security systems to protect itself, its partner organisations and its patients. The Trust applies information governance standards in accordance with the ISO 27001:2005 ensuring confidentiality, security of personal information, access to records and compliance with the Data Protection Act. Internal information systems will allow appropriate information flow from 'board to ward' and 'ward to board'.

Quality Assurance and Governance Framework : 2016 Bi-annual Assessment

Quality Assurance Committee

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Purpose of report

- Outline quality governance framework

- Outline process and MFT assessment

- Discuss and agree assessment

- Discuss and agree actions

Definition of Quality Governance

The combination of structures and processes at and below Board level to lead on trust-wide quality performance[1] including:

- Ensuring required standards are achieved[2]

- Investigating and taking action on substandard performance

- Planning and driving continuous improvement

- Identifying, sharing and ensuring delivery of best practice

- Identifying and managing risks to quality of care

1 **Quality performance incorporates safety, clinical effectiveness and patient experience** and is measured across inputs, processes and outputs

2 **Required external standards include**, but are not limited to: legal requirements for on-going registration with CQC; satisfaction of agreed levels of service provision; and delivery against national targets and standards

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Monitor's framework for assessing good Quality Governance

Strategy

1A Does quality drive the trust's strategy?

1B Is the board sufficiently aware of potential risks to quality?

Capabilities & Culture

2A Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?

2B Does the board promote a quality focused culture throughout the trust?

Processes & Structures

3A Are there clear roles and accountabilities in relation to quality governance?

3B Are there clearly defined, well understood processes for escalating issues and managing quality performance?

3C Does the board actively engage patients, staff and other key stakeholders on quality?

Measurement

4A Is appropriate quality information being analysed and challenged?

4B Is the board assured of the robustness of the quality information?

4C Is quality information used effectively?

Scoring against the framework

Score	Risk rating	Definition	Evidence
0	Green	**Meets** or **exceeds** expectations	**Many elements** of good practice **+ no major omissions**
0.5	Amber/Green	**Partially meets** expectations but **confident in management's capacity** to deliver green performance within reasonable timeframe	**Some elements** of good practice **+ no major omissions** **+ robust action plans** for shortfalls and **proven track record of delivery**
1	Amber/Red	**Partially meets** expectations but **some concerns** on capacity to deliver within a reasonable timeframe	**Some elements** of good practice **+ no major omissions** **+ action plans for shortfalls in early stages and limited evidence of delivery in past**
4	Red	Does not meet expectations	**Major omission in quality governance identified** **+ significant volume of action plans** required, **concerns on management delivery capacity**

- Authorisation criteria is a score of 3.5 or less
- Quality Governance score of 4 or worse cannot be authorised
- Overriding rule states no category can be rated entirely Amber/Red

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Evidence: not just documents

- External assurance – KPMG and PWC,CQC, commissioner visits, external reviews

- Internal Assurance- BAF, risk registers, audit, IAC, performance metrics, service reviews, CIPs, PMO, walk rounds, governors, governance meetings, Quality and aligned Strategies, SI/incident reporting process,

- Audit and Monitoring: Annual Audit plan, Ward to Board dashboards, CQC self -assessments (Health Assure)

- Management and leadership: responsibilities agreed, Policy framework review, CPD, Whistleblowing

- Patient/Carer feedback: F&FT, Surveys, Complaints

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Where are we now?

Results from 2016 review		RAG rating	Score
Strategy	**1A** Does quality drive the trust's strategy?	Amber/Green	0.5
	1B Is the board sufficiently aware of potential risks to quality?	Green	0
Capability & Culture	**2A** Does the board have the necessary leadership, skills and knowledge to ensure delivery of the quality agenda?	Amber/Green	0.5
	2B Does the board promote a quality focused culture throughout the trust?	Amber/Green	0.5
Processes & structure	**3A** Are there clear roles and accountabilities in relation to quality governance?	Green	0
	3B Are there clearly defined, well understood processes for escalating issues and managing quality performance?	Amber/Green	0.5
	3C Does the board actively engage patients, staff and other key stakeholders on quality?	Amber/Greed	0.5
Measurement	**4A** Is appropriate quality information being analysed and challenged?	Amber/Green	0.5
	4B Is the board assured of the robustness of the quality information?	Amber/Green	0
	4C Is quality information used effectively?	Amber/Green	0.5
Overall score		**Green**	**3.5**

- Authorisation criteria is a score of 3.5 or less – 4 or worse cannot be authorised
- Overriding rule states that no category can be rated entirely Amber/Red

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What are the key actions?

Strategy (1b) :

- Overarching Quality and Assurance Framework – revised Oct Board 2016

- CQUINs regularly reviewed as part of Governance and performance management framework

- Risk registers have been reviewed and updated with a new format. Developed from the service level to Board. BAF developed, September Board.

Capability and Culture (2a)

- Board/NEDs: training in good governance, ongoing board development with quarterly awaydays.

Process and Structure (3b/c)

- Governance structures –reviewed, directorate structures established, need to ensure escalation processes utilised appropriately

- Governor/Patient engagement in quality agenda is present but not fully established

Measurement (4a/c):

- Performance information- introducing more analysis and challenge as date quality has improved (QAC September and October

- Introduced early warning dashboards, increasing benchmarking against similar Trusts (methods analytic tool)

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Reporting/Assurance process…

- Process change for monitoring: QGAF action plan and quarterly review via QIG and QAC

- Executive team taking a lead and ownership of actions aligned to BAF responsibilities

- Health Assure data/information primary evidence against assessment

- 6 monthly re-assessments utilise 90 day forum, time to review evidence ,observe, interviews by non-executives.

- Annual Independent Assessment January 2017

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Report to the Board of Directors

Board Date : 27 October 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 daily messaging based on priority themes • Better political and community engagement • 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 ☒

COMMUNICATIONS REPORT: OCTOBER 2016

EXECUTIVE SUMMARY

As we continue 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.

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

At the start of October we introduced daily messages, seven days a week, under an overall Theme of the Week. Themes so far have included safeguarding, medicines management, and improving safety. The aim is to ensure all staff are made aware of important messages relating to priority areas in patient care.

So that we can be sure that as many staff as possible see or hear the messages, we have introduced additional ways of highlighting them, including discussing them at handover and team meetings, displaying on posters in staff areas, and through the use of screen savers on computers. A stand relating to the theme of the week is also set up in the staff area of the restaurant during the week so materials can be handed out and the messages discussed with staff.

Following on from the publication of our staff handbook for colleagues, reminding them of the CQC's five domains, and helping them feel confident about the forthcoming CQC inspection, we are also producing a handbook for Non-Executive Directors and Board members.

The same priority themes were discussed at the monthly senior staff meeting, where colleagues were also asked to feed back on how they are supporting staff to feel positive about the trust as we continue on our improvement journey. In addition they considered how they could contribute to helping the Trust achieve financial stability. The meeting was in a workshop format, which we have found to be a more effective means of engaging senior staff.

MEDIA

The Trust has featured in the media throughout the past month, both in the printed press, radio and on television.

We welcomed a camera crew from ITV Meridian to film in the Sunderland Day Care Centre with one of our leading orthopaedic consultants, Professor Amit Tolat. This is in relation to a new procedure being carrying out with patients suffering from a frozen shoulder – a very

painful and debilitating condition. The procedure we're now using has resulted in a near 100 per cent success rate, and is helping patients resume normal duties at work and at home.

And we received pleasing coverage for the official opening by local MP Rehman Chishti of the recently refurbished Transitional Care Unit on Pearl Ward. This is where babies can receive that extra bit of clinical care if they need it.

In Baby Loss Awareness Week our Head of Midwifery, Dot Smith, was interviewed for a feature about baby bereavement on ITV news, which was broadcast nationally. Medway was the only Trust to be featured in this sensitive news piece, in acknowledgement of the excellent care we are now providing for parents suffering bereavement.

Our new bereavement suite has been publicised in the Medway Messenger following a visit by the former Bucks Fizz star Cheryl Baker, who is Patron of the charity Abigail's Footsteps. We are expecting further coverage when the suite is official opened by the Countess of Wessex on 1 November.

Meanwhile, we received less positive press in the Daily Mail which cited a CQC report on social care pressures linking it with some old data and focusing on hospitals in special measures.

The Daily Mail, along with other media, also covered the story of a baby who sadly died, and whose parents are making some claims about the care they received at Medway. The Trust confirmed that it was undertaking a review, and expressed condolences to the parents.

Meanwhile, there has been coverage of the resignation of the Trust chair, Shena Winning, after we issued a statement.

And finally, at the time of writing we are anticipating further reports and photographs about our Smokefree launch. A choir from the local Robert Napier School sang in reception, new banners and posters were displayed and there were balloons to mark the launch on 17 October.

SOCIAL MEDIA

In my previous report, I touched on the new policy for staff to encourage them to promote the Trust on social media where they feel inclined to do so. This has now gone live and we are working with certain teams in the organisation to encourage them to increase their use of social media.

Over the past 30 days we have engaged with 35,000 people on Twitter and 35,600 people on Facebook. We have gained 54 new followers on Twitter and 25 on our Facebook account, taking our total number of followers to 2,251 and 3,644 respectively. Key topics over the last month were our Smoke-free initiative, Baby Loss Awareness Week and a look ahead to Fab Change Day on 19 October. We continue to build relations with local and national health organisations with our posts retweeted/shared by HealthWatch Medway, Medway Community Healthcare and NHS Medway CCG.

COMMUNITY ENGAGEMENT

We continue to widen engagement with groups with whom the Trust has had limited contact. Following the attendance of a representative from Medway Youth Parliament at the AGM, colleagues from the Women's and Children's directorate and the lead governor will meeting members of the Parliament in the next few days to gain input on how the services we provide meet the needs of children and young people. We are also engaging with ethnic minority representative groups. A workshop will take place with governors in the next few days (at the time of writing) to gauge how effective our earlier steps in community engagement have been. Meanwhile, we are planning how patients and the community can be involved in the evolution of our service for outpatients.

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

Following a visit to the hospital in September, Philip Dunne MP, Minister of State for Health, spoke in a Parliamentary debate about the importance of better bereavement care for parents who suffer the tragic loss of losing a child, when he referred to Medway's 'superb' bereavement suite.

Helen Whately MP, who represents Faversham and Mid Kent, spoke favourably about the Trust during the Conservative Party conference. She had visited the hospital in September, when she toured the Emergency Department and heard about progress on our recovery plan.

The chair and chief executive presented an update to the Kent Health Overview and Scrutiny Committee in early October when they described improvements that have taken place in recent months, including a reduction in the length of stay on admissions wards, fewer people staying in hospital unnecessarily, a significant drop in nursing vacancies in the Emergency Department, and a reduction in the number of deaths in hospital.

OTHER ACTIVITIES

Among other activities which we have been carrying out are:

- Continued development of a new website – content is now being added to the new site for an anticipated rollout later this year
- Continued communications to support our Smokefree initiative, both among staff and with patients and the local community.

Quality Assurance Committee Chair's Report -25 September 2016

I have attempted to benchmark our own QAC, by attending that of a nearby Trust which has recently emerged from Special Measures. I am pleased to be able to report to the Board that there were considerable similarities, and that I was reassured that we do not seem to be wide of the mark. Indeed, if anything, I noted more internal dissent than at Medway and also that the other Trust's QAC tended to hear reports which their authors had volunteered to present, rather than probing into challenging topics.

Despite there being no Board in August, the Quality Assurance Committee (QAC) decided to convene in order to maintain watch over quality matters within the Trust.

We heard the quarterly report from the Coordinated Surgical Care Directorate, covering the CQC domains.

We examined the Integrated Quality and Performance Report and felt that we would value seeing more challenge and interrogation of the data by the Quality Improvement Group (QIG) and by Directorates, in order to prevent any slipping back in areas where we have made positive progress.

The committee considered the Risk Register, Safeguarding and the CQC Action Plan, and cued further updates in September.

September's QAC was somewhat frustrating as a short-notice Ministerial visit was imposed which drew members away and rendered us non-quorate. However, we continued to meet as best we could and provided a week for follow-up out-of-committee reading and agreement. No further correspondence having been received, the QAC approved the papers, which were:

Detailed Breakdown of the Red/Amber/Green status of CQC Must/Should Dos.

The Safeguarding Annual Report. Our approval is subject to corrections being made to the arithmetical errors in some of the tables.

An Update on Serious Incident Reviews.

The Draft Risk Register, which should be presented to the Board in October.

Minutes of QIG and the Integrated Quality and Performance Review.

The Good Governance Institute's advice on Deep Dives.

Additionally we had a verbal report from the Acute & Continuing Care Directorate.

In October QAC will look at MCA/DLOS and radiology as well as reviewing our effectiveness as a committee.

E B Carmichael

Non-Executive Director; Chair, Quality Assurance Committee

26 September 2016

Minutes

of the Quality Assurance Committee held on Thursday, 15 September 2016 at 0900 hrs in the Christina Rossetti Room.

Members

Name:	Job Title:	Initial
Ewan Carmichael	Non-Executive Director (Chairman)	EC
Trisha Bain	Chief Quality Officer	TB
Vivien Bouttell	Patient Governor Representative	VB

In attendance:

Name:	Job Title:	Initial
Margaret Dalziel	Director of Clinical Operations – Acute & Continuing Care	MD
Simone Hay	Deputy Director of Nursing	SH
David Rice	Company Secretary	DR
Rob Nicholls	Deputy Director of Nursing, Acute & Continuing Care	RN
Katy White	Head of Governance & Risk	KW

Apologies:

Name:	Job Title:	Initial
Busola Ade-Ojo	Interim Chief Pharmacist	BA
Lesley Dwyer	Chief Executive	LD
Bridget Fordham	Head of Safeguarding	BF
Amanda Gibson	Acting Deputy Director of Nursing	AG
Diana Hamilton-Fairley	Medical Director	DHF
James Lowell	Director of Clinical Operations, Women's &	JL

	Children's Directorate	
Karen McIntyre	Deputy Director of Nursing, Womens' and Children	KMc
Martin Nagler	Patient Representative	MN
Dr Ghada Ramadan	Consultant Neonatologist/Associate Medical Director – Quality & Safety	GR
Karen Rule	Director of Nursing	KR
Ben Stevens	Director of Clinical Operations, Co-ordinated Surgical Directorate	BS
Jan Stephens	Non-Executive Director	JS
Shena Winning	Trust Chairman	SW

1. **Chairman's Welcome, Apologies and Introductions**

   The Chairman welcomed members and their deputies to the meeting. Apologies were noted as referred to above. Due to a ministerial visit at the Trust that morning a number of staff were unable to attend and the meeting was not quorate.

2. **Minutes of previous meetings**

   It was agreed that the minutes of the August meeting were approved as a correct record of the matters discussed.

3. **Matters Arising/Action Log**

   The Committee Action Log was reviewed and updated accordingly.

4. **Directorate Assurance Report / ED Improvement**

   4.1 The Committee noted the report referred to above. MD introduced the main points:

   - there were three risks ahead of the CQC inspection and to not coming out of Special Measures: staffing, ED and everything else;
   - the essential action for the Trust was to improve flow through the Medical Model;

- as at 5th September 2016 there were 88 patients awaiting discharge tying up 3 wards and 75 nurses.

4.2 In ED there had been an increase of 12% in attendances which amounted to between 300-350 patients each day. Whilst this trend had stabilized over recent months it had not translated into improved performance statistics.

4.3 For Safe Staffing there were various initiatives to ensure safe staffing including overseas recruitment for NICUs, a nursing workforce scorecard has been developed and there were twice daily temporary staffing reviews to prioritise areas to fill shifts. There were, however, delays for those patients on the Mental Health Pathway with limited nursing home places available. VB commented the effect of the closure of St Barts and MD noted that there were initiatives to increase the number of beds in the community.

4.4 There was a discussion about the deteriorating patient and how the Acute Response Teams (ARTs) were being developed to ensure that patients received the most appropriate care.

4.5 MD explained that the discharge of patients was a difficult area to resolve. There was a "Choice Policy" whereby patients ready for discharge were allowed 7 days to consider nursing homes available for them and if a suitable home was not found then the patient would be provided with a temporary place until a longer term solution could be found.

4.6 RN noted that workforce was also a continuing problem with regards to recruitment and retention, with the exception of ED. With regards to ED in August last year there was a 60% vacancy rate and this is currently at 20%. There had been some success this year in recruiting staff for ED and this was on target to meet their internal trajectory. 9 Associate Nurse Practitioners would be starting at the Trust shortly. Given the high usage pf agency staff it was essential that all agency nurses had been properly inducted to ensure safe staffing and delivery of quality care.

5. **Safeguarding Annual Report**

5.1 The Safeguarding Annual Report 2015-16 was discussed. The purpose of the annual report was to inform the Quality Assurance Committee of the Safeguarding activities at the Trust between 1 April 2015 and 31 March 2016. The Safeguarding Annual Report was approved, subject to correcting some arithmetical errors and receiving any comments from other members of the Committee.

6. **Update of SI Review of Risks & Revised Processes**

6.1 The Committee noted the review of risks and suggested revised processes for Serious Incidents. A policy would be presented to a future Board meeting for approval.

7. **Quality Assurance and Governance Framework (QAGF): 2016 Bi-annual Assessment**

7.1 The QGAF was taken as read. It was noted that the purpose of the report was to:

- Outline quality governance framework
- Outline the process and MFT assessment
- Discuss and agree the assessment
- Discuss and agree actions

7.2 There was a discussion on the scoring against the framework where:

- 0 (Green) meets or exceeds expectations
- 0.5 (Amber/Green) partially meets expectations and is confident in mangement's capacity to deliver green performance within a reasoanble timeframe
- 1 (Amber/Red) partially meets expectations but there are some concerns on the capacity to deliver within a reasonable timeframe
- 4 (Red) does not meet expectations

7.3 There were four categories under review as follows:
- Strategy
- Capability & Culture
- Processes & structure
- Measurement

The overall score was a total of 6.0 which represented Red "Does not meet expectations".

7.4 The scores for the BAF were discussed and it was noted that these were rated as at the current time. It was confirmed that this linked in to the CQC Assure project being co-ordinated by Lynne Stuart and Katy White and this would involve the Executive leads together with the NEDs as observers to assess evidence going forward.

7.5 RN queried whether the scores had been validated. TB confirmed that the scores had been based on the information held within "Health Assure" together with a

review by the Executive. KW confirmed that these would be subject to external validation in February 2017.

7.6 Following a detailed discussion it was suggested that the answer to the question 1B "Is the board sufficiently aware of potential risks to quality?" should be kept to 1 as shown in the Committee paper given that the Board were seeing the BAF and risk register at the Board in October. As the group were not quorate this view was circulated for consent to members who had not attended the meeting of the Committee.

8. **Any Other Business**

The Chairman explained that those who had been unable to attend the meeting should be e-mailed a summary of the meeting and given until the end of the week to provide any comments.

9. **Date and Time of Next Meeting**

The next meeting will be held on Thursday, 20 October 2016, 9.30 – 11.30 hrs in the Trust Boardroom

Signed by Chair:

Ewan Carmichael

Date: ……………