Agenda

NHS Medway NHS Foundation Trust

Public Meeting of the Trust Board

Date: On 01 November 2018 at 12.30pm – 3.30pm

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

Item	Subject	Presenter	Format	Time	Action
1.	Patient Story	Director of Nursing	Verbal	1230	Note
	Opening of the Meeting				
2.	Chair's Welcome	Chairman	Verbal	1300	Note
3.	Quorum	Chairman	Verbal		Note
4.	Register of Interests	Chairman	Paper		Note
	Meeting Administration				
5.	Minutes of the previous meeting held on 6 September 2018	Chairman	Paper	1305	Approve
6.	Matters arising and actions from last meeting	Chairman	Paper		Discuss
	Main Business				
7.	Chair's Report	Chairman	Verbal	1310	Note
8.	Chief Executive's Report	Chief Executive	Paper	1315	Note
9.	Strategy			1320	
	a) STP Update	Chief Executive	Paper		Note
	b) Transformation Programme	Deputy Chief Executive	Paper		Note
10.	Quality			1350	
	a) IQPR	Director of Nursing & Medical Director	Paper		Discuss
	b) Corporate Policy – Complaints Management	Director of Nursing	Paper		Approve
	c) Q1 Mortality and Morbidity Report	Medical Director	Paper		Discuss
11.	Performance			1410	
	a) Finance Report	Interim Director of Finance	Paper		Discuss

Agenda

	b) Board Assurance Framework c) Corporate Policy – Information Governance d) Communications Report	Interim Company Secretary Director of Operational HR Director of Communications	Paper Paper Paper		Assurance Approve Discuss
12.	People a) Workforce Report b) Corporate Policy – HR and Organisational Development	Director of Operational HR Director of Operational HR	Paper	1450	Assurance Approve
Reports from Board Committees					
13.	Quality Assurance Committee Report	QAC Chair	Verbal	1500	Assurance
14.	Finance Committee Report	FC Chair	Paper		Assurance
For Noting					
15.	Council of Governors' Update	Governor Representative	Verbal	1520	Discuss
16.	Any other business	Chairman	Verbal		Note
17.	Questions from members of the public	Chairman	Verbal		Discuss
18.	Date and time of next meeting: 10 January 2019, 12.30pm-3.30pm, Trust Boardroom				

NHS Medway NHS Foundation Trust

MEDWAY NHS FOUNDATION TRUST

REGISTER OF INTERESTS FOR BOARD MEMBERS

1.	Jon Billings Non-Executive Director	• Director of Fenestra Consulting Limited • Associate of Healthskills Limited • Associate of FMLM Solutions • Chair of the Medway NHS Foundation Trust Quality Assurance Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
2.	Ewan Carmichael Non-Executive Director	• Timepathfinders Ltd • Chair of the Medway NHS Foundation Trust Charitable Funds Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
3.	Stephen Clark Chair	• Chairman Marshalls Charity • Chairman 3H Fund Charity • Non-Executive Director Nutmeg Savings and Investments • Member Strategy Board Henley Business School • Access Bank UK Limited – Non Executive Director • Chairman Advisory Council- Brook Street Equity Partner LLP • Chairman of the Medway NHS Foundation Trust • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
4.	Richard Boyce Director of Finance and Business Services	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
5.	James Devine Deputy Chief Executive & Director of HR & OD	• Member of the London Board for the Healthcare People Management Association • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
6.	Lesley Dwyer Chief Executive	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
7.	Anthony Moore Non-Executive Director	• Chair of the Medway NHS Foundation Trust Finance Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
8.	Joanne Palmer Non-Executive Director	• Director of Lloyds Gresham Nominee1 Limited • Director of Lloyds Gresham Nominee 2 Limited • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
9.	Karen Rule Director of Nursing	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
10.	Mark Spragg Non-Executive Director	• Trustee for the Marcela Trust

		• Trustee of the Sisi & Savita Charitable Trust • Director of Mark Spragg Limited • Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
11.	David Sulch Medical Director	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
12.	Adrian Ward Non-Executive Director	• Trustee of the Bella Moss Foundation • Director of Award Veterinary Sciences Limited • Chair of NMC Fitness to Practice Panel • Member of the RCVS Preliminary Investigation Committee • Member of the BSAVA Scientific Committee • Member of the Medway NHS Foundation Trust Quality Assurance Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds

Meeting in Public

NHS Medway NHS Foundation Trust

Board of Directors Meeting in Public on 06/09/2018 held at Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Ms L Dwyer	Chief Executive	LD
	Mr J Billings	Non-Executive Director	JB
	Mr E Carmichael	Non-Executive Director	EC
	Mrs T Cotterill	Director of Finance and Business Services	TC
	Mr J Devine	Deputy Chief Executive and Executive Director of HR & OD	JD
	Mr T Moore	Non-Executive Director	TM
	Mrs J Palmer	Non-Executive Director	JP
	Mrs K Rule	Director of Nursing	KR
	Mr M Spragg	Non-Executive Director	MS
	Dr D Sulch	Acting Medical Director	DS
Attendees:	Ms G Alexander	Director of Communications	GA
	Ms V Boutell	Public Governor for Medway	VB
	Ms J Dron	Dementia Clinical Nurse Specialist (Item 1 only)	JDR
	Dr G Fargher	Organ Donation Committee Chair (item 10 only)	GF
	Mr N Gerrard	Transition Lead	NG
	Dr P Hayden	Clinical Lead Organ Donation (item 10 only)	PH
	Mrs A Hill	Specialist Nurse Organ Donation (item 10 only)	AH
	Mr L Hinton	Director of Operational HR & OD	LH
	Ms D King	Governor Board Representative	DK
	Mr J Lowell	Director of Planning and Partnerships	JL
	Mr G Lupton	Director of Estates & Facilities	GL
	Ms G Mahil	Director of Clinical Operations	GM
	Mrs K Mukherjee	Deputy Medical Director (Item 11b	KM

		only)	
	Mrs B Notaraianni	Patient Story (Item 1 only)	BN
	Miss H Puttock	Minute Taker	HP
Apologies:	Mr J Coleman	Director of Clinical Operations	JC
	Dr D Hamilton-Fairley	Director of Strategy	DHF
	Mr A Ward	Non-Executive Director	AW

1. Patient Story

1.1 SC and KR welcomed BN and JDR to the meeting.

1.2 BN delivered a detailed presentation on her father's negative treatment at the Trust, specifically highlighting how the Trust failed to listen to the family, even though her father was a dementia patient.

1.3 SC apologised on behalf of the Board to BN and her family for the way her father was dealt with at the Trust.

1.4 JDR advised as part of the new emergency department, there would be two specific side rooms for patients with dementia, which were designed specifically for dementia patients. JDR further advised the Trust continued to provide dementia training as part of the nurse's induction.

1.5 JDR highlighted the Trust was now holding quarterly dementia workshops, which BN had been a part of and noted the Trust had also signed up to John's Campaign.

1.6 DS highlighted to the Board, the Trust was currently looking at patients who attend the emergency department regularly, and how they can be managed, as well as setting up an Acute Elderly Ward, so elderly patients can be moved from emergency department into a ward more efficiently.

1.7 It was agreed an update on dementia should be brought to the next public Board meeting.

ACTION: An update on dementia to be brought to the next public Board meeting.

1.8 The Board passed on their thanks to BN for her detailed presentation.

2. Welcome and Apologies for Absence

2.1 The Chairman welcomed everyone to the meeting.

2.2 Apologies for absence were noted as stated above.

3. Quorum

3.1 The meeting was declared quorate.

4. Register of Interests

4.1 The Register of Interests was noted.

5. Minutes of the Previous Meeting

5.1 The minutes of the previous public meeting were **APPROVED** as a true and accurate record of the matters discussed.

6. Matters Arising and Action Log

6.1 The Board of Directors **RECEIVED** the Action Log and noted all actions on the action log had been closed.

7. Chair's Report

7.1 SC highlighted the importance of having the patient story at the Trust Board meetings, to remind the Board of what is happening out in the Trust.

7.2 SC advised since the last Board meeting, the Trust had received its CQC report and remained at 'requires improvement', with a number of services being rated as good. However it was noted there was still work to be done, and this had already begun in the directorates.

7.3 It was noted the Trust continued to develop its transformation plan, and SC passed thanks to all staff involved. SC highlighted the extensive work being carried out to ensure the Trust was sustainable for the future and meets the needs of the community it serves.

7.4 SC advised Stella Dick, Lead Governor, who becoming to the end of her role as Lead Governor at the end of September and passed the Trust's thanks to Stella, for the hard work and dedication she had put into the role.

7.5 SC noted the summer fair for NHS70 had taken place in July, which was a great success and thanked all of those who organised it.

8. Chief Executive's Report

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

8.2 LD advised since the last Board meeting, the Trust had received its CQC report and had been rated as 'requires improvement'. LD noted the report highlighted the progress the Trust had made, as well as the Trust maintaining safety.

8.3 It was highlighted the CQC inspection regime had significantly changed, and the Trust would now be visited by the CQC every quarter to look at services that were not inspected, and at the end of the 12 months the CQC will have already looked at the Trust's core services, and will then carry out a well led inspection.

8.4 LD advised the Trust had now launched its new culture programme, which will help staff to think about how the Trust can work better together to make the Trust more efficient and sustainable.

8.5 LD highlighted the positive feedback the Trust had received in regards to the Employer with Heart Charter.

8.6 LD fed back the Trust had presented plans for the Hyper Acute Stroke Unit earlier this week, with a final decision due to be published early in 2019.

8.7 The changes to the executive team were highlighted with Tracey Cotterill stepping down as Finance Director, Diana Hamilton-Fairley moving to a new role in the Trust as Director of Strategy, and David Sulch acting as Medical Director in the interim. It was further noted James Lowell had been seconded to the role of Director of Planning and Partnerships, whilst his role of Director of Clinical Operations is covered by John Coleman.

9. Strategy

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

9.1 LD asked the members and attendees to take the paper as read.

9.2 LD highlighted clinical strategy had been one of the main focuses of the STP, and the STP was starting to determine what needs to be done across Kent to set the standards around quality and the level of care we provide. It was noted DHF attends the work group on behalf of the Trust.

9.3 It was noted the Trust was working closely with Medway Community Healthcare in regards to the consultation for adult community services.

9.4 LD advised she leads the work group of the productivity board of the STP, which is looking at the growing role of the Kent and Medway Commissioner and creating a single regulatory system across the region.

9.5 LD confirmed the STP was reviewing digital transformation, to ensure all Trusts would eventually be using the same systems across the region, including having an integrated care record. The Board noted the importance of investing in technology.

9.6 In regards to the role of a Kent and Medway strategic commissioner, the Board noted the importance of ensuring there was robust statutory governance around decision making and LD advised this was something NHSI and NHSE were beginning to create. It was recognised as DHF was part of the clinical strategy group, she would also be involved in this discussion.

9b) Trust Improvement Plan

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

9.8 JD advised the CIP target remained at £21m, with the Trust currently working above plan, however JD noted more CIPs needed to be identified in quarter 3 and 4 to ensure the control total is met.

9.9 It was noted the transformation team continued to review services across the Trust, in line with model hospital to improve quality of care.

9.10 JD highlighted the Trust would be working with wards over the next 8 weeks to reduce the average length of stay by two days, and would focus on 6 specific areas in the Trust first.

9.11 In regards to improvements with the emergency department, JD advised there were 6 core workstream that had been co-designed by the emergency department, which focused on why performance in the emergency department is variable. JD noted further information would be provided on this at the next Board meeting.

9.12 JD highlighted the significant challenge of making £21m in cost savings, however noted the Trust's confidence in the CIPs already identified to date, whilst noting more CIPs would need to be identified in the second half of the year. TC noted if additional CIPs cannot be identified, then other options will have to be taken into consideration on how the cost savings can be made.

9.13 JD confirmed CIPs are constantly risk-assessed and stress tested to ensure they will deliver. TM recognised this is reported back at the Transformation Assurance Group and Finance Committee.

9.14 Concerns were raised in regards to how clinical staff are being engaged in the cost saving schemes. JD advised the length of stay plan and emergency department improvement plan were both clinically led, and each workstream had a clinical lead and was co-designed by the clinical teams.

9.15 SC highlighted the importance of the transformation plan to ensure the Trust was sustainable for the future and meets the needs of the community both now and in the future.

10. Organ Donation

10.1 SC welcomed GF, PH and AH to the meeting.

10.2 PH asked the members and attendees to take the report as read and gave a detailed presentation on the Organ Donation annual report.

10.3 PH highlighted to the Board in 2017/18, there were 11 consented organ donors, of which 8 proceeded, with a total of 16 organs being transplanted.

10.4 GF highlighted the Organ Donation's Committees strategic objectives for 2018/19 and the achievements against the 2017/18 strategic objectives.

10.5 The Board noted and endorsed the Organ Donation annual report.

10.6 SC provided his thanks to GF, PH and AH.

11. Quality

11a) IQPR

11.1 KR asked the members and attendees to take the report as read and to note the report was based on July's performance.

11.2 KR highlighted the important work the transformation team were doing in regards to patient flow and emergency department improvements, and noted how critical this was to avoiding mixed sex accommodation breaches. KR noted the way mixed sex accommodation breaches is reported has changed, and noted the Trust would expect to see a spike in breaches over the next 2 months due to this, however it would then become steady again.

11.3 It was noted there had been one MRSA outbreak and a full review had been carried out.

11.4 KR passed her thanks to the directorates in regards to investigations into serious incidents, and noted there were currently no serious incident investigations breaching. KR noted the Trust continued not to report on duty of candour, due to the way of reporting being changed going forward.

11.5 KR noted NHSI had released new guidance on reporting pressure ulcers; however the tissue viability team had been heavily involved in the change of the reporting and have already implemented some of the changes within the guidance.

11.6 DS noted the emergency department continued to be challenged, partially due to not being able to admit patients quickly enough due to beds not being available.

11.7 DS advised a full report on mortality would be available at the next Board meeting, and the issue with coding for end of life care would be discussed shortly, with a full investigation taking place to see how this affects our HSMR. DS noted if the end of life care team were coded correctly the Trust's HSMR

would be 103, not 111 and this was being discussed with the CCG. JB noted external providers had also supported the Trust and noted this is a coding issue, and have provided assurances around this.

11.8 DS noted the good relationships between the end of life care team and the palliative care team, and highlighted the benefits to the patient by having an on-site end of life care team. The Board noted the importance of delivering care in the best place possible for the patient.

11.9 DS highlighted the SHIMI had continued to come down, and was in line with the national average.

11.10 In regards to RTT, GM advised the Trust had achieved 82.52% compliance, however there had been 2 patients who waited over 52 weeks, and confirmed full reviews had been carried out and no harm had been caused to the patient.

11.11 GM reported the Trust achieved 92% compliance against the 2 week wait.

11.12 In regards to emergency department, it was noted the Trust achieved 82.76% compliance against the four hour wait trajectory. It was noted there had been an increased number of attendances, with four 12 hour breaches.

11.13 KR noted there had been an increase in falls and advised a review had taken place and an action plan had been put in place.

11.14 It was noted there had been national coverage on elective C-Sections and KR noted the Trust did not offer elective C-Sections, but would refer who wanted an elective C-Section to another service.

11b) Medical Appraisal & Revalidation Annual Report

11.15 KM asked the members and attendees to take the report as read.

11.16 KM advised the purpose of the report was to provide assurance to the Trust Board that the medical appraisal and revalidation had been completed and to seek approval of the statement of compliance confirming the Trust is in compliance with regulation.

11.17 KM noted the report had gone to the Medical Revalidation Group before being brought to Board. It was noted the governance process for this report needed to be reviewed.

11.18 It was agreed going forward statutory and mandatory training needed to be part of job planning and appraisals, and if the statutory and mandatory training is not up to date, then their appraisals cannot take place.

11.19 The Board approved the Medical Appraisal and Revalidation Annual Report and approved KM as the responsible office for medical appraisal and revalidation, until a permanent medical director is appointed.

12. Performance

12a) Finance Report

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

12.2 TC advised at Month 4 the Trust reported a position of £1.3m favourable to plan pre PSF, however due to the PSF not being achieved in fully achieved and therefore the funding not being achieved, the Trust was adverse to plan by £0.82m. The Board noted the importance of getting the PSF funding for quarter 3 and 4.

12.3 It was noted the Trust had now received the money for the pay award and this had now been paid to staff.

12.4 TC highlighted there was still a significant risk in regards to CIPs for Unplanned Care. It was noted there had been a large focus on forecasting, to mitigate any risks and to identify where additional CIPs are required. TC advised £16m of CIPs had been identified, which left a £6m risk for the Trust to meet its control total.

12.5 In regards to the balance sheet, it was noted the Trust had £26m negative assets and the loan values now stand at £230m.

12.6 TC noted in regards to the capital plan of £31m, the forecast shows the Trust as on plan, however noted there may be some delay around the spend for the emergency department.

12.7 TC highlighted that the concordat had now been signed and the Trust was reporting against a block contract.

12.8 DS advised the transformation work around the improvements for flow through the emergency department would be significant, in order for the Trust to achieve the PSF funding.

12b) Standing Financial Instructions

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

12.10 TC advised the amendments to the standing financial instructions had been through the Integrated Audit Committee who endorsed the amendments.

12.11 TC highlighted the amendments to the scheme of delegations, proposed increasing delegating to the Director of Estates and Facilities and the Directors of Clinical Operations, as well as adding in new roles, including the Deputy Chief Executive.

12.12 The Board approved the amendments to the standing financial instructions.

12c) Communications Report

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

12.14 GA advised the communications team continued to actively engage staff in transformation projects.

12.15 It was noted the Trust continued to actively communicate with local councillors and MPs to ensure that are kept up to date with the Trust's transformation and understand the challenges the Trust faces.

12.16 GA highlighted the new culture programme 'You are the Difference' had started to be communicated to staff.

12.17 It was recognised there had been a lot of communication in regards to the CQC report, staff awards, NHS70 and the employer with a heart charter. GA advised the employer with a heart charter generated an enormous amount of media activity.

12.18 GA advised the communications team continued to support the governors with engaging with their communities.

13. People

13a) Workforce Report

13.1 LH asked the members and attendees to take the report as read.

13.2 LH highlighted 13 registered nurses had started with the Trust in July.

13.3 It was noted the initial Philippines recruitment plan for nursing continues with a total of 59 candidates being processed for posts at MFT.

13.4 LH advised 14 international nurses successfully undertook their objective clinical examination (OSCE) and are now working as registered staff nurses in the Trust. JD provided thanks to KR and her team for the joint working on this.

13.5 LH noted staff turnover had increased to 12%, the sickness rate had increased to 4% and the compliance with appraisals had reduced to 81%. LH advised part of the increase in staff turnover was due to the best choices scheme.

13.6 It was noted the spend for agency staff in July was down to 5%, which was the lowest spend on agency in a month for over 4 years.

13.7 The Board discussed the Trust annual statement for Modern Slavery and approved the statement to say the Trust has 0% tolerance to slavery.

13.8 It was agreed the Modern Slavery annual statement should continue to come to the Board for approval.

14. Quality Assurance Committee Report

14.1 JB asked the members and attendees to take the report as read and to note the Infection Control Annual report.

14.2 There were no questions.

15. Integrated Audit Committee Report

15.1 MS asked the members and attendees to take the report as read.

15.2 There were no questions.

16. Finance Committee Report

16.1 TM asked the members and attendees to take the report as read.

16.2 It was agreed the Finance Committee self-assessment should be brought to the next Board for review once it had been finalised. It was noted this was on the annual planner for all Board Committees.

17. Council of Governors' Update

17.1 VB queried what systems were in place to ensure any outsourced services provided the correct level of quality for the community. SC advised quality of care is always the first thing taken into consideration, and ensuring equality can be maintained. LD advised this is also part of the services specification.

17.2 VB noted concerns had been raised in regards to the provision of food and drinks being provided out of hours. KR confirmed food and drink is available to all patients at all times, and a catering group was being established to look at the types of food available to patients, particularly with special diets.

17.3 VB queried when the new Emergency Department would be open. GL noted further problems had been identified with the new ED department, and these needed to be addressed before the building could be handed over to the

Trust. It was noted the new ED department was expected to open at the beginning of November.

17.4 VB advised concerns had been raised in regards to waiting times for pharmacy. TC advised this was being monitored as part of the transformation plan, and improvements had started to be made already.

17.5 VB passed on the Council of Governors thanks to the Board for being the first Trust to sign up to the Employer with Heart Charter.

18. Any Other Business

18.1 SC noted TC would be leaving the Trust shortly and passed on the Board's thanks to TC for contribution to the Board.

19. Questions from members of the public

19.1 There were no questions from the public

19.2 SC provided his thanks to all those in attendance and closed the meeting.

The next Public Board will be held on Thursday 1st November 2018 at 12.30pm.
Venue: Boardroom, Post Graduate Centre, Medway NHS Foundation Trust

The meeting closed at 3.30pm

Stephen Clark: Date:
Chair

Meeting Actions Log

NHS Medway NHS Foundation Trust

Public Board **Date: 01/11/2018**

Action Log Number	Agenda Item Description	Action Due Date	Outcome	Owner	Status
0401	An update on dementia to be brought to the next public board meeting	01/11/2018	Verbal update to be provided at November Board meeting.	Director of Nursing	

Chief Executive's Report – October 2018

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

Board is asked to note the content of this report.

In and around Medway

Farewell and thank you to the Board

As most of you will be aware, this is my last Board meeting before I leave the Trust to take up a new role back home in Australia. I have very mixed emotions as I write this final report – excited about a new challenge and especially being able to see more of my family, but genuinely very sad to be leaving Medway. This has been my second home and my second family and Medway will always hold a special place in my affections. I will, of course, continue to follow the Trust's progress and will be wishing you all well every step of the way.

I would like to place on record my thanks to the Board for the commitment and determination you have shown in your desire to improve care for our patients, in the face of many significant challenges. On a personal note, I would like to thank you for the incredible support you have shown me over the past three years. Medway is very fortunate to have a Board of this calibre, with individuals who genuinely want to make a difference and have the drive to do so. Difficult though it will be for me to say goodbye, I know I am leaving the Trust in capable hands, which gives me every confidence that you will succeed in making Medway Brilliant!

Transformation and a visit from Lord Carter of Coles

Work to deliver the improvements we need to ensure the Trust becomes the efficient, effective organisation it needs to be, continues at pace. Clinical staff have been working alongside members of the Transformation Team to embed some of the changes we know will help us to deliver the best of care to our patients, while reducing our financial deficit.

In October we launched the new Sapphire Acute Frailty Unit (SAFU) which I am delighted to say is now open and caring for patients. I believe this will be a real benefit for particular patients, especially as we enter winter.

The unit provides short stay capacity to care for frail elderly patients and those with dementia. We know that home is the best place for these patients and our aim is to ensure that they are admitted through the frailty pathway in our ED, treated and discharged home within 48 hours.

We know that the journey to brilliant will be a long one, but it is vital that we continue to make these improvements, with the support of local system partners and our regulators. Therefore, it was a great honour to receive a visit from the nationally renowned health advisor Lord Carter of Coles and his colleague from NHS Improvement, Hugh Marshall.

Lord Carter was guided through the Trust, meeting with staff and visiting areas including the Emergency Department, to see some of the work taking place across the organisation and the ways we are looking to develop Medway in line with the 'Model Hospital' recommendations. These were borne out of a review on productivity in the NHS conducted by Lord Carter.

The visit provided us with the opportunity to showcase some of our improvements, but also to learn from others. We know that we still have much to do, but Lord Carter's visit highlighted all that we have already done and can be proud of.

Culture Programme

The 'You Are The Difference' programme, in which we are looking to address and redefine the culture here at Medway, has got off to a great start. Senior manager sessions have taken place with more than 400 staff attending. The feedback has been extremely positive, with managers making their commitment to working to improve the way we think of ourselves as an organisation and the way we interact with colleagues, patients and their families.

The programme is continuing through October and November, with all staff now being encouraged to attend so that we gain the momentum needed to ensure this is a positive change that 'sticks'.

Of course, this isn't just a programme – it gets to the heart of our staff being 'the best of people'. In delivering the best of care to our patients, they really are the difference.

Supporting our staff

We know that sometimes staff need more support both in and outside of work and so I was very pleased to be able to launch a brand new Employee Assistance Programme (EAP) for all staff. The EAP will provide confidential, impartial advice and support 24 hours a day, 365 days a year and is free for staff to access whenever they need.

The service provides counselling and also telephone information and advice on a range of subjects, as well as an online platform with articles and advice and access to counsellors by web chat.

Celebrating the best of Medway

The recognition of the great work undertaken by our staff continues to be celebrated and I was proud to learn that two brilliant staff members have received Excellence in Teaching Awards from King's College.

Dr Paul Kitchen, consultant gastroenterologist, received his award for his outstanding contribution to teaching fifth year medical students from King's Medical School. He is also the consultant lead for fifth year students at Medway.

Daniella James, administrator for the King's students, received her award in recognition of all the work she does with undergraduates. She has served in this role for many years and always goes the extra mile to make sure the students have the best educational experience they can while at Medway. Both awards are extremely well deserved.

I was also absolutely delighted that Amanda Epps and Becky Watt were announced as Diabetes Healthcare Professionals of the Year at the Quality in Care Diabetes Awards last night. This is a fantastic achievement from two staff members who really do live out the Trust's values and have shown a real commitment to delivering the best of care to our patients and local community. I am really proud of their achievements and I know they will be too.

Prehabilitation Programme

I was honoured to take part in the opening of the Trust's Prehabilitation Unit on 16 October, along with Medway's Director of Public Health James Williams and many colleagues from across the Trust. The unit is the first of its kind in the south east and it has been achieved thanks to the passion and commitment of Dr Rampal and her team – Dr Manisha Shah and Roberto Laza Cagigas.

There is a huge amount of evidence that shows people who have optimal health before surgery recover faster and are able to get back to their pre-operative way of life more quickly, and I am so proud that Medway is now a leader in this field.

We heard from a patient who had been declared too unfit to undergo surgery for his cancer, but having gone through the programme was able to improve his fitness to the extent that he was able to have surgery – the programme gave him options that he did not have before.

Congratulations to Dr Rampal and her team on their contribution to making Medway brilliant. We are all looking forward to hearing what ideas and innovation they will bring back from their visit to McGill University in Montreal, following their award of the inaugural Chief Executive's Scholarship for Brilliance.

I would also like to thank the League of Friends for their support in helping us to purchase a specialist exercise bike for the unit.

Annual Members' Meeting

At the end of September we had our Annual Members' Meeting (AMM), our yearly gathering of our Trust members and stakeholders where we were pleased to present our annual report and financial accounts. This year we welcomed more than 120 people to the meeting.

As well as the presentations from the senior team, I was really proud to hear Neil Kukreja, our Clinical Co-director for Surgical Services, and Sarah Hare, one of our consultant anaesthetists and the National Clinical Lead for the National Emergency Laparotomy audit, share their ground-breaking work in setting up a support group for patients who have had emergency laparotomies, a high risk surgery that we undertake 200 times each year.

Sarah and Neil were joined by Donna, a patient who is a member of the group, who spoke about how her life changed after the procedure and the support we gave to her in her recovery. She told us about how much she and other patients value being listened to by clinicians; being asked what more we could do to improve the experience is something we need to do more of, and I am so pleased that we are leading the way in this through Sarah

and Neil. It is always very moving to hear the stories of our patients and really brings home how the excellent care we provide can make a huge difference.

Changes to the Executive Team

I am pleased to say that we recently welcomed some new faces to Medway. Having the best of people here at Medway means recruiting the very best talent from the NHS and beyond and it gives me a real sense of pride to see the number of talented and highly experienced people who want to come and work here. It demonstrates that news is spreading about the great work we are doing at Medway and the exciting plans we have for the future.

Earlier this week, we welcomed Harvey McEnroe, who joined us as Chief Operating Officer for Unplanned and Integrated Care. Harvey is an experienced NHS manager who has worked at a number of high-profile London trusts and joins us from Kings College Hospital NHS Foundation Trust. Harvey's role is not an entirely new one but builds some additional responsibilities into the Director of Clinical Operations role that we have had until now; this will bring our organisational structures more in line with other trusts. To mirror this change in Unplanned Care, Gurjit Mahil will become Chief Operating Officer for Planned Care

I'm also pleased to announce that we have appointed Morfydd Williams from NHS England as our new Director of IT Transformation. For the first time this role will be at Executive level, a signal of our intent to place technology at the forefront of our future strategy. This is in line with national priorities identified by the Health and Social Care Secretary, Matt Hancock.

We have also appointed Brenda Thomas as our new Company Secretary. Brenda has solid experience from other parts of the NHS. We don't have starting dates for Morfydd or Brenda just yet but I will keep you updated!

Celebrating two years of a smoke-free Medway

On Wednesday 17 October we were proud to mark the two-year anniversary of the hospital becoming a smoke-free site by signing up to the NHS Smokefree Pledge, along with James Williams, Director of Public Health, Councillor David Brake and colleagues from the Medway Stop Smoking Service. The pledge is designed to be a clear and visible way for NHS organisations to show their commitment to helping smokers to quit and to providing smoke-free environments which support them, something we have been working towards since October 2016 with the support of Medway Council's fantastic Stop Smoking Service.

Medilead

I was delighted to welcome the new cohort of Medileadians to the Trust in September – the Medliead course is designed specifically for junior doctors and supports them to feel valued and empowered to provide the highest quality care for our patients.

During our session on 17 October, I sent the group on a walkabout to visit those important supporting roles that are so essential to the smooth running of our hospital, yet often go unnoticed. Each MediLeadian paired up with colleagues from Estates, HR, Finance, Portering, Housekeeping , IT, Communications and Engagement, Waste and Transport and Pharmacy to learn more about what each other does, and how they can each support one another in making their roles brilliant.

Each pair then fed back to the group the things they had learnt about their colleagues' roles which sparked some interesting discussion. It was a powerful, insightful session and I hope the experience will go some way to building a greater understanding and insight into each other's challenges.

North Kent Pathology Service

The Pathology Services provided by Medway NHS Foundation Trust and Dartford and Gravesham NHS Trust merged at the end of last year. The new North Kent Pathology Service (NKPS) is provided from a laboratory at Darent Valley Hospital (DVH), and the merged blood science testing went live in June 2018.

Unfortunately, during the late summer issues within the NKPS laboratories processes led to blood samples not being processed in time, resulting in the need to repeat tests for more than 2,000 patients We appreciate this would have caused worry for some patients. All affected patients have since been contacted and a significant number of patients have now been retested.

Patient safety is our absolute priority. Processes at the DVH laboratory have been modified to prevent any reoccurrence. The incidents have been reported as serious Incidents and are undergoing formal investigation by both Trusts.

The NKPS board has also commissioned an independent review by the Royal College of Pathologists.
We remain committed to ensuring that the best possible pathology service be provided for our patients and continue to work in partnership to deliver a joint service.

NHS Providers Conference

The Chair, James and I, along with colleagues from our Emergency Department, were delighted to represent the Trust at the annual NHS Providers Conference early in October. The conference brings together NHS chairs, chief executives and other executives from across the country to discuss the issues that our organisations face as providers of healthcare and to share ideas on how we can rise to the challenges we face.

It provided us with an opportunity to showcase the work we have done to strengthen our Emergency Department and the support we have provided to patients and families in our planned care directorate: our stand focused on some of the incredible changes that have been developed and delivered by our frontline staff – the success of the nursing team in reducing their vacancy rate and turnover of staff; the turnaround of the performance of our breast screening service; and the initiatives from our surgical teams in prehabilitation, supporting emergency laparotomy patients and the families of the bereaved.

It was great to see the stand there and it was great to hear from more than one chief executive telling me how impressed they were with what our staff had accomplished.

Medway Leadership Programme

We have been fortunate to be part of the Medway Leadership programme, which is unique to Medway and which several members of our staff are part of. The programme involves managers and leaders across multiple agencies coming together to gain an appreciation of the breadth of services that we work alongside such as policing, defence, council, education

and housing – and looks at how working together could provide a greater benefit to the people of Medway.

The most recent session was held on 12 October and we were proud to host the event here at the Trust. Our Director of Nursing Karen Rule delivered a Question and Answer session where she spoke of how nursing and care has changed since she was a junior nurse, before the group moved on to our Simulation Centre, where colleagues had the opportunity to roll their sleeves up and understand what our reality here at Medway is!

It was a brilliant session, with really positive feedback from colleagues across the variety of sectors, and proved that by working together with our local partner organisations, we can continue striving to provide the best of care for our local community.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/11/2018 Agenda item

09a

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

NHS Medway NHS Foundation Trust

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 This report provides an update on activity at an STP level since the last Board meeting.

1.2 An announcement of a preferred option for the future of stroke services was made in September, along with an announcement about vascular services.

1.3 Work towards the establishment of a strategic commissioner is continuing.

2 ACUTE STROKE SERVICES

2.1 On 13 September the Joint Committee of Clinical Commissioning Groups recommended a preferred option to establish three hyper acute stroke units (HASUs) alongside acute stroke units at Darent Valley Hospital, Dartford, Maidstone Hospital, and William Harvey Hospital, Ashford.

2.2 Medway had been included in three of the five shortlisted options, but was not in the preferred option.

2.3 We have made clear that we are very disappointed at the news, but that we continue support the concept of HASUs, and believe three is the right number for Kent. We agree that establishing HASUs will lead to better outcomes for stroke patients.

2.4 Meanwhile, we will continue to improve stroke services at Medway for our patients now, with a view to a safe transfer in future.

2.5 Local stakeholders, including MPs for the area and Medway Council, have expressed their concerns that Medway is not included in the preferred option and have said they will consider challenging the decision-making process.

2.6 Councillors have also emphasised that social care should be included as part of the discussion on rehabilitation services.

2.7 Work is now taking place at STP level to develop a Decision Making Business Case (DMBC) for the Joint CCGs to consider before they make a final decision in January.

2.8 The DMBC will set out an implementation plan covering areas such as workforce, estates and the capital requirement. This will then be reviewed by various bodies including the Clinical Senate, NHS England and NHS Improvement. The Joint Health Overview and Scrutiny Committee will continue to be involved.

3 VASCULAR SERVICES

3.1 Medway is being recommended as a non-arterial site for vascular services in the future, with a recommendation that the arterial site is at Kent and Canterbury

Best of care Best of people

Report to the Board of Directors

Hospital. This follows a long period of review and engagement with patients and public, to find the best configuration of vascular services for the county.

3.2 This is a recommendation from the Kent and Medway Vascular Review Programme Advisory Board to NHS England specialised commissioning, and is for an interim solution for vascular services. Although not technically an STP project, it concerns the future of vascular services for the whole county.

3.3 We had felt that Medway could have been the arterial centre, with the non-arterial centre in east Kent, however we accept this recommendation and will work with other providers and commissioners to ensure that the vascular services that will be provided in Medway in future, including appointments before surgery and follow-up in outpatients, are the best they can be.

3.4 A preferred option had already been identified to locate a single arterial inpatient centre in east Kent. The final decision on the hospital in which this would be located is linked to the East Kent Transformation Programme, which is looking at options for the future delivery of urgent and emergency care.

3.5 The timescale to identify and implement this reconfiguration is likely to not see a future solution in place for five to seven years, hence NHS England felt it was important to consider interim solutions.

4 SYSTEM TRANSFORMATION

4.1 A Strategic Commissioner Steering Group has been established, chaired by Dr Bob Bowes, Clinical Chair of West Kent CCG. This group will lead and shape the development of future commissioning arrangements.

4.2 This is the first priority for the Kent and Medway Integrated Care System (ICS), whose purpose is to integrate primary care, mental health, social care and hospital services, redesigning care around people at risk of becoming acutely unwell.

4.3 Meanwhile, plans are in hand to appoint an independent chair for the STP, and to set up a group to provide non-executive oversight of the delivery of the STP.

5 DIGITAL WORKSTREAM

5.1 CCGs are being asked to support a proposal to commit to one interoperative solution to establish an electronic Kent and Medway Care Record (KMCR).

5.2 They are also being asked to agree funding to implement and run the solution.

Report to the Board of Directors

5.3 Clinicians and local authorities will be involved in the development of the system.

6 EAST KENT UPDATE

6.1 The East Kent Transformation Programme is in the process of developing a pre-consultation business case (PCBC), including clinical and service models.

6.2 This is due to be finalised by December 2018, with sign off and submission to NHS England in January.

6.3 Pre-consultation engagement meetings are being held across east Kent during October and November.

NHS Medway NHS Foundation Trust

Performance Report to the Trust Board (public)

Committee Date: 01/11/2018 **Agenda item** 09 b

Title of Report	**Transformation (Improvement) - Performance Report**
Prepared By:	James Devine, Deputy CEO Jack Tabner, Associate Director of Transformation
Lead Director	James Devine, Deputy CEO
Committees or Groups who have considered this report	Transformation Assurance Group Trust Executive Team
Executive Summary	This report summarises the progress made to date (as at M6) on the cost improvement programme. In addition, an update is provided on the work of the transformation team more broadly, and the support provided on Trust wide improvement initiatives. The reported position for CiP delivery at M6 is129% to plan; with £7.3m achieved against a plan of £5.6m – this is slightly ahead of the last reporting period. Against the CiP target of £21m, schemes valuing £20.6m have been identified, with further schemes in validation phase to further bridge the gap and mitigate any risk adjustments required. Whilst this is an encouraging start, it is acknowledged that the majority of the schemes are due to be delivered in M7-M12, and therefore the existing review mechanisms will be further enhanced to assess delivery and escalate when necessary. As previously reported, the second half of the year will be challenging in CiP terms, with an increase in the savings required in Q3 and Q4 to meet the CiP target, and ultimately the 2018/19 control total. The work on using Model Hospital to better refine services defined as a specialist emergency centre continue with the Trust working closely with Medway CCG in reviewing alternative referral pathways, and/or service provision that is right for patients. Further work is ongoing within particular specialities to review areas such as service efficiency, workforce and reducing variation. The projects on reducing length of stay, and ED (emergency department) improvement have also commenced since the last report to the Board, with an improvement of almost one day in length of stay across the pilot wards, and a slight improvement in Trust length of stay overall. Within the flow workstreams, there is

Performance Report to the Trust Board

	progress on streaming at the front door, ambulant patients, and the frailty pathway following the opening of the frailty unit on 03 October 2018. There is more work to do in other project areas such as ambulance handovers, and better planning with the estimated date of discharge. In September, the Trust launched its culture programme (You Are The Difference), with now over 450 managers having attended, and over 200 staff since the launch of the staff sessions on 11 October 2018. The Trust Board also attended one of the sessions, with members of the executive opening each of the sessions on a rotational basis.
Resource Implications	None at this time
Risk and Assurance	There is no change to the risks previously highlighted. The assurance mechanism remains in place; this being the transformation assurance group (TAG)
Legal Implications/Regulatory Requirements	Financial Special Measures (linked to non-delivery of CiP)
Improvement Plan Implication	The work of the transformation team spans across the 13 workstreams of Better, Best, Brilliant
Quality Impact Assessment	Not required at this stage
Recommendation	The Board are recommended to note the performance reported and consider as is appropriate.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

NHS Medway NHS Foundation Trust

Performance Report to the Trust Board

1 COST IMPROVEMENT (CIP)

1.1 The reported position for CiP delivery at M6 is129% to plan; with £7.3m achieved against a plan of £5.6m.

1.2 As seen below, against the CiP target of £21m, schemes valuing £20.6m have been identified, with further schemes in validation phase to further bridge the gap and mitigate any risk adjustments required. Whilst this is an encouraging start, it is acknowledged that the majority of the schemes are due to be delivered in M7-M12, and therefore the existing review mechanisms will be further enhanced to assess delivery and escalate when necessary.

2018/19 CIP Forecast vs Target Month 6

Directorate Split	Unplanned Care (£'000)	Planned Care (£'000)	Corporate (£'000)	Estates (£'000)	Totals (£'000)
Target	(10,100)	(8,174)	(2,021)	(726)	(21,021)
CIP Budget as % of Expenditure Budget	7.0%	7.0%		3.1%	6.9%
Identified	(6,733)	(6,948)	(6,067)	(868)	(20,616)
Unidentified	(3,367)	(1,226)	4,046	142	(405)
% Identified to Target	67%	85%	300%	120%	98%
YTD Target	(2,993)	(2,421)	(12)	(266)	(5,692)
YTD Actual	(3,484)	(3,118)	(423)	(314)	(7,339)
YTD Variance	491	697	411	48	1,647
YTD % Delivery	116%	129%	3525%	118%	129%

1.3 The £7.3m delivered to date is made up of £2.8m in non-recurrent savings (38%) and £4.5m in recurrent savings (62%). The £21m plan is split 71% recurrent and 29% non-recurrent. This will further benefit the 2019/20 cost improvement programme.

1.4 Progress against cost improvement programmes is discussed in greater detail at the finance committee, and the transformation assurance group, which at the most recent meeting, discussed the risks to delivery as we enter the second half the year. The risks largely focus on full delivery of identified schmes each month between M7 and M12, and the identification and delivery of additional schemes to bridge the gap.

1.5 In October, NHS Improvement undertook a 'deep-dive' on the Trusts cost improvement programmes, and quality impact assessments. The initial feedback was largely positive, with directorate teams cited as being able to provide 'greater detail on their CiP plans since the last NHSI deep dive'.

Performance Report to the Trust Board

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

2 PROGRAMME STATUS UPDATES

Flow & Length of Stay

2.1 A 5% improvement in 4 hour emergency access target has been achieved since the programme commenced in August 2018. This is primarily as a result of effective streaming and the management of ambulatory patients within ED which is delivering excellent Non-Admitted performance. That said, it is acknowledged that this performance needs to be sustained until the programme can be seen as successful.

2.2 As we move into winter the acuity of patients arriving in ED will inevitably increase and poor Admitted performance will pose the greatest risk to continuing performance against 4 Hour Emergency Access target. The Trust is working well with system partners, and predominantly Medway CCG and the Local A&E Delivery Board (LEADB) to stress test the plans for winter.

2.3 As part of the change in approach to ambulant patients, direct referrals have increased by 10 patients per week in this period, and STREAMing rates have increased by 2% since August 2018. Again, there is more work to do in order to embed these practice changes, and the clinical teams continued engagement is key.

2.4 In other work streams associated with flow, there is more work to do in order to progress the objectives set at the outset. Ambulance handovers have improved but lack consistency over a 7 day period, and use of the estimated date of discharge to better plan also requires further work. These areas will be addressed as part of the project groups.

2.5 On length of stay, the new frailty assessment unit opened on 03 October 2018 with patients pathway now directly to the unit.

2.6 On the pilot ward areas, overall, length of stay has reduced by almost one day, with the Trust overall length of stay also reducing. There is much more to do on length of stay, with the table below showing good improvements in most of the pilot areas, but increases in others. It is worth noting that these are complex wards, and they were selected to ensure that the process could be tested robustly.

Performance Report to the Trust Board

w/c	Aug 6th	Aug 13th	Aug 20th	Aug 27th	Sept 3rd	Sept 10th	Sept 17th	Sept 24th
Byron	8.62	13.21	13.92	6.43	16.17	7.53	7.64	13.20
Keats	7.92	6.17	10.18	5.20	6.40	10.86	7.23	9.50
Milton	17.60	8.82	18.33	12.75	18.57	10.44	15.31	11.64
Nelson	9.20	7.68	7.80	7.14	8.29	6.96	4.81	7.60
Tennyson	12.59	8.96	6.33	7.46	13.43	10.31	11.65	7.53
Will Adams	6.61	12.64	6.69	11.71	7.29	14.32	5.12	8.16
Pilot Wards	10.04	9.20	9.48	8.49	10.99	9.91	8.22	9.14

A more detailed summary is provided as an appendix to this document

3 CULTURE – YOU ARE THE DIFFERENCE

3.1 The Trust launched the new culture programme; 'You Are The Difference' on 12 September 2018 with now over 450 managers having attended, including the Trust Board and Executive team. On 11 October 2018, the staff sessions commenced with over 200 staff having attended up to and including 24 October 2018.

3.2 The feedback has been overwhelmingly positive, with plans to capture more tangible data to provide a strong evidence base of improved engagement.

3.3 All attendees are asked to sign up to a pledge, with the plan to exhibit these on the hospital walls.

3.4 Over 20 culture ambassadors have signed up – meaning that they will continue to support the programme once all of the sessions have finished.

3.5 The largest group so far 110 (below) were from the theatre team

Performance Report to the Trust Board

4 RECOMMENDATIONS

4.1 The Board are asked to note the progress made to date on CiP, flow and length of stay, acknowledging that there is more to do as part of the projects to embed change.

---Ends---

NHS
Medway
NHS Foundation Trust

Trust Board - Transformation Update

01 November 2018

Jack Tabner
Associate Director of Transformation
Rita Lawrence
Head of Culture & Engagement
James Devine
Deputy CEO

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NHS Medway NHS Foundation Trust

CIPs and financial performance – Month 6 update

Flow update (ED, LoS reduction, Frailty Unit)

Best of care Best of people

CIP overview

NHS Medway NHS Foundation Trust

Month 6 Position

Year to date position

£7.3 m

£1.6m favourable to plan

18/19 CIP Forecast

Year end forecast

£20.6 m

Up from £17.9m at Month 5

Planning RAG:

- £3.4m
- £2.6m
- £14.6m

We are over-programming to ensure we mitigate a) any slippage and b) cost pressures / budgetary overspend

1. ***Theatres utilisation and DC rates***
2. ***Outpatient productivity***
3. ***NEL LoS reduction***
4. ***Coding***

18/19 ideas → delivery

As we move into the process of planning for next year there are currently a total of 12 schemes with an indicative value of

£12 m

…in addition to the recurrent FYE of 18/19 schemes to be quantified

19/20 Emerging Opportunities

YTD delivery at Month 6 of CIP is £1.6m favourable to plan

NHS Medway NHS Foundation Trust

2018/19 CIP Forecast vs Target Month 6

Directorate Split	Unplanned Care (£'000)	Planned Care (£'000)	Corporate (£'000)	Estates (£'000)	Totals (£'000)
Target	(10,100)	(8,174)	(2,021)	(726)	(21,021)
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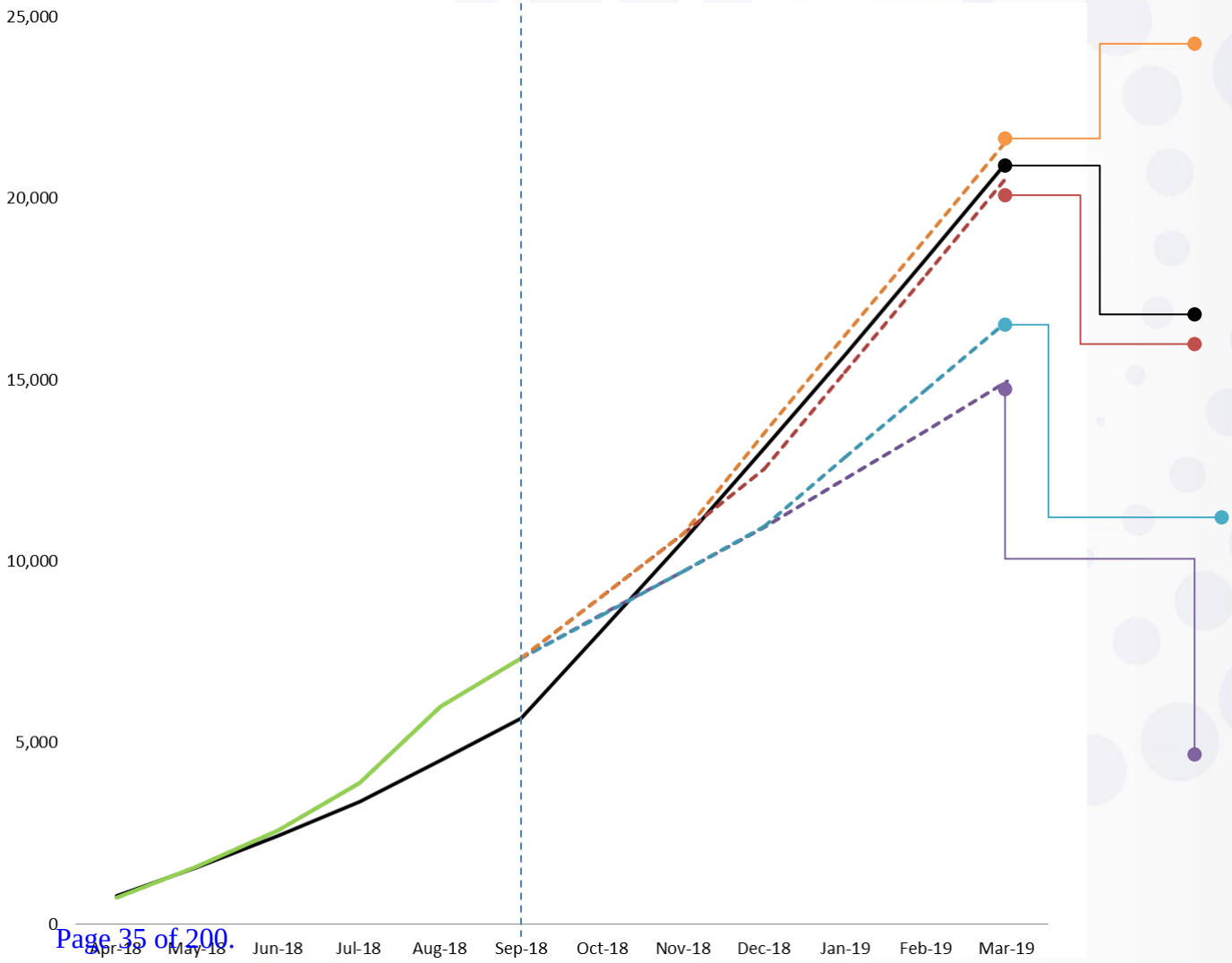
YTD % Delivery	116%	129%	3525%	118%	129%

YTD delivery at Month 6 of CIP is £1.6m favourable to plan – YTD the Trust has delivered £7.3m against a £5.7m target.
The £7.3m delivered is made up of £2.8m in non-recurrent savings (38%), £4.5m in recurrent savings (62%). The £21m plan is split 71% recurrent and 29% non-recurrent.

The Month 6 forecast is £20.6m based on the assumption that all schemes currently in the plan deliver

Medway NHS Foundation Trust



Do more – Forecast to deliver in full plus an additional PYE £1m from ideas to deliver in 18/19 £21.6m total (additional theatres utilisation programme)

Target - £21m NHS I plan

Forecast base case - £20.6m total reported as at M6

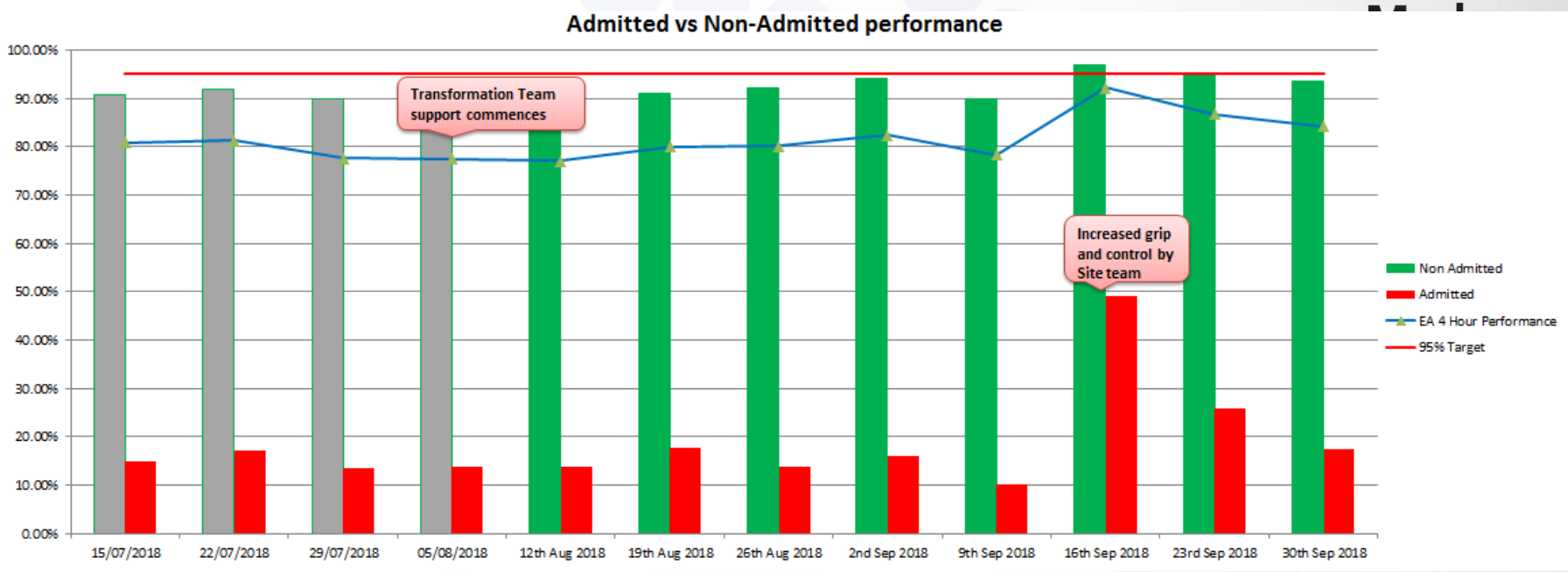
Further risk adjustment – YTD actuals banked and 70% (avg. acute Trusts CIP delivery in 17/18) of future months forecast £16.6m total

Assumption that SWG schemes do not deliver (extreme risk adjustment) – none of the SWG to deliver this year £14.9m total

Flow update (ED, LoS reduction, Frailty Unit)

Medway NHS Foundation Trust

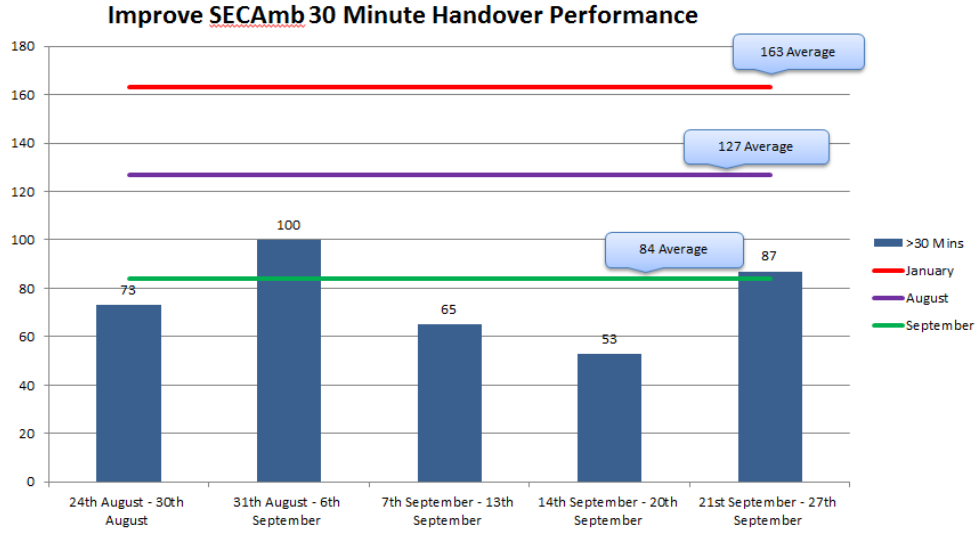
- **Programme objective(s):** Improve performance against the ED access standard; reduce median LoS by 2-days across the Unplanned bed base through improved discharge processes
- **Workstreams:** Emergency Access Pathway Improvement Plan (6 sub-streams), Criteria for discharge, EDNs and TTOs, Red2Green, Role of Therapies, Sapphire Acute Frailty Unit
- **Key metrics:** ED 4-hour performance (%), ALOS (Unplanned bed base), % occupancy rate, # outliers, # discharges per day, # discharges before noon
- **Activities:**
  - Board Round support – Programme leadership, matrons, and Transformation Team progress chasers
  - Communications drive – ‘There’s no place like home’
  - Improved protocols – Full Hospital protocol; SOP for Frailty Unit, Effective Board Round policy
  - Development of training and educational materials
  - Best Flow week (6-12 Nov) & MADE event upcoming (7 & 8 Nov)
  - Governance review and ToRs refresh; merging EAPIP, Flow and Frailty groups

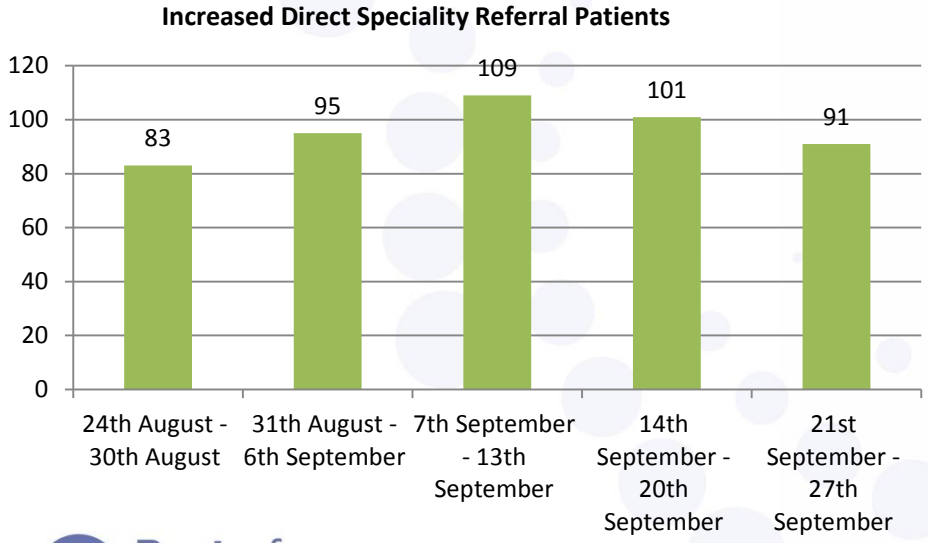


A 5% improvement in 4 hour emergency access target has been achieved since EAPIP commenced in August. This is primarily as a result of effective streaming and the management of ambulatory patients within ED which is delivering excellent Non-Admitted performance.

As we move into winter the acuity of patients arriving in ED will inevitably increase and poor Admitted performance will pose the greatest risk to continuing performance against 4 Hour Emergency Access target.

Emergency Access Pathway Improvement Plan





Ambulance Arrivals

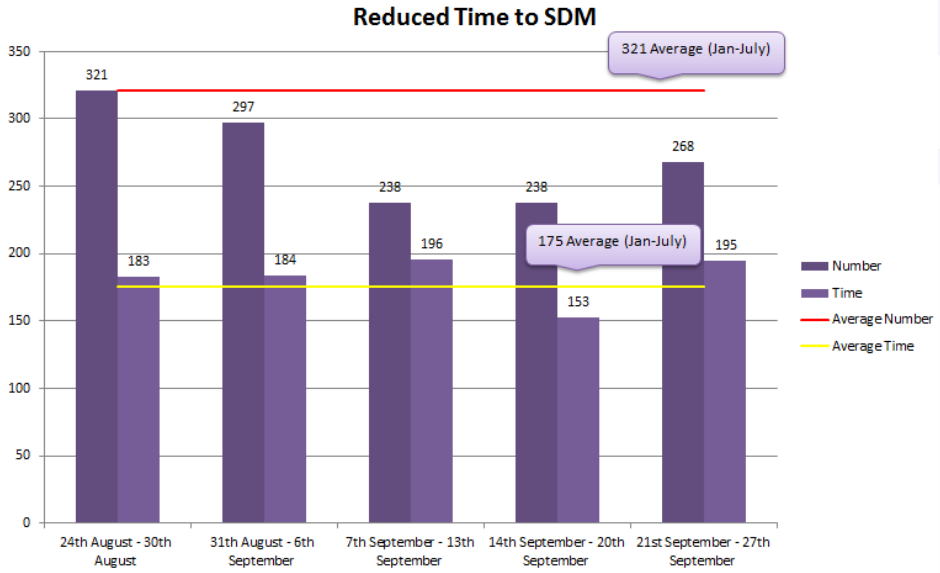
Objectives	Update and Mitigations
1. Establish RAA SOP (RAT/SPA/FEAT) 2. Become best nationally by Q4 3. Establish Frailty fast-track service 4. Reduction in HIU and primary care patients	• SOP in place, further ambulance handover improvements anticipated when RAA opens (08/11/18) • Therapies involved in developing Frailty areas in RAA • Work commenced on engaging SECambs and 111 in relation to High Impact Users

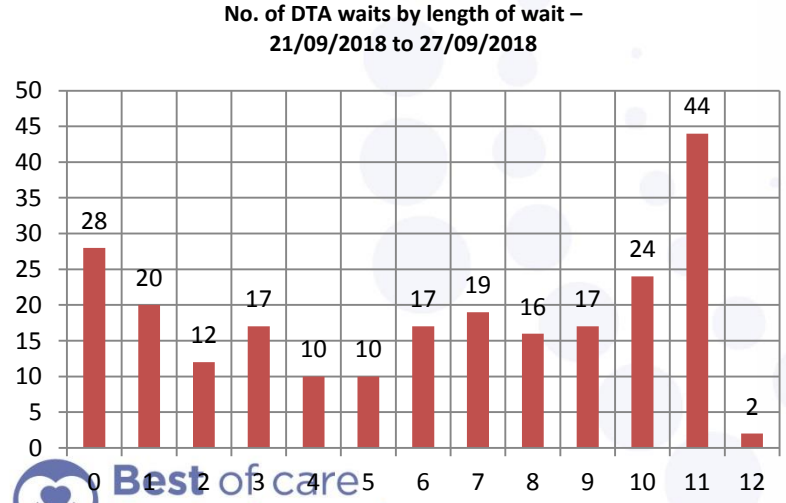
Ambulant Patients

Objectives	Update and Mitigations
1. Fully functioning Major Lite 2. Direct referral to Specialties 3. Increased Primary Care referral	• Majors Lite commenced on 01/10/18 plan to be fully staffed by 01/11/18 • Direct referrals have increased by 10 patients per week in this period • STREAMing rates have increased by 2% since August

Best of care
Best of people

Emergency Access Pathway Improvement Plan

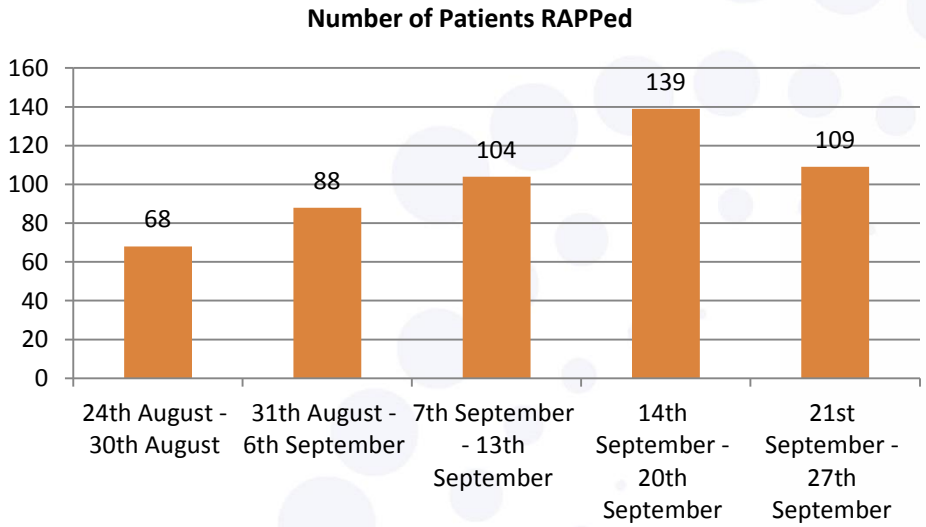


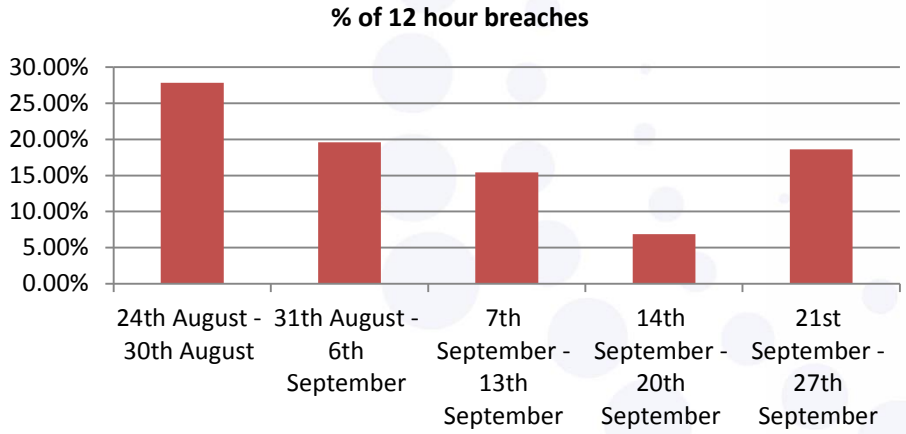


Speciality Referrals	
Objectives	**Update and Mitigations**
1. Instigation of Medical triage 2. Direct access model in place 3. Joint clerking <secondary junior clerking	• 10 additional chairs in MAU from 08/10/18 to improve flow of ambulant patients and avoid unnecessary overnight stays (impact to be evaluated prior to establishment of medical triage. • IT solution developed to speed up referrals to Medical 'Take' list

Managing a full ED	
Objectives	**Update and Mitigations**
1. Full Hospital Protocol in place (Push when no pull – patients in right place)	• Process mapping underway to inform use of Full Hospital Protocol • MFT Protocol to be developed

Emergency Access Pathway Improvement Plan





Assessment Areas	
Objectives	**Update and Mitigations**
1. 24-hour speciality assessments areas 2. Resilient assessment areas 3. Introduce Frailty Assessment Area	• The numbered of patients being RAPPed will continue to increase once RAA is functioning • Additional capacity (increased seating in MAU from 08/10/18) • Frailty Assessment areas and pathway to SAFU to be established

Site and Flow	
Objectives	**Update and Mitigations**
1. Use of EDD for live correlation between 2. Increased MAU transfers within set timeframes 3. Reduction in late bed allocations 4. End 12-hour breaches	• Hospital wide comm.s regarding definition of EDD required • Site Team now attending ED Board Rounds • Introduction of 11 hour model has reduced 12 hour breaches

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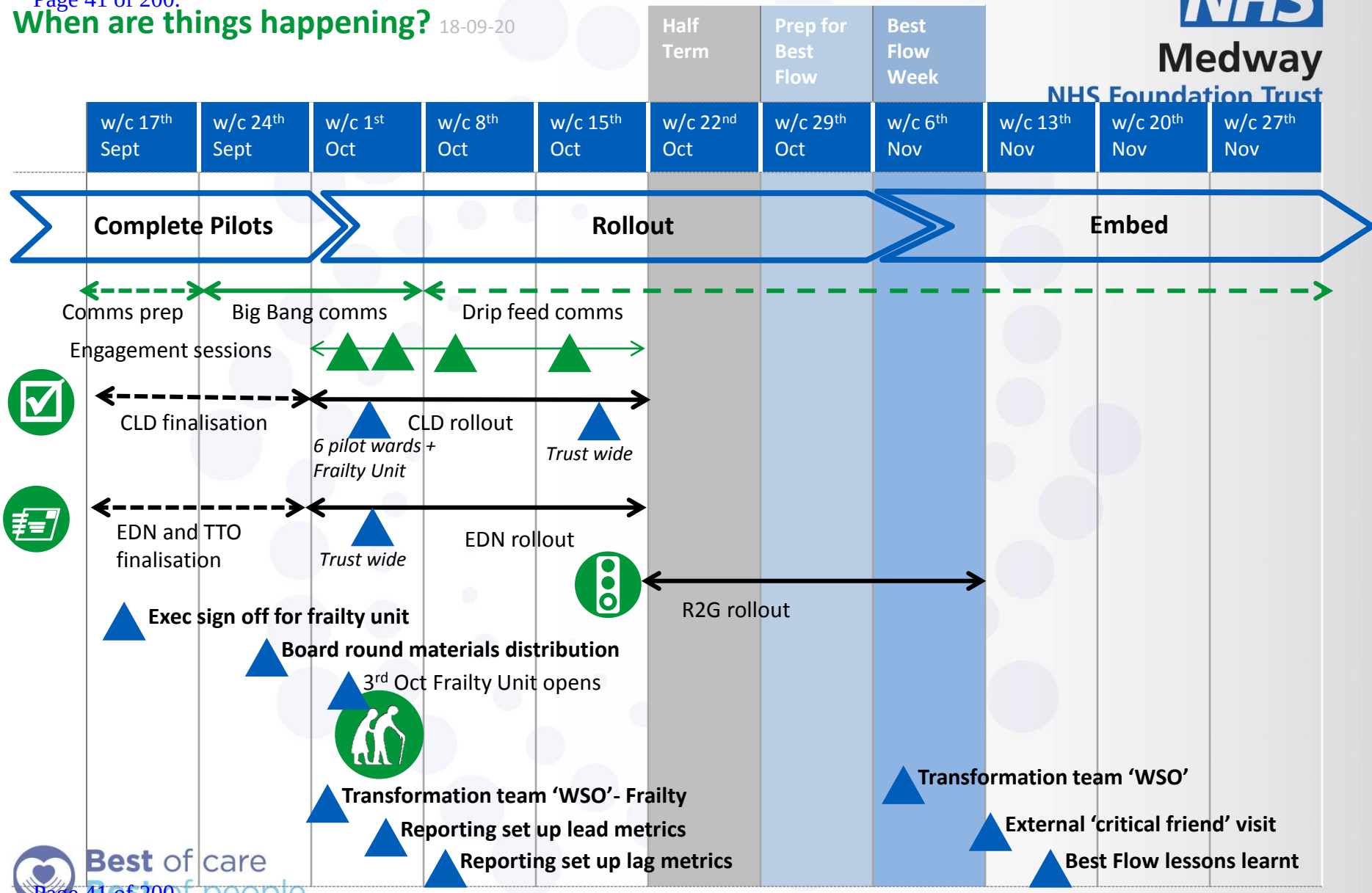
When are things happening? 18-09-20

NHS Medway NHS Foundation Trust



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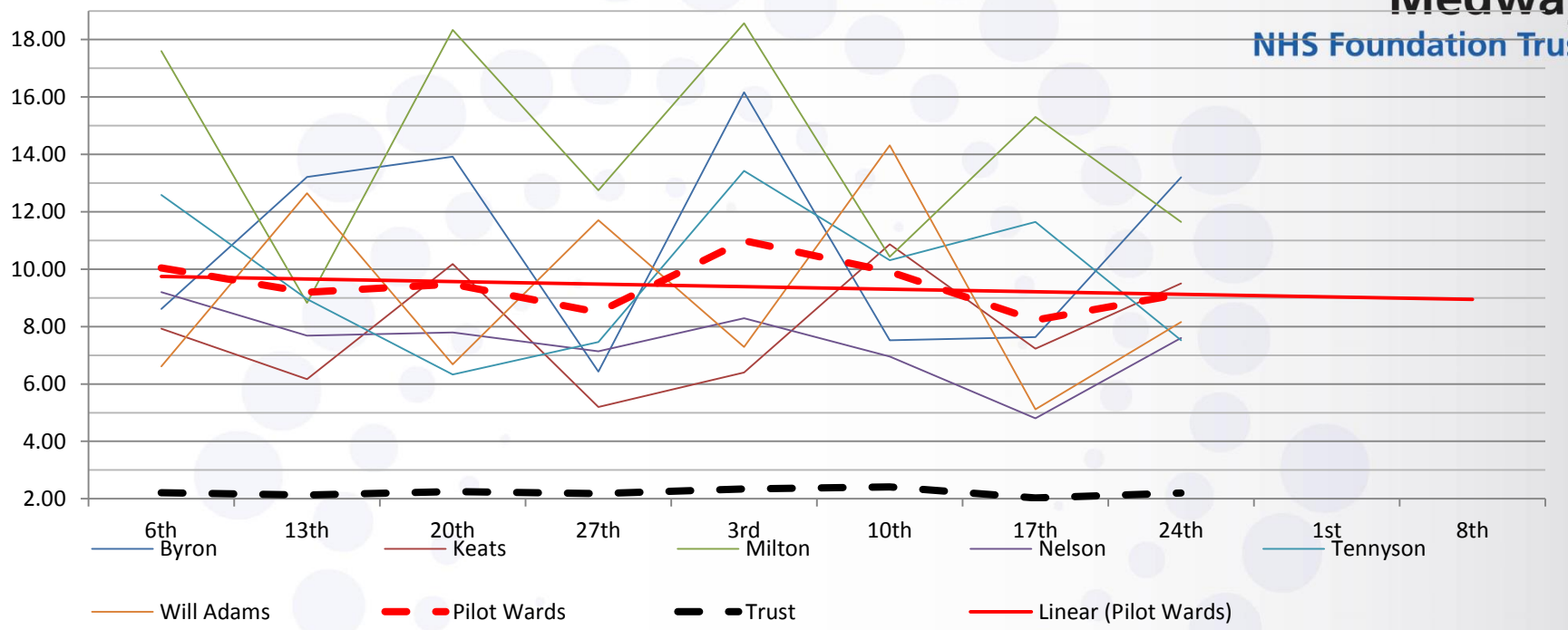
Transformation team 'WSO'= Week Supporting Operations

Length of Stay 18-10-02

NHS Medway NHS Foundation Trust



w/c	Aug 6th	Aug 13th	Aug 20th	Aug 27th	Sept 3rd	Sept 10th	Sept 17th	Sept 24th
Byron	8.62	13.21	13.92	6.43	16.17	7.53	7.64	13.20
Keats	7.92	6.17	10.18	5.20	6.40	10.86	7.23	9.50
Milton	17.60	8.82	18.33	12.75	18.57	10.44	15.31	11.64
Nelson	9.20	7.68	7.80	7.14	8.29	6.96	4.81	7.60
Tennyson	12.59	8.96	6.33	7.46	13.43	10.31	11.65	7.53
Will Adams	6.61	12.64	6.69	11.71	7.29	14.32	5.12	8.16
Pilot Wards	**10.04**	**9.20**	**9.48**	**8.49**	**10.99**	**9.91**	**8.22**	**9.14**
Trust	**2.21**	**2.13**	**2.25**	**2.18**	**2.34**	**2.42**	**2.03**	**2.20**

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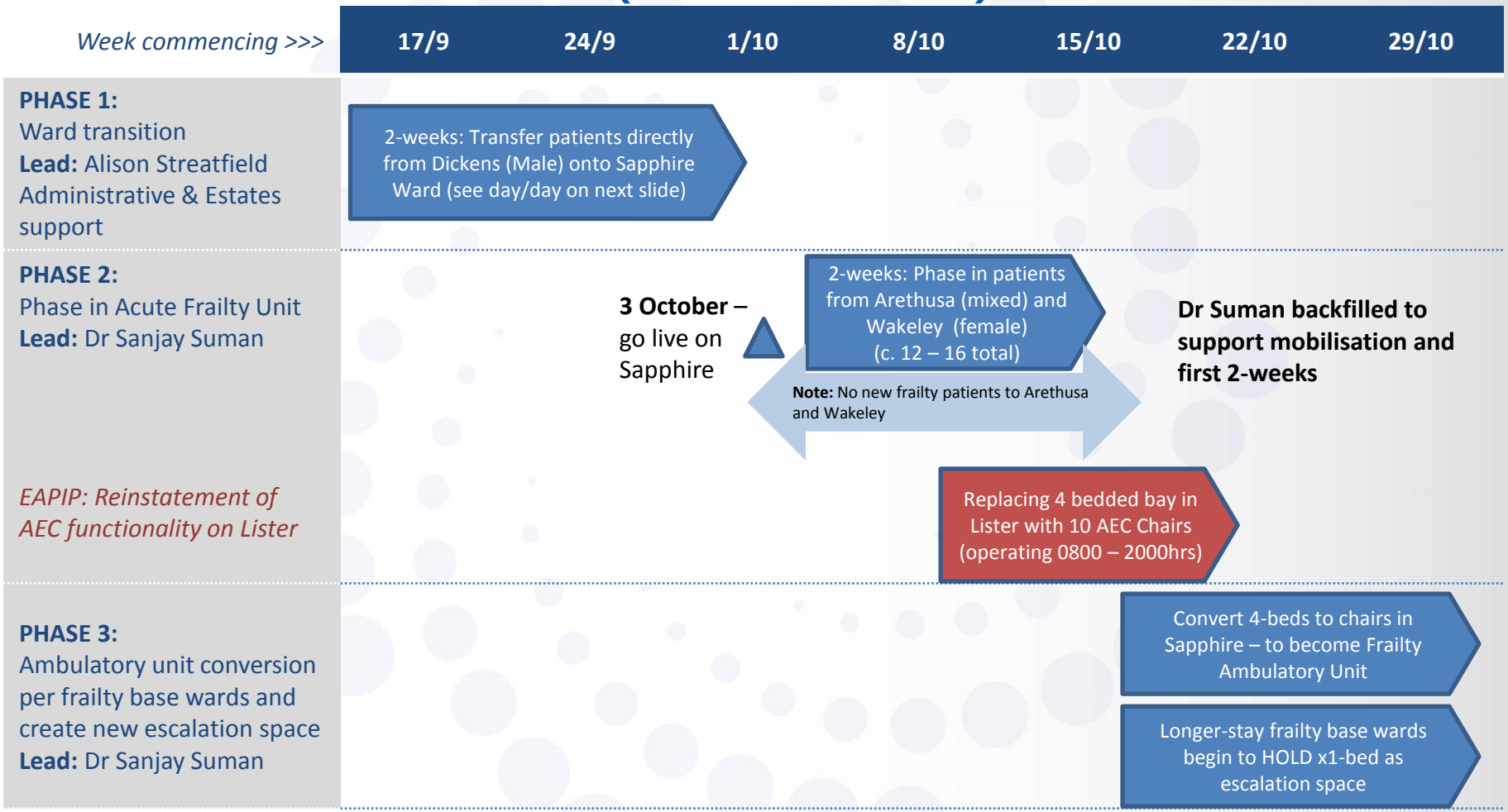
Sapphire Acute Frailty Unit: Mobilisation Plan (Short Term)

Medway NHS Foundation Trust



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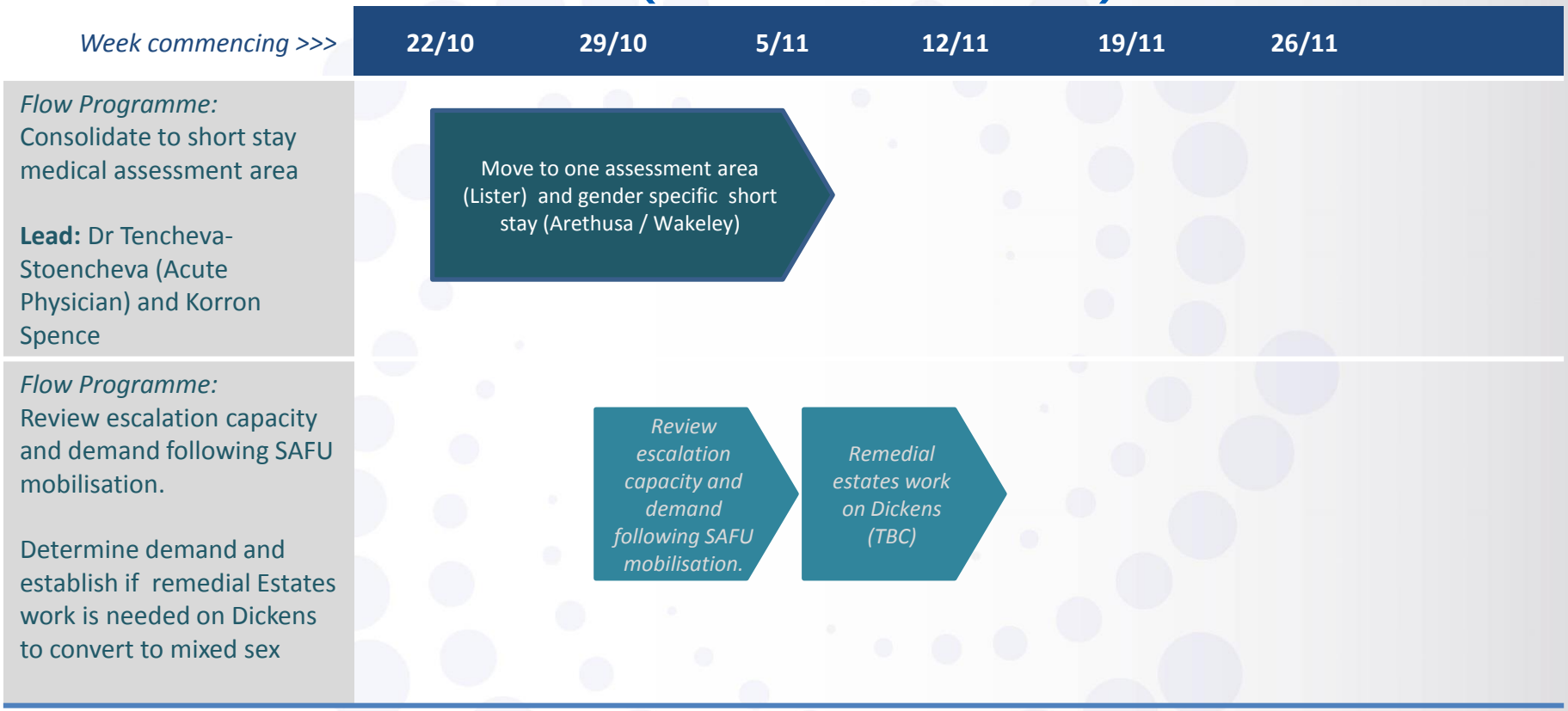
Sapphire Acute Frailty Unit: Mobilisation Plan (Medium Term)

Medway NHS Foundation Trust



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Reflections on the first full week

NHS Medway NHS Foundation Trust

- Streaming of appropriate patients to SAFU is starting to occur (w/c 15th Oct)
- Improving a.m. discharge profile on SAFU (>4 daily since 17th Oct)
- Clarity on information and source required for a.m. Hudddle to enable flow
- Pharmacy Business case profiled at Exec

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Practical steps being taken to operationalise SAFU correctly

- Visual Management Tools in use daily to support achievement against targets
- Transfer or discharge any remaining GM patients to allow “pure” Frailty patients
- Formalise the flow of patients into and across the Frailty Bed Base on Extramed to aid Site and wards
- Maintain and improve 2 x daily huddles and 1 x daily Board Round

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 31/10/2018 Agenda item

10a

Title of Report	**Integrated Quality Performance Dashboard - Update**
Prepared By:	Associate Director of Business Intelligence
Lead Director	Executive Team
Committees or Groups who have considered this report	Draft to Quality Improvement Committee
Executive Summary	To inform Board Members in the form of a flash report of September's performance across all functions and key performance indicators. A full report will be presented to the next Board. Key points are: • The Trust did not achieve the **four hour ED target** in the month but performance has improved from 85.98% in August to 90.32% in September. • There were no **12 hour breaches** in September. • **HSMR** data reported in this month's IQPR is for the period from July 2017 to June 2018. This is currently 113.6, which is within expected range. • This month saw a 12.74% decrease in the number of **Mixed Sex Accommodation** breaches, which totalled 226 in September. An IT system has been launched to support the wards in accurately recording and reviewing MSA breaches. • **RTT** performance has slightly decreased to 81.77% from 82.55%. This is below the national standard of 92% but above the trajectory for the month. • All 31-day **Cancer targets** have been achieved in August. The 2-week wait and 62-day targets have not been met. The 2-week wait symptomatic breast

Report to the Board of Directors

	performance has decreased by 9.57% to 88.89%. The 62-day GP performance was not achieved in August, with performance dropping by 5.64% to 79.17%. The 62-day screening standard was also not achieved in August, and performance has decreased by 5.08% to 81.13%. • There was a 10.8% decrease in the number of **falls** in September (58) compared to August (65). • 51 complaints were reported in the month, a decrease from August's 64. There were no complaint returners in September.
Resource Implications	N/A
Risk and Assurance	See report
Legal Implications/Regulatory Requirements	N/A
Improvement Plan Implication	Supports the Improvement Programme in the following areas: Workforce, Data Quality, Nursing, Finance
Quality Impact Assessment	See report as appropriate
Recommendation	N/A
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

NHS Medway NHS Foundation Trust

Integrated Quality and Performance Report

October 2018

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

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Contents

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

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10104 Patients visited our ED , which is a **0.34% increase** on the previous month, with **90.32%** seen within 4 hours, compared to 85.98% . **1232** Patients were admitted, with a **decrease** in conversion rate of **12.19%** compared to 15.00% in August.

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There were **5296** total patient admissions in September, and **5333** patients were discharged.

Bed Occupancy **increased** by **1.59%** in September to **95.75%**.

2935 patients arrived at ED via ambulance which is a **4.40% decrease** on last month.

42.2% Of ambulance patients were seen in under 15 minutes.

September's Story....

414 Babies were delivered in the month of September (41 less than August) with Emergency C-Section rate with an **increase** of **3.09%** from the previous month to **20.48%.**

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HSMR is **113.6** and within expected parameters (107.6 – 119.9) compared to 113.7 as reported in August.

80% of staff have had an appraisal compared to **81%** in August.

33938 Patients attended an outpatient appointment with **8.84%** DNA rate which is an increase of **0.19%** on last month.

There were **58** total falls in September, compared to **65** in August.

RTT Overall Incomplete Pathways for September was **81.77%** which decreased by **0.78%** on previous month. This is above the Trust improvement trajectory. The Trust also reported **11 x 52** week waiters which has decreased compared to August.

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

2 Week Wait symptomatic breast was below the target of **93%** in August with performance of **88.89%** - decreased by 9.57%.

2 Week Wait cancer performance for August was **72.61%** (reported one month in arrears) . This is a **17.83%** decrease from July's performance.

September's Performance....

99.24% of patients waited under 6 weeks for diagnostic tests in the month of September, which has increased by **1.04%** since August's reported performance.

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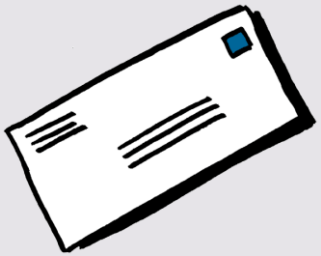
We received **51** complaints in September, decreasing from those received in August by **13**. The number of complaint returners has decreased to **0** in September.



There were **226** Mixed Sex Accommodation breaches in September which is a **12.74%** decrease on August's performance.

Safe Page 10

Legend
- Compliant with target
- Breaching target

Infection Control

C. Difficile Trust-attributable

- There were four C. Difficile cases in September, attributed to Phoenix, Tennyson, Dickens and Arethusa wards. A full post-infection review is in progress.

Serious Incidents (SI)

The CCG Deputy Chief Nurse has completed the SI thematic review of the SI investigation reports submitted for analysis which included those submitted before 24 April 2018.

The Patient Safety Team has incorporated the 23 recommendations into a trust wide thematic action plan so that the hospital can develop system-wide solutions with the purpose of learning and prevention of recurrence. The Director of Nursing has approved these recommendations and the Patient Safety Team are liaising with Medway CCG to request agreement to close down all the Serious Incidents contained within the report.

As at 30th September 2018 there are a total of:

- Open SIs within allocated timeframe: 19
- Open SIs breaching the allocated timeframe: 0
- New SIs reported on STEIS in September 2018: 6

Never Events

The last reported Never Event was in November 2017.

Overview of Current SI Performance

In line with the NHS England SI Framework (2015) and Schedule C (Quality) of the NHS Standard Contract 2017/18, the Trust is required to:

- Report 100% of all serious incidents within 2 working days of the incident being reported on Datix. Trust wide compliance for September 2018 is 67% .
- Submit a 72 hour report to the Clinical Commissioning Group (CCG) within 3 working days of the SI being reported. Trust wide compliance for September 2018 is 100%.
- Submit 100% of all serious incident final reports to the CCG within 60 working days. Trust wide compliance for September 2018 is 100%.

NICE Technology Appraisals (TA)
There were two TAs published in September 2018. These related to Haematology. One has been assessed as fully implemented and the other is not applicable to the Trust.

Eight TAs had a deadline for assessment in September 2018. Five have been fully implemented, one has been partially implemented, and one has been superceded by subsequent guidance published by NICE. The remaining TA has breached the 90 day implementation deadline; however, this TA relates to chemotherapy and we are awaiting a response from Maidstone & Tunbridge Wells with regard to compliance.

NICE Clinical Guidelines (CG)
There were six CGs published in September 2018; one of these has been assessed as partially implemented and the remaining five guidelines remain within the 90 day standard deadline (December 2018) for assessment.

Six CGs had a deadline for assessment in August 2018; three have been assessed as not applicable to the Trust and the remaining three have all been partially implemented.

NICE Quality Standards (QS)
There were four QS published in September 2018; these have not yet been reviewed but are within the 90 day standard deadline (December 2018) for assessment.

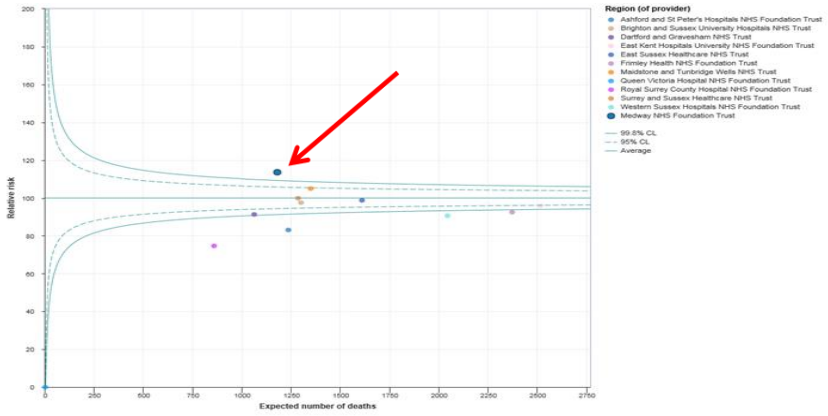
One QS had a deadline for assessment in September 2018. This has been fully implemented.

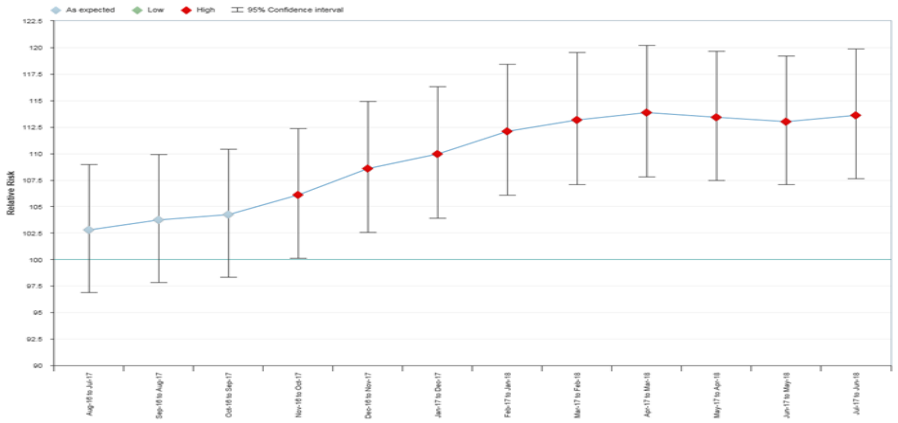
Mortality

The HSMR for the period June 2017 – May 2018 is **113.6** (95% confidence interval 107.6 – 119.9). This represents an increase from the previous rolling 12 month value of 113.0 and is highlighted as high for the ninth consecutive month by Dr Foster.

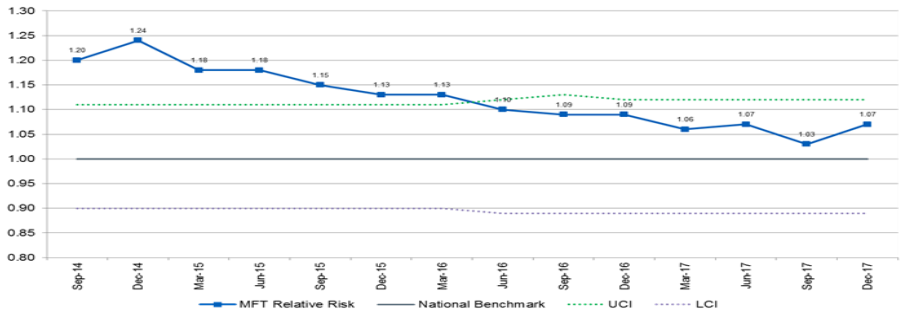
Following an in-depth analysis by Dr Foster, it has been identified that palliative care coding for the Trust has decreased by 23.1% in the 12 data points to May 2018. This is in line with the local understanding that the increase in HSMR may be related to a decrease in palliative care coding. After further discussion with Dr Foster, the Trust has been advised that the input provided by the End of Life Care team meets the Palliative Care coding criteria, and so a change in coding practice is proposed. All stakeholders will need to agree to this before any changes are implemented.

Peer comparison shows that the Trust currently has the highest relative risk in the area.

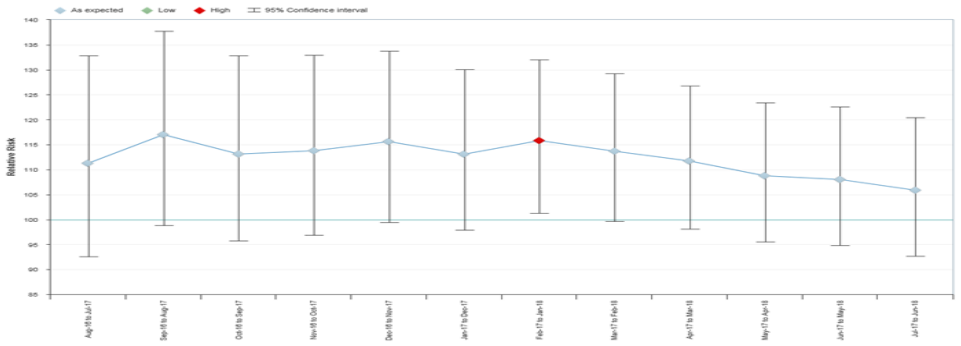




The latest Summary Hospital-level Mortality Indicator (SHMI) for the period January – December 2017 was published on 20 September 2018, and shows an increase at **1.07**; however, this remains within the 'as expected' bracket.



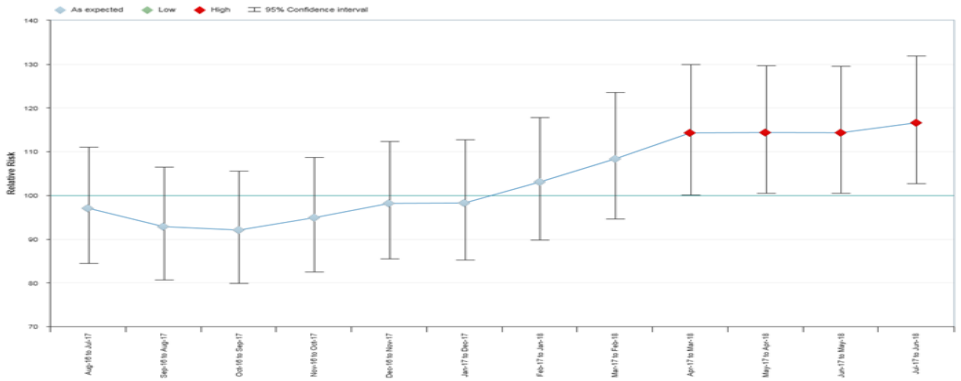
The HSMR for Septicaemia is currently **105.9** (95% confidence interval 92.7 – 120.4) and remains within the expected range. This is the fifth consecutive decrease in HSMR for septicaemia.



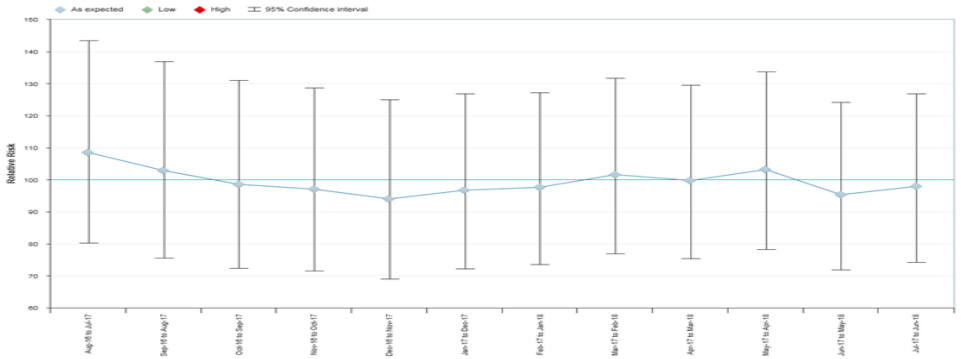
The HSMR for Pneumonia is currently **116.6** (95% confidence interval 102.7 – 131.8); this represents an increase compared to 114.3 for June 2017 – May 2018 and is flagging as high for the fourth consecutive data point. It is the tenth consecutive increase in HSMR for pneumonia.

There appears to be an inverse relationship between pneumonia and sepsis HSMR, and this is currently being investigated.

All patients with pneumonia included in Part 1 of their cause of death will be subject to a Structured Judgement Review.



The HSMR for congestive heart failure is **97.9** (95% confidence interval 74.2 – 126.9) and is within expected limits.

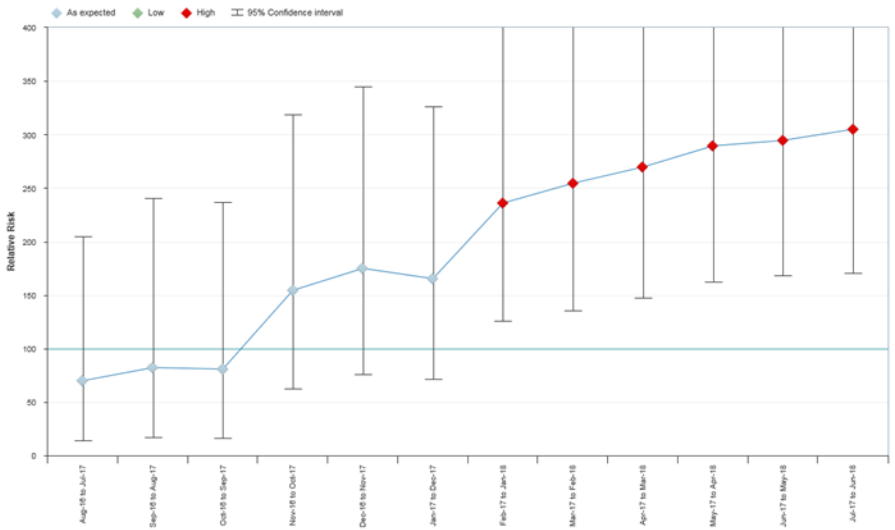


The diagnosis group Complications of surgical procedures or medical care has flagged as having a high relative risk for five consecutive months; however, total numbers are low (only 15 deaths out of 551 patients in the period July 2017 to June 2018).

14 of the 15 cases have been reviewed; 4 relate to complications from procedures that were not performed within the Trust. Of the remaining 10 patients reviewed, three were felt to have died as a result of surgical complications. Six patients are included in the cohort due to vagaries of coding within the Dr Foster diagnosis group.

The Trust's mortality group are reassured by this data. The diagnosis group will continue to be monitored, but unless there is a spike in mortality for this group, no further in-depth investigation is required.

The data is correct at the time of compilation: Tuesday 02 October 2018.



Caring Page 23

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

We have seen a decrease in MSA breaches from last month; analysis has been undertaken to highlight the areas of focus to improve upon MSA breaches, and as part of that a new process has been created to ensure better stepdown for patients in critical care wards who no longer require critical care. On the 12th October the Trust attended an NHSI Improvement Collaborative group, highlighting between local trusts the improvements and best practices made over the last few months, and these are being worked into our BAU policies.

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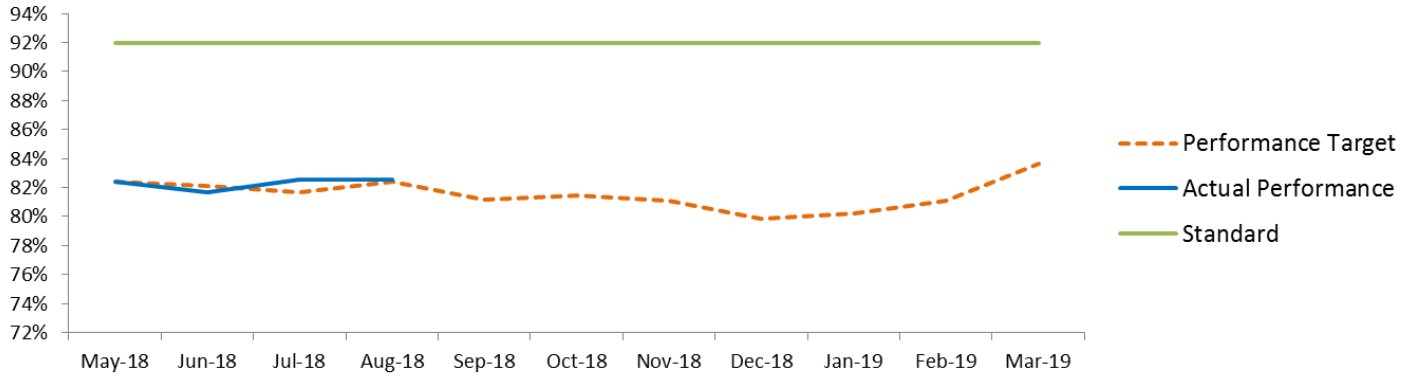
- **RTT**

RTT	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Incomplete pathways < 18 weeks	17637	17143.83	16892.14	16866.8	16018.38	15772.7	15281.7	15060.17	15186.74	15873.15	16396.14
Incomplete pathways > 18 weeks	3773	3732.649	3783.496	3595.19	3718.608	3585.401	3564.131	3803.535	3748.818	3707.744	3200.953
Performance Target	82.38%	82.12%	81.70%	82.43%	81.16%	81.48%	81.09%	79.84%	80.20%	81.06%	83.67%
Actual Performance	82.38%	81.68%	82.52%	82.55%							
Variance	0%	-0.44%	0.81%	0.12%							
52 Week Breaches	1	0	2	12							
Dermatology Excluded		85.50%	85.97%	86.12%							



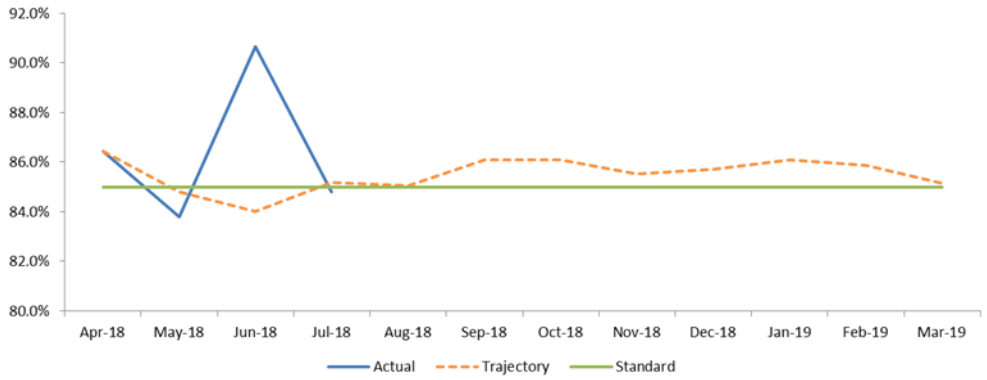
- Performance for August was 82.55% v 82.43% trajectory
- 12 52 Week breaches – 1 T&O and 11 Dermatology
- 6-4-2 model to improve efficiencies now in place.
- Four Eyes consultancy are currently auditing services
- NHSI demand & capacity tool being rolled out across the specialties

Although down on last month, RTT remains on trajectory for the 3rd consecutive month. 52-week breaches are down on last month. However, we are still seeing a high number of breaches largely down to one specialty. The Trust is currently running demand and capacity sessions throughout the organisation to help bridge the gap and improve overall percentage.

- **Cancer**

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual	86.4%	83.8%	90.6%	84.8%								
Trajectory	86.4%	84.8%	84.0%	85.2%	85.1%	86.1%	86.1%	85.5%	85.7%	86.1%	85.9%	85.1%
Standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

- 62 day performance remains strong; an improved performance in June 18 to 90.64% with 8 breaches in total; performance fell in July 18 to 84.81% with 12 breaches (5 of the 12 breaches being over 104 days)
- 2WW was recorded in June as 92.76% with a drop in July 18 to 90.44% - driven by dermatology capacity challenges
- Capacity review required in large demand specialities, to ensure capacity at least meets demand (lung, skin, ENT, Breast), with built in expected growth forecast
- Dermatology remains a large risk to cancer performance, in both 2ww and 62 day
  - The loss of a consultant and inability to replace has resulted in rapidly reducing clinic and MOP capacity
  - There has been challenge in being able to source a replacement Consultant (substantive or locum)
  - There has been a reduction in the use of Telehealth for Dermatology
- A successful bid for Transformation funds was achieved to support recruitment of pathway navigator roles to support the clinic to diagnostic element of the cancer pathway and support the new 28d cancer standard



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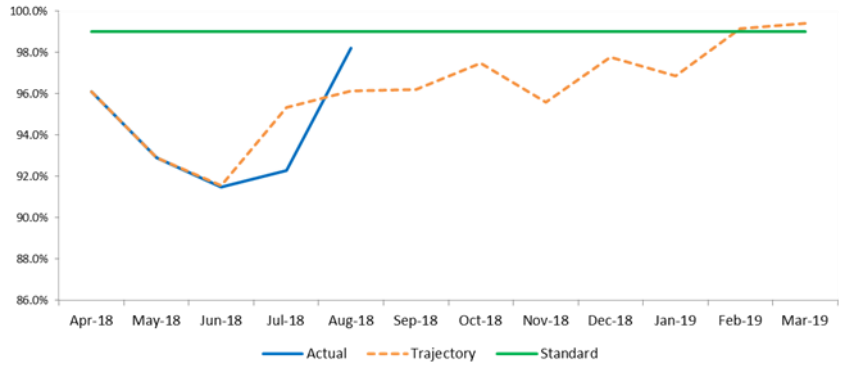
- **Diagnostics**

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual	96.1%	92.9%	91.5%	92.3%	98.2%							
Trajectory	96.1%	92.9%	91.6%	95.3%	96.2%	96.2%	97.5%	95.6%	97.8%	96.8%	99.1%	99.4%
Standard	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%

- Diagnostic performance has improved and delivered above trajectory in August. The operational teams believe that this improvement will be sustained and that we will meet the year trajectory.
- There continues to be pressure on Gastro due to third party provider performance with GA patients which is being managed via the operational and contracting team.
- USS demand has been significantly reduced, through the implementation of the BMUS vetting criteria
- Additional capacity ha been introduced for MRI as planned.
- Audiology capacity issues have been addressed.
- Data Quality validation is occurring in all diagnostic areas and will be complete in October allowing go live of reporting from the new automated diagnostic PTL.
- DNA rate is an ongoing issue and is being reviewed by the services. Adherence to access policy and booking process are the initial areas of focus with patient agreed bookings being part of the phase 2 work.



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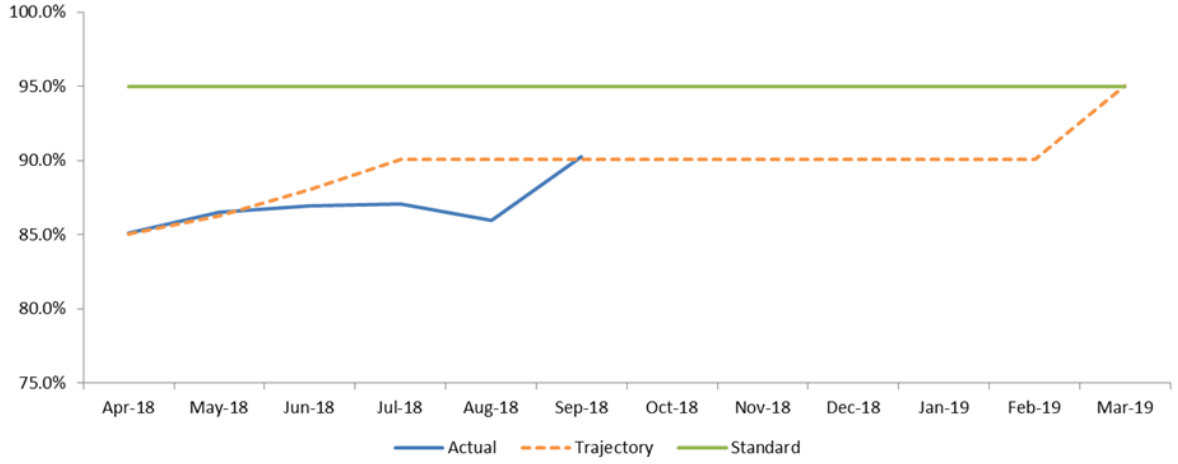
- **ED**

Month	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Actual	85.1%	86.5%	87.0%	87.1%	86.0%	90.2%						
Trajectory	85.1%	86.3%	88.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	95.0%
Standard	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%



Pre front door: Number of attendances has not reduced significantly, the system teams via UCOG and Urgent care workstreams continue to work on identifying interventions that will have an impact on readmissions and re-attendances.

Front door: Streaming remains at 25% to MedOCC and primary care, streaming to assessment units has increased dependent on capacity.

We continue to work with **SECAmb** on actions to improve handover compliance still further, with a focus on 15 minute handover

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Well Led Page 25

Voluntary Turnover at 12.0% is down (-0.1) compared to August and remains above the tolerance level of 8%.

Overall Sickness absence rate at 4.02% has gone up by (+0.04) compared to August and is above the tolerance level of 4%. Short term sickness absence at 1.97% is up by (+0.02) compared to August whilst long term sickness absence, at 2.05% is up by (+0.02) compared to August. The ratios of long-term sickness to short-term sickness remain broadly even.

Temporary staff (as a percentage of pay bill) at 18.92% is higher by (+5.69%) compared to the month of August and is above YTD Average. The Trust continues to meet its agency ceiling cap. Ongoing work to reduce use of agency workforce remains in place and focus on converting agency staff into substantive and or bank assignments continues.

The number of new starters, at 55 is down by (-61) compared to August and is below YTD Average.

The number of leavers, at 71 is down by (-6) compared to August but remains lower than YTD average.

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Data Quality Validation Update

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

Existing work projects:

- **Maternity Euroking Upgrade** – Working in conjunction with IT project team, BI and maternity team. Ensuring that data provided on monthly submission is accurate and ensuring new system when live will not impact data or patient care. Working on a maternity PTL with BI to improve patient care and department efficiency.
- **Inpatients Dataset** – DA Analysts are just beginning a deep dive project on the inpatient dataset, interviewing stakeholders and logging all issues, they will then use a rage of tools available to do some benchmarking for analysis. From this the HODA will be able to write a recommendation paper.
- **DM01** – Working with services to ensure the data on the new DM01 is clean and accurate, assisting with the data cleanse process.
- **Infusion Suite** – Working with PSC developing report to identify GP referrals registered that have not come through e-referral, leading to potential loss of income.

Data Quality Training

New Trainer/Auditor post working on identifying areas within the Trust that require updates and improvements, producing data analysis to demonstrate areas that may require assistance. In progress of redesigning and relaunching RTT training to make it more interactive.

Other DQ Validation Work:

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

The team works in collaboration with the BI team to look at the CCG challenges that are sent through, to ensure that the data provided is accurate. Working on collaborative approach with service teams to improve DQ by DA officers working within the services to offer support and be a visual presence.

3. Safe

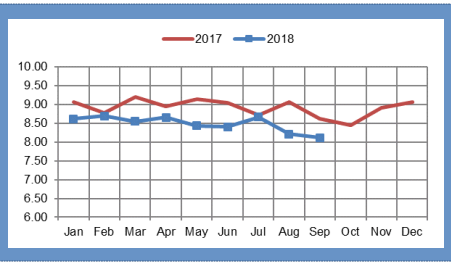
		Monthly Target	RAG Status	Trend Jul-18	Aug-18	Sep-18	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
1.1.3.2	NRLS Organisational Reporting Rate (6 monthly)		G	46.74 (national median 40.14)								
1.1.4	Never events	0	G	0.00	0.00	0.00	⇔	0.1				✓
1.1.4.1	Never Events - Incidence Rate	0.00%	G	0.00%	0.00%	0.00%	⇔	0.0			✓	
1.1.5	Incidents resulting in death	0	R	2.00	3.00	3.00	⇔	4.1				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days)	0.30	G	0.20	0.20	0.20	⇔	0.31				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days)	2.20	G	0.94	0.98	0.80	⇓	1.4				✓
1.1.14	Pressure ulcers (low harm)	10	R	20.00	16.00	16.00	⇔	14.9				✓
1.1.15	Pressure ulcers (moderate, high level and SI)	0	R	2.00	1.00	1.00	⇔	1.1				✓
1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	0.2	G	0.00	0.07	0.13	⇑	0.1				
1.1.18	Falls per 1000 bed days	6.63	G	5.25	4.26	3.85	⇓	5.0				
1.1.19	Number of falls to fracture (per 1000 bed days)	0.2	G	0.00	0.07	0.07	⇔	0.1				
1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.00	0.00	0.00	⇔	0.0			✓	
1.2.2	New VTEs - point prevalence in month	0.36%	G	0.49%	0.24%	0.27%	⇑	0.7%			✓	
1.2.7	Emergency c-section rate	<15%	R	18.0%	17.4%	20.5%	⇑	18.8%				
1.3.1	MRSA screening of admissions	95%	G	99.1%	99.8%	100.0%	⇑	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	G	1.00	3.00	0.00	⇓	1			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	R	0.00	2.00	4.00	⇑	2			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	113.6 (107.6-119.9)							✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	112.1 (100.6-124.6)							✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	1	G	1.07 (0.89-1.12)							✓	✓

Commentary	Actions
See Executive Summary	See Executive Summary

Safe Staffing – Nursing Update - Highlights

Care Hours per Patient per Day

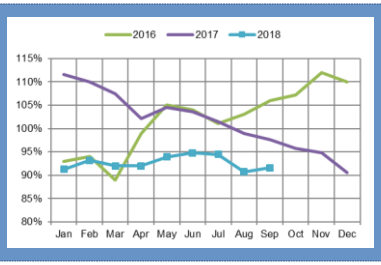
We have continued to see stable performance remaining over the target of 8 for September.



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

Safe Staffing

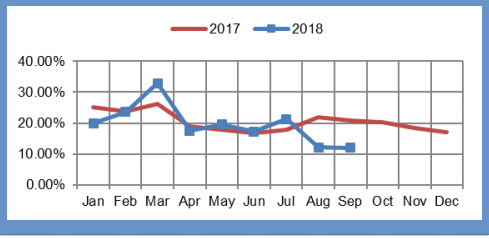
Safe staffing remain above target for September and has been stable over the past few months.



Staff issues are being risk assessed multiple time daily. Staff are redeployed when necessary to ensure wards are safely staffed.

Temporary Staffing

The Trust remains below target for Temporary Staffing.



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

Staffing Levels – Nursing & Clinical Support Workers

		Day				Night				Day		Night	
		Registered Staff		Care Staff		Registered Staff		Care Staff					
WARD	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	*Average fill rate - registered staff (%)*	*Average fill rate - care staff (%)*	Average fill rate - registered staff (%)	Average fill rate - care staff (%)
Arethusa Ward	27	1770	1028	1156	1196	1100	1069	660	989	*58%*	*103%*	*97%*	*150%*
Bronte Ward	18	1146	907	736	760	1058	1020	705	740	*79%*	*103%*	*96%*	*105%*
Byron Ward	26	1606	773	1046	1450	1013	923	1013	1118	*48%*	*139%*	*91%*	*110%*
CCU	4	1018	702	0	208	690	667	0	0	*69%*		*97%*	
Delivery Suite	16	2733	2707	666	648	2741	2733	348	324	*99%*	*97%*	*100%*	*93%*
Dickens Ward	25	1559	947	1519	1471	1001	958	990	1003	*61%*	*97%*	*96%*	*101%*
Dolphin (Paeds)	30	3074	3000	1576	1398	2415	2438	345	380	*98%*	*89%*	*101%*	*110%*
Harvey Ward	25	1593	1022	1560	1509	1013	991	1024	1058	*64%*	*97%*	*98%*	*103%*
ICU	9	3792	2758	0	0	3375	2599	0	0	*73%*		*77%*	
Keats Ward	26	1521	866	1074	1896	990	1105	990	1513	*57%*	*177%*	*112%*	*153%*
Kent Ward	24	1030	968	595	595	707	660	636	646	*94%*	*100%*	*93%*	*102%*
Kingfisher SAU	22	1863	1520	1100	1227	1650	1531	649	770	*82%*	*112%*	*93%*	*119%*
Lawrence Ward	19	1097	985	1107	1162	1013	1001	664	731	*90%*	*105%*	*99%*	*110%*
Lister Assessment Unit	19	2607	1573	1778	1838	1350	1137	674	717	*60%*	*103%*	*84%*	*106%*
McCulloch Ward	29	1958	1324	1258	1115	1650	1558	671	726	*68%*	*89%*	*94%*	*108%*
Medical HDU	6	1393	1191	352	326	1378	1272	0	12	*85%*	*93%*	*92%*	
Milton Ward	26	1560	758	1415	2167	1013	949	1011	1280	*49%*	*153%*	*94%*	*127%*
Nelson Ward	24	1593	982	1196	1155	990	949	660	629	*62%*	*97%*	*96%*	*95%*
NICU	32	3831	3700	421	420	3692	3612	161	150	*97%*	*100%*	*98%*	*93%*
Ocelot Ward	12	870	831	510	503	720	720	360	348	*96%*	*99%*	*100%*	*97%*
Pearl Ward	23	1038	1038	565	559	1020	1038	360	361	*100%*	*99%*	*102%*	*100%*
Pembroke Ward	27	1764	1469	1085	1467	1650	1574	660	1074	*83%*	*135%*	*95%*	*163%*
Phoenix Ward	30	1986	1331	1177	1204	1320	1189	990	1034	*67%*	*102%*	*90%*	*104%*
Sapphire Ward	23	1741	278	1253	885	990	535	638	517	*16%*	*71%*	*54%*	*81%*
SDCC	26	2178	1242	1177	943	495	568	220	438	*57%*	*80%*	*115%*	*199%*
Surgical HDU	10	2224	2029	374	339	1977	1843	0	0	*91%*	*91%*	*93%*	
Tennyson Ward	27	1574	853	1191	1564	990	935	979	1023	*54%*	*131%*	*94%*	*104%*
The Birth Place	9	1051	1045	341	336	1068	1067	348	288	*100%*	*99%*	*100%*	*83%*
Victory Ward	18	1090	708	765	810	990	793	660	749	*65%*	*106%*	*80%*	*113%*
Wakeley Ward	25	1583	1013	1507	1454	1013	1091	1013	1035	*64%*	*96%*	*108%*	*102%*
Will Adams Ward	26	1596	1126	1116	1443	990	1115	1001	1276	*71%*	*129%*	*113%*	*127%*
Trust total	**663**	**55,437**	**40,670**	**29,613**	**32,045**	**42,058**	**39,634**	**18,429**	**20,925**	***73.4%***	***108.2%***	***94.2%***	***113.5%***

Staffing Levels – Nursing & Clinical Support Workers

		Quality Metrics / Actual Incidents								Internal KPIs
WARD	Beds	Number of escalations of nurse staffing	Number of hospital acquired Pressure Ulcers grade 2 and above	Number of Falls with moderate to severe harm	Number of patient related medication errors - moderate to severe harm	Number of complaints relating to nursing care	Post 72 Hour CDIFF Acquisitions	MRSA Colonisations Post 48 hours	MRSA Bacteraemia Post 48 Hours	Overall fill rate
Arethusa Ward	27	3	1	0	0	0	1	0	0	*91%*
Bronte Ward	18	2	2	0	0	1	0	0	0	*94%*
Byron Ward	26	0	0	0	0	1	0	0	0	*91%*
CCU	4	0	0	0	0	0	0	0	0	*92%*
Delivery Suite	16	1	0	0	0	0	0	0	0	*99%*
Dickens Ward	25	1	0	0	0	0	1	0	0	*86%*
Dolphin (Paeds)	30	0	0	0	0	1	0	0	0	*97%*
Harvey Ward	25	0	1	0	0	0	0	0	0	*88%*
ICU	9	1	1	0	0	0	0	0	0	*75%*
Keats Ward	26	3	1	0	0	0	0	2	0	*118%*
Kent Ward	24	0	0	0	0	0	0	0	0	*97%*
Kingfisher SAU	22	0	0	0	0	0	0	0	0	*96%*
Lawrence Ward	19	0	0	0	0	0	0	0	0	*100%*
Lister Assessment Unit	19	1	0	0	0	1	0	0	0	*82%*
McCulloch Ward	29	0	1	0	0	0	0	1	0	*85%*
Medical HDU	6	0	0	0	0	0	0	0	0	*90%*
Milton Ward	26	0	1	0	0	0	0	0	0	*103%*
Nelson Ward	24	0	1	0	0	0	0	0	0	*84%*
NICU	32	0	0	0	0	0	0	0	0	*97%*
Ocelot Ward	12	0	0	0	0	0	0	0	0	*98%*
Pearl Ward	23	2	0	0	0	0	0	0	0	*100%*
Pembroke Ward	27	0	1	0	0	1	0	1	0	*108%*
Phoenix Ward	30	1	2	0	0	0	1	0	0	*87%*
Sapphire Ward	23	1	0	1	0	0	0	0	0	*48%*
SDCC	26	1	0	0	0	0	0	0	0	*78%*
Surgical HDU	10	0	0	0	0	0	0	0	0	*92%*
Tennyson Ward	27	0	2	0	0	0	1	0	0	*92%*
The Birth Place	9	3	0	0	0	0	0	0	0	*97%*
Victory Ward	18	0	0	0	0	0	0	0	0	*87%*
Wakeley Ward	25	2	1	0	0	1	0	0	0	*90%*
Will Adams Ward	26	3	1	0	0	1	0	1	0	*105%*
Trust total	**663**	**25**	**16**	**1**	**0**	**7**	**4**	**5**	**0**	**91.6%**

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Safe Staffing– Nursing Update KPIs

		Monthly Target	RAG Status	Trend Jul-18	Aug-18	Sep-18	Movement	YTD avg	Trend	Data Quality
1.5.2	Vacancy Rate (Overall)	*8%*	G					25.86%		
1.5.3	Total Vacancies (WTE)	*TBC*						400.0		
1.5.4	Vacancy Rate (Band 5)	*TBC*						36.16%		
1.5.5	Vacancy Rate (Band 6)	*TBC*						24.10%		
1.5.6	Vacancy Rate (CSW)	*TBC*						18.78%		
1.5.7	Nursing Starters	*TBC*		10	14	30	↑	17.3		
1.5.8	Nursing Leavers	*TBC*		13	19	16	↓	15.0		
1.5.9	CSW Starters	*TBC*		4	1	1	↔	5.0		
1.5.10	CSW Leavers	*TBC*		12	14	11	↓	10.8		
1.5.11	Rolling annual turnover rate	*8%*	R	11.92%	12.14%	12.04%	↓	11.51%		
1.5.16	Safe Staffing	*94.00%*	R	94.5%	90.7%	91.6%	↑	95.3%		
1.5.17	CHPPD	*8.00*	G	8.67	8.21	8.12	↓	8.54		

Commentary	Actions

Best of care
Best of people

4. Effective

		Monthly Target	Status	Trend						Alignment		
			Status	Jul-18	Aug-18	Sep-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
2.5.4	Emergency Readmissions within 30 days (1 month in arrears)	*10%*	R	11.30%	10.03%		↓	11%			✓	
2.5.4.1	Emergency Readmissions within 30 days Under 65 (1 month in arrears)	*10%*	G	8.14%	7.88%		↓	8%			✓	
2.5.4.2	Emergency Readmissions within 30 days 65 + (1 month in arrears)	*10%*	R	15.38%	12.81%		↓	14%			✓	
2.6	Discharges before noon	25%	R	19.52%	19.63%	20.80%	⇑	19%			✓	✓

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5. Caring

		Monthly Target	RAG Status	Trend Jul-18	Aug-18	Sep-18	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	*83%*	G	87.1%	83.9%	84.5%	↑	88%			✓	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	*65%*	G	78.4%	77.0%	80.7%	↑	82%			✓	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	*79%*	G	100.0%	99.3%	98.8%	↓	99%			✓	
3.1.3	Mixed Sex Accommodation breaches	*15*	R	186	259	226	↓	48.1			✓	
3.4.1	Number of Complaints	*45*	R	62	64	51	↓	67			✓	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	*85%*	R	75.5%				49%			✓	
3.4.3	Number of complaint returners	↓	G	5	3	0	↓	3.1			✓	

Commentary	Actions
See Executive Summary	See Executive Summary

6. Responsive

		Monthly Target	Status	Trend						Alignment		
			Status	Jul-18	Aug-18	Sep-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
4.1.1	RTT – Incomplete pathways (overall)	*92%*	R	82.52%	82.55%	**81.77%**	↓	**82.14%**			✓	
4.1.2	RTT - Treatment Over 52 Weeks	*0*	R	2	12	11	↓	**27**				
4.2.3	**A&E 4 hour target (all Types from Nov 2017)**	*95%*	R	87.12%	85.98%	**90.32%**	↑	**86.64%**			✓	
4.3.1	**Cancer – 2 week wait (1 month in arrears)**	*93%*	R	90.44%	72.61%		↓	**85.90%**				
4.3.2	**Cancer - 2 Week Wait Breast (1 month in arrears)**	*93%*	R	98.46%	88.89%		↓	**89.83%**				
4.3.3	**Cancer - 31 day first treatment (1 month in arrears)**	*96%*	G	98.66%	96.60%		↓	**97.01%**				
4.3.4	**Cancer – 31 day subsequent treatments – surgical (1 month in arrears)**	*94%*	G	96.43%	100.00%		↑	**97.11%**				
4.3.5	**Cancer – 31 day subsequent treatments - drug (1 month in arrears)**	*98%*	G	100.00%	100.00%		↔	**97.42%**				
4.3.6	**Cancer - 62 day consultant upgrade (1 month in arrears)**	*N/A*		76.67%	78.38%		↑	**73.93%**				
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	*85%*	R	84.81%	79.17%		↓	**78%**			✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	*90%*	R	86.21%	81.13%		↓	**86%**			✓	
4.4.1	Diagnostic waits - under 6 weeks	*99%*	G	92.30%	98.20%	**99.24%**	↑	**96%**			✓	
4.5.8	**Patients seen by a stroke consultant within 24 hours (Apr to Jun figures reported)**	*95%*	R	37.70%	**33.30%**	**33.30%**	↔	**56%**				✓
4.6.1	Average elective Length of Stay	*<5*	G	3.44	2.46	**3.19**	↑	**2.3**				✓
4.6.2	Average non-elective Length of Stay	*<5*	R	6.12	6.68	**6.72**	↑	7.1				✓
4.6.6	Average occupancy	*90%*	R	92.78%	94.16%	**95.75%**	↑	**95%**				✓

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

Commentary	Actions
See Executive Summary	See Executive Summary

7. Well led

		Monthly Target	Status	Trend						Alignment		
			Status	Jul-18	Aug-18	Sep-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
5.2.1	Staff Friends and Family – Recommend as place to work (Quarterly)	62%	R		51.2%		↓	58.0%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	79%	R		71.2%		↓	70.7%			✓	
5.3.7	Rolling annual turnover rate	8%	R	11.9%	12.1%	12.0%	↓				✓	
5.3.7.1	Executive Team Turnover Rate	TBA		7.7%	0.0%	0.0%	↔	3.8%			✓	
5.3.8	Overall Sickness rate	4.0%	R	3.99%	3.98%	4.02%	↑	3.8%				
5.3.9	Sickness rate – Short term	3.0%	G	1.95%	1.95%	1.97%	↑	1.9%			✓	
5.3.10	Sickness rate – Long term	1.0%	R	2.04%	2.03%	2.05%	↑	1.9%			✓	
5.3.11	Temporary staff % of pay bill	15%	R	21.3%	12.8%	18.90%	↑	h			✓	
5.3.14	Starters	N/A		74	116	55	↓	85.1				
5.3.15	Leavers	N/A		62	77	71	↓	69.3				

Commentary	Actions
See Executive Summary	See Executive Summary

8. Enablers

		Monthly Target	Status	Trend						Alignment		
			Status	Jul-18	Aug-18	Sep-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
7.2.1	APC – NHS number completeness (1 month in arrears)	*99%*	G	99.2%				98.9%				✓
7.2.8	A&E – Attendance disposal (1 month in arrears)	*99%*	G	99.7%				93.4%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	*11*	R	70	124		↑	144.6		✓		✓
7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	*0*	G	0	0		↔	0.0				
7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	*99.25*	G	46	50		↑	102.0		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	*1%*	G	0.2%	0.2%		↑	0.5%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	*103.50*	G	17	4		↓	3.86				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	*0.00*	R	7.00	3.00		↓	2.14				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	*949*	R	2151	2104		↓	1346.0		✓		✓
7.3.13b	A&E % missing breach reason on breached attendances (1 month in arrears)	*50%*	G	100.0%	100.0%		↔	100.0%		✓		✓
7.3.17	Cancer 2ww invalid NHS Number (1 month in arrears)	*0.25*	R	2	2		↔	1.6		✓		✓
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	*13.25*	G	3	8		↑	0.7		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	*0.01*	G	0.05	0.04		↓	1%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	*2*	R	11	3		↓	3.0		✓		✓
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	*1.25*	G	1	1		↔	0.3		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	*1.25*	G	4	1		↓	2.9		✓		✓
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	*1*	R	5	5		↔	1.1		✓		✓

Commentary	Actions
See Executive Summary	See Executive Summary

NHS Medway NHS Foundation Trust

Performance Report to the Trust Board (public)

Committee Date: 01/11/2018 **Agenda item** 10 b

Title of Report	**Corporate Policy: Complaints Management Report**
Prepared By:	Karen Rule, Executive Director of Nursing
Lead Director	Karen Rule, Executive Director of Nursing
Committees or Groups who have considered this report	Quality Steering Group
Executive Summary	Corporate Policy is intended to be a high level overview of the organisation's policy in the relevant area, with the detailed instructions / guidance being laid out in supporting documentation which is referenced in the Corporate Policy and therefore linked to the overarching policy document. The corporate policy areas are: • Information Governance • Consent • Complaints • Serious Incidents • Safeguarding • Emergency Planning, Resilience and Response • Human Resources/employee handbook • Health and Safety / Fire Safety • Standards of Business Conduct • Medicines Management • Risk Management • Patient Care and Management • Security and Estates • Duty of Candour • Finance The corporate Complaints Management Policy is due for review in November 2018. The review of the policy took into consideration the recommendations from the July 2018 KPMG complaints audit which considered and reported on the Trust process for complaints management. The Corporate Policy for Complaints Management has been

Performance Report to the Trust Board

	updated to reflect the recommendations and is attached for Board approval. The policy updates are as follows: • Clarity provided in regard to the types of complaints that are covered by the policy – section 2 • Appropriate agencies identified in relation to those registered under the Care Standards Act 2000 – section 2.4.6 • Further guidance provided in regard to responding to electronic communication – section 11.4 • The policy has been updated to reflect the Francis recommendation *'actual or intended litigation should not be a barrier to the processing or investigating a complaint at any level*' - section 13.2. • Section eight and nine of the policy has also been updated to reflect Trust process in regard to the Freedom of Information act and complaints recorded as serious incidents.
Resource Implications	None at this time
Risk and Assurance	Further to discussions in 2017 between the Chief Executive and the Executive Group, it was resolved to map all policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) under one of a number of overarching Policy Areas with a high level Board approved Corporate Policy covering each area. One of those being the Policy on Complaints Management. 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.

Performance Report to the Trust Board

	The Trust worked with KPMG to ensure updates within the policy are correct and fulfil the audit recommendations.
Legal Implications/Regulatory Requirements	Corporate Policies are drafted to reflect legal and regulatory requirements. The Trust is required to have in place a Policy on complaints management to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 - Statutory Instrument 2009/309 ("the Regulations"), conform to the NHS Constitution and reflect the recommendations from the Francis Report (2013). The Trust is expected to meet the standards set out within the policy.
Improvement Plan Implication	Quality, Governance and Standards
Quality Impact Assessment	Not required at this stage
Recommendation	It is recommended that the Board approves the new Corporate Policy for Complaints Management.
Purpose & Actions required by the Board :	**Approval** ☒ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

CORPORATE POLICY: Complaints Management

Author:	Ann Bushnell Head of Quality Governance
Document Owner:	Julie Wilson, Governance & Complaints Co-ordinator
Revision No:	8
Document ID Number	POLCGR005
Approved By:	Trust Board
Implementation Date:	November 2018
Date of Next Review:	November 2021

Complaints Management Policy

Document Control / History	
Revision No	**Reason for change**
1	General Review
2	General Review
3	New legislation
4	General Review and update
4.1	Insert new section - Complaints Requiring Reimbursement
4.2	Add QC in monitoring and review table
4.3	General Review and update
5.0	General Policy Review – duty of candour, directorate responsibilities.
6.0	Changes in response to new process and responsibilities
7.0	General Review and update
8.0	Review & update following KMPG Audit

Consultation
Director of Nursing
Head of Patient Experience
Directorate Governance Leads
Executive Group
Chief Executive

Complaints Management Policy

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Complaints Management Policy

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

1 Introduction

1.1 This Policy outlines the Trust's commitment to dealing with complaints about its services and provides information on how we manage, respond to and learn from complaints made about our services.

1.2 The Trust's Policy on complaints management is to meet the requirements of the Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 - Statutory Instrument 2009/309 ("the Regulations"), conform to the NHS Constitution and reflect the recommendations from the Francis Report (2013).

1.3 The Trust will treat complaints seriously and ensure that complaints, concerns and issues raised by patients, relatives and carers are properly investigated in an unbiased, non-judgmental, transparent, timely and appropriate manner. The outcome of any investigation, along with resulting actions will be explained to the complainant.

1.4 The Trust's policy is to follow the "Good Practice Standards for NHS Complaints Handling" (Sept 2013) outlined by the Patients Association:

1.4.1 Openness and Transparency – well publicised, accessible information and processes, and understood by all those involved in a complaint;

1.4.2 Evidence based complainant led investigations and responses. This will include providing a consistent approach to the management and investigation of complaints;

1.4.3 Logical and rational in our approach;

1.4.4 Systematically respond to complaints and concerns in appropriate timeframes;

1.4.5 Provide opportunities for people to offer feedback on the quality of service provided;

1.4.6 Provide complainants with support and guidance throughout the complaints process;

1.4.7 Provide a level of detail appropriate to the seriousness of the complaint;

1.4.8 Identify the causes of complaints and take action to prevent recurrences;

1.4.9 Effective and implemented learning – use "lessons learnt" as a driver for change and improvement;

1.4.10 Ensure that the care of complainants is not adversely affected as a result of making a complaint;

1.4.11 Ensure that Medway NHS Foundation Trust meets its legal obligations;

1.4.12 Act as a key tool in ensuring the good reputation of Medway NHS Foundation Trust.

1.5 The complaints system also incorporates the Parliamentary and Health Service Ombudsman's 'Principles of Good Complaints Handling, Principles of Good Administration and Principles for Remedy' which include:

- Getting it right
- Being customer focused
- Being open and accountable
- Acting fairly and proportionately
- Putting things right
- Seeking continuous improvement

2 Purpose / Aim and Objective

2.1 The purpose of this Policy is to provide a framework for dealing with complaints relating to services provided by Medway NHS Foundation Trust and to ensure that patients, relatives, carers and all other users of services have their complaints and concerns dealt with in confidence and impartiality, with courtesy and empathy in a timely and appropriate way.

2.2 The aim of the policy is to ensure that all complaints (formal or informal) are treated in a courteous and sympathetic manner by any person to whom the complaint is made.

2.3 It is also intended for distribution to patients and members of the public who require more detailed information than that contained in the Trust's leaflet 'How to make a complaint'

2.4 It is intended that the Trust's complaints procedures:

2.4.1 Provide a single process which deals with complaints

2.4.2 Provide a flexible approach to investigating complaints locally and to providing people with a rapid, open, and honest response

2.4.3 Are fair to staff and complainants alike.

2.4.4 Enable the Trust to use the information it receives from patients' complaints to improve its services for patients.

2.4.5 Use complaints as an opportunity to gain insight into the patient experience and improve the quality of care and treatment and overall experience.

2.4.6 Complaints between NHS bodies, providers and local authorities may require a collaborative response covering all complaints across health and social care, including primary, secondary and tertiary health care. The investigation may involve collegues in other NHS Trusts or agencies. In negotiation with the other organisations involved, a single trust should lead and co-ordinate the response. In these circumstances any response that we provide to another organisation should be signed off by the CEO in the usual

way. Equally where we are leading, the final response should be sent to other organisations involved.

3 Definitions

3.1 A **complaint or concern** is an expression of dissatisfaction about an act, omission or decision, either verbal or written, and whether justified or not, that requires a response. Patients may not always use the word "complaint." They may offer a comment or suggestion which can be extremely helpful but it is important to recognise those "comments" which are really complaints and need to be handled as such.

3.2 **Regulations** - Local Authority Social Services and National Health Service Complaints (England) Regulations 2009 - Statutory Instrument 2009/309. The Regulations set out the statutory framework that the Trust follows including

3.2.1 Persons who can make complaints

3.2.2 Duty to handle complaints

3.2.3 Complaints about the provision of health services

3.2.4 Complaints not required to be dealt with

3.2.5 Duty to co-operate

3.2.6 Time limit for making a complaint

3.2.7 Procedure before investigation

3.2.8 Investigation and response

3.2.9 Forms of communication, Publicity, Monitoring, Annual Reports

3.2.10 Full details of the Regulations are available via: http://www.legislation.gov.uk/uksi/2009/309/contents/made

4 (Duties) Roles & Responsibilities

4.1 **Trust Board**

4.1.1 Responsible for approving the Trust's Corporate Policy for complaints management.

4.1.2 Responsible for reviewing and approving the annual report to the Board on complaints.

4.1.3 Responsible for understanding the statutory framework for management of complaints and assuring itself on the adequacy of the Trust arrangements for meeting requirements.

4.2 **Chief Executive**

4.2.1 In accordance with the Regulations the Chief Executive is the designated "Responsible Person".

4.2.2 Overall accountability for ensuring the Trust's Corporate Policy for complaints management meets the statutory requirements as set out in the Regulations.

4.2.3 Responsible for approving and signing complaints response letters. Regulation 4 (2) of the Regulations allows the functions of the Responsible Person to be performed by any person authorised by Medway NHS Foundation Trust to act on the Responsible Person's behalf. Accordingly, Medway NHS Foundation Trust has delegated responsibility for signing of complaints within the parameters set out in appendix 1.

4.3 Head of Quality Governance

4.3.1 Is responsible for complaints management and is the designated "Complaints Manager" required by the Regulations. Complaints management is managed operationally by the Central Complaints Team.

4.4 Central Complaints Team

4.4.1 Is responsible for the implementation and co-ordination of the Trust's complaints policy.

4.4.2 Is responsible for ensuring all complaints are read and recorded.

4.4.3 Is responsible for the collation and submission of any returns required in relation to complaints e.g KO41.

4.4.4 Is responsible for the preparation of the annual report in relation to complaints.

4.4.5 Is the Systems Manager for the Trust's complaints management system with responsibility for ensuring the correct usage and application of the system and the extraction of data to meet reporting requirements.

4.5 Executive Directors of Clinical Operations

4.5.1 The Executive Directors of Clinical Operations have operational responsibility to ensure that their directorate has adequate procedures and resources for investigating and responding to complaints in accordance with the requirements of the Regulations.

4.5.2 They also have responsibility for ensuring that there are effective Directorate governance processes for reviewing and embedding the learning from complaints.

4.6 Directorate Governance Lead

4.6.1 Has responsibility for following the Trust procedure for managing and reviewing the complaints it receives; the focus of which will be to review and, where necessary, change practice, develop learning outcomes and improve the quality of patient care.

4.6.2 Directorate reports will be provided for review through the directorate's governance structure detailing the work being undertaken to learn from complaints. Good practice initiatives will be shared across the organisation

and issues of concern will be addressed through the Trust's governance and performance process.

4.6.3 Has responsibility for allocating complaints to an Investigating Manager and ensuring that they respond in accordance with the established procedures.

4.6.4 Has responsibility to ensure complaint responses are coordinated and completed within the given deadlines.

4.6.5 Where recommendations or action plans are produced by the Parliamentary and Health Service Ombudsman following their investigations, it is the responsibility of the Directorate Governance Lead to implement and monitor these recommendations and plans. All Parliamentary and Health Service Ombudsman recommendations will be reported through the Directorate Governance Lead.

4.6.6 The Directorate Governance Lead is responsible for identifying when an action plan is required and ensuring actions are completed and monitored and uploaded to datix.

4.7 Directorate Governance Facilitators/Administrators

4.7.1 In circumstances whereby a local resolution meeting with directorate staff members is required, directorate governance staff will coordinate the meeting arrangements in a timely manner and ensure that a record of the meeting is taken (this may be written or recorded) and that notes of the recording are uploaded onto Datix.

4.7.2 Are responsible for ensuring that all evidence relating to the complaint and its investigation is uploaded onto Datix ensuring the integrity of the audit trail and completeness of the complaint record on Datix. On some occasions, an internal high level review or serious incident will be necessary as part of the complaint and these documents must be scanned into Datix.

4.7.3 Are responsible for providing a complaints management service to the Directorate Programme, including the analysis of the complaint, setting up meetings, gathering of information required to respond to the complainant, ensuring that the complaint is responded to within the specified timeframe.

4.7.4 Collate and analyse patient experience data both quantitative and qualitative (complaints, PALS, surveys, Friends and Family etc.) identifying emerging and consistent themes and trends. Provide patient experience reports at both speciality and programme level.

4.7.5 Co-ordinate the Duty of Candour process, ensuring that outcomes are communicated and recorded and included within complaint responses.

4.8 Investigating Manager

4.8.1 Has a responsibility to thoroughly investigate the concerns raised in each complaint. Statements will be gained from the relevant staff involved. All statements and supporting information will be forwarded to the Directorate Governance team for uploading onto Datix, which is the Trust's complaints database.

4.9 **Complaints Direct to CEO Office**

- Complaint received direct to CEO and/or medical director.
- Acknowledged by CEO Executive Assistant.
- CEO Executive Assistant sends to CCT.
- CCT acknowledges & requests consent where required.
- CCT log compliant and allocate to directorate.
- Complaint will then follow trust process OTCGR187 - Complaints - Process Flowchart

4.10 **Staff**

4.10.1 Staff and managers on the wards, in clinics and at reception desks are those most likely to receive verbal concerns or complaints. The first responsibility of anyone who receives a complaint or concern is to ensure that the immediate health care needs of the patient concerned are being met. This may require urgent action before any matters relating to the complaint are tackled. The recipient should then seek a full understanding of the complaint, including any aspects which might not be immediately apparent. This needs to be undertaken with tact and sensitivity. Complainants should be encouraged to speak openly and freely about their concerns and be assured that whatever they say will be treated in confidence. Staff should refer to the procedures in SOP0219 - Complaints - Handling Verbal Concerns for further guidance

4.10.2 The aim should always be to satisfy the complainant that his or her concerns are being treated seriously, to offer an apology and an explanation and to take the necessary action to resolve the complaint. Any response given to a complainant which refers to matters of clinical judgement must be agreed by the clinician concerned and, in the case of medical care, by the consultant concerned. A record of such complaints should be made and managed within the directorate.

4.10.3 All staff should feel empowered to manage a complainant's concerns, however it is recognised that this will not always be the case. If the member of staff feels they cannot help the complainant further they should contact their immediate line manager. The manager should make the complainant a priority and should try to allay all fears and put the situation right. This may or may not be followed up in writing or with a telephone call; this is dependent on the situation. If the complainant remains dissatisfied and wishes to pursue it further then the complainant will be advised of the formal complaint process and provided with the Trust's complaints leaflet.

4.11 **Patient Advice and Liaison Service (PALS)**

4.11.1 Is responsible for promoting their service across the organisation to patients, and acting as the first point of contact for complainants as it is the right of every member of the public to contact them to help them resolve a situation.

5 Policy Framework

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

SOP0190 - Complaints Procedure This procedure outlines the process for how we deal with complaints received.
GUCGR026 - Complaints - Responding to Letters of Complaint This document provides guidance on how to respond positively to complaint letters allowing staff to apologise to our patients if something has gone wrong.
OTCGR187 - Complaints - Process Flowchart A flowchart detailing the process from the beginning to end including timeframes.
Complaints Patient Information Leaflets PIL00001114 - Complaints - Easy Read How to make a complaint A leaflet for patients that tells them our process for making a complaint.
Complaints – Supporting Procedures
SOP0219 - Complaints - Handling Verbal Concerns
SOP0217 - Complaints - Process for Managing Persistent and Unreasonable Contact in relation to Complaints
SOP0235 - Complaints - Datix Web

6 Accessible Information Standard

6.1 When responding to complaints, the Trust will comply with the requirements of The Accessible Information Standard, which aims to make sure that people who have a disability or sensory loss get information that they can access and understand, and any communication support that they need. The Standard tells organisations how they should make sure that patients and service users, and their carers and parents, can access and understand the information they are given. This includes making sure that people get information in accessible formats.

6.2 The Standard also tells organisations how they should make sure that people get support from a communication professional if they need it, and about changing working practices to support effective communication. By law (section 250 of the Health and Social Care Act 2012), all organisations that provide NHS care or adult social care have been required to follow the Standard in full from 31 July 2016 onwards.

6.3 The Standard says that patients, service users, carers and parents with a disability or sensory loss should:

6.3.1 Be able to contact, and be contacted by, services in accessible ways, for example via email, text message or Text Relay.

6.3.2 Receive information and correspondence in formats they can read and understand, for example in audio, braille, easy read or large print.

6.3.3 Be supported by a communication professional at appointments if this is needed to support conversation, for example a British Sign Language interpreter.

6.3.4 Get support from health and care staff and organisations to communicate, for example to lip-read or use a hearing aid.

7 Principles underpinning complaints handling

7.1 People complain for many different reasons. The vast majority of people receiving NHS services do not set out to become complainants, so when they do express a concern, or raise a complaint, we recognise that it is usually a significant thing for them to do.

7.2 When members of the public raise matters with the Trust if things have gone wrong we commit to:

7.2.1 Signposting them to the relevant organisation if responsibility for dealing with the complaint does not rest with the Trust;

7.2.2 Inviting the complainant to have a say in how the case is handled and how things are to be put right;

7.2.3 Providing an honest and open response to all the concerns;

7.2.4 Providing a thorough and detailed explanation concerning events leading up to the complaint;

7.2.5 Providing an apology where things have gone wrong;

7.2.6 Providing a response in a timely manner adhering to Trust response deadlines

7.2.7 Providing an explanation to the complainant concerning what the organisation will learn from this experience, with the reassurance that other patients will have a better outcome as a consequence;

7.2.8 Consider making a financial contribution to the complainant if they have suffered a financial loss as a direct consequence.

7.3 No one should be discriminated against or treated badly as a result of making a complaint or raising a concern. Where the complainant is a patient, it is important that their right to quality care is not compromised by their complaint and that they are not treated adversely.

7.4 It is important to listen and react appropriately when patients, carers or relatives express a concern or make a complaint. Not everything that patients, relatives and carers raise as a concern is necessarily a "complaint". Most complaints and concerns can and should be resolved informally by the people to whom they were addressed or by their immediate manager. All possibilities should be explored in an attempt to resolve the complaint positively.

7.5 Where patients find it difficult to complain, or are unable to complain, the Trust will welcome complaints from a close family member or a patient advocate in appropriate circumstances. When someone complains on behalf of a patient, the organisation will need to satisfy itself that the patient has agreed to their information being shared for the purposes of investigation and resolution of the complaint.

7.6 Information received from a complainant will remain confidential and be communicated only to those people who need to know. Specific patient information will be anonymised wherever possible.

7.7 The Trust's complaints leaflet will be published on the Trust's website and be available to patients upon request.

7.8 If the complainant is dissatisfied with the final response of the Trust, s/he has the right to take their complaint to the Parliamentary and Health Service Ombudsman.

8 Entitlement to complaint documentation

8.1 The Freedom of Information Act provides a right to access official information. Under the Freedom of Information Act the complainant will have the right to request any recorded information held by a public authority. The complainant can ask for any information they think the public authority may hold. The Act only covers recorded information which includes information held on computers, in emails and in printed or handwritten documents as well as images, video and audio recordings. The complainant should identify the information required as clearly as possible. The request can be in the form of a question, rather than a request for specific documents, but the authority does not have to answer this question if it would mean creating new information or giving an opinion or judgment that is not already recorded. Some information may not be given because it is exempt, for example because it would unfairly reveal personal details about somebody else. Further information can be located on the following link https://ico.org.uk/your-data-matters/official-information/

9 Complaints & Serious Incidents

9.1 On receipt of a complaint that is already recorded as a serious incident, the complaint will be logged onto datix and linked to the serious incident. The complaint response due date will be the same target date set for the serious incident and the complainant will be notified of this date and of the existing investigation.

10 Matters Excluded from the NHS Complaints Procedure and this Policy

10.1 The following complaints are excluded from the scope of the NHS Complaints Procedure:

10.1.1 A complaint made by a Trust employee about any matter relating to their contract of employment;

10.1.2 A complaint made by another NHS body which relates to contractual arrangements with the Trust;

10.1.3 A complaint which is or has been investigated by the Parliamentary and Health Service Ombudsman;

10.1.4 A complaint relating to a failure to comply with a request for information under the Freedom of Information Act 2000;

10.1.5 An oral complaint which is resolved to the complainant's satisfaction although understanding that feedback about the service can help continuous improvement;

10.1.6 A matter that has already been investigated under the complaints regulations;

10.1.7 A matter arising out of an alleged failure to comply with a data subject request under the General Data Protection Regulations 2018;

10.1.8 If a complaint is also part of an ongoing police investigation or legal action it will be discussed with the relevant police authority or legal advisor and only continue as a complaint if it does not compromise the police or legal action.

10.2 The Trust will write and explain the reasons for not dealing with the complaint.

11 Who may Complain and Timescales for Complaints

11.1 The Trust will act on complaints from people who are receiving, or have recently received, the services which it provides. People may complain on behalf of existing or former patients, where this is the explicit wish of the patient and consent has been given. They may also complain on behalf of a patient who is not competent to give consent, for example because he or she is too ill at the time or because they have parental responsibility or for a patient who has died. The Trust will establish that the person is able to act on behalf of the patient. Particular attention will be given to the need to respect the confidentiality of the patient and any known wishes expressed by the patient before death.

11.2 A complaint should always be made as soon as possible after the incident in question. The Trust will not normally investigate a complaint which is made more than 12 months after the event giving rise to it. The Trust may use its discretion to extend the time limit in cases where, for example, the complainant has suffered particular distress or trauma which prevented him or her from complaining earlier, where it is still possible to investigate the complaint effectively and efficiently.

11.3 The target response time for all complaints is 30 working days, For complex complaints or those where a Serious Incident investigation is required the complainant will be informed the Trust will require 60 working days to allow sufficient time for the investigation and resulting report. The target for a response to a complaint relating to two or more agencies is likely to be longer than 30 working days; the complainant will be notified of the timeframe. The response should include information on what action the complainant should take if they remain dissatisfied with the response. Where it is not possible to provide a full reply within 30/60 working days, contact should be made with the complainant by the directorate explaining the reason for the delay and the anticipated timescale for resolution. The Trust aims to answer 85% of complaints within 30 working days.

11.4 The Trust leaflet entitled 'How to make a complaint' giving guidance on the complaints procedure will be made freely available in all patient areas. Complainants will also be advised that written complaints may be sent via email directly to the Complaints Team. The original communication method i.e. letter or email will be the route in which the Trust will enter into corresponding with the complainant. The leaflet provides details of advocacy services that can support people in making a complaint.

11.5 The Trust recognises the role mediation and conciliation can play in resolving complaints. If a complaint warrants mediation or conciliation in order to resolve matters, this should be discussed with the Executive Director of Clinical Operations. The use of external mediation services will be considered on a case by case basis.

12 Complaints Requesting Reimbursement

12.1 Complaints may contain an explicit request for reimbursement of costs incurred for travelling or parking when travelling to hospital for clinic appointments that are cancelled without prior notification. In cases such as these the Executive Director of Clinical Operations will consider the request made by the complainant and include the decision on reimbursement in their response including the rationale for the decision taken. Funds for reimbursement will be paid from directorate funds. This is in conjunction with the Parliamentary and Health Service Ombudsman's Principles for Remedy. This is only appropriate for patients undergoing care and treatment provided by Medway NHS Foundation Trust. In the case of a complaint where another organisation is involved reimbursement must be considered separately by that specific organisation.

12.2 Where a request is made for reimbursement of onsite parking costs due to cancelled clinic appointments, or cancelled treatment, the Executive Director of Clinical Operations will consider reimbursing the costs in full only if no attempt was made to contact the patient to warn them of the cancellation. It is reasonable to expect that contact should be made by the most appropriate means in the circumstances such as by text, mobile phone, email or letter. Additional parking costs incurred for late running clinics will not be reimbursed.

12.3 No other costs (egg. salary, petrol) will be reimbursed. This is recognising that the NHS has finite resources that must be prioritised on patient care.

12.4 Patients remain responsible for their personal belongings whilst on Trust premises. Therefore, requests for reimbursement of lost property will not be considered further unless the items were handed over to the Trust for safekeeping and a receipt issued by the Trust. Patients will be signposted to their home insurers for reimbursement.

13 Complaints and Legal Action

13.1 Where the complaint is made concurrently with a legal claim or shortly after the legal claim has already been notified to the Trust, the Central Complaints Team will take legal advice from the Trust's Legal Services Team, who in giving that legal advice shall have regard to the current law and guidance which is relevant, about whether the complaint should be dealt with at that time or whether it should be put into abeyance pending resolution of the legal claim.

13.2 The default position is that the Executive Director of Clinical Operations will ensure they investigate the complaint concurrently with the Legal Team. Actual or intended litigation will not be a barrier to the processing or investigating of a complaint.

14 Parliamentary and Health Service Ombudsman Procedure

14.1 Where a complainant is dissatisfied with the response received from the Trust and the outcome of any further attempts to resolve the complaint locally has not been accepted, he or she may make a request to the Parliamentary and Health Service Ombudsman for review of the complaint. Any requests received by the Trust must be forwarded to the Ombudsman within the timescales specified.

14.2 The information produced by the Parliamentary and Health Service Ombudsman describing its role, should be made available to complainants on request – http://www.ombudsman.org.uk/make-a-complaint/how-to-complain

14.3 The Trust will respond promptly to the Parliamentary and Health Service Ombudsman, and in accordance with any targets set by them. All correspondence and records which are requested for their investigation will be coordinated through the Central Complaints Team.

15 Disruptive and unreasonably persistent complainants

15.1 There are a small number of complainants who, because of the frequency of their contact with the Trust, hinder the Trust's consideration of their, or other people's, complaints. We refer to such complainants as 'persistent complainants' and, in exceptional cases, where this contact is unreasonable, we will take action to limit their contact with the Trust.

15.2 The decision to restrict access to our service is taken at a senior executive level and any restrictions imposed are appropriate and proportionate.

15.3 In all cases we will write to tell the complainant why we believe their behaviour falls into this category, and request that they change it.

15.4 If the behaviour continues, we will write to the complainant explaining that we are limiting their access to the Trust. We will also tell them how they can complain if they disagree with that decision.

15.5 Advice for staff on handling unreasonable, regular or persistent complainants is found in a separate SOP - SOP0217 - Complaints - Process for Managing Persistent and Unreasonable Contact in relation to Complaints

15.6 The Trust follows NHS England (NHSE) guidance on dealing with persistent and unreasonable contact set out in appendix two of the NHSE Complaints Policy which is available via this link: https://www.england.nhs.uk/wp-content/uploads/2016/07/nhse-complaints-policy-june-2017.pdf

16 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	Executive Director for Complaints Team	Executive Group / Board	
30 working day response target	DATIX table demonstrating the status of complaints / Monthly	Directorate Governance Manager	Deputy Director of Nursing	
Complaints analysed and trends identified	Monthly via DATIX and reports to PRMs	Directorate Governance Team	Directorate Governance groups Quality Steering Group	Where gaps are recognised, action plans will be put into place by each directorate governance lead
Overdue complaints and directorate response times	Directorate Governance Team liaise with the appropriate specialty where matters of concern arise	Directorate Governance Manager	Deputy Director of Nursing	Review DATIX fields and tables
Turnaround times regarding collaboration with external organisations (joint responses)	Monthly	Directorate Governance Manager	Deputy Director of Nursing External organisations	Review DATIX fields and tables
The number of Ombudsman requests	Monthly	Central Complaints Team (CCT)	Quarterly complaints report weekly CEO report	

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Changes as a result of formal complaints	Changes in practice discussed at monthly directorate and governance meetings	Directorate Governance Manager Deputy Director of Nursing	Directorate Management Board	Each Directorate will demonstrate learning and where necessary a change of practice
Dashboard incorporating complaints, serious incidents and DOC response rates	Monthly, submitted to IQPR and quarterly to QSG	Central Complaints Team	Quality Steering Group SI Panel	

17 Training and Implementation

17.1 Staff Training

17.1.1 The Head of Quality Governance is responsible for ensuring that the training requirements for staff are identified and met.

17.1.2 Directorate Governance Leads will be responsible for ensuring that all staff receive the relevant training in complaint management provided by the Trust in order to address their specific needs.

17.1.3 All staff need to know how to react and what to do if someone makes a complaint as the initial response may either help resolve the situation on the spot or provide the complainant with the reassurance that their concerns will be treated appropriately.

17.1.4 The Trust will provide training and support for all staff required to deal with complaints from or on behalf of the Trust.

18 References

POLCGR005 - CORPORATE Complaints Management Policy
OTCGR187 - Complaints - Process Flowchart
SOP0190 - Complaints Procedure
GUCGR026 - Complaints - Responding to Letters of Complaint
SOP0235 - Complaints - Datix Web
SOP0219 - Complaints - Handling Verbal Concerns
SOP0217 - Complaints - Process for Managing Persistent and Unreasonable Contact in relation to Complaints
PATIENT INFORMATION LEAFLETS
PIL00001114 - Complaints - Easy Read

Appendix 1

Initial assessment of complaint	Type of complaint	Level of investigation, response period and signatory
Low level (Green) - formal complaint	Simple, non-complex complaints e.g. Cancelled outpatient appointment/admission Waiting time, Car Parking	Simple investigation required. Response may be provided verbally or in writing by the **Matron/Service Manager**, with the complainant's agreement. Response period – Within **10 working days** from date complaint opened or when consent received. Alternatively a written response can be signed by the Executive **Director of Clinical Operations or Deputy Director of Nursing.**
Medium level (Amber) – formal complaint	May be several issues and/or involve clinical care	More detailed investigation involving clinical matters. Response to be signed by Executive **Director of Clinical Operations** unless: • Complaint crosses more than one directorate – in which case either the **Director of Nursing or Medical Director** can sign; a judgment will need to be made as to which of these is most appropriate in light of the complaint issues • Investigation results in initial assessment changing from amber to red • Is subject to an incident / Serious Incident investigation Response period – within **30 working days** from date complaint opened or when consent received.
High level (Red) – formal complaint	Complex complaint involving several Directorates or more than one organisation. Issues may have been investigated as a Serious Incident (or need to be) or may have the potential for legal action.	Detailed investigation with option to obtain advice from Associate Medical Director/Lead Clinician. Response to be signed by **Chief Executive** Response period within **60 working days**

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High level (Blue) – formal complaint	MP's involvement Solicitor's involvement	Response period – within **30 working days** from date complaint opened or when consent received.

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Report to the Trust Board

Date: 01/11/2018

Agenda item 10 c

Title of Report	Q1 Mortality and Morbidity Report - Responding to Deaths
Prepared By:	Hayley Usmar, Clinical Effectiveness Facilitator Denise Thompson, Head of Clinical Effectiveness
Lead Director	Dr David Sulch, Medical Director
Committees or Groups who have considered this report	Trust Mortality & Morbidity Group
Executive Summary	**Background:** **The purpose of this report is to provide the Board with:** • The updated Learning from Deaths Dashboard containing data for quarter 1 of 2018/19 • Information regarding the Trust's position against published mortality indicators • The current position and progress made against the Learning from Deaths action plan
Resource Implications	-
Risk and Assurance	-
Legal Implications/Regulatory Requirements	Failure to comply with national reporting requirements could result in regulatory action or a prosecution under the Care Quality Commission (Registration) Regulations 2009.
Improvement Plan Implication	-
Quality Impact Assessment	-
Recommendation	**The Board is requested to note:** • The content of the updated Learning from Deaths Dashboard 2018/19 • The Trust's position with regard to published mortality indicators • The progress against the Learning from Deaths Action Plan. • Actions arising from review of the Guidance for NHS trusts on working with bereaved families and carers
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

The National Quality Board (NQB): Learning from Deaths Update (October 2018)

1. Introduction

The purpose of this report is to provide the Board with:

- The updated Learning from Deaths Dashboard containing data for 2017-18
- The current position and progress made against the Learning from Deaths action plan

2. Background

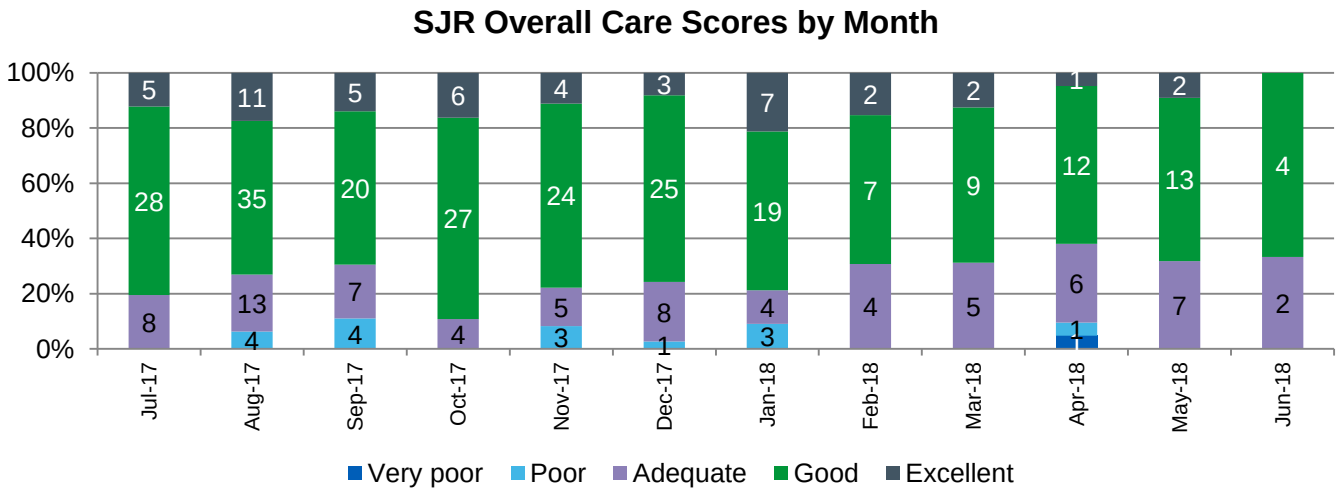
In March 2017, the National Quality Board published the National Guidance on Learning from Deaths. This document builds on the recommendations of the CQC's Learning, Candour and Accountability, published in December 2016, and provides guidance on how organisations should monitor, review, respond to and report death with a view to providing a more standardised approach across the NHS. The guidance aims to improve the quality of investigations and embed learning more effectively. The guidance pertains to all deaths, not just those subject to a Serious Incident investigation.

3. Learning from Deaths Dashboard for 2017/18

From April 2017, Trusts have been required to collect and publish specified information on deaths on a quarterly basis. Information pertaining to the Trust's mortality must also be presented in the annual Quality Accounts.
The table below outlines mortality monitoring that has taken place for patients who have died in quarter 1 of 2018/9. During this period, 0 patients with a Learning Disability died in the Trust.

2018/19	Monitoring & Screening			Case Review	
	Total number of adult inpatient deaths	Total number of adult deaths in ED	Total number of deaths screened	Number reviewed using SJR tool	Total number referred for consideration as SI
April	107	6	60	21	1
May	108	4	91	24	2
June	94	10	54	7	0
Total Q1	**309**	**20**	**205**	**52**	**3**

The overall care scores for patients who died in the 12 months up to June 2018 for whom a Structured Judgement Review has been undertaken are detailed in the chart below.



Of the patients who died in Quarter 1 of 2018/19:

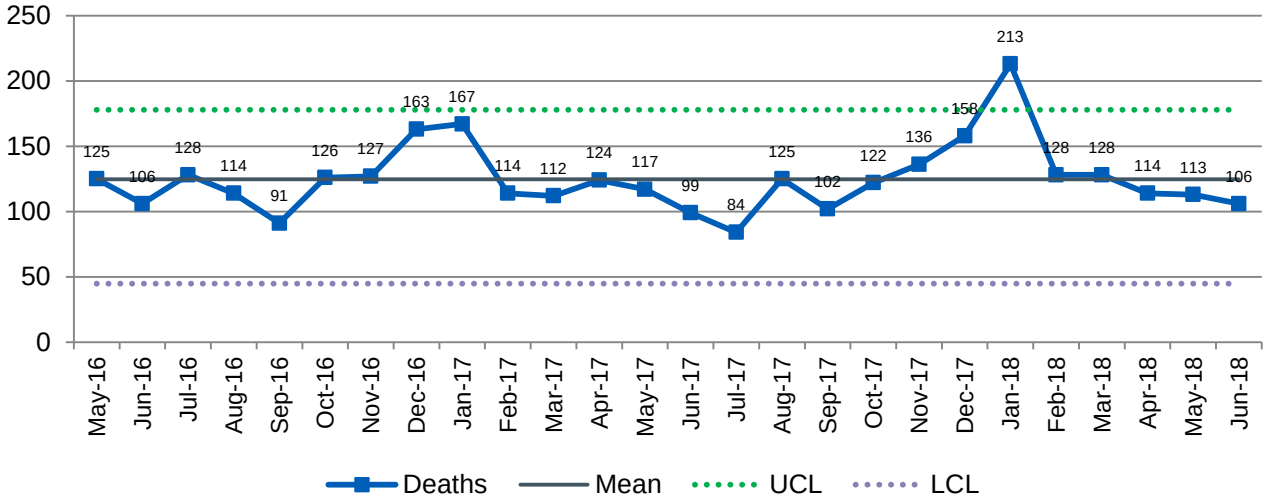
- 2% (1) had an overall care score of very poor
- 2% (1) had an overall care score of poor,
- 28% (15) had an overall care score of adequate,

- 53% (28) had an overall care score of good,
- 4% (2) had an overall care score of excellent

4. Mortality Indicators

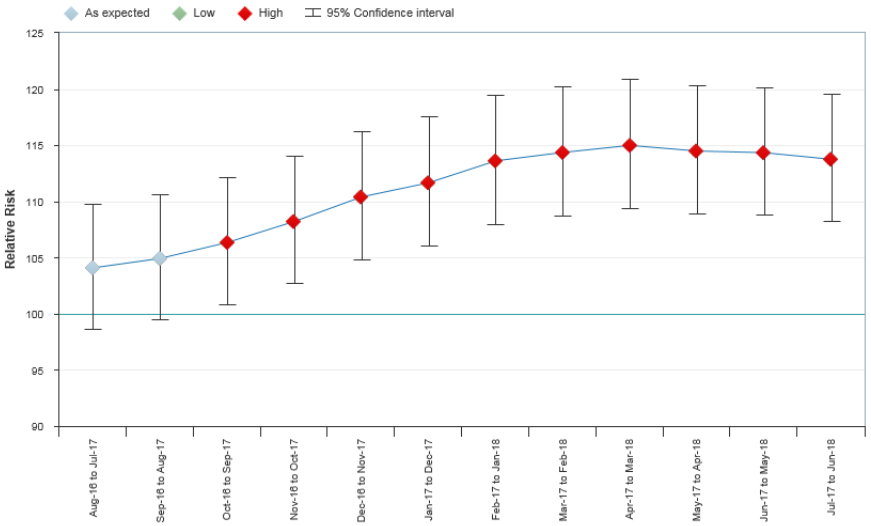
4.1 Crude Mortality Rate

The chart below shows the Trust's crude mortality rate for the 24 months to June 2018 Crude mortality has remained within expected variation for this period with the exception of a spike in deaths in January 2018; this is a trend that is reflected nationally and the Trust's crude rate has returned to baseline since then.



4.2 Hospital Standardised Mortality Ratio (HSMR)

Dr Foster published the HSMR for the period July 2017 – June 2018 on 20 September 2018. The Trust's HSMR for this period is **113.6**. This represents the tenth consecutive month where the relative risk of death for the Trust has been classed as high by Dr Foster, as demonstrated on the graph to the right. This has been investigated extensively locally, and Dr Foster has also provided an in-depth analysis of mortality during this period.



The main reason for the high HSMR seems to be a reduction in palliative care coding at the Trust. This is due to the increased presence of the End of Life Care team. Coding practice requires patients to be seen by a Specialist Palliative Care nurse in order to receive the code "Z515 – Encounter for palliative care'. As the End of Life Care team do not provide specialist palliative care, patients reviewed by them do not qualify for this code. Medway NHS Foundation Trust is unusual in that there are separate End of Life Care and Specialist Palliative Care Teams. After discussion, it is felt that the most appropriate response to this is to exception report a high HSMR and continue to

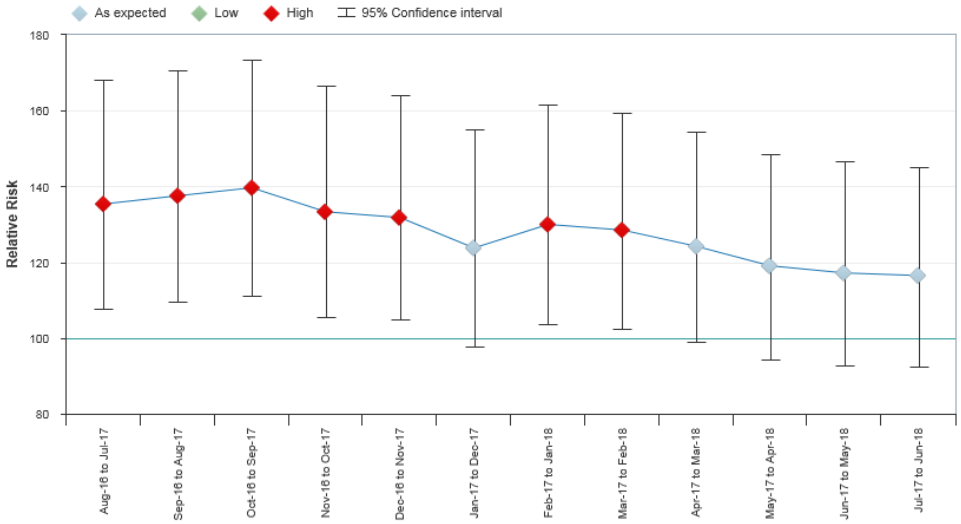
follow agreed coding practice. It is reassuring to note that the crude mortality rate as remained static at an average of 4.4%.

4.2.1 Dr Foster Groups of Concern

The following diagnosis groups have been identified by Dr Foster as having a high relative risk for a period of three or more consecutive months.

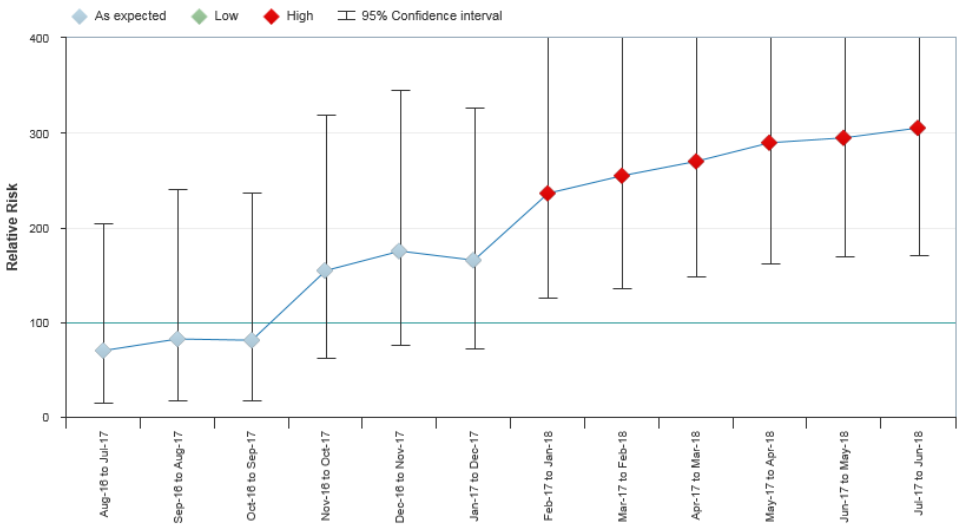
Acute Cerebrovascular Disease

Acute cerebrovascular disease (stroke) was identified as having a high relative risk by Dr Foster in the 2017/18 financial year. A deep dive undertaken by the Stroke Clinical Lead and the Deputy Medical Director did not identify any obvious areas of concern. In response to the indicator's persistent elevation, all patients who had a diagnosis of stroke recorded on Part I of their death certificate were referred for Structured Judgement Review to ensure that there were no themes or trends contributing to the increased relative risk. Since April 2018, the relative risk for this diagnosis group has returned to the expected range, as illustrated in the graph below.



Complications of surgical procedures or medical care

Complications of surgical procedures or medical care was first highlighted as a diagnosis group with high relative risk by Dr Foster in April 2018, and has remained consistently high since then, as illustrated by the graph below:

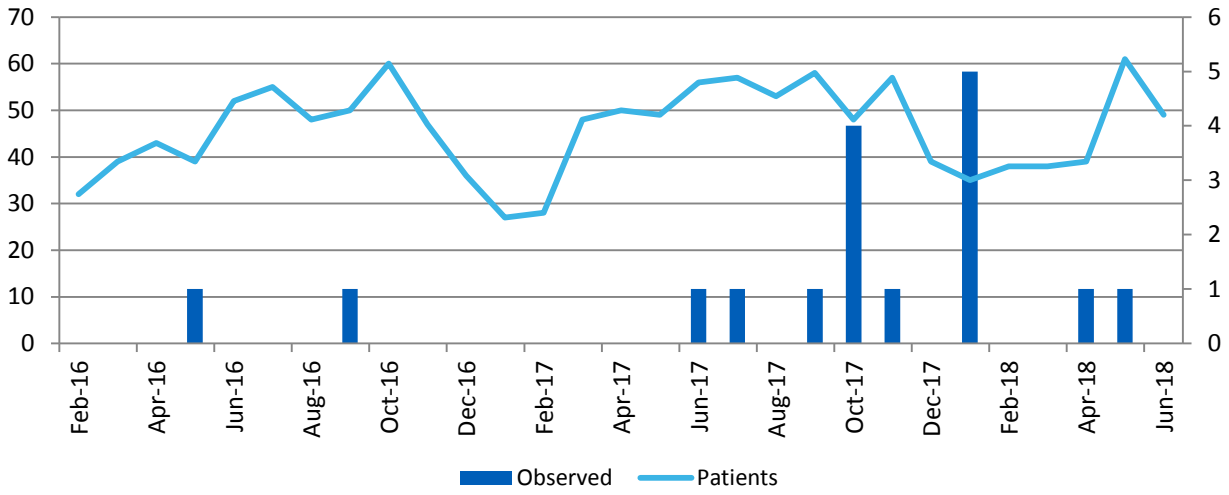


Trust policy is to investigate any diagnosis group that flags with a high relative risk for three consecutive months; consequently, a deep-dive has been undertaken to review this cohort of patients.

In the period July 2017 – June 2018, 15 patient deaths were attributed to this diagnosis group (from a cohort of 551). Of the 15 patients who died, 13 case records have been reviewed.

- Three of the patients had complications relating to a procedure not performed by the Trust; one of these patients actually died at the originating Trust but due to the superspell effect[1], the death has been jointly attributed to Medway.
- Seven of the patients did have procedures prior to the final admission, but their deaths were not as a result of complications from these procedures.
- Three of the patients died as a result of complications of surgery.
    - In two cases, the patient had been discharged following surgery and re-presented with wound infections. Both patients had significant comorbidity that prevented aggressive surgical intervention and were palliated.
    - The remaining case has been subject to a Higher Level Internal Investigation by the Trust and has been reported through that process.

The distribution of deaths in this diagnosis group over a two year period is illustrated in the graph below:



The elevated relative risk can be attributed to two spikes in deaths, in October 2017 and January 2018. The cause of these spikes is unclear, but it is reassuring that the rate of deaths has returned to baseline in the five months since January.

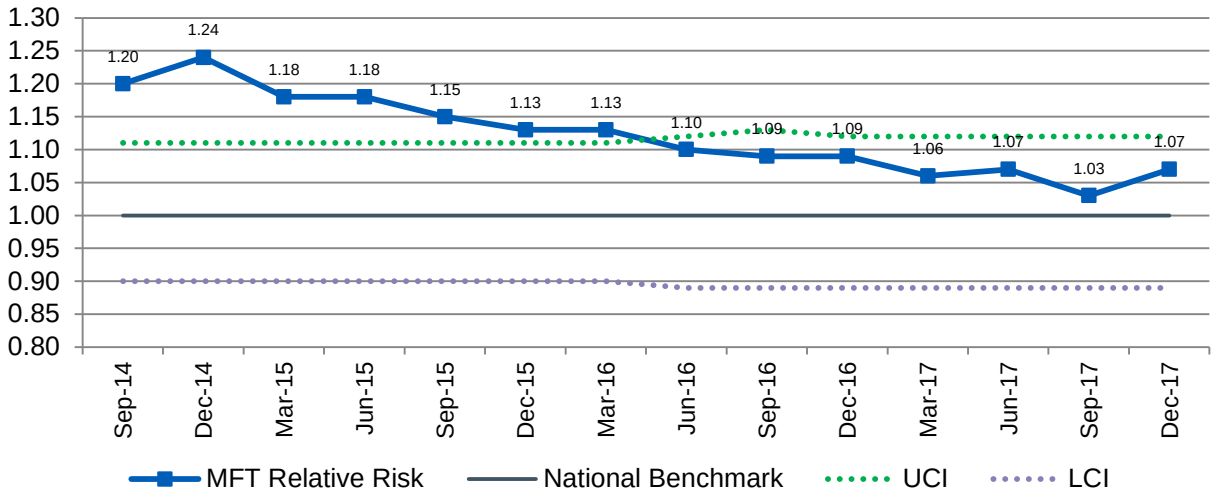
As relative risk is calculated using a rolling 12 months' data period, it is unlikely that the relative risk for this diagnosis group will return to baseline until data for February 2018 – January 2019 is published. Until the group returns to baseline, the crude rate of deaths in this group will be monitored; if this remains at baseline then further investigation is not required, but should another spike occur the Trust will undertake further investigation.

4.3 Standardised Hospital-level Mortality Indicator (SHMI)

NHS England published the SHMI for April 2017 – March 2018 on Thursday 20 September 2018. Medway NHS Foundation Trust's SHMI for this period is 1.07; this represents an increase since the

[1] Any continuous patient episode of care is known as a superspell; where a patient is transferred from one hospital to another as an inpatient, this counts as one superspell. If a patient dies at another hospital without being discharged, then the death will be attributed to all providers of care.

previous period, but remains within the expected range. The graph below illustrates the SHMI trend for the Trust since September 2014.



5. Learning from Deaths Action Plan

In response to the national guidance, the Trust has developed an action plan which shows the key recommendations and progress against these. An overview is given below of the current status and the full action plan can be found on pages 5 – 11.

5.1 Updates and changes

5.1.1 Guidance for NHS trusts on working with bereaved families and carers

The National Quality Board published a paper on working with bereaved families and carers in July 2018. Following review of this guidance (see Appendix 1), the following actions were agreed at the Trust Mortality & Morbidity meeting on 20 September 2018:

- The Trust booklet *What to do following a death: Information for Bereaved Relatives & Friends* will be revised to incorporate the additional information as outlined by the NQB template, and cross-referenced with the corresponding policies including Duty of Candour, Complaints, Serious Incidents.
- The Trust will explore how to provide a 'Carers' Conversation' service
- Relevant policies will be reviewed and updated in light of publication

These actions have been added to the overarching Learning from Deaths Action Plan.

5.2 Ongoing Training (action 4.1)

Further to the Royal College of Physicians (RCP) training session, 22 members of staff at Medway NHS Foundation Trust have now received Structured Judgement Review methodology training. The Clinical Effectiveness team are currently looking at translating this training into an e-learning module to make it more accessible to all staff.

5.3 Exceptions

All actions on the Learning from Deaths Action Plan have progressed as required with the exception of the following action points. A robust monitoring process is in place via monthly review at the Trust Mortality & Morbidity Group, who will ensure that issues are escalated appropriately.

- **Actions 3.1, 3.3 and 9.2** – These actions all relate to updating the Serious Incident policy; the Trust is awaiting the publication of the updated national Serious Incident Framework before undertaking these updates.
- **Action 4.1** – There is no regular training available for Trust staff at present; the Clinical Effectiveness Team are exploring whether it is possible to provide this via e-learning.
- **Action 9.1** – LD deaths are being reported as necessary to the national programme, however the corresponding Standard Operating Procedures (SOP's) have yet to be updated.

- **Action 9.2** – The necessary procedures and processes are already in place to review LD deaths for potential safeguarding concerns and whether they meet Serious Incident (SI) criteria. The policy has been reviewed and updated in line with the national guidance and is currently awaiting final sign-off; in view of this the due date has been amended to June 2018.
- **Action 5.1** – Providers should offer a bereavement service for families and carers of people who die under their management and care. The Trust currently offers a surgical bereavement service offering relatives the opportunity to have questions about their loved one's care answered by medical staff; however, there is no central bereavement service available offering counselling and associated support. Where this is required, referral to outside agencies is made as appropriate.
  This action has also been expanded to include the guidance from the National Quality Board regarding working with bereaved families and carers.
- **Action 5.4** - Providers should ensure that their staff, including family liaison officers, have the necessary skills, expertise and knowledge to engage with bereaved families and carers. There is currently no trust-wide training in place for dealing with bereaved families and carers. The Trust must review the need for bereavement training to ensure compliance with national guidance.

Please see full action plan overleaf.

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National Quality Board: National Guidance on Learning from Deaths (March 2017)

A Framework for NHS Trusts and Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
2. Data Collection and Reporting **From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths (Policy and approach by end of Q2 and publication of the data and learning points from Q3 onwards. The data should include the total number of the Trusts inpatients deaths (including emergency department deaths) and those deaths that the Trust has subjected to a case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged to have been due to problems in care.**								
2.3	Changes to Quality Accounts regulations will require that the data providers publish will be summarised in the Quality Accounts from June 2018.	Preparation of the Trust Quality Account is overseen by the Associate Director of Quality who will ensure inclusion in the Trust Quality Account 2017/18. **September 2018: This information was included in the Quality Accounts for 2017/18.**	Data published will be summarised in the Quality Accounts for 2017/18.	Denise Thompson Head of Clinical Effectiveness	Quality Account 2017/18	June 2018	**June 2018**	Completed
3. Mortality Governance **National Guidance on Learning from Deaths should be aligned to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths. The Trust will need to enhance its current procedures and develop a policy to ensure it meets all the key principles contained within the national guidance.**								
3.1	Providers should review an investigation and/or review they undertake following any linked inquest and issue of a "Regulation 28 report to Prevent Future Deaths" in order to examine the effectiveness of their own review process.	The Learning from Deaths Policy reflects this requirement. The Serious Incident Policy is currently in the process of being reviewed and will be adjusted to reflect the recommendation. **September 2018: The current SI policy is due for review in October 2019. Awaiting updated national SI framework prior to update. Process in place for review of Reg 28 reports between Patient Safety and Mortality teams.**	Review Serious Incident Policy to reflect the recommendation.	Ann Bushnell Head of Quality Governance Denise Thompson Head of Clinical Effectiveness	SI policy in place which meets requirements	October 2019 **Extended deadline – waiting for updated National SI framework publication**		Active

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
3.3	Where possible problems are identified relating to other organisations, the relevant organisation is informed. They should consider whether they can routinely arrange joint case record reviews or investigations for groups of patients where more than one organisation is routinely providing care at the time of death.	The Trust liaises with other organisations regarding SI investigations under the Serious Incident framework. Joint case record reviews are not currently undertaken. The Serious Incident Policy is currently in the process of being reviewed. **September 2018: The current SI policy is due for review in October 2019. Awaiting updated national SI framework prior to update. Process already in place for joint working with other organisations.**	Review Serious Incident Policy to reflect the recommendation.	Ann Bushnell Head of Quality Governance Denise Thompson Head of Clinical Effectiveness	SI policy in place which meets requirements	October 2019 **Extended deadline – waiting for updated National SI framework publication**		Active
4. <u>Skills and Training</u> Providers should review skills and training to support the National Guidance with specialist training and protected time under their contract hours to review and investigate deaths to a high standard.								
4.1	Acute Trusts will receive training to use the Royal College of Physicians Structured Judgment Review Case Note Methodology.	21 clinicians are trained in RCP methodology. E-learning is being explored to supplement classroom training. **September Update: The RCP have recently released an e-learning module which is being reviewed with a view to rolling out across the Trust.**	Ensure RCP training is rolled out across the Trust with support from KSS AHSN.	Dr David Sulch, Medical Director	All reviewing clinicians trained in the RCP methodology	March 2018		Active
			Explore / develop e-learning package	Hayley Usmar Clinical Effectiveness Facilitator		**January 2019**		Active
5. <u>Engagement with Bereaved Families and Carers</u> Providers should have a clear policy for engagement with bereaved families and carers, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.								

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
	Following review of the National Quality Board (NQB): Learning from Deaths Guidance for NHS trusts on working with bereaved families and carers (July 2018), the following recommendations from the guiding principles have been made: • **Review the Trust booklet to incorporate the additional information as outlined by the NQB template, and cross-referenced with the corresponding policies including Duty of Candour, Complaints, Serious Incidents – NEW ACTION 5.1.a** • **The Trust should provide a 'Carers' Conversation' service by extending the current Surgical Bereavement Service across the Directorates – see Action 5.1** • **Review and update relevant policies in light of publication – NEW ACTION 5.1.a**							
5.1	Providers should offer a bereavement service for families and carers of people who die under their management and care. This should include bereavement advisors to help families and carers through the practical aspects following the death of a loved one.	The Trust provides access to bereavement services in some specialties. There is a patient affairs and chaplaincy service in place throughout the Trust, Sep 17 – A new service has been introduced in the Co-ordinated Surgical Care Directorate with a view to roll this out across the Trust. However, this is not a bereavement service as it does not provide counselling. The Trust must consider the need for a Bereavement Service. **September 2018:**	A review of the existing provision in place should be undertaken to determine whether a trust wide approach is required.	Karen Rule, Director of Nursing Dr David Sulch, Medical Director	**Appropriate processes in place to support bereaved carers and relatives**	March 2018	**July 2018**	Complete
5.1.a	National Quality Board (NQB): Learning from Deaths Guidance for NHS trusts on working with bereaved families and carers	The Trust booklet has been reviewed against Annex 1 of the NQB's Learning from Deaths: Guidance for NHS trust on working with bereaved families and carers (NQB template).	Update Trust *Information for Bereaved Relatives & Friends* booklet to include all elements recommended in the guiding principles	Hayley Usmar, Clinical Effectiveness Facilitator Denise Thompson, Head of Clinical Effectiveness	**Relatives are provided with appropriate information following the death of a loved one**	January 2019		Active
		The Trust has a Learning from Death policy in place. This should be reviewed to ensure that the guiding principles are embedded.	Review Learning from Death policy and update to reflect new guidance.	Hayley Usmar, Clinical Effectiveness Facilitator Denise Thompson, Head of Clinical Effectiveness	**Policy in place reflective of guidance from NQB.**	November 2018		Active

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
5.4	When a patient dies under the management and care of a trust, bereaved families and carers should be informed immediately after the death. Providers should ensure that their staff, including family liaison officers, have the necessary skills, expertise and knowledge to engage with bereaved families and carers.	The Trust has a Patient Affairs Office in place as well as an End of Life Care Team. **September 2018: Local policies in place regarding appropriate communication with bereaved families and relatives.** **ESR has a course 'Initiating Conversions about EoLC'; course objectives include 'strategies for starting conversations with patients and their families'. These are transferrable skills.**	**Review provision of difficult communication training for staff**	Karen Rule, Director of Nursing Dr David Sulch, Medical Director	**Difficult conversation training in place**	March 2018	**August 2018**	Complete
8. Mental Health **Regulations require registered providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the CQC without delay.**								
8.1	Undertake a review of policies and processes to ensure that they are in line with current best practice and national guidance.	The SI policy is currently under review. Safeguarding policies are already in place. **September 2018: All deaths in this category are reportable as Serious Incidents and investigated within the current process.**	Review of policies and processes to be done to ensure they are in line with best practice and national guidance.	Denise Thompson Head of Clinical Effectiveness Ann Bushnell Head of Quality Governance Bridget Fordham Head of Safeguarding	Policies reflect best practice	March 2018	**July 2018**	Completed

9. Learning Disabilities **There is unequivocal evidence that demands additional scrutiny be placed on deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review Programme. Once fully rolled out by NHS England, the programme will receive notifications of all deaths of people with Learning Disabilities. This will support a standardised approach and the reviews will be conducted by trained staff.**								
9.1	Learning disability (LD) deaths should be referred to the national LeDeR programme for external review from 07/08/2017.	Deaths will be reported as necessary through the LD and Safeguarding Teams. Child LD deaths will be reported through the Families and Clinical Support Services Directorate. Oct 17 – Relevant deaths are being referred already and a death register has been established as required to monitor all LD deaths and their referral to the LeDeR programme. The Safeguarding Team is working on an SOP for this process. There has been a delay in finalising this action due to delays in the roll out of the national programme to the South East. Therefore the deadline has been amended to January 2018. **September 2018: LeDER programme now in place in South East.**	Ensure procedures are in place.	Bridget Fordham Head of Safeguarding Richard Patey Clinical Director FCSS	Updated SOP's in place	January 2018	**May 2018**	Completed
9.2	Review all deaths of people with learning disabilities for potential safeguarding concerns and whether it meets the criteria for a serious incident.	LD deaths will be reviewed internally through the mortality review process. They are also reviewed by the LD, Safeguarding and Patient Safety Teams for potential safeguarding concerns and whether they meet SI criteria. Nov 17 – The necessary processes and procedures are already in place to underpin the recommendation, however there is a requirement to reference the National guidance within the policy framework, This will be done as part of the SI review planned to be completed by the end of March 2018. **September 2018: The current SI policy is due for review in October 2019. Awaiting updated national SI framework prior to update. Patients with LD are already identified during the SI process.**	Ensure policies and procedures are in place which meet national requirements.	Ann Bushnell Head of Quality Governance	Updated Policies/SOP's in place	**October 2019**		Active

6. Conclusion

The Board is requested to note:

- The content of the updated Learning from Deaths Dashboard for 2017/18
- The Trust's position with regard to published mortality indicators
- The progress against the Learning from Deaths Action Plan
- Actions arising from review of the Guidance for NHS trusts on working with bereaved families and carers

Authors:

Hayley Usmar, Clinical Effectiveness Facilitator
Denise Thompson, Head of Clinical Effectiveness

September 2018

Appendix 1

Medway NHS Foundation Trust

The National Quality Board (NQB): Learning from Deaths Guidance for NHS trusts on working with bereaved families and carers (July 2018)

Introduction

The purpose of this briefing is to:

- Provide an overview of the National Quality Board (NQB) Learning from Deaths Guidance for NHS trusts on working with bereaved families and carers
- Identify any actions that the Trust need to take in response to the guidance
- Provide assurance that the Trust has appropriate arrangements in place to address the requirements of the guidance

Summary

NQB's guidance of March 2017 sets clear expectations for how trusts should engage meaningfully and compassionately with bereaved families and carers at all stages of responding to a death. It also described trust boards' responsibilities for ensuring effective implementation of all aspects of learning from deaths, including timely and compassionate engagement with bereaved families.

The new guidance from the NQB *Learning from Deaths Guidance for NHS trusts on working with bereaved families and carers* is about improving how trusts engage with families and how we learn when things go wrong. It consolidates existing guidance and provides a perspective from many family members, who have experienced bereavement within the NHS. The guidance advises trusts on how they should support, communicate and engage with families following a death of someone in their care.

The NQB have not mandated a 'one size fits all' approach in recognition that each family and each trust is different. They believe that the principles set out in the guidance will help trusts to identify where they can make improvements in how they engage with families.

1. Guiding principles

NQB's guidance set the principles that families can expect trusts to follow after the death of someone in NHS care

1. Bereaved families and carers should be treated as equal partners following bereavement

2. Bereaved families and carers must always receive a clear, honest, compassionate and sensitive response in a sympathetic environment

3. Bereaved families and carers should receive a high standard of bereavement care which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support

4. Bereaved families and carers should be informed of their right to raise concerns about the quality of care provided to their loved one

5. Bereaved families' and carers' views should help to inform decisions about whether a review or investigation is needed

6. Bereaved families and carers should receive timely, responsive contact and support in all aspects of an investigation process, with a single point of contact and liaison

7. Bereaved families and carers should be partners in an investigation to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations

2. Review and Response to NQB Publication

Following the death of a patient at Medway NHS Foundation Trust, bereaved relatives and carers are supported by ward staff; they will provide them with the Trust's *What to do following a death: Information for Bereaved Relatives & Friends* booklet (Trust booklet) and advise them that they will be contacted by Patient Affairs the next working day.

Patient Affairs coordinates subsequent interaction with the bereaved relatives and carers; in the initial telephone conversation the process of death certification is explained and it is ascertained whether the deceased is to be cremated. If referral to the coroner is required, this is also explained. The Trust aims to issue a medical cause of death within 48 hours, and the bereaved relatives and carers are then invited to collect the death certificate at an agreed time. Where cases are referred to the coroner, it can take up to five working days for the coroner's office to respond to the initial enquiry and consequently the process for these patients is generally longer.

The Trust booklet was reviewed against Annex 1 of the NQB's *Learning from Deaths: Guidance for NHS trust on working with bereaved families and carers* (NQB template). Looking at the content of the NQB template, the Trust already provides much of the required information; however, there are areas which would benefit from further information; these include:

- Introduction
    - Information on how to comment on the care your loved one received
    - Process for relatives to raise significant concerns about care provided

- Contacting us
  The NQB template suggests providing a named contact for the bereaved; currently the Trust booklet does not provide this.

- Understanding what happened
    - The Trust leaflet currently suggests liaising with a member of ward staff that looked after the deceased; however, this seems to be more in relation to immediate practical tasks to be addressed. The NQB template suggests that staff who were involved in treating the deceased should be able to answer questions about care – this would link in with the Surgical Bereavement Service (Carers' Conversations).

- Reviews of deaths in our care / Investigations
    - The NQB template explains the Learning from Deaths and investigation processes. Currently we do not provide any information regarding these to the bereaved routinely.
    - This includes advising the bereaved that they can seek independent advice / an independent advocate. Details of relevant services should be provided.
    - Duty of Candour is also explained.

- Providing feedback, raising concerns and/or making a complain
    - Providing feedback – the bereaved are invited to provide feedback to help develop an understanding of the things being done right and the things that need to improve.
    - Raising concerns – highlights the importance of the bereaved being able to raise concerns, and suggests that the team treating the deceased should be approached in the first instance. After this, the named contact is listed as the best person to answer questions and concerns. The bereaved are advised that they may wish to contact PALS if they wish to speak to someone who was not directly involved in the care of the deceased.
    - Making a complaint – this section provides full details of how to make a complaint, including explaining that complaints can be made whilst investigations are being undertaken. Details of the Health Ombudsman are also listed.

- Independent information, advice and advocacy
    - The Trust booklet provides details of support organisations and the Hospital chaplaincy; the NQB template also includes information relating to independent advocacy organisations locally and nationally.

- Frequently asked questions (FAQs)
    - The NQB template includes a section of FAQs:
        - What should I do if I have concerns about the treatment my relative/friend received prior to their death?
        - Who orders a post mortem or inquest?
        - What should I do if I think the treatment was negligent and deserving of compensation?
        - What should I do if I think individual health professionals' poor practice contributed to the death and remains a risk to other patients?
        - Where can I get independent advice and support about raising concerns?

      This section also includes details of other organisations that may be of help, such as CCGs, the CQC, NRLS, NHS England, the NMC, the GMC and HSIB.

3. Policies and Procedures

In addition to the Trust booklet, the Trust has a number of policies and procedures in place that outline how staff should support the bereaved following the death of a patient:

- GUDPCM001-AN - Death - procedure following the death of a baby - DOCTORS GUIDANCE - OLIVER FISHER UNIT (1 attachment)
- POLLPCM027 - Death on Table (1 attachment)
- SOP0049 - End of Life Care - Nursing Care After Death (1 attachment)
- SOP0047 - End of Life Care Policy - Care After Death (1 attachment)
- GUDNM018 - Maternal Death Guidelines (1 attachment)
- GULPCM186 - Death of a Paediatric Patient Guideline (1 attachment)
- POLCGR130 - Responding to Deaths Policy (1 attachment)
- SOP0262 - Verification of Death - SOP0262 (1 attachment)
- What to do following a death – information for bereaved relatives & families booklet

4. Recommendations

- Review the Trust booklet to incorporate the additional information as outlined by the NQB template, and cross-referenced with the corresponding policies including Duty of Candour, Complaints, Serious Incidents.
- The Trust should provide a 'Carers' Conversation' service by extending the current Surgical Bereavement Service across the Directorates.
- Review and update relevant policies in light of publication
- Update NQB Guidance on Learning from Death action plan to include actions arising from this review

Denise Thompson
Head of Clinical Effectiveness

Hayley Usmar
Clinical Effectiveness Facilitator

September 2018

NHS Medway NHS Foundation Trust

Report to the Board

Committee Date: 01/11/2018 Item No. 11a

Title of Report	**Finance Report Month 6**
Prepared By	Tracey Easton - Deputy Director of Finance
Lead Director	Richard Boyce – Interim Director of Finance & Business Services
Committees or Groups who have considered this report	Finance Committee 25th October 2018
Executive Summary	The purpose of this report is to summarise the M6 financial performance of the Trust against the agreed plan. Key points are : 1. Month 6 has been reported as a deficit of £25.56m year to date pre Provider Sustainability Funding (PSF). This is £1.47m favourable to the planned deficit of £27.0m pre PSF. The PSF was not achieved in full and therefore this element of funding is adverse to plan by £1.33m, bringing the overall performance to a favourable variance of £0.13m at month 6. 2. Income – Clinical income to date at month 6 is favourable by £2.0m. Of this £1.3m relates to High Cost Drugs and is offset by expenditure. 3. Activity within the block contract is being monitored to inform future contracting rounds, and to enable a system approach to demand management. Based on the activity reported for month 1 to 6 there are variances between services, but overall the financial value of services delivered is close to the block contract value. 4. Other income –Other income is favorable to plan by £3.0m year to date – of this £1.7m relates to additional funding received for the Agenda for Change pay award. 5. Expenditure – Month 6 expenditure is adverse to plan by £3.9m. Pay is adverse by £0.9m, non-pay adverse by £3m. Pay is due to increased spend on bank costs. Non pay is due to drugs expenditure (which is matched by corresponding

NHS Medway NHS Foundation Trust

Report to the Board

	income), and clinical supplies which are not procured evenly across the year. 6. The forecast position for the year is on plan pre PSF, with an adverse variance post PSF of £1.3m due to the loss of PSF with regard to the A&E target achievement. 7. At month 6 CIP delivery is above plan by £1.8m. However it must be recognized that a significant proportion of the CIP plan is phased over the last 2 quarters of the financial year. 8. Cash has been drawn down from DH in the form of loans in line with the revised deficit position. The Trust is holding a cash balance of £7.4m. 9. The Trust has a Capital plan for the year of £31m. Year to date spend is £4.9m against a plan of £13.3m, with the programme being heavily weighted to the latter part of the year. 10. The balance sheet turned to a negative equity position during 2017/18 and this continues at Month 6, with a forecast further increase in net liabilities as the year progresses. This is due to the high level of loans required to support the ongoing deficit position as well as those drawn for capital requirements.
Resource Implications	As outlined
Risk and Assurance	1. CIP Delivery of £21m for 2018-19 is a risk with a level of unidentified CIP. **The Board is asked to note that actions are already being taken to improve the delivery process.** • **Benchmarking analysis of peer Trusts and the national benchmarking data are being used to identify opportunities and inform planning for 2018/19.** • **The new PMO team is now fully resourced and has commenced a number of transformation projects to support the directorates as well as leading on organisation wide efficiency projects.** • **The Trust has appointed a Turnaround Director to**

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Report to the Board

	support the financial recovery plan. • **The Medway health partners are working on a system recovery plan that addresses financial and operational performance both in the current year and over the longer term.** • **The Trust is also undertaking a review of fragile services** 2. The acceptance of the control total has provided the Trust with £12.6m of PSF income. As per 2017/18, 30% of this income will be subject to achievement of the A&E target. The Trust is currently not achieving this target putting this component of the PSF income at risk. **The Board is asked to note that actions need to be taken to ensure that this income is received.** 3. Trust infrastructure and estate remains a risk due to age and condition, and lack of cash for capital investment. **The Board is asked to note that the capital programme is being managed within the capital limits, with prioritisation criteria for spend being risk based as well as invest to save.**
Legal Implications/Regulatory Requirements	Lack of achievement of the proposed control total for 2018-19 may lead to further Regulatory actions. Inappropriate Estate and insufficient Facilities lead to higher than acceptable risk to Patients, visitors and staff and could lead to further regulatory action.
Improvement Plan Implication	Financial Recovery is one of the nine programmes of Phase 2 Recovery. In year, financial stability is one of 4 programmes in Better, Best, Brilliant which includes financial recovery, commercial efficiency and estate planning.
Quality Impact Assessment	All actions will follow an appropriate QIA process
Recommendation	To note the contents of the report

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Report to the Board

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

Finance Report

Month 06

2018/19

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NHS Foundation Trust

Finance Report - September 2018

1. Liquidity
    a. Cash Flow

2. Financial Performance
    a. Consolidated I&E
    b. Run Rate Analysis - Financial
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    d. Run rate analysis Pay
    e. Agency costs
    f. Clinical Activity
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3. Balance Sheet
    a. Statement of Financial Position
    b. Trade Receivables
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4. Capital
    a. Capital Summary

5. CIP Achievement

6. Use of Resources

7. Better Payment Practice Code

1. Liquidity

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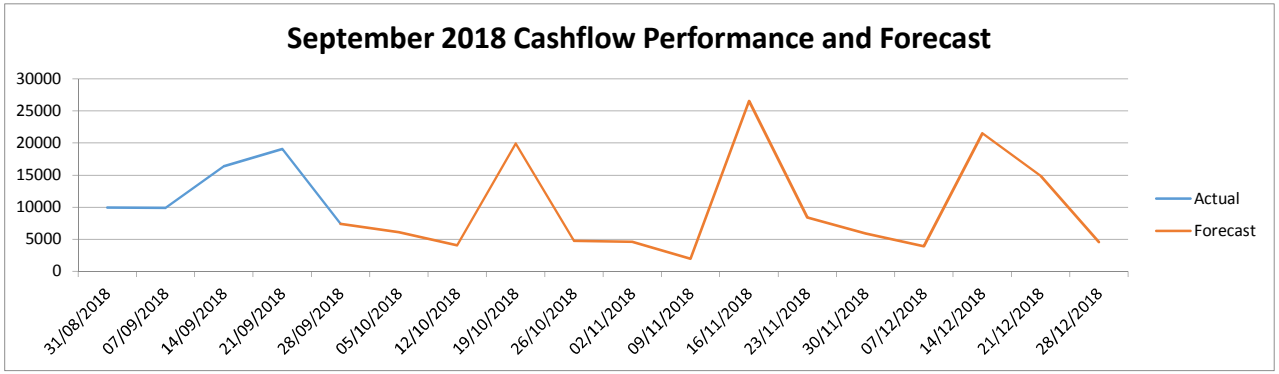
1a. Cashflow

13 Week Forecast **w/e**

£m	Actual					Forecast												
	31/08/18	07/09/18	14/09/18	21/09/18	28/09/18	05/10/18	12/10/18	19/10/18	26/10/18	02/11/18	09/11/18	16/11/18	23/11/18	30/11/18	07/12/18	14/12/18	21/12/18	28/12/18
BANK BALANCE B/FWD	**12.29**	**9.93**	**9.88**	**16.37**	**19.09**	**7.41**	**6.06**	**4.06**	**19.91**	**4.75**	**4.58**	**1.93**	**26.59**	**8.40**	**5.90**	**3.87**	**21.50**	**14.89**
Receipts																		
NHS Contract Income	0.20	0.10	8.28	11.72	0.11	0.02	0.03	21.08	0.00	0.00	0.00	21.01	0.26	0.00	0.00	20.95	0.26	0.00
Other	0.25	0.40	0.69	0.11	0.42	0.51	0.48	0.49	0.28	2.60	0.61	0.28	0.28	0.28	0.73	0.40	0.28	0.28
STF Funding	0.00	1.33	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 receipts	**0.45**	**1.83**	**8.97**	**11.83**	**0.53**	**0.53**	**0.50**	**21.57**	**0.28**	**2.60**	**0.61**	**21.28**	**0.53**	**0.28**	**0.73**	**21.35**	**0.53**	**0.28**
Payments																		
Pay Expenditure (excl. Agency)	(0.38)	(0.31)	(0.33)	(7.60)	(8.51)	(0.32)	(0.32)	(2.80)	(12.98)	(0.31)	(0.30)	(0.30)	(15.48)	(0.31)	(0.30)	(0.30)	(7.40)	(8.38)
Non Pay Expenditure	(0.41)	(1.58)	(2.15)	(3.38)	(1.84)	(1.55)	(2.18)	(5.20)	(2.46)	(0.10)	(2.96)	(7.11)	(3.11)	1.90	(2.46)	(3.43)	(4.19)	(2.26)
Capital Expenditure	(2.02)	0.00	0.00	0.00	(1.85)	0.00	0.00	0.00	0.00	(2.36)	0.00	0.00	0.00	(4.36)	0.00	0.00	0.00	0.00
Total payments	**(2.81)**	**(1.89)**	**(2.48)**	**(10.98)**	**(12.21)**	**(1.87)**	**(2.51)**	**(8.00)**	**(15.44)**	**(2.77)**	**(3.26)**	**(7.41)**	**(18.59)**	**(2.77)**	**(2.76)**	**(3.73)**	**(11.59)**	**(10.64)**
Net Receipts/ (Payments)	**(2.36)**	**(0.06)**	**6.49**	**0.84**	**(11.68)**	**(1.34)**	**(2.00)**	**13.57**	**(15.17)**	**(0.17)**	**(2.65)**	**13.87**	**(18.06)**	**(2.50)**	**(2.03)**	**17.63**	**(11.05)**	**(10.37)**
Funding Flows																		
FTFF/DOH - Revenue	0.00	0.00	0.00	3.24	0.00	0.00	0.00	1.71	0.00	0.00	0.00	1.72	0.00	0.00	0.00	0.00	1.88	0.00
STF Advance	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.74	0.00	0.00	0.00	3.84	0.00	0.00	0.00	0.00	1.07	0.00
FTFF/DOH - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	5.09	0.00	0.00	0.00	0.00	1.53	0.00
Incentive Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.13	0.00	0.00	0.00	0.00	0.11	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	(1.37)	0.00	0.00	0.00	(0.18)	0.00	0.00	0.00	0.00	(0.13)	0.00	0.00	0.00	(0.16)	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	0.00	**0.00**	**0.00**	**1.88**	**0.00**	**0.00**	**0.00**	**2.28**	**0.00**	**0.00**	**0.00**	**10.79**	**(0.13)**	**0.00**	**0.00**	**0.00**	**4.44**	**0.00**
BANK BALANCE C/FWD	**9.93**	**9.88**	**16.37**	**19.09**	**7.41**	**6.06**	**4.06**	**19.91**	**4.75**	**4.58**	**1.93**	**26.59**	**8.40**	**5.90**	**3.87**	**21.50**	**14.89**	**4.52**



Commentary

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

The opening cash balance for September 2018 was £9.9m, with a closing balance of £7.4m. This cash balance was slightly higher than planned due to ongoing delays in settlement of capital expenditure in relation to the ED project.

Receipts in the month were £21.8m, plus £3.2m loans & funding, therefore the total cash inflow for September was £25m.

Payments, including capital, were £27.5m. Salary payments for the month were £16.7m with £9.4m in relation to direct salary costs and £7.3m employer costs.

Monthly payments for 2018/19 have so far averaged at £27.5m, with 57% relating to payroll costs. Monthly receipts (excluding loans) for 18/19 have so far averaged at £23.3m.

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2. Financial Performance

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2a. Consolidated Income & Expenditure

30 September 2018

	Current Month			Year to Date			Annual		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Forecast*	*Plan*	*Variance*
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical income	19,122	18,971	151	114,164	113,157	1,006	226,095	225,459	636
High Cost Drugs	1,881	1,967	-86	12,445	11,396	1,049	24,200	21,158	3,042
Other Operating Income	2,045	1,930	115	13,515	11,577	1,938	20,833	23,246	-2,413
Pay Award Funding	258	0	258	1,548	0	1,548	3,102	0	3,102
Total Revenue	**23,306**	**22,868**	**438**	**141,672**	**136,130**	**5,541**	**274,231**	**269,863**	**4,367**
Expenditure									
Substantive	-13,681	-16,864	3,183	-84,976	-102,754	17,778	-167,869	-197,968	30,100
Bank	-2,232	0	-2,232	-12,568	0	-12,568	-23,326	0	-23,326
Agency	-969	0	-969	-6,113	0	-6,114	-12,924	0	-12,924
Total Pay	**-16,881**	**-16,863**	**-18**	**-103,658**	**-102,754**	**-904**	**-204,119**	**-197,968**	**-6,151**
Clinical supplies	-2,440	-2,349	-91	-15,523	-14,346	-1,177	-27,054	-27,947	894
High Cost Drugs Expense	-1,982	-1,763	-219	-12,490	-10,578	-1,913	-23,326	-21,156	-2,168
Drugs	-857	-701	-156	-3,505	-4,207	702	-3,731	-8,412	4,681
Consultancy	-129	-85	-44	-612	-508	-104	-1,027	-1,017	68
Other non pay	-3,838	-4,004	165	-24,590	-24,026	-564	-48,872	-46,268	-2,682
Total Non Pay	**-9,247**	**-8,902**	**-345**	**-56,721**	**-53,664**	**-3,057**	**-104,007**	**-104,800**	**793**
Total Expenditure	**-26,128**	**-25,765**	**-363**	**-160,378**	**-156,418**	**-3,960**	**-308,126**	**-302,768**	**-5,358**
EBITDA	**-2,822**	**-2,897**	**75**	**-18,707**	**-20,288**	**1,581**	**-33,895**	**-32,905**	**-990**
	-12%	*-13%*	*17%*	*-13%*	*-15%*	*29%*	*-12%*	*-15%*	*0%*
Post EBITDA									
Depreciation	-781	-833	51	-5,126	-4,920	-206	-9,699	-10,092	393
Interest	-294	-322	28	-1,730	-1,820	90	-3,352	-3,949	597
Dividend	0	0	0	0	0	0	0	0	0
Profit/(Loss) on sale of asset	0	0	0	0	0	0	0	0	0
	-1,075	**-1,155**	**80**	**-6,856**	**-6,740**	**-116**	**-13,051**	**-14,041**	**990**
Net Surplus/(Deficit) excluding PSF	**-3,897**	**-4,052**	**155**	**-25,563**	**-27,028**	**1,465**	**-46,946**	**-46,946**	**0**
PSF Income	590	845	-255	3,102	4,432	-1,330	11,333	12,663	-1,330
Net Surplus/(Deficit) including PSF	**-3,307**	**-3,207**	**-100**	**-22,461**	**-22,596**	**135**	**-35,614**	**-34,283**	**-1,330**

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2b. Finance Report for September 2018- APPENDICES

Anaylsis of 15 monthly performance - Financials

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue															
Clinical income	20.0	20.7	19.8	15.6	19.2	13.7	20.0	16.4	16.8	18.7	18.8	18.4	20.6	18.6	19.1
High Cost Drugs	1.8	1.8	1.7	2.2	1.9	1.6	1.5	2.0	2.0	1.9	2.2	2.1	2.4	2.1	1.9
STF Income	0.6	0.4	0.6	0.4	0.9	-1.9	0.0	0.0	0.0	0.0	0.0	1.3	0.6	0.6	0.6
Other Operating Income	2.0	2.0	1.9	1.7	1.9	1.9	1.9	1.9	3.4	2.4	2.1	1.4	1.8	3.7	2.0
Pay award funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	1.0	0.3
Total Revenue	**26.4**	**26.9**	**25.9**	**21.5**	**25.8**	**17.2**	**25.3**	**22.3**	**25.6**	**23.0**	**23.1**	**23.2**	**25.6**	**26.1**	**23.9**
Expenditure															
Substantive															
Bank	-14.1	-14.3	-13.9	-14.5	-14.2	-14.1	-14.8	-13.5	-15.0	-13.9	-14.3	-14.0	-14.1	-14.9	-13.7
Agency	-1.8	-2.4	-2.3	-2.4	-2.2	-2.0	-2.6	-2.3	-2.3	-2.0	-2.0	-1.9	-2.9	-1.4	-2.2
Total Pay	-1.3	-1.6	-1.4	-1.3	-1.1	-0.9	-1.1	-1.9	-2.6	-0.9	-1.5	-1.0	-0.9	-0.8	-1.0
	-17.2	**-18.3**	**-17.6**	**-18.2**	**-17.4**	**-17.0**	**-18.5**	**-17.7**	**-19.9**	**-16.9**	**-17.8**	**-17.0**	**-17.9**	**-17.2**	**-16.9**
Clinical supplies															
High Cost Drugs Expense	-3.1	-3.3	-3.3	-3.2	-3.0	-2.9	-2.9	-2.4	-3.0	-2.6	-2.8	-2.5	-2.9	-2.3	-2.4
Drugs	-1.5	-1.5	-9.2	-2.0	-1.9	-1.5	-1.7	-1.7	-1.5	-1.9	-2.0	-1.6	-3.3	-1.7	-2.0
Consultancy	-1.1	-1.4	6.3	-2.0	-1.7	1.0	-1.3	-0.8	-1.1	-1.1	-0.8	-0.7	0.8	-0.8	-0.9
Other non pay	-0.2	-0.3	-0.1	0.0	-0.1	-0.1	-0.1	-0.1	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1
Total Non Pay	-4.3	-1.4	-2.6	-3.2	-2.3	0.3	-3.0	-3.2	-8.1	-4.0	-3.6	-3.1	-3.6	-6.4	-3.8
	-10.2	**-7.9**	**-8.9**	**-10.4**	**-8.9**	**-3.2**	**-9.0**	**-8.2**	**-13.8**	**-9.6**	**-9.3**	**-8.0**	**-9.1**	**-11.4**	**-9.2**
Total Expenditure	**-27.4**	**-26.2**	**-26.5**	**-28.6**	**-26.3**	**-20.1**	**-27.5**	**-26.0**	**-33.8**	**-26.5**	**-27.2**	**-25.0**	**-27.0**	**-28.6**	**-26.1**
EBITDA	**-1.0**	**0.7**	**-0.6**	**-7.1**	**-0.5**	**-2.9**	**-2.2**	**-3.6**	**-8.2**	**-3.6**	**-4.1**	**-1.8**	**-1.4**	**-2.5**	**-2.2**
Post EBITDA															
Depreciation	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.9	-0.8	-0.8	-0.8	-1.1	-0.9	-0.8
Interest	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.2	-0.3	-0.4	-0.3	-0.3	-0.3
Dividend	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fixed Asset Impairment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Profit on sale of asset	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	-1.0	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.2**	**-0.9**	**-1.1**	**-1.2**	**-1.4**	**-1.2**	**-1.1**
Net Surplus / (Deficit)	**-2.0**	**-0.3**	**-1.6**	**-8.1**	**-1.5**	**-4.0**	**-3.2**	**-4.6**	**-9.3**	**-4.5**	**-5.1**	**-3.0**	**-2.8**	**-3.7**	**-3.3**

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2b. Finance Report for September 2018- APPENDICES

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
		WTE	WTE	WTE	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	197	227	-30	2.59	2.55	0.04	2.37	14.92	15.22	-0.31	14.81
	Junior Medical	352	387	-34	2.04	2.43	-0.40	1.81	11.96	14.48	-2.53	11.59
	Nurses & Midwives	1,117	1,533	-416	4.24	6.19	-1.95	4.05	25.12	32.83	-7.71	24.54
	Scientific, Therapeutic & Technical	337	437	-100	1.08	1.15	-0.07	1.37	6.53	9.68	-3.15	8.16
	Healthcare Assts, etc	479	582	-104	1.08	1.18	-0.10	1.04	6.62	7.84	-1.23	6.18
	Admin & Clerical	778	939	-161	2.09	2.55	-0.47	2.18	13.13	15.71	-2.57	12.96
	Executives	6	6	0	0.14	0.10	0.04	0.09	0.68	0.60	0.08	0.70
	Other Non Clinical	411	489	-78	0.90	1.06	-0.16	0.93	5.62	7.63	-2.01	5.57
	Pay Reserves	0	0	0	-0.47	-0.35	-0.12	0.07	0.41	-1.24	1.65	0.39
	Substantive Total	**3,678**	**4,600**	**-922**	**13.68**	**16.86**	**-3.18**	**13.90**	**84.98**	**102.75**	**-17.77**	**84.90**
Agency	Consultants	1	0	1	-0.03	0.00	-0.03	2.37	0.28	0.00	0.3	1.11
	Junior Medical	3	0	3	0.07	0.00	0.07	0.12	0.66	0.00	0.7	1.37
	Nurses & Midwives	119	0	119	0.73	0.00	0.73	0.69	3.58	0.00	3.6	3.86
	Scientific, Therapeutic & Technical	19	0	19	0.09	0.00	0.09	0.32	0.89	0.00	0.9	1.45
	Healthcare Assts, etc	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.14
	Admin & Clerical	7	0	7	0.06	0.00	0.06	0.04	0.40	-0.04	0.4	0.27
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	15	0	15	0.05	0.00	0.05	0.06	0.29	0.00	0.3	0.39
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Agency Total	**165**	**0**	**164**	**0.97**	**0.00**	**0.97**	**3.60**	**6.11**	**-0.04**	**6.15**	**8.59**
Bank	Consultants	12	5	7	0.23	0.00	0.23	0.27	1.19	0.00	1.2	0.67
	Junior Medical	55	0	55	0.73	0.00	0.73	0.48	3.91	0.00	3.9	2.46
	Nurses & Midwives	126	0	126	0.56	0.00	0.56	0.61	3.23	0.00	3.2	3.36
	Scientific, Therapeutic & Technical	18	0	18	0.09	0.00	0.09	0.05	0.49	0.00	0.5	0.17
	Healthcare Assts, etc	155	0	155	0.39	0.00	0.39	0.56	2.24	0.00	2.2	2.67
	Admin & Clerical	53	3	50	0.12	0.00	0.12	0.23	0.77	0.04	0.7	1.48
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	56	1	55	0.12	0.00	0.12	0.11	0.74	0.00	0.7	0.73
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Bank Total	**474**	**8**	**466**	**2.23**	**0.00**	**2.23**	**2.32**	**12.57**	**0.04**	**12.53**	**11.53**
	Workforce Total	**4,317**	**4,609**	**-292**	**16.88**	**16.86**	**0.02**	**19.83**	**103.66**	**102.75**	**0.90**	**105.02**

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2d. Run rate analysis pay

		Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	192	190	193	192	192	191	196	197	190	195	192	197
	Junior Medical	354	339	359	356	352	357	358	351	353	350	341.65	352.07
	Nurses & Midwives	1,161	1,148	1,128	1,125	1,138	1,139	1121	1115	1132	1126	1112.37	1117.4
	Scientific, Therapeutic & Technical	446	438	433	425	419	342	340	339	316	322	326.99	336.68
	Healthcare Assts, etc	492	494	485	480	484	475	484	492	488	481	488.05	478.86
	Admin & Clerical	841	831	831	842	839	837	827	832	804	804	792.97	778.4
	Executives	6	6	6	6	6	6	7	7	7	6	6.25	6.08
	Other Non Clinical	441	436	437	435	440	429	425	428	424	419	415.81	410.9
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0
	Substantive Total	**3,934**	**3,882**	**3,872**	**3,861**	**3,871**	**3,776**	**3,758**	**3,761**	**3,715**	**3,703**	**3,676**	**3,678**
Agency	Consultants	11	12	4	3	8	6	6	7	6	5	2.06	1.13
	Junior Medical	12	23	20	17	14	13	13	12	11	11	6.98	3.25
	Nurses & Midwives	153	90	93	153	105	127	-20	19	127	123	109.7	119.03
	Scientific, Therapeutic & Technical	34	31	32	24	18	27	42	52	27	48	21.36	19.08
	Healthcare Assts, etc	0	0	0	0	0	0	0	0	0	0	0	0.15
	Admin & Clerical	3	3	3	5	4	8	7	8	9	7	7.79	7.09
	Executives	0	0	0	0	0	0	0	0	0	0	0	0
	Other Non Clinical	26	20	19	18	19	19	16	18	20	17	21.53	15.04
	Pay Reserves	0	0	0	0	0	0	0	0	0	0	0	0
	Agency Total	**238**	**179**	**171**	**220**	**168**	**201**	**65**	**117**	**200**	**212**	**169**	**165**
Bank	Consultants	14	15	14	15	12	12	12	14	8	17	7.83	11.54
	Junior Medical	48	39	32	41	35	42	43	47	48	69	41.34	55.32
	Nurses & Midwives	125	124	105	195	167	158	118	111	132	155	88.82	126.05
	Scientific, Therapeutic & Technical	12	16	17	22	22	23	19	34	16	10	14.57	17.51
	Healthcare Assts, etc	203	195	182	208	191	222	161	142	156	173	102.49	154.76
	Admin & Clerical	91	75	58	59	55	60	52	53	57	70	34.52	53.05
	Executives	-	-	-	-	-	-	0	0	0	0	0	0
	Other Non Clinical	65	56	59	66	62	74	59	63	63	71	42.82	56.26
	Pay Reserves	-	-	-	-	-	-	0	0	0	0	0	0
	Bank Total	**558**	**518**	**467**	**606**	**544**	**591**	**464**	**465**	**480**	**565**	**332**	**474**
	Workforce Total	**4,730**	**4,579**	**4,510**	**4,687**	**4,583**	**4,567**	**4,287**	**4,343**	**4,395**	**4,480**	**4,178**	**4,317**

Analysis of 12 monthly performance - £

		Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.54	2.41	2.40	2.39	2.48	2.48	2.52	2.46	2.47	2.41	2.47	2.59
	Junior Medical	2.22	2.01	2.05	2.08	1.96	1.88	1.99	1.99	1.97	1.95	2.01	2.04
	Nurses & Midwives	4.08	4.07	3.88	4.06	4.05	4.03	4.11	4.01	4.11	4.17	4.47	4.24
	Scientific, Therapeutic & Technical	1.38	1.36	1.36	1.27	1.31	1.12	1.11	1.10	1.02	1.07	1.16	1.08
	Healthcare Assts, etc	1.02	1.05	1.04	1.05	1.04	1.01	1.03	1.06	1.07	1.08	1.31	1.08
	Admin & Clerical	2.15	2.20	2.27	2.22	2.10	2.01	2.11	2.12	2.04	2.18	2.60	2.09
	Executives	0.09	0.09	0.09	0.14	0.18	-0.02	0.10	0.10	0.10	0.15	0.09	0.14
	Other Non Clinical	0.91	0.90	0.90	0.94	0.93	0.90	0.90	0.91	0.90	0.92	1.08	0.90
	Pay Reserves	0.07	0.07	0.07	0.66	-0.52	1.52	0.03	0.58	0.35	0.18	-0.27	-0.47
	Substantive Total	**14.47**	**14.16**	**14.06**	**14.81**	**13.53**	**14.93**	**13.90**	**14.33**	**14.03**	**14.11**	**14.92**	**13.69**
Agency	Consultants	0.18	0.09	0.02	0.08	0.08	0.10	0.06	0.07	0.10	0.04	0.04	-0.03
	Junior Medical	0.12	0.21	0.12	0.26	0.14	-0.01	0.15	0.16	0.08	0.07	0.13	0.07
	Nurses & Midwives	0.75	0.43	0.44	0.72	0.49	2.46	0.32	0.87	0.58	0.68	0.41	0.73
	Scientific, Therapeutic & Technical	0.20	0.18	0.22	0.02	0.23	0.64	0.27	0.24	0.11	0.10	0.10	0.09
	Healthcare Assts, etc	0.00	0.00	0.00	0.00	0.00	0.02	0.00	0.00	0.00	0.00	0.00	0.00
	Admin & Clerical	0.00	0.12	0.04	0.03	0.10	0.13	0.09	0.11	0.09	-0.02	0.08	0.06
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Other Non Clinical	0.06	0.05	0.05	0.06	0.05	0.03	0.06	0.05	0.06	0.03	0.04	0.05
	Pay Reserves	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Agency Total	**1.31**	**1.08**	**0.89**	**1.17**	**1.09**	**3.37**	**0.95**	**1.50**	**1.02**	**0.90**	**0.80**	**0.97**
Bank	Consultants	0.26	0.22	0.21	0.24	0.20	0.12	0.17	0.19	0.08	0.38	0.13	0.23
	Junior Medical	0.58	0.47	0.50	0.58	0.43	0.52	0.59	0.56	0.62	0.92	0.49	0.73
	Nurses & Midwives	0.56	0.51	0.44	0.81	0.83	0.69	0.52	0.51	0.53	0.75	0.36	0.56
	Scientific, Therapeutic & Technical	0.05	0.12	0.08	0.10	0.10	0.03	0.09	0.12	0.07	0.08	0.05	0.09
	Healthcare Assts, etc	0.51	0.49	0.48	0.52	0.47	0.66	0.40	0.37	0.37	0.48	0.24	0.39
	Admin & Clerical	0.28	0.21	0.18	0.18	0.16	0.11	0.14	0.12	0.14	0.17	0.07	0.12
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	Other Non Clinical	0.14	0.12	0.13	0.14	0.14	0.19	0.13	0.13	0.13	0.14	0.09	0.12
	Bank Total	**2.38**	**2.15**	**2.02**	**2.58**	**2.34**	**2.33**	**2.04**	**2.00**	**1.94**	**2.92**	**1.43**	**2.24**
	Workforce Total	**18.16**	**17.39**	**16.97**	**18.56**	**16.96**	**20.63**	**16.89**	**17.83**	**16.99**	**17.93**	**17.15**	**16.90**

2d. Run rate analysis pay continued

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Summary by Staff Group												
Consultants	2.98	2.72	2.63	2.72	2.76	2.70	2.75	2.72	2.65	2.83	2.64	2.79
Junior Medical	2.92	2.69	2.67	2.92	2.53	2.39	2.73	2.71	2.67	2.94	2.63	2.84
Nurses & Midwives	5.39	5.01	4.76	5.59	5.37	7.18	4.95	5.39	5.22	5.60	5.24	5.53
Scientific, Therapeutic & Technical	1.63	1.66	1.66	1.39	1.64	1.79	1.47	1.46	1.20	1.25	1.31	1.26
Healthcare Assts, etc	1.53	1.54	1.52	1.57	1.51	1.69	1.43	1.43	1.44	1.56	1.55	1.47
Admin & Clerical	2.43	2.53	2.49	2.42	2.36	2.25	2.34	2.35	2.27	2.33	2.75	2.27
Executives	0.09	0.09	0.09	0.14	0.18	- 0.02	0.10	0.10	0.10	0.15	0.09	0.14
Other Non Clinical	1.11	1.07	1.08	1.14	1.12	1.12	1.09	1.09	1.09	1.09	1.21	1.07
Pay Reserves	0.07	0.07	0.07	0.66	- 0.52	1.52	0.03	0.58	0.35	0.18	- 0.27	- 0.47
Total InclSubstantive and Temp	**18.16**	**17.39**	**16.97**	**18.56**	**16.95**	**20.62**	**16.89**	**17.83**	**16.99**	**17.93**	**17.15**	**16.90**

	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18
	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Summary by Staff Group												
Consultants	217	217	211	210	212	210	213	218	204	217	202	210
Junior Medical	414	401	411	414	401	413	414	411	412	430	390	411
Nurses & Midwives	1,438	1,362	1,326	1,473	1,410	1,424	1,219	1,245	1,392	1,404	1,311	1,362
Scientific, Therapeutic & Technical	492	485	482	471	459	392	401	425	359	381	363	373
Healthcare Assts, etc	695	689	667	688	675	697	646	634	644	653	591	634
Admin & Clerical	935	909	892	906	898	906	886	894	870	881	835	839
Executives	6	6	6	6	6	6	7	7	7	6	6	6
Other Non Clinical	532	512	515	519	521	521	500	509	506	507	480	482
Pay Reserves	0	0	0	0	0	0	0	0	0	0	-	-
Total InclSubstantive and Temp	**4,730**	**4,579**	**4,510**	**4,687**	**4,583**	**4,568**	**4,287**	**4,343**	**4,395**	**4,480**	**4,178**	**4,317**

2e. Agency and Bank Costs

Agency/Bank as % of Spend	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	2018/19
Agency/Bank - A&C	240	230	230	230	150	150	180	1,170
Substantive - A&C	2,010	2,110	2,120	2,040	2,180	2,600	2,090	13,140
		↑	↑	↓	↑	↑	↓	
Agency/Bank as %	11%	10%	10%	10%	6%	5%	8%	8%
Agency/Bank - Reg'd Nursing	3,150	840	1,380	1,110	1,430	770	1,290	6,820
Substantive - Reg'd Nursing	4,030	4,110	4,010	4,110	4,170	4,470	4,240	25,110
		↑	↓	↑	↓	↑	↓	
Agency/Bank as %	44%	17%	26%	21%	26%	15%	23%	21%
Agency/Bank - Unreg'd Nursing	680	400	370	370	480	240	390	2,250
Substantive - Unreg'd Nursing	1,010	1,030	1,060	1,070	1,080	1,310	1,080	6,630
		↑	↑	↑	↓	↑	↓	
Agency/Bank as %	40%	28%	26%	26%	31%	15%	27%	25%
Agency/Bank - Medical	730	970	980	880	1,410	790	1,000	6,030
Substantive - Medical	4,360	4,510	4,450	4,440	4,360	4,480	4,630	26,870
		↓	↓	↑	↓	↑	↓	
Agency/Bank as %	14%	18%	18%	17%	24%	15%	18%	18%
Agency/Bank - Scientific/Tech	670	360	360	180	180	150	180	1,410
Substantive - Scientific/Tech	1,110	1,110	1,100	1,020	1,070	1,160	1,080	6,540
		↑	↓	↑	↑	↑	↓	
Agency/Bank as %	38%	24%	25%	15%	14%	11%	14%	18%
Agency/Bank - Other Non Clinical	220	190	180	190	170	130	170	1,030
Substantive - Other Non clincial	900	900	910	900	920	1,080	900	5,610
		↑	↑	↓	↑	↑	↓	
Agency/Bank as %	20%	17%	17%	17%	16%	11%	16%	16%
Agency/Bank - Total	5,690	2,990	3,500	2,960	3,820	2,230	3,210	18,710
Substantive - Total	13,420	13,770	13,650	13,580	13,780	15,100	14,020	83,900
		↑	↓	↑	↓	↑	↓	
Agency/Bank as %	30%	18%	20%	18%	22%	13%	19%	18%

Figures exclude Pay reserves

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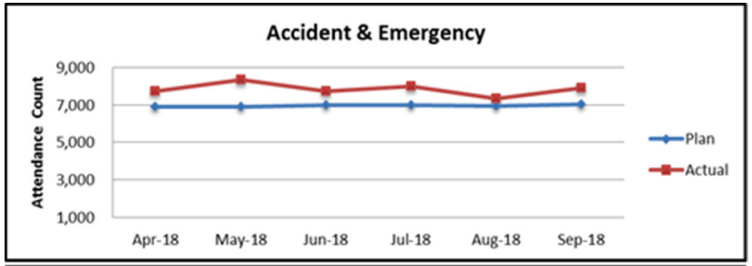
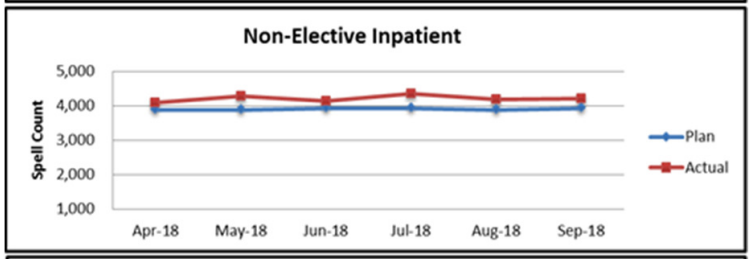
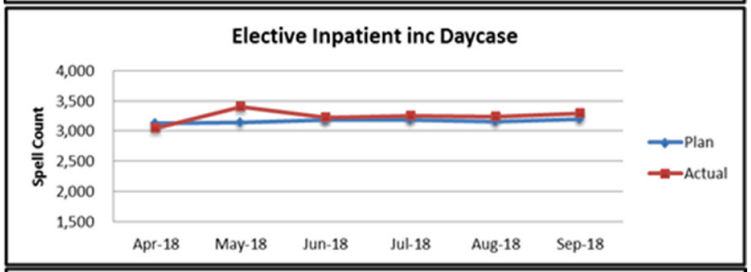
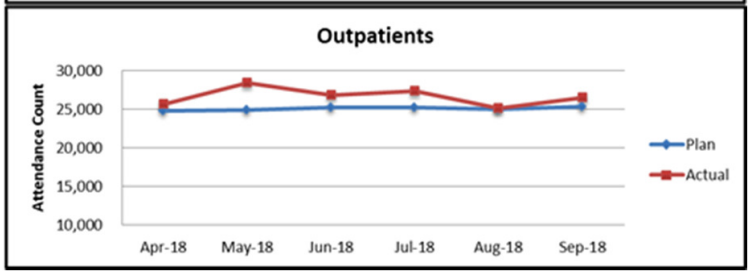
24. Clinical Activity

	Month 6			Year to date			
	Plan	Actual	Variance	Plan	Actual	Variance	17/18
PbR Lines							
Accident and Emergency	7,015	7,895	880	41,730	47,014	5,284	46,655
Adult Critical Care	862	850	(12)	5,125	5,141	16	4,885
Neonatal Critical Care	977	1,186	209	5,810	6,075	265	5,780
Elective Daycase	1,983	2,256	273	11,798	13,008	1,210	11,807
Elective Inpatient	519	532	13	3,086	3,242	156	3,523
Non-Elective Inpatient	3,940	4,217	277	23,444	25,279	1,835	25,227
Excess beddays	688	498	(190)	4,094	3,204	(890)	4,643
Maternity Pathway	895	864	(31)	5,325	5,268	(57)	5,277
Outpatient Firsts	6,067	7,685	1,618	36,094	45,721	9,627	42,355
Outpatient Follow-up	13,959	13,982	23	83,041	84,356	1,315	90,719
Outpatient Procedures	5,281	4,854	(427)	31,415	29,810	(1,605)	32,390
Outpatient Diagnostic	6,210	8,915	2,705	37,241	54,435	17,194	44,179
Chemotherapy	479	996	517	2,847	6,070	3,223	5,238
PbR Total	**48,875**	**54,730**	**5,855**	**291,051**	**328,623**	**37,572**	**322,678**
Non-PbR Lines							
Direct Access	205,390	181,448	(23,942)	1,221,795	1,165,036	(56,760)	1,271,440
Devices	95	54	(41)	566	484	(82)	543
High Cost Drugs	12,395	15,281	2,886	73,813	76,514	2,701	67,686
Other	7,635	8,132	497	45,417	48,288	2,871	49,841
Non-PbR Total	**225,515**	**204,915**	**(20,600)**	**1,341,591**	**1,290,322**	**(51,270)**	**1,389,510**
Grand Total	**274,390**	**259,645**	**(14,745)**	**1,632,642**	**1,618,945**	**(13,697)**	**1,712,188**



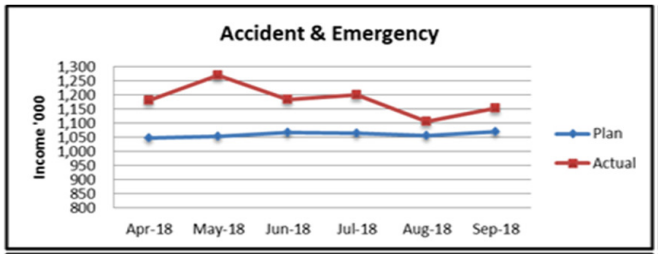


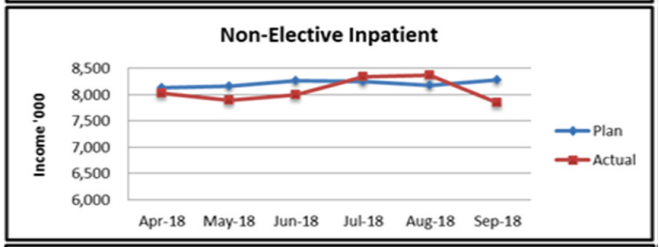


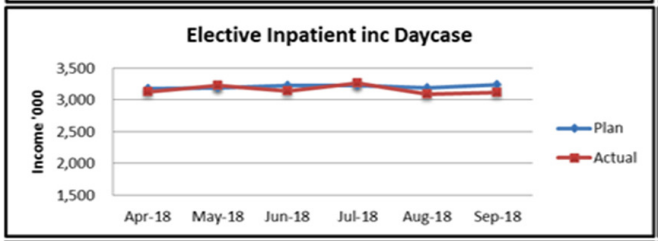


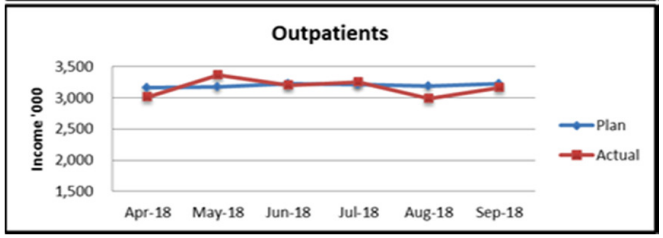
2g. Clinical Income

	Month 6			Year to date		
	Plan	Actual	Variance	Plan	Actual	Variance
PbR Lines						
Accident and Emergency	1,068	1,153	85	6,352	7,090	738
Adult Critical Care	937	899	(38)	5,574	5,322	(252)
Neonatal Critical Care	752	1,092	340	4,475	4,836	361
Elective Daycase	1,544	1,619	74	9,188	9,809	622
Elective Inpatient	1,506	1,371	(135)	8,957	8,319	(638)
Non-Elective Inpatient	8,275	7,847	(428)	49,232	48,460	(772)
Excess beddays	185	130	(55)	1,102	849	(253)
Maternity Pathway	893	838	(55)	5,312	5,119	(193)
Outpatient Firsts	1,189	1,224	34	7,076	7,390	314
Outpatient Follow-up	1,208	1,134	(74)	7,188	6,764	(424)
Outpatient Procedures	827	808	(20)	4,922	4,803	(119)
Outpatient Diagnostic	339	479	141	2,029	2,950	921
Chemotherapy	135	151	16	801	923	122
PbR Total	**18,859**	**18,745**	**(114)**	**112,209**	**112,636**	**426**
Non-PbR Lines						
Direct Access	544	796	253	3,233	4,739	1,505
Devices	143	64	(79)	850	471	(378)
High Cost Drugs	1,868	2,241	373	11,146	12,449	1,303
Adjustment	(844)	(541)	303	(5,049)	(5,641)	(591)
Other	979	421	(558)	5,827	6,295	468
Expert_Determination_Adjustments	(611)	(724)	(113)	(3,663)	(4,341)	(678)
Non-PbR Total	**2,079**	**2,258**	**179**	**12,344**	**13,972**	**1,628**
Grand Total	**20,938**	**21,003**	**65**	**124,553**	**126,608**	**2,054**









3. Balance Sheet

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3a. Statement of Financial Position

	Last Month Actual £m	Current Month Actual £m	Plan £m	Variance £m
Non current Assets				
Property, Plant and Equipment	195.4	194.8	203.4	-8.6
Trade and Other Receivables: Other	0.3	0.3	0.0	0.3
Total Non current Assets	**195.8**	**195.1**	**203.4**	**-8.3**
Current Assets				
Inventories	7.6	7.3	7.4	-0.1
Trade and Other Receivables: Trade	20.7	22.5	17.2	5.3
Trade and Other Receivables: Accruals	15.2	13.8	10.6	3.2
Trade and Other Receivables: Prepayments	4.5	4.6	3.5	1.1
Trade and Other Receivables: Other	2.0	2.0	1.5	0.5
Cash and Cash Equivalents	9.9	7.4	6.1	1.3
Total Current Assets	**59.9**	**57.5**	**46.3**	**11.2**
Current Liabilities				
Borrowings	-57.9	-57.5	-58.2	0.7
Trade and Other Payables: Trade	-12.2	-11.9	-9.6	-2.3
Trade and other payables: Accruals	-23.3	-22.6	-18.0	-4.6
Trade and other payables: Other	-8.9	-8.1	-6.5	-1.6
Other liabilities: Deferred Income	-3.9	-3.1	-3.6	0.5
Provisions	-0.2	-0.2	-0.6	0.4
Total Current Liabilities	**-106.3**	**-103.4**	**-96.5**	**-6.9**
Total Assets Less Current Liabilities	**149.3**	**149.2**	**153.2**	**-4.0**
Non Current Liabilities				
Borrowings	-178.0	-181.3	-177.0	-4.3
Provisions	-1.0	-1.0	-0.9	-0.1
Total Non Current Liabilities	**-179.0**	**-182.2**	**-177.9**	**-4.3**
Net Assets Employed	**-29.6**	**-33.0**	**-24.7**	**-8.3**
Taxpayers Equity				
Public Dividend Capital	137.7	137.7	137.7	0.0
Retained Earnings	-213.5	-216.8	-209.8	-7.0
Revaluation Reserve	46.1	46.1	47.3	-1.2
Total taxpayers' equity	**-29.6**	**-33.0**	**-24.7**	**-8.3**

Commentary

Non Current Assets

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

Current Assets

Trade and Other Receivables have been reported over four separate headings to provide further detail:

Trade, these are balances owed to the Trust for trading activities for which sales invoices have been raised and are yet to be paid.

Accruals, these relate to balances owed to The Trust which are yet to be invoiced.

Prepayments, payments made in advance for purchases such as equipment, software, maintenance. Payments for some of these services are paid annually in advance which is the reason for the current variance on plan. This balance should reduce each month unless additional prepayments are made in the month.

Other, included in other are further RTA debts and VAT Contracted Out Services refunds.

Cash and Cash Equivalents

A condition of the deficit loans is for The Trust to hold a balance of £1.4m to ensure there is always an adequate balance from which to make emergency payments. The balance as at 30th of September 2018 was £7.4m. Please see 1a Cashflow for further detail.

Current Liabilities

Borrowings, this balance relates to both capital and deficit loans due in this financial year.£56.8 being the deficit support loan and the balance being the capital loan.

Trade and Other Payables

Trade, please see note 4c for further information. This balance is expected to steadily and slightly decrease each month as old queried supplier balances are cleared.

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

Deferred Income, This mainly relates to Maternity Pathway income from Medway and Swale CCG's in respect of the agreed accounting treatment for Maternity Income billed at the start of the Clinical Pathway. This balance also includes deferred income for Research & Development Funds and organ donation fees.

Non Current Liabilities

Borrowings, this balance relates to both capital and deficit loans repayments due in future financial years. £68.2m 2014/15 and 2015/16 deficit support loans are repayable in 2019/20, £41.5m 2017/18 deficit support loans are repayables in 2020/21. The remaining balance relates to capital repayments which are repayable over a much longer term, some of which do not start until 2035/36.

Taxpayers Equity

Variances in retained earningsare because the plan is the expected cumulative positive at the year end. There are minimal expected changes in other areas of taxpayers equity.

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

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4b Trade Receivables

Aged Debtors in Sales ledger

	Total	Current	31 to 60 Days	61 to 90 Days	91 to 180 Days	6 Months +
	£m	£m	£m	£m	£m	£m
NHS FTs	**2.40**	0.33	0.27	0.06	0.51	1.24
NHS Trusts	**2.72**	0.31	0.18	0.72	0.70	0.80
DH	**0.00**	0.00	0.00	0.00	0.00	0.00
Public Health England	**0.00**	0.00	0.00	0.00	0.00	0.00
Health Education England	**0.00**	0.00	0.00	0.00	0.00	0.00
CCGs and NHS England	**16.31**	2.42	3.32	0.21	10.05	0.30
Special Health Authorities	**0.05**	0.00	0.00	0.00	0.00	0.05
NDPBs	**0.00**	0.00	0.00	0.00	0.00	0.00
other DH bodies	**0.00**	0.00	0.00	0.00	0.00	0.00
Total NHS Debtors	**21.48**	**3.06**	**3.77**	**0.99**	**11.26**	**2.39**
other WGA bodies	**0.01**	0.00	0.00	0.00	0.00	0.01
Local Authorities	**0.10**	0.00	0.00	0.00	0.00	0.09
Bodies external to Government	**2.43**	0.28	0.16	0.12	0.24	1.64
Total Non NHS Debtors	**2.54**	**0.28**	**0.16**	**0.12**	**0.24**	**1.74**
Total Debtors	**24.02**	**3.34**	**3.93**	**1.11**	**11.50**	**4.13**

Commentary

Total outstanding Trade Receivables as at the 30th September 2018 are £24.02m , for which there is a doubtful debt provision of £1.83m .

NHS Debt is £21.48m , £11.93m of this relates to the debt with the Trust's three main Commissioners and relate to PY setltlement which are being reconciled. There is a further £6m of Debt with local trusts mainly for provider to provider and dispensing services. Some of these payments are being witheld until like for like payments can be arranged.

Non NHS Debt is £2.54m, 39%, £0.99m with Medway Community Healthcare CIC(MCH), for which there are some ongoing disputes. The Trust is also owed significant sums from Dartford (DVH) and Queen Victoria(QVH) , creditor balances are being witheld until like for like payments can be agreed.

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

Fig.1 - Aged Debtor Analysis by financial year

	2018/19	2017/18	2016/17	2015/16 and before	Total
NHS	1.13	16.56	2.86	0.98	21.52
NON NHS	0.81	0.57	0.78	0.33	2.50
Total	1.94	17.13	3.64	1.31	24.02

Fig.2 - Aged Debtor Analysis by ageing category

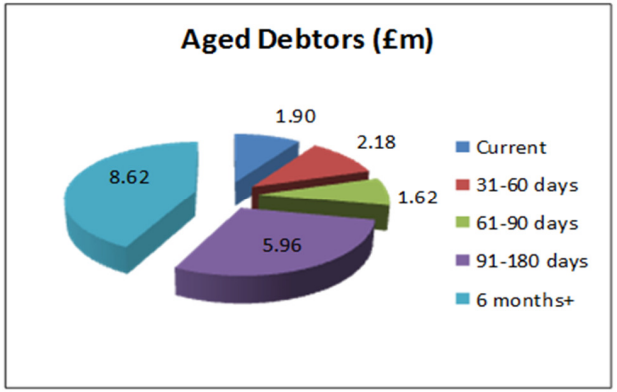

Fig.3 - Aged Debtor Analysis

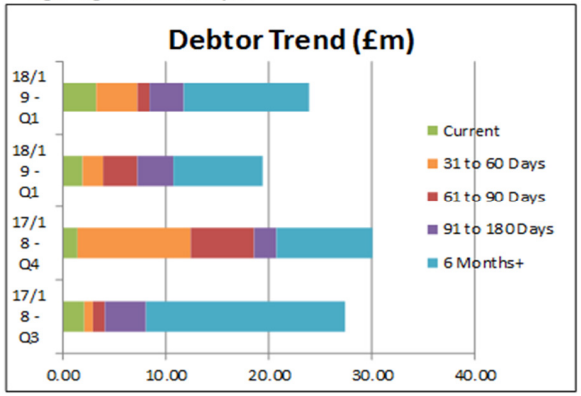

Fig.4 - Aged Debtor Analysis

Top 10 Debtors (£m)

		£m
1	NHS Medway CCG	4.49
2	NHS Dartford Gravesham & Swal	3.90
3	NHS Swale CCG	3.54
4	DARTFORD & GRAVESHAM NHS TRUST	1.57
5	NHS West Kent CCG	1.55
6	QUEEN VICTORIA HOSP. NHS TRUST	1.12
7	MEDWAY COMM HEALTHCARE CIC	0.99
8	E.K.HOSP.UNIV.NHS.FOUNDA.TRUST	0.98
9	NHS England South Region	0.94
10	MAIDSTONE AND TUNBRIDGE WELLS	0.65

3c. Trade Payables

Aged Trade Creditors

	Total £m	Current £m	31 to 60 Days £m	61 to 90 Days £m	91 to 180 Days £m	6 Months + £m
NHS FTs	1.69	0.05	0.17	0.16	0.10	1.22
NHS Trusts	2.23	0.67	0.33	0.41	0.23	0.57
DH	0.00	0.00	0.00	0.00	0.00	0.00
Public Health England	0.00	0.00	0.00	0.00	0.00	0.00
Health Education England	0.00	0.00	0.00	0.00	0.00	0.00
CCGs and NHS England	0.00	0.00	0.00	0.00	0.00	0.00
Special Health Authorities	-0.83	-0.99	0.05	0.06	0.02	0.02
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.22	0.01	0.01	0.00	0.04	0.16
Total NHS Creditors	**3.31**	**-0.26**	**0.56**	**0.63**	**0.39**	**1.97**
other WGA bodies	0.10	0.10	0.00	0.00	0.00	0.00
Local Authorities	0.84	0.00	0.00	0.00	0.83	0.00
Bodies external to Government	7.70	3.46	1.11	0.81	1.13	1.18
Total Non NHS Creditors	**8.64**	**3.56**	**1.11**	**0.81**	**1.96**	**1.18**
Total Trade Creditors	**11.95**	**3.30**	**1.67**	**1.44**	**2.35**	**3.15**

Commentary

Total outstanding creditors in the purchase ledger as at 30th September 2018 were £11.9m (679 creditors) of which £8.6m were overdue.

Of the £8.6 overdue, £2.2m are approved and ready to pay. Payment is being witheld due to credit balance and/or overdue debtor balances with the creditor

£6.4m (2,398 invoices) are unapproved;
- £1.9m (1,000) are in the PO system
- £0.4m pre-date the electronic system,
- £2.2m are with unplanned managers
- £1m with planned care managers

and the remaining
- £0.9m with Finance, Corporate & F&E managers.

£3.15m creditor balances are more than 6 months old, £1.1m are approved but remain unpaid due to debtor balances outstanding.

Fig. 1 shows aged creditiors anaysed by ageing category: Fig. 2 shows the rolling creditor trend: & Fig. 3 provised a list of the top ten creditors by value.

Fig.1 - Aged Creditor Analysis

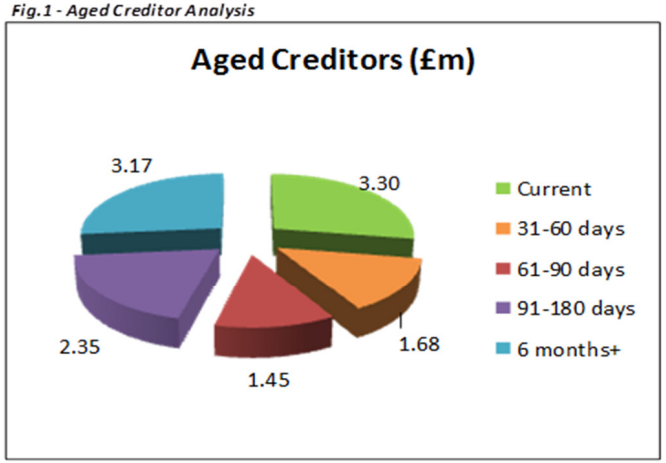

Fig.2 - Aged Creditor Trend

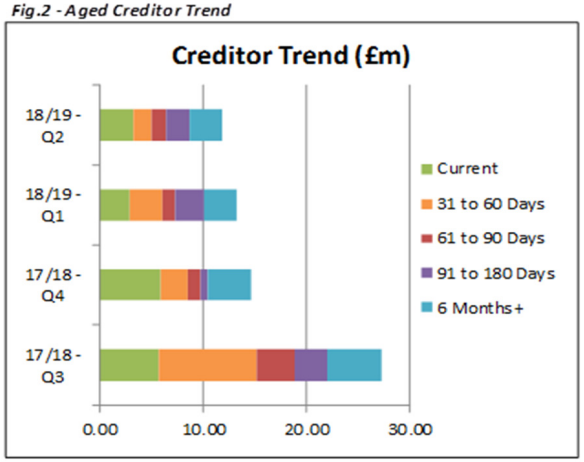

Fig.3 - Top 10 Aged Creditors

Top 10 Creditors

		£m
1	MAIDSTONE TUNBRIDGE WELLS NHST (RWF)	1.24
2	DARTFORD & GRAVESHAM NHS TRUST (RN7)	0.98
3	MEDWAY COUNCIL	0.83
4	EAST KENT HOSPITALS NHS TRUST (RVV)	0.70
5	NHS SUPPLY CHAIN	0.59
6	KINGS COLLEGE HOSPITAL NHS TRUST (RJZ)	0.58
7	MEDWAY COMMUNITY HEALTHCARE CIC	0.56
8	NHS SUPPLY CHAIN-ORDERS	0.52
9	IH STERILE SERVICES LTD	0.48
10	CARE UK CLINICAL SERVICES LTD	0.33

4. Capital

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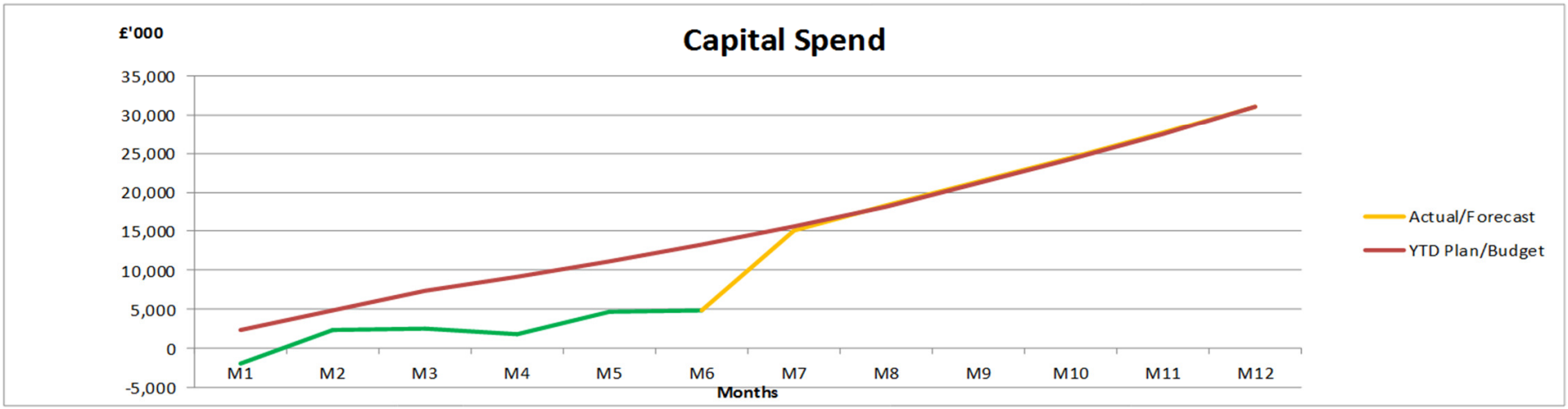
7. Capital

Capital Programme Summary

	Current Month			Year to Date			Forecast year end Outturn		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Original Plan £m	Forecast Outturn £m	Forecast Variance £m
Expenditure									
Recurrent Estates & Site Infrastructure	1.36	1.28	0.08	3.03	6.94	-3.92	19.50	19.50	0.00
IM&T	0.43	0.16	0.27	0.75	0.81	-0.06	2.20	2.20	0.00
Medical & Surgical Equipment	0.71	0.09	0.62	0.85	0.48	0.37	1.30	1.30	0.00
Specific Business Cases	0.00	0.08	-0.08	0.21	0.22	-0.01	0.60	0.60	0.00
Transform Projects (ED/AAU)	-0.21	0.36	-0.57	-0.16	4.28	-4.44	6.48	6.48	0.00
Medical Asssessment Unit(MAU)	0.16	0.09	0.07	0.18	0.50	-0.32	1.00	1.00	0.00
Total	**2.45**	**2.06**	**0.39**	**4.85**	**13.24**	**-8.38**	**31.08**	**31.08**	**0.00**

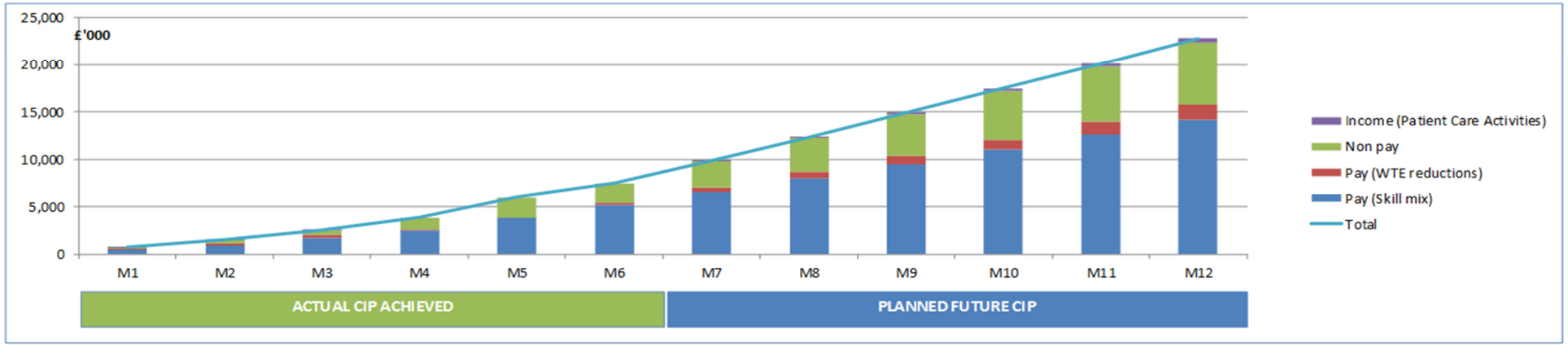
The total capital spend for the period ending 30 September 2018 was £4.85m against a plan of £13.24m for the same period giving an underspend of £8.38m.
All Capital areas show an underspend with the exception of Medical Devices.
Phase 1 of the ED project is due to complete in October, and further work on the next phases will delayed. As a result there is expected to minimal further expenditure in relation to the project. Once this has been agreed the capital forecast for ED is likely to be reduced by £6m bringing the overall plan doen to £25m. This will be agreed and changed for the month 7 reporting.

Capital Monthly Profile



5. CIP Acheivement (as reported to NHSI)

Scheme No	Project	Type of Expenditure / Income	Recurrent or Non Recurrent	Status	Efficiency Programme Area	Risk Rating	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000
Trust scheme 1	Bank/Agency Reductions	Pay (Skill mix)	Recurrent	Plans in Progress	Workforce (Nursing)	Medium	498	-	- 498
Trust scheme 2	Nursing skill mix changes	Pay (Skill mix)	Recurrent	Fully Developed	Workforce (Nursing)	Low	1,500	975	- 525
Trust scheme 3	Early Retirements	Pay (WTE reductions)	Recurrent	Plans in Progress	Workforce (Other)	Low	66	-	- 66
Trust scheme 4	Best Choices initiative	Pay (WTE reductions)	Recurrent	Fully Developed	Workforce (Other)	Low	225	233	8
Trust scheme 5	VSM Pay freeze	Pay (Skill mix)	Recurrent	Fully Developed	Workforce (Other)	Low	12	-	- 12
Trust scheme 6	Remove vacant posts	Pay (WTE reductions)	Recurrent	Fully Developed	Workforce (Other)	Low	252	-	- 252
Trust scheme 7	Workforce Initiatives	Pay (WTE reductions)	Recurrent	Plans in Progress	Workforce (Other)	Medium	200	-	- 200
Trust scheme 8	Radiology digitalisation	Pay (WTE reductions)	Recurrent	Fully Developed	Imaging	Low	30	-	- 30
Trust scheme 9	Drug spend initiatives	Non pay	Recurrent	Plans in Progress	Hospital Medicine and Pharmac	Medium	750	332	- 418
Trust scheme 10	Support services rota changes	Pay (WTE reductions)	Recurrent	Plans in Progress	Estates and Facilities	Low	66	-	- 66
Trust scheme 11	Implementation of Order Comms	Pay (WTE reductions)	Recurrent	Fully Developed	Pathology	Low	20	-	- 20
Trust scheme 12	Digital Dictation Project	Pay (WTE reductions)	Recurrent	Fully Developed	Corporate and Admin	Low	20	-	- 20
Trust scheme 13	Cessation of non profitable service areas	Non pay	Recurrent	Opportunity	New Care Models (NCM)	High	-	-	-
Trust scheme 14	Implementation of Carter opportunities	Pay (Skill mix)	Recurrent	Opportunity	Workforce (Medical)	High	1,250	1,234	- 16
Trust scheme 15	Implementation of Carter opportunities	Non pay	Recurrent	Opportunity	Estates and Facilities	High	400	-	- 400
Trust scheme 16	Paediatrics Critical Care	Income (Patient Care Activities)	Recurrent	Fully Developed	New Care Models (NCM)	Low	402	-	- 402
Trust scheme 17	Stretch target	Pay (Skill mix)	Non Recurrent	Opportunity	Other Savings plans	High	-	-	-
Trust scheme 18	Stretch target	Non pay	Non Recurrent	Opportunity	Other Savings plans	High	-	-	-
New trust scheme 1		Pay (Skill mix)	Recurrent	Plans in Progress	Other savings plans	Medium	-	3,022	3,022
New trust scheme 2		Non pay	Recurrent	Plans in Progress	Other savings plans	Medium	-	1,683	1,683
							5,691	7,479	1,788



5. Use of Resources Metric

Finance and use of resources rating	Expected Sign	03AUDITPY Audited PY 31/03/2018 Year ending Number	03PLANYTD Plan 30/09/2018 YTD Number	03ACTYTD Actual 30/09/2018 YTD Number	03VARYTD Variance 30/09/2018 YTD Number	03PLANCY Plan 31/03/2019 Year ending Number	03FOTCY Forecast 31/03/2019 Year ending Number	03VARCY Variance 31/03/2019 Year ending Number
Capital service cover rating	+	4	4	4		4	4	
Liquidity rating	+	4	4	4		4	4	
I&E margin rating	+	4	4	4		4	4	
I&E margin: distance from financial plan	+	4		1			2	
Agency rating	+	1	1	1		1	1	

Overall finance and use of resources risk rating	Expected Sign	03AUDITPY Audited PY 31/03/2018 Year ending Number	03PLANYTD Plan 30/09/2018 YTD Number	03ACTYTD Actual 30/09/2018 YTD Number	03VARYTD Variance 30/09/2018 YTD Number	03PLANCY Plan 31/03/2019 Year ending Number	03FOTCY Forecast 31/03/2019 Year ending Number	03VARCY Variance 31/03/2019 Year ending Number
Overall rating unrounded	+	3		2.80			3.00	
If unrounded score ends in 0.5	+	0		0.00			0.00	
Risk ratings before overrides	+	3		3			3	
Risk ratings overrides:								
Any ratings in table 6 with a score of 4 override - if any 4s "trigger" will show here	Text	Trigger		Trigger			Trigger	
Any ratings in table 6 with a score of 4 override - maximum score override of 3 if any rating in table 6 scored as a 4	+	3		3			3	
Control total override - Control total accepted	Text	YES		Yes			Yes	
Control total override - Planned or Forecast deficit	Text	Yes		Yes			Yes	
Control total override - Maximum score (0 = N/A)	+	0		0			0	
Is Trust under financial special measures	Text	No		No			No	
Risk ratings after overrides	+	3		3			3	

7. BPPC

Better Payment Practice Code (BPPC)

NHS Payables	2018/19 YTD		Prior Year	
	Volume	Value £	Volume	Value £
Total bills paid in the year	825	12,188	1,742	20,216
Total bills paid within target	118	3,420	28	876
Percentage of bills paid within target	**14.3%**	**28.1%**	**1.6%**	**4.3%**

Non NHS Payables	2018/19 YTD		Prior Year	
	Volume	Value £	Volume	Value £
Total Non -NHS Invoices paid Outside of Target	33,298	50,061	67,886	104,336
Total Non -NHS Invoices paid within Target	15,033	18,378	3,705	10,664
Percentage of bills paid within target	**45.1%**	**36.7%**	**5.5%**	**10.2%**

All Payables	2018/19 YTD		Prior Year	
	Volume	Value £	Volume	Value £
Total Non -NHS Invoices paid Outside of Target	34,123	62,249	69,628	124,552
Total Non -NHS Invoices paid within Target	15,151	21,798	3,733	11,540
Percentage of bills paid within target	**44.4%**	**35.0%**	**5.4%**	**9.3%**

The Better Payment Practice (BPPC) code requires 95% of all valid invoices to be paid within 30 days or their agreed payment terms.

NHS Medway NHS Foundation Trust

Report to the Board

Meeting Date: 01/11/2018 Agenda item 11b

Title of Report	**Board Assurance Framework**
Prepared By:	Sarah Anderson – Interim Trust Secretary
Lead Director	Sarah Anderson – Interim Trust Secretary
Committees or Groups who have considered this report	Executive Group
Executive Summary	The Board Assurance Framework (BAF) was considered by the July Board where the paper was noted. In addition, it was agreed that the BAF would be discussed again at a future board development session. This has not yet occurred.
Resource Implications	N/A
Risk and Assurance	Within report
Legal Implications/Regulatory Requirements	The Board is responsible for ensuring that the organisation has appropriate strategic risk management processes in place to deliver its strategic objectives and comply with the registration requirements of the regulator, including risks to compliance with the terms of authorisation. The Trust Board is accountable for ensuring an appropriate system of internal control and stewardship is in place which supports the achievement of the organisation's objectives.
Improvement Plan Implication	Governance and Standards
Quality Impact Assessment	N/A
Recommendation	The Board note the BAF and that this needs further consideration at a Board Development Session.

Report to the Board

Purpose and Actions required by the Board :	Approval	Assurance	Discussion	Noting
	☐	☐	☐	☒

NHS Medway NHS Foundation Trust

Report to the Board

1 EXECUTIVE OVERVIEW

1.1 The Board Assurance Framework is presented at appendix 1. No updates have been made since the Board last considered the Board Assurance Framework. The Board will consider the Board Assurance Framework in detail at a forthcoming Board Development Day.

2 BOARD ASSURANCE FRAMEWORK (BAF)

2.1 The role and purpose of the Board Assurance Framework (BAF) is to clearly identify the principle risks which may prevent the organisation from achieving its strategic objectives.

2.2 The Trust has identified its four Strategic Objectives for 2018 and the Principle Risks to the organisation which may prevent the Trust from achieving these objectives, i.e. the Strategic Risks.

2.3 The BAF was discussed at the July Board and will be discussed at an upcoming Board Development Day.

2.4 The BAF is presented at Appendix 1. Appendix 2 is the Trust Risk Rating Guidance.

Appendix 1 - Board Assurance Framework (BAF) 2018 / 2019

Strategic Objective One - Integrated Health Care: We will work collaboratively with our local partners to provide the best of care and the best patient experience.				
Strategic Aim				
Working strategically, as a trusted partner in the Sustainability and Transformation Plan (STP) we will work with partner organisations and the public to transform out-of-hospital care through the integration of primary, community and social care and re-orientate elements of traditional acute hospital care into the community. We will work collaboratively and progressively to develop an Accountable Care System (ACS), ensuring that protecting our local Trust interests does not stand in the way of achieving benefits for the wider health economy and public.				
Board / Board Committee for review - Trust Board				
Strategic Risks	**Initial Risk (CxL)**	**Current Risk (CxL)**	**Target Risk (CxL)**	**Assurance**
Failure of partnership and integration There is a risk that the Trust may not be seen as an organisation to partner with.	**12** (4x3)	**9** (3x3)	**6** (2x3)	The Trust is working closely with the STP and is the leader of the STP clinical strategy and participating in shaping local care delivery for Medway and Swale. The Trust is fully engaged with the system Transformation Board work and an active participant in developing new integrated services via the planned and local care work streams. As part of this partnership work the Trust has developed a frailty pathway including community programme for elderly (PACE), community geriatrician clinics and nursing home attendance and buddying systems to support complex case management. Monthly monitoring has shown a reduction in falls in the community; the Trust is developing a similar model for Chronic Obstructive Pulmonary Disease (COPD). The recent consultation on stroke services across the county has identified that the Trust will not be a Hyper Acute Stroke Unit. The Trust will retain a high quality stroke service to support the Hyper Acute Stroke Services across the county. The Trust is actively reviewing all services provided with other organisations to ensure continued and improved integrated partnership working with all partners. Strategic commissioner arrangements have been put in place and the organisations are working on an aligned incentive contract to better facilitate an Integrated Care Partnership (ICP) in the future. The Trust is engaged with the delivery of the new Urgent treatment centre clinical model design and is leading on the development of the awarded £1m DH fund to deliver a remodelled Urgent Treatment Centre on the MFT site as part of the Medway Model, which was taken to public consultation by Medway sector Partners in 2017 .
Brand failure – The Trust may have a brand failure in that confidence may be lost in the Trust.	**12** (4x3)	**9** (3x3)	**6** (2x3)	
Collaborating with partners There may be a lack of confidence in the Trust by fellow STP partners and the STP may fail.	**16** (4x4)	**9** (3x3)	**6** (2x3)	
Gaps in control and Actions to address				
The Trust Improvement Plan is aligned with the STP and will take account of STP strategy. On-going work regarding Accountable				

Care Partnerships (ACP) and engagement with GPs. Strategic commissioner arrangements have been put in place and will operate in shadow form from April 2018.

Strategic Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care.

Strategic Aim

We will protect people from harm, providing evidence based treatments and ensuring that they experience the best of care. We will create an open and sharing environment where research and innovation can flourish achieving the dual aims of enhancing and improving the quality of patient care and health outcomes as well as contributing to the financial sustainability of the organisation. We will have a culture where staff are given the opportunity, training and resources to research and innovate. We will proactively develop partnerships with other organisations, underpinned by robust governance arrangements, to enable execution and exploitation of innovation projects to benefit the population that we serve.
This will be underpinned by increasing the use of modern technology and the availability of quality information systems. We will take both a local and whole system approach to implementing a digital strategy that will result in providing real time access to patient information across all providers of healthcare in Kent and Medway.

Board / Board Committee for review - Finance Committee

Strategic Risks	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Assurance
Innovation Strategy There may be difficulty in making appropriate decisions with imperfect information on the future clinical and IT strategy of the STP and the organisation's role therein.	**16** (4x4)	**12** (4x3)	**9** (3x3)	Organisational structure devised to ensure services aligned and encourage innovation. Further work in progress on colocation of services to assist best working practices. Working with Getting it Right First Time (GIRFT) to improve efficiency and effectiveness of surgical pathways.
Capability There is a risk that the Trust does not have sufficient capacity and capability to implement the required technology.	**9** (3x3)	**9** (3x3)	**4** (2x2)	Innovative front door model streaming to Primary Care (MEDOCC), ambulatory emergency centre and assessment areas. £1m capital Investment received for Urgent Care Front Door. Trust investment in the R&D department which has shown success attracting NHS and private funding for trials. Ensuring communication and engagement with patients eligible for trials so they are aware of opportunities to join trials.
Funding There is a risk that the Trust will be unable to secure sufficient funding for investment in clinical research.	**9** (3x3)	**9** (3x3)	**4** (2x2)	Partnering arrangements being secured for managed services in a

There is a risk that the Trust will be unable to secure sufficient capital to invest in the desired new technologies.				number of areas to enable cost of innovation to be spread over the life, as well as ensuring there is sufficient expertise for optimum implementation and adoption. IT project office has a programme for delivering a number of digital solutions in the year. Working across the STP on digital plan for interoperability between partners.
Gaps in control and Actions to address				
Better, Best, Brilliant improvement programmes looking at ways to improve use of digital technology, such as Extramed, to provide the best of care for patients. Development of Digital Strategy within Trust and across STP footprint.				

Strategic Objective Three - Financial Stability: We will deliver financial sustainability and create value in all we do.				
Strategic Aim				
We will maximise efficiency in service delivery and operational management. We will regain and retain financial control. We will be outward looking, actively working in partnership with the wider health economy through the Kent and Medway Sustainability and Transformation Partnership (STP) to maximise transformation opportunities in service delivery workforce, back-office functions, digital strategy and estates utilisation.				
Board / Board Committee for review - Finance Committee				
Strategic Risks	**Initial Risk (CxL)**	**Current Risk (CxL)**	**Target Risk (CxL)**	**Assurance**
Going Concern The Trust's Going Concern assessment is at risk given the proportionality of the continued and sustained deficit, which could lead to further licence conditions and potential regulatory action.	**16** (4x4)	**16** (4x4)	**6** (2x3)	Recovery programmes with monthly Cost Improvement Programmes (CIP) sprints, keeping focus on achieving CIPs and efficiencies; improvements in procurement, grip and control, vacancy control measures. Agency usage has reduced and bank usage increased – continue to focus on this, and to address bank rate differentials.
Risk that central funding is not made available as required to support the deficit, capital investment, and loan repayments that	**16** (4x4)	**8** (4x2)	**6** (2x3)	

fall due Risks to the Trust's Viability / Sustainability. May be unable to field adequate resources to maintain high quality, safe services. There is also a risk to the transformation plan if there is insufficient cash to invest in new technologies.				Carter Model Hospital has identified a potential £30m opportunity that is being analysed at specialty level and actions developed to achieve. Implementing patient level costing for reference costs submission to provide granularity of Carter opportunity.
Unable to deliver our financial control total The Trust may be unable to establish financial sustainability within the required timeframe. The Trust may not be able to realise efficiencies necessary to return to balance or receive payment for all activity.	**16** (4x4)	**16** (4x4)	**6** (2x3)	Monitoring controls: Monthly reporting of actual v budget performance for review at Performance Review Meetings (PRMs) and presented to the Board. Weekly performance overview meetings. Internal accountability framework at programme level. Capacity and capability: Appointment of financial improvement director. Recruitment to PMO/transformation team to support the CIP and transformation programme. External support from KPMG on key projects. Fortnightly system transformation meetings to look at efficiency across the care pathway. Monthly Integrated Assurance Meetings with regulators. Developing planning tools to better triangulate resources with activity. Operational plan has been submitted which should assure central funding to support cash needs.
Gaps in control and Actions to address				
Better, Best, Brilliant improvement programme supporting the Financial Recovery of the Trust. Entered block contract for 2018/19 to focus on system change instead of inter-organisational flows, but need to ensure demand is managed. Further engagement at senior level to ensure that CIP schemes are identified and implemented. Controls to capture and validate CIP and budget delivery.				

Strategic Objective Four - Our People: We will enable our people to give their best and achieve their best.
Strategic Aim
We will have effective and appreciative leadership throughout the organisation, creating a high performance environment where staff have

Appendix 1 - Board Assurance Framework (BAF) 2018 / 2019

clarity about what is expected of them, receive regular feedback and understand that poor performance will be addressed. Our employees will be engaged, committed to continuous improvement and embrace change. We will be an employer of choice.

Board / Board Committee for review - Quality Committee

Strategic Risks	Initial Risk (CxL)	Current Risk (CxL)	Target Risk (CxL)	Assurance
Recruit / Retain sufficient qualified staff The Trust may be unable to attract, recruit and retain high quality staff impacting on a continued dependency on temporary staff and safe staffing levels, affecting quality of care, and financial costs.	**16** (4x4)	**12** (4x3)	**4** (2x2)	The Trust has undertaken a huge recruitment drive locally, nationally and internationally, introducing recruitment and retention incentives. For the first time in late 2017 the Trust had more starters than leavers and this has been maintained. The directorates undertake reviews of roles, particularly in high vacancy areas to assess role redesign (including roles such as physicians associate and nurse associate). We are reviewing usage of the apprentice levy to support retention of staff (career development) and new opportunities with Henley Business School. Shifts are reviewed on a daily basis and usage of the same temporary (bank) workers where possible to maintain continuity of care. Retention group launched to share best practice and consider retention initiatives for nursing roles in particular. The Trust has developed a clinical compact for all senior clinicians of all professions - forming the basis of the promoting professionalism programme. The Trust has undertaken a review of its governance structures and processes. The Quality Assurance Committee is developing a Quality and Safety framework that will be used from the wards to the board. Medical Model and patient surveillance e.g. NEWS, Physician associate posts developed.

Gaps in control and Actions to address

Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).

We will continue to consider role redesign in hard to recruit areas (using case studies) or work from other NHS Trusts.

Risk Rating Guidance

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on Safety of Patients, Staff, Visitors	Minimal injury requiring no / minimal intervention or treatment. No time off work	Minor injury/illness requiring minor intervention Time off work <3 days Increase in LOS by 1-3 days Affects 1-2 people	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay 4-14 days RIDDOR/agency reportable incident An event which impacts on a small number of patients Affects (3-15) people	Major injury leading to long-term incapacity/disability >14 days off work Increase in LOS by >15 days Mismanagement of patient care with long term effects An event which impacts on moderate numbers (16-50)	Death Multiple permanent injuries or irreversible health effects An event which impacts on large numbers (>50)
Business objectives / projects	Insignificant cost increase / schedule slippage.	<5% over project budget	5-10% over budget	10-25% over budget	>25% over budget
Finance	Small loss <£1000	Loss of 0.1 -0.25 % of budget	Loss of 0.26-0.5% of budget	Loss of 0.51-1.0% of budget Uncertain delivery of key objectives Purchasers failing to pay on time	Loss of >1% of budget Non-delivery of key objectives Failure to meet specification/ slippage Loss of contract/service/payment by results

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Quality/Audit	Peripheral element or treatment or service suboptimal	Overall treatment or service suboptimal Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Noncompliance with national standards with significant risk to patients if unresolved Low performance rating Critical report	Totally unacceptable level or quality of treatment / service Gross failure of patient safety if findings not acted on Gross failure to meet national standards
Complaints / Claims	Locally resolved complaint Potential for settlement /litigation <£500	Overall treatment /service substandard Formal justified complaint (stage 1) Claim <£10K	Justified complaint (stage 2, with potential to go to independent review) involving lack of appropriate care Claims between £10k - £100K	Multiple justified complaints Independent review Claim(s) between £100k - £1m	Multiple justified complaints Inquest (involving legal representation) ombudsman inquiry Multiple claims or single major claim Claim(s) >£1 million
Human resources	Low staff morale affecting one person	Low staff morale (1%-25% of staff)	Low staff morale (26%-50% of staff)	Very low staff morale (51%-75% of staff)	Very low staff morale >75%

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Organisational development /	Minor competency related failure reduces service quality <1 day	75% - 95% staff completing mandatory/key training	50% - 74% staff completing mandatory/key training	25% - 49% staff completing mandatory/key training	<25% of staff completing mandatory/key training
Staffing competence	Short term low staffing level temporarily reduces service quality (<1 day), Minor competency related failure reduces service quality <1 day	On-going low staffing level resulting in minor reduction in the quality of patient care, Unresolved trend relating to competency reducing service quality	Late delivery of key objective/service due to lack of staff, Unsafe staffing level > 1 day, Minor error due to ineffective training	Uncertain delivery of key objective/service due to lack of staff, Unsafe staffing level or competence (>5 days), Serious error due to ineffective training, Loss of key staff	Non-delivery of key objectives/service due to lack of staff, Ongoing unsafe staffing levels/competence, Loss of several key staff, Critical error due to insufficient training/competency
Compliance / Audit / Governance	Minor lapse in governance or process; affects one person; single instance of failure relating to human error with no patient harm; policy is out of date by < 1 month, minor non-compliance with standards/guidance	Non-compliance with policy or process in a single department; policy is out of date by < 2 months; affects up to 5 people but causes no patient harm; policy is out of date by < 2 months, Non-compliance with standards/guidance	Failure of governance/process impacting beyond a single department; policy out of date by 2-6 months; affects 5-20 people or results in patient harm; improvement or non-compliance notice received	Trust wide governance failure/multiple breaches; policy out of date > 6mths/non-existent; failure affects 20-50 people; Major non-compliance with core standards	Governance failure resulting in prosecution; gross failure in governance; significant patient harm and/or death, Prosecution, severely critical report, overall rating of inadequate against any of the CQC 5 questions

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Adverse publicity / Reputation	Rumours Potential for public concern	Local media coverage – short term reduction in public confidence Elements of public expectation not being met	Local media coverage Long term reduction in public confidence	National media coverage < than 3 days Confidence on organisation undermined Use of services affected	National media coverage with > 3 days service well below reasonable public expectation MP concern (questions in house) Total loss of public confidence
Service / business interruption	Loss/interruption of >1 hour, no impact on delivery of patient care/ability to provide services	Loss/interruption of >8 hours	Loss/Interruption of > 1 day Disruption causes unacceptable impact on patient care	Loss/interruption of > 1 week Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked Temporary service closure	Permanent loss of core service or facility Disruption to facility leading to significant knock-on effect across the local health economy
Environmental Impact	Minimal or no impact on the environment	Minor impact on environment	Moderate impact on environment	Major impact on environment	Catastrophic impact on environment
Agreed Targets	Not Applicable for this Risk Type	1% off planned Fail to meet National target 1 quarter	2%-4% off planned Fail to meet National target 2 qtrs. Amber light	5%-10% off planned. Fail to meet National target > 2 quarters Red light	>10% off planned Failure to meet National target > 2 quarters, by more than 20%

Table 1	Consequence score (severity levels) and examples of descriptors				
Domains	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Fire Safety/General Security	Minor short term (<1day) shortfall in fire safety system Security incident no adverse outcome	Temporary (<1 month) shortfall in fire safety system / single detector etc. (non-patient area) Security incident managed locally Controlled drug discrepancy accounted for	Fire code non-compliance / lack of single detector – patient area etc. Security incident leading to compromised staff / patient safety. Controlled drug discrepancy – not accounted for	Significant failure of critical component of fire safety system (patient area) Serious compromise of staff / patient safety	Failure of multiple critical components of fire safety system (high risk patient area) Infant / young person abduction
Information Governance / IT	Breach of confidentiality – no adverse outcome. Unplanned loss of IT facilities < half a day Health records / documentation incident – no adverse outcome	Minor breach of confidentiality – readily Resolvable Unplanned loss of IT facilities < 1 day Health records incident / documentation incident – readily resolvable	Moderate breach of confidentiality – complaint initiated Health records documentation incident – patient care affected with short term consequence	Serious breach of confidentiality – more than one person Unplanned loss of IT facilities >1 day but less than one week Health records / documentation incident – patient care affected with major consequence	Serious breach of confidentiality – large Numbers Unplanned loss of IT facilities >1 week Health records / documentation incident – catastrophic consequence

Table 2	Likelihood score
Level	**Description**
1 Rare	<3% probability. **Not expected to occur for years**, but may occur, but only in exceptional circumstances. • Loss, accident or illness could only occur under freak conditions • The situation is well managed and all reasonable precautions have been taken Ideally, this should be the normal state of the workplace
2 Unlikely	3%-10% probability. **Expected to occur at least annually**. The situation is generally well managed. However occasional lapses could occur. • This also applies to situations where people are required to behave safely in order to protect themselves but are well trained
3 Possible	11%-30% probability. **Expected to occur at least monthly**. • Insufficient or substandard controls in place • Loss is unlikely during normal operation, however, may occur in emergencies or non – routine conditions.
4 Likely	31%-90% probability. **Expected to occur at least weekly.** • Serious failures in management controls • The effects of human behaviour or other factors could cause an accident but is unlikely without this additional factor.
5 Almost Certain	>90% probability. **Expected to occur at least daily.** • Absence of any management controls • If conditions remain unchanged there is almost a 100% certainty that the hazard will be realised

Table 3	Risk Matrix				
	Likelihood				
Consequence	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
5 Catastrophic	5 Moderate	10 High	15 Extreme	20 Extreme	25 Extreme
4 Major	4 Moderate	8 High	12 High	16 Extreme	20 Extreme
3 Moderate	3 Low	6 Moderate	9 High	12 High	15 Extreme
2 Minor	2 Low	4 Moderate	6 Moderate	8 High	10 High
1 Negligible	1 Low	2 Low	3 Low	4 Moderate	5 Moderate

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NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/11/2018

Agenda item 11 c

Title of Report	**Corporate Policy: Information Governance**
Prepared By:	Paul Mullane, Head of Integrated Governance & Legal
Lead Director	James Devine, Deputy Chief Executive
Committees or Groups who have considered this report	Executive Team Senior HR Team
Executive Summary	All policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) are 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 reference in the Corporate Policy and therefore linked to the overarching document. Accordingly, the Corporate Policy for Information Governance has been updated and is attached for Board approval. Specific updates includes reference to General Data Protection Regulation (GDPR) and replacement of the Information Governance (IG) toolkit with the Data Security & Protection (DSP) toolkit.
Resource Implications	None
Risk and Assurance	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	Individual Trust policies are subject to regular review to ensure compliance with legal and regulatory requirements.

Report to the Board of Directors

Improvement Plan Implication	Governance & Standards
Quality Impact Assessment	Not applicable
Recommendation	The Board approves the updated Corporate Policy for Information Governance.
Purpose & Actions required by the Board :	**Approval** ☒ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

Medway NHS
NHS Foundation Trust

Medway NHS Foundation Trust
Corporate Policy: Information Governance

Author:	Paul Mullane Head of Integrated Governance & Legal
Document Owner	Paul Mullane Head of Integrated Governance & Legal
Revision No:	3
Document ID Number	POLCGR129
Approved By:	Executive Group
Implementation Date:	November 2018
Date of Next Review:	November 2019

Best of care
Best of people

Medway NHS
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Medway NHS Foundation Trust
Information Governance Policy

Document Control / History	
Revision No	**Reason for change**
1	New document combined Information Governance Framework, Policy & Strategy
2	Annual review 2017
3	Annual review 2018, inclusion of GDPR, revision from IG toolkit to DSP toolkit

Consultation
SIRO
Executive Group

Best of care
Best of people

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Medway NHS Foundation Trust
Information Governance Policy

Table of Contents

Medway NHS Foundation Trust
Information Governance Policy

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

1 Introduction

1.1 Information Governance (IG) is, at its simplest, a framework that draws together statutory, mandatory and best practice standards about the management of information - whether personal (patient or staff) or corporate. Good quality information is at the heart of decisions made by staff, not only in terms of patient care but also in the management of the organisation and maintaining public confidence in the services that the Trust provides.

1.2 The Trust is required to evidence its compliance with these standards through the Data Security & Protection (DSPT) , which sets a route map for self-assessment and improvement against set criteria year on year in addition to performance against data security.

2 Purpose / Aim and Objective

2.1 **Information Governance Framework and Policy Statement**

Medway NHS Foundation Trust has defined governance structures laid out in the IG framework. These set the governance, accountability and responsibilities for ensuring it maintains and improves standards of IG compliance aligned to an IG strategy that evidentially supports the DSPT requirements.

2.2 The Policy framework ensures that key compliance areas provide the Senior Information Risk Owner (SIRO) with timely, reliable and fit for purpose information to meet reporting requirements, to support legislative and regulatory compliance and to assist in management decision making. Trust managers will provide commitment and leadership in respect of IG and ensuring information is accurate, robust and timely.

2.3 Assurances will be provided to the Caldicott Guardian and Trust Board through reports from the Trust SIRO (Senior Information Risk Owner) - these reports will promote openness and transparency in how the Trust is progressing against the DSPT requirements, and highlight key areas of risk and non-compliance.

2.4 The Trust aims to ‘Be the BEST’ in everything it sets out to, and this extends to embedding IG at the heart of how it protects, manages and uses patient, staff and corporate information.

3 Policy Framework

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

Information Security Policy POLCGR018 - Information Security Policy The Trust's Information Security policy is a high level document that utilises a number of controls to protect the organisation's information. The controls are delivered through policies, standards, processes, procedures, supported by tools and user training.
USB, Removable Media and Media Destruction Policy POLCGR086 - USB, Removable media and Media Destruction Policy This policy supports the Information Security Policy to ensure that strict procedures are followed to prevent patient and staff personal data is not compromised, lost or stolen through the use of removable media.
User Access Management Policy POLCGR079 - User Access Management Policy This policy governs the prevention of unauthorised access to the Trust's information systems and forms the umbrella rules supporting the Access to Confidential Information Audits.
Records Management & Lifecycle Policy STRCGR002 - Records Management & Lifecycle Policy The Trust's records are its corporate memory, providing, evidence of actions and decisions, and representing a vital asset to support daily functions and operations. Records support policy formation and managerial decision-making, protect the interests of the Trust and the rights of patients, staff and members of the public. They support consistency, continuity, efficiency and productivity and help deliver services in consistent and equitable ways. This document governs the cycle of records from their collection to disposal.
Data Protection Policy POLCGR007 - Data Protection Policy This policy provides a framework for the Trust to ensure compliance with its confidentiality obligations, and in particular the General Data Protection Regulation (GDPR) and the Data Protection 2018. The Trust, as a Data Controller, has a legal obligation to comply with all appropriate legislation with regard to the processing of personal data. It also should comply with guidance issued by the Department of Health, NHS England, other advisory groups to the NHS, and guidance issued by professional bodies. General Data Protection Regulation and the Data Protection Act 2018 guidance for agreement owners (OTCGR269)

Freedom of Information Policy POLCGR009 - Freedom of Information Act 2000 Policy This policy provides a framework for the Trust to ensure compliance with the FOIA, Re-use of Public Sector Information Regulations 2005 and the Environmental Information Regulations 2004
Use of Cameras, video and audio recorders on Trust premises GUCGR023 - Use of cameras video and audio recorders on Trust premises Policy and Procedure This guidance ensures that patient images remain confidential and for the purposes of helping with the assessment and evaluation of a patient's condition through the use of clinical photography; and service users and patients do not make recordings (covert or otherwise) of other patients, or staff engaged in clinical interventions with patients.
Secure Transfer of Information Policy POLCGR077 - Secure Transfer of Information Policy This policy governs the transfer of patient identifiable or staff identifiable information. Its aim is to ensure such transfers meet Caldicott principles in preventing information becoming lost in transit, erroneously sent to the wrong person or sent to the correct destination but in an insecure manner.
Acceptable Use of Trust Information Systems and Assets POLCGR113 - Acceptable Use of Trust Information Systems and Asset Policy The aim of this policy is to ensure the proper use of the Trust's NHS information systems and assets and make users aware of what the Trust deems to be acceptable and unacceptable use of these.
Data Quality Policy POLCOM037 - Data Quality Policy This policy describes why Data Quality is important to the Trust; where responsibilities for maintaining and improving Data Quality lie; the means by which its continual improvement will be effected; and the processes which will ensure that the Board can be assured over the effectiveness of the systems, processes and controls over reported performance information.
Network Security Policy POLCGR082 - Network Security Policy This policy sets out the goals of protecting systems from misuse and keeping them available to users. It aims to ensure the confidentiality, integrity and availability of the Trust's information assets.
Registration Authority Policy POLCGR093 - Registration Authority This policy applies to all processes, procedures and activities carried out by the RA in relation to Trust systems which require Smartcard

4 Roles and Responsibilities

4.1 Trust Board

4.1.1 The Trust Board is ultimately responsible for ensuring that the Trust corporately meets its legal responsibilities and for the adoption of internal and external governance requirements.

4.1.2 The Trust Board is responsible for approving the Trust's Corporate Policy for information governance.

4.1.3 The Trust Board is responsible for reviewing reports from the SIRO, Data Protection Officer[1] (DPO) and Caldicott Guardian to the Board on information governance arrangements.

4.1.4 The Trust Board is responsible for understanding the statutory framework and assuring itself on the adequacy of the Trust arrangements for meeting requirements.

4.2 Chief Executive

4.2.1 The Chief Executive has overall responsibility for ensuring that sufficient resources are provided to support information governance requirements.

4.3 Caldicott Guardian

4.3.1 The Medical Director is the Trust's Caldicott Guardian who is responsible for ensuring that MFT satisfies the highest practical standards for handling patient identifiable information. The role encompasses:

- acting as the 'conscience' of MFT;
- facilitating and enabling information sharing and advising on options for lawful and ethical processing of information;
- representing and championing Information Governance requirements and issues at Board level;
- receiving training as necessary to ensure they remain effective in their role as the Caldicott Guardian;
- ensuring that confidentiality issues are appropriately reflected in organisational strategies, policies and working procedures for staff; and

[1] As assigned under the General Data Protection Regulation

- overseeing all arrangements, protocols and procedures where confidential patient information may be shared with external bodies both within, and outside, the NHS.

4.4 Director with IG portfolio responsibility[2]

4.4.1 Is the designated Director for Information Governance with responsibility for ensuring that the Trust has plans and policies in place to fulfil the requirements of the statutory framework;

4.4.2 Is the Chair of the Information Governance Group, ensuring upward reporting to the Executive Group;

4.4.3 acts as champion for information risk on the Board and provides written advice to the Accounting Officer on the content of the Organisation's Annual Governance Statement in regard to information risk;

4.4.4 understands how the strategic business goals of MFT and how other NHS organisations' business goals may be impacted by information risks, and how those risks may be managed;

4.4.5 implements and leads the NHS Information Governance risk assessment and management processes within MFT;

4.4.6 advises the Board on the effectiveness of information risk management across MFT; and

4.4.7 Is the Trust Senior Information Risk Owner (SIRO) with responsibility for fulfilling the requirements of the role.

4.5 Information Governance Group

4.5.1 This Group is established on the authority of the Executive Group to assist the Trust Board in fulfilling its responsibilities in relation to information governance. Its purpose is to monitor and co-ordinate implementation of the Information Governance Policy and the DSPT - requirements and other information related legal obligations. Terms of Reference setting out the full responsibilities of the Group are available here.

4.6 Director of ICT

4.6.1 The formulation and implementation of ICT related policies and the creation of supporting procedures, and ensuring these are embedded within the service developing, implementing and managing robust ICT security arrangements in line with best industry practice;

4.6.2 Effective management and security of Trust

- resources, for example, infrastructure and equipment;
- Developing and implementing a robust IT Disaster Recovery Plan;

- Ensuring that ICT security levels required by NHS Statement of Compliance are met;
    - Ensuring the maintenance of all firewalls and secure access servers are in place at all times, and;
    - Ensuring the provision of Information Asset Owners for the ICT infrastructure with specific accountability for computer and telephone equipment and services that are operated by corporate and clinical work force, e.g. personal computers, laptops, personal digital assistants and related computing devices, held as a NHS asset.

4.7 **Chief Operating Officer (Planned Care)**

4.7.1 The Chief Operating Officer (Planned Care) is responsible for the management and delivery of the function of health records management in accordance with information governance policies.

4.8 **Information Asset Owners (IAO), who will:**

4.8.1 lead and foster a culture that values, protects and uses information for the success of MFT;

4.8.2 know what information comprises or is associated with the asset, and understands the nature and justification of information flows to and from the asset;

4.8.3 receive training as necessary to ensure they remain effective in their role as an Information Asset Owner;

4.8.4 know who has access to the asset, whether system or information, and why, and ensures access is monitored and compliant with policy; and

4.8.5 understand and address risks to the asset, and provide assurance to the SIRO.

4.9 **The Information Governance Manager, who will:**

4.9.1 maintain an awareness of Information Governance issues within MFT

4.9.2 act as the operational lead for delivery of the Information Governance agenda;

4.9.3 Manage the information governance team;

4.9.4 review and update the suite of Information Governance policies, strategies, framework and guidance in line with local and national requirements;

- review and audit all procedures relating to this policy where appropriate on an ad-hoc basis; and
- ensure that staff are aware of the requirements of the policy.

4.10 Information Governance Team & Partner Subject-Matter Experts

4.10.1 The Information Governance Team are responsible for:

- Providing expert advice and guidance to all staff on all elements of Information Governance.
- Developing internal Information Governance policies and procedures to meet NHS information governance guidance and legislation.
- Developing Information Governance awareness and training programmes for staff.
- Ensuring compliance with Data Protection, Information Security and other information related legislation.
- Co-ordinating the response to freedom of information requests.

4.11 Line Managers

4.11.1 Line managers are responsible for ensuring that the Information Governance Policy is implemented within their group or directorate.

4.12 All Staff

4.12.1 All staff are responsible for adhering to the policy and fulfilling mandatory training requirements.

5 Monitoring and Review

What will be monitored	How/Method / Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Information Governance Manager	SIRO & IG Group	Where gaps are recognised action plans will be put into place
Compliance with the Trust's DSPT requirements	Managed via (1) quarterly feedback to the IG Group (2) Half year SIRO reports to Board	(1) IG Manager (2) Head of Integrated Governance and Legal	(1) The IG Group (2) The Executive Group	Where gaps are recognised action plans will be put into place

6 Training and Implementation

6.1 To support the implementation and embedding of the IG policy and procedures;

6.1.1 Mandatory e-learning training supported by face to face sessions available to all staff;

6.1.2 Bespoke training for dedicated cohorts and staff groups.

7 Equality Impact Assessment Statement & Tool

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

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

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

9 References

Document	**Ref No**
References:	
NHS Digital Data Security & Protection toolkit	
General Data Protection Regulation (GDPR) and the Data Protection 2018	
Freedom of Information Act 2000	
Information Security Management ISO 27001:2005	
Information Governance Alliance Code of Practice on Records Management	
NHS Confidentiality Code of Practice	
Trust Associated Documents:	
POLCGR079 - User Access Management Policy	POLCGR079
Disclosure of Medical Records SOP Disclosure of Medical Records	SOP
OTCGR139 - Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation	OTCGR139
OTCGR004 - Code of Conduct For Staff in Respect of Confidentiality	OTCGR004

Medway NHS Foundation Trust
Information Governance Policy

OTCGR040 - Kent and Medway Information Sharing Agreement	OTCGR040

END OF DOCUMENT

NHS Medway NHS Foundation Trust

Report to the Board

Board Date: 01/11/2018 Agenda item

11 d

Title of Report	**Communications and Engagement report**
Prepared By:	Glynis Alexander
Lead Director	Glynis Alexander, Director of Communications and Engagement
Committees or Groups who have considered this report	NA
Executive Summary	There is an ongoing focus on communications and engagement with staff and stakeholders to support the transformation of services. We take every opportunity to promote good news stories, and to respond openly where concerns have been raised about care. Internally considerable effort has gone into promoting our culture programme, *You Are The Difference*. Externally we continue to engage with community groups to create opportunities to discuss improvements at the hospital, and to hear what's important to patients and public. We support our Governors to engage with their constituents both within the hospital and out and about in Medway and Swale.
Resource Implications	NA
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA
Improvement Plan Implication	Communications and engagement activity is aligned with the Better, Best, Brilliant transformation plan.

Report to the Board of Directors

Quality Impact Assessment	NA			
Recommendation	The Board is asked to note the report.			
Purpose and Actions required by the Board :	**Approval** ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 There is an ongoing focus on communications and engagement with staff and stakeholders to support the transformation of services.

1.2 We take every opportunity to promote good news stories, and to respond openly where concerns have been raised about care.

1.3 Internally considerable effort has gone into promoting our culture programme, *You Are The Difference.*

1.4 Externally we continue to engage with community groups to create opportunities to discuss improvements at the hospital, and to hear what's important to patients and public.

1.5 We support our Governors to engage with their constituents both within the hospital and out and about in Medway and Swale.

2 ENGAGING COLLEAGUES

2.1 We have continued to engage staff in transformation projects under our Better, Best, Brilliant improvement programme, including reducing the length of stay for patients, and improving flow.

2.2 We have raised awareness of the opening of the new Acute Frailty Unit to staff and the public. The unit provides short stay capacity to care for frail elderly patients and those with dementia. We know that home is the best place for these patients and our aim is to ensure that they are admitted through the frailty pathway in our ED, treated and discharged home within 48 hours.

2.3 We have continued to raise awareness of the Trust's financial position and to communicate the work taking place to improve patient care and achieve financial sustainability as part of Better, Best, Brilliant.

Report to the Board of Directors

2.4 Communications to promote awareness of the 'You are the Difference' culture programme have continued and the internal campaign has led to significant number of bookings to the sessions from both managers and staff.

2.5 The Communications and Organisational Development teams have worked together to promote actions taken to improve the working environment for staff following feedback from the last NHS Staff Survey.

2.6 We have designed and implemented a flu vaccination campaign. The campaign uses images of patients and staff to promote the importance of having the jab. We are pleased to see that uptake for the vaccination so far this year among staff has increased compared to the same period last year, however there is still some way to go to achieve the target.

3 MEDIA

3.1 Since the beginning of September this year the communications team has had 40 interactions with the media including press enquiries and media releases. This has covered local, regional and specialist media.

3.2 Positive stories resulting in regional and local coverage have ranged from the success of our security team in reducing violent incidents at the Trust, to our simulation team's 'Teddy Bear Hospital' event. Other articles have featured the increased number of elderly patients we care for, and the visit to the Trust by Lord Carter.

3.3 There was also communications activity around the official opening of the Prehabilitation Unit – the first in the south east.

Report to the Board of Directors

3.4 Since September we have handled enquiries into our challenging A&E performance, our proposed withdrawal from dermatology service provision, the conviction of a former member of staff for fraud, an arson attack at the Trust, changes in senior staff, and our Best Choices scheme.

3.5 Progress towards the opening of our new Emergency Department building has generated media interest, and we are looking forward an official opening in the near future.

4 SOCIAL MEDIA

4.1 Since the last update Medway has maintained its position as Kent's most-followed acute Trust on Twitter.

4.1 Several key announcements were shared across our social media accounts in this period, resulting in almost 100,000 people viewing our posts throughout September and October (31,832 on Facebook and 67,700 on Twitter, as of 23 October 2018).

4.2 Medway's social media account followers now total 4,339 on Twitter (up from 4,283 at the last update), 6,038 on Facebook (up from 5,998) and 1,053 on Instagram (up from 1,016).

Report to the Board of Directors

4.3 Our social media channels primarily raised awareness of our regular members' and Governor events, including our 2018 Annual Members' Meeting; Lord Carter of Coles' visit to the hospital; our upcoming Christmas Fair; alternative treatment options for those considering visiting our Emergency Department during periods of increased pressure; the Trust's Apprenticeship Workshop; and the publication of the Autumn edition of our News@Medway magazine.

5 COMMUNITY ENGAGEMENT

5.1 Governors

5.1.1 Since the last Board meeting we held our first Non-Executive Director and Governor drop-in informal session.

5.1.2 This was an opportunity for our Governors to speak with Non-Executives and ask any questions they had.

5.1.3 Both Governors and Non-Executive Directors found the session useful and will continue to meet on a quarterly basis.

5.1.4 Our recent Governor coffee morning was held in the hospital. Governors were able to engage with a number of patients and families, who spoke about issues around pharmacy, lack of communication, referral processes and waiting times.

5.2 Members

5.2.1 The Trust's Annual Members' Meeting took place on 25 September in the hospital. More than 120 members of the public and staff attended – the highest number in recent years.

5.2.2 Trust staff showed displays and discussed their services before the meeting got underway.

5.2.3 The formal meeting was opened by the Trust Chair, Stephen Clark, and included reports on the year by the Chief Executive Lesley Dwyer, Finance Director Tracey Cotterill, and outgoing Lead Governor Stella Dick.

Report to the Board of Directors

5.2.4 Our governors also held an engaging and productive membership recruitment stand in the hospital at the beginning of October.

5.2.5 Many patients and visitors praised staff and spoke highly of care received. Concerns raised included poor communication and waiting times.

5.3 Reaching out to less engaged audiences

5.3.1 Our community engagement officer was invited to the Asian Fire Service Association and heard presentations on engagement with ROMA communities and how to recruit from Eastern European communities.

5.3.2 Since our last report we have supported our simulation team to engage with young children from Bryon Road Primary school through our pilot Teddy Bear Hospital.

Report to the Board of Directors

5.3.3 This was a huge success and we are now receiving requests from other schools and organisations to get involved.

5.3.4 We were delighted to receive enthusiastic students from the University of Kent Academies Trust/ UKAT Sixth Form at a Virtual Reality event.

5.3.5 This went extremely well and the students threw themselves in with enthusiasm.

5.4 Other engagement

5.4.1 We continue to engage with our local community and since the last update we have attended the Medway and African and Caribbean Association Black History launch at the Chatham Historic Dockyard.

5.4.2 We have also participated in various Medway Clinical Commissioning Group service consultation events.

5.4.3 We also attended Rochester Kent Fire and Rescue Fire Service open day. This was a well-attended event and we were able to engage with a large number of families at this fun day.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Report Date: 01/11/2018

Agenda item 12 a

Title of Report	**Workforce Report**
Prepared By:	Elizabeth Nyawade, Deputy Director of HR & OD
Lead Director	Leon Hinton, Director of Operational HR & OD
Committees or Groups who have considered this report	Senior HR Team
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The Trust's recruitment campaigns, including national, local and international have delivered 398 candidates to date – 52 candidates supplied to us by Cpl Healthcare and 168 candidates provided by HCL. The original Philippines recruitment plan for nursing continues with a total of 74 candidates being processed for posts at MFT. Trust turnover has increased at 12.17% (+0.03 from 12.14%), sickness absence at 4.02% (+0.04% from 3.98%) is above the Trust's tolerance level of 4%, appraisal compliance deteriorated to 80.02% (-1.46% from 81.48%) against target of 85%. There was a decrease in the percentage of pay bill spent on substantive staff in September at (81%) compared to 87% in the month of August. The percentage of agency usage at 6% (+1% from 5%) is up compared to the month of August. The percentage of pay bill spent on bank staff at 13% in September is higher by (5%) compared to August.
Resource Implications	None
Risk and Assurance	• Nurse Recruitment • Temporary Staffing Spend

NHS Medway NHS Foundation Trust

Report to the Board of Directors

	The following activities are in place to mitigate this through: 1. Targeted campaign to attract local and national nurses 2. Update on overseas campaign 3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway 5. Agency/Temporary Staffing Workstream as part of the 2018/19 cost improvement programme
Legal Implications/Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators.
Improvement Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).
Quality Impact Assessment	Not applicable
Recommendation	Not applicable
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

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NHS Medway NHS Foundation Trust

Report to the Board of Directors

1 INTRODUCTION

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

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During September 2018, 26 FTE registered nurses and midwives joined the Trust on a substantive basis, alongside 1 FTE substantive clinical support worker.

2.2 The initial international campaign in the Philippines continues. Harvey Nash, our international recruitment partner agency working on Filipino nurse recruitment campaign is continuing to process 74 of the Filipino nurses that remain engaged in the process. Six Filipino nurses have commenced in post via Harvey Nash. A further 15 Harvey Nash candidates have recently passed their International English language Test (IELTS). There are 74 candidates awaiting IELTS results and/or getting their tests reviewed. It is anticipated that the 15 nurses that successfully passed the IELTS will commence in post in the early part of 2019.

2.3 Twenty international nurses undertook their objective structured clinical examination (OSCE) in September 2018, 17 nurses passed and are now working in their allocated wards. Three nurses who failed will be retaking the exam in October 2018. The Trust currently has an OSCE pass rate above 91%. The latest cohort of 16 international nurses will undertake the OSCE exam in November 2018.

2.4 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Two Cpl international nurses have commenced in post. 21 HCL nurses have also commenced in post, with a further 168 candidates with offers being processed.

2.5 The Trust is also working with 7 additional permanent recruitment agency providers: We Solutions, Imperial MS, MSI Group, Medline, HealthPerm, Xander Hendrix and IELTS Medical. The agency partners are working with the Trust on developing a pipeline of nurses.

Report to the Board of Directors

2.6 To support the Trust in achieving its targets new campaigns are being launched with a select number of agencies: Medline, We Solutions, Ascend and Imperial MS.

Table 1 below summarises the Trust's recruitment pipeline via all our partner agency providers.

Agency Provider	Commenced	Pipeline	Agency total	Anticipated new starters over the next 12 months from pipeline
Harvey Nash	6	74	80	(26%) 19
Cpl Healthcare	2	52	54	(15%) 8
HCL	21	168	189	(29%) 50
Person Anderson	24	4	25	(100%) 4
Imperial	12	51	68	(19%) 10
MSI Group	3	5	8	(60%) 3
Xander Hendrix	3	12	14	(58%) 7
We Solutions	1	25	26	(60%) 15
Blue Thistle	0	8	8	(0%) 0
Medline	0	25	25	(60%) 15
HealthPerm	0	7	7	(100%) 7
IELTS Medical				
Total	72	398	504	138

(Table 1: Nurse recruitment pipeline as of September 2018)

2.7 To increase reach the Trust commissioned the services of Medical Careers Global, a careers advertising platform for 12 months on a fixed fee. All clinical posts are advertised on this platform with a view to attracting more applicants. To date 75,435 individuals have viewed MFT vacancies and 46 applications have been received. The applications received through this platform from candidates who are yet to undertake the required IELTS/OET examinations will be stored to create a local talent pool.

Table 2 below summarises offers made, starters and leavers for September 2018.

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses & midwives	26 (26 NHS Jobs/open days & 36 international)	26	16
Clinical support workers	0	1	8

(Table 2: Nursing starters and leavers September 2018)

Report to the Board of Directors

2.8 During September 2 substantive consultants were appointed in Colorectal Surgery and Microbiology.

2.9 The Trust had a good fill rate from Health Education England, Kent Surrey and Sussex Deanery (HEEKSS) for the October junior doctors' rotation. Table 3 below summarises the HEEKSS October 2018 rotational fill and gaps.

Specialty	Expected	Grade	Allocated	Comment	Variance
Intensive Care	2	ST3+	2	Filled	0
Acute Medicine	2	ST3+	2	Filled	0
Cardiology	2	ST3+	2	Filled	0
Endocrinology and Diabetes	2	ST3+	1	The one vacancy is being covered **by 1 MTI** Doctor as part of training	0
Geriatrics	3	ST3+	3	Filled	0
Orthodontics	1	ST3+	1	Filled	0
Respiratory	3	ST3+	2	Out to Advert	1
Rheumatology	1	ST3+	0	Post on HEEKSS Hold	1
Obs & Gynae	5	ST3+	5	Filled	0
General Surgery	8	ST3+	8	Filled	0
ENT	2	ST3+	2	Filled	0
T&O	5	ST3+	5	Filled	0
Urology	1	ST3+	1	Filled	0
Total	37	-	35	**Total gaps**	**2**

(Table 3: HEEKSS October 2018 allocation)

3 DIRECTORATE METRICS

3.1 The table below (table 4) shows performance across five core indicators by the directorate. Turnover, at 12.17% (+0.03% from 12.14%), remains above the tolerance level of 8%. HR Business Partners will work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let's work together commissioned by Health Education England) and staff survey results to implement service specific retention plans. Sickness absence at 4.02% (+0.04% from August) is above the tolerance level of 4%. Employee Relations are proactively carrying out analysis to support managers to manage sickness and reviewing trends for interventional support.

3.2 The Trust appraisal rate stands at 80.02% (-1.46% from 81.48%) and is below the Trust target of 85%, two directorates (Corporate and Estates and Facilities) are meeting the appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two

NHS Medway NHS Foundation Trust

Report to the Board of Directors

new ratings have been included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics.

		Trust			Corporate			Estates & Facilities			Planned Care			Unplanned & Integrated Care		
	Trust Target	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend
Turnover rate (Voluntary, 12-month rolling)	8%	12%	▲		13%	▼		6%	▲		12%	▲		14%	▲	
Vacancy rate	12%	17%	▼		16%	▲		13%	▼		16%	▼		20%	▼	
Sickness rate (12-month rolling)	4%	4%	▲		3%	▲		6%	▲		4%	▲		4%	▼	
Statutory & Mandatory Training	85%	n/a	▲		n/a	▲		n/a	▲		n/a	▲		n/a	▲	
Medway Appraisal	85%	80%	▼		91%	▼		87%	▼		76%	▼		78%	▲	
Agency costs (as % of total paybill)		6%	▲		3%	▼		4%	▲		3%	▼		6%	▼	
Bank costs (as % of total paybill)		13%	▲		2%	▼		11%	▲		12%	▲		18%	▲	
Substantive costs (as % of total paybill)		81%	▼		95%	▲		85%	▼		85%	▼		76%	▼	

(Table 4: Key workforce metrics)

4 TEMPORARY STAFFING

Table 5 below demonstrates that temporary staffing expenditure increased in September 2018 compared to August 2018.

		Mar-17	Mar 18	Apr 18	May 18	June 18	July 18	Aug 18	Sept 18
Spend	Agency	3,890,198	2,597,697	943,419	1,502,866	1,003,597	895,452	799,288	968,606
	Bank	920,473	2,329,768	2,307,191	2,003,992	1,939,086	2,914,663	1,441,538	2,231,622
	Substantive	13,611,458	13,542,990	13,904,703	14,328,856	14,032,556	14,112,477	14,916,485	16,881,300
% Pay bill	Agency	21%	14%	5.5%	8%	6%	5%	5%	6%
	Bank	5%	12%	13.5%	11%	11%	16%	8%	13%
	Substantive	74%	74%	81%	81%	83%	79%	87%	81%

(Table 5: Workforce profile based on contractual arrangement)

4.1 The agency cap breaches across all staff groups continues to decrease as illustrated in chart 1 below. During the month of September 2018 the Trust reported an average of 22 breaches per week.

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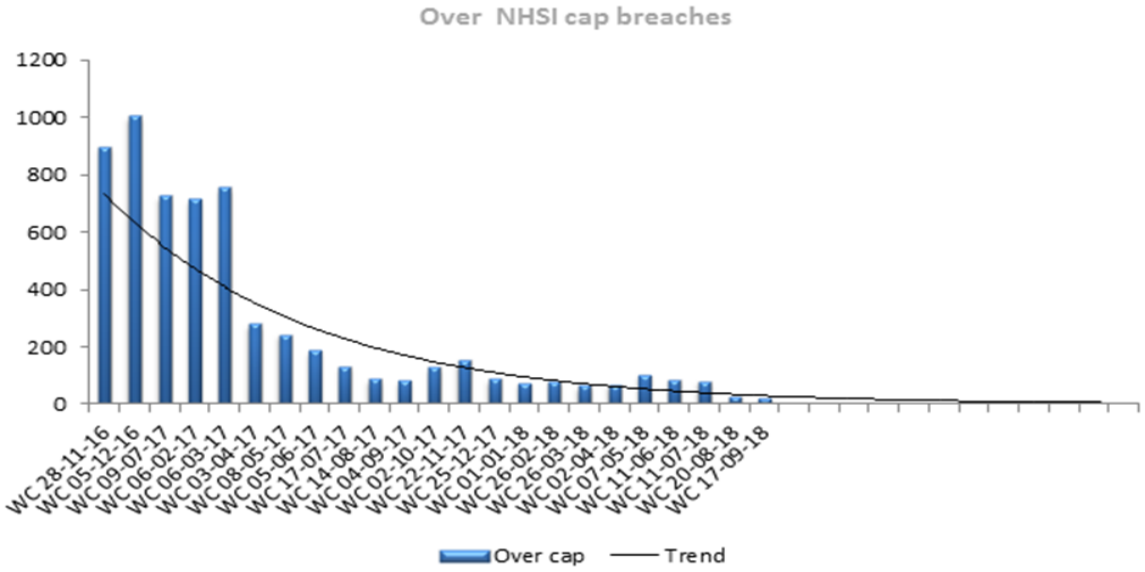
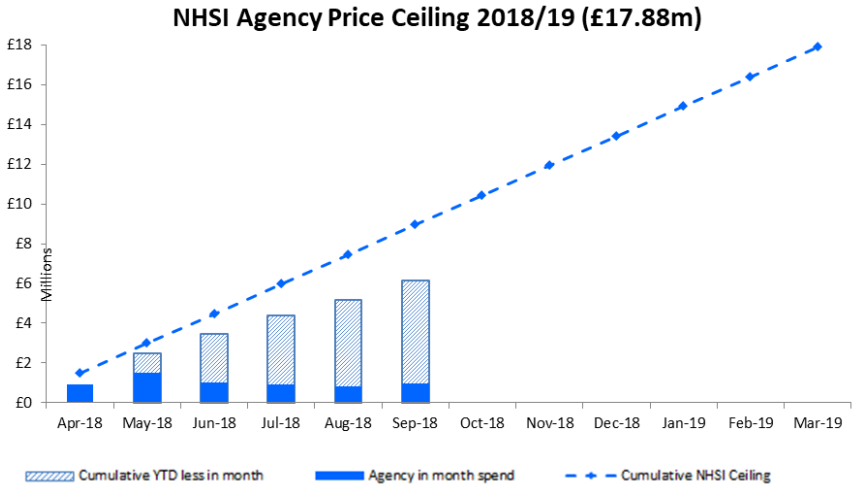
Report to the Board of Directors



(Chart 1: NHSI cap breaches)

4.2 The Trust's NHSi annual agency spend celing has decreased from £21.6m in 2017/18 to £17.88m (corrected ceiling based on Model hospital figures) in 2018/19. Based on cumulative agency spend YTD, the Trust is £1.8m below the NHSi agency ceiling cap target as illustrated in the chart and table below.



(Chart 2: NHSI agency ceiling)

Report to the Board of Directors

Table 6 below shows NHSI agency ceiling performance

	May-18	Jun-18	Jul-18	Aug-18	Sep-18
Cumulative NHSI ceiling target	£2,980,000	£4,470,000	£5,960,000	£7,450,000	£8,940,000
Agency in month actual spend	£1,502,866	£1,003,597	£895,452	£799,288	£986,606
Cumulative below ceiling	£539,882	£1,020,285	£1,620,833	£2,311,544	£1,8464,332

(Table 6: NHSI agency ceiling performance)

4.3 Temporary nursing demand in September 2018 increased slightly compared to August 2018 (8,776 shifts requests in September 2018 compared to 8693 shifts requests in August 2018). The fill rate remained the same at 72%. Medical locum demand decreased in September 2018 compared August 2018 (1,309 shifts requests in September 2018 compared to 1,607 shifts requests in August). The average demand over the summer period for Nursing and Midwifery staff was 8,735 per month whereas Medical staff fell to 1,458 requests per month. The average fill rate across both services remains high at 81%.

End

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/11/2018

Agenda item 12 b

Title of Report	**Corporate Policy: Human Resources and Organisational Development**
Prepared By:	Leon Hinton, Director of Operational HR
Lead Director	James Devine, Deputy Chief Executive & Executive Director of HR & OD
Committees or Groups who have considered this report	Executive Team Senior HR Team
Executive Summary	All policies, Standard Operating Procedures (SOPs) and Administrative Guidance Notes (AGNs) are 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 reference in the Corporate Policy and therefore linked to the overarching document. Accordingly, the Corporate Policy for Human Resources and Organisational Development has been updated and is attached for Board approval. Modern Slavery policy has been included.
Resource Implications	None
Risk and Assurance	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	Individual Trust policies are subject to regular review to ensure compliance with legal and regulatory requirements.

Report to the Board of Directors

Improvement Plan Implication	Governance & Standards			
Quality Impact Assessment	Not applicable			
Recommendation	The Board approves the updated Corporate Policy for Human Resources and Organisational Development.			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☒	☐	☐	☐

Medway NHS
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Medway NHS Foundation Trust
Corporate Policy: Human Resources and Organisational Development

Author:	Director of Operational HR & OD
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Best of care
Best of people

Medway NHS
NHS Foundation Trust

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Human Resources and OD Policy

Document Control / History	
Revision No	**Reason for change**
1	New document
2	Annual revision, policy list updated

Consultation
JSC (for policy items)
Executive Group

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

1 Introduction

1.1 Human Resources and Organisational Development (HR & OD) supports Medway NHS Foundation Trust achieve the Best of Care through the Best of People. The department supports excellent patient care through the recruitment, retention and development of all employees. The HR & OD directorate also focuses on employee engagement and helps shape the culture of the Trust.

1.2 The directorate also ensures compliance with employment legislation and best practice when dealing with any workforce issues.

2 Purpose / Aim and Objective

2.1 The purpose and aim of this document is to provide an overview of the key elements of HR & OD and to identify through supporting policies and procedures the various employment legislation and local processes to which the directorate is expected to work to.

The key elements of the HR & OD Directorate are:

- HR Strategy and Planning; this includes Employee Relations, Workforce Intelligence, Occupational Health and Tiny Tugs Nursery;
- HR Resourcing; this includes Resourcing, Temporary Resourcing, Medical Resourcing and e-Rostering;
- Workforce Development and Organisational Development; this includes Organisational and Professional Development and Workbased Learning.

2.2 The objective of this document and all supporting policies and procedures is to identify, at high level and in detail, the relevant employment legislation and standards which govern the provision of HR and OD services, and to provide all Trust staff with detailed guidance, references and clarity on a range of topics relating directly to HR and OD service provision.

2.3 The Trust aims to ‘Be the BEST’ in everything it sets out to, and this extends to the management of staff who are at the heart of the Trust and its commitment to patient care.

3. Policy Framework

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

Employee Relations
Respect - Countering Bullying in the Workplace Policy (POLCHR002) **Respect - Countering Bullying in the Workplace Procedure (SOP0168)**
Grievances Policy (POLCHR003) **Grievance Procedure (SOP0249)**
Performance Management Policy (POLCHR004) **Performance Management Procedure (SOP0227)** **Probationary Period Procedure (SOP0252)** **Medical and Dental Policy for Managing Conduct, Capability and Health (PROCHR004)**
Organisational Change Policy (POLCHR005) **Organisational Change Procedure (SOP0242)**
Long Service Recognition Policy (POLCHR009)
Modern Slavery Policy (POLCHR049)
Freedom to Speak Up - Raising Concerns at Work - Whistleblowing Policy (POLCHR014) **Freedom to Speak Up Guardians Procedure (SOP0251)**
Attendance Management Policy (POLCHR017) **Attendance Management Procedure (SOP0286)** **Attendance Management - Return to Work Form (OTCHR050)**
Worklife and Family Policy (POLCHR019a) **Flexible Working Procedure - Worklife Balance (SOP0250)** **Paternity Leave Procedure (SOP0274)** **Parental Leave Procedure (SOP0275)** **Maternity Leave Procedure (SOP0276)** **Carer Dependant Leave Procedure (SOP0277)** **Other Leave Procedure (SOP0278)**

Adoption Leave Procedure (SOP0279) Career Break Policy (POLCHR034) Annual Leave Procedure (SOP0287) Medical Staff Leave Procedure (SOP0290)
Managing Work Related Stress Policy (POLCHR021)
Partnership Agreement Between Medway NHS Foundation Trust and NHS Trade Unions Policy (POLCHR030)
Inclusion Policy (POLCHR044) Disability in Employment Policy (POLCHR045)
Disciplinary Policy (PROCHR002) Disciplinary Procedures (SOP0226) Bank Worker Disciplinary Procedure (SOP0320)
Exit Procedure (SOP0317)
Occupational Health
Occupational Health Clearance and Immunisations for New Healthcare Workers Guidelines (GUCGR015)
Avoidance and Management of the Effects of Latex Allergy Policy (POLCGR002) Avoidance and Management of the Effects of Latex Allergy Screening Questionnaire for Employees at Risk of Increase Occupational Latex Exposure (OTCHR037) Avoidance and Management of the Effects of Latex Allergy Procedure (SOP0237)
Prevention and Management of Tuberculosis in Health Workers Policy (POLCPCM076) Prevention and Management of Tuberculosis in Health Care Workers Procedures (SOP0241) Prevention and Management of Tuberculosis in Health Care Workers - Annual Tuberculosis Symptom Questionnaire (OTLS030)
Misuse of Drugs and Alcohol Policy (POLCHR013)
Management and Procedure for the Provision of Post Exposure Prophylaxis (PEP) following a Sharps or Blood/Body Contamination Incident (POLCS014)

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Organisational & Professional Development
On Boarding - New Employee Departmental Welcome Record - Local Induction (OTCHR035)
On Boarding 1 - Final Preparations for New Starter Joining the Trust (SOP0209)
On Boarding 2 - MFT Welcome (SOP0210)
On Boarding 3 - Role Relevant Training and NSDWR (SOP0211)
On Boarding 4 - Settling and Performing into the Role (SOP0213)
On Boarding 5 - Performing into the Role (SOP0214)
Statutory and Mandatory Training Procedure (PROCHR006)
Apprenticeship Policy (POLCHR043)
Work Placement - Work Experience Policy (POLLHR001)
Achievement Review Guidelines (GUCHR007)
Appraisal and Revalidation of Medical Staff Policy (POLCHR037)
Study Leave and Funding Policy (POLLHR002)
Study Leave and Funding Procedure (SOP0322)
Applying for Funding Towards Continuing Professional Development Procedure (SOP0291)
Resourcing & Rostering
Recruitment and Selection Policy (POLCHR039)
Recruitment Procedure (SOP0178)
Secondment Procedure (SOP0180)
Disclosure and Barring Service Check Procedure (SOP0177)
Managers Guide to Checking - Duty of Care - Documents (SOP0013)
Temporary Workforce Policy (POLCHR042)
Temporary Workforce - Principles of Engagement Guidance (GUDCHR001)
Fit and Proper Persons Policy (POLCHR041)
Fit and Proper Persons Procedure (SOP0174)
Job Evaluation Policy (POLCHR036)
eRostering Policy (POLCNM017)

Remediation of Medical Staff Policy (POLCM006)
Honorary Contracts Procedure (SOP0179)
Removal and Relocation Expenses Procedure (SOP0319)
Employment Terms and Conditions – Local Terms and Conditions
Employment Terms & Conditions – Local Terms & Conditions (Note)

4. Roles and Responsibilities

4.1 Trust Board

4.1.1 The Trust Board is ultimately responsible for ensuring that the Trust corporately meets its legal responsibilities.

4.1.2 The Trust Board is responsible for approving the Trust's Corporate Policy for HR & OD.

4.2 Chief Executive

4.2.1 The Chief Executive has overall responsibility for ensuring that sufficient resources are provided to support HR & OD requirements.

4.3 Executive Director of HR and OD

4.3.1 Has overarching responsibility for the effective and efficient management and delivery of all HR & OD services within the Trust and for development of policies and procedures in support of these functions.

4.3.2 Ensure that all policies and procedures are in line with relevant employment legislation and best practice.

4.3.3 Development of the Workforce Strategy that all policies and procedures underpin.

4.3.4 Advises the Board on the effectiveness of HR & OD management across MFT.

4.4 Deputy Director of HR & OD

4.4.1 Has responsibility for ensuring that Employee Relations processes are fair and thorough; following policies and procedures accordingly;

4.4.2 Ensuring that Workforce Intelligence is accurate and readily available when required. Also, to ensure that ESR and EPay are fit for purpose and utilised effectively to bring efficiency to payroll processing and workforce information;

4.4.3 Leading an effective occupational health service provision across the Trust;

4.4.4 Has responsibility for the onsite nursery, Tiny Tugs, ensuring that the service is run safely, efficiently and in line with relevant legislation.

4.5 Group Head of HR - Resourcing

4.5.1 Has responsibility for ensuring that all resourcing functions (including medical staffing and temporary staffing) processes are fair and thorough; following policies and procedures accordingly;

4.5.2 Ensure all resourcing policies and procedures are in line with relevant employment legislation and best practice;

4.5.3 Monitor all resourcing policies to ensure compliance across the Trust.

4.6 Associate Director of Workforce Development and OD

4.6.1 Has responsibility for ensuring that all Organisational & Professional Development processes are fair and thorough ensuring equity of access; following policies and procedures accordingly;

4.7 HR and OD Team

4.7.1 The whole HR & OD Team are responsible for:

- Providing expert advice and guidance to all staff on all elements of HR & OD;
- Developing internal HR and OD policies and procedures to meet employment legislation, Agenda for Change and best practice;
- Developing HR and OD awareness and training programmes for staff;
- Ensuring compliance with policies, procedures, legislation and best practice.

4.8 Line Managers

4.8.1 Line managers are responsible for ensuring that the HR & OD Policy is implemented within their group or directorate;

4.8.2 They are also responsible for seeking advice from a relevant member of the HR and OD team if they are unsure about the application of a policy or procedure;

4.8.3 Line managers should discuss any concerns they have regarding their staff with a relevant member of staff as soon as the issue arises.

4.9 All Staff

4.9.1 All staff are responsible for adhering to all HR & OD policy.

5. Monitoring and Review

What will be monitored	How/Method / Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Deputy Director of HR and OD		Where gaps are recognised action plans will be put into place

6. Training and Implementation

6.1 To support the implementation and embedding of HR and OD policies and procedures;

- Bitesize training sessions for staff on different policies will be run regularly;
- Bespoke training and coaching for managers will be delivered on an ad hoc basis.

7. Equality Impact Assessment Statement & Tool

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

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

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

9 References

Document	Ref No
References:	
Trust Associated Documents:	
See framework	

END OF DOCUMENT

Key Issues Report

Medway NHS Foundation Trust

From a meeting of Finance Committee held on 27/09/2018

Report to:	**Board of Directors**	**Date of meeting:**	**01/11/2018**
Presented by:	**Tony Moore Chair Finance Committee**	**Prepared by:**	**Tracey Cotterill, Director of Finance**

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Matters for escalation

1. Month 5 was submitted favourable to plan before and after Provider Sustainability Funding (PSF). The trust is anticipating a further loss of PSF income relating to ED performance for Q2. Whilst the loss of PSF does not affect delivery of the agreed financial position, it does increase the reported deficit. The forecast assumes that the remaining PSF will be earned.
2. Additional Capital has been allocated to the STP to support the digital transformation, and a proportion of that will transfer to MFT in relation to the EDRMS project. It was noted that some organisations received more than others, but there was an expectation that this would be evened out over the 3 years for which the allocation applies.

Matters considered by the group:

3. The standard reporting pack was discussed.

   Key items brought to the committees attention included:

   - The year to date position and forecast outturn particularly with regard to PSF. It was noted that the Unplanned Care directorate was adverse to plan, whilst the other directorates were favourable.
   - Activity volumes and values vs plan was considered, and the impact of a block v. variable contract is being monitored. To date the variable value of activity is close to the block value, but there is a benefit to the Trust in relation to the CQUIN and BPT element.
   - Cash balance was noted at £9.9m, with cash being held against some large payments expected in the early part of the next month.
   - Capital is currently behind plan. It was noted that the capital allocation is not transferrable to other schemes, and any slippage will need to be captured in the next financial year.
   - The committee was advised that the pay award has been received in relation to month 5 as well as for month 1-3 back pay.
   - The risk and opportunity schedule was discussed and it was noted that a system risk schedule had been prepared for the

	regulators. • Loans currently stand at £236m, and the balance sheet has net liabilities of £29.6m. 4. The CIP progress was discussed, with the committee being advised of the current gross and risk adjusted values of the schemes. 5. Contract update - It was noted that the contract workplan has deadlines for CCG and Trust actions of 30th September and further work is still required in these areas. There was discussion around the planning round for 2019/20 and update on the latest feedback received on likely national timetables. 6. An update was received on the Sustainability and Transformation Partnership and it was noted that there has been an allocation of additional capital for digital transformation which has been allocated to a number of IT schemes across the STP. 7. The committee had an update on the Emergency Department build. 8. The procurement update included reference to the changes associated with the national supply chain, and the intention for running costs to be funded from a tariff top slice 9. The committee considered the options for the ledger upgrade project and supported the recommended option, noting that this had been agreed with executive. The paper will be going to the capital control meeting in October as part of the capital governance process. 10. Board Assurance Framework was taken as read – noting that there were no changes to the risks scores this month.
Key decisions made/ actions identified:	11. The committee approved the proposed option for upgrade of the ledger.
Risks:	12. Risk register relating to 2018/19 is unchanged from last month. 13. The capital plan is significant but funding is available. 14. PSF relating to operational performance is a risk to the overall financial position, but NHSI have confirmed that the financial control total is measured pre PSF. 15. CIPs are noted as a risk to delivery of the control total.

Key Issues Report

From a meeting of Finance committee held on 25/10/2018

Report to:	**Board**	**Date of meeting:**	**01/11/2018**
Presented by:	**Tony Moore, Finance committee chair**	**Prepared by:**	**Richard Boyce, interim Director of Finance**

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Matters for escalation	1. 2019/20 forecast being developed taking account of all risk factors including income, expenditure, CIPS and plans for managing the elective/non-elective split of work over the winter period. 2. Timetable to be provided for board to gain assurance of and sign off on any adverse outturn performance versus control total prior to advising NHS Improvement. 3. The board to be appraised on the preparedness of the Trust to operate under a PbR contract and options for contractual form and management arrangements for 2019/20.
Other matters considered by the group:	4. Financial position at Month 6 marginally ahead of plan 5. CIPS year to date £7.3m as against plan of £5.7m. Current 18/19 'green' rated CIPS £14.9m. NHSI feedback positive but considerable more to do to reach £21m target. Concern that 38% of the delivered CIPS are non-recurrent and that this percentage could increase. 6. Greater assurance and formality was provided over the development and management of capital schemes. 7. New ED works continuing to revised plan of 8 November operational 8. Noted good work in the Procurement team on stock management, and CIP delivery.
Key decisions made/ actions identified:	Additional to actions included under matters for escalation. 1. CIP presentation to include matrix: recurrent and non-recurrent; pay and non-pay; year to date and year to go. 2. Reporting of both full year outturn performance and underlying financial run rate reporting to be strengthened. 3. The Finance Team to report back on progress in clearing 60+

	day non NHS creditors.
Risks:	4. No new risks identified
Assurance:	5. No items of assurance discussed