Agenda

Public Meeting of the Trust Board

Date: On 18 January 2018 at 12.30pm – 3.30pm

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

Item	Subject	Presenter	Time	Action	Format
1.	Patient Story	Director of Nursing	12.30pm	Discuss	Paper
Opening of the Meeting					
2.	Chair's Welcome	Chairman	1.00pm	Note	Verbal
3.	Quorum	Chairman		Note	Verbal
4.	Register of Interests	Chairman		Note	Paper
Meeting Administration					
5.	Minutes of the previous meeting held on 3 November 2017	Chairman	1.05pm	Approve	Paper
6.	Matters Arising Action Log	Chairman		Note	Paper
Main Business					
7.	Chair's Report	Chairman	1.10pm	Note	Verbal
8.	Chief Executive's Report	Chief Executive	1.15pm	Note	Paper
9	Strategy a) STP Update b) Trust Improvement Plan Better Best Brilliant	Chief Executive Director of HR & OD	1.20pm	Note Discussion	Paper Paper
10.	Quality a) IQPR b) Mortality Report (Responding to Deaths) c) Safe Working Hours Annual Report (Doctors and Dentists in training)	Executive Medical Director	1.35pm	Discussion	Paper Paper Paper
11	Performance a) Finance Report	Director of Finance & Business Services	2.15pm	Discussion	Paper

Agenda

	b) Communications Report	Director of Communications		Discussion	Paper
12.	People a) Workforce Report	Director of HR & OD	2.30pm	Assurance	Paper
For Approval					
13.	Corporate Safeguarding Policy	Director of Nursing	2.40pm	Approval	Paper
14.	Corporate Consent Policy	Director of Corporate Governance	2.43pm	Approval	Paper
15.	Corporate Estates and Facilities Policy	Director of Finance & Business Services	2.45pm	Approval	Paper
Reports from Board Committees					
16.	Quality Assurance Committee Report	QAC Chair	3.00pm	Assurance	Paper
17.	Integrated Audit Committee Report	IAC Chair	3.15pm	Assurance	Paper
AOB					
18.	Council of Governors' Update	Governor Representative	3.20pm	Discussion	Verbal
19.	Any other business	Chairman		Note	Verbal
20.	Questions from members of the public	Chairman		Discussion	Verbal
Close of Meeting					
	Date and time of next meeting: 1 March 2018 Boardroom, Post Graduate Centre, Medway NHS Foundation Trust				

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

		• Director of Lloyds Halifax Premises Limited • Director of Lloyds Gresham Nominee1 Limited • Director of Lloyds Gresham Nominee 2 Limited • Director of Lloyds Lloyds Commercial Properties Limited • Director of Lloyds Lloyds Bank Properties Limited • Director of Lloyds Lloyds Commercial Property Investments Limited • Director of Lloyds Target Corporate Services Limited
9.	Karen Rule Director of Nursing	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
10.	Mark Spragg Non-Executive Director	• Trustee for the Marcela Trust • Trustee of the Sisi & Savita 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.	Tracey Cotterill Director of Finance and Business Services	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
12.	Adrian Ward	• TBC

Meeting in Public

NHS Medway NHS Foundation Trust

Board of Directors Meeting in Public on 03/11/2017 held at Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Mrs L Dwyer	Chief Executive	LD
	Mr J Billings	Non-Executive Director	JB
	Mr E Carmichael	Non-Executive Director	EC
	Mr T Moore	Non-Executive Director	TM
	Mr M Spragg	Non-Executive Director	MS
	Mrs T Cotterill	Director of Finance and Business Services	TC
	Mr J Devine	Director of HR and OD and Director of Improvement	JD
	Ms Simone Hay	Acting Director of Nursing	SH
	Dr G Ramadan	Acting Medical Director	GR
Attendees:	Ms G Alexander	Director of Communications	GA
	Mr A Lindsay	Co-Director of Clinical Operations – Family and Clinical Support Services Directorate	AL
	Ms D King	Governor Board Representative	DK
	Mr C Bradley	2020 (item 9b only)	CB
	Ms B Adams-Reynolds	Information Governance Manager and Data Protection Officer (presentation only)	BA
	Ms S Murphy	Trust Secretary	SM
	Ms K White	Acting Director of Corporate Governance, Compliance, Risk and Legal	KW
	Mr J Lowell	Director of Clinical Operations – Acute and Continuing Care Directorate	JL
	Mr B Stevens	Director of Clinical Operations – Co-ordinated Surgical	BS
	Mrs A Meadows	Assistant Trust Secretary (minute taker)	AM
	Dr. Janette Cansick	Director of Medical Education (item 10b only)	JC

	Carol Atkins	Medical Education Manager (item 10b only)	CA
Apologies:	Mr A Ward	Non-Executive Director	AW
	Dr D Hamilton-Fairley	Medical Director	DHF
	Mrs J Palmer	Non-Executive Director	JP
	Mrs K Rule	Director of Nursing	KR

1. Presentation: General Data Protection Regulation(GDPR) Update

1.1 KW introduced BA as the presenter and noted the importance of the organisation being GDPR compliant. BA gave a very detailed presentation on GDPR and achieving compliance should be achieved.

1.2 BA noted that GDPR is a replacement for the UK Data Protection Act and that it sets out an ambitious and prescriptive list of requirements that must be included in data processing. BA referred to Board accountability and governance, the legal requirement to appoint a DPO including their responsibilities, subject rights, the requirement for data controllers to pay a fee, consent privacy notices and breach notification.

1.3 BA noted a compliance framework is in place. It was noted that the priorities to quarter 4 would include delivering greatest impact and building early communications and engagement. Questions were taken.

1.4 SC thanked BA for the detailed presentation and progress made in this area so far.

2. Welcome and Apologies for Absence

2.1 The Chairman welcomed everyone to the meeting.

2.2 Apologies for absence were noted as stated above.

3. Quorum

3.1 It was confirmed that the meeting was quorate.

4. Register of Interests

4.1 This was noted and requested to be updated in view of the recent development regarding QAC membership.

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 meeting subject to minor amendments.

6. Matters Arising and Action Log

6.1 The Board of Directors **RECEIVED** the Action Log and the following changes and updates were noted:
0390 and 0391 – Actions closed;
0392– It was agreed that this action should be reworded and left open.

7. Chair's Report

7.1 SC noted that the Trust is moving forward in its improvement programme and thanked staff who had stepped forward to lead improvement projects.

7.2 SC referred to the well-attended Medway and Swale events where members of the public had the chance to comment on and support proposals for changes following a review of urgent care including a plan to create an urgent care centre within the hospital. SC noted that the Medway Model will enhance local care and help avoid unnecessary hospital admissions. SC noted a recent conference marking the first anniversary of the STP.

7.3 SC noted that the Trust AGM held on 26 September was one of the most successful with a 25% increase in attendance. SC noted that JD gave an excellent update on the past year's achievement; TC provided the finance report and the lead governor noted governors' activities. There was a presentation about the Trust's first year as a smokefree site, and specific initiatives to reduce the number of women who continue to smoke in pregnancy.

7.4 SC noted the official launch of robotic surgery this morning. SC added that the da Vinci robot is an example of how the organisation is committed to improving outcomes and patient experience. It was noted that a patient had already benefitted from surgery carried out through the use of the robot.

7.5 The special measures quality leadership event was noted including the widely shared video on social media in which Jeremy Hunt spoke to Lesley about how the Trust's turnaround had been achieved. SC noted national endorsements for the Trust. Likely winter challenges and efforts made to deal with these were noted.

8 Chief Executive's Report

8.1 The Board was asked to note the content of the report. LD raised concern over achieving consistent high performance against the 4 hour Emergency Department (ED) target in the last month and advised that there is a need to deliver a more consistent level of flow through to discharge to ensure delivery of best care to all patients.

8.2 LD noted the recent reviews with system partners of patients who are considered "delayed transfers of care". It was noted that a reduction is now being seen in the numbers with patients being transferred to where they will receive the most appropriate care. LD advised that a "stranded patient" audit will be undertaken next week with the system partners. It was noted that currently 48% of the patients have been in hospital more than 7 days. LD

noted the purpose of the audit and advised that the Trust is close to closing its escalation ward.

8.3 LD noted the 62 day cancer standard and steps being taken to meet the target. It was noted that the Trust had been awarded some money from the Cancer Improvement Fund. The key things this will be used to improve were outlined.

8.4 The Trust's financial position and initiatives/steps being taken to improve the challenging position were noted. The continued vigilance and strong oversight on fire safety led by MS were also noted.

8.5 In relation to the new ED, it was noted that work continues to ensure that the building is of the necessary standard and specification. However it is now anticipated that the new ED will complete in late January due to some identified defects

8.6 LD noted the important role played by the Trust's Freedom to speak up guardians and advised that there will be a reflection day with them together with workplace listeners and trade unions to improve collective practice, strengthen their role and learn from the past 12 months together.

8.7 The Trust's endoscopy unit has successfully achieved Joint Advisory Group (JAG) accreditation following reassessment of the unit in August 2017 and is now seen as an exemplar. There was an update on Nursing and Midwifery Language Tests and also the Quality Special Measure Conference November which was attended by LD and DHF.

8.8 In relation to winter resilience, LD noted that teams have been working hard to ensure the Trust has resilience plans in place. LD noted that influenza vaccination is critical but a significant number of staff have not taken up the offer of vaccination. DK noted that the public are concerned at the poor uptake of the flu vaccination by staff. It was noted that this will be addressed through the directorates and trust-wide messages.

8.9 There was an update on antibiotic resistance. It was noted that the NHS plan to fight obesity diabetes and tooth decay is to be supported by trusts. LD also noted that currently, the Trust is exploring a collaborative bid through the STP to procure an electronic patient record system with an e-prescribing module.

9 Strategy

9a) STP Update

9.1 The report was taken as read. LD updated the Board on the recent progress in Medway, North and West Kent, and across the county. LD noted that ways to collaborate much more are being considered so as to generate efficiencies in the way services are run.

9.2 LD noted that it was important for the Trust to contribute to the STP as some things could be done collectively and more efficiently. It was noted that the contribution is under £500k. There was a discussion around this including support for local care and the need for the STP to pick up pace.

9b) Trust Improvement Plan

9.3 JD noted that performance in terms of ED 4 hour target had been variable but advised that overall performance since flow month is better. JL explained that quality issues having been addressed, there is now focus on performance with right pathways in place and right people in the front door so as to ensure that patients get the quickest care as possible.

9.4 In addition to the above, JD noted that the team is focussing on embedding and communicating the new flow model; standardisation of processes in flow-critical areas; co-ordination of flow- critical activity; and improving discharge processes and reducing length of stay.

9.5 JD noted that financial recovery had also improved with the commencement of four week sprints with regard to a number of schemes to expedite the project. It was noted that a four week initiative to improve portering efficiency and quality had been completed. The team also completed internal and external benchmarking to identify opportunities in admin and clerical, which will be tested through a new working group. The importance of this in financial improvement was noted.

9.6 CB advised that 20 priority projects had been identified with the Executives leading the projects. An update was provided in relation to this and the plan to review progress. JD provided assurances that a significant amount of improvement work is ongoing and that the important step is toward sustaining these.

9.7 SC advised interdependence, team work and consistency. He thanked the team for the significant improvement made so far.

10 Quality

10a) IQPR

10.1 The Board was asked to note the IQPR for September performance. SH noted that continued improvement is demonstrated. She noted that the HSMR data remained in line with the national benchmark, although mixed sex accommodation breaches increased slightly, this was partly due to reporting.

10.2 It was noted that the Trust's C-Diff trajectory for the quarter had been met with a total of 14 cases for the year against a trajectory of 20. It was noted that significant work led by DHF and KR is on-going to improve compliance with infection prevention practice.

10.3 An update was provided in relation to falls, complaints and Serious Incidents (SIs). These are being properly documented and monitored through directorates with training of staff and increased staff capacity. JD advised that the last performance review focused on SIs and Complaints, there was a swarm event where themes were identified and this is part of the discussion with CCG. Assurances were provided that they are routinely reviewed and not just numbers.

10b) Annual Medical Education Report

10.4 JC and CA were welcomed by Board. The paper which provided an update on medical education strategy was taken as read.

10.5 JC was pleased to inform Board that the Trust was the highest scorer for overall satisfaction in acute trusts in Kent, Surrey and Sussex in the 2017 GMC Trainee survey, with a score above the average national mean.

10.6 JC provided summaries of quality visits, the positives identified and areas for improvement. It was noted that the visit to pharmacy will be followed up. JC noted that significant work has been done in working closely with service leads, Clinical Directors and Directors of Operations, to improve patient safety and trainee experience bringing about significant progress in this area.

10.7 JC advised that another significant area of focus in the last year has been to improve induction for trainees joining the Trust. She noted that progress has also been made in obtaining oversight of the Postgraduate Medical Education (PGME) budget.

10.8 The risks identified with training and mitigations were noted. JC advised that a revised medical education strategy had been formed following further analysis identifying opportunities and difficulty , review of GMC red flags, and consultation with medical education (Local Faculty Group) leads.

10.9 There was a discussion around establishing a recognised hospital at night programme following JC's advice that medical registrars in the Trust require better support at night. It was noted that the night model will be in place with the improvement programmes.

10.10 The report was commended by Board. SC thanked JC and her team for their vigilance, hard work and for keeping up the momentum.

11 Performance

11a) Finance Report

11.1 The Board noted the report which summarised the Month 6 year to date. TC stated that capital had been a challenge but noted that some monies had started coming in from chasing aged debt.

11.2 TC noted that the year-end balance approach was agreed with the Commissioners and that this will be split. It was noted Q1 raised challenges but this is being worked through. The STF performance in Q1 and Q2 were noted as losses. In relation to capital funding, TC noted that NHSI finally agreed to provide the Trust with an additional working capital funding in the middle of November. CIP delivery is a concern but TC provided assurances that actions are already being taken to improve the delivery process.

11.3 TM noted that the financial assumption around revenue issues with the Commissioners will have to be addressed in Month 7 and advised that this will affect the figures. However, it was noted that this problem is not peculiar to

the Trust as other trusts have the same issue.. TC explained that reserves held in July are now being spent on some of the organisation's cost improvement programmes.

11.4 SC referred to the several meetings he and LD had attended with the CCG and noted their willingness to support the Trust. TC agreed that that the CCG are being supportive of the Trust and looking at ways to provide resources. It was noted that support from the regulators has kept the Trust from financial special measures.

11b) Communication Report

11.5 The Board noted the report. GA provided highlights on internal and external communications and engagement activity. GA noted that the main focus for internal communications has been on winter preparedness. The communications have supported the flu prevention programme with repeated messages urging staff to be vaccinated.

11.6 GA noted that staff are continually engaged in the Better, Best, Brilliant programme, particularly around flow and finance. In the media, GA noted that there has been a good level of positive coverage and response received toward ways of promoting improvements for patients. It was noted that effort put into social media is increasing with Twitter particularly effective concerning breast cancer.

11.7 GA noted that community engagement is going well with more contacts and useful connections. Governors continue to engage with networks across Medway and Swale; a Governor coffee morning is planned for Magpie Road, Luton on 16 November. Membership recruitment stands have been scheduled for the next few months and regenerating the membership data process is live. GA noted that a number of MP meetings are scheduled for the next few weeks to keep them informed about the progress the Trust is making.

11.8 SC commended the team for the good work being undertaken by them.

12 Governance

12a) Corporate Governance Report

12.1 The report was taken as read. KW highlighted the main points. The CQC engagement schedule for the next inspection phase was noted.

12.2 KW noted that the Human Tissue Authority (HTA) carried out an inspection of the Trust on 26 October 2017 regarding the HTA licencing framework at MFT. The inspection was successful with positive feedback received. In the course of inspection, 2 recommendations were highlighted; no concerns were raised. KW noted that the 2 recommendations had been worked on already.

12b) Health & Safety Report

12.3 The Board was asked to note the report which provided assurance on how the current framework for the management of health and safety is working to date along with a commitment to achieve the agreed deadline of 28/02/18 in the completion of the Workplace Health and Safety Standards Audit action plan.

12.4 KW advised that the audit status update as of the 19/10/17 is able to evidence the progress that has been achieved in the past seven months by either the closure of the identified risks or indeed the reduction of the risk from status red to that of amber. KW confirmed that there are no more red risks.

12.5 KW stated that in order to be compliant with Health and Safety at Work Regulations 1999, section 5 and the HSAWA section 7 and 37, the Trust is required to nominate a Non-Executive Director to scrutinize the health and safety performance. KW noted that the Trust Chairman had recently appointed AW to this role.

12c) Winter Resilience Plan

12.6 The Board was asked to note the report which assures them that the internal plans are robust. It was noted that in the preparation of the plan, resources were tested, such as, the stock holding of salt grit, the Trust's snow plough, the arrangement for mutual aid with Medway Council 4X4 response and the arrangements for using staff accommodation to retain staff on site (SOP0157).

12.7 The validation exercise stress tested the Winter Resilience Plan to ensure that it would stand up to the scrutiny of the operational staff on the subjects of norovirus, seasonal flu and high winds with snow drifts, all of which had the potential to reduce workforce.. The structured feedback confirmed it did and additionally highlighted four areas for immediate improvement. The requirement for improvement in these areas is underway and will be completed by 13 November. KW noted that the winter plan was submitted to NHSI in September following approval by LD.

12d) SIRO report incorporating the annual FOI report

12.8 The Board was asked to note the report. Whilst there is significant progress in relation to compliance, KW noted that there remains more to do on information governance. The current status of the 2017-18 information governance toolkit and proposed changes for 2018-19 were noted.

12e) Emergency Preparedness, Resilience and Response Report (EPRR)

12.9 The Board was asked to note the positive report and take assurances from the same. KW noted that the 2017 audit report revealed that the Trust is fully compliant with the core standards of self-assessment.

12.10 KW explained that NHS England undertakes annual deep dives and that the 2017 one was around governance. There was a recommendation to Board to nominate a Non-Executive Director to hold the portfolio for EPRR and attend the Trust EPRR Group. KW advised that SC had appointed TM to the role and that there was an introductory meeting with the team in the morning chaired by TM

13 People

Workforce Report

13.1 The Board was asked to note the workforce report which detailed the core workforce risks and provided assurance that robust plans are in place to mitigate and remedy these risks.

13.2 JD noted the broader workforce agenda across the hospital. There has been a focus on recruiting nurses and benefits are now seen in relation to the

European initiative. JD noted that doctors training initiative is a focus for the Trust. Re-designed roles have been launched and benefit of that is being seen.

13.3 Directorate metrics have changed but it was noted that this has no negative impact. There is greater control particularly around temporary staffing and agency cap breaches are decreasing.

13.4 There was a discussion around flu vaccination uptake and response to the staff survey which would be addressed by increasing awareness. It was noted this is the trend across the NHS and the Trust is in a better position compared to last year.

14 Corporate Safeguarding Policy

14.1 The Corporate Safeguarding Policy was presented to Board for approval. However, on discussion, the Board asked for further detail in the policy Suggestions were made by JB and LD in terms of clarity and assurance in the area of staff knowledge of their role and responsibilities.

14.2 The Board agreed that the policy should be returned for consideration.

Action: Corporate Safeguarding Policy to be represented for approval.

15 Corporate HR Policy

15.1 JD presented the policy for approval. TM raised a query in relation to the 6 month notice period for Executives. JD noted that this was consistent with NHS Executive Director's notice period requirement. TC noted that most organisations merge it downwards. It was noted that this needed to be looked into and possibly reviewed.

Action: JD to do more benchmarking in relation to notice periods for Executive Directors.

15.2 The policy was **APPROVED**.

16 Risk Appetite Statement

16.1 The Risk Appetite Statement was withdrawn as further work is required.

Action: Risk Appetite Statement to be represented for approval at a subsequent meeting

17 Quality Assurance Committee (QAC) Report

17.1 JB updated Board as new Chair of QAC. JB noted that the Committee had agreed to commence discussions on the meaning of quality. It was also noted that there was a more detailed briefing on C.Diff and MRSA outbreaks; there is a need to get a grip around antimicrobial stewardship and this message has been sent back to directorates. The Board was asked to note the key issues report from QAC.

18. **Finance Committee Report**

18.1 TM advised the Board to note the detailed report from the last Finance Committee.

19. Charitable Funds Committee Report

19.1 The Board was asked to note the statement of financial position which was presented to the last meeting of the charitable funds committee. TM advised that a charity funds manager had been appointed. The manager was said to have made significant progress looking at governance and is now working on rationalisation of funds. Progress is also being made in building of relationships. TM advised that he will be handing over as Chair to EC in the December meeting.

20. Council of Governors' Update

20.1 DK as Governor Board Representative raised the following query:

- How many patient notes are still being lost, what reasons are given for these, electronic replacement for this?

BS noted that one of the CQC actions is around monitoring of patient notes. He advised that there is a process in place for that and the same is now being monitored. It was agreed that BS should meet with DK on the issue raised and provide feedback. It was noted that one of the governors will be in attendance at the meeting.

Action- BS to meet with DK and another Governor separately on patient notes and provide feedback to Board.

20.2 SC added that the Board are aware of the issue. It was also noted that the Trust is moving gradually to the digital age.

21. AOB

21.1 SC announced that it was KW's last Board as she would be retiring. SC noted that KW was renowned for her tenacity and getting things done within time. SC thanked KW on behalf of Board for being a valuable member of staff. KW thanked everybody.

21.2 AL and KM for whom it was their last Board given the new directorate metrics/structure were also thanked for their hard work.

22. Questions from members of the public

22.1 There were no members of the public.

Date of the next Private/Public Board Thursday will be confirmed. Venue: Boardroom, Post Graduate Centre, Medway NHS Foundation Trust

The meeting closed at 5pm.

Stephen Clark: Date:
Chair

PUBLIC BOARD ACTION LOG
ITEM 06

NHS Medway NHS Foundation Trust

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB - 0392	07/09/17	16.1	Governors to be invited to participate in the organ donation group	Trust Secretary	Work in progress	Open
PUB - 0393	03/11/17	14.2	Corporate Safeguarding Policy to be represented for approval	Director of Nursing	See agenda item 14	Closed
PUB - 0394	03/11/17	15.1	JD to do more benchmarking in relation to notice periods for Executive Directors.	Executive Director of HR and OD		Open
PUB - 0395	03/11/17	16.1	Risk Appetite Statement to be represented for approval at a subsequent meeting	Director of Corporate Governance		Open
PUB - 0396	03/11/17	20.1	BS to meet with DK and another Governor separately on patient notes and provide feedback to Board.	Director of Clinical Operations – Co-ordinated Surgical		Open

Chief Executive's Report – January 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.

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

In and around Medway

Performance – Emergency Department four- hour target

Our Emergency Department has continued to be challenged, with fluctuating performance against the four-hour target, which in turn affects flow through the hospital and patient experience.

Like many other NHS trusts, we experienced an increased demand for emergency services, with those presenting of a higher acuity than usual, during, and immediately after the Christmas period. The Trust declared OPEL 4 status as a result of these challenges. We took the decision to reopen Sapphire on 27 December, as an escalation area focussed on discharge, but under strict criteria that continues to allow us space should we need it.

Our focus has been on safety and quality care, and we were in daily contact with Medway CCG, SECAMB, Kent NHS chief executives, social care, and the regional NHS Improvement team who were satisfied that we are doing everything we should be to manage this situation.

We have used our public website and social media channels to provide information to the public about the pressures on hospital, and encouraging them to consider whether ED is the most appropriate place for their care.

I would like to express my thanks to the staff who have gone above and beyond to provide safe care for our patients during this challenging time. We have seen many instances of staff taking on additional tasks, arriving early and staying late to support flow across the whole hospital; they have demonstrated the very highest levels of team-work and commitment.

Elective and day case activity

As has been widely covered in the media, Trusts have been asked to temporarily stop undertaking routine and elective inpatient and day case surgery.

Cancelling operations is absolutely not something we want to do and will always avoid where possible. We know that patients having operations are already going through a time of worry and concern and we don't want to add to that. However, taking this step has provided us with an opportunity to free up beds and reallocate staff to improve flow. We need to do this to get back to a stable position and return to business as usual as soon as possible. We are continuing to undertake surgery on urgent cases such as cancer.

Our financial position

As you will hear in the financial report, The Trust's financial situation remains a significant concern and we have a recovery plan in place with workstreams making progress to create a more stable and sustainable position.

We have secured additional senior finance resource to support a number of transformational projects which will create efficiencies without adversely affecting patient care. We are also reviewing our income as it essential that we receive payment to reflect activity both this this year and into the next.

We have begun to engage staff in the recovery plan, making sure they are aware of and understand the scale of our financial challenge and have opportunities to feed in ideas on where efficiencies can be achieved.

New organisational structures

I have recently introduced a new organisational structure for the Trust which goes some way to making Medway a genuinely clinically-led organisation. When we set up the previous directorate and programme structures, I had always intended to review them at a point in time, and coming out of special measures gave us that opportunity to pause and reassess whether our structures truly allowed us to become 'brilliant' and embed the principle of decisions being made closer to where care is provided.

Starting with the executive structure, we reviewed posts when people left us, and in some cases decided not to recruit to the role and instead distribute the work of that person among the remaining team, and widen portfolios.

This same principle was applied at directorate level, where, in November 2017, we moved from a three directorate model, to two directorates – namely Planned Care, and Unplanned and Integrated Care – and again in December 2017 when we completed the changes to the programme level triumvirate structure where we have moved from 13 programmes, to six.

Each of the Directorates is led by a triumvirate leadership team consisting of a Director of Clinical Operations, a Deputy Director of Nursing and a Deputy Medical Director. Each of the programmes retains a triumvirate model, but is now led by a Clinical Co-Director (doctor), a Clinical Co-Director (nurse) and a Head of Operational Performance.

I have also reviewed our executive structure and I am delighted to say that James Devine has agreed to be the Deputy Chief Executive. James started his career at Medway and along with the other executive members has been the driving force behind our ***Better, Best, Brilliant*** improvement programme. James retains his role as Executive Director of HR and Organisational Development.

Best Choices scheme

We are running a Best Choices scheme, like the one we ran last year, as part of the current focus on cost reduction and service redesign – ie 'best sizing' the organisation and making sure we have the right people in the right roles for the future.

Last year some staff took advantage of the scheme in line with their personal objectives, and we recognise that once again staff may welcome an opportunity to review their current working arrangements.

The Best Choices Scheme allows individuals to pursue one of four options: mutually agreed resignation (with severance pay), career break, retirement, or flexible working.

Participation in this scheme is entirely voluntary from both the Trust's and employee's point of view. The closing date is 2 February.

Unite Ballot

You may be aware that before Christmas the Unite union was balloting its members working in the theatres department about potential strike action. This was in relation to changes to the rostering of theatre staff to improve how we care for patients and their safety, as well as staff wellbeing.

We want to make sure that we make the most of our operating theatres, and by moving to the new rota system we will be able to work more efficiently. We know that our patients want to be seen and treated as soon as possible, and by making our staffing more efficient we will be able to conduct more procedures, which means more people being treated earlier.

When the ballot closed in December fewer than 50 per cent of members had voted and the ballot was therefore declared invalid. We will continue to hold discussions with the union to resolve outstanding concerns. Meanwhile the new rosters were introduced some weeks ago.

Community Services

Medway Clinical Commissioning Group is undertaking a review and redesign of adult community health services. Clinical and non-clinical representatives from the Trust have been involved in the redesign, attending workshops on the subject and contributing to an engagement exercise.

The new service will be closely linked to the Medway Model, the CCG's way of joining up local services to deliver care closer to people's homes and involve them in maintaining their own health and wellbeing.

The contract for delivering community health services is due to be awarded in September 2019 and will be in place from April 2020.

Medway Leadership Programme

I was pleased to attend a reception at the House of Commons along with a handful of Trust staff, celebrating the conclusion of this year's Medway Leadership Programme. New candidates were also welcomed at the evening, not just from the Trust but from health and other public sector organisations across Medway.

It was good to be able to celebrate this joint leadership development programme, which both inspires leaders to meet the challenges we face, and equips them to provide direction to our staff day-to-day.

NHS70

In July this year we will be celebrating the 70th anniversary of the formation of the NHS. We are currently planning how to mark this significant anniversary.

Beyond Medway

East Kent update

A joint committee of the four east Kent CCGs has announced that two options for the future of A&E services will be considered following an offer from a developer to build the shell of a new hospital in return for planning permission for 2,000 homes.

The possibility of a major hospital in Canterbury is a new option. Previously discussions had focused on the future of the QEQM at Margate and William Harvey at Ashford as the A&Es for east Kent.

The commissioners are also looking at six options for inpatient orthopaedic care in east Kent.

New faces

Dr Anne Rainsberry, the former regional director of NHS London, has been brought in by NHS England to head up operations across the East Kent area. Dr Rainsberry has been engaged through consultants Carnall Farrar, who have also been involved in the Kent and Medway STP. She will work across the whole NHS system in East Kent. At East Kent Hospitals she will work closely with Susan Acott who is the interim chief executive, and interim chair Peter Carter, through to the end of March.

Meanwhile, Miles Scott has been announced as chief executive of Maidstone and Tunbridge Wells NHS Trust. He is the former chief executive of St George's University Hospitals FT in London, and takes up his post this month. Mr Scott has recently led an ambulance improvement programme for NHS Improvement, but is most widely known for the five years he spent at St George's until April 2016.

Citizens' Rights Agreement

This has been a period of uncertainty for our EU staff and I am pleased an agreement has been reached which means that EU citizens living lawfully in the UK and UK nationals living lawfully in the EU by 29 March 2019, will be able to stay and enjoy broadly the same rights and benefits as they do now.

This agreement also provides certainty on healthcare, pensions and other benefits. It will mean that EU citizens who have paid into the UK system can benefit from what they've already put in and continue to benefit from existing coordination rules for future contributions. Those covered by the agreement will be able to continue to receive healthcare as they do now.

We have taken care to keep our staff updated on this aspect of the Brexit negotiations, as we know uncertainty about the future has been a cause of concern for our staff from the EU.

CQC inspections extended

For the first time, all healthcare organisations in England that offer regulated care are to be rated by the Care Quality Commission. Organisations will have to display their inspection ratings so patients can clearly see safety standards.

The CQC's current ratings programme – which covers hospital care, social care and GPs – will be extended to include more than 800 additional providers. This includes independent doctors that offer primary care online.

The CQC will require providers affected by these changes to publicly display their rating, for instance on their website or business premises. This will allow patients to make an informed choice when deciding which care service they want to use. The ratings scheme has been 'future-proofed' to cover services that may develop in the future.

The changes will bring the services in line with the rest of the NHS. It will reassure patients who use digital GP apps provided by independent doctors about the quality and safety of the service they are choosing.

NHS workforce strategy

Facing the Facts, Shaping the Future, A health and care workforce strategy for England to 2027 is a whole national system consultation document, produced by Health Education England with content from NHS England, NHS Improvement, Public Health England, the Care Quality Commission, National Institute for Clinical Excellence and Department of Health. This document is a draft, with the final version due to be published to coincide with the anniversary of the NHS in July.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 18/01/2018

Agenda item 9a

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	The Improvement Plan 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** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 The STP continues to make progress, both at a Medway, North and West Kent level, and across the wider Kent and Medway footprint.

1.2 In particular the development of the clinical strategy, a key piece of work in relation to the future provision of healthcare, is now moving forward.

1.3 Consultation on stroke services will take place over the coming months following a long period of review and engagement.

2 CLINICAL STRATEGY

2.1 The Clinical and Professional Board is creating a Clinical Strategy. In the past few months, there has been significant work completed by the Public Health teams to revise and refresh the Case for Change.

2.2 Additional information has been included to strengthen the Case for Change, and a new section has been added dedicated to children and young people.

2.3 A strapline 'Quality of Life, Quality of Care' has been agreed.

2.4 A draft Clinical Vision, that addresses the Case for Change, has also been written.

2.5 In the development of the Clinical Strategy, a number of care models will need to be created. Care models that address all areas in the population needs assessment will collectively form a holistic clinical strategy. Some of these are already in place, while others are being developed.

2.6 Thorough engagement with a wide group, including clinicians as well as patients, will be needed to agree the care models.

2.7 Priorities for the care models are: urgent and emergency care, children and young people, mental health, cancer and prevention.

3 STROKE REVIEW

3.1 A review of stroke services across Kent and Medway has taken place over a long period, acknowledging that none of the seven sites currently providing stroke services meets the required national standards.

3.2 Public engagement has been a key part of the review, with stroke patients broadly in support of proposals to move from the existing provision of seven units to three highly-specialist units.

3.3 A longlist of options was reduced to four, each including three sites, as a result of a robust process. A fifth option has recently been added following further analysis of data.

3.4 In addition to wide public engagement, the stroke review has been discussed by a Joint Health Overview and Scrutiny Committee on several occasions.

3.5 Full public consultation is expected to take place from early February 2018.

4 THE WIDER PICTURE IN KENT AND MEDWAY

4.1 The Medway, North and West Kent Delivery Board is now well established, and has decided that cancer, elective care, diagnostics (including endoscopy, CT, MRI), specialist care in cardiology, neurology and dementia, and services for children and families, should be early clinical priorities for the delivery programme. Development of local care, and improving stroke services, are other priority areas where work is already taking place.

4.2 An East Kent programme has been established for considerably longer, and engagement with public and patients has taken place about the future delivery of hospital services.

4.3 A model for hospital care consisting of a Major Emergency Centre with Specialist Services, an Emergency Centre and a Medical Emergency Centre has been developed. More recently a second option has been added following the offer from a developer of a new hospital building in Canterbury. This has been widely publicised, although the detail is yet to be worked up.

Report to the Board of Directors

Board Date: 18/01/2018 Agenda item: 9b

Title of Report	Better, Better, Best, Brilliant – Our Trust Improvement Programme
Prepared By:	James Devine, Executive Director of HR&OD and Improvement
Lead Director	Lesley Dwyer, CEO
Committees or Groups who have considered this report	Executive Group
Executive Summary	The third delivery sprint started on 8th January 2018 following on from good work from the first two sprints. The financial position remains a significant challenge and opportunities have been identified to improve both operational efficiency and patient care and experience, which need to be implemented. A number of projects have been identified as priorities which will report into the PRM. Over the next three weeks the focus will be on priority areas of the strategy. A service improvement team has been created.
Resource Implications	As outlined in the presentation.
Risk and Assurance	There are regulatory risks associated with both the four hour ED target, and finance.
Legal Implications/Regulatory Requirements	As above
Improvement Plan Implication	Flow and Financial Recovery are two components of the Better Best Brilliant Improvement programme.

Report to the Board of Directors

Quality Impact Assessment	All actions continue to follow an appropriate QIA process			
Recommendation	**The Board is asked to note the progress made in the report and the further work required.**			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☐	☒	☐	☐

Better, Best, Brilliant

Our improvement programme

Board Update 8th January 2018

Best of care
Best of people

NHS
Medway
NHS Foundation Trust

The third Delivery Sprint started on 8th January and builds upon the good work from the first two sprints to ensure that we deliver impact

1. Our financial position is a significant challenge and we must ensure that these projects deliver savings

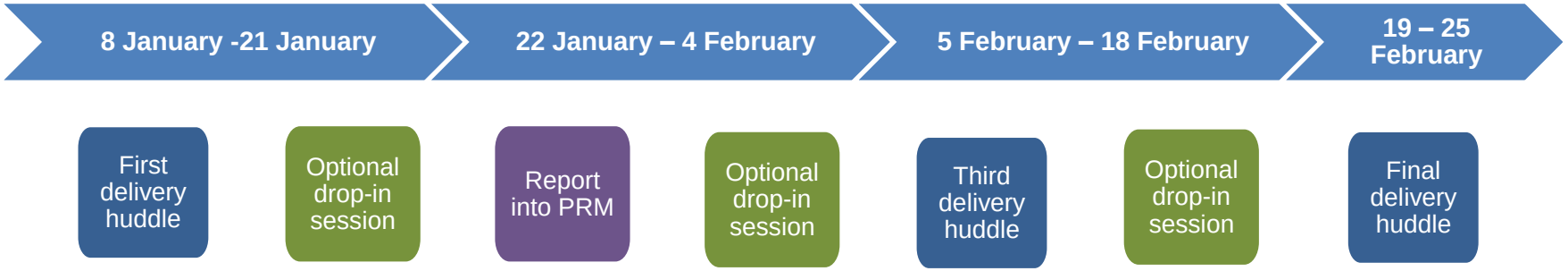
2. We have identified **opportunities to improve both operational efficiency and patient care and experience** and we need to implement these to achieve 'Best of care' and 'Best of people'
   a) For example, the pharmacy and radiology projects will support improved patient flow
   b) The theatres projects will support improved patient experience through reducing waits

The following projects have been identified as priorities for the Delivery Sprint and assigned an SRO

#	Project Name	Project Lead	SRO
1	**Theatres: start and finish times**	Michael Hepworth	Jerome Lim
2	**Theatres: Increasing knife to skin time**	Michael Hepworth	Jerome Lim
3	**Theatres: Pre-op assessment**	Michael Hepworth & Belinda Stringer	Jerome Lim
4	**Theatres: Benchmarking staff**	Victoria Wilton-Oluwole	Jerome Lim
5	**Theatres: Scheduling**	Michael Hepworth	Jerome Lim
6	**Women's case type mix**	Benn Best	Richard Patey
7	**Reduce outsourcing**	Michael Hepworth	Ben Stevens
8	**Outpatient utilisation**	Michael Hepworth	Ben Stevens
9	**Correct ratio of first to follow ups**	Jill Lane & Steph Parrick	Ben Stevens & James Lowell
10	**TTOs dispensing from discharge lounge**	Busola Ade-Ojo	James Lowell
11	**Remove FP10s**	Busola Ade-Ojo	James Lowell
12	**Radiology strategy refresh**	Maadh Aldouri, Ray Davey & 2020	David Sulch
13	**Radiology outsourcing**	Zita Varga & Ray Davey	David Sulch
14	**Admin & clerical - ward clerks**	Leon Hinton	James Devine
15	**Sewing room**	Laura Smith	Tracey Cotterill
16	**Catering**	Laura Smith	Tracey Cotterill

To ensure delivery, sprint governance will consist of alternating weekly huddles and drop-in sessions. Projects will report into PRM

GOVERNANCE FOR THE SIX WEEK SPRINT



Delivery huddles	• 16 projects report into the huddle at one of three 15 minute slots to agree next steps and access senior support to unblock issues
Optional drop-in session	• Optional drop-in session with 2020 Delivery and Tracey Cotterill • Projects behind plan are expected to attend
Report into PRM	• Projects will report into PRM to ensure projects are held accountable for delivering against plans

We're focusing on four main areas of Theatre in this delivery sprint

1. Increasing **knife to skin time** to 65% across theatres
   - Start and finish times
   - Turnaround time between patients

- Each of these will increase knife to skin time, and deliver **higher quality patient care,** a **better working environment for staff,** and enable a **financially sustainable** position for theatres
- **Turnaround time** will take place by **PDSA** cycles in theatre 4 initially, to iterate and test to the most efficient process
- This can then be standardised and rolled out to other theatres

2. Designing a **new pre-assessment pathway** to reduce the number of DNAs, face to face appointments, and to improve the quality of patient care
3. **Benchmarking** of theatre nursing staff to identify opportunities and optimal staffing and skill mix
4. Improving **scheduling** of theatre lists
   - Reducing number of dropped lists
   - Within list scheduling effectively

- **Weekly working groups** have been set up across knife to skin time, pre-assessment pathway and scheduling to ensure that there is engagement across and expertise drawn from both **clinical and non-clinical staff**, and to enable a group of people who can deliver and ensure implementation

The pre-assessment working group has moved through current state analysis and quick wins, to designing a new future pathway

1. **The current pathway and quick wins**
   - Analysed current problems and pain points: high DNAs, patient database, higher use of anaesthetists time compared to other trusts, all patients pre-assessed no matter on requirement
   - Identified quick wins and implementing
     - **Text messages to patients** to attend pre-assessment
     - Communication regarding resolving patient duplication in the database

2. **Designed the future model**
   - Agreed criteria the model will be assessed against
   - Considered **external best practice and digital innovation**
   - **Created future design** and identified stages for phased implementation
   - Detailed the components of the pathway
   - **Identified which patients require which category of pre-assessment**
   - Designed patient questionnaire and contract
   - Liaised with other key team members e.g. outpatients, dietetics etc

The radiology strategy refresh undertaken through the delivery sprint is built on 5 key elements

1. **Scanning and reporting capacity is sourced at the best value available**
    - Internal scanning and reporting capacity is maximised to ensure demand is met at the lowest possible cost, with outsourcing only where cost effective
    - Outsourced MRI scanning is brought in-house to save £0.4-£0.8m pa
    - Outsourced overnight reporting is delivered cheaply through the East of England framework to save £90k with no change to service provision
2. **Equipment is up to date and configured to deliver high quality care efficiently**
    - A number of existing analogue x-ray machines are replaced with digital x-ray machines to reduce cycle times with potential to reduce the significant bank spend on Radiographers and save £8m over 10 years with a 2.8:1 ROI
    - Further analysis will be required to determine the need for equipment upgrades in nuclear medicine and mammography
3. **Medway has an effectively sized and skilled workforce**
    - Radiographers are highly trained with potential for career advancement, including in chest x-ray reporting
    - The admin & clerical workforce is appropriately sized and skilled with the reception estate configured to allow consolidation of x-ray, ultrasound and MRI reception desks
    - High levels of consultant radiologist reporting productivity are consistently maintained
4. **Demand is managed through suitable vetting procedures** where electronic referral and auto-vetting prevent inappropriate requests
    - eReferral, auto-vetting and auto-protocolling can prevent inappropriate requests
5. **Processes are standardised and efficient**
    - Standardised patient self-preparation with on-the-day preparation areas will improve scanning productivity, avoiding future costs associated with growth in demand
    - eReferral can avoid inappropriate patient attendances and wasted admin & clerical time.

Over the next 3 weeks we will focus on priority areas of the strategy: identifying operational improvements, developing business cases for digitising x-ray and economic investment of MRI scanning and supporting analysis on out-of-hours reporting

8 -14 January	15 – 22 January	23 – 28 January

Operational efficiency and investment: led by 2020

Identifying operational improvements in CT, MRI, x-ray and DEXA

RIS data analysis	Observations	Identifying operational improvements

Developing financial case for investment into digitising x-ray

Structure business case	Gather evidence	Synthesis narrative

Developing financial case for economic investment of MRI scanner

Structure business case	Gather evidence	Synthesis narrative

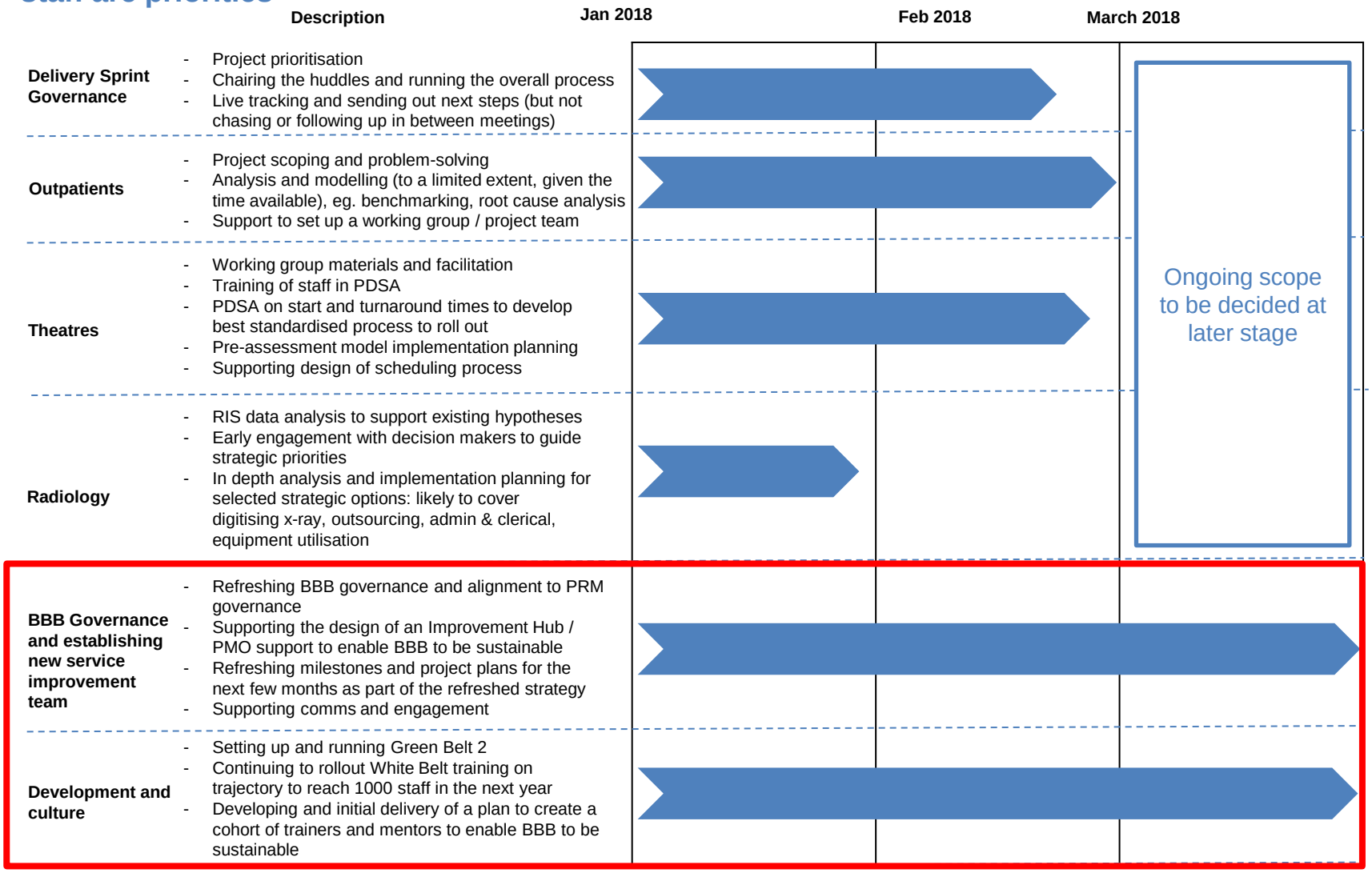
Financial controls: led by Ray Davey

Contracting, service level agreements & recharges; budget & spend analysis (including MIUs); WTE costs

Out-of-hours reporting outsourcing: procurement supported by 2020

East of England framework entered into for out-of-hours reporting outsourcing

In addition to sprint delivery, creation of a Service Improvement Team and continued training of Trust staff are priorities



NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 19/01/2018 Agenda item 10a

Title of Report	Integrated Quality Performance Dashboard – November
Prepared By:	BI Team, Operational Leads
Lead Director	Executive Team
Committees or Groups who have considered this report	Draft to Quality Assurance Committee Draft to Quality Improvement Committee

Executive Summary	To inform Board Members in the form of a flash report of November's performance across key performance indicators.
	
	Key points are:
	
	• The Trust did not achieve the **four hour ED target** for November but performance has improved from 86.93% in October to 90.45% in November.
	  ○ Non-compliance of the target is primarily through lack of internal flow from the main bed base to discharge.
	  ○ The drivers for delays in the time of day for discharge alongside delays in actual discharge are multifactorial and span the entire continuum both internal and external to the Trust.
	  ○ There was a 1.28% decrease in total attendances but the flow out of ED remained challenged.
	  ○ Ambulance arrivals in November have increased by 1.43% compared to October.
	  ○ Bed occupancy has increased at 97.58% for November compared to 94.43% in October.
	
	• There were no **12 hour breaches** in November.
	  •
	• **HSMR** data reported is for the period from September 2016 to August 2017. This is currently 101.05, which is within expected range.
	
	• This month saw an 28.13% decrease in the number of **Mixed Sex Accommodation** breaches, which totalled 46 in

	November. • **RTT** performance has slightly decreased to 81.76% from 83.32 %. This is below the national standard of 92%, as well as the agreed 85% trajectory. • The 62-day **Cancer target** for GP performance was not achieved in October, but has increased by 2.71% to 75.00%. This was predominantly due to complex pathways, patient choice, Imaging delays and tertiary referral delays. • • There was a 12.7% increase in the number of **falls** in November (71) when compared to October (63). • 62 complaints were reported in month, an increase on October's 74. The number of complaint returners has decreased to 2 from 3 in the previous month.
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	N/A
Recommendation	N/A
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

NHS Medway NHS Foundation Trust

Integrated Quality and Performance Report

December 2017

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

Best of care
Best of people

Contents

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

Best of care
Best of people

10205 Patients visited our ED , which is a **1.3% decrease** on the previous month, with **90.45%** seen within 4 hours, compared to 86.93% . **2086** Patients were admitted, with an **decrease** in conversion rate of **20.44%** compared to 24.04% in October.

There were **5994** total patient admissions in November, and **5553** patients were discharged.

Bed Occupancy **increased** by **3.15%** in November to **97.58%**.

3402 patients arrived at ED via ambulance which is a **1.43% increase** on last month.

38.7% Of ambulance patients were seen in under 15 minutes.

November's Story....

424 Babies were delivered in the month of November (9 less than October) with Emergency C-Section rate with a **decrease** of **2.69%** from the previous month to **15.09%.**

HSMR is **101.05** and within expected parameters (95.31 – 107.04) compared to 99.86 as reported in October.

81% of staff have had an appraisal compared to **82%** in October.

26702 Patients attended an outpatient appointment with **8.76%** DNA rate which is a decrease of **0.20%** on last month.

There were **71** total falls in November, compared to **63** in October.

RTT Overall Incomplete Pathways for November was **81.76%** which decreased by **1.56%** on previous month. This is below the Trust improvement trajectory. The Trust also reported **8 x 52** week waiters which decreased by **7** compared to October.

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

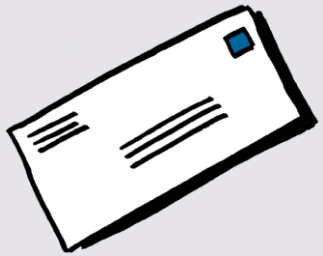
2 Week Wait symptomatic breast was above the target of **93%** in October with performance of **96.67%** - improved by 3.71%.

2 Week Wait cancer performance for October was **95.28%** (reported one month in arrears) . This is a **3.65%** increase from September's performance.

November's Performance....

96.91% of patients waited under 6 weeks for diagnostic tests in the month of November, which has deteriorated by **0.45%** since October's reported performance.

We received **62** complaints in November, decreasing from those received in October by **12**. The number of complaint returners decreased to **2** in November.



There were **46** Mixed Sex Accommodation breaches in November which is an **28.13%** decrease on October's performance.

Safe Page 17

Legend: Compliant with target; Breaching target

- **Infection Control**

MRSA bacteraemia Trust-attributable

- There was one case in November; the fourth case attributed to Keats ward to-date. This was due to a contaminant.
- Lessons learned have been identified from the post infection review and an action plan developed to deliver improved compliance with the Saving Lives High Impact interventions.

C Diff post 72 hours

- One post 72-hour case in November, attributed to Will Adams ward.
- Post-infection review considered this to be an avoidable infection and a level 3 lapse of care due to inappropriate antimicrobial prescribing and poor antimicrobial stewardship.

Serious Incidents

- As at 30th November there are a total of 139 open Serious Incidents (SIs) including SIs that are subject to an active investigation (77), SIs that have been submitted for review at the CCG SI Closure Panel and referred back to the Trust for further information (1) and SI investigations that have been completed and are awaiting review at a forthcoming CCG SI Closure Panel (61).

- 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 November is 40% against a YTD average of 31%.
  - Submit a 72 hour report to the Clinical Commissioning Group (CCG) within 3 working days of the SI being reported. Trust wide compliance for is 100% against a YTD average of 59%.
  - Submit 100% of all serious incident final reports to the CCG within 60 working days. Trust wide compliance for November is 31% against a YTD average of 25%.

- **Never Events**

The organisation has reported two never events during November 2017, the details are as follows:

- 2017/26981 - A Never Event with the classification of misplaced nasogastric tube was identified on 1 November and reported on 2 November 2017. The incident has been escalated as a serious incident within the required timeframes and is currently subject to an RCA investigation.
- 2017/28242 - A Never Event with the classification of overdose of insulin due to use of incorrect device was identified and reported on 10 November 2017. A Patient Safety Alert has been issued to staff via the Trust global communication system. The incident has also been escalated as a serious incident and is currently subject to an RCA investigation.

NICE Technology Appraisals (TA)
There were 9 TAs published in November 2017, of which 1 was assessed as not applicable to the Trust. The remaining 8 relate to Cancer Services, Rheumatology and Ophthalmology. 3 TAs have been assessed, with 3 to be assessed by 31 January 2018 and 2 be assessed by 5 February 2018 (the 90 day standard deadline).

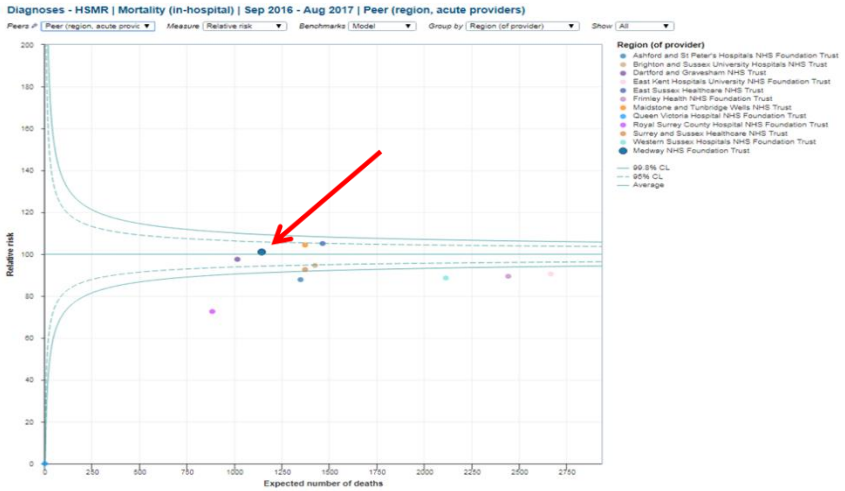
NICE Clinical Guidelines (CG)
There were 7 CGs published in November 2017, of which 3 were assessed as not applicable to the Trust. The remaining 4 relate to Pathology, Trauma & Orthopaedics and Gynaecology. 1 is to be assessed by 31 January 2018 and 3 by 13 February 2018 (the 90 day standard deadline).

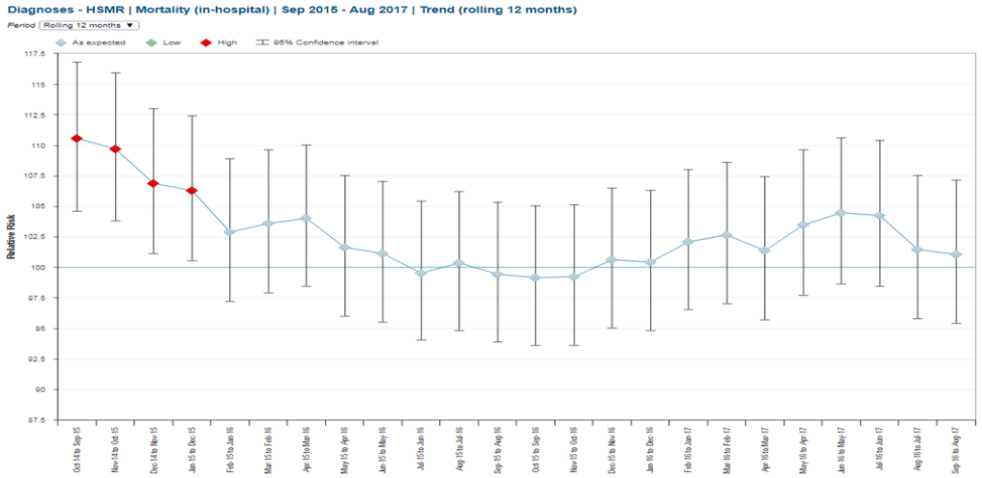
NICE Quality Standards (QS)
There was 1 QS published in November 2017, relating to Ophthalmology and is to be assessed by 31 January 2018 (the 90 day standard deadline).

Other news
A new process for the review of NICE guidelines has been implemented, with set escalation deadlines. This is designed to support the directorates and specialty leads in completing reviews of guidelines. Since April 2017, 147 guidelines have been published by NICE, 80 of which are applicable to the Trust. 58 (73%) have been reviewed, 55 (95%) within 90 days. Of the remaining 22 guidelines awaiting review, 17 remain within their 90 days of publication, and these continue to be escalated to the individual clinicians, specialty leads, governance teams and Directorates.

Mortality

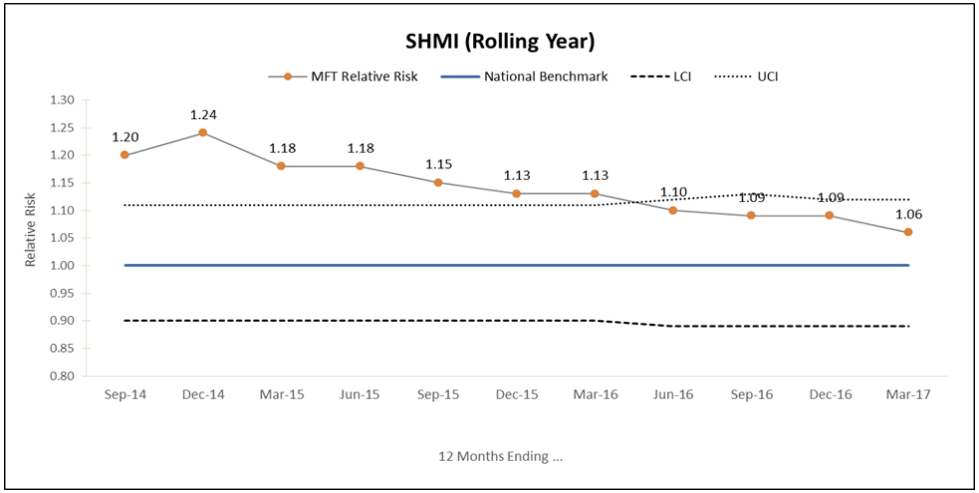
The Hospital Standardised Mortality Ratio (HSMR) is currently 101.05 (for the period from September 2016 to August 2017) which is in line with the national benchmark (100). The current peer comparison and rolling HSMR trend are demonstrated in the following graphs.



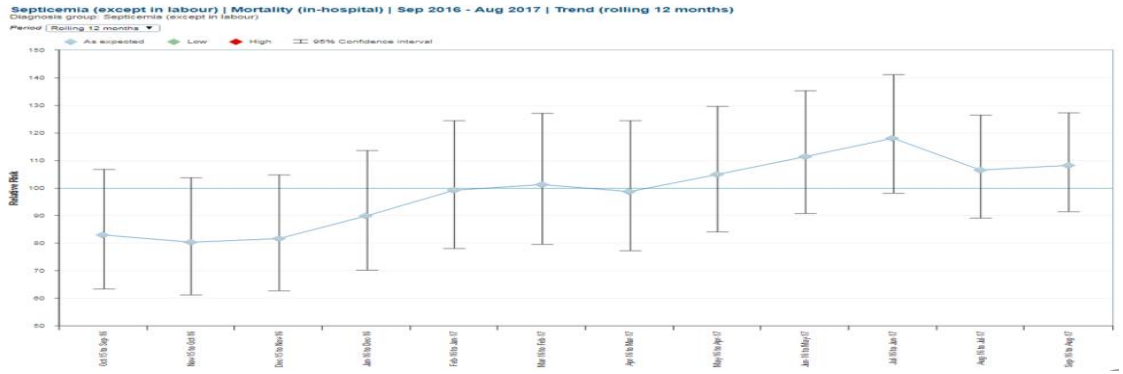


The latest SHMI value for the period April 2016 – March 2017 was published on Thursday 21 September 2017. The value has decreased from 1.09 in December 2016 to 1.06 in March 2017. The SHMI continues to remain within the expected range.

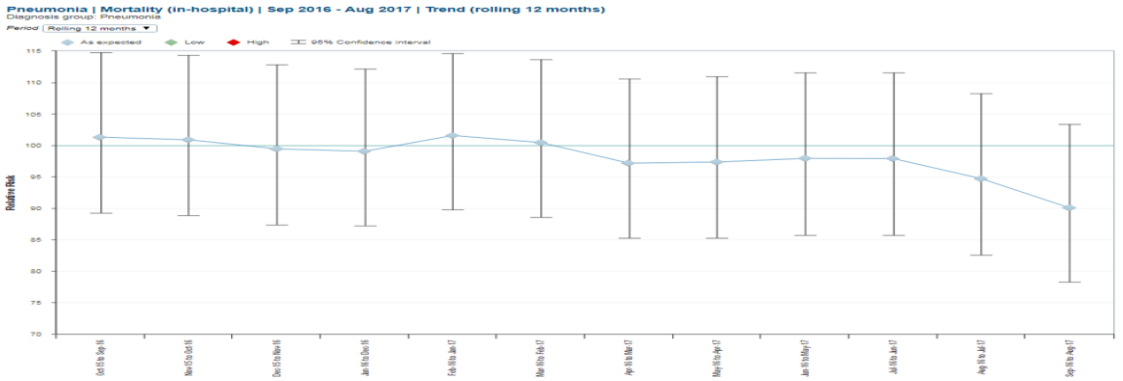
The rolling year trend is illustrated on the right.



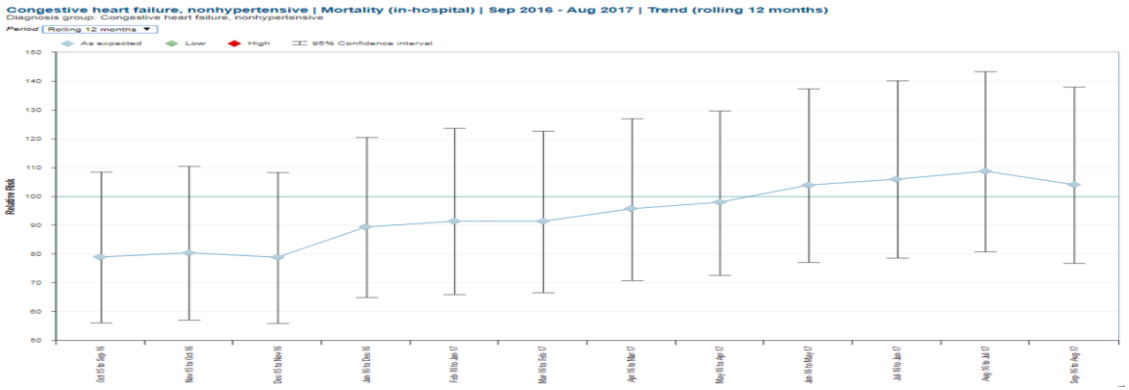
The HSMR for Septicaemia has increased slightly and is currently 108.74, which is within the expected range.



The HSMR for Pneumonia remains below the national benchmark (100) at 90.25.



The HSMR for Congestive Cardiac Failure is currently 104.00, which is well within the expected range.

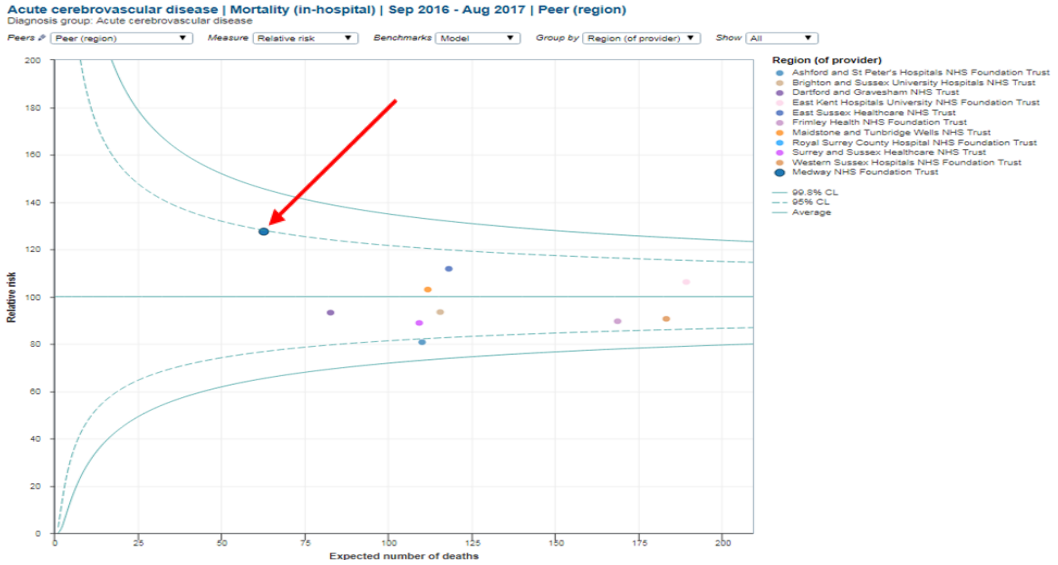


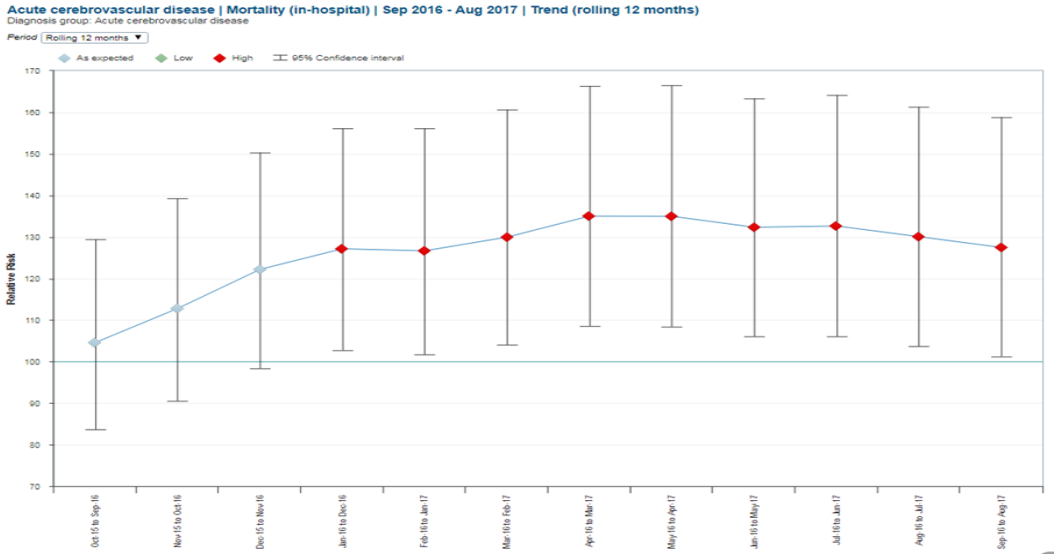
The HSMR for Acute Cerebrovascular Disease has decreased slightly, but remains slightly above the expected range at 127.47. The current peer comparison and rolling trend for this diagnosis group are demonstrated by the graphs.

A clinical audit is currently being undertaken by Dr Richard Leach (Associate Medical Director – Clinical Effectiveness and Research) and Dr Sanmuganathan (Stroke Lead). Findings will be presented at the next Trust M&M meeting to be held on Friday 15 December 2017.

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

The data is correct at the time of compilation – Friday, 1 December 2017.





Effective Page 22

CQUIN – currently showing latest quarter 2 position. The Trust is awaiting signed-off update.

Caring Page 23

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

This month saw an 28.13% decrease in the number of **Mixed Sex Accommodation** breaches, which totalled 46 in November.

The NHS South MSA project group has circulated revised MSA guidance which the Trust is currently reviewing . It is expected revised reporting methodology will be implemented from February 2018.

Responsive Page 24

- **RTT**

The RTT deteriorated slightly to 81.8% and the weekly trend for December appears to be about the same. The overall incomplete waiting list size has reduced by 342 but the number of patients passed 18 weeks has increased by 270 compared to October.

The change in performance relates primarily to 4 specialties: Trauma & Orthopaedics, General Medicine, Cardiology and Dermatology.

Dermatology is the specialty of most concern, accounting 67% of the increase in number of patients waiting longer than 18 weeks.

Recovery plans are being developed for each of the specialties.

The number of patients waiting greater than 52 weeks for treatment in November was 8, a reduction of 7 from October.

The impact of the cancellations for January of both routine elective inpatient and day case work as well as some outpatient work will be significant and will take some time to recover from.

Cancer

October performance against the cancer waiting time standards has improved on last month with compliant performance against all the standards with exception of the 62 day GP referral standard. The 62 day GP referral performance is non-compliant against the 85% standard and improvement trajectory.

- **2WW** - The Trust is compliant with the GP 2-week wait and symptomatic breast standards.
  - There were 60 breaches in October across a number of tumour sites but only Children (Skin), Head & Neck and Skin were non-compliant.
  - Breaches were predominantly as a result of patients being unavailable for the first OPA or rescheduling booked appointments.
  - 29 out of the 35 2-week wait breaches were booked within the target 48 hours from receipt of referral.

- **31D** – The Trust is compliant with the first definitive, subsequent drug and subsequent surgery treatments.
  - There were no breaches against any of the 31 day standards.

- **62D** - The Trust failed to achieve compliance with the GP 62-day GP referral standard but was compliant with the 62 day screening standard.
  - The 62-day GP standard performance was 75.00%, failing both the 85% standard and the improvement trajectory.
  - The shadow 38-day reporting performance was slightly improved at 73.21% against the 62-day GP standard.
  - There were 14 breaches against the 62-day GP referral standard, an reduction on September's breaches. These are detailed as 3 Breast, 1 Gynaecology, 1.5 Lower GI, 1.5 Upper GI and 5.5 Urology patients.
  - Pathway breaches were varied due to complex pathways, patient choice, Imaging delays and tertiary referral delays.
  - Although breaches were significantly lower than September, the total number of treated patients was also lower, specially in Skin, which has adversely affected overall performance against the standard.
  - There were 5.5 breaches over 104 days and 7 breaches between 62 and 76 days.
  - The Trust held a Cancer Summit on 14th December, with Clinical Leads presenting performance improvement plans and internal timed pathways which will support a revised CWT improvement trajectory. Additional Cancer Business informatics and management support has also been implemented.

Month	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
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%
Trajectory	82.0%	83.5%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%
Actual	84.7%	74.24%	80.00%	82.07%	80.11%	72.29%	75.00%					

- **Diagnostics**

  - The Diagnostic performance for October continues to improve but is still below the standard and improvement trajectory at 3.09% (96.91%).
  - The diagnostic waiting list backlog continues to reduce.

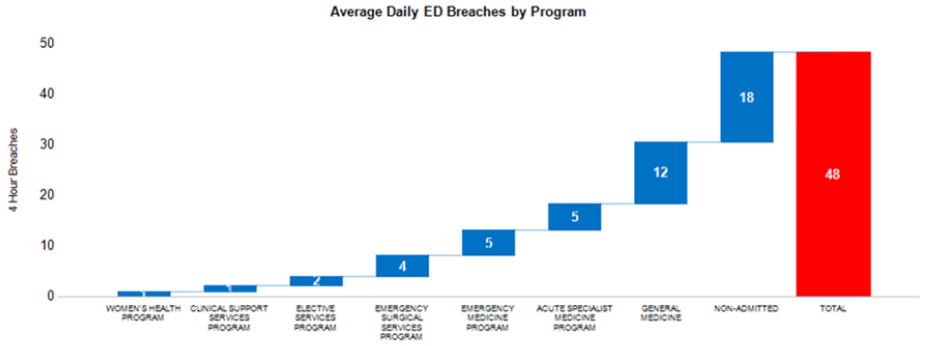
Diagnostic 6 Week Waiting Time Performnance Summary												
Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Standard	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%
	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Trajectory	92.10%	93.20%	94.40%	95.60%	96.80%	98.00%	99.20%	99.80%	99.80%	99.80%	99.80%	99.80%
Actual	95.16%	96.53%	96.13%	97.79%	95.09%	96.17%	97.36%	96.91%				
	4.84%	3.47%	3.87%	2.21%	4.91%	3.83%	2.64%	3.09%				

- **ED**

The Trust's performance against the national 4 hour standard for November was 90.45%, October was 86.92%, September was 83.78%.

November saw a 3.52% uplift in 4 hour performance on October and was 4.55% below planned trajectory of 95% for the month.

Reduction in performance for October is primarily through lack of internal flow from the main bed base to discharge. The trust observed an average of 44 4hour breaches each day, an improvement of 3, the majority of which are within Medicines and due to bed availability.



- **ED (cont'd)**

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

With a 1.28% decrease in total attendances, flow out of the ED remained challenged.

Admitted 4 hour performance for October was 61.55%, an drop of 0.66% on the previous month and the Non-admitted pathway was 93.52%, an increase on October's 92.43%. Minors and ED paediatrics both performed above 98%.

MFT remains consistently one of the top performers' in the region for ambulance handover with 38.7% of offloads within 15 minutes, seeing the largest number of conveyances in the region (3402).

November saw the continuance of the Better, Best, Brilliant (BBB) Flow workstream. The BBB work continued to focus on Delayed Transfers of Care reduction with a sector wide executive level daily teleconference being instigated. The November DToC position was 1.1% which is a significant improvement when compared to 8.5% in November 2016. This is a crucial part of the trusts winter preparations.

November also saw the continuation of the "Winter Preparedness, Director on call (DoC) escalation and teleconference" which better supported patients flow into the evening and night time.

Agreed board round standard operating procedure aimed at ensuring consistent and transparent standards of board round with a focus on SAFER bundle and ensuring all patients have clear plans, accountability for actions and discharge is progressed.

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

Pharmacy have commenced a phased roll out of dispensing carts in the discharge lounge & short stay wards to further target delays in discharge due to medication dispensing. The goal is to move this throughout the trust and include patients being discharged within 24 hours.

The SAFER care bundle and a reduction in the stranded patient rate continues to be a key focus for improving bed availability in November with an aim to reduce bed occupancy going into December.

As part of the trusts winter resilience work, November also saw the final stage planning for ensuring that the expansion of the medical assessment unit and opening of the winter escalation ward would be ready as planned in December 2017.

Well Led Page 25

Voluntary turnover (across all staff groups) has increased to 11.2% (+0.7%) based on smaller intakes of staff November 2017 and remains above the tolerance level of 8%; turnover is expected to plateau in December 2018 and then begin to decrease. Sickness absence at 3.76% remains largely static and remains below the tolerance level of 4%. Ratios of long-terms sickness to short-term sickness remain largely static.

In November, the Trust saw a net decrease in staffing (fewer starters than leavers) by 29 FTE. The number of leavers remains below the year to date average. Administrative and clerical were the largest leaver group (17 individuals) followed by nursing (11 individuals).

Temporary staff (as a percentage of the Trust's pay bill) has continued to reduce slightly by 1.8% to 18.5% from October to November. Plans continue to be implemented to further reduce our agency expenditure and support staff in moving from temporary to substantive posts and working with agency suppliers across Kent.

Enablers Page 26

Data Quality Validation Update

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

Existing work projects:

- **Cancer PTL Open Pathways update:** the DQ Team continues to support investigations into open cancer pathways on the Infoflex system pre 2015 period. The purpose of the project has been to close historic open pathways in preparation of a new InfoFlex system upgrade in 2018. Since the data validation project commenced in November 2017, the Team have investigated 4130 of 5937 records covering the Breast, Head & Neck and Lower GI tumour groups and successfully closed 3546 open patient pathways.

- **E-referral bookings:** DQ team are assisting the e-referral project team, to identify potential data quality issues that might affect the changeover to complete e-referral booking system. Potential issues such as incorrect outcome linking, how information is displayed on the PAS system, are just a couple of identified quality issues.

Data Quality Training

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

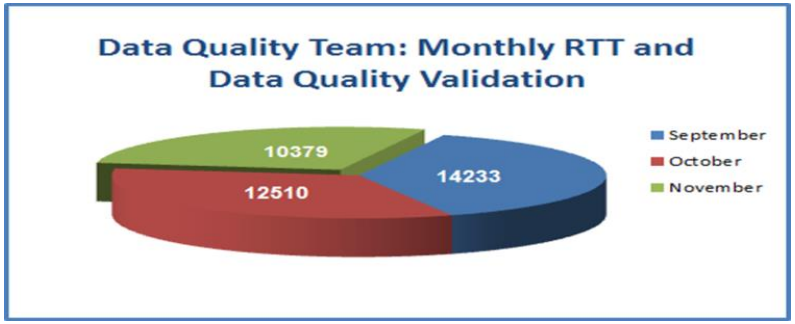
- RTT Decision Making and Review List: the training sessions continue to support operational staff's management of data entry on the PAS system.
- Cancer Information System: fully supports monitoring of the pathways of suspected cancer patients from receipt of referral until discharge or diagnosis and then on to treatment.

Other DQ Validation Work:

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

Quarterly DQ statistics

The chart below, gives a quarterly overview of combined RTT and DQ related validation of patient records across the clinical directorates that has been carried out by the DQ team between September – November 2017.



A quarterly breakdown of patient records that have been validated has been attributed to supporting RTT targets and other related data quality is shown below.

Data Quality Validation statistics		
Month	RTT Validation	DQ Validation
Sept	5766	8467
Oct	5531	6979
Nov	3760	6619

3. Safe

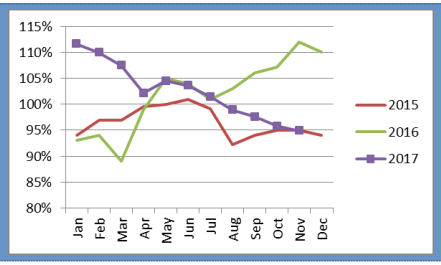
		Monthly Target	RAG Status	Trend Sep-17	Oct-17	Nov-17	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
1.1.3.2	NRLS Organisational Reporting Rate (6 monthly)		G	46.74 (national median 40.14)								
1.1.4	Never events	0	R	1.00	0.00	2.00	↑	0.1				✓
1.1.4.1	Never Events - Incidence Rate	0.00%	R	0.01%	0.00%	0.02%	↑	0.0			✓	
1.1.5	Incidents resulting in death	0	R	5.00	4.00	4.00	↔	4.1				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days)	0.30	R	0.08	0.15	0.31	↑	0.31				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days)	2.20	G	1.59	1.38	0.92	↓	1.4				✓
1.1.10	Incidents with moderate or severe harm with duty of candour response	100%	R	10.7%	4.2%	15.0%	↑	0.1				✓
1.1.14	Pressure ulcers (grade 2) attributable to trust	10	G	6.00	10.00	5.00	↓	7.1				✓
1.1.15	Pressure ulcers (grade 3&4)	0	G	1.00	2.00	0.00	↓	0.9				✓
1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	0.2	R	0.23	0.23	0.23	↔	0.1				
1.1.18	Falls per 1000 bed days	6.63	G	5.06	4.85	5.46	↑	5.0				
1.1.19	Number of falls to fracture (per 1000 bed days)	0.2	R	0.08	0.23	0.23	↔	0.1				
1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.00	0.00	0.00	↔	0.0			✓	
1.1.21	% Duty of Candour with first letter	100%	R	3.6%	4.2%	0.0%	↓				✓	
1.2.2	New VTEs - point prevalence in month	0.36%	G	1.17%	0.00%	0.00%	↔	0.7%			✓	
1.2.7	Emergency c-section rate	<15%	R	18.2%	17.8%	15.1%	↓	18.8%				
1.3.1	MRSA screening of admissions	95%	G	95.6%	95.7%	97.3%	↑	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	R	1.00	3.00	1.00	↓	1			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	G	3.00	1.00	1.00	↔	2			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	101.05 (95.31-107.04)							✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	109.97 (98.28-122.66)							✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	1	G	1.06 (0.89-1.12)							✓	✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

Safe Staffing – Nursing Key Indicators

Safe Staffing

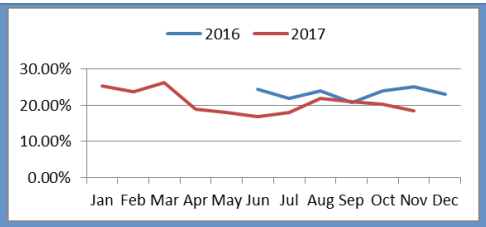
Fill rate is 94.9% against safe planned rate if 94%.



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

Temporary Staffing

The Trust remains below target for Temporary Staffing however is on a downwards trend.



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

Safe Staffing - Planned v Actual – November 2017

		Day				Night				Day		Night		Associate Chief Nurse (Divisonal) review		
		Registered Staff		Care Staff		Registered Staff		Care Staff								
WARD	Bed	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	*Average fill rate - registered staff (%)*	*Average fill rate - care staff (%)*	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	ACND rag rating	Assurance statement	ACND signoff
Arethusa Ward	27	1707	1632	1148	1555	1309	1320	957	1348	*96%*	*136%*	*101%*	*141%*			
Delivery Suite	15	2795	2799	672	672	2796	2865	396	396	*100%*	*100%*	*102%*	*100%*		unit safely staffed	
Dolphin (Paeds)	34	1883	1331	1490	1603	1287	1265	1309	1464	*71%*	*108%*	*98%*	*112%*		unit safely staffed	
ICU	9	1602	1335	1076	1893	990	1286	979	1628	*83%*	*176%*	*130%*	*166%*			
Kent Ward	24	2271	1656	0	0	1617	1618	0	0	*73%*		*100%*			incomplete data but ward safely staffed	
Kingfisher SAU	14	1086	988	857	881	675	675	675	675	*91%*	*103%*	*100%*	*100%*			
McCulloch Ward	29	1385	1282	343	340	1371	1224	0	127	*93%*	*99%*	*89%*				
Medical HDU	6	1526	1043	2109	2587	979	996	1946	2190	*68%*	*123%*	*102%*	*113%*			
NICU	25	861	814	525	519	720	718	360	360	*95%*	*99%*	*100%*	*100%*		unit safely staffed	
Ocelot Ward	12	3123	3061	808	1042	2413	2460	345	322	*98%*	*129%*	*102%*	*93%*		ward safely staffed	
Pearl Ward	23	1068	1289	580	536	1068	1044	360	324	*121%*	*92%*	*98%*	*90%*		ward safely staffed	
Pembroke Ward	27	2120	1535	1439	1760	1617	1609	1320	1493	*72%*	*122%*	*100%*	*113%*			
Phoenix Ward	30	2353	1332	1484	1514	1639	1551	1309	1390	*57%*	*102%*	*95%*	*106%*			
SDCC	26	2304	1609	1301	1004	561	528	308	308	*70%*	*77%*	*94%*	*100%*			
Surgical HDU	10	2191	2104	352	379	1637	1909	0	46	*96%*	*108%*	*117%*				
The Birth Place	9	1080	1036	360	360	1080	1071	312	299	*96%*	*100%*	*99%*	*96%*			
Victory Ward	18	1437	878	676	622	957	878	561	526	*61%*	*92%*	*92%*	*94%*		unit safely staffed by moving staff across the maternity unit as a whole	
Bronte Ward	18	1294	1029	1089	1119	1032	1009	999	881	*80%*	*103%*	*98%*	*88%*			
Byron Ward	26	1535	1176	1926	2321	1013	1166	1350	1515	*77%*	*120%*	*115%*	*112%*			
CCU	4	931	706	0	0	690	714	0	0	*76%*		*103%*				
Gundulph	25	1565	1007	1590	1456	1001	964	1350	1361	*64%*	*92%*	*96%*	*101%*			
Harvey Ward	24	3673	3084	0	0	3360	2857	0	0	*84%*		*85%*				
Keats Ward	27	993	1003	396	402	696	697	629	629	*101%*	*102%*	*100%*	*100%*			
Lawrence Ward	19	2378	1466	1159	1304	1650	1614	990	1089	*62%*	*113%*	*98%*	*110%*			
Milton Ward	27	1554	1092	1227	1238	979	990	627	792	*70%*	*101%*	*101%*	*126%*			
Nelson Ward	24	3492	3510	150	150	3442	3384	0	12	*101%*	*100%*	*98%*				
Sapphire Ward	28	1065	192	2164	639	539	143	1210	275	*18%*	*30%*	*27%*	*23%*			
Tennyson Ward	27	1550	1071	1925	1922	1001	935	1350	1436	*69%*	*100%*	*93%*	*106%*			
Wakeley Ward	25	1933	1503	1489	1564	1328	1296	1339	1474	*78%*	*105%*	*98%*	*110%*			
Will Adams Ward	26	1542	1119	1014	1818	979	1233	979	1276	*73%*	*179%*	*126%*	*130%*			
Trust total	**638**	**54,290**	**43,680**	**29,345**	**31,197**	**40,425**	**40,015**	**21,958**	**23,634**	***80.5%***	***106.3%***	***99.0%***	***107.6%***			

Nursing & Midwifery - Clinical Indicators – November 2017

			Quality Metrics / Actual Incidents								
Directorate	WARD	Bed	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	Number of complaints relating to nursing care	Post 72 Hour CDIFF Acquisitions	MRSA Colonisations Post 48 hours	MRSA Bacteraemia Post 48 Hour
Planned Care	Arethusa Ward	27	2	1	0	0	0	0	0	0
Planned Care	Delivery Suite	15	2	0	0	0	0	0	0	0
Planned Care	Dolphin (Paeds)	34	0	0	0	1	1	0	0	0
Planned Care	ICU	9	1	2	0	0	1	0	0	0
Planned Care	Kent Ward	24	0	0	0	0	0	0	0	0
Planned Care	Kingfisher SAU	14	0	0	0	0	4	0	0	0
Planned Care	McCulloch Ward	29	0	0	0	0	0	0	0	0
Planned Care	Medical HDU	6	0	1	0	0	0	0	0	0
Planned Care	NICU	25	0	0	0	0	0	0	0	0
Planned Care	Ocelot Ward	12	0	0	0	0	0	0	0	0
Planned Care	Pearl Ward	23	0	0	0	0	1	0	0	0
Planned Care	Pembroke Ward	27	2	1	1	0	1	0	0	0
Planned Care	Phoenix Ward	30	0	1	0	0	1	0	0	0
Planned Care	SDCC	26	1	0	0	0	0	0	0	0
Planned Care	Surgical HDU	10	0	0	0	0	0	0	0	0
Planned Care	The Birth Place	9	0	0	0	0	2	0	0	0
Planned Care	Victory Ward	18	1	0	0	0	0	0	0	0
Unplanned & Integrated Care	Bronte Ward	18	0	2	0	0	0	0	0	0
Unplanned & Integrated Care	Byron Ward	26	1	1	0	0	0	0	0	0
Unplanned & Integrated Care	CCU	4	1	0	0	0	0	0	0	0
Unplanned & Integrated Care	Gundulph	25	0	1	0	0	2	0	3	0
Unplanned & Integrated Care	Harvey Ward	24	2	1	0	0	1	0	0	0
Unplanned & Integrated Care	Keats Ward	27	2	1	1	0	1	0	1	1
Unplanned & Integrated Care	Lawrence Ward	19	0	0	1	1	0	0	0	0
Unplanned & Integrated Care	Milton Ward	27	1	0	0	0	0	0	2	0
Unplanned & Integrated Care	Nelson Ward	24	0	0	0	1	1	0	0	0
Unplanned & Integrated Care	Sapphire Ward	28	0	0	0	0	0	0	0	0
Unplanned & Integrated Care	Tennyson Ward	27	1	0	1	0	1	0	2	0
Unplanned & Integrated Care	Wakeley Ward	25	0	0	0	0	1	0	1	0
Unplanned & Integrated Care	Will Adams Ward	26	2	0	0	0	0	1	2	0
	Trust total	**638**	**19**	**12**	**4**	**3**	**18**	**1**	**11**	**1**

Safe Staffing– Nursing KPIs

		Monthly Target	RAG Status	Trend Sep-17	Oct-17	Nov-17	Movement	YTD avg	Trend	Data Quality
1.5.2	Vacancy Rate (Overall)	*8%*	R	26.64%	25.85%	26.47%	↑	26.21%		
1.5.3	Total Vacancies (WTE)	*TBC*		422.72	409.90	419.54	↑	413.0		
1.5.4	Vacancy Rate (Band 5)	*TBC*		37.25%	36.79%	36.32%	↓	36.63%		
1.5.5	Vacancy Rate (Band 6)	*TBC*		23.95%	23.39%	20.92%	↓	23.09%		
1.5.6	Vacancy Rate (CSW)	*TBC*		17.74%	10.09%	13.34%	↑	14.99%		
1.5.7	Nursing Starters	*TBC*		15	25	7	↓	15.5		
1.5.8	Nursing Leavers	*TBC*		14	15	16	↑	14.3		
1.5.9	CSW Starters	*TBC*		9	26	1	↓	12.5		
1.5.10	CSW Leavers	*TBC*		8	10	12	↑	9.0		
1.5.11	Rolling annual turnover rate	*8%*	R	9.84%	10.51%	11.17%	↑	10.37%		
1.5.16	Safe Staffing	*94.00%*	G	97.6%	95.8%	94.9%		98.2%		
1.5.17	CHPPD	*8.00*	G	8.62	8.45	8.91		8.79		

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

Commentary	Actions

4. Effective

		Monthly Target	Status	Trend						Alignment		
			Status	Sep-17	Oct-17	Nov-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
2.5.4	Emergency Readmissions within 28 days	10%	R	10.70%	10.67%	11.84%	↑	12%			✓	
2.5.4.1	Emergency Readmissions within 28 days Under 65	10%	R	10.30%	10.32%	10.51%	↑	10%			✓	
2.5.4.2	Emergency Readmissions within 28 days 65 +	10%	R	11.30%	11.34%	14.43%	↑	11%			✓	
2.6	Discharges before noon	25%	R	21.78%	20.42%	21.30%	↑	19%			✓	✓

	CQUIN DESCRIPTION		CQUIN LEAD	Value	Q2	Reporting Frequency to Commissioners
1	Improving Health and Wellbeing of Staff	CCG	Gemma Nauman, Service Manager, Occupational Health	157,525	No report required. CQUIN to be reported and realised at Q4.	Annual report to the CCG on the publication of 2017 (year 1) & 2018 (year 2) staff survey – expected to be released in February 2018 & 2019 respectively
2	Healthy food for NHSE staff, visitors and patients	CCG	Laura Smith, Head of Facilities	157,525	No report required. CQUIN to be reported and realised at Q4.	End of Quarter 4
3	Improving the update of flu vaccinations for front line staff within providers	CCG	Gemma Nauman, Service Manager, Occupational Health	157,525	No report required. CQUIN to be reported and realised at Q4.	1) Providers to submit cumulative data monthly on the ImmForm website. 2) Final report to the CCG at Q4
4	Timely Identification of Sepsis in ED and acute inpatient settings	CCG	Cliff Evans, Nurse Consultant (ED) and Stephanie Gorman (Inpatient)	118,144	Submitted 31/10/17. Awaiting reconcillation	Quarterly reports
5	Timely treatment for Sepsis in ED and acute inpatient settings	CCG	Cliff Evans, Nurse Consultant (ED) and Stephanie Gorman (Inpatient)	118,144	Submitted 31/10/17. Awaiting reconcillation	Quarterly reports
6	Antibiotic review	CCG	Busola Ade-Ojo, Chief Pharmacist	118,144	Submitted 31/10/17. Awaiting reconcillation	1). Monthly audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal. 2) Quarterly report on an empiric review of notes as per CQUIN milestones
7	Reduction in antibiotic consumption per 1,000 admissions	CCG	Busola Ade-Ojo, Chief Pharmacist	118,144	Data submitted to PHE. Final requirement is at Q4. No partial payments until final indicator report at Q4.	1) Quarterly submission of antibiotic consumption data to be submitted to PHE 2) Annual report to the CCG
8	Improving services for people with mental health needs who present to A&E	CCG	Clare Hughes, Lead Matron Emergency Pathways	472,576	Submitted 31/10/17. Awaiting reconcillation	1) Quarterly submissions to CCG relating to the milestones set out in the CQUIN. 2) Single annual submission to NHS England Digital.
9	Offering advice and guidance (non emergency A&G)	CCG	Karensa Deroberto, IT Programmes Manager	472,576	Submitted 31/10/17. Awaiting reconcillation	The provider will meet with Commissioners at least quarterly, initially to review the implementation of the A&G service and then to monitor impact through the main indicator.
10	NHS e-referrals	CCG	Benn Best, General Manager	236,288	Submitted 31/10/17. Awaiting reconcillation	Quarterly reports
11	Supporting proactive and safe discharge	CCG	Tarina Phillips, Lead Matron for Discharge	472,576	No response or report provided by Directorate.	1) Quarterly data using HES data available via NHS Digital 2) Quarterly report to the CCG
17	Hospital Medicines Optimisation	NHSE	Busola Ade-Ojo, Chief Pharmacist	96,000	The Trust is still waiting for NHSE to confirm CQUIN value and milestones. At contract	Quarterly reports
18	Shared Decision Making	NHSE	Alistair Lindsay, Director of Operations	120,000	meeting with NHSE on 31/10/17, they confirmed that they are working on this for all	Quarterly reports
19	Complex Device Optimisation	NHSE	Simon Weeks, General Manager	40,000	Trusts and that this lack of clarity from NHSE is affecting other Trusts in Kent, not just	
20	School Age Immunisations	NHSE	Amanda Shears, Lead Nurse for School Health	3,154	Submitted 31/10/17. Awaiting reconcillation	Quarterly reports

5. Caring

		Monthly Target	RAG Status	Trend Sep-17	Oct-17	Nov-17	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	*83%*	G	86.2%	88.8%	89.9%	↑	88%			✓	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	*65%*	G	79.5%	80.7%	81.8%	↑	82%			✓	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	*79%*	G	98.3%	99.1%	99.2%	↑	99%			✓	
3.1.3	Mixed Sex Accommodation breaches	*15*	R	72.00	64.00	46.00	↓	48.1			✓	
3.4.1	Number of Complaints	*45*	R	83.00	74.00	62.00	↓	67			✓	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	*85%*	R	42.5%				52%			✓	
3.4.3	Number of complaint returners	↓	G	2.00	3.00	2.00	↓	3.1			✓	

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

6. Responsive

		Monthly Target	Status	Trend						Alignment		
			Status	Sep-17	Oct-17	Nov-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CoQUIN
4.1.1	RTT – Incomplete pathways (overall)	92%	R	83.65%	83.32%	81.76%	↓	82.14%			✓	
4.1.2	RTT - Treatment Over 52 Weeks	0	R	23	15	8	↓	27				
4.2.3	A&E 4 hour target (all Types from Nov 2017)	95%	R	83.78%	86.93%	90.45%	↑	86.64%			✓	
4.3.1	Cancer – 2 week wait (1 month in arrears)	93%	G	91.63%	95.28%		↑	85.90%				
4.3.2	Cancer - 2 Week Wait Breast (1 month in arrears)	93%	G	92.96%	96.67%		↑	89.83%				
4.3.3	Cancer - 31 day first treatment (1 month in arrears)	96%	G	95.68%	100.00%		↑	97.01%				
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	94%	G	96.30%	100.00%		↑	97.11%				
4.3.5	Cancer – 31 day subsequent treatments - drug (1 month in arrears)	98%	G	94.44%	100.00%		↑	97.42%				
4.3.6	Cancer - 62 day consultant upgrade (1 month in arrears)	N/A		50.00%	78.57%		↑	73.93%				
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	R	72.29%	75.00%		↑	78%			✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	90%	G	81.25%	92.86%		↑	86%			✓	
4.4.1	Diagnostic waits - under 6 weeks	99%	R	96.17%	97.36%	96.91%	↑	96%			✓	
4.5.8	Patients seen by a stroke consultant within 24 hours (Apr to Jul figures reported)	95%	R	53.90%	53.90%	53.90%	↔	56%				✓
4.6.1	Average elective Length of Stay	<5	G	2.32	2.58	2.13	↓	2.3				✓
4.6.2	Average non-elective Length of Stay	<5	R	7.85	6.11	6.11	↔	7.1				✓
4.6.6	Average occupancy	90%	R	95.30%	94.43%	97.58%	↑	95%				✓

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

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

7. Well led

		Monthly Target	Status	Trend						Alignment		
			Status	Sep-17	Oct-17	Nov-17	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
5.2.1	Staff Friends and Family – Recommend as place to work (Quarterly)	*62%*	R		52.7%		↓	58.0%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	*79%*	R		66.6%		↓	70.7%			✓	
5.3.7	Rolling annual turnover rate	*8%*	R	9.8%	10.5%	11.2%	↑				✓	
5.3.7.1	Executive Team Turnover Rate	*TBA*		7.7%	0.0%	6.7%	↑	3.8%			✓	
5.3.8	Overall Sickness rate	*4.0%*	G	3.76%	3.72%	3.76%	↑	3.8%				
5.3.9	Sickness rate – Short term	*3.0%*	G	1.83%	1.81%	1.81%	↔	1.9%			✓	
5.3.10	Sickness rate – Long term	*1.0%*	R	1.93%	1.91%	1.95%	↑	1.9%			✓	
5.3.11	Temporary staff % of pay bill	*15%*	R	20.9%	20.3%	18.5%	↓	19.3%			✓	
5.3.14	Starters	*N/A*		80	107	27	↓	85.1				
5.3.15	Leavers	*N/A*		61	66	56	↓	69.3				

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

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8. Enablers

		Monthly Target	Status	Trend						Alignment		
			Status	Sep-17	Oct-17	Nov-17	Movement	YTD avg	Data Quality	Carter	SDF	Bounty Account / CQUIN
7.2.1	APC – NHS number completeness (2 month in arrears)	99%	G	99.6%				99.0%				✓
7.2.8	A&E – Attendance disposal (2 month in arrears)	99%	R	93.7%				95.1%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	11	R	191	143		⇩	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	91	71		⇩	102.0		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	1%	G	0.4%	0.3%		⇩	0.5%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	103.50	G	6	3		⇩	3.86				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	0.00	R	0.00	1.00		⇧	2.14				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	949	R	1635	1348		⇩	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	1	1		⇔	1.6		✓		✓
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	13.25	G	0	0		⇔	0.7		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	0.01	G	0.01	0.01		⇔	1%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	2	G	0	1		⇧	3.0		✓		✓
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	1.25	G	0	0		⇔	0.3		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	1.25	G	0	0		⇔	2.9		✓		✓
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	1	G	1	0		⇩	1.1		✓		✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

Report to the Board of Directors

NHS Medway NHS Foundation Trust

Board Date: 18/01/2018

Agenda item 10b

Title of Report	Responding to Deaths
Prepared By:	Kim Willsea, Mortality Learning Co-ordinator Michelle Woodward, Associate Director of Quality
Lead Director	Dr Diana Hamilton-Fairley, Medical Director
Committees or Groups who have considered this report	Mortality and Morbidity Group Quality Assurance Committee
Executive Summary	**Background:** In line with the publication of CQC Learning, candour and accountability (December 2016) and the CQC's recommendations following its review of how the NHS investigates patient deaths, the National Quality Board published the first edition of a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths'. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning. It encompasses how Trusts respond to deaths in care generally, not just those amounting to 'serious incidents', which will continue to be dealt with under the existing 'Serious Incident Framework'. The focus of the new framework is on improving governance processes around patient deaths (including new board leadership roles, a new system of 'case record reviews', quarterly reporting of specific information about deaths in care and a new Trust policy on how individual organisations will be implementing all this) and on ensuring the families/carers of patients who have died in care are properly involved at every stage. In the future, the CQC is likely to be closely monitoring how Trusts are performing in terms of compliance with the new framework. **The purpose of this report is to provide the Board with:** • A summary of updates with respect to the National Quality Board (NQB) guidance on learning from deaths (March 2017) • The amended policy reflecting updates as described in this report • The updated Learning from Deaths Dashboard containing data for Q1 and Q2 2017-18

	• 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 actions taken and assurances given in response to NHSI and RCP updates with respect to the implementation of the NQB National Guidance on Learning from Deaths • The content of the updated Learning from Deaths Dashboard for Q1 and Q2 • The progress against the Learning from Deaths Action Plan. **The Board is requested to take the following action:** • Approve the revised Responding to Deaths Policy which incorporates the NHSI/RCP updates
Purpose and Actions required by the Board :	**Approval** ☒ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

The National Quality Board (NQB):

Learning from Deaths Update (January 2017)

1. Introduction

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

- A summary of updates with respect to the National Quality Board (NQB) guidance on learning from deaths (March 2017)
- The amended policy reflecting updates as described in this report
- The updated Learning from Deaths Dashboard containing data for Q1 and Q2 2017-18
- The current position and progress made against the Learning from Deaths action plan

2. Background

In line with the publication of CQC Learning, candour and accountability (December 2016) and the CQC's recommendations following its review of how the NHS investigates patient deaths, the National Quality Board published the first edition of a new national framework for NHS Trusts - 'National Guidance on Learning from Deaths'.

The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning.

It encompasses how Trusts respond to deaths in care generally, not just those amounting to 'serious incidents', which will continue to be dealt with under the existing 'Serious Incident Framework'.

The focus of the new framework is on improving governance processes around patient deaths (including new board leadership roles, a new system of 'case record reviews', quarterly reporting of specific information about deaths in care and a new Trust policy on how individual organisations will be implementing all this) and on ensuring the families/carers of patients who have died in care are properly involved at every stage.

In the future, the CQC is likely to be closely monitoring how Trusts are performing in terms of compliance with the new framework.

3. Key Issues Updates

NHSI presented an update on the Learning from Deaths Framework at the Dr Foster Learning from Deaths Workshop on 24 October 2017. Points to note following the presentation and discussion are as follows:

- There is no meaningful measure of ‘avoidable’ mortality at trust level. NHSI use the term ‘deaths thought to be more likely than not to be due to problems in care’.
- The NHS England Learning from Deaths Dashboard template does not capture this information currently. Trusts are welcome to develop their own local dashboards in order to capture the necessary information.
- Implementing the framework is challenging and the whole system is learning together – NHSI do not expect perfection.
- NHSI require the following information to be published quarterly:
    - Number of deaths
    - Percentage of deaths reviewed
    - Number of deaths investigated under the Serious Incident (SI) framework and declared as serious incidents.
    - Estimate of the number of deaths reviewed/investigated and as a result considered more likely than not to be due to problems in care.
    - Themes and issues identified from review and investigation
    - Actions taken and progress in implementation

- Next steps for NHSI and NHS England:
    - Self-assessment tool for policy review
    - Updated Learning from Deaths Framework (2018)
    - Updated Learning from Deaths Dashboard template
    - NHS England guidance on family/carer involvement (January 2018)

- RCP held a local training session in Maidstone on 4 October 2017 on the Structured Judgement Review (SJR) methodology. Points to note are as follows:
    - Stage 2 mortality reviews are no longer recommended. If stage 1 mortality review produces an outcome of very poor/poor care (or actual harm identified), RCP suggest that this should immediately trigger investigation through the SI framework; stage 2 review is likely to cause unnecessary delays.
    - RCP will be making some changes to the recommended SJR form including changing the harm categories. This is due to be finalised early 2018.

The Trust response to the key issues raised by NHSI and the RCP are detailed in sections 4 and 5 below.

4. Responding to Deaths Policy

In response to the recent developments from the RCP, the Trust has amended the mortality review process in line with the updated RCP SJR review process.

The Trust Responding to Deaths Policy has been updated to reflect the changes as highlighted by the continuing development of the Learning from Deaths Framework as noted by NHSI and RCP. The following amendments have been made to the policy:

- The mortality review process has been amended with stage 2 reviews being removed. Cases which are reviewed and where the outcome is very poor/poor (or actual harm is identified) will feed directly into the SI process.
- The screening form has been amended to reflect this new pathway.

Please see appendix 1 for the full updated policy

5. Learning from Deaths Dashboard for Q1 and Q2 (2017/18)

In response to the recent developments from NHSI, the Trust will also update its Learning from Deaths Dashboard to the Public Trust Board to incorporate the suggested criteria for inclusion.

The Trust is required to publish the specified information quarterly; this requirement is satisfied through the presentation of this paper and dashboard at the public section of the Trust Board.

Following the national developments mentioned previously, the Trust has produced a revised dashboard which includes data for Q1 and Q2.

Please see full dashboard overleaf.

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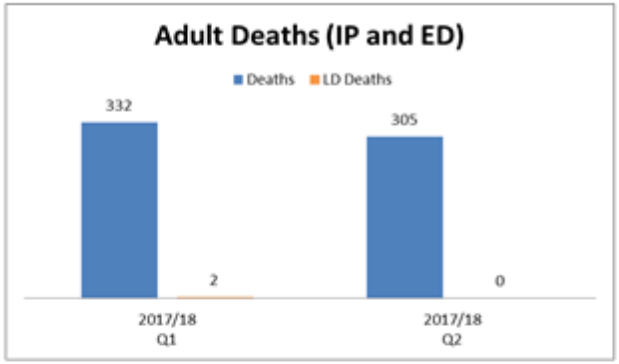
Learning from Deaths Dashboard Q1-Q2 2017/18

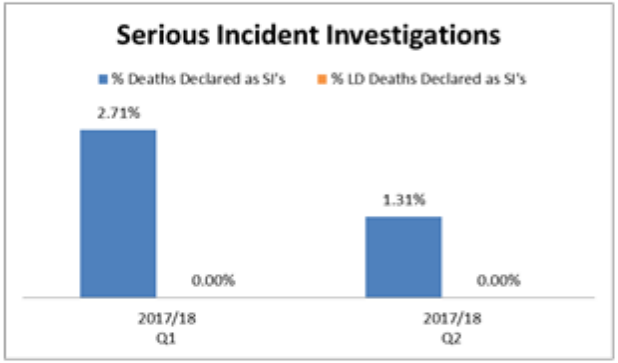
NHS
Medway
NHS Foundation Trust

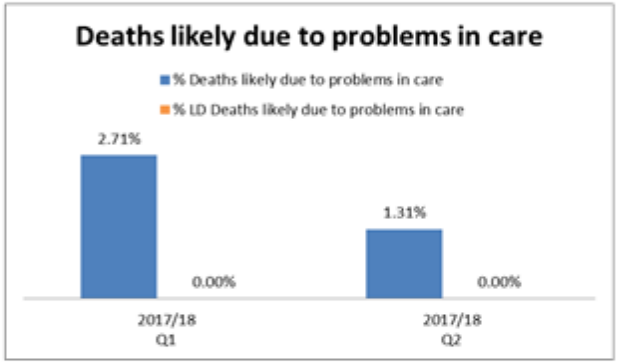
Trust	Medway NHS Foundation Trust
Org Code	RPA02
Month	January
Year	2017-18

NHS
Medway
NHS Foundation Trust

Financial Year	Quarter	Total Deaths (not LD)	Total Deaths Reviewed (not LD)	Deaths Avoidable > 50% (not LD)	LD Deaths	LD Deaths Reviewed	LD Deaths Avoidable > 50%
2017-18	1	332	199	9	2	2	0
2017-18	2	305	112	4	0	0	0







Themes/Issues Identified from Mortality Review and SI Investigation:

- Delay in GI bleeds being reviewed by Gastroenterology team - no out of hours emergency contact
- Management of patients with acute abdominal pathology
- In-hospital CPR is higher than comparable units
- Critical Care documentation issues identified by own team and others
- Displaced tracheostomy

SI Type Reported on STEIS	Q1-Q2
Suboptimal care of a deteriorating patient	6
Diagnostic incident including delay	3
Delayed treatment	2
Never Event - Retained foreign object post-procedure	1
Surgical/invasive procedure incident meeting SI criteria	1

National Mortality Indicators

Hospital Standardised Mortality Ratio (HSMR): The current HSMR figure (for the period Oct 16 -Sep 17 is **100.21** which is in line with the national benchmark (100).

Summary Hospital-Level Mortality Indicator (SHMI): The current SHMI figure (for the period Jul 16-Jun 17 is **1.07** which lies within the expected range.

Actions Taken following Mortality Reviews and SI Investigations:

- Collaboration between Critical Care and Gastroenterology teams - a Gastroenterology referral mobile number has been set up with patients to be seen within 24hrs. For out of hours emergencies, switchboard will contact the on call GI bleed clinician.
- The hospital is taking part in the National Emergency Laparotomy Audit (NELA) which is ongoing. This is to ensure that the management of these patients is compliant with national guidelines.
- An audit has been carried out which identified the need for completion of the Treatment Escalation Plan (TEP) to realistically determine if level 3 care is appropriate. The TEP form has been revised and a TEP working Group was initiated. A re-audit has been planned,
- Regular education of staff to improve Critical Care documentation and refining of electronic templates.

6. 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 in Appendix 3.

6.1 Achievements

The Learning from deaths action plan has progressed well since implementation, and the following actions have been completed since the last Board report:

- A Non-Executive Director has been appointed (action 1.2).
- The revised mortality review process has been embedded (action 2.1).
- The Responding to Deaths Policy has been published on the Trust website (actions 2.4, 3.1).
- The Terms of Reference for the Trust Mortality & Morbidity Group have been updated in line with the guidance (action 3.2).
- The process for completion of Death Notifications on the EDN system has been reviewed; the new process was implemented on 01/11/17. This will ensure GP's are informed of cause of death details in a timely manner as required in the national guidance (action 5.5).
- Learning Disability (LD) Deaths are now being referred as required to the national LeDeR programme and a death register has been set up to capture this information (9.4).

6.2 Ongoing Training (action 4.1)

National training is now being rolled out by the Royal College of Physicians (RCP) on the 'Structured Judgement Review' (SJR) methodology for undertaking case record reviews.

The local training session was held in Maidstone on 04/10/ 2017. The following representatives attended for the Trust:

- Dr Ghada Ramadan (Associate Medical Director – Quality & Safety)
- Dr Caris Grimes (Lead for Governance, Safety and Quality – Co-ordinated Surgical Care Directorate)
- Dr Will Ogburn (Patient Safety Lead – Acute & Continuing Care Directorate)
- Kimberley Willsea (Mortality Learning Co-ordinator)

Internal training is now taking place across the Trust to disseminate the learning. The first session was held on 3 November 2017 and was attended by 7 members of staff. Representatives were present from all directorates and attendees included consultants, junior doctors, physiotherapists and nursing staff.

These sessions will continue until all reviewers have been trained in the new methodology. The next session is being held on 11/01/2018 and 16 people are currently registered to attend. The majority of attendees for this session are consultants and service managers. Places have also been offered for clinicians at EKHUFT to attend as part of the collaborative work with the Kent Surrey and Sussex Academic Health Science Network (KSS AHSN) Mortality Community of Practice.

6.3 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.

- **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. There has been some delay to the roll-out of the national programme in the South East and the most recent area meeting was to be held on 09/11/2017, but was cancelled. Therefore there has been some delay in obtaining the necessary information to ensure the updated policies and procedures are in line with requirements. The deadline has therefore been amended to January 2017, which coincides with the date of the rescheduled local area LeDeR meeting.
- **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. There is a requirement for the relevant policies to reference the national guidance; this will be done as part of the SI review planned to be

completed by the end of November 2017. Therefore, the deadline has been amended accordingly to November 2017.

- **Action 5.1** – Providers should offer a bereavement service for families and carers of people who die under their management and care. There is currently no central Bereavement Service and the Trust must consider how it will meet national requirements regarding this.
- **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.

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
1. Board Leadership Mortality Governance should be a key priority for Trust Boards. Executives and Non-Executive Directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.								
1.1	Have an existing board-level leader acting as patient safety director to take responsibility for the learning from deaths agenda.	Diana Hamilton-Fairley (Medical Director) is the Executive Director with leadership responsibility for mortality.	No further action required.	Lesley Dwyer, Chief Executive	Executive Director in place	September 2017	March 2017	Completed
1.2	Have a Non-Executive Director in place to take oversight of the progress.	The Trust does not currently have a non-executive director appointed for mortality. Sep 17 – Awaiting NED to be appointed. Executive assistants contacted 20/09/2017 to confirm if a NED was appointed at the Board meeting. Oct 17 – NED appointed: Ewan Carmichael	Non-Executive Director to be appointed by the Board.	Dr Diana Hamilton-Fairley, Medical Director	Non-Executive Director in place	September 2017	October 2017	Completed
1.3	Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership.	The Trust has an allocated operational lead for mortality, Dr Richard Leach, Associate Medical Director for Clinical Effectiveness & Research. Dr Leach chairs the Trust Mortality & Morbidity Group (MMG), which consists of multi-disciplinary membership is underpinned by terms of reference and meets on a monthly basis. The MMG reports into the Trust Quality Assurance Committee (QAC) and the Trust Board.	No further action required.	Dr Richard Leach, M&M Chair	Terms of reference, meeting schedules, agendas and minutes of meeting	September 2017	March 2017	Completed
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.								

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
2.1	The mortality review process must use evidence-based methodology for reviewing the quality of care provided to those patients who die. The structured judgment review (SJR) methodology developed by the Royal College of Physicians (RCP) is one such approach.	The mortality proforma and process has been amended in line with the RCP methodology. This was implemented on 01/08/17.	No further action required.	Kim Willsea, Mortality Learning Coordinator / Michelle Woodward, Associate Director of Quality	SJR proforma implemented within the Trust	August 2017	August 2017	Completed
2.2	Trusts must collect and publish on a quarterly basis specified information on deaths through a paper and agenda item to a public Board meeting. The publication of the data and learning points must be from Q3 onwards.	The Trust has adopted the DH national learning from deaths dashboard, which has been populated as of 1 April 2017.	Dashboard to be featured in the Public Session of the Trust Board in September 2017.	Kim Willsea, Mortality Learning Coordinator / Michelle Woodward, Associate Director of Quality	Dashboard published in public session of the Trust Board	December 2017	September 2017	Completed
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.	Data published will be summarised in the Quality Accounts for 2017/18.	Michelle Woodward, Associate Director of Quality	Quality Account 2017/18	June 2018		Active
2.4	Briefing paper and agenda item to a Public Board meeting outlining the Trust's policy and approach to the new recommendations.	The briefing paper has been written and is on the agenda for the Public Board meeting on 07/09/17. Sep 17 – The paper was presented at Trust Board on 07/09/17.	Complete briefing paper for sign-off by MMG and QAC in advance.	Kim Willsea, Mortality Learning Coordinator / Michelle Woodward, Associate Director of Quality	Paper presented to the Board	September 2017	September 2017	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.	Complete review of Serious Incident Policy to reflect the recommendation.	Michelle Woodward, Associate Director of Quality / Ann Bushnell, Patient Safety Manager / Denise Thompson, Head of Clinical Audit and Effectiveness	SI policy in place which meets requirements	March 2018		Active

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
3.2	Trusts should have systems for deriving learning from reviews and investigations and acting on this learning. Findings should be part of, and feed into, robust clinical governance processes and structures.	Specialty M&M meetings are established across the Trust. Specialties are required to complete action plans and minutes to capture learning. These meetings feed into directorate governance meetings and specialties also present their findings and learning on a regular basis to the MMG. Sep 17 – Updated Terms of Reference drafted and on the agenda to be agreed at next Trust M&M meeting on 06/10/17. Oct 17 – ToR agreed at Trust M&M 6/10/17.	Review MMG terms of Reference to ensure that the meeting has appropriate attendance, enabling learning to be shared.	Kim Willsea, Mortality Learning Coordinator / Michelle Woodward, Associate Director of Quality	Updated Terms of Reference	September 2017	October 2017	Completed
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.	The Learning from deaths and SI policies must reflect this recommendation.	Kim Willsea, Mortality Learning Coordinator / Denise Thompson, Head of Clinical Audit and Effectiveness / Michelle Woodward, Associate Director of Quality	Revised SI policy	March 2018		Active
3.4	Each trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care.	The policy has been drafted. Sep 17 – Policy was agreed at Trust Board on 07/09/17 and subsequently published on the intranet and public section of the Trust website.	To be presented at the Trust M&M meeting 18/08/2017.	Kim Willsea, Mortality Learning Coordinator / Denise Thomson, Head of Clinical Effectiveness and Audit	The new policy published on QPULSE after presentation to Public Trust Board	September 2017	September 2017	Completed
4. Skills and Training 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.								

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
4.1	Acute Trusts will receive training to use the Royal College of Physicians Structured Judgment Review Case Note Methodology.	Three clinicians (one from each directorate) have been registered to attend RCP training on 04/10/17. Oct 17 – 4 representatives attended the RCP training on 04/10/17 (Ghada Ramadan, Caris Grimes, William Ogburn and Kimberley Willsea). Nov 17 - The first internal training session took place on 03/11/17 with 7 attendees present. The next session is scheduled for 11/01/18 – 20 attendees are currently registered.	Ensure RCP training is rolled out across the Trust with support from KSS AHSN.	Dr Richard Leach, M&M Chair	All reviewing clinicians trained in the RCP methodology	March 2018		Active
5. Engagement with Bereaved Families and Carers 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.								
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.	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 Diana Hamilton-Fairley, Medical Director	Bereavement Service in place throughout the Trust	March 2018		Active
5.2	If the care of a patient who has died is selected for case record review providers should communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed to the future.	The new review process has been implemented and stage 2 reviews will be undertaken to assess the impact of problems in care identified through stage 1 reviews. Communication with family will be undertaken within the remit of the Duty of Candour Policy. Nov 11 – Duty of Candour Policy already reflects requirements for communication where there has been a problem with care.	Duty of Candour of Policy to be reviewed to ensure it reflects the requirements explicitly.	Michelle Woodward, Associate Director of Quality	Revised Duty of Candour Policy	November 2017	November 2017	Completed

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
5.3	If a provider feels that an investigation into a death is needed, early contact should have been made with bereaved families and carers so that their views helped to inform the decision.	The SI policy is currently under review. The Duty of Candour Policy is already in place. Nov 17 – Duty of Candour Policy and SI Policy already reflect requirements for communication where there has been a problem with care.	Complete the SI policy and review the Duty of Candour Policy, ensuring they meet national requirements.	Michelle Woodward, Associate Director of Quality	Revised Duty of Candour and SI Policy	November 2017	November 2017	Completed
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. Oct 17 – There is currently no trust-wide training for dealing with bereaved families and carers. This must be reviewed.	Review provision of bereavement training in place.	Karen Rule, Director of Nursing Dr Diana Hamilton-Fairley, Medical Director	Bereavement training provision in place	March 2018		Active
5.5	The provider should ensure that the deceased person's GP is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation.	GP's are informed of deaths via the electronic discharge notification (EDN) system. However, this is not currently completed at the same time as the medical certificate. Sep 17 – A new process has been developed to ensure clinicians complete the EDN at the same time as the death certificate. This will be effective from 01/11/17. Nov 17 – this process is now in place. Updated policies have been drafted for approval at Trust M&M on 24/11/17. Dec 17 – Updated SOP's have been agreed and published on the intranet.	Review the policies and procedures to ensure EDN's are completed by the appropriate clinician at the same time as the medical certificate.	Dr Diana Hamilton-Fairley, Medical Director	Timely notification to GP. Updated SOP's	November 2017	December 2017	Completed
6. Children and Young People NHS England is currently undertaking a review of child mortality review process both in hospital and Community. A National Mortality Database is currently being commissioned. Further guidance is expected in late 2017.								
6.1	Undertake a review of policies and processes to ensure that they are in line with current best practice and national guidance.	Policies and procedures are already in place regarding paediatric deaths. Sep 17 – Policy and procedures already in place which meet national guidelines for child deaths. New policy published April 2017.	Review of policies and processes to be done to ensure they are in line with best practice and national guidance.	Richard Patey, Clinical Director FCSS	Updated policy/SOP in place	October 2017	April 2017	Completed

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
7. Maternity Services Maternal deaths and stillbirths occurring in acute and community Trusts should be included by Trusts in quarterly reporting from April 2017. This will also include deaths that occur in local midwifery units, or during home births. The definition also covers up to 42 days after the end of pregnancy.								
7.1	Undertake a review of policies and processes to ensure that they are in line with current best practice and national guidance.	Policies and procedures are already in place regarding maternity service deaths. Nov 17 – The existing policy has been reviewed against the national guidance. The Head of Midwifery & Gynaecology Nursing has confirmed it meets requirements.	Review of policies and processes to be done to ensure they are in line with best practice and national guidance.	Dot Smith, Head of Midwifery & Gynaecology Nursing	Updated policy/SOP in place	October 2017	November 2017	Completed
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.	Review of policies and processes to be done to ensure they are in line with best practice and national guidance.	Michelle Woodward, Associate Director of Quality , Ann Bushnell, Patient Safety Manager / Denise Thompson, Head of Clinical Audit and Effectiveness / Bridget Fordham, Head of Safeguarding	Revised SI policy	March 2018		Active
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 2017.	Ensure procedures are in place.	Bridget Fordham, Head of Safeguarding / Richard Patey, Clinical Director FCSS	Updated SOP's in place	January 2017		Active

No.	National Recommendations	Current Position	Actions	Owner	Assurance	Deadline	Date of actual completion	Status
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.	Ensure policies and procedures are in place which meet national requirements.	Bridget Fordham, Safeguarding Lead / Michelle Woodward, Associate Director of Quality	Updated Policies/SOP's in place	March 2018		Active
9.3	Nominate a Lead for the organisation that will attend the Steering Group and act as a point of contact for LeDeR when a death has occurred.	Bridget Fordham has been named as the Lead for the Trust.	No further action required.	Karen Rule, Director of Nursing	Lead appointed for the organisation	September 2017	August 2017	Completed
9.4	Set up a learning Disability death register.	LD deaths are recorded on the mortality spreadsheet. Oct 17 - A new LD register has been established to record deaths and referrals to the LeDeR programme.	No further action required.	Bridget Fordham, Safeguarding Lead	LD Register in place	September 2017	August 2017	Completed

7. Conclusion

The Board is requested to note:

- The actions taken and assurances given in response to NHSI and RCP updates with respect to the implementation of the NQB National Guidance on Learning from Deaths
- The content of the updated Learning from Deaths Dashboard for Q1 and Q2
- The progress against the Learning from Deaths Action Plan.

The Board is requested to take the following action:

- Approve the revised Responding to Deaths Policy which incorporates the NHSI/RCP updates

Authors:

Kim Willsea, Mortality Learning Co-ordinator
Michelle Woodward, Associate Director of Quality

January 2018

Responding to Deaths Policy

Author:	Kimberley Willsea (Mortality Learning Co-ordinator) Michelle Woodward (Associate Director of Quality) Denise Thompson (Head of Clinical Effectiveness)
Document Owner:	Diana Hamilton-Fairley (Medical Director)
Revision No:	2
Document ID Number	
Approved By:	Trust Board
Implementation Date:	September 2017
Date of Next Review:	September 2018

Document Control / History	
Revision No	**Reason for change**
1	Introduction of new policy as required by the National Quality Board (NQB) guidance: National Guidance on Learning from Deaths (March 2017).
2	To incorporate updates since the release of the national guidance.

Consultation
All Consultants
Clinical Directors of Operations
Deputy Directors of Nursing
Associate Medical Directors
Directorate Governance Leads
Service/General Managers
Mortality and Morbidity Group
Director of Nursing
Medical Director
Trust Board

Table of Contents

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

Introduction

1.1 Concern about patient safety and scrutiny of mortality rates has intensified with investigations into NHS hospital failures that have taken place over the last few years. There is an increased drive for NHS Trust boards to be assured that deaths are reviewed and appropriate changes made to ensure patients are safe.

1.2 It is now recognised that the review of mortality statistics can give an indication to the levels of quality and safety and help identify causes of deaths in hospitals that are avoidable through better, safer and more efficient or effective healthcare delivery.

1.3 This was reinforced by the recent findings of the Care Quality Commission (CQC) report 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England' (December 2016). The report found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

1.4 The National Quality Board (NQB) guidance 'National Guidance on Learning from Deaths' was published in March 2017. The purpose of the new framework is to introduce a more standardised approach to the way NHS Trusts report, investigate and learn from patient deaths, which should lead to better quality investigations and more embedded learning.

1.5 It encompasses how Trusts respond to deaths in care generally, not just those amounting to 'serious incidents', which will continue to be dealt with under the existing 'Serious Incident Framework'.

1.6 The focus of the new framework is on improving governance processes around patient deaths (including new board leadership roles, a new system of 'case record reviews', quarterly reporting of specific information about deaths in care and a new Trust policy on how individual organisations will be implementing all this) and on ensuring the families/carers of patients who have died in care are properly involved at every stage.

Purpose / Aim and Objective

1.7 To clarify the framework within which the organisation will review and learn from deaths, including:

1.7.1 How the Trust determines which patients are considered to be under its care and included for case record review.

1.7.2 Reporting the death within the organisation and to other organisations who may have an interest.

1.7.3 Responding to the death of an individual with a learning disability or mental health need, an infant or child death and a stillbirth or maternal death.

1.7.4 Reviewing the care provided to patients who the Trust does not consider to be under its care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past.

1.7.5 Reviewing the care provided to patients whose death may have been expected.

1.7.6 Recording the outcome of the decision whether or not to review or investigate the death.

1.7.7 Engaging meaningfully and compassionately with bereaved families and carers.

1.7.8 Offering guidance, where appropriate, on obtaining legal advice for families, carers or staff.

Definitions

1.8 **Case record review:** The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.

1.9 **Investigation:** The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

1.10 **Death due to a problem in care:** A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

1.11 **Hospital Standardised Mortality Ratio (HSMR):** The ratio of the observed number of in-hospital deaths at the end of a continuous inpatient spell to the expected number of in-hospital deaths (multiplied by 100) for 56 diagnosis groups in a specified patient group.

1.12 **Summary Hospital-Level Mortality Indicator (SHMI):** The ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

1.13 **Learning Disability** is defined according to 'Valuing People: A New Strategy for Learning Disability for the 21st century' A White Paper (Appendix 7).

(Duties) Roles & Responsibilities

1.14 **Trust Board** is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust and for taking into consideration the views of the Board of Governors. The Board must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care.

1.15 **All Trust Directors (executive and non-executive)** have a responsibility to constructively challenge the decisions of the board and help develop proposals on strategy. Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective to the boardroom and should scrutinise the performance of the provider's management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

1.16 **Medical Director** is the existing board-level leader responsible for the learning from deaths agenda.

1.17 **The named Non-Executive Director** has responsibility to ***understand the review process*** (ensuring the processes for reviewing and learning from death are robust and can withstand external scrutiny), ***champion quality improvement*** (that leads to actions that improve patient safety) and ***assure published information*** (that it fairly and accurately reflects the organisation's approach, achievements and challenges).

1.18 **Directorates (Including Clinical Directors of Operations, Associate Medical Directors, Deputy Directors of Nursing, General/Service Managers and Governance Leads)** are collectively responsible for ensuring the quality and safety of healthcare services delivered by the Directorate. The Directorate must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care.

1.19 **Trust Mortality & Morbidity Group** (MMG) is the committee responsible for the learning from deaths agenda.

1.20 **Mortality Learning Co-ordinator** provides expert knowledge, guidance and support on the implementation of the framework. Monitors the implementation of the framework and collates the necessary assurance on behalf of the MMG.

1.21 **All Medical Staff** have a responsibility to undertake structured judgement reviews and proactively participate in the successful implementation of this framework.

1.22 **All staff** have a responsibility to comply with the requirements of this policy and proactively participate in the successful implementation of this framework.

Criteria for Review

How the Trust determines which patients are considered to be under their care, and in scope for review.

1.23 The Trust will screen all adult inpatient and Emergency Department (ED) deaths in order to assess whether they meet the review criteria. This will include patients with a learning disability or severe mental illness, and those patients on End of Life Care at the time of death. There are no adult inpatient or ED deaths which will be excluded from the screening process.

1.24 The Trust will review/investigate care provided to patients who it does not consider to have been under its care at the time of death, but where another organisation suggests that the Trust should review the care provided to the patient in the past.

1.25 All infant or child, stillbirth and maternal deaths will be reviewed in accordance with the appropriate policies and guidelines identified in section 12.

How the Trust decides which deaths to review.

1.26 The Trust will review deaths of patients in the following categories:

1.26.1 Infant or child (under 18) deaths

1.26.2 Perinatal or maternal deaths

1.26.3 Deaths of patients with learning disabilities or severe mental illness

1.26.4 Deaths in areas where people are not expected to die

1.26.5 All deaths where bereaved families and carers or staff, have raised a significant concern about the quality of care provision

1.26.6 All inpatient, outpatient and community patient deaths of those with learning disabilities (the LeDeR review process outlined in Appendix 1 must be used in all aforementioned cases).

1.26.7 All deaths in a service specialty, particular diagnosis or treatment group where an ‘alert’ has been raised with the Trust through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator)

1.26.8 Deaths which should be investigated under the Serious Incident framework, including any inpatient detained under Mental Health Act in circumstances where there is reason to believe the death may have been due or in part due to problems in care. This includes suspected self-inflicted death which must be reported as a serious incident and investigated appropriately and via STEIS to the provider's commissioner(s). Consideration will also be given to commissioning an independent investigation as detailed in the Serious Incident framework.

1.26.9 Deaths where learning will inform existing or planned improvement work, for example if work is planned on improving sepsis care, relevant deaths will be reviewed, as determined by the Trust.

1.26.10 A further sample of other deaths that do not fit the identified categories to provide an overview of where learning and improvement is required. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday. This will include patients whose death was expected and may have had an End of Life Care Plan in place.

Process for Review

1.27 Regardless of the type of review, its findings must form an integral part of and feed into the Trust clinical governance processes and structures. Findings from reviews should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust's wider strategic plans and safety priorities.

1.28 The mortality review process should be completed in a reasonable timeframe and must not delay any other process, for example the release of the deceased for burial or cremation.

1.29 The Trust will apply rigorous judgement to the needs for deaths to be subject to a Serious Incident reporting and investigation. This will be done according to the existing Serious Incident Policy.

1.30 There may be instances where deaths clearly meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken). If at any stage of the mortality review process, it is suspected that the death may meet SI reporting criteria, the case will be referred directly for SI investigation (see appendix 2). After mortality review, if the overall care score is 1 (very poor) or 2 (poor) or actual harm is identified, the case will also be referred for SI investigation.

1.31 Where possible all relevant information should contribute to the review; this may include the multi-disciplinary health record (all sources), reports prepared for HM Coroner, post-mortem examination reports, testimony of family, parents, loved ones or carers and incident / complaints information.

1.32 The Trust will report all deaths within the organisation and to other organisations who may have an interest (including the deceased person's GP), and early discussion must take place after death as to any other interested party to whom the death must be reported. This may include HM Coroner, another trust in which the patient may have been cared for, social services the patient may have been receiving, or the police.

1.33 The Trust will review a case record review or investigation following any linked inquest and issue of a 'Regulation 28 Report on Action to Prevent Future Deaths' in order to examine the effectiveness of the review and investigation process.

1.34 **Adult deaths**

1.34.1 Adult deaths will be reviewed under the adult mortality review process (Appendix 2).

1.34.2 All adult deaths are screened using the Adult Mortality Screening Tool (Appendix 3) in order to identify those cases which meet mandatory review criteria.

1.34.3 The decision regarding whether to review a death will be recorded on the screening form and this information will be collated on to a spreadsheet.

1.34.4 All mortality reviews will be undertaken using the Royal College of Physicians (RCP) structured judgement review (SJR) methodology as recommended in the NQB guidance (Appendix 4).

1.34.5 Mortality reviews (Appendix 5) will receive an overall care score

- Score 1 - Very Poor Care
- Score 2 – Poor Care
- Score 3 – Adequate Care
- Score 4 – Good Care
- Score 5 – Excellent Care

1.34.6 An overall care score of 1 or 2, or the identification of actual harm will indicate a 'cause for concern' and initiate the Serious Incident process as required in line with the National Serious Incident Framework.

1.34.7 Mortality reviews should be completed and returned to the Mortality Learning-Co-ordinator within 30 days of the request being sent.

1.35 Infant or child (under 18), stillbirth and maternal deaths

1.35.1 Infant, child, maternal and stillbirth deaths will be reviewed and investigated according to the corresponding guidelines and policies identified in Section 12.

1.35.2 After the death of an Infant or child (under 18), stillbirth or maternal death which involves treatment across the health care pathway (primary; secondary; tertiary care), it is expected that mortality review processes will not be duplicated. The review of these deaths will be undertaken according to existing national requirements.

1.35.3 The NHS England child death review programme is mindful of expectations arising from the Serious Incident Framework, which sets out the circumstances in which further investigation is warranted in certain situations. It is therefore anticipated that when a review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this is reported via the risk management systems to the National Reporting and Learning System (NRLS).

1.36 Learning Disability deaths

1.36.1 In addition to the Trust internal review, any death of a patient aged 4 and above with a recognised learning disability as defined by the Learning Disabilities White Paper 'Valuing People' (2001) will be referred to the Learning Disabilities Mortality Review (LeDeR) programme (Appendix 7) in line with national guidance.

1.37 Severe mental illness deaths

1.37.1 In line with national guidance, all deaths of patients with severe mental illness will be reviewed through the Trust mortality review process (Appendix 2).

Engagement with Bereaved Families and Carers

1.38 The Trust aims to engage meaningfully and compassionately with bereaved families and carers, this will include informing the bereaved families or carers if the Trust intends to investigate the care provided. In the case of an investigation, this will include details of how families / carers will be involved and to what extent they wish to be involved. Initial contact with families / carers should, where possible, be managed by the Clinicians responsible for the care of the patient.

1.39 If the care of a patient who has died is selected for review the Trust will have formed the decision based on the views of the family and carers. The Trust will review cases where family and carers have raised significant concern about the quality of care provision.

1.40 The Trust will communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed to the future (see Duty of Candour Policy).

1.41 The Trust will offer guidance, where appropriate, on obtaining legal advice for bereaved families, carers and staff.

1.42 The Complaints Management policy (see section 12) 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.

1.43 The Duty of Candour Policy (see section 12) aims to ensure that patients and/or their family/carers are told about patient safety incidents that have affected them. That they receive a genuine apology, are kept informed of investigations and are supported to deal with the consequences.

1.44 The End of Life Care Policy (see section 12) aims to standardise and provide a co-ordinated approach to the management of End of Life Care across the Trust in conjunction with national recommendations and guidelines. This includes meeting the needs of the patient and their bereaved families and carers and giving them an opportunity to discuss any concerns they may have.

1.45 The Inpatient Death process and Coroner's Inquest Policy (see section 12) outlines the process for completing the Medical Certificate of Cause of Death (MCCD) and informing the GP of the death. This will be done simultaneously, in accordance with the NQB guidance.

Mortality Governance and Learning from Deaths

1.46 The Trust recognises that mortality review does not replace the need to consider national mortality data (HSMR and SHMI). As such, the Trust Mortality & Morbidity group (MMG) provides assurance to the Trust regarding mortality indicators in addition to results of case record reviews.

1.47 The MMG will monitor national mortality indicators and review mortality reports from directorates and specialties regarding mortality reviews and learning from deaths.

1.48 In accordance with national guidance, the Trust will consider findings of reviews and investigations alongside other information and data including complaints, clinical audit information, mortality data, patient safety incident reports and data outcome measures in order to promote learning.

1.49 The MMG will ensure that learning identified at specialty and directorate level is shared appropriately to all relevant parties across the Trust.

1.50 Each specialty (where applicable) will conduct mortality and morbidity meetings on a regular basis. These should be multi-disciplinary in nature and seek to identify areas where learning can be identified. Minutes and action logs should be completed to capture outcomes of mortality review and resulting actions and learning.

1.51 Each specialty mortality review group will be chaired by a consultant Mortality Lead. The group will report to the directorate governance meeting and highlight any issues that will improve care and reduce avoidable mortality.

1.52 The Inpatient Death Process and Coroner's Inquests Policy (see section 12) provides information and guidance to all staff on the process and systems to follow in the event of a death, including certification of death and referral to the Coroner's Office. The policy outlines legal requirements, individual responsibilities of staff, and explains the support and guidance available throughout the process.

1.53 As required, the Trust will present information quarterly at the public meeting of the Board of Directors. This data will include the total number of the Trust's inpatient deaths (including Emergency Department deaths, maternal deaths, neonatal deaths and stillbirths) and those deaths that the Trust has subjected to mortality review. Of these deaths subjected to review, the Trust will provide estimates of how many deaths were judged more likely than not to have been due to problems in care.

1.54 The required mortality data will also be published in the Trust Quality Accounts from June 2018, including evidence of learning and actions as a result of information and an assessment of the impact of actions that the Trust has taken.

Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	First review in one year and then every three years	Author	Mortality & Morbidity Group, Quality Assurance Committee	This policy will be reviewed in conjunction with national guidance and Trust objectives. The policy will be published on the Trust Intranet.
Number of deaths, including Learning Disability (LD) deaths specifically.	Monthly Integrated Quality and Performance Report (IQPR)	Mortality Learning Co-ordinator	Mortality & Morbidity Group, Quality Assurance Committee	Any shortfalls identified will have an action plan put in place to address which will have timescales included for re-audit / monitoring.
Number of eligible deaths reviewed, including LD deaths specifically.	Quarterly reports to the Board	Mortality Learning Co-ordinator	Mortality & Morbidity Group, Quality Assurance Committee, Public Board	Any shortfalls identified will have an action plan put in place to address which will have timescales included for re-audit / monitoring.
Time taken to return mortality review forms	Monthly reports to directorates and the Trust Mortality & Morbidity Group	Mortality Learning Co-ordinator	Mortality & Morbidity Group	Appropriate action taken as necessary by the MMG where specialties/ directorates are identified as not meeting the required timeframe for review (30 days from request).
Performance against key mortality metrics – crude death rate, HSMR and SHMI	Monthly IQPR	Mortality Learning Co-ordinator	Mortality & Morbidity Group, Trust Board	Alerts will be investigated accordingly in collaboration with the Clinical Coding Team and relevant specialties.

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Learning from deaths	Directorate/ specialty presentations, reports and minutes. To be assessed quarterly in line with MMG specialty rota.	Directorate and specialty mortality leads	Mortality & Morbidity Group	Directorates and specialties should be able to demonstrate learning through M&M minutes and reports/presentations to the MMG. Appropriate action will be taken by the MMG as necessary where this is not evident. Learning from M&M reviews will be reflected in quarterly reports to appropriate trust-level committees.
Engagement with families and carers	Duty of candour, SI reports	Directorate and specialty mortality leads	Mortality & Morbidity Group	Where mortality review and investigations identify problems in care, documentation should be available to show that the Duty of Candour process has been implemented.

Training and Implementation

1.55 Training in the Royal College of Physicians (RCP) case note review methodology will be provided to trusts. The Trust will ensure that the appropriate staff members are identified to receive training.

1.56 Trained clinicians will cascade the RCP case note review methodology learning to fellow reviewers.

1.57 Reviewers will apply the RCP methodology and best practice when conducting mortality reviews.

Equality Impact Assessment Statement & Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide “evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]”; in effect to undertake equality impact assessments on all procedural documents and practices. Authors should use the Equality Impact Toolkit to assess the impact of the document.
In the first instance this will mean screening the document and, where the screening indicates, completing a full assessment. The Toolkit can be found on the Trust website http://www.medway.nhs.uk/our-foundation-trust/publications/equality-and-diversity/equality-impact-assessments/

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

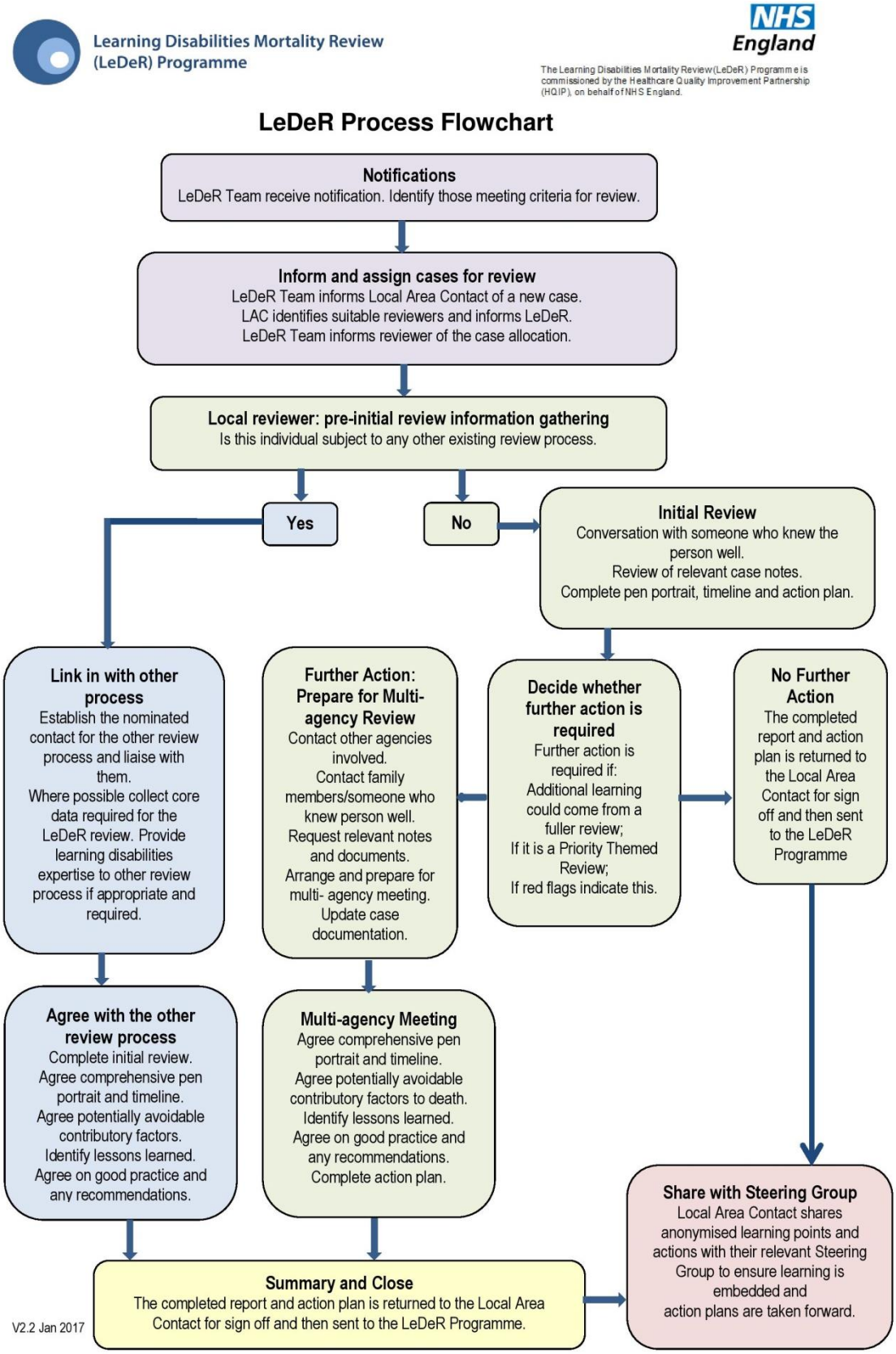
References

Document	Ref No
References:	
National Quality Board ‘National Guidance on Learning from Deaths’ (March 2017)	Framework
Royal College of Physicians National Mortality Case Record Review Programme ‘Using the structured judgement review method: Data collection form, England version’ (May 2017)	Resource
Sir Bruce Keogh KBE ‘Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report’ (July 2013)	Report

Care Quality Commission 'Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England' (December 2016)	Report
Mazars 'Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015' (December 2015)	Report
NHS England Serious Incidents Framework (2016)	Framework
NHS Improvement 'Implementing the Learning from Deaths framework: key requirements for trust boards' (July 2017)	Framework
Central Manchester University Hospitals NHS Foundation Trust 'Mortality Review Policy' (June 2017)	Policy

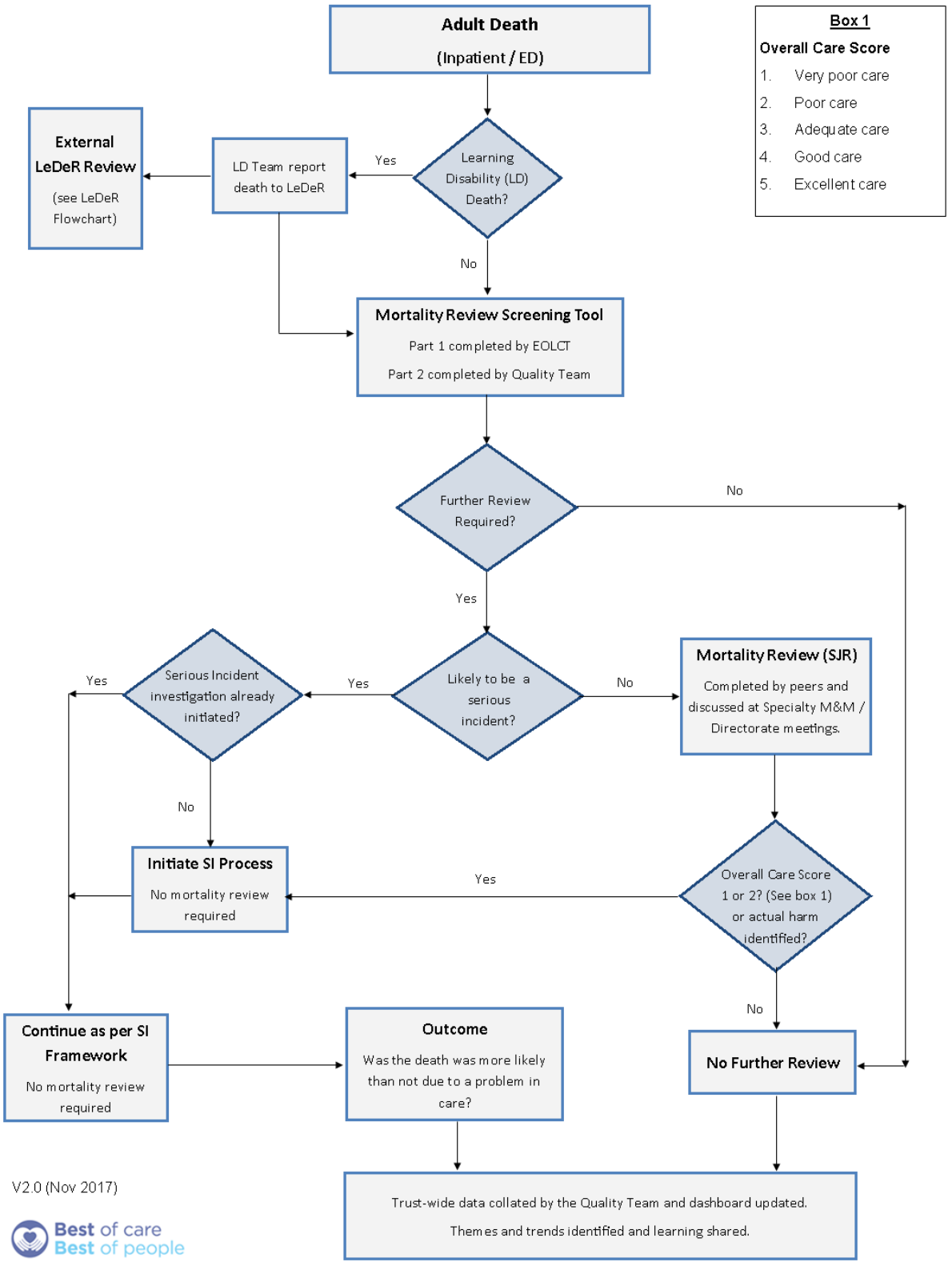
Trust Associated Documents:	
Serious Incident Policy	POLCGR071 - CORPORATE POLICY - Serious Incident SI (1 attachment)
Duty of Candour Policy	POLCGR064 - CORPORATE POLICY - Duty of Candour Policy (Being Open) (1 attachment)
Inpatient Death Process and Coroner's Inquest Policy	POLCGR127 (DRAFT) – yet to be published on QPULSE
Complaints Management Policy	POLCGR005 - CORPORATE POLICY: Complaints Management (1 attachment)
End of Life Care Policy	POLCPCM058 - End of Life Care Policy (1 attachment)
Patient Affairs – Administrative practical support of the bereaved	AGN00108 - AGN - Patient Affairs - Administrative Practical Support for the Bereaved (1 attachment)
Maternal Death Guidelines	GUDNM018 - Maternal Death Guidelines (1 attachment)
Oliver Fisher Neonatal Guidelines: Death – procedures following the death of a baby	GUDPCM001-AN - Death - procedure following the death of a baby - DOCTORS GUIDANCE - OLIVER FISHER UNIT (1 attachment)
Death of a Paediatric Patient Guideline	GULPCM186 - Death of a Paediatric Patient Guideline (1 attachment)
Safeguarding Vulnerable Adults	GUCPCM001 - Safeguarding Vulnerable Adults (1 attachment)
Kent and Medway Safeguarding Children Procedures	POLCPCM055 - Kent & Medway Safeguarding Procedures (1 attachment)
Safeguarding Children – Responding to Child Death Procedure	PROCPCM001 - Safeguarding Children - Responding to Child Death Procedure (1 attachment)
Pregnancy Loss and Termination of Pregnancy for Foetal Abnormality Policy	POLLNM010 - Pregnancy Loss and Termination of Pregnancy for Fetal Abnormality (1 attachment)

- Appendix 1 (LeDeR Process Flowchart)



Adult Mortality Review Process

NHS Medway NHS Foundation Trust



V2.0 (Nov 2017)

Best of care Best of people

Adult Mortality Review Screening Tool

Part 1 *Completed by End of Life Care Team*

Patient ID	
Patient Name	
Date of Death	Click here to enter a date.
Ward of Death	
Cause of Death (if available)	
Was this death reported to the Coroner?	☐ Yes ☐ No
Consultant at Time of Death	
Was the patient on EOLC?	☐ Yes ☐ No

	Criteria for Case Record Review	Yes	No
1	Have family members or carers raised a significant concern about the quality of care provision?	☐	☐
2	Have any staff members raised a significant concern about the quality of care provision?	☐	☐
3	Did the patient have a learning disability?	☐	☐
4	Did the patient have a severe mental illness?	☐	☐
5	Is this a death in an area where people are not expected to die? *(e.g. patients attending for a routine elective procedure)*	☐	☐
6	Do you have any other cause to think that this death would benefit from a Serious Incident Investigation or mortality review? *(Please indicate your reasons below)*	☐	☐

Completed by: **Date completed:** Click here to enter a date.

Job Title:

Part 2 *Completed by Quality Team*

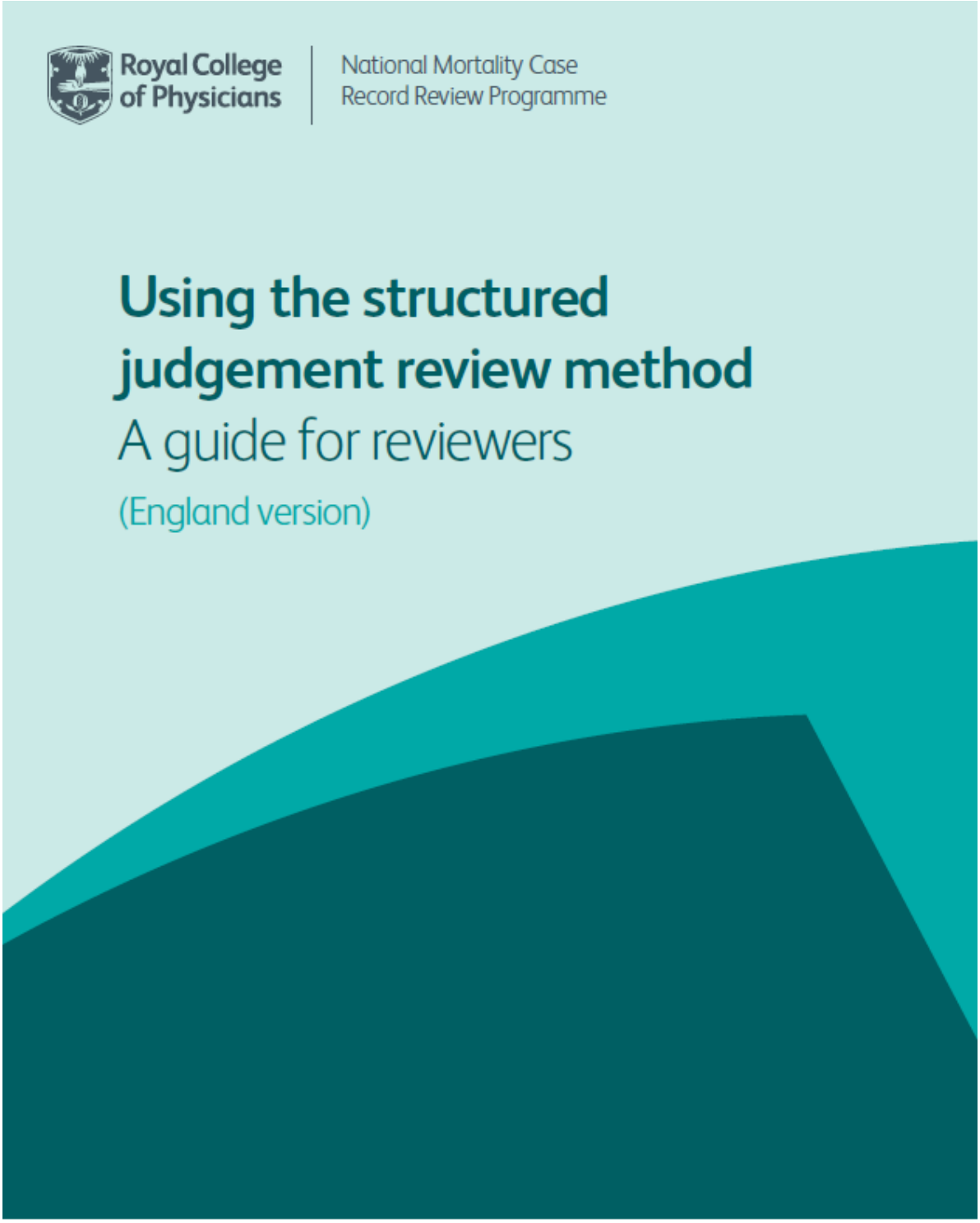
Criteria for Case Record Review		Yes	No
1	Has an alarm been raised on Dr Foster?	☐	☐
2	Has a concern or red flag been raised in relation to an area which is already under investigation or subject to review?	☐	☐
3	Is there an incident recorded on Datix which directly relates to the death, or which raises concerns about the care provided?	☐	☐
4	Is there a complaint or PALS concern relating to this case?	☐	☐
5	Is there a safeguarding concern relating to this case?	☐	☐
6	Has the CQC or any other regulatory organisation raised a concern in an area relating to this case?	☐	☐
7	Does this case relate to any existing or planned quality improvement work?	☐	☐
8	Do you have any other cause to think that this death would benefit from a Serious Incident Investigation or mortality review? *(Please indicate your reasons below)*	☐	☐

Completed by: **Date completed:** Click here to enter a date.

Job Title:

Outcome *Completed by Quality Team*

Is further review required or already underway?	☐ Yes ☐ No
If 'Yes', which review process?	☐ Mortality Review (SJR) ☐ Currently subject to an SI Investigation ☐ Currently under Coroner's investigation / Inquest ☐ To be considered within the SI Framework
Date review requested	Click here to enter a date.
Request sent to	
Request sent by	



Dr Allen Hutchinson

Emeritus professor in public health
University of Sheffield

Date	Version number	Document owner	Review date
15 March 2017	One	Clare Wade – programme manager	September 2017

Structured judgement review

1 Background to the method and its strengths

In order to provide the benefits to patient care that are commensurate with the effort put into case note review, review methods need to be standardised, yet not rigid, and usable across services, teams and specialties.

Structured judgement review blends traditional, clinical-judgement based review methods with a standard format. This approach requires reviewers to make safety and quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.[1] The result is a relatively short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.

The objective of the review method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions.

Structured judgement case note review can be used for a wide range of hospital-based safety and quality reviews across services and specialties, and not only for those cases where people die in hospital. For example, it has been used to assess the care provided for people who have had a cardiac arrest in hospital, to review safety and quality of care prior to and during non-elective admission to intensive care settings and to review the care provided for people admitted at different times of the week.

An important feature of the method is that the quality and safety of care is judged and recorded whatever the outcome of the case, and good care is judged and recorded in the same detail as care that has been judged to be problematic. Evidence shows that most care is of good or excellent quality and that there is much to be learned from the evaluation of high-quality care.

2 How the structured judgement review method works

2.1 Who does what and when?

There are two stages to the review process. The first stage is mainly the domain of what might be called 'front line' reviewers, who are trained in the method and who undertake reviews within their own services or directorates, sometimes as mortality and morbidity (M&M) reviews, sometimes as part of a team looking at the care of groups of cases. This is where the bulk of the reviewing is done and most of the reviews are completed at this point.

A second-stage review is recommended where care problems have been identified by a first-stage reviewer and an overall care score of 1 or 2 has been used to rate care as very poor or poor. This second-stage review is usually undertaken within the hospital governance process and normally uses the same review method. At this stage the hospitals may also choose to assess the potential avoidability of a death where harms due to care have been identified (see Section 4 below and *A clinical governance guide* (RCP 2016) associated with the review guide).

2.2 Phases of care – the 'structure' part of the method

The phase of care structure provides a generalised framework for the review and also allows for comparisons among groups of cases at different stages of care. The principal phase descriptors are shown in Box 1. However the use of the phase structure depends on the type of care and service being reviewed – not all phase of care headings will be used for any particular case. Thus the procedure-based review section may only be required in a few medical cases (eg a lumbar puncture, a chest drain or non-invasive ventilation) but are likely to be used in many surgical cases. It is up to the reviewer to judge which phase of care forms are appropriate in a particular case.

Box 1 Phase of care headings

- Admission and initial care – first 24 hours
- Ongoing care
- Care during a procedure
- Perioperative/ procedure care
- End-of-life care (or discharge care)*
- Assessment of care overall

*Note that discharge care is included because this method is just as applicable for the review of care for people who do not die during an admission.

2.3 Explicit judgement comments – the core of the method

The purpose of the review is to provide information from which teams or the organisation can learn. Explicit judgement commentaries serve two main purposes. First, they allow the reviewer to concisely describe how and why they assess the safety and quality of care provided. Second, they provide a commentary that other health professionals can readily understand if they subsequently look at the completed review.

When asked to write comments on the quality and safety of care, clinical staff often tend to write a resume of the notes or make an *implicit* critique of care. This is not helpful when others try to understand the reviewer's real meaning. So the central part of the review process comprises short, written, *explicit* judgement statements about the perceived safety and quality of care that is provided in each care phase.

This review guide does not include a glossary of explicit terms that reviewers might choose from, because this approach would inevitably be constraining or would fail to cover all eventualities in the complexities of clinical practice. Instead, reviewers are asked to use their own words in a way that explicitly states their assessment of an aspect of care and gives a short justification for why they have made the assessment.

Explicit statements use judgement words and phrases such as 'good', 'unsatisfactory', 'failure' or 'best practice'. See Box 2 and Box 3 for examples.

Box 2 Examples of phase of care structured judgement comments

- Continued omission to provide oxygen and respiratory support – poor care.
- Team still failed to discuss potential diagnosis with patient – unsatisfactory.
- Referral to intensive treatment unit (ITU) was too late.
- There was some evidence of good management by the overnight team, with prompt review and intervention.
- Although patient discussed with a consultant once and a specialist registrar (SpR) once, for 4 days they were only seen by junior doctors – this is completely unsatisfactory.
- Very good care – rapid triage and identification of diabetic ketoacidosis with appropriate treatment.

Additionally, these judgement words are accompanied by short statements that provide an explicit reason why a judgement is made – eg 'unsatisfactory because, etc' and 'for example, resuscitation and ceiling of treatment decisions made far too late in course of admission – poor care'. The purpose here is not to write long sentences but to encapsulate the clinical process in a few explicit statements.

Judgement comments should be made on anything the reviewer thinks is important for a particular case. Among other things, this will include the appropriateness of management plans and subsequent implementation together with the extent to which, and how, care meets good practice. In some cases, there may be care in a phase that has both good and poor aspects. Both should be commented on.

Commentary on holistic care is just as important as commentary on technical care, particularly where complex ceiling of treatment and end-of-life care discussions might be held. Judgements should be made on how the teams have managed end-of-life decision making and to what extent patients and their relatives have been involved. Thus, for example, a judgement comment might be couched as 'end-of-life care met recommended practice, good ceiling of treatment discussion with patient and family'. Similar approaches and levels of detail are required when care is thought not to have gone well, or where aspects of care are judged to be only just acceptable. Then words such as 'unsatisfactory', 'poor' or 'doesn't meet good practice standards' might be necessary.

Sometimes it is just not clear what has been happening during part of the process of care, where there appears to be a lack of decision making or guidance. Here, judgement words such as 'delay', 'poor planning' and 'lack of leadership' etc may be used. Or if this lack of clarity is due to the level of documentation, comments such as 'inadequate record keeping' may apply.

Overall, phase of care comments are intended to bring a focus to the review by asking for an explicit, clear judgement on what the reviewer thinks of the whole care episode, taking all aspects into consideration. It is not necessary to repeat all of what has been commented on before, although it is sometimes useful to repeat some key messages – that is a reviewer's choice. Again, however, it is important to make clear and explicit what the overall judgement is and why. Examples are given in Box 3.

Box 3 Examples of overall care structured judgement comments

- Overall, a fundamental failure to recognise the severity of this patient's respiratory failure.
- Good multidisciplinary team involvement.
- On the whole, good documentation of clinical findings, investigation results, management plan and discussion with other teams.
- Poor practice not to be aware of the do not attempt resuscitation (DNAR) status of the patient, especially when it has been discussed with family, clearly documented when first put in place and reviewed later on.

Cause of death information should form part of the review framework. If, on review, the certified cause of death causes the reviewer some concern, this should be explicitly stated, because there may be a clinical governance question involved.

So, the overall message about review language is that it should be explicit and clear, in order that you, the reviewer, feel you have made the points clearly and that others who read the review will be able to understand what you have said and why.

2.4 Giving phase of care scores

Box 4 Phase of care scores

1. Very poor care
2. Poor care
3. Adequate care
4. Good care
5. Excellent care

Care scores are recorded after the judgement comments have been written, and the score is in itself the result of a judgement by the reviewer. Only one score is given per phase of care: it is not necessary to score each judgement statement.

Scores range from 'Excellent' (score 5) to 'Very poor' (score 1) – see Box 4 – and are given for each phase of care that is commented on and for care overall.

These scores have a number of uses. For the individual reviewer, scores help them to come to a rounded judgement on the phase of care, particularly when there may be a mix of good and unsatisfactory care within a phase. The reviewer must judge what their overall decision is about the care provided for each phase and for care overall. Scoring makes this very explicit.

Overall care scores are particularly important in the review process. A score of 1 or 2 is given when the reviewer decides that care has been very poor or poor. Research evidence suggests that this might happen in upwards of 10% of cases in some circumstances, but less in others. A score at this level should trigger a second-stage review through the hospital clinical governance process (see Section 4).

2.5 Judging whether problems in care have caused harm

Problems in care take many forms and may have a range of impacts, some of which are potential rather than actual. Some of these events cause harms, but many do not.

The first-stage reviewer has an important role here in assisting the hospital to identify both actual and potential threats to patient safety. Using the assessment sheet at Appendix 1, reviewers are asked three questions in relation to problems identified in care. These are in the following format.

A) Were there one or more problems in care during this admission? Yes or no

B) If so, in which area(s) of the care process did this/these occur?

C) And for each of these problems, did any cause harm?

While the results of this assessment will be of importance in clarifying the issues in each review, it is the information aggregated across reviews that may pick up more fundamental care process issues that require attention.

2.6 Judging the quality of recording in the case notes

Case note review of course depends critically on the content and the legibility of the records. Safety of care also depends to some extent on good record keeping. Therefore, as part of the overall care assessment, the reviewer is also asked to record their judgement on the quality and legibility of the records, again using a score of 1–5.

3 The review in practice

Case note review takes up expensive clinical resource so that the time spent on establishing the purpose and desired outcome of the review is important.

In some hospitals, the majority of mortality reviews take place in an M&M context and so they are often already being considered to be potentially problematic cases. Structured judgement review has been found to be of value in providing a reproducible process for M&Ms.

However the challenge for hospitals has often been the gathering together of the material from the reviews so that it can be used to examine care processes. Data from M&M cases should be entered into the hospital reviews database. Aggregated information is more powerful in the longer term than the data from individual cases.

Screening deaths for possible problems is another means of indicating where focused reviews are necessary. Valuable information about specific issues can be gained in this way, although generalising messages from complex cases can produce 'solutions' that may themselves have unintended consequences.

Another approach is to evaluate care for all or some patients who come to a particular service, or to explore the care provided for the majority of people who die in hospital over a particular time period in particular services; for example, all elective surgery deaths or people who die from acute kidney injury might require review. This aspect is covered in some detail in the *governance guidance* which forms part of the overall guidance materials.

Given the constraints on reviewer availability and the need to produce usable information from the reviews, the principle of 'less is more' applies.

A simple time-based longitudinal sample of around 40–50 cases will produce a rich source of quantitative and qualitative information on what goes right and what is not working properly. Timely review, rather than review after a delay, provides better information.

Time spent on the analysis and information presentation outweighs the benefit of adding a few more cases to the sample. The textual information allows for themes to be developed that then allows a focus for the next improvement steps. Such an approach also has the benefit of enabling individuals to learn from, and celebrate, the cases where care has gone well.

4 Second-stage review

In the context of the National Mortality Case Record Review Programme, second-stage review takes place within the hospital governance framework when the first-stage 'front line' reviewer judges care overall to be very poor (score 1) or poor (score 2), or when harms have been identified, or if concerns have been raised about a case.

Second-stage review is also undertaken using the structured judgement method and is effectively a process of validation of the first reviewer's concerns. If the second-stage reviewer broadly agrees with the initial case review (with poor or very poor overall scores and/or where actual harm(s) is judged to have occurred), the hospital governance group may decide on an additional assessment concerning the potential avoidability of the patient's death.

Judging the level of the avoidability of a death is a complex assessment that can be challenging to undertake. This is because the assessment goes beyond judging safety and quality of care by also taking account of such issues as comorbidities and estimated life expectancy. Recent evidence suggests the levels of agreement can be very low when assessing potential avoidability of death.

The judgement is framed by a six-point scale (6 – no evidence of avoidability, to 1 – definitely avoidable). This scale has been used in a number of recent national mortality review studies in Canada, the Netherlands and England.[2] Additionally, the national review process, the second-stage reviewer supports the score choice with an explicit judgement comment justifying why the score decision was made.

The avoidability scale is shown in Box 5, together with an example of an 'avoidability of death' judgement comment. A score of 1, 2 or 3 on the avoidability scale would indicate a governance 'cause for concern'.

Appendix 1 – Assessment of problems in healthcare

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm.

Were there any problems with the care of the patient? (Please tick)

No ☐ (please stop here) Yes ☐ (please continue below)

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please tick all that relate to the case.

Problem types

1. **Problem in assessment, investigation or diagnosis** *(including assessment of pressure ulcer risk, venous thromboembolism (VTE) risk, history of falls)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

2. **Problem with medication / IV fluids / electrolytes / oxygen** *(other than anaesthetic)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

3. **Problem related to treatment and management plan** *(including prevention of pressure ulcers, falls, VTE)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

4. **Problem with infection control:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

5. **Problem related to operation/invasive procedure** (*other than infection control)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

6. **Problem in clinical monitoring** *(including failure to plan, to undertake, or to recognise and respond to changes)*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

7. **Problem in resuscitation following a cardiac or respiratory arrest** *(including cardiopulmonary resuscitation (CPR))*: Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

8. **Problem of any other type not fitting the categories above:** Yes ☐
   Did the problem lead to harm? No ☐ Probably ☐ Yes ☐

Adapted from Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239

Editorial note

This document has been adapted with permission from: Hutchinson A, McCooe M, Ryland E. *A guide to safety, quality and mortality review using the structured judgement case note review method*. Bradford: The Yorkshire and the Humber Improvement Academy, 2015. (Copyright The Yorkshire and the Humber Improvement Academy.)

The case note review methods discussed in this guide were primarily developed in a research study published as: Hutchinson A, Coster JE, Cooper KL, McIntosh A, Walters SJ, Bath PA *et al*. Comparison of case note review methods for evaluating quality and safety in health care. *Health Technol Assess* 2010;14(10):1–165.

All clinical examples and structured judgement comments in this document are taken from hypothetical scenarios.

Please note that this guide is subject to change following conclusion of the pilot phase of the programme.

References

1. Hutchinson A, Coster JE, Cooper KL, Pearson M, McIntosh A, Bath PA. A structured judgement method to enhance mortality case note review: development and evaluation. *BMJ Quality and Safety* 2013;22:1032–1040. DOI: 10.1136/bmjqs-2013-001839.
2. Hogan H, Zipfel R, Neuberger J, Hutchings A, Darzi A, Black N. Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis. *BMJ* 2015;351:h3239. DOI: 10.1136/bmj.h3239.
3. Royal College of Physicians. *Using the structured judgement review method – a clinical governance guide to mortality case record reviews*. London: RCP, 2016.

Mortality Case Record Review Form

Name of reviewer	
Reviewing specialty *(e.g. cardiology)*	
Patient ID	
Patient name	
Age at death *(years)*	
Sex	☐ Male ☐ Female
First 3 / 4 digits of postcode	
Date of admission	
Time of admission	
Date of death	
Time of death	
Place of death *(ward)*	
Specialty at time of death	☐ Surgical ☐ Medical
Specialty team at time of death *(e.g. cardiology)*	
Consultant at time of death	
Type of admission	☐ Emergency ☐ Elective ☐ Day Case
Recorded cause of death *(part 1a on death certificate)*	

Phase of Care Scores

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice (for example, your professional standards or your professional perspective). If there is any other information that you think is important or relevant that you wish to comment on then please do so.
Please rate the care received by the patient during each phase. Please circle only one score for each.

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Phase of care	Score and explicit judgements
Admission and initial management *(approximately the first 24 hours)*	
	Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Phase of Care Scores Continued

1 = very poor care 2 = poor care 3 = adequate care 4 = good care 5 = excellent care

Phase of care	Score and explicit judgements
Ongoing care	

	Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Care during a procedure *(excluding IV cannulation)*	
	Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Perioperative care	
	Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
End of life *(or discharge care in the event that this form is used for a morbidity review)*	
	Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Overall Care Score

Overall assessment *(explicit judgements about quality of care the patient received overall)*	
	Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5
Quality of patient record *(patient notes)*	
	Score: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Assessment of Problems in Healthcare

Were there any problems with the care of the patient?

☐ **No** *(please stop here)* ☐ **Yes** *(please continue below)*

If you did identify problems, please identify which problem type(s) from the selection below and indicate whether it led to any harm. Please circle all problems which relate to this case.

Problem Type	**Yes?** *(tick as appropriate)*	**Did the problem lead to harm?** *(include comments as necessary and tick as appropriate)*
Problem in assessment, investigation or diagnosis *(including assessment of pressure ulcer risk, VTE risk, history of falls)*	☐	☐ No ☐ Probably ☐ Yes
Problem with medication / IV fluids / electrolytes / oxygen *(other than anaesthetic)*	☐	☐ No ☐ Probably ☐ Yes
Problem related to treatment and management plan *(including prevention of pressure ulcers, falls, VTE)*	☐	☐ No ☐ Probably ☐ Yes
Problem with infection control	☐	☐ No ☐ Probably ☐ Yes
Problem related to operation / invasive procedure *(other than infection control)*	☐	☐ No ☐ Probably ☐ Yes
Problem in clinical monitoring *(including failure to plan, to undertake, or to recognise and respond to changes)*	☐	☐ No ☐ Probably ☐ Yes
Problem in resuscitation following a cardiac or respiratory arrest *(including cardiopulmonary resuscitation - CPR)*	☐	☐ No ☐ Probably ☐ Yes
Problem of any other type not fitting the categories above	☐	☐ No ☐ Probably ☐ Yes

This section is for your notes only and will not be entered on to the central database. However, a copy of all forms will be held centrally in line with the management and retention of records policy and can be accessed by contacting: met-tr.mortalitycoordinator@nhs.net

Please return completed forms to:
Mortality Learning Co-ordinator, Eliot Ward

met-tr.mortalitycoordinator@nhs.net

Mortality review forms must be returned promptly to facilitate early learning and prevent delays.

- Appendix 6 ('Valuing People' A White Paper)

Extract from 'Valuing People: A New Strategy for Learning Disability for the 21st century' A White Paper.

Report - Valuing People, A New Strate

What is Learning Disability?

1.4 *Valuing People* is based on the premise that people with learning disabilities are people first. We focus throughout on what people can do, with support where necessary, rather than on what they cannot do.

1.5 Learning disability includes the presence of:

- A significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with;
- A reduced ability to cope independently (impaired social functioning);
- which started before adulthood, with a lasting effect on development.

1.6 This definition encompasses people with a broad range of disabilities. The presence of a low intelligence quotient, for example an IQ below 70, is not, of itself, a sufficient reason for deciding whether an individual should be provided with additional health and social care support. An assessment of social functioning and communication skills should also be taken into account when determining need. Many people with learning disabilities also have physical and/or sensory impairments. The definition covers adults with autism who also have learning disabilities, but not those with a higher level autistic spectrum disorder who may be of average or even above average intelligence – such as some people with Asperger's Syndrome. We consider the additional needs of people with learning disability and autism in more detail in Chapter 8.

1.7 'Learning disability' does not include all those who have a 'learning difficulty' which is more broadly defined in education legislation.

END OF DOCUMENT

Report to the Board of Directors

Board Date: 18/01/2018

Agenda item 10c

Title of Report	**ANNUAL REPORT ((2016 to August 2017) SAFE WORKING HOURS**
Prepared By:	Miss Delilah Hassanally, Guardian of Safe Working (GSW)
Lead Director	Dr Diana Hamilton-Fairley
Committees or Groups who have considered this report	Not applicable
Executive Summary	The new Junior Doctor contract 2016 required all NHS Trusts to appoint a Guardian of Safe Working Hours (GSWH). The GSWH is independent of Trust management structures with a specific remit to ensure that safe working practices for doctors in training are embedded. There is an annual requirement to provide a report on compliance with the contract to the Trust Board. This report outlines progress at Medway NHS FT between August 2016 and August 2017 in introducing the new contract. The Trust Board is asked to note the progress made and to be assured that we have implemented reporting and management systems that enable compliance with the contract. The report also includes the number of exception reports, fines levied and issues that have arisen in the introduction of the system.
Resource Implications	No additional resource
Risk and Assurance	Not applicable

Report to the Board of Directors

Legal Implications/Regulatory Requirements	Contractual requirement of new Junior Doctors contract that this report is presented on annual basis to the board to provide assurance that appropriate controls and processes are in place to deliver safe working hours for medical staff in training.			
Improvement Plan Implication	Not applicable			
Quality Impact Assessment	Not applicable			
Recommendation				
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☐	☒	☒	☒

Report to the Board of Directors

1. Executive summary

The new Junior Doctor contract 2016 required all NHS Trusts to appoint a Guardian of Safe Working Hours (GSWH). The GSWH is independent of Trust management structures with a specific remit to ensure that safe working practices for doctors in training are embedded. There is an annual requirement to provide a report on compliance with the contract to the Trust Board.

This report outlines progress at Medway NHS FT between August 2016 and August 2017 in introducing the new contract. The Trust Board is asked to note the progress made and to be assured that we have implemented reporting and management systems that enable compliance with the contract.

The report also includes the number of exception reports, fines levied and issues that have arisen in the introduction of the system.

2. Introduction

The New Junior Doctor contract went live on 3rd August 2016 and its implementation commenced in October 2016 after discussion between the Department of Health and the BMA. The implementation schedule is shown in Appendix 3.

Guardian of Safe Working Hours

A key part of the new contract is the appointment of a Guardian of Safe Working (GSWH) Hours. All NHS Trusts are required to appoint a GSWH and the role is independent of Trust management with a specific remit to ensure safe working practices for doctors in training are embedded and to provide assurance of this to the Trust Board. This is essential to promote patient safety within the Trust.
The contract has been implemented in all NHS organisations and the Guardian of Safe Working Hours at Medway NHS Foundation Trust is Miss Delilah Hassanally, Consultant Breast Surgeon who has time allocated to this role in her contract.

Forum of Trainee Safe Working (FTSW)

The Guardian regularly meets Junior Doctors at the Forum of Trainee Safe Working where issues are identified and decisions made on interpreting contractual issues.

Two specific features of this contract are work schedules and exception reports (ER).

Work Scheduling

Work scheduling refers to a generic work schedule sent to the trainee prior to commencement of post and then personalised by discussion between the trainee and the educational supervisor shortly after starting the post.

Exception Reporting

Exception reporting (ER) is a new process that replaces the current hour-monitoring (diary card exercise). ERs are submitted by a trainee when their day-to-day work varies significantly from their agreed work schedule.

ERs may relate to

- variations in the hours worked
- the pattern of work
- missed educational and learning opportunities
- lack of support available to the doctor whilst at work.

If the trainee is in doubt they have been encouraged both by the new contract and the GSW to express their concerns and log an ER.

Penalties and Fines

As per the Terms and Conditions of this New Contract penalty/fines may be levied against the Trust by the Guardian of Safe Working when working hours breach one or more of the following parameters:

a) The 48 hour average weekly working limit
b) Contractual limit on maximum 72 hours worked within any consecutive 7 day period
c) Minimum 11 hour rest period has been reduced to less than 8 hours
d) Where meal breaks are missed on more than 25 per cent of occasions over a rota cycle.

All four of these stipulations are firmly centered on the need for all trainees to work safe hours, to ensure patient safety and doctor safety.

3. **Information on working hours for doctors in training**

3.1 High level data

Total number of job offers Trust is expected to make under the new contract by the end of the implementation process (end of October 2017).	227
Number of doctors / dentists in training on 2016 TCS (total):	227
Amount of time available in job plan for guardian to do the role:	1 PA
Admin support provided to the guardian (if any)	Supported by Medical Workforce team and Medical Directors Office.
Amount of job-planned time for educational supervisors	0.25 PAs per trainee

3.2 Exception reports (with regard to working hours and /or education)

Exception Reports (ERs) are notified to the relevant Educational (overall trainee supervisor usually for the 1 year attachment) or Clinical supervisor (trainee supervisor for individual four-monthly attachments during Foundation year – supported by Educational supervisor) by an electronic reporting system and are copied to either the Director of Medical Education (Dr Janette Cansick) for training issues, or to the Guardian of Safe Working (Miss Delilah Hassanally) for rest and hours issues. Due to the diversity of the different jobs within the Foundation year it was decided within the FTSW that the relevant Clinical supervisor for each attachment would be the best consultant to deal with the ERs. Both Educational and Clinical supervisors have been granted access to the reporting system with their own 'log-ins' to address the reported issues.

The Educational/Clinical supervisor is responsible for deciding on the outcome of an ER and informing the trainee of this decision using the DRS4 system. A presentation

at the 'Grand Round' has been given for instruction and guidance to support supervisors and trainees in the use of the system.

Two videos have also been internally produced, one for trainees and one for supervisors, to demonstrate how to use of the reporting system; these have been distributed by the Medical Workforce Team.

For the period 7th December 2016 to 2nd August 2017, there were 160 ER's generated.

Period 07/12/2016 to 02/08/2017

Total	160
Education	11
Hours and Rest	135
Hours, rest & Education	14

Period 02/08/2017 to 21/11/2017

Total	152
Education	1
Hours and Rest	144
Hours rest & Education	3

Exception reports (with regard to working hours)

Exception reports by department				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
Medicine	0	198	161	37
Emergency Med	0	5	4	1
O&G	0	0	0	0
Surgery general	0	67	38	29
Paediatrics	0	4	4	0
T&O	0	0	0	0

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
F1	0	251	222	29
F2	0	10	5	5

CT1-2 / ST1-2	0	13	0	13
SpR	0	0	0	0
Total	0	274	227	47

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
FY1 medicine	0	189	165	24
SHO medicine	0	9	0	9
ST3 O&G	0	0	0	0
F1/2 Surgery	0	67	38	29
FY1 T&O	0	0	0	0
Emergency Medicine	0	5	4	1
Paediatrics FY1	0	4	4	0
Total	0			

At the start of the New Contract 'Safe working programme', many supervisors had difficulty with log-ins and access to the electronic system, and many ERs remained unresolved. This resulted in escalation of the reports to Medical Director level, and payments were made for excess hours worked. As a result of this, an escalation process was introduced to involve the relevant clinical directors and clinical leads to ensure ERs were dealt with promptly. This has become well established and is proving more productive. Administrative support staff are now involved with maintaining the system and a new and improved electronic process will be used to support this process from January 2018.

3.3 Work schedule reviews

There have been two work schedule reviews during the reporting period.

The first analysed the 'medicine' rota which was subsequently amended to meet the hours and rest requirements.

The second related to the urology rota which although appearing fully compliant, led to one doctor exceeding weekly hours because the electronic system calculated

weekly hours from Monday to Sunday 11.59pm, whereas the doctor worked Sunday night through to Monday morning.

This urology issue resulted in a GSW penalty/fine during the relevant period. (See 3.4 below).

With regard to time off after a day 'on call', it was found that this regularly impacted on education hours for some FY2 doctors. This has been discussed with the junior doctors and alternatives offered.

Work schedule reviews

Work schedule reviews by grade	
FY1	0
FY2	2
CT1-2 / ST1-2	0
ST3+	0

3.4 Fines

As outlined in 3.3 one fine was agreed and related to the urology rota.

Fines by department		
Department	Number of fines levied	Value of fines levied
Urology	1	£87.80
Total	1	£87.80

Fines (cumulative)			
Balance at end of last quarter	Fines this period	Disbursements this quarter	Balance at end of this quarter
£0	£87.80	£87.80	£87.80

4. Meeting Contractual Requirements of the New Contract

The Guardian of Safe Working the role has been organised as per section 6 of the TCS 2016 of the New Contract. As such Medway Hospital has:

- Functioning and quorate Forum of Trainee Safe Working (FTSW). This group met once a month for 3 months during the implementation phase of the new contract, and subsequently meets quarterly at the Junior Doctors Forum (JDF). This group has an agreed TOR based on the ideal model from NHS Employers.
- Weekly meeting with Medical Workforce team. This meeting reviews exception reports and highlights changes needed.
- Local agreements on compensatory Time off in Lieu vs pay to provide clarity on process for trainees and supervisors.
- Local agreed ER escalation process to support supervisor timely response and ER closure.
- Representation at National GSW meetings. This has enabled sharing of good practice.
- Effective links with other local organisations via a GSW network group.

5 Overview of Progress and Issues

The new contract implementation was welcomed by trainees although there was some skepticism regarding the Guardian role.

Positive Culture

To overcome this the Guardian has built a positive and embracing culture with the trainees and they have seen positive results and improved working conditions through submitting ER's which has been encouraged via the Junior Doctors Forum. The Guardian ensured effective engagement with Doctor's in training through introducing herself and making contact with FY1 and FY2 doctors at their weekly teaching sessions, and actively encouraged them to engage with the Reporting system. A generic email address has been issued for trainees to write in with any issues or queries to the GSW. The Guardian has also made herself available for trainees once a week for one to one discussion as needed.

At the beginning of the new contract, FY1 doctors on the same rotations through the year complained of disparity in their remuneration due to the order of their attachments. This was resolved by the medical director by offering equal pay to the FY1 Doctors and ensuring parity throughout.

Engagement with Supervisors

Engagement with the supervisors – both Educational and Clinical was initially slow but has improved over the year. Engagement was initiated by a presentation at the 'Grand round' to inform supervisors of the new system. Further instruction and help has been provided by way of videos and personal instruction on the use of the programme to respond to ERs. Information has been disseminated to all Educational/Clinical supervisors over the year outlining their duties and the processes involved.

There is an agreed and effective email reminder system in place to help supervisors address and close ERs within the target time frame. The Guardian has benefitted from a strong administrative team including Matthew Bradd and Sue Ahmad from Medical Staffing at the beginning of her appointment and this has been further enhanced with the appointment in the Medical Directors Office of Rebecca Loates whose role was developed to include specific ER/GSW duties.

Engagement with supervisors is an ongoing need and will require regular support and education of supervising consultants in all aspects of reporting and dealing with ERs.

Electronic System

There have been difficulties with the reporting software. The functionality of the DRS-4 reporting system means that the Medical workforce team has to serially check all ERs for safe hour infringements where the IT system should be doing this automatically causing potential delays and safety issues. It is hoped that these will be resolved form January 2018 with the implementation of a new software program by 'Allocate'.

Resource

There is 1PA of time (4 hours per week) for the GSW role. This was initially inadequate initially as systems were being introduced and learned, particularly when the F1 trainees came onto the new contract in December 2016. Since then, the system has evolved well and administrative support has been setup to assist with this.

6 Summary

As part of the new junior doctor contract TCS 2016 this is the first annual report to the Trust Board by myself as Guardian of Safe Working. During this reported period up until August 2017 there have been 160 exception reports.

The Guardian is reasonably satisfied that the trainees seem happy to report exceptions via this new process and feel supported in doing so – both by the Guardian and their supervising consultants. There was concern early on around possible issues that could occur if the trainees logged reports but such concerns were aired at the JDF and discussed with the junior doctors to allay their fears. There has been a steady logging of ERs and in discussion with other GSW Medway NHS FT is receiving roughly comparable numbers of ERs appropriate for the size and structure of the organisation.

There has been recent explicit support letters from NHS Improvement and the GMC in reference to both the GSW role and the encouragement of a culture of welcoming ERs. These messages will be actively promoted within Medway Hospital (Appendix 1 and 2)

The reporting process has highlighted areas of concern and has allowed timely intervention and adjustment of rotas with some success. Further areas have since been identified and reviewed.

The Guardian is satisfied that she has support in her role from Medical Workforce colleagues and Medway Hospital Medical Director, Dr Diana Hamilton-Fairley.

Although it is not possible to assure the Board that all rotas are safe for our current trainees the Guardian can give assurance that those trainees on the new contract are engaged with the new Guardian process and as such we have seen positive changes to rotas where the hours have been found to be unsafe.

As such the Guardian confirms that we have effective processes in place that are demonstrably working for trainees, supervisors and the GSW team alike.

The Guardian will continue to need support in her role from the board and the Executive Team to enable her to have the time to engage with trainees and supervising consultants and secondly the reassurance that she has appropriate authority to request changes to rotas when they have been identified unsafe for

trainees as clearly a rota that is deemed unsafe in respect of hours and rest will be unsafe for patients being cared for by trainees working such a rota. The authority vested in the GSW must have the ability to be both swift and decisive enough to cut through all potential Divisional barriers to immediately diffuse any safety risk once identified.

There remain several gaps in the rotas and an apparent large demand on bank and agency work (appendix 4 outlines bank agency usage). These areas will be a focus for the medical workforce team in the next year.

7 Appendices

Appendix 1

NHS
Improvement

Medical Directorate

NHS Improvement
Wellington House
133 – 135 Waterloo Road
London SE1 8UG

T: 020 3747 0000
E: nhsi.enquiries@nhs.net
W: improvement.nhs.uk

22 February 2017

To: NHS Trust and Foundation Trust Medical Directors

Dear Colleague

I am writing to ask for your support for a real focus on the role of the Guardian of Safe Working, introduced as part of the implementation of the new contractual arrangements for trainee doctors. I know that you will understand the importance of this role, not just for the trainee doctors but also crucially for the safety of patients.

The NHS has shown its commitment to this role, with every Trust now having made a permanent appointment. With the Guardians now in place, they will need to be supported at all levels to work with appropriate autonomy to ensure that safe working principles are upheld and concerns relating to hours worked and access to training opportunities are properly addressed.

The Exception Reporting process is key to the success of the Guardian's role since it is the mechanism through which concerns about safe working and training arrangements are raised. This process, together with the role of the Guardian generally, will be new to all doctors, whether they are in training or a consultant. I would appreciate your support with ensuring that the reporting process and the role of the Guardian are properly understood and used as set out in advice from NHS Employers, without any detriment to the trainee doctors.

Thank you for your help with this important development.

Yours sincerely

Dr Kathy McLean
Executive Medical Director
NHS Improvement

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Appendix 2

General Medical Council

GMC Statement - GMC encourages doctors in training to use exception reports

Thursday 9 March 2017

'We continue to be concerned that the time doctors have for training is being adversely affected by excessive pressures on healthcare services in all four countries of the UK. As we reported last year, doctors in training with heavy workloads said that they were three times more likely than their peers to leave a local teaching session to answer a clinical call. One in three trainers said that they did not have enough time to fulfil their educational roles.

'While we acknowledge that treatment in busy environments is an occupational inevitability, training time must be protected as much as possible. Good rota design that takes account of both training and service needs is vital – which is why we will be adding new questions to this year's National Training Survey to help us identify the areas where good practice exists and those where it could be improved.

'Exception reporting is a new mechanism under the 2016 terms and conditions for doctors in approved national training programmes in England that will allow doctors to report concerns with their training – such as educational opportunities that have been missed and breaches in hours worked which may compromise their safety or training. We strongly support the introduction of this new system. It is in everyone's interests that we develop detailed evidence of where problems are occurring, so that efforts to address them can be targeted.

'We strongly encourage doctors in training to make use of these reports, to highlight issues in a timely way that allows for problems to be put right as they occur. We understand some doctors in training may be reluctant to report issues that affect them, especially minor ones, because they are mindful of the current pressures on

Appendix 3

The implementation of the new contract occurred in the last year with different specialties joining at appropriate times, as shown below in Table 1:

Table 1

2016 JUNIOR DOCTORS CONTRACT

IMPLEMENTATION TIMELINE FOR MEDWAY NHS FOUNDATION TRUST

DATE	SPECIALTY
5th October 2016	Obs &Gynae – Highers **(3)**
7th December 2016	FY1 Doctors **(40)**
6th March 2017	Paediatrics – all grades Highers ST1/2/3 **(14)**
5th April 2017	General Surgery – FY2/CT1/CT2/Highers new appointments **(7)** Urology - FY2 **(4)** Psychiatry - FY2/GPVTS ST1 **(3x F2) & 1 x ST1**
2nd August 2017	Anaesthetics - all grades **(10)** A&E – All Grades Obs & Gynae – FY2/ST1/ST2 Medicine FY2/GPVTS ST1/Core trainees Pathology – FY2 ENT – FY2/GPVTS ST1 Paediatric FY2/GPVTS The numbers below cover the specialties above: 37 FY1's 40 FY2's 21 GPVTS 4 Core Surgical Trainee 8 CMT's 2 Clinical Radiologists
4th September 2017	All New Paediatric starters **(9)**
4th October 2017	Orthopaedics - Highers **(3)** Urology – Highers **(1)** ENT – Highers **(1)** General Surgery – Highers **(8)** Medicine – Highers **(10)** O&G Highers **(4)** O&G Lower **(3)**

Highers = ST3 + (Except in Neonatology and Paediatrics ST4 +)

Appendix 4

1. Locum bookings

The following table details the locum bookings required over a time period to demonstrate total numbers of hours. This is then further broken down to show how many of these hours which were filled by agency, bank or own employees and also those shifts/hours that remained unfilled.

Table 4.1: Total shifts available for bank/agency staff by Division/specialty

2017-18 period				
Hrs worked	Demand			
Description	Agency Filled	Bank filled	Unfilled	Grand Total
A&E	**3080.00**	**4244.50**	**3061.50**	**10386.00**
ED	3080.00	4244.50	3061.50	10386.00
Anaesthetics	**1287.75**	**328.75**	**133.25**	**1749.75**
Acute on Call	25.00	0.00	0.00	25.00
Anaesthetics	1250.25	266.25	120.75	1637.25
Critical Care	12.50	62.50	12.50	87.50
Childrens services	**684.00**	**178.50**	**929.02**	**1791.52**
Children Services	318.50	79.00	240.50	638.00
Neonatology	91.00	13.00	456.00	560.00
Paediatrics	274.50	86.50	232.52	593.52
General surgery	**1037.00**	**250.00**	**1404.00**	**2691.00**
Breast Surgery	602.00	0.00	167.00	769.00
Colorectal Surgery	176.00	52.00	96.00	324.00
ENT	72.00	45.00	811.00	928.00
Surgery	171.00	36.00	314.00	521.00
Urology	0.00	93.00	0.00	93.00
Vascular Surgeon	16.00	24.00	16.00	56.00
Medicine	**18773.50**	**4779.50**	**5464.00**	**29017.00**
Acute on call	100.00	100.00	0.00	200.00
AEC	72.00	30.00	0.00	102.00
Medicine	18601.50	4649.50	5464.00	28715.00
Orthopedics	**3122.75**	**276.00**	**252.50**	**3651.25**
Surgery	589.50	21.50	99.50	710.50
Trauma & Orthopedics	2533.25	254.50	153.00	2940.75
Womans Healthcare	**50.00**	**123.00**	**0.00**	**173.00**
Obstetrics & Gynaecology	50.00	123.00	0.00	173.00
Grand Total	**28035.00**	**10180.25**	**11244.27**	**49459.52**

NHS Medway NHS Foundation Trust

Report to the Board

Committee Date: 18/01/2018 Agenda item 11a

Title of Report	**Finance Report Month 8**
Prepared By:	Tracey Easton, Deputy Director of Finance
Lead Director	Tracey Cotterill – Director of Finance & Business Services
Committees or Groups who have considered this report	
Executive Summary	The purpose of this report is to summarise the M8 year to date and forecast financial performance of the Trust against the agreed plan. Key points are : 1. In month performance has been reported as a deficit of £5.7m. The Trust position has moved adversely against plan in month by £0.6m. The main reason for this is that the Trust has reduced the level of expectation for additional income above plan being receivable from the Commissioners. This is based on the best estimate of the likely impact of the resolution of contractual issues between the Trust and the main CCG. Whilst there are a number of unresolved issues, it is likely that the majority of these will be resolved locally leaving one item of significant financial value which may require mediation. Of this £5.7m adverse position a significant proportion is attributable to costs not accrued in the prior year (c.£1m), a further c£300k has been incurred as part of agreement of year end balances with NHSE. In addition £1.2m has been incurred for the final settlement agreements with the 3 main Kent CCGs, bringing the attributable impact of prior year issues to £2.5m. The Trust has secured additional senior Finance resource to support a number of transformational projects which will reduce the ongoing run rate both for this year and into next. The financial impact of these schemes over the remainder of 2017-18, and on the 2018-19 run rate is being evaluated. 2. Year End Forecast – The forecast outturn is currently aligned

Report to the Board of Directors

	to plan but it is recognised that there are a number of risks and opportunities that will arise during the year. The finance committee reviews the risks and impacts in detail, and considers the worst case, best case and most likely impacts, to determine a risk adjusted forecast outturn position. The largest risk in the forecast is clinical income and delivery of CIP. 3. Expenditure – Month 8 expenditure is adverse to plan by £2m attributable to pay and break even on non-pay due to reserves. There are significant pay overspends in most of the Directorates with the exception of Corporate. 4. Income – Clinical income is below plan by £3.2m ytd at month 8, following the reduction in assumed over performance as per point 1. 5. Other income – at month 8 other income is below plan by £0.1m. In addition £0.8m of STF funding has been lost at Q2 due to the failure to achieve the A&E performance target. 6. CIP – the year end forecast for CIP is delivery to plan. At month 8 CIP delivery is behind plan by £4.5m.This largely relates to the current unidentified CIP target, and the phasing of the plan, as well as savings delivered not yet captured and reported as Non-recurrent CIP. 7. Cash has been drawn down from DH in the form of loans in line with the revenue plan. Additional cash has been provided to support the ED build. Pressure on cash will increase if STF funding is lost relating to non-achievement of the A&E target. This is a potential full year loss of income and cash of £2.499m. 8. Capital – The 2 year operational plan submitted in March 2017 included £32m capital spend. The current forecast is for c. £21m based on ED works and programmes funded by internally generated funds. Additional funds have been secured (£2m in year) for essential backlog maintenance.
Resource Implications	As outlined
Risk and Assurance	• Contract Work plan – this is a large risk to the organisation

as the full value of provider intentions is included in our plan, leading to a system gap.

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

- CIP Delivery is a risk with a significant level of unidentified CIP and a further £3.4m stretch target.
  The Board is asked to note that actions are already being taken to improve the delivery process.

  - **2020 are currently supporting the Improvement workstream for Financial Recovery with "sprints" on transformation schemes, as well as implementation planning of projects that have previously been through the sprint process.**
  - **Focus on specialty contribution to highlight target areas for savings**
  - **Cost centre detailed review and challenge of areas with high adverse variances.**
  - **Expenditure controls enhanced for non-essential non-clinical spend.**
  - **Enforcement of the Ordering controls relating to no Purchase order, no payment policy.**
  - **Clinical and operational engagement on CIP opportunities is occurring, with further workshops planned over coming weeks.**
  - **Communications across the Trust are now enhanced to reflect the financial position and raise awareness, as well as providing opportunity for all staff to contribute ideas for savings.**
  - **Additional senior finance resource has been secured to take forward a number of the larger potential transformation projects over the next 6 months.**
  - **Benchmarking analysis of peer Trusts is being undertaken to better inform the main areas to**

Report to the Board of Directors

	review and provide granular detail of differences in cost and wte. • Inefficient use of Trust resources remains a risk due to assurance gaps in the financial controls environment. **The Board is asked to note that work has already commenced to enhance the financial controls environment as part of the Trust Financial Recovery Plan and will further roll out through the Autumn of 2017 as part of the Trust FRP. The Grip and Control Toolkit provided by NHSI has been completed with actions identified to close gaps and seize opportunities.** • Trust infrastructure and estate remains a risk due to age and condition, and lack of cash for capital investment. **The Board is asked to note that improvements have already commenced on both minor and major works, including ED. However, as there is no additional capital funding available over and above funding already agreed, the capital programme has had to be scaled back, and there is a re-prioritisation of schemes.**
Legal Implications/Regulatory Requirements	Lack of achievement of the agreed control total will lead to further regulatory actions. Inappropriate Estate and insufficient Facilities lead to higher than acceptable risk to Patients, visitors and staff and could lead to further regulatory action.
Improvement Plan Implication	Financial Recovery is one of the nine programmes of Phase 2 Recovery. In year, financial stability is one of 4 programmes in Better, Best, Brilliant which includes financial recovery, commercial efficiency and estate planning.
Quality Impact Assessment	All actions will follow an appropriate QIA process
Recommendation	To note the contents of the report
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

Finance Report

Month 8

2017/18

Best of care
Best of people

Medway NHS
NHS Foundation Trust

Finance Report for November 2017

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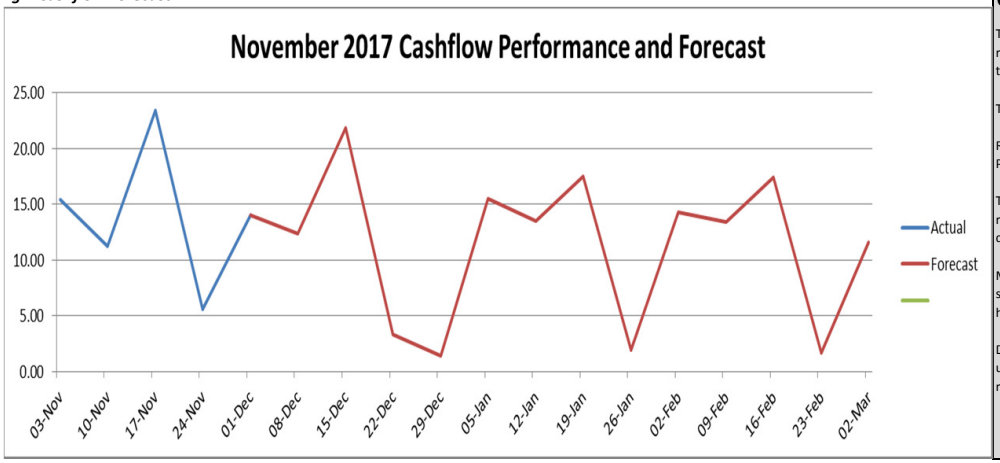
1. Liquidity

1a. Cash Flow

13 Week Forecast

	Actual				Forecast												
Week Ending	03/11/17	10/11/17	17/11/17	24/11/17	01/12/17	08/12/17	15/12/17	22/12/17	29/12/17	05/01/18	12/01/18	19/01/18	26/01/18	02/02/18	09/02/18	16/02/18	23/02/18
BANK BALANCE B/FWD	**4.43**	**15.38**	**11.23**	**23.43**	**5.64**	**14.04**	**12.33**	**21.82**	**3.33**	**1.41**	**15.51**	**13.50**	**17.47**	**1.91**	**14.28**	**13.38**	**17.38**
Receipts																	
NHS Contract Income	10.05	0.16	7.50	0.05	10.35	0.72	7.51	0.00	0.00	14.27	0.00	3.54	0.00	14.27	0.00	3.37	0.00
Other	5.07	0.45	0.31	0.19	0.20	0.18	0.80	0.28	0.28	2.43	0.61	0.40	0.28	0.40	0.61	0.40	0.28
STF 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	1.80
Total receipts	**15.11**	**0.61**	**7.81**	**0.24**	**10.55**	**0.90**	**8.32**	**0.28**	**0.28**	**16.71**	**0.61**	**3.94**	**0.28**	**14.67**	**0.61**	**3.77**	**2.08**
Payments																	
Pay Expenditure (excl. Agency)	(0.34)	(0.33)	(2.84)	(12.96)	(0.32)	(0.33)	(0.30)	(16.00)	(0.30)	(0.30)	(0.30)	(2.74)	(12.93)	(0.31)	(0.30)	(0.30)	(15.37)
Non Pay Expenditure	(3.82)	(4.43)	(3.74)	(5.00)	0.59	(2.28)	(3.39)	(2.74)	(0.10)	(2.31)	(2.31)	(3.74)	(2.91)	(0.26)	(1.21)	(1.21)	(2.26)
Capital Expenditure	0.00	0.00	0.00	0.00	(2.41)	0.00	0.00	0.00	(1.79)	0.00	0.00	0.00	0.00	(1.73)	0.00	0.00	0.00
Total payments	**(4.16)**	**(4.76)**	**(6.58)**	**(17.96)**	**(2.14)**	**(2.61)**	**(3.69)**	**(18.73)**	**(2.19)**	**(2.61)**	**(2.61)**	**(6.48)**	**(15.84)**	**(2.30)**	**(1.51)**	**(1.51)**	**(17.63)**
Net Receipts/ (Payments)	**10.95**	**(4.15)**	**1.23**	**(17.72)**	**8.40**	**(1.71)**	**4.62**	**(18.46)**	**(1.92)**	**14.10**	**(2.01)**	**(2.54)**	**(15.56)**	**12.37**	**(0.91)**	**2.26**	**(15.55)**
Funding Flows																	
FTFF/DOH - Revenue	0.00	0.00	8.02	0.00	0.00	0.00	2.55	0.00	0.00	0.00	0.00	2.57	0.00	0.00	0.00	2.50	0.00
STF Advance	0.00	0.00	1.99	0.00	0.00	0.00	2.31	0.00	0.00	0.00	0.00	1.05	0.00	0.00	0.00	(0.75)	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	3.10	0.00	0.00	0.00	0.00	0.00
Incentive Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	1.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	(0.04)	(0.08)	0.00	0.00	0.00	(0.03)	0.00	0.00	0.00	(0.21)	0.00	0.00	0.00	0.00	(0.14)
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**	**10.98**	**(0.08)**	**0.00**	**0.00**	**4.87**	**(0.03)**	**0.00**	**0.00**	**0.00**	**6.51**	**0.00**	**0.00**	**0.00**	**1.75**	**(0.14)**
BANK BALANCE C/FWD	**15.38**	**11.23**	**23.43**	**5.64**	**14.04**	**12.33**	**21.82**	**3.33**	**1.41**	**15.51**	**13.50**	**17.47**	**1.91**	**14.28**	**13.38**	**17.38**	**1.69**

Fig1. Cashflow Forecast



Commentary

The opening cash balance for November 2017 was £1.2m, with a closing balance of £4m. This is above the minimum liquidity level (£1.4m) required by DH by £2.6m. This additional cash balance was due to receipt of 16/17 overperformance from Medway CCG (£4.2m) at the end of the month.

The graph shows the actual cashflow for November and the projected weekly cashflow up to and including w/e 3 March 2018.

Receipts in the month were £23.8m, plus £10.9m loans & funding, therefore the total cash inflow for November was £34.7m. Payments, including capital in the month were £31.8m.

The Trust has received £27.3m of deficit loan funding YTD in the form of an uncommitted revenue loan with a further £4.1m 'exceptional loan' received during November. In addition, the Trust has received £1.1m Q1 STF YTD with a further £2.2m in STF advances. The Trust has also drawn PDC of 3.2m and capital loans of £6.7m in relation to the Emergency Department capital project and CT scanner.

Monthly payments for 17/18 have so far averaged at £28.6m, with 57% relating to payroll costs. This includes £9.5m per month for direct salary payments and £6.7m in relation to employer costs. Monthly receipts (excluding loans & STF) for 17/18 have averaged at £23.5m, however it should be noted that this includes an additional monthly contract payment received from Medway CCG during April.

During November, receipts in relation to DOH 'exceptional' funding and 2016/17 additional clinical performance from NHS Medway were utilised to bring down creditor payment terms to more acceptable levels along with a reduction in NHS debt. Whilst this has temporarily reduced some pressure from suppliers it is anticipated that this will increase significantly as we enter the final quarter of the financial year.

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

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

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

2. Financial Performance

2a. Consolidated Income & Expenditure

Consolidated I&E (November 2017)

	Current Month			Year to Date (YTD)			Annual		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Forecast*	*Plan*	*Variance*
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical income	19,213	19,534	-321	153,125	157,444	-4,319	231,969	237,854	-5,885
High Cost Drugs	1,855	1,565	290	14,783	13,720	1,063	21,895	20,596	1,299
Other Operating Income	1,932	2,055	-123	15,249	16,285	-1,036	22,982	24,724	-1,742
Total Revenue	**23,000**	**23,153**	**-153**	**183,157**	**187,450**	**-4,293**	**276,846**	**283,174**	**-6,328**
Expenditure									
Substantive	-14,171	-16,534	2,364	-113,650	-129,330	15,680	-170,887	-194,417	23,530
Bank	-2,155	-182	-1,973	-16,079	-63	-16,016	-23,145	-1,088	-22,057
Agency	-1,072	-848	-224	-10,959	-9,316	-1,643	-17,462	-13,016	-4,446
Total Pay	**-17,397**	**-17,564**	**167**	**-140,688**	**-138,709**	**-1,979**	**-211,494**	**-208,521**	**-2,973**
Clinical supplies	-3,039	-2,846	-193	-25,263	-24,768	-495	-37,164	-36,647	-517
High Cost Drugs Expense	-1,871	0	-1,871	-13,069	0	-13,069	-17,147	0	-17,147
Drugs	-1,653	-2,509	856	-10,666	-20,211	9,545	-14,900	-30,208	15,308
Consultancy	-80	-67	-13	-1,156	-690	-466	-1,731	-959	-772
Other non pay	-2,786	-3,381	595	-22,224	-26,725	4,501	-28,301	-40,729	12,428
Total Non Pay	**-9,429**	**-8,804**	**-625**	**-72,379**	**-72,394**	**15**	**-99,243**	**-108,544**	**9,301**
Total Expenditure	**-26,826**	**-26,368**	**-458**	**-213,067**	**-211,103**	**-1,964**	**-310,737**	**-317,065**	**6,328**
EBITDA	**-3,826**	**-3,215**	**-611**	**-29,910**	**-23,653**	**-6,257**	**-33,891**	**-33,891**	**0**
Post EBITDA									
Depreciation	-809	-807	-2	-6,494	-6,462	-32	-9,693	-9,693	0
Interest	-211	-266	55	-1,536	-2,124	588	-3,186	-3,186	0
Dividend	-7	-7	0	-56	-56	0	-81	-81	0
Profit/(loss) on sale of asset	0	0	0	0	0	0	0	0	0
Net (Surplus) / Deficit - Pre STF	**-4,853**	**-4,295**	**-558**	**-37,996**	**-32,295**	**-5,701**	**-46,851**	**-46,851**	**0**
STF Income	901	901	0	4,210	4,954	-744	8,262	9,006	-744
Net (Surplus) / Deficit - Pre STF	**-3,952**	**-3,394**	**-558**	**-33,786**	**-27,341**	**-6,445**	**-38,589**	**-37,845**	**-744**

Commentary

Net (Surplus) / Deficit

The Trust reported a £4.9m deficit in November before STF, which is a £0.6m deficit against Plan. The YTD position before STF is a deficit of £37.9m (£5.7m adverse to plan). The YTD STF position is a shortfall of £0.8m due to A&E.

Clinical Income

Clinical Income is adverse to plan by £3.2m at month 8. This is split £4.3m adverse on clinical income, £1.1m favourable on high cost drugs. Clinical income has reduced on revised expectations of the ability to receive income in excess of contract.

Other Operating Income

Other Income is adverse to plan by £0.1m in month 8 and £1.0m adverse YTD, reflecting CIP under-delivery and a change in categorisation of actual income from Other Operating Income to Clinical Income.

Pay

Pay expenditure is favourable to plan in month by £0.1m and shows an adverse variance YTD of £2m. However the position in the individual Directorates shows significant overspends in ACC,CSD, FCSS and Estates and Facilities of £1m, £1.4m, £2m and £0.6m respectively.

Non Pay

Non pay expenditure is £0.6m adverse to plan at month 8. (YTD Break even)

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

CIP

As of Month 8 £3.9m of CIP has been achieved, £4.5m adverse to the YTD NHSI plan submission. Despite this it is felt the programme is on track, a variance on the phasing on the expected savings is the reason for the current variance not a lack of achieving or identified schemes. Schemes to the value of £12.2m (PYE) have been identified for the year. This represents 88% delivery against the £12.6m target. In addition, pipeline schemes of £2.6m have been identified and are in the process of being scoped and validated.

The risk assessed value is now £8.3m (PYE) which represents 66% delivery to target.

Risks and Mitigations

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

Sustainability & Transformation funding will be contingent upon achievement of the financial and A&E performance targets. The risk to STF income for the non achievement of A&E targets is £2.499m for the full year. It is possible that some of this will not be received but this has not been reflected in the forecast posiiton with the exception of the £744k relating to Q2.

2b. Run Rate Analysis - Financial

Anaylsis of 15 monthly performance - Financials

	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue															
Clinical income	19.3	19.9	19.5	18.4	19.7	18.6	22.6	18.5	19.1	19.8	20.0	20.7	19.8	15.6	19.2
High Cost Drugs	2.0	1.8	1.7	1.5	1.8	1.6	1.6	1.7	1.9	1.9	1.8	1.8	1.7	2.2	1.9
STF Income	0.7	0.7	0.7	0.7	0.7	1.0	2.4	0.1	0.9	0.5	0.6	0.4	0.6	0.4	0.9
Other Operating Income	2.2	2.0	1.7	2.0	2.3	2.1	3.0	2.0	1.6	2.1	2.0	2.0	1.9	1.7	1.9
Total Revenue	**24.2**	**24.4**	**23.6**	**22.6**	**24.6**	**23.4**	**29.5**	**22.3**	**23.6**	**24.3**	**24.4**	**24.9**	**24.0**	**19.8**	**23.9**
Expenditure															
Substantive	-13.7	-13.6	-14.0	-13.6	-13.9	-14.0	-13.6	-14.0	-14.3	-14.3	-14.1	-14.3	-13.9	-14.5	-14.2
Bank	-0.6	-0.6	-0.9	-0.8	-0.7	-0.8	-0.9	-1.1	-1.2	-2.7	-1.8	-2.4	-2.3	-2.4	-2.2
Agency	-3.6	-3.5	-3.8	-3.5	-3.7	-3.6	-3.9	-2.2	-1.9	-0.2	-1.3	-1.6	-1.4	-1.3	-1.1
Total Pay	**-17.8**	**-17.6**	**-18.6**	**-17.9**	**-18.3**	**-18.3**	**-18.4**	**-17.3**	**-17.4**	**-17.2**	**-17.2**	**-18.3**	**-17.6**	**-18.2**	**-17.4**
Clinical supplies	-3.2	-2.8	-2.7	-2.8	-2.9	-3.1	-3.0	-2.7	-3.8	-2.8	-3.1	-3.3	-3.3	-3.2	-3.0
High Cost Drugs Expense	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-1.5	-1.5	-1.5	-1.5	-1.5	-9.2	-2.0	-1.9
Drugs	-2.8	-2.5	-2.1	-1.7	-2.4	-2.4	-2.4	-1.0	-1.2	-1.1	-1.1	-1.4	6.3	-2.0	-1.7
Consultancy	-0.1	0.0	0.1	0.0	-0.1	0.0	0.0	-0.2	-0.1	-0.2	-0.2	-0.3	-0.1	0.0	-0.1
Other non pay	-2.4	-2.9	-3.0	-3.0	-3.0	-2.9	-7.0	-3.5	-2.5	-2.5	-3.3	-2.1	-2.5	-2.9	-2.8
Total Non Pay	**-8.5**	**-8.2**	**-7.8**	**-7.4**	**-8.5**	**-8.4**	**-12.4**	**-8.9**	**-9.1**	**-8.1**	**-9.2**	**-8.6**	**-8.8**	**-10.2**	**-9.4**
Total Expenditure	**-26.3**	**-25.8**	**-26.4**	**-25.3**	**-26.8**	**-26.7**	**-30.8**	**-26.2**	**-26.5**	**-25.3**	**-26.4**	**-26.9**	**-26.4**	**-28.4**	**-26.8**
EBITDA	**-2.1**	**-1.4**	**-2.8**	**-2.7**	**-2.2**	**-3.3**	**-1.3**	**-4.0**	**-2.9**	**-1.0**	**-2.0**	**-2.0**	**-2.4**	**-8.6**	**-2.9**
Post EBITDA															
Depreciation	-0.8	-0.8	-0.9	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8
Interest	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
Dividend	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	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	0.1	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	-1.1	**-1.0**	**-1.2**	**-1.1**	**-1.1**	**-0.9**	**-1.0**	**-1.1**	**-0.9**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**
Net Surplus / (Deficit)	**-3.2**	**-2.4**	**-3.9**	**-3.8**	**-3.3**	**-4.2**	**-2.2**	**-5.1**	**-3.8**	**-2.0**	**-3.0**	**-3.0**	**-3.4**	**-9.6**	**-4.0**

2c. Workforce

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
		WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Substantive	Consultants	190	213	-23	2.41	2.43	-0.02	2.34	19.75	19.31	0.44	18.82
	Junior Medical	339	372	-33	2.01	1.99	0.02	1.97	15.83	16.01	-0.18	15.35
	Nurses & Midwives	1148	1585	-437	4.07	5.47	-1.40	3.95	32.70	43.28	-10.58	31.48
	Scientific, Therapeutic & Technical	438	519	-81	1.36	1.56	-0.20	1.39	10.90	12.44	-1.54	11.03
	Healthcare Assts, etc.	494	616	-122	1.05	1.28	-0.23	0.96	8.26	10.24	-1.98	7.68
	Admin & Clerical	831	948	-117	2.20	2.31	-0.11	2.04	17.38	19.20	-1.82	16.10
	Chair & NEDs	1	7	-6	0.01	0.01	0.00	0.02	0.10	0.10	0.00	0.10
	Executives	6	9	-3	0.09	0.14	-0.05	0.10	0.87	1.23	-0.36	0.95
	Other Non Clinical	436	499	-63	0.90	1.00	-0.10	0.96	7.33	8.00	-0.67	7.40
	Pay Reserves	0	0	0	0.07	0.34	-0.27	0.00	0.52	-0.48	1.00	0.00
	Substantive Total	**3,883**	**4,769**	**-886**	**14.17**	**16.53**	**-2.36**	**13.73**	**113.65**	**129.33**	**-15.68**	**108.92**
Agency	Consultants	12	0	12	0.09	0.25	-0.16	0.29	1.39	2.21	-0.8	2.59
	Junior Medical	23	0	23	0.21	0.36	-0.15	0.62	1.69	2.85	-1.2	4.69
	Nurses & Midwives	90	0	90	0.43	0.13	0.30	1.81	5.04	1.71	3.3	10.50
	Scientific, Therapeutic & Technical	31	0	31	0.18	0.05	0.13	0.29	1.82	0.52	1.3	2.09
	Healthcare Assts, etc.	0	0	0	0.00	0.01	-0.01	0.15	0.14	0.13	0.0	0.85
	Admin & Clerical	3	3	1	0.12	0.02	0.10	0.52	0.39	1.67	-1.3	3.96
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	20	0	20	0.05	0.03	0.02	0.10	0.49	0.24	0.3	0.98
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Agency Total	**179**	**3**	**177**	**1.08**	**0.85**	**0.23**	**3.78**	**10.96**	**9.32**	**1.64**	**25.66**
Bank	Consultants	15	0	15	0.22	0.00	0.22	0.00	1.39	0.00	1.4	0.00
	Junior Medical	39	0	39	0.47	0.00	0.47	0.00	3.28	0.01	3.3	0.00
	Nurses & Midwives	124	0	124	0.51	0.15	0.36	0.27	4.03	-0.32	4.4	1.63
	Scientific, Therapeutic & Technical	16	0	16	0.12	0.00	0.12	0.06	0.35	0.01	0.3	0.44
	Healthcare Assts, etc.	195	0	195	0.49	0.00	0.49	0.28	4.07	0.13	3.9	2.05
	Admin & Clerical	75	4	71	0.21	0.02	0.19	0.14	1.98	0.17	1.8	0.77
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	56	1	55	0.12	0.00	0.12	0.10	0.98	0.07	0.9	0.24
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Bank Total	**518**	**5**	**513**	**2.15**	**0.18**	**1.97**	**0.85**	**16.08**	**0.06**	**16.02**	**5.14**
	Workforce Total	**4,580**	**4,777**	**-197**	**17.40**	**17.56**	**-0.16**	**18.36**	**140.69**	**138.71**	**1.98**	**139.72**

Commentary:
Pay expenditure is over spent compared to plan in month by £0.9m. Month 7 YTD pay is over spent by £2m. Agency has reduced slightly from month 7 and although bank has also reduced slightly from month 7 it is remains higher than trend.

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

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

	Current Month						Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
Staff Group:	WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Consultants	217	213	4	2.72	2.68	0.04	2.63	22.53	21.52	1.02	21.41
Junior Medical	401	372	29	2.69	2.35	0.34	2.59	20.80	18.87	1.94	20.04
Nurses & Midwives	1,362	1,585	-224	5.01	5.75	-0.74	6.03	41.77	44.67	-2.90	43.62
Scientific, Therapeutic & Technical	485	519	-34	1.66	1.61	0.05	1.74	13.07	12.97	0.10	13.56
Healthcare Assts, etc.	689	616	73	1.54	1.29	0.25	1.39	12.47	10.50	1.98	10.58
Executives	6	9	-3	0.09	0.14	-0.05	0.10	0.87	1.23	-0.36	0.95
Chair & NEDs	1	7	-6	0.01	0.01	0.00	0.02	0.10	0.10	0.00	0.10
Admin & Clerical	909	955	-46	2.53	2.35	0.18	2.70	19.75	21.04	-1.28	20.83
Other Non Clinical	512	500	12	1.07	1.03	0.04	1.16	8.80	8.31	0.49	8.62
Pay Reserves	0	0	0	0.07	0.34	-0.27	0.00	0.52	-0.48	1.00	0.00
Workforce Total	**4,580**	**4,777**	**-197**	**17.40**	**17.56**	**-0.16**	**18.36**	**140.69**	**138.71**	**1.98**	**139.72**

2d. Run rate analysis pay

		Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	179	180	181	180	179	178	179	180	184	187	186	189	189	192	190
	Junior Medical	334	328	329	327	321	321	330	315	320	320	320	348	346	354	339
	Nurses & Midwives	1,097	1,105	1,106	1,098	1,118	1,134	1,120	1,087	1,096	1,148	1,148	1,152	1,142	1,161	1,148
	Scientific, Therapeutic & Technical	456	442	446	450	448	448	446	437	437	426	425	429	442	446	438
	Healthcare Assts, etc	457	458	459	463	455	472	479	470	478	491	489	492	492	492	494
	Admin & Clerical	809	808	809	809	812	821	817	894	889	825	835	840	839	841	831
	Chair & NEDs	7	6	6	6	6	6	5	3	11	7	2	6	6	1	1
	Executives	8	8	10	6	5	7	7	7	8	8	7	7	6	6	6
	Other Non Clinical	458	464	458	434	433	438	441	440	445	446	445	449	442	441	436
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Substantive Total	**3,805**	**3,801**	**3,804**	**3,772**	**3,777**	**3,823**	**3,824**	**3,833**	**3,868**	**3,857**	**3,853**	**3,912**	**3,904**	**3,935**	**3,883**
Agency	Consultants	25	20	18	18	19	20	28	20	15	14	9	14	10	11	12
	Junior Medical	65	68	61	70	62	53	56	47	40	33	28	24	24	12	23
	Nurses & Midwives	340	324	364	290	366	339	411	168	125	141	102	171	153	153	90
	Scientific, Therapeutic & Technical	28	35	54	63	50	37	35	46	32	38	35	50	46	34	31
	Healthcare Assts, etc	63	49	57	45	82	63	53	1	1	-	-	-	-	-	-
	Admin & Clerical	22	22	57	57	51	47	24	12	8	8	5	4	4	3	3
	Chair & NEDs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Executives	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Non Clinical	35	44	45	45	45	51	47	31	22	26	2	28	21	26	20
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Agency Total	**578**	**562**	**656**	**588**	**675**	**611**	**654**	**325**	**243**	**261**	**181**	**291**	**258**	**238**	**179**
Bank	Consultants	-	-	-	-	-	-	-	-	-	7	11	10	13	14	15
	Junior Medical	44	53	57	57	39	64	107	71	79	97	96	45	41	48	39
	Nurses & Midwives	-	-	-	-	-	1	3	5	22	21	33	137	126	125	124
	Scientific, Therapeutic & Technical	17	18	20	21	6	3	11	1	1	10	12	11	12	12	16
	Healthcare Assts, etc	108	114	124	127	121	134	209	130	142	161	173	249	207	203	195
	Admin & Clerical	51	59	78	59	67	64	52	263	105	84	83	114	74	91	75
	Chair & NEDs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Executives	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Non Clinical	3	13	45	40	41	44	40	37	41	44	47	71	59	65	56
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Bank Total	**223**	**257**	**324**	**304**	**274**	**310**	**422**	**507**	**390**	**423**	**455**	**637**	**532**	**558**	**518**
	Workforce Total	**4,606**	**4,619**	**4,784**	**4,664**	**4,726**	**4,743**	**4,900**	**4,665**	**4,502**	**4,540**	**4,489**	**4,840**	**4,694**	**4,730**	**4,580**

Analysis of 15 monthly performance - £

		Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.30	2.48	2.48	2.34	2.40	2.46	2.19	2.55	2.36	2.55	2.52	2.47	2.37	2.54	2.41
	Junior Medical	1.95	1.96	2.10	1.95	2.01	1.86	2.08	1.84	1.95	2.00	1.90	2.09	1.81	2.22	2.01
	Nurses & Midwives	3.92	3.92	3.91	3.89	3.91	4.14	3.96	3.94	4.03	4.12	4.04	4.13	4.05	4.08	4.07
	Scientific, Therapeutic & Technical	1.42	1.18	1.39	1.40	1.40	1.42	1.36	1.33	1.36	1.34	1.32	1.33	1.37	1.38	1.36
	Healthcare Assts, etc	0.97	0.94	0.96	0.94	1.02	0.97	0.93	1.00	1.05	1.04	1.03	1.03	1.04	1.02	1.05
	Admin & Clerical	2.02	2.03	2.04	2.08	2.06	2.07	2.08	2.26	2.43	2.14	2.20	2.20	2.20	2.15	2.20
	Chair & NEDs	0.01	0.01	0.02	0.00	0.01	0.01	0.04	0.01	0.02	0.02	0.01	0.01	0.01	0.01	0.01
	Executives	0.13	0.10	0.10	0.12	0.09	0.10	0.14	0.17	0.16	0.12	0.11	0.10	0.09	0.09	0.09
	Other Non Clinical	0.94	0.93	0.96	0.85	0.89	0.92	0.91	0.90	0.94	0.93	0.90	0.91	0.92	0.91	0.90
	Pay Reserves	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.02	0.02	0.07	0.06	0.07	0.07	0.07	0.07
	Substantive Total	**13.66**	**13.56**	**13.96**	**13.57**	**13.78**	**13.96**	**13.69**	**14.01**	**14.32**	**14.32**	**14.09**	**14.34**	**13.93**	**14.48**	**14.17**
Agency	Consultants	0.44	0.31	0.29	0.37	0.41	0.37	0.42	0.37	0.18	0.03	0.14	0.25	0.15	0.18	0.09
	Junior Medical	0.64	0.57	0.62	0.72	0.61	0.64	0.52	0.39	0.24	0.18	0.23	0.21	0.12	0.12	0.21
	Nurses & Midwives	1.58	1.56	1.81	1.43	1.82	1.69	2.03	0.19	1.25	0.37	0.61	0.76	0.69	0.75	0.43
	Scientific, Therapeutic & Technical	0.14	0.24	0.29	0.25	0.21	0.10	0.18	0.29	0.19	0.16	0.23	0.26	0.32	0.20	0.18
	Healthcare Assts, etc	0.16	0.12	0.15	0.13	0.31	0.19	0.14	0.01	0.00	0.00	0.02	-	-	-	-
	Admin & Clerical	0.42	0.56	0.52	0.50	0.49	0.41	0.21	0.13	0.01	0.06	0.04	0.01	0.04	-	0.12
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-
	Other Non Clinical	0.17	0.10	0.08	0.09	0.08	0.16	0.11	0.21	0.07	0.07	0.04	0.08	0.06	0.06	0.05
	Agency Total	**3.55**	**3.47**	**3.76**	**3.49**	**3.94**	**3.55**	**3.61**	**1.58**	**1.94**	**0.87**	**1.27**	**1.57**	**1.38**	**1.31**	**1.08**
Bank	Consultants	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.21	0.19	0.21	0.25	0.26	0.22
	Junior Medical	0.16	0.10	0.27	0.31	0.20	0.24	0.29	0.25	0.03	1.16	0.45	0.59	0.48	0.58	0.47
	Nurses & Midwives	0.00	0.00	0.00	0.00	0.00	0.01	0.05	0.09	0.23	0.50	0.39	0.53	0.61	0.56	0.51
	Scientific, Therapeutic & Technical	0.06	0.06	0.06	0.07	0.02	0.01	0.04	0.00	0.01	0.04	0.04	0.03	0.05	0.05	0.12
	Healthcare Assts, etc	0.24	0.26	0.28	0.27	0.30	0.31	0.58	0.33	0.35	0.81	0.47	0.54	0.57	0.51	0.49
	Admin & Clerical	0.09	0.05	0.14	0.11	0.12	0.15	0.15	0.97	0.58	0.89	0.21	0.39	0.23	0.28	0.21
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-
	Other Non Clinical	0.01	0.09	0.10	0.09	0.07	0.08	0.09	0.07	0.08	0.23	0.09	0.16	0.11	0.14	0.12
	Bank Total	**0.57**	**0.55**	**0.85**	**0.85**	**0.71**	**0.80**	**1.20**	**1.70**	**1.21**	**2.05**	**1.84**	**2.45**	**2.30**	**2.38**	**2.15**
	Workforce Total	**17.78**	**17.58**	**18.58**	**17.91**	**18.43**	**18.30**	**18.50**	**17.29**	**17.47**	**17.23**	**17.20**	**18.36**	**17.61**	**18.17**	**17.40**

3. Balance Sheet

3a. Statement of Financial Position

	Last Month Actual £m	Current Month Actual £m	Plan £m	Variance £m
Non current Assets				
Property, Plant and Equipment	183.3	182.9	188.6	-5.7
Trade and Other Receivables: Other	0.4	0.3	0.5	-0.2
Total Non current Assets	**183.7**	**183.3**	**189.1**	**-5.8**
Current Assets				
Inventories	7.4	7.4	6.4	1.1
Trade and Other Receivables: Trade	27.3	28.9	12.4	16.6
Trade and Other Receivables: Accruals	18.9	16.1	6.9	9.2
Trade and Other Receivables: Prepayments	4.3	4.9	2.1	2.8
Trade and Other Receivables: Other	1.9	2.3	1.0	1.3
Cash and Cash Equivalents	1.1	4.0	1.3	2.7
Total Current Assets	**60.8**	**63.7**	**29.9**	**33.8**
Current Liabilities				
Borrowings	-78.3	-88.2	-1.3	-86.9
Trade and Other Payables: Trade	-35.0	-31.1	-20.9	-10.3
Trade and other payables: Accruals	-12.5	-13.3	-8.9	-4.4
Trade and other payables: Other	-5.2	-5.4	-3.6	-1.8
Other liabilities: Deferred Income	-12.0	-10.4	-8.2	-2.2
Provisions	-4.4	-4.4	0.0	-4.4
Total Current Liabilities	**-147.4**	**-152.9**	**-43.0**	**-109.9**
Total Assets Less Current Liabilities	**97.1**	**94.1**	**176.1**	**-82.0**
Non Current Liabilities				
Borrowings	-84.6	-84.6	-164.5	79.9
Provisions	-0.7	-0.8	-0.9	0.1
Total Non Current Liabilities	**-85.3**	**-85.3**	**-165.4**	**80.1**
Net Assets Employed	**11.8**	**8.8**	**10.7**	**-1.9**
Taxpayers Equity				
Public Dividend Capital	136.7	137.7	138.8	-1.1
Retained Earnings	-162.0	-166.0	-160.3	-5.7
Revaluation Reserve	37.1	37.1	32.3	4.8
Total taxpayers' equity	**11.8**	**8.8**	**10.7**	**-1.9**

Commentary

Non Current Assets

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

Current Assets

Trade and Other Receivables have been reported over four separate headings to provide further detail:
Trade, these are balances owed to the Trust for trading activities for which sales invoices have been raised and are yet to be paid. The balance at month 8 is currently higher than the plan due to high levels of unresolved balances with commissioners in relation to previous financial years. Please see note 4b. which further analyses over debtor categories and age.
Accruals, these relate to balances owed to The Trust which are yet to be invoiced for. Contract Invoicing is up to date the current balance mainly relates to Partially Completed Spells(PCS) which always remains as an accrual and overperformance.
Prepayments, payments made in advance for purchases such as equipment, software, maintenance. Payments for some of these services are paid annually in advance which is the reason for the current variance on plan. This balance should reduce each month unless additional prepayments are made in the month.
Other, included in other are further RTA debts, VAT Contracted Out Services refunds.

Cash and Cash Equivalents

A condition of the deficit loans is for The Trust to hold a balance of £1.4m to ensure there is always an adequate balance from which to deal with any emergency payments. The balance as at 30th November 2017 was £4.0m. This additional cash balance was due to receipt of 16/17 overperformance from Medway CCG (£4.2m) earlier than anticipated.

Current Liabilities

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

Trade and Other Payables

Trade, please see note 4c for further information. The main reason for the variance on plan relates a process change in Finance, it is estimated the previous manual Accounts Payable system undertstated the value of payables significantly as invoices were not immediately being registered.

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

Deferred Income, this balance mainly relates to a cash advance made by Medway Clinical Commissioning Group(CCG). This advance is being partially recovered throughout the year and in month 12. The remaining deferred Income relates to the agreed accounting treatment for Maternity Income billed at the start of the Clinical Pathway, Research & Development Funds and some private patients fees.

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

Taxpayers Equity

Variances relate to the phasing of the PDC drawdown (-£1.1m) and the year end upwards revaluation of the hospital site and associated residences and dwellings (£4.8m).

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

3b. Debtors

Aged Debtors

	Total	Current	31 to 60 Days	61 to 90 Days	91 to 180 Days	6 Months +
NHS						
CCGs and NHS England	23.01	9.98	2.56	0.40	1.61	8.45
NHS FTs	2.05	0.28	0.21	0.18	0.38	1.00
NHS Trusts	1.35	0.18	0.14	0.19	0.33	0.51
Health Education England	0.24	(0.00)	0.00	0.11	0.14	(0.01)
Special Health Authorities	0.05	0.00	0.00	0.00	0.00	0.05
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.00	0.00	0.00	0.00	0.00	0.00
Total NHS	**26.70**	**10.44**	**2.91**	**0.89**	**2.46**	**10.01**
Non NHS						
Bodies external to Government	2.58	0.37	0.15	0.15	0.36	1.54
other WGA bodies	0.01	0.00	0.00	0.00	0.00	0.01
Local Authorities	0.09	0.00	0.01	0.01	0.02	0.06
Total Non NHS	**2.68**	**0.38**	**0.16**	**0.16**	**0.38**	**1.61**
Bad Debt Provision	(0.53)	0.00	0.00	0.00	0.00	(0.53)
Other Receivables	0.08	0.00	0.00	0.00	0.00	0.00
Total Receivables	**28.94**	**10.81**	**3.07**	**1.05**	**2.84**	**11.09**

Commentary

Total outstanding Trade Receivables as at the 30 November 2017 are £28.94m. This includes a £0.53m bad debt provision & £0.08m of other receivables.

There is a general provision of £4.2m that will be utilised against this balance.

NHS Debt excluding PCS is £26.70m (92.3%), the majority of which is with Clinical Commissioning Groups and relates to unpaid invoices for overperformance, non contract activity and High Cost drugs.

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

Fig 1 Aged Receivables Analysis

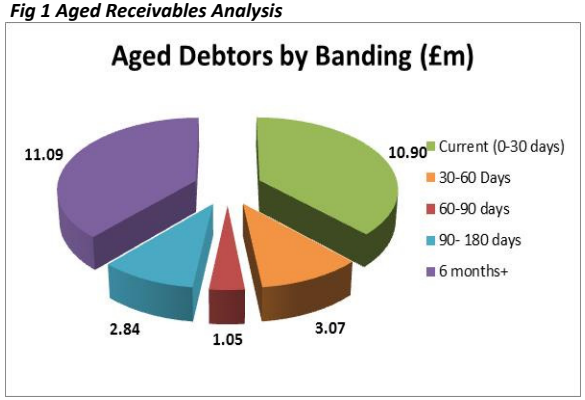


Fig 2 - Debtor Trends

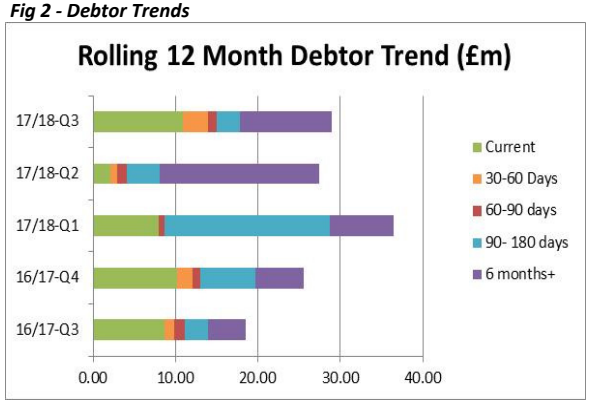


Fig.3 Top Ten Debtors

Top 10 Debtors

		£m
1	NHS MEDWAY CCG	13.22
2	NHS SWALE CCG	5.06
3	NHS DARTFORD GRAVESHAM & SWAL	1.93
4	E.K.HOSP.UNIV.NHS.FOUNDATION TRUST	1.07
5	MEDWAY COMM HEALTHCARE CIC	0.84
6	NHS WEST KENT CCG	0.82
7	MAIDSTONE AND TUNBRIDGE WELLS NHS	0.69
8	QUEEN VICTORIA HOSPITAL NHS TRUST	0.64
9	DARTFORD & GRAVESHAM NHS TRUST	0.39
10	NHS ENGLAND	0.31

3c. Creditors

Aged Creditors

	Total	Current	31 to 60 Days	61 to 90 Days	91 - 180 Days	6 months +
	£m	£m	£m	£m	£m	£m
NHS FTs	1.93	0.15	0.37	0.13	0.39	0.89
NHS Trusts	2.61	0.50	0.29	0.28	0.23	1.33
Public Health England	0.01	0.00	0.00	0.00	0.00	0.01
Special Health Authorities	0.48	0.13	0.12	0.12	0.12	0.00
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.66	0.00	0.03	0.04	0.06	0.53
Total NHS Payables	**5.67**	**0.75**	**0.80**	**0.57**	**0.79**	**2.77**
other WGA bodies	0.11	0.12	(0.01)	0.01	0.00	0.00
Local Authorities	0.02	0.00	0.00	0.00	0.00	0.01
Bodies external to Government	19.87	6.32	6.55	2.03	2.40	2.57
Total Non NHS Payables	**20.00**	**6.44**	**6.54**	**2.04**	**2.40**	**2.58**
Capital	2.46	2.46	0.00	0.00	0.00	0.00
Payroll	2.99	2.99	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00
Total Other Trade Payables	**5.45**	**5.45**	**0.00**	**0.00**	**0.00**	**0.00**
Total Trade Payables	**31.13**	**12.64**	**7.35**	**2.60**	**3.19**	**5.34**

Commentary

Total outstanding creditors as at 30th November were £31.13m of which 59% (£18.49m) were overdue based on 30 day payment terms.

The Trust is currently paying approved invoices in approx 60 to 65 days from the invoice date. There are material unapproved creditor balances that exceed the 60 day target mainly due to issues with purchase orders (PO's), including lack of receipting, mismatches on price, unit of issue, VAT and carriage. Finance and Procurement teams are working together with directorates to resolve these issues. The introduction of NO PO/NO PAY will require suppliers to take more ownership of the terms of the PO. This will decrease these issues over time.

Average payment days for 16/17 were 61.31 days. Average Payment days in 17/18 have been adverse to last year due to cash flow issues, in the last couple of months many suppliers have been paid in excess of 80 days. However, the trust recently received 16/17 settlements from the CCGs and additional loan monies which have enabled an improvement in the Trade Creditor position.

The Trust has £5.34m creditors over 6 months; Fig. 1 shows aged creditors analysed by ageing category; Fig.2 shows the rolling creditor trend; & Fig.3 provides a list of the top 10 creditors by value.

Fig.1 - Aged Payables Analysis

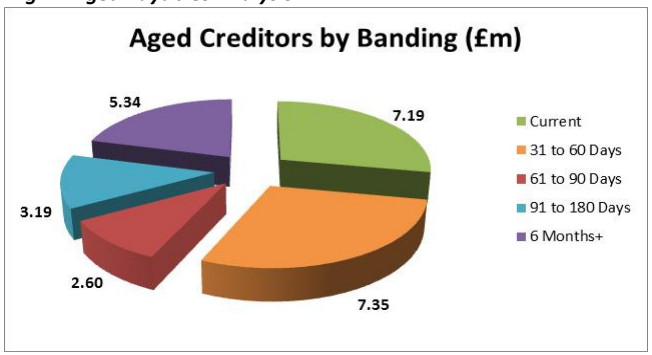


Fig.2 - Creditor Trends

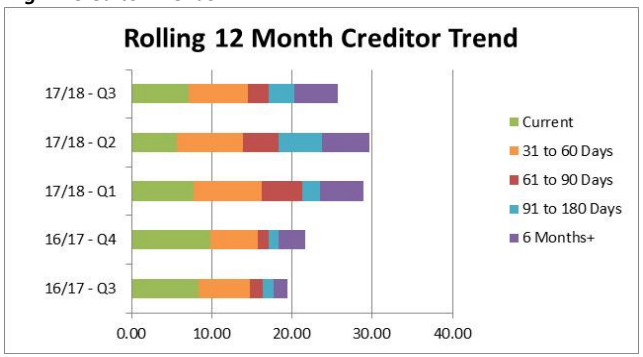


Fig.3 - Top 10 Creditors

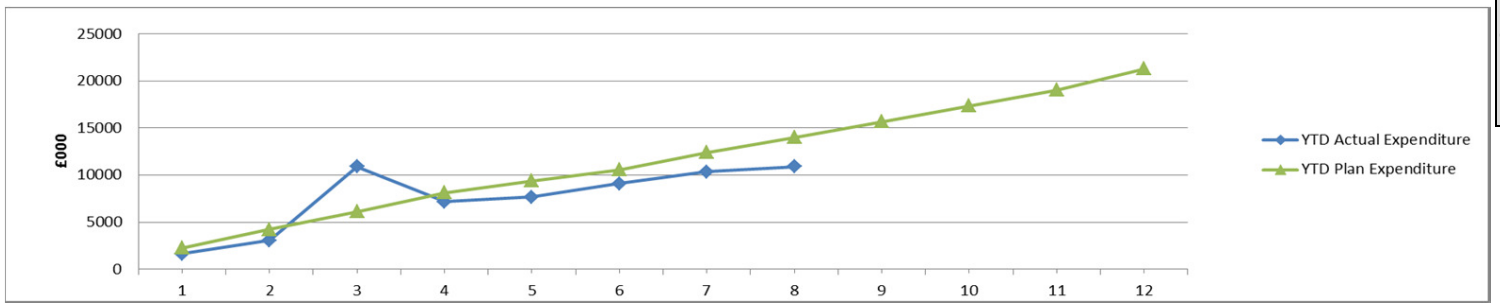
	Top 10 Creditors	£m
1	MAIDSTONE TUNBRIDGE WELLS NHS TRUST	1.48
2	NHS SUPPLY CHAIN	1.26
3	HEALTHCARE AT HOME LTD	1.07
4	DARTFORD & GRAVESHAM NHS TRUST	0.98
5	MEDWAY COMMUNITY HEALTHCARE CIC	0.87
6	KINGS COLLEGE HOSPITAL NHS TRUST	0.75
7	EAST KENT HOSPITALS UNIVERSITY NHS TRUST	0.59
8	JOHNSON & JOHNSON MEDICAL LTD	0.59
9	TFS HEALTHCARE	0.55
10	NHS BSA	0.48

4. Capital

4a. Capital

Capital Programme Summary

	Current Month			Year to Date			Forecast year end position		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Original Plan £m	Forecast Out-turn £m	Forecast Variance £m
Expenditure									
Recurrent Estates & Site Infrastructure	0.22	0.43	-0.21	2.35	2.58	-0.23	4.90	5.93	-1.03
IM&T	0.14	0.26	-0.12	0.93	1.57	-0.64	2.85	3.65	-0.80
Medical & Surgical Equipment	0.03	0.14	-0.11	0.32	0.81	-0.49	1.50	1.42	0.08
Specific Business Cases	0.02	0.17	-0.15	0.94	1.17	-0.23	1.85	0.10	1.75
Transform Projects (ED/AAU)	0.11	0.63	-0.52	6.34	7.89	-1.55	10.32	10.32	0.00
Medical Asssessment Unit (MAU)	0.01	0.05	-0.04	0.01	0.05	-0.04	0.00	1.00	-1.00
Total	**0.53**	**1.68**	**-1.15**	**10.89**	**14.07**	**-3.18**	**21.42**	**22.42**	**-1.00**



Commentary

Cumulative capital spend as at month 8 amounted to £10.89m, representing an underspend of £3.18m below the original plan of £14.07m for the period to date.

There is a substantial underspend for ED which accounts to £1.55m of slippage on Phase 1 of the Project.

All other areas show underspends to date now as we approach the last 4 months of the current financial year.

It is important to note the addition of an additional expenditure line for a new Medical Assessment Unit to be funded by £1m of funds allocated to the trust through the Urgent Emergency Care Fund. This funding is ring fenced and must be spent by 31 March 2018.

Expenditure is still dominated by the ED project and CT Scanner, which is now fully operational. All remaining projects continue to be carefully monitored against a planned funding envelope of £22.42m to identify cost escalation at the earliest opportunity wherever possible.

5. Cost Improvement Programme

5a. 2016/17 Cost Improvement Programme Summary

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

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Report to the Board of Directors

Board Date: 18/01/2018

Agenda item 11b

Title of Report	**Communications report**
Prepared By:	Glynis Alexander
Lead Director	Glynis Alexander, Director of Communications and Engagement
Committees or Groups who have considered this report	N/A
Executive Summary	Over the past month we have used all our internal and external communications channels to make sure staff, patients and public are informed about services at the hospital during the busy winter period. We have also worked closely with partner organisations to encourage people to consider whether the Emergency Department is the most appropriate place for their care. Meanwhile, we have continued to engage staff in our Better, Best, Brilliant programme, particularly around flow and finance. In December a number of Christmas initiatives were publicised, raising staff morale and cheering patients who spent the festive season in hospital. In the media we have received a good level of positive coverage, and been proactive in seeking out opportunities to promote improvements for our patients.
Resource Implications	N/A
Risk and Assurance	N/A
Legal Implications/Regulatory Requirements	N/A

Report to the Board of Directors

Improvement Plan Implication	The communications and engagement activity is aligned with the Trust's improvement plan.
Quality Impact Assessment	N/A
Recommendation	The Board is asked to note to the report.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1. Over the past month we have used all our internal and external communications channels to make sure staff, patients and public are informed about services at the hospital during the busy winter period.

1.2. We have also worked closely with partner organisations to encourage people to consider whether the Emergency Department is the most appropriate place for their care.

1.3. Meanwhile, we have continued to engage staff in our Better, Best, Brilliant programme, particularly around flow and finance.

1.4. In December a number of Christmas initiatives were publicised, raising staff morale and cheering patients who spent the festive season in hospital.

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

2 ENGAGING COLLEAGUES

2.1 Internal communications have continued to engage staff in the Better, Best, Brilliant improvement programme. Our approach to this has been to keep the widest range of staff informed about flow and finance, encouraging them to think how they can help improve performance.

2.2 A full communications and engagement plan has been produced to support the Trust's financial recovery, and this will be delivered over the coming weeks and months.

2.3 The Chief Executive produced a video message for staff just before Christmas. This was well-received, with more than 300 views on YouTube by the beginning of January.

2.4 In future a monthly video message by the Chief Executive will complement her weekly email to staff.

2.5 A highly successful staff briefing was attended by more than 300 staff in December. Topics included current clinical performance, an update on the STP and an overview of our current financial position.

2.6 In the run-up to Christmas staff were invited to attend the Christmas Tree lights switch-on which included carols from a local choir.

2.7 They were also encouraged to enter the Christmas Decoration Challenge. This was well supported, with many wards and patient areas made to look bright and cheerful.

2.8 There was also a children's Christmas Party attended by characters from the local pantomime.

2.9 During December and January focus groups have been held with staff as part of a project to define and embed a 'Brilliant Medway' culture.

2.10 A new app for staff – @MFT has been created to support training, updates, HR, and useful information. The app has been downloaded by more than 800 staff and has had over 13,000 visits.

3 MEDIA

3.1 The Communications Team has dealt with an unprecedented number of press enquiries relating to winter pressures and how the Trust is coping – around 30 in the first week of January.

3.2 Compared to the same period last year (especially the first week of the New Year) there has been a much higher level of media interest, largely driven by the national coverage and announcements, for example about deferral of elective surgery.

3.3 We have provided information about mitigations in place including preparedness before Christmas, and given statements about the situation within the hospital.

3.4 We have co-ordinated responses with partners in the health and care system, for example advising people of other sources of advice and treatment.

3.5 ITV and KMTV filmed in the Emergency Department for a feature on how the Trust had prepared to cope with pressures over the winter period. This has been followed up with coverage on the pressures felt across the whole system over the festive period.

3.6 The launch of the da Vinci robot in November generated a lot of media interest with segments on ITV Meridian and KMTV and pieces in the Messenger group papers, including an interview with a prostate patient whose procedure had been performed using the machine.

3.7 Various fund-raising and charity activities have been covered, including the Trust's Christmas stocking appeal, which got television coverage from KMTV as well as the Messenger Group papers, as did visits from Gillingham Football Club (which was filmed by the BBC), Rochester United FC and other charitable donors over the festive season.

3.8 Artwork commemorating organ donors that is displayed in the atrium won an international award at the FESPA International Printing Awards held in Hamburg. The award was covered in the local press.

3.9 For International Volunteers Day, BBC Radio 5 Live interviewed two of our volunteers.

3.10 The Nursing Times featured the success of a new hip fracture pathway in ED that has led to a decrease in the mortality rate for these patients.

3.11 An interview with Trust Deputy Chief Executive James Devine discussing the failure of Unite's ballot about strike action ran on ITV Meridian.

3.12 The Medway Messenger continued our campaign to increase breast screening rates with regular features and interviews.

4 SOCIAL MEDIA

4.1 Over a 28-day period we engaged with 73,100 followers on Twitter (18 per cent increase) and 117,405 on Facebook (nine per cent increase).

4.2 The team has continued to use the social media management tool, Crowd Fire, to help manage and grow our online presence; this along with engaging content, particularly during the Christmas period, has led to an increased overall following.

4.3 Trust social media account followers now total 3,247 on Twitter (up from 3,064 at the last update), 5,061 on Facebook (up from 4,876) and 316 on Instagram (up from 189); this represents a steady increase across all channels and marks a milestone for the Trust in reaching more than 5,000 followers on a single platform (Facebook).

4.4 In addition to promoting key news updates, our social media accounts raised awareness of numerous visits to the Trust by local high-profile figures in the build up to Christmas; Fab Change Day 2017; and the first in a series of internal staff debates. Elsewhere, interactions with notable figures online included MP Rehman Chishti, actress Claire Sweeney, and several Gillingham FC players.

4.5 The Trust social media accounts were used to distribute key messages to the public regarding the pressures faced by the organisation immediately following the Christmas period. The messages encouraged the public to consider whether the Emergency Department was the best place for their treatment and provided navigation to other services.

4.5 In future, we plan to post further engaging social media content, including a regular video feature with staff which will highlight a typical day in the life of Trust employees.

5 COMMUNITY ENGAGEMENT

5.1 Community engagement activity is now focused on five areas

5.1.1 Supporting Trust Governors to engage with local residents.

5.1.2 Ensuring Trust members have opportunities to hear what's happening at the Trust and to get involved.

5.1.3 Supporting services to engage with patients and public about service improvements.

5.1.4 Reaching out to less engaged parts of the community to raise awareness of the Trust and ensure as wide a range of people as possible can have a say in future developments.

5.1.5 Providing opportunities for patients and public to be engaged in the development of proposals as part of the Sustainability and Transformation Partnership.

5.2 Governors

5.2.1 Our governors continue to engage with networks across Medway and Swale. There was a Governor coffee morning in Luton and Wayfield on 16 November, which was well-received. Four governor coffee mornings are planned for 2018.

5.2.2 Discussions are taking place about how Governors can support patient experience improvements.

5.2.3 Governors are involved in membership recruitment, with stands held on a regular basis in the hospital main entrance.

5.2.4 Governors now receive an enhanced news update via board representative Doreen King.

5.3 Members

5.3.1 Bi-monthly member events have been planned for 2018 and publicised through News@Medway and on the Trust website.

5.3.2 Members receive a monthly newsletter from the Chair.

5.4 Supporting services to engage with patients and public

5.4.1 The Community Engagement Officer worked with Darzi Fellow, Dr Coral Akenzua, in the planning and facilitation of a focus group for people living with lung conditions. The aim was to gather patient experiences and journeys to help inform and shape future plans for Medway integrated respiratory services. Fourteen people took part in the focus group. The qualitative data on the content related to their journeys is still being analysed. However, exit feedback from the patients was positive, with 93 per cent feeling they had been listened to.

5.4.2 We will be working with BME groups to raise the profile of organ donation within these communities.

5.5 Reaching out to less engaged audiences

5.5.1 We have made links with Brompton Academy and Chatham Girls Grammar School. Both schools have educational programmes that could be enhanced by senior clinician presentations and we aim to pursue these opportunities in 2018.

5.5.2 Our Community Engagement Officer and Senior Physiotherapist gave presentations to 150 people at Kent Active Retirement Association roadshows in Walderslade and Rainham.

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

5.6 Engagement in the STP

5.6.1 We are working closely with our STP partners and supported their November and December meetings with local people on their community services review and the Medway Model for local care.

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Report to the Board of Directors

Board Date: 18/01/2018

Agenda item 12

Title of Report	**Workforce Report**
Prepared By:	Leon Hinton, Deputy Director of HR & OD
Lead Director	James Devine, Deputy Chief Executive & Executive Director of HR & OD
Committees or Groups who have considered this report	Executive Team
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the hospital. The Trust's recruitment campaigns, including national, local and international have delivered 44 candidates to-date from India via Cpl, 23 candidates to-date via HCL and 57 from other partner agency providers. The initial Philippines recruitment plan for nursing continues with a total of 197 nurses being processed for posts at MFT. Trust turnover has increased to 11.1% (+0.66% from 10.51%), sickness remains under 4% (+0.04% from 3.72%) at 3.76%, compliance with mandatory training compliance has worsened to 77% (-1% from 78%), achievement review compliance improved to 80% (+0.07% from 80%). An increase in the percentage of pay bill spent on substantive staff is reported for November (to 81.4% by +1.8%) with a decrease (of 1%) in agency usage and a decrease (of 0.9%) to bank usage.
Resource Implications	None
Risk and Assurance	• Nurse Recruitment • Temporary Staffing Spend

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 2017/18 cost improvement programme
Legal Implications/Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators.
Improvement Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).
Quality Impact Assessment	Not applicable
Recommendation	Not applicable
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 INTRODUCTION

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

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. The nursing open evening held on 11 November was well attended and resulted in 24 Registered Nurses and 1 Clinical Support Worker (CSW) being offered posts. Four further assessments days took place in November resulting in 15 Registered Nurses and 15 CSWs accepting a job offer. There are planned recruitment activities in place for 2018.

2.2 The international campaign in the Philippines continues. Harvey Nash, our international partner agency working on our Filipino nurse recruitment campaign, is continuing to process 197 of the Filipino nurses that remain engaged in the process (14 individuals have withdrawn and 30 individuals have failed to follow-up on the offer). The first cohort will arrive in the Trust on 04 January 2018 to join the new six-week objective structured clinical examination (OSCE) training programme that commences on 08 January 2018.

2.3 Further to the collaborative regional procurement approach to International Nurse Recruitment the Trust selected two partner providers; Cpl Healthcare (Cpl) and HCL Clarity (HCL). Cpl is working with the Trust on developing a pipeline of nurses with start dates from April 2018 onwards. To date 44 nurses have been offered posts via Cpl. In line with NHS Employment Standards, all international, national and local recruitment offers are subject to checks governing suitability and right to work. Offers made to candidates via Skype have identity confirmed as part of the NHS Employment Standards and checked against the individual interviewed.

2.4 HCL is working with the Trust to recruit 75 NMC ready nurses from the UK and the EU. Fortnightly Skype and face-to-face interview have been scheduled. Six cohorts of NMC ready nurses have been interviewed resulting in 23 experienced nurses accepting posts.

2.5 The Trust is also working with two additional permanent recruitment agency providers. The Trust under took Skype interviews with both providers over September, October and November resulting in an additional 54 nurses accepting posts.

2.6 The Trust has commissioned the services of HealthSectorJobs (HSJ), a specialist health sector advertising company to undertake a four-week targeted nurse

recruitment advertising campaign on behalf of the Trust. The first cohorts of HSJ candidates have been interviewed resulting in three candidates accepting posts.

2.7 The table below summarises offers made, starters and leavers for November 2017. Four of the 'registered nurse' leavers are ward-based nurses and ward-based midwives. The remainder are practice educators, ward managers and specialist nurses.

Role	Offers made in month	Actual Starters	Actual Leavers
Registered Nurses	94	7	11
Clinical Support Workers	21	1	11

(Table 1: Monthly starters and leavers)

2.8 Five non-training doctors commenced in post during November.

3 DIRECTORATE METRICS

3.1 The table below (table 2) shows performance across five core indicators by the new directorate structures. Turnover, at 11.17% (+0.66% from October), remains above the tolerance level of 8%. Sickness absence (+0.04% at 3.76%) remains below the tolerance level of 4%. 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. In conjunction with outputs from the January unconference and culture workstreams, with the aim to implement a service-specific retention plan through quarter 4 17/18 and quarter 1 18/19.

3.2 Trust achievement review rate stands at 80.07% (+0.07%), below the Trust target of 85%, Mandatory training remains below target (at 77.0%, worsened by 1%) – one directorate is meeting the mandatory training target (Corporate - no change to previous month) and one directorate is meeting the achievement review target (Corporate – down from two in previous month). A revised achievement review (AR) system will be implemented across the Trust from 01 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 new ratings will be included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation. The appraisal paperwork will be replaced to streamline the process and reduce the burden of paperwork. The mechanism will also change to support an ongoing performance and objective conversation rather than an annual report and will capture training and development needs for intelligent commissioning.

Report to the Board of Directors

	Planned Care			Unplanned & Integrated Care			Corporate			Estates & Facilities			Trust		
	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend
Turnover rate (8%)	11%	-	-	12%	-	-	14%	▼		7%	▲		11%	▲	
Vacancy rate	22%	-	-	22%	-	-	15%	▲		10%	▲		18%	▲	
Sickness rate (4%)	4%	-	-	4%	-	-	2%	▲		5%	▲		4%	▶	
Mandatory Training (85%)	84%	-	-	80%	-	-	90%	▲		52%	▶		77%	▼	
Achievement Review (85%)	83%	-	-	77%	-	-	88%	▲		76%	▼		80%	▲	

(Table 2: Key workforce metrics)

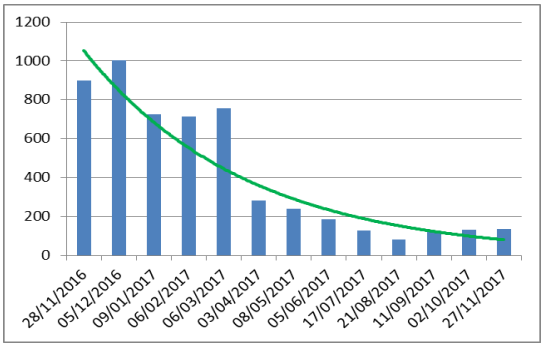
4 TEMPORARY STAFFING

4.1 Table 3 below demonstrates that temporary staffing expenditure decreased in November compared to October. November's £3.2m temporary spend is average compared to previous months.

		Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17
Spend	Agency	3,890,198	1,573,361	1,944,694	860,106	1,256,661	1,571,620	1,379,621	1,301,379	1,077,195
	Bank	920,473	1,695,546	1,214,160	2,046,593	1,829,949	2,440,472	2,307,063	2,390,624	2,148,189
	Substantive	13,611,458	14,302,903	14,302,903	14,326,916	14,096,790	14,337,577	13,920,369	14,484,907	14,171,980
% Pay bill	Agency	21%	9.11%	11.14%	4.99%	7.31%	8.56%	7.84%	7.16%	6.19%
	Bank	5%	9.81%	6.95%	11.88%	10.65%	13.30%	13.10%	13.15%	12.35%
	Substantive	74%	81.08%	81.91%	83.13%	82.04%	78.14%	79.06%	79.69%	81.46%

(Table 3: Workforce profile based on contractual arrangement)

4.2 The agency cap breaches across all staff groups for November were fairly static with approximately 110 price cap breaches per week. Additionally, the Trust is on target to be £5.2m below its NHSi agency spend ceiling.



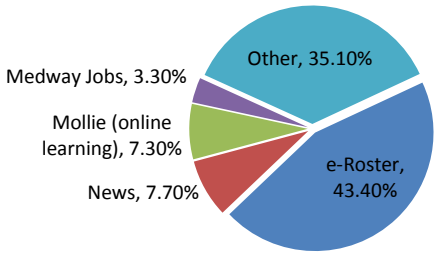
(Table 4: NHSI Agency cap breaches per week)

4.3 Temporary nursing demand in November decreased compared to October (9,892 shifts requests in Nov compared to 10,817 in Oct) and fill rate increased by 4% to 79%. Medical locum demand remained unchanged in November with 819 requests of which 80% were filled.

5 @MFT – SMARTPHONE APPLICATION FOR STAFF

5.1 The Trust launched its new smartphone staff app to android and iOS users on 13 November 2017. The free app is available to all staff and provides access to news (CEO weekly message, theme of the week and important news updates); welcome information for new starters; access to Trust programmes (Better, Best Brilliant); benefits for working at MFT; how to raise concerns; access to other links (e-Roster, Mollie online learning and Doctors' toolbox) and other services (Jobs at Medway, Nursing, Development). The app continues to be developed and updated.

5.2 Following go-live the app has proven popular with 804 downloads (just under 20% of staff) and used over 12,000 times. Usage is broken down as follows, with e-Roster (the ability to view rosters, request leave and shift swaps) the dominant usage.



6 EQUALITY DELIVERY SYSTEM (EDS2) UPDATE

6.1 The purpose of the Equality Delivery System (EDS) for the NHS is to help local NHS organisations, in discussion with local partners including local people, review and improve their performance for people with characteristics protected by the Equality Act 2010, and to deliver on the public sector Equality Duty (PSED).

6.2 Following the publication of the Trust's EDS2 assessment in September 2017, the equality and inclusion training offerings have been redesigned to address the gaps in service provision. This includes the equality module of the Medway Leadership Programme (MLP), a masterclass session on Managing Teams Fairly, and cross-

cultural awareness/affinity bias, and joint work with patient experience and procurement regarding the accessible information standard. Work with the directorates to self-assess against EDS2 standards is underway to be concluded by March 2018.

6.3 Following Board acceptance, the following next steps are planned:

6.3.1 Consultation with partners/community to enable a second assessment in 2018 (by February 2018);

6.3.2 Reassessment of EDS2 (March 2018).

-End

CORPORATE POLICY: Safeguarding

Author:	Safeguarding Team
Document Owner	Head of Safeguarding
Revision No:	1
Document ID Number	POLCPCM082 (replaces GUCPCM001)
Approved By:	Trust Board
Implementation Date:	
Date of Next Review:	

Medway NHS Foundation Trust
Safeguarding Policy

Document Control / History	
Revision No	**Reason for change**
1	New high level document combining adults and children

Consultation
Executive Group
Trust Board

Medway NHS Foundation Trust
Safeguarding Policy

Table of Contents

Medway NHS Foundation Trust
Safeguarding Policy

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

1 Introduction

1.1 The Safeguarding policy provides an overarching framework to co-ordinate, lead and develop services to prevent harm occurring and protect the most vulnerable Adult's and Children, embracing both the acute and community services provided by the Trust. i.e. COAST (community outreach and specialist team)

2 Purpose / Aim and Objective

2.1 Safeguarding children, young people and adults is everyone's business, however specialist safeguarding staff are employed in dedicated roles, and we have clear safeguarding structures within the Trust. These staff, with executive support will embed and drive the safeguarding agenda forward, provide a framework that supports best practice and allows the Trust to fulfil its statutory responsibilities.

2.2 All Trust business and activity relating to safeguarding will follow the Trust's governance processes for oversight and monitoring purposes.

2.3 The Policy framework ensures that key compliance areas sets out how we will improve services in five key domains:

- Effective safeguarding structures and governance.
- Mainstream safeguarding children, young people and adults into everyday business
- Working in partnerships
- Learning through experience and the development of knowledge and skills for staff
- Engaging with service users

2.4 The Medway NHS Foundation Trust (MFT) Safeguarding Assurance Group will provide assurance to the Trust Board via an annual report that there are robust and effective safeguarding measures in place to execute statutory safeguarding duties.

2.5 The Trust aims to 'Be the BEST' in everything it sets out to do, and this extends to embedding safeguarding at the heart of how it protects and manages vulnerable patients.

3 Policy Framework

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

STRCS016 - Safeguarding Strategy 2016-2018 The strategy outlines the objectives the Trust will achieve over the next two years to strengthen its safeguarding arrangements whilst working in partnership with other key stakeholders.
Adult GUCPCM001 - Safeguarding Vulnerable Adults This document then has been developed to meet and work within the safeguarding adult lawful requirements set out within the Care Act 2014; it's supporting Statutory Guidance and the associated Schedules and Regulations.
SOP0194 - Safeguarding Adults - Making Safeguarding Referrals Explains how to make a safeguarding referral.
SOP0195 - Safeguarding Adults - Process for Applying for a Deprivation of Liberty Safeguards - DoLS Explains how to apply for a Deprivation of Liberty Safeguards – DoLS.
STRCPCM001 - Safeguarding and Protecting Children Training Strategy (1 attachment) Training required to ensure all staff in the Trust understand their role in safeguarding children and can recognise when a child is at risk and know what to do if they are concerned about a child.
Children POLCPCM055 - Kent & Medway Safeguarding Procedures Joint procedures that reflect the level of cross boundary work undertaken by many of the agencies and organisations who use the procedures. They reflect those local procedures that relate only to Kent or Medway.
POLCPCM027 - Safeguarding and Protecting Children Policy Local policy document used in conjunction with Kent and Medway procedures.
SOP0053 - Safeguarding Children - Raising Concerns Provides guidance on how to raise a concern about children.
SOP0051 - Safeguarding Children - Child Abuse Neglect Sexual Exploitation and trafficking This guidance is to support staff in the management of children who are at risk of abuse or where abuse has been identified.
SOP0050 - Safeguarding Children - Community This document is produced to assist staff working in the community to fulfil their

safeguarding responsibilities.
SOP0054 - Safeguarding Children - Interagency Working This document ensures all staff know what is expected in their role particularly when working with partner agencies.
SOP0052 - Safeguarding Children - Female Genital Mutilation - FGM Local guidance for clinicians who have direct contact with patients where this practice may be identified or where a disclosure may be made.
GUDNM228 - Safeguarding Children - Kent and Medway Female Genital Mutilation Kent and Medway guidance for clinicians who have direct contact with patients where this practice may be identified or where a disclosure may be made.
SOP0055 - Safeguarding Children - Looked After Children - Consent Explains how to obtain consent for Looked After Children.
SOP0117 - Safeguarding Children - In the Emergency Department including gangs Principles of safeguarding children in ED and information on gangs.
SOP0060 - Safeguarding Children - Useful Contacts Supplies staff with contact details of safeguarding teams both in and out of the Trust to support their work in safeguarding children.
PROCPCM001 - Safeguarding Children - Responding to Child Death Procedure Describes the mandatory process that must be followed when a child dies.
GULPCM202 - Safeguarding Children - Safeguarding Children who may have been trafficked - HM Government Home office guidance for trafficked children
GUDNM231 - Safeguarding Children on the Neonatal Unit - Neonatal Nursing Local guidance for the Neonatal Unit.

4 Roles and Responsibilities

4.1 Trust Board

4.1.1 The Care Act 2014 provides a clear legal framework for how all healthcare organisations will work in partnership with other public services, to protect adults at risk. As a statutory partner of the Kent and Medway Safeguarding Adult Board (SAB) and Medway Safeguarding Children's Board, (MSCB) and Kent Safeguarding Children's Board (KSCB), Medway NHS Foundation Trust (MFT) has corporate commitment to safeguard our patients and our local community.

4.2 Chief Executive

4.2.1 The Chief Executive devolves the responsibility for compliance and monitoring to the Director of Nursing

4.3 Board Leads for Safeguarding

4.3.1 The Executive Board Lead is the Director of Nursing whose role it is to represent the Trust at the Safeguarding Adult and Children's Boards in Medway and Kent.

4.3.2 The Executive Board lead will be responsible for senior strategic leadership and decision making on behalf of the Trust and will report to the Trust Board on safeguarding arrangements within the Trust.

4.3.3 The Executive Board Lead will also provide reassurance to the Board that we meet our statutory requirements.

4.3.4 The Non Executive Board lead will work with the Safeguarding Assurance Group to ensure that the Trust fulfils its statutory and legislative responsibilities, whilst prioritising patient care supporting the governance and strategic development of safeguarding across the Trust, offering collaborative challenge and advice.

4.4 Head of Safeguarding

4.4.1 Work at a strategic level across the health and the social care community, fostering and facilitating multi-agency working and training in respect of Safeguarding Adults and Children.

4.4.2 To be the strategic lead within the Trust for safeguarding of adults and children

4.4.3 To facilitate policies and procedures related to safeguarding adults and children

4.4.4 Providing assurance reports for the Executive Lead on Safeguarding Adult and Children legal compliance.

4.5 MFT Safeguarding Assurance Group

4.5.1 MFT has an established multidisciplinary Safeguarding Assurance Group which provides strategic direction to safeguarding activities across the Trust. The membership of the Safeguarding Assurance Group includes representatives from local Clinical Commissioning Groups and Kent and Medway Safeguarding Adult Board.

4.5.2 The Safeguarding Assurance Group provides assurance to both the Trust Board (via the Quality Assurance Committee) and the Commissioners via the Kent and Medway Safeguarding Adults Board and Children's Board.

4.6 Safeguarding Steering Group

4.6.1 The Children and Adult Safeguarding Group provides an operational overview to influence our strategic aims for Safeguarding services at Medway Foundation Trust. This group will share information in relation to their work plans and representation at multi-agency meetings and learning events. The group will also discuss operational issues and concerns in relation to their specific area of work, identify solutions and support mechanisms required to ensure that actions are taken to lead and execute safeguarding practices across Medway Foundation Trust.

4.7 Named Nurse Safeguarding Children

4.7.1 The Named Nurse will provide leadership at an operational level to all staff within the Trust.

4.7.2 The Named Nurse will ensure the Trust is compliant with its duties and ensure policies are in place and up dated and available for all staff.

4.7.3 The Named Nurse will ensure processes to safeguard children and young people are in place and that staff at the frontline are supported in their day to day work

4.7.4 The Named nurse will represent the Trust at the Safeguarding Boards', subgroups ensuring there is good participation and information sharing when contributing to Multi agency audits.

4.7.5 The Named Nurse ensures there is a robust training programme in place to support staff in their understanding of safeguarding children and young people.

4.7.6 The Named nurse will provide supervision and support to staff at the frontline on a day to day basis

4.7.7 The Named nurse ensures there are processes in place to collect data as required by the safeguarding children boards and the CCG.

4.7.8 The Named nurse works closely with external partners sharing information and contributing to assessments of risk to vulnerable children and young people

4.7.9 The Named nurse chairs the Trust safeguarding forum

4.8 Named Midwife for Safeguarding

4.8.1 The Named Midwife is responsible for the coordination of all cases where there are vulnerable babies

4.8.2 The Named Midwife works closely with the frontline midwives in both the community and on the maternity wards, providing supervision and support on any difficult cases

4.8.3 The Named Midwife works closely with external partners ensuring information sharing is provided in the best interest of the babies

4.8.4 The Named Midwife contributes to assessments when a vulnerable woman or young person is pregnant.

4.8.5 The Named Midwife coordinates the maternity hub where vulnerable cases are discussed.

4.8.6 The Named Midwife provides information to the MARAC process when vulnerable pregnant women are discussed.

4.9 Line Managers

4.9.1 Line managers are responsible for ensuring that the Safeguarding Policies are implemented within their programmes and directorate.

4.10 All Staff

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

5 Monitoring and Review

What will be monitored	How/Method / Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Head of Safeguarding	Director of Nursing	Where gaps are recognised action plans will be put into place
Mental Capacity and Deprivation of Liberty (DoLS)	Annually Audited	Adult Safeguarding Lead	Head of Safeguarding / Director of Nursing	Compliance monitoring and effectiveness of education and support required.
Safeguarding Adult section 42 enquiry compliance audit	Annually Audited	Adult Safeguarding Lead	Head of Safeguarding / Director of Nursing	SAF Multi agency response and multi professional appropriate and timeliness response monitored – affecting ongoing work plan
S11 Self-assessment document of compliance to the Children Act.	Bi annually for Kent LSCB and Medway LSCB. These are completed alternately annually	Named Nurse for Children	Head of Safeguarding / Director of Nursing	Ensure that in discharging their functions staff have regard to the need to safeguard and promote the welfare of children.

What will be monitored	How/Method / Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
KMSAB Self-assessment framework	Annually	Head of Safeguarding	Director of Nursing / KMSAB	Where gaps recognised the Assurance Group to decide remedial actions required

6 Training and Implementation

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

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

6.1.2 Bespoke training for dedicated cohorts and staff groups.

7 Equality Impact Assessment Statement & Tool

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

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

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

9 References

Document	Ref No
References:	
Trust Associated Documents:	
See framework	

END OF DOCUMENT

CORPORATE POLICY - Consent Policy

Author:	Head of Legal Services, Corporate Compliance and Resilience – Paul Mullane in conjunction with Brachers LLP
Document Owner:	Trust Secretary and Director of Corporate Compliance and Legal Services – Sheila Murphy
Revision No:	7
Document ID Number	POLCGR034
Approved By:	Trust Board
Implementation Date:	January 2018
Date of Next Review:	January 2019

Consent Policy

Document Control / History	
Revision No	**Reason for change**
Updated	Alteration to reflect changes to legislation – Mental Capacity Act (2005) and Human Tissue Act (2004) and Department of Health: Reference guide to consent for examination or treatment 2nd Edition 2009
1	Amendment – change of contact details for IMCA – see 1.3.8.
2	Changes to Case Law and Legislation; inclusion of Monitoring Table and Equality Impact Assessment
3	Inclusion of consent for post mortems
4	To accommodate revisions to NHSLA risk management standards
5	Scheduled update – no changes to guidance
6	Policy updated and split into individual SOPs
7	Reviewed – remove Form 8 – no longer required

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

Consent Policy

Table of Contents

Consent Policy

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

1 Introduction

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

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

2 Purpose / Aim and Objective

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

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

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

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

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

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

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

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

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

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

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

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

3 Definitions

3.1 Capacity

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

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

3.1.3 have capacity to take the particular decision;

3.1.4 have received sufficient information to take it; and

3.1.5 not be acting under duress.

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

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

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

3.4 **Risk**

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

4 (Duties) Roles and Responsibilities

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

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

4.3 Completing consent forms

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

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

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

4.4 Delegation of Consent

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

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

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

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

- an appropriate professional has addressed any outstanding concerns of the patient; and
- the patient has received full information to enable him/her to make a decision on whether or not they wish the proposed procedure to go ahead.

4.5 Responsibility of health professionals

4.5.1 It is a health professional's own responsibility:

- to ensure that if a colleague seeks consent on their behalf they are confident that the colleague is competent to do so; and
- to work within their own competence and not to agree to perform tasks which exceed that competence.

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

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

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

5 Monitoring and Review

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

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

6 Training and Implementation

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

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

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

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

7 Equality Impact Assessment Statement and Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide "evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]"; in effect to undertake equality impact assessments on all procedural documents and practices. Authors should use the Equality Impact Toolkit to assess the impact of the document.
In the first instance this will mean screening the document and, where the screening indicates, completing a full assessment. The Toolkit can be found on the Trust website http://www.medway.nhs.uk/our-foundation-trust/publications/equality-and-diversity/equality-impact-assessments/

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

8 References

Document	**Ref No**
References:	
Care Quality Commission Fundamental Standard	Regulation 11
Human Tissue Act 2004	
Mental Capacity Act 2005	
Consent: Supported Decision Making – a good practice guide (Royal College of Surgeons November 2016)	
Good practice in consent implementation guide (Department of Health 2002)	
Trust Associated Documents:	
Consent Procedure	SOP0131
Consent - Tissue	SOP0134
Consent - Clinical photography and conventional or digital video recordings	SOP0135
Consent - Medway Elective Surgical Consent Pathway	OTCGR161
Consent - Consent Flow Chart for Children Under 16 Years of Age	OTCGR162
Consent - Form 1 - Patient agreement to investigation or treatment	OTCGR165
Consent - Form 2 - Parental agreement to investigation or treatment	OTCGR166
Consent - Form 3 - Patient-parental agreement to investigation or treatment -procedures where consciousness not impaired	OTCGR167
Consent - Form 4 - Form for adults who are unable to consent to investigation or treatment	OTCGR168
Consent - Form 6 - Supplementary Consent for Gifting of Tissue	OTCGR158
Consent - Form 7 - Consent to photography and conventional or digital video recordings	OTCGR159
Consent - Form 9 - Post Mortem Consent Form - Baby	OTCGR163

Consent Policy

Management and Publication of Written Patient Information Policy and Procedure	POLCGR019
Interpreter/Translator Policy	POLCGR023
Use of Unlicensed Products	POLCPCM034

END OF DOCUMENT

Corporate Policy: Estate and Facilities

Author:	Deputy Director of Estates and Facilities
Document Owner:	Director of Estates and Facilities
Revision No:	2
Document ID Number	POLCOM049
Approved By:	Trust Board
Implementation Date:	November 2016
Date of Next Review:	November 2018

Estates and Facilities Corporate Policy

Document Control / History	
Revision No	**Reason for change**
1	New Corporate Policy –Estates and Facilities leads had consultation and input.
2	Review of Policy – General updates and minor amendments

Consultation
Director of Estates and Facilities
Head of Estates
Head of Facilities
Deputy Director of Estates and Facilities
Local Security Management Specialist (LSMS)
Head of Clinical Engineering

Table of Contents

Estates and Facilities Corporate Policy

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

1. Introduction

1.1 The Estates and Facilities Directorate has a corporate responsibility to operate and maintain all Trust land, premises, equipment and all associated support facilities and services in an efficient and effective manner. In addition there is also a responsibility to ensure the premises are safe, secure, clean, fit for purpose and appropriate to the delivery of clinical healthcare services.

1.2 The information within this overarching policy and all subsequent supporting Estates, Facilities, Security and Clinical Engineering policies and procedures provides detail on how the above requirements and standards are to be met. It provides information on levels of accountability and responsibility, implementation of specific policies and procedures, benchmarking and measurement of performance, and reporting mechanisms, in order to provide assurance to the Trust Board.

2. Purpose / Aim and Objective

2.1 The purpose and aim of this document is to provide an overview of the four strands of Estates and Facilities and to identify through supporting policies and procedures the various regulatory frameworks to which the directorate is expected to work at the National level, and at Trust level.

The four strands of the Estates and Facilities Directorate are:

- Estates Services (inc. Fire Safety)
- Facilities Services

  Clinical Engineering Services
- Security Services

2.2 The objective of this document and all supporting policies and procedures is to identify, at high level and in detail, the relevant statutory regulations and standards which govern the provision of Estates and Facilities services. These documents will provide all Trust staff with detailed guidance, references and clarity on a range of topics relating directly to the Estates and Facilities service provision in order to ensure that the principles of providing a safe, secure and clean healthcare environment are met.

3. Regulatory Frameworks

The following outlines the Regulatory frameworks which govern all Estates and Facilities activities within the Trust:

3.1 National Frameworks and Regulations

3.1.1 Regulatory Requirements: Standards of Quality and Safety

The Care Quality Commission (CQC) regulates all providers of regulated health and adult social care activities in England. The CQC's role is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and to encourage care services to improve.

At the time of preparing this document, registration requirements are set out in the Care Quality Commission (Registration) Regulations 2009 (CQC Regulations) (Part 4) (as amended) and include requirements relating to:

- Safety and suitability of premises;
- Safety, availability and suitability of equipment; and
- Cleanliness and infection control.

The CQC is responsible for assessing whether providers are meeting the registration requirements. Failure to comply with the CQC Regulations is an offence and, under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3). the CQC has a wide range of enforcement powers that it can use if the provider is found to be non-compliant. The regulations stipulate that all premises and equipment used must be safe, clean, secure and suitable for the purpose for which they are being used, and properly used and maintained.

3.1.2 NHS Constitution

The NHS Constitution sets out the rights to which patients, public and staff are entitled. It also outlines the pledges that the NHS is committed to achieve, together with responsibilities that the public, patients and staff owe to one another to ensure that the NHS operates fairly and effectively. All healthcare organisations are required by law to take account of this Constitution in their decisions and actions.

Healthcare organisations need to "ensure that services are provided in a clean and safe environment that is fit for purpose, based on national best practice".

In order to deliver on this pledge, it specifically advises NHS organisations to take account of:

- National best-practice guidance for the design and operation of healthcare facilities.(HTM's and HBN's – see 3.2.1 & 3.2.2)
- The NHS Premises Assurance Model (NHS PAM).

3.1.3 Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations.

The DH have commissioned and published an independent report by Lord Carter of Coles into productivity and efficiency in non-specialist acute hospitals in England.

The report concluded that there is significant unwarranted variation across all main resource areas. The report notes that the unwarranted variations are worth £5bn in terms of efficiency opportunity and goes on to make 15 recommendations designed to tackle this variation and help trusts to improve their performance.

The recommendations (recommendation 6) relating to the hospital estate are summarised as follows:

- Total estates and facilities running costs per area (£/m2)

  Trusts are considered good if their metric is lower than £320. (The current variation is between £105 and £970)

- Non clinical space (% of floor area)

  Trusts are considered good if their metric is lower than 35% (The current variation is between 12% and 69%)

- Unoccupied or under used space (% of floor area)

  Trusts are considered good if their metric is lower than 2.5%

- Trust are required to have in place, by April 2017 a strategic estates and facilities plan to deliver the above benchmarks by April 2020 so that estates and facilities resources are used in a cost effective manner.

3.1.4 Health and Safety legislation

The Health & Safety Executive (HSE) is the national regulator for workplace health and safety.

The following primary and secondary legislation places legal duties on various duty holders:

- The Health and Safety at Work etc. Act 1974
- The Health and Safety (Display Screen Equipment) Regulations 1992(amended 2002)
- Management of Health and Safety at Work Regulations (2006 amendment & 1999)
- Manual Handling Operations Regulations 1992 (As amended)(MHOR)
- Personal Protective Equipment at Work Regulations 1992
- Workplace (Health, Safety and Welfare) Regulations 1992
- Provision and Use of Work Equipment Regulations 1998(PUWER)
- The Control of Substances Hazardous to Health Regulations (COSHH) 2002

Other regulations specific to Estates and Facilities function are expanded further in the supporting policy documentation relating to Estates, Facilities, Security and Clinical Engineering.

3.1.5 Fire Safety Legislation

Fire Safety in buildings in the UK is governed by two pieces of legislation. These being:

- The Regulatory Reform (Fire Safety) Order 2005 covers general fire safety management in healthcare premises. The body responsible for enforcing this fire safety legislation is the Kent Fire and Rescue Service (KFRS)

- The Building Regulations 2010, Part B, Fire Safety which applies to building design.

In addition, all Trusts are expected to comply with HTM 05-05 (Fire Code).

3.1.6 NHS Premises Assurance Model (PAM)

The NHS has developed, with the support of DH, the NHS Premises Assurance Model (NHS PAM), the remit of which is to provide assurance for the healthcare environment and to ensure patients, staff and visitors are protected against risks associated with hazards such as unsafe premises.

Primarily aimed at providing governance and assurance to Trust Boards, it allows organisations that provide NHS funded care and services to better understand and assess the effectiveness, quality and safety with which they manage their estate and facilities services and how that links to patient experience and patient safety.

Key questions are underpinned by prompt questions which require the production of evidence. Healthcare organisations should prepare and access this evidence to support their assessment of the NHS PAM.

The model also includes reference to evidence and guidance as a helpful aide-memoir to assist in deciding the level of NHS PAM assurance applicable to a particular healthcare site or organisation.

NHS PAM is designed to be available as a universal model to apply across a range of Estates and Facilities management services.

3.2 Estates Related Frameworks and Regulations.

3.2.1 NHS Estate code (HBN 00-08) – Strategic Framework for the Efficient Management of Healthcare Estates and Facilities.

HBN 00-08 provides information primarily related to the provision of a compliant healthcare estate and the performance of the estate in terms of efficiencies. It specifically links with Regulations 12 and 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and with regard to the safety and suitability of premises used for the delivery of healthcare.

Regulation 12 - specifically deals with the protection of users against infection

Regulation 15 - specifically deals with the protection of users against risks of unsafe and unsuitable premises.

HBN 00-08 provides information, in two parts, to all Estates and facilities professionals in the NHS on ways in which efficiencies in the running of land and property can be achieved and on the active management of land and buildings used for healthcare services.

Parts A and B cover the strategic framework references and further detailed guidance in relation to the following areas:

- improvements to the efficient and effective running of the estate;

- improved efficiency, including value for money, in capital procurement and construction;

- adherence to best practice land management, ensuring optimum solutions are implemented, including the identification and disposal of surplus land.

3.2.2 Health Technical Memorandum (HTM 00)

HTMs are the main source of specific technical guidance for all healthcare estates and facilities professionals. They give comprehensive advice and guidance on the design, installation and operation of specialised building and engineering technology used in the delivery of healthcare.

HTM 00 is supported by the HTM suite of guidance. The aim of HTM 00 is to ensure that everyone concerned with the strategic and operational management, design, procurement and use of the healthcare facility understands the requirements (including regulatory) of the specialist, critical building and engineering technology involved. The core guidance (including professional support) is applicable to all building engineering services including those not covered by HTMs (for example, steam, gas and pressurised hot water services).

HTM 00 addresses the general principles, key policies and factors common to all engineering and building services within a healthcare organisation.

Key issues include:

- Compliance with policy and relevant legislation;
- Professional support and operational management policy;
- Design and installation;
- Maintenance;
- Training requirements.

3.2.3 Health Building Notes (HBN's)

HBN's are the main source of guidance to all healthcare estates and facilities professionals on the specific planning and design requirements for healthcare environments and settings.

Health Building Notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/ extension of existing facilities.

3.2.4 Sustainability Regulatory Frameworks.

- UK Climate Change Act (2008)
- National Adaptation Programme (NAP)
- The Carbon Reduction Commitment Energy Efficiency Scheme (CRC)
- Environmental Protection Act 1990
- Clean Air Act 1993
- Water Resources Act 1991

- The Civil Contingencies Act (2004) (CCA)

3.3 Facilities related Frameworks and Regulations.

3.3.1 Catering Services

The catering department provides nutritional support, food and hydration for patients, staff and members of the public. The guidance and regulatory frameworks that the catering department are governed by are listed below:

- The Food Safety Act 1990
- The General Food Hygiene Regulations 2004
- Food Hygiene (England) Regulations 2006
- D.H.S.S. Guidelines For Cook/ Chill & Cook / Freeze Meals
- NHS Codes of Practice for the manufacture, distribution & Supply of Food, ingredients and related products
- Food Information for Consumers Regulation 2014 (Allergens)
- Local council Food premises registration

3.3.2 Housekeeping Services

The Housekeeping department manages the cleanliness of the Hospital and the provision of food to patients.

The guidance and regulatory frameworks that the Housekeeping department are governed by are listed below:

- PAS 5748 (2014): Specification for the planning, measurement and review of cleanliness services in hospitals.
- The national specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes April 2007.

3.3.3 Waste & Transport Services

The Waste and Transport Department manages all domestic, clinical, confidential and recycling waste activities and all Trust owned and leased vehicles. The frameworks and guidance governing the waste and transport services are listed below:

Waste

- HTM 07-01 Safe Management of Healthcare Waste
- The Environmental Protection Act 1990 (including the Duty of Care Regulations)
- The Hazardous Waste (England and Wales) Regulations 2005
- The Waste (England and Wales) Regulations 2011

Transport

- The Transport Act 2000
- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2009
- Road Traffic Act 1991
- EU drivers hours regulations(EC)561/2006
- Radioactive Substances Act 1993

3.3.4 Portering Services

The Portering Services department manages the movement of patients, records, general and medical equipment.

The frame work and guidance governing the Portering service is shown below:

- HTM02-01 (Medical Gas Pipeline systems)
- Pressure Equipment Regulations of 1999
- Manual Handling Operations Regulation 1992 (as amended 2002)

3.3.5 Laundry Services

The Laundry department provide linen services for the Trust.

The framework and guidance governing the Laundry Service is:

- HTM 01-04 (Decontamination of Linen for health and social care)

3.1.6 Accommodation Services

The accommodation service provides short and long stay accommodation for staff and approved visitors. The regulatory framework and guidance that the Accommodation Department are governed by is listed below:

- Landlord & Tenant Act 1985
- Housing Act 2004
- Tenancy Deposit Protection Scheme.

3.4 Clinical Engineering Services related Frameworks and Regulations:

3.4.1 The framework and guidance governing the Clinical Engineering Department is shown below:

- SI 2002 (618): The Medical Devices Regulations 2002;
- MHRA Managing Medical Devices: Guidance for Health and Social Services Organisations April 2015;
- IEC62353 (Ed10) Medical Electrical Equipment: Recurrent test and test after repair of medical electrical equipment.

3.4.2 There are three principal policies relating to Medical Equipment and Devices which ensure that the Trust is compliant with regard to the requirements of the MHRA and CQC for managing Medical Devices:

- Management of Reusable Medical Devices and Equipment;
- Training of Staff with Medical Equipment;
- Management of Single Use and Single Patient Use Medical Devices.

3.5 Security related Frameworks and Regulations.

3.5.1. Each NHS Trust is required to employ a Local Security Management Specialist in accordance with Secretary of State's Directions (2004). The LSMS ensures that pro-security culture is embedded and that the Security Standards for Providers, which serve as a framework for security arrangements, are complied with. Medway NHS FT aims to implement these standards in every aspect of the healthcare services provided.

3.5.2. There are two CQC Regulations that relate to security management. They are both part of the core quality and safety standards:

Regulation 13: Safeguarding service users from abuse and improper treatment. "Abuse", in relation to a service user, means—

- sexual abuse;
- physical or psychological ill-treatment;
- theft, misuse or misappropriation of money or property; or
- neglect and acts of omission which cause harm or place at risk of harm

Regulation 15: Premises and equipment. Service users and others having access to premises are protected against the risks associated with unsafe or unsuitable premises, by means of

- suitable design and layout;
- appropriate measures in relation to the security of the premises
- adequate maintenance and, where applicable, the proper:
    - operation of the premises, and
    - use of any surrounding grounds
- Protecting personal safety, which includes restrictive protection
- Protecting personal property and/or money
- Providing appropriate access to and exit from protected or controlled areas
- Not inadvertently restricting people's movement
- Providing appropriate information about access and entry

- Using the appropriate level of security needed in relation to the services being delivered.

  In addition, if any form of surveillance is used for any purpose, the provider must make sure that this is done in the best interests of people using the service.

3.5.3 Other security management components, such as Security Management, Lock Down Plan, CCTV, Violence, Aggression and Disruptive Behaviour, are covered in Trust policies where regulation and legislation is detailed further.

4. (Duties) Roles & Responsibilities

4.1 Trust Board

4.1.1 Responsible for approving the Trust's Corporate Policy for Estates and Facilities.

4.1.2 Responsible for reviewing and approving the annual report to the Board on Estates and Facilities activity and performance.

4.1.3 Responsible for understanding the statutory frameworks governing the delivery of Estates and Facilities services and assuring itself on the adequacy of the Trust arrangements for meeting the requirements of these frameworks.

4.2 Chief Executive

4.2.1 Department of Health Guidance (HBN00-08 Part A: Strategic framework for the efficient management of healthcare estates and facilities) indicates that the Chief Executive, as an accountable officer, has a corporate responsibility to enact the principles set out in HBN00-08.

4.2.2 To support this arrangement an Executive is designated to take responsibility for Estates and Facilities on behalf of the organisation.

4.3 Director of Finance

4.3.1 Is the designated Executive for Estates and Facilities services with responsibility for ensuring that the Trust has resources, plans and policies in place to fulfil the requirements of the statutory frameworks.

4.3.2 Is the nominated Security Management Director, as registered with NHS Protect, and as such the responsible lead for security related issues within the Trust.

4.3.3 Is the nominated Fire Safety Management Director.

4.4 Director of Estates and Facilities

4.4.1 Has overarching responsibility for the effective and efficient management and delivery of all Estates, Facilities, Security and Clinical Engineering services within the Trust and for development of policies and procedures in support of these functions.

4.5 Head of Estates

4.5.1 Is responsible for the management and delivery of all Estates Operational services in line with the Regulatory and NHS frameworks and specific standard operating procedures described within Estates policies.

4.6 Deputy Director of Estates and Facilities

4.6.1 Is responsible for the management and delivery of the Trusts Capital, Estates and Facilities Compliance and Sustainability Programmes and for the development of programmes for capital schemes in line with the Trusts overarching strategies, clinical strategies and local and national healthcare regulatory frameworks and guidance.

4.7 Head of Facilities

4.7.1 Is responsible for the management and delivery of the catering, housekeeping, waste and transport, portering and laundry services in line with Trust policies and overarching procedures, and in line with governing regulations and regulatory/NHS frameworks described within this policy.

4.8 Head of Clinical Engineering

4.8.1 Is responsible for ensuring the delivery of the Medical Equipment Service in line with Regulatory and NHS Frameworks and specific and standard operating procedures described in this policy and covering Medical Devices Policies.

4.9 Head of Security & Traffic Management

4.9.1 Is responsible for the provision of Trust wide operational support regarding the security of staff, assets and premises, in line with security related Trust, national security policies and standard operating procedures.

4.10 Local Security Management Specialist (LSMS)

4.10.1 Local Security Management Specialist ensures that the Secretary of State's Directions (2004) are fulfilled and a pro-security culture is embedded within the organisation.

5. Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Every three years	Director of Estates and Facilities	Director of Finance	Where deficiencies are recognised - action plans will be put into place and reviewed regularly.
Estates and Facilities Directorate performance against Regulatory Frameworks and DH requirements.(DH Level)	Through annual review of PAMs/ERIC metrics Feedback from NHS Improvement & DH. Through ongoing review of metrics relating to Carter review recommendation 6.	Deputy Director of Estates and Facilities	Director of Estates and Facilities	Where deficiencies are recognised - action plans will be put into place and reviewed regularly.
Estates and Facilities Directorate performance against Regulatory Frameworks and DH requirements.(Trust Level)	Through ongoing Estates & Facilities compliance forums and Senior Management Teams. Through annual PAMs review and Benchmarking through ERIC.	Deputy Director of Estates and Facilities (in conjunction with Head of Estates)	Director of Estates and Facilities	Where deficiencies are recognised - action plans will be put into place and reviewed regularly
Staff training and awareness	Through annual review of training statistics and review and update of training needs matrices.	All E+F Heads of Service	Director of Estates and Facilities	Where shortfalls in training completion are identified - actions will be taken to ensure that training requirements are fulfilled and monitored on a monthly basis until all training is up to date
Staff training and awareness	Through review of individual staff personal development plans at Achievement reviews.	All E+F Managers and Heads of Service	Director of Estates and Facilities	Where shortfalls in training completion are identified - actions will be taken to ensure that training requirements are fulfilled and monitored on a monthly basis until all training is up to date
Implementation and Monitoring/Review	Through sign off processes/collation of evidence on usage of policies (i.e. derogation schedules/design	Deputy Director of Estates and Facilities	Director of Estates and Facilities	Where deficiencies are recognised - action plans will be put into place and reviewed regularly

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
	team minutes and specification content). Reviewed annually as part of Estates and Facilities compliance audit			

6. Training and Implementation

6.1 This policy and all subsequent subordinate estates and facilities policies will be implemented through directorate and service level forums such as Senior Management Team meetings, Project Team meetings and Design Team meetings, and also through group and individual training and awareness sessions.

6.2 All Estates and Facilities staff will receive formal training in all areas of expertise and competency required, and to ensure that the requirements of the regulatory framework are met in full.

6.3 Training needs analysis will take place through individual performance reviews and development plans, and through departmental analysis of the requirements for staff ratios and skill mix to ensure that suitably trained and competent staff are always available.

6.4 The Estates and Facilities directorate will undertake regular reviews of training requirements and will take steps to ensure that suitably trained staff will be in place where legislative requirements deem, where legislation changes over time and where new legislation is introduced.

6.5 In terms of the requirement to monitor and review effectiveness, the Estates and Facilities Directorate will undertake an annual audit of estates and facilities, security and clinical engineering services compliance in order to identify gaps in compliance, to generate action plans and to provide assurance to the Trust that the requirements of the previously stated regulatory frameworks are met.

7. Equality Impact Assessment Statement & Tool

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

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

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

8. References

Document	Ref No
References:	
Care Quality Commission (Registration) Regulations 2009 (CQC Regulations)	
The NHS Constitution	
Operational Productivity and Performance in English NHS Acute Hospitals: Unwarranted Variations. (an independent report for the Department of Health by Lord Carter of Coles) (February 2016)	
The Health and Safety at Work etc. Act 1974	
Secondary Health and Safety related regulations (various)	
The Regulatory Reform (Fire Safety) Order 2005	
NHS Premises Assurance Model (PAM) (2016)	
NHS Estatecode (HBN 00-08) – Strategic Framework for the Efficient Management of Healthcare Estates and Facilities. (2014)	
UK Climate Change Act (2008)	
National Adaptation Programme (NAP)	
The Carbon Reduction Commitment Energy Efficiency Scheme (CRC)	
The Civil Contingencies Act (2004) (CCA)	
The Food Safety Act 1990	
Food Information for Consumers Regulation 2014 (Allergens)	
Local council Food premises registration	
D.H.S.S. Guidelines For Cook/ Chill & Cook / Freeze Meals	
NHS Codes of Practice for the manufacture, distribution & Supply of Food, ingredients and related products	
The General Food Hygiene Regulations 2004	
Food Hygiene (England) Regulations 2006	
PAS 5748 (2014): Specification for the planning, measurement and review of cleanliness services in hospitals.	
The national specifications for cleanliness in the NHS: a framework for setting and measuring performance outcomes April 2007.	
HTM 07-01 Management & disposal of healthcare waste	
The Environmental Protection Act 1990 (including the Duty of Care Regulations)	
The Hazardous Waste Directive 2011	
The Waste (England and Wales) Regulations 2011	

Road Traffic Act 1991	
EU drivers hours regulations(EC)561/2006	
HTM02-01 (Medical Gas Pipeline systems)	
Pressure Equipment Regulations of 1999	
HTM 01-04 (Decontamination of Linen for health and social care)	
SI 2002 (618): The Medical Devices Regulations 2002	
MHRA Managing Medical Devices: Guidance for Health and Social Services Organisations April 2015	
IEC62353 (Ed10) Medical Electrical Equipment: Recurrent test and test after repair of medical electrical equipment	
Trust Associated Documents:	
POLCS001	Arson - Prevention and Control
POLCOM003	Security Management Policy
POLCS002	Bomb Threats Policy & Procedures
POLCS015	CCTV (Close Circuit Television) Policy
POLCS011	Smoke-Free Policy
POLCOM022	Car Parking Policy
POLCGR036	Water Safety Policy
POLCOM019	Food Hygiene Policy
POLCOM020	Planned and Preventative Maintenance
POLCOM023	Health and Safety Permit to Work Policy
POLCS016	Testing of Portable Electrical Equipment For Safety
POLCS003	Environment Policy
POLCOM001	Medical Gas Pipeline Systems and Associated Equipment Operational Policy
POLCS009	Safe Operation of Land & Buildings
POLCGR116	Access Control Policy
POLCOM004	Use, return, cleaning and maintenance of Hospital Wheelchairs
POLCOM021	Pest Control Policy
POLCS024	Fire Safety Policy
POLCGR105	Management of Single Use and Single Patient Use Medical Devices
POLCGR020	Management of Reusable Medical Devices & Equipment
POLCGR030	Medical Device Training Policy
POLCGR089	Specialist Cleaning Team
POLCOM024	Civil Penalty Notice Scheme Policy
POLCS010	Violence and Aggression Policy
POLCOM028	Lockdown Policy
POLCS024	Fire Safety Policy
POLCS018	Window Management Policy
POLCS022	Asbestos Policy

END OF DOCUMENT

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Quality Assurance Committee held on 22/12/2017

Report to:	**Trust Board**	**Date of meeting: 18 January 2018**		**1**
Presented by:	**Jon Billings** **Chair, Quality Assurance Committee**	**Prepared by:**	**Jon Billings** **Non-Executive Director**	

Matters for escalation or highlighting	• Findings of a stroke mortality review triggered internally in response to increasing HSMR for stroke were presented. Detailed casenote reviews found no indication of systemic care quality concerns, but need for more precise coding and cause of death recording. QAC noted and commended that the audit was undertaken by the Trust without being prompted by external bodies, as an example of the growing quality and safety culture in the Trust. • Report received on performance against Medicines Management Checklist. Audit carried out quarterly to ensure compliance with issues highlighted during previous CQC inspection. An action plan is in place to improve performance and most actions are on track. However, the audit has highlighted inconsistent performance. QAC emphasised the priority of this area for quality, safety and efficiency, and the need for clear responsibility and accountability at team and individual levels. DoN and chief pharmacist are monitoring closely.
Other matters considered by the committee:	• IQPR • Issues for escalation from trust-wide governance groups • Corporate quality risks scoring >12 (primarily workforce related) • CQC update • Safeguarding update • Feedback from quality strategy workshop 24 November • Forward look
Key decisions made/ actions identified:	• QAC will invite Director of HR&OD to future meeting to discuss workforce challenges, opportunities, and mitigations in relation to quality and safety.
Risks:	• The key quality and safety risks on the risk register mainly relate

	to workforce – note decision above to have a focused session on this at QAC.
Assurance:	QAC has agreed to sequence its formal meetings on the alternate month to the Board to ensure there is a formal governance forum each month at which quality issues can be raised and discussed if necessary. A discussion with the full Board about the quality strategy refresh will be arranged at a future Board development session.

Key Issues Report

NHS Medway NHS Foundation Trust

Attendance Log: shade out dates when member was not in post/not a member. Put x for any meetings missed regardless of reason and use ✓ to mark attendance. Only members (as laid out in the terms of reference) need to be included – not attendees.

Name and Job Title of Member	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Insert name and job title												
Ewan Carmichael, NED & Chair				✓								
Vivien Bouttell, Governor Representative				x								
Lesley Dwyer, Chief Executive				✓								
Diana Hamilton-Fairley, Medical Director				x								
Martin Nagler, Patient Representative				✓								
Karen Rule, Director of Nursing				✓								
Jan Stephens, NED				✓								
Jon Billings, NED				✓								

Best of care Best of people

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Integrated Audit Committee held on 27/11/2017

Report to:	**Board of Directors**	**Date of meeting:**	**27/11/2017**
Presented by:	**Mark Spragg. Chair Integrated Audit Committee**	**Prepared by:**	**Tracey Cotterill. Director of Finance & Bus Svcs**

1

Matters for escalation	1. The committee noted the timetable for the submission of the annual report and accounts and recommends that the Board delegate authority to the committee to approve the annual report and accounts on its behalf.
Other matters considered by the group:	1. Audit reports were received on Business Continuity (Amber/Green rating) and Financial Management (Green). The committee commended the finance team for the significant progress in this area from the previous year. 2. Progress against the Internal Audit plan was reviewed and the DoF requested days be allocated to some additional areas which were of potential concern to her. 3. Progress against the Local Counter Fraud Services Plan was reviewed. It was noted that there has been continued staff engagement and communication.. 4. External Auditors presented the audit plan for 2017-18, identifying the key areas of risk which would inform the audit. There was discussion regarding the level of materiality which is to remain at 2%. There was further discussion regarding the going concern statement that would once again be a matter of emphasis in the audit report. 5. The committee considered an update report on cyber security. 6. Losses & Special Payments for the period 1st August to 31st October 2017 were presented. 7. The single tender waivers report was presented for information, and is extended in compliance with the SFIs to report on direct awards from the framework. 8. The Director of Nursing presented an update on Serious Incident reporting. 9. The quarterly declaration of gifts and hospitality was presented and discussion ensued regarding the completeness of the return.

Key decisions made/ actions identified:	1. Agreed an addition to the IA plan to review processes and controls for Healthcare at Home expenditure, and to slip the IA on safeguarding adults by 1 month into the first quarter of 2018/19. 2. Approved the proposed approach for the valuation of land and buildings at the year end.
Risks:	The risks associated with all items on the agenda were considered, and in particular the risks relating to financial reporting and cyber security.
Assurance:	Assurance was provided on; 1. Business Continuity plans audit gives significant assurance with minor improvement opportunities. 2. Core Financial Systems audit gives significant assurance. 3. Update received on cyber security, and early indication that the IA for this area will give significant assurance with minor improvement opportunities once agreed with executive lead. 4. Expenditure on waivers and framework awards is being appropriately managed and controlled to minimise risk of fraud. 5. Serious Incident reporting.