# Agenda

## Trust Board Meeting in Public

**Date:** On Thursday 10 January 2019 at 12.30pm – 3.00pm  
**Location:** Trust Boardroom, Postgraduate Centre, Medway NHS Foundation Trust

<table>
<thead>
<tr>
<th>Item</th>
<th>Subject</th>
<th>Presenter</th>
<th>Page</th>
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<td>1.</td>
<td>Patient Story</td>
<td>Director of Nursing</td>
<td>Verbal</td>
<td>1230</td>
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<td>2.</td>
<td>Preliminary Matters</td>
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<td>2.1</td>
<td>Chair’s Welcome and Apologies</td>
<td>Chairman</td>
<td>Verbal</td>
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<td>2.2</td>
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<td>2.3</td>
<td>Register of Interests</td>
<td>Chairman</td>
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<td>3.</td>
<td>Minutes of the previous meeting and matters arising</td>
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<td>3.1</td>
<td>Minutes of the previous meeting held on 1 November 2018</td>
<td>Chairman</td>
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<td>1255</td>
<td>Approve</td>
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<td>3.2</td>
<td>Matters arising and actions from last meeting</td>
<td>Chairman</td>
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<td>1255</td>
<td>Discuss</td>
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<td>4.</td>
<td>Standing Reports and Updates</td>
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<td>4.1</td>
<td>Chair’s Report</td>
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<td>4.2</td>
<td>Chief Executive’s Report</td>
<td>Chief Executive</td>
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| 4.3  | Strategy  
   a) Sustainability and Transformation Plan Update  
   b) Transformation Programme Update | Director of Strategy  
   Associate Director of Transformation/Chief Operating Officers | Verbal | 1300 | Discuss |
| 5.   | Quality | | | | |
| 5.1  | Integrated Quality and Performance Report | Director of Nursing/Medical Director/Chief Operating Officers | | 1330 | Discuss |
| 6.   | Performance | | | | |
| 6.1  | Finance Report - Month 8 | Director of Finance (Interim) | | 1355 | Discuss |
| 6.2  | Board Assurance Framework | Company Secretary | | 1355 | Approval |
| 6.3  | Communications Report | Director of Communications | | 1425 | Discuss |
| 7.   | People | | | | |
| 7.1  | Workforce Report | Director of HR/OD | | 1425 | Assurance |
## Agenda

### 8. Reports from Board Committees

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<td>Integrated Audit Committee Report</td>
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<td>Assurance</td>
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### 9. For Noting

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<th>Governor Representative</th>
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<tr>
<td>9.1</td>
<td>Council of Governors Update</td>
<td>Governor Representative</td>
<td>Verbal</td>
<td>Discuss</td>
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<td>9.2</td>
<td>Any other business</td>
<td>Chairman</td>
<td>Verbal</td>
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<td>9.3</td>
<td>Questions from members of the public</td>
<td>Chairman</td>
<td>Verbal</td>
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### 10. Date and time of next meeting: 7 March 2019, 12.30pm-3.30pm, Trust Boardroom
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<thead>
<tr>
<th>Name</th>
<th>Position</th>
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<tbody>
<tr>
<td>Stephen Clark</td>
<td>Chairman</td>
<td>Marshalls Charity</td>
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<td>3H Fund Charity</td>
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<td>Nutmeg Savings and Investments</td>
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<td>Henley Business School</td>
<td>Member Strategy Board</td>
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<td>Access Bank UK Limited</td>
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<td>Brook Street Equity Partner LLP</td>
<td>Chairman Advisory Council</td>
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<td>Member of the Corporate Trustee</td>
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<td>Jon Billings</td>
<td>Non-Executive Director</td>
<td>Fenestra Consulting Limited</td>
<td>Director</td>
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<td>Healthskills Limited</td>
<td>Associate</td>
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<td>FMLM Solutions</td>
<td>Associate</td>
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<td>Chair Quality Assurance Committee</td>
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<tr>
<td>Ewan Carmichael</td>
<td>Non-Executive Director</td>
<td>Timepathfinders Ltd</td>
<td>Chair of Charitable Funds Committee</td>
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<td>Anthony Moore</td>
<td>Non-Executive Director</td>
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<td>Chair of Finance Committee</td>
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<td>Mark Spragg</td>
<td>Non-Executive Director</td>
<td>Marcela Trust</td>
<td>Trustee</td>
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<td>Sisi &amp; Savita Charitable Trust</td>
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<td>Mark Spragg Limited</td>
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<td>Adrian Ward</td>
<td>Non-Executive Director</td>
<td>Bella Moss Foundation</td>
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<td>Veterinary Sciences Limited</td>
<td>Director of Award</td>
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<td>National Midwifery Council</td>
<td>Chair Fitness to Practice Panel</td>
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<td>RCVS Preliminary Investigation Committee</td>
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<td>BSAVA Scientific Committee</td>
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<tr>
<td>Joanne Palmer</td>
<td>Non-Executive Director</td>
<td>Lloyds Gresham Nominee1 Limited</td>
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<td>Lloyds Gresham Nominee2 Limited</td>
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<tr>
<td>James Devine</td>
<td>Chief Executive Officer</td>
<td>London Board for the Healthcare People Management Association</td>
<td>Member</td>
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<tr>
<td>Ian O'Connor</td>
<td>Director of Finance (Interim)</td>
<td>OCOBROWN Health Ltd.</td>
<td>Director</td>
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<td>Essex Partnership Trust</td>
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<tr>
<td>Karen Rule</td>
<td>Director of Nursing</td>
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<tr>
<td>David Sulch</td>
<td>Medical Director</td>
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<tr>
<td>Morfydd Williams</td>
<td>Director of IT Transformation</td>
<td>ZebraDot Logistics (Freight and Transport)</td>
<td>Director</td>
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Meeting in Public

Board of Directors Meeting in Public on 01/11/2018 held at Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members:

<table>
<thead>
<tr>
<th>Name</th>
<th>Job Title</th>
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<tbody>
<tr>
<td>Mr S Clark</td>
<td>Chairman</td>
<td>SC</td>
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<tr>
<td>Ms L Dwyer</td>
<td>Chief Executive</td>
<td>LD</td>
</tr>
<tr>
<td>Mr J Billings</td>
<td>Non-Executive Director</td>
<td>JB</td>
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<tr>
<td>Mr R Boyce</td>
<td>Director of Finance and Business Services</td>
<td>RB</td>
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<tr>
<td>Mr E Carmichael</td>
<td>Non-Executive Director</td>
<td>EC</td>
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<tr>
<td>Mr J Devine</td>
<td>Deputy Chief Executive and Executive Director of HR &amp; OD</td>
<td>JD</td>
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<tr>
<td>Dr D Hamilton-Fairley</td>
<td>Director of Strategy</td>
<td>DHF</td>
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<tr>
<td>Mr T Moore</td>
<td>Non-Executive Director</td>
<td>TM</td>
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<tr>
<td>Mrs J Palmer</td>
<td>Non-Executive Director (from item 10)</td>
<td>JP</td>
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<tr>
<td>Mrs K Rule</td>
<td>Director of Nursing</td>
<td>KR</td>
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<tr>
<td>Mr M Spragg</td>
<td>Non-Executive Director</td>
<td>MS</td>
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<tr>
<td>Dr D Sulch</td>
<td>Acting Medical Director</td>
<td>DS</td>
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<td>Mr A Ward</td>
<td>Non-Executive Director</td>
<td>AW</td>
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Attendees:

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<tr>
<th>Name</th>
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<tr>
<td>Ms G Alexander</td>
<td>Director of Communications</td>
<td>GA</td>
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<tr>
<td>Mrs S Anderson</td>
<td>Interim Trust Secretary (Minute Taker)</td>
<td>SA</td>
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<tr>
<td>Mr N Gerrard</td>
<td>Transition Lead</td>
<td>NG</td>
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<tr>
<td>Mrs S Gorman</td>
<td>Clinical Co-Director (Item 1 only)</td>
<td>SG</td>
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<tr>
<td>Mr A Harding</td>
<td>Lead Governor</td>
<td>AH</td>
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<tr>
<td>Mr L Hinton</td>
<td>Director of Operational HR &amp; OD</td>
<td>LH</td>
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<tr>
<td>Mrs J Johnson</td>
<td>Patient Story (Item 1 only)</td>
<td>JJ</td>
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<tr>
<td>Ms D King</td>
<td>Governor Board Representative</td>
<td>DK</td>
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<tr>
<td>Mr J Lowell</td>
<td>Director of Planning and Partnerships</td>
<td>JL</td>
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<tr>
<td>Mr G Lupton</td>
<td>Director of Estates &amp; Facilities</td>
<td>GL</td>
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<tr>
<td>Ms G Mahil</td>
<td>Director of Clinical Operations</td>
<td>GM</td>
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<tr>
<td>Mr H McEnroe</td>
<td>Director of Clinical Operations</td>
<td>HM</td>
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<tr>
<td>Mrs F Taylor</td>
<td>Patient Story (Item 1 only)</td>
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Observers: Seven members of the Governors, public or press
1. **Patient Story**

1.1 SC and KR welcomed FT and JJ along with SG to the meeting. SC noted that the family has had an apology and do not want anyone else to have their experience. He thanked FT and JJ for being brave enough to come in and talk to the Board. SC stated that anything that goes wrong with care is the responsibility of management who need to ensure that every person is well-cared for and helped as every day is special. SC apologized on behalf of the Trust and noted that the Trust should be working for the people of Medway and Swale.

1.2 FT and JJ gave a detailed presentation on their mother’s experience at the Trust, specifically highlighting that the family, who were the carers, had not been consulted with regard to her discharge.

1.3 JB asked what the Trust has done to consider the views of the family/carers when discussing discharge with patients. LD thanked the family for coming in and noted the pre-learning and changes that have been put in place following their experience and that these will be followed in the coming busy times. No one should have that experience and this should not happen to anyone else.

1.4 DS observed that not all doctors consult with or listen to the family, who are better placed to recognize subtle signs of change in a patient. Medicine has become very scientific and younger doctors should be encouraged to think and observe patients holistically. Regular patients should be admitted to specialist wards and not through A&E.

1.5 KR noted that it is key that the Trust learns from issues and identifies what it can do better. She reported an exercise that had occurred the previous day where the Trust was able to identify improvements and transformation work.

1.6 The Board passed on their thanks to FT and JJ for their detailed presentation.

2. **Welcome and Apologies for Absence**

2.1 The Chairman welcomed everyone to the meeting.

2.2 There were no apologies for absence to be noted.

3. **Quorum**

3.1 The meeting was declared quorate.

4. **Register of Interests**

4.1 The Register of Interests was noted.

5. **Minutes of the Previous Meeting**

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

5.2 KR gave an update on dementia as per minute 1.7. Noted that there is a screening process in place to identify patients with dementia and provide specialized support required. Butterfly Representatives are on the wards and work with staff and patients to identify patients with dementia who need additional support. Also work with dementia buddies to identify which area needs most support. The Trust has implemented dementia training for all doctors when they rotate in ED. The Trust is regularly auditing the passport which should stay with patients and work with families when discussing care.
The Trust supports carers of dementia patients and is working in the community with these people.

6. **Matters Arising and Action Log**

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

7. **Chair’s Report**

7.1 SC highlighted that the Board meetings like to start with a patient story and his concern when things do go wrong that the Trust needs to learn from this. However, he was concerned at the number of negative care stories coming to Board. KR noted that the learning is important and implemented from all bad experiences.

7.2 SC reported on the Annual Members Meeting (AMM) and the change in Lead Governor and gave his thanks to Stella Dick for her contribution as the Lead Governor.

7.3 SC referred to the Transformation Plans to improve the Hospital and reminded Board members and the public to have their flu jabs. He noted that the winter resilience plan has been developed and the Trust is as best prepared as it can be.

7.4 Many of the improvements at the Trust have come about under LD’s leadership. SC thanked and wished her well. She is leaving the Trust in good hands and has built a strong executive team which should survive the test of time and continue as her legacy. LD was presented with some flowers.

8. **Chief Executive’s Report**

8.1 LD noted the continuing to work to deliver transformation plans at pace. The Sapphire Acute Frailty Unit has been launched and the Trust is now able to place patients in the right place, which brings benefits for their health.

8.2 Noted the Lord Carter of Coles visit and his feedback. Reported on the ‘You are the Difference’ work, which is to be rolled out beyond the senior managers and Board. The Trust will get stronger and staff are adamant that the organisation will not slip backwards.

8.3 LD highlighted the Excellence in Teaching Awards from Kings College and the Diabetes Healthcare Professionals of the Year at the Quality in Care Diabetes Awards, which have been won by members of the Trust staff. She referred to the keenness of the organisation to learn. LD noted the change in job title to Chief Operating Officer for the two Directors of Clinical Operations and the new appointments.

8.4 LD noted that the Hospital is reducing smoking in pregnancy. She highlighted the Medilead programme with doctors visiting non-clinical areas and learning other roles.

8.5 LD noted that the North Kent Pathology Service (NKPS) has experienced some issues and concerns. She noted the change in practice and review that has been commissioned to ensure that health and safety of patients can remain the Trust’s primary concern.

8.6 Saving the best to last, LD noted that the role of Chief Executive at Medway is a great job and that she would like to place this on record to the unitary board,
which has had to show commitment and determination. She is proud of where the Trust has come to and what it can be. No-one sits back and all learn and move forward.

8.7 As part of her transition LD handed over the position of Chief Executive at the Board meeting to JD.

8.8 The Board and public applauded LD and JD.

9. **Strategy**

9a) **Sustainability and Transformation Partnership (STP) Update**

9.1 LD updated the Board on the hyper acute stroke unit review and noted the disappointment that the Trust was not selected but that it is supportive of the proposal which will ensure the best care for patients. The Trust is working with MPs and other stakeholders to ensure joined up services for the people covered by the STP.

9.2 The Trust has been asked to nominate a NED to work with the STP and will keep Board informed. JB welcomes the move to involve NEDs across the system as this has been a gap in governance for the STP.

9b) **Transformation Programme**

9.3 JD noted that the report summarises two or three points that the transformation team is working on. Often the focus is on cost improvement but should also be improving the efficiency of how and where care is delivered. JD noted the links to the Strategy Unit led by DHF.

9.4 The Trust is ahead of plan but has much more to do on cost improvement and efficiency. He noted that flow and length of stay are key but that it is sometimes appropriate for patients to be here longer than average and that the Trust must do what best for patients.

9.5 JD noted that the variance between good and bad days in performance is lower and that the recovery is faster. The Trust is preparing for a better winter and has learnt lessons from last year as well as working with the A&E Delivery Board across the system. He is meeting with senior managers to refresh and remind them of processes.

9.6 The culture programme has had good numbers and created a positive vibe across the Trust. The metric slides in the report contain more detail to provide the Board with assurance and enable the Board to focus on projects.

9.7 SC noted that the transformation programme is the most critical project that the Trust has undertaken in the last few years. It will refocus the Trust for the population, but this needs to be done in the context of the system too. The Trust is working with clinicians, not management consultants, as all believe in making Medway a better place for the community.
10. Quality

10a) IQPR

10.1 KR reflected that culture programme is absolutely critical to the success of the Trust and reiterated the commitment of the executives.

10.2 KR highlighted that mortality is being addressed separately along with workforce.

10.3 JP entered the meeting

10.4 KR noted that take up of the flu jab is going well and that the Trust has more to do to get to the 100% uptake target.

10.5 Safe staffing is still an area for concern but is performing better than last year and compares to the Model Hospital model as well as coming down to national benchmark levels. The temporary staffing metric is reporting significantly below the last two years and reflects the reviews undertaken and adjustments made. New assessment tools are enabling a more robust and focussed consideration.

10.6 From the directorate viewpoint, GM highlighted some performance data and HM noted that the transformation is the most robust plan he has seen with clear objectives.

10.7 JB raised a concern around the language and wondered how the Trust manages performance and links to quality and patient experience. He asked about staffing and who runs the daily huddles and how the outcome is recorded. KR explained the process, which occurs in directorates at handover each morning where they consider the staff and their need to flex, a site meeting and both directorates review the Trust-wide position and use a web based tool to inform decision making, review at end of day and have good handover for the site team.

10.8 SC noted the overwhelming amount of data and the need for the Board to trust the analysis when looking at front line assurance.

10b) Corporate Policy – Complaints Management

10.9 KR highlighted that this is one of the policies that comes to Board for review and approval. The Trust recently had an internal audit of complaints and has strengthened the policy and been more specific of the agencies it works with. The revision also included adding guidance on electronic communications and how the Trust manages complaints that are also recorded as serious incidents.

10.10 SC asked who owns the policy, and KR noted in was herself. There is a small central team that receipts and manages the complaints which are forwarded to the directorates – if both directorates are involved they will agree who will lead. The Chief Operating Officers have delegated authority to investigate and resolve complaints.

10.11 TM asked whether this policy makes it easy for a carer of a patient with a problem to find out information. KR noted that the policy aim is to resolve all concerns locally and where they are raised, so believes so.

10.12 RB asked whether the Trust knows that there is a serious incident before the complaint is raised. KR noted that the Head of Legal Services looks at all incidents and ensures the appropriate classification.
10.13 The Board APPROVED the Complaints Management Policy.

10c) Q1 Mortality and Morbidity Report

10.14 DS highlighted the action to consider changing the coding process which is making the Trust look like an outlier. He explained the annual audits on mortality and review of Dr Foster system. He noted that there will be an independent internal audit of the process by KPMG.

10.15 DS set out the Medical Examiner model of review for mortality which is to discuss issues with coroners at a meeting. The medical examiner should be independent of the organisation. This structure can be implemented relatively quickly and could be embedded by April 19.

10.16 IC queried why the learning from deaths dashboard and SELs on the table did not match up. DS suspected that this was due to a miscalculation.

10.17 JB queried the engagement with outside organisations on external reviews. DS said it appears to be a coding related issue and will review.

10.18 JD said that CQC noted our view on the imbalance on coding across areas. This is evidence that the Trust is getting to the detail. EC noted that patients who pass through the hospital to a hospice are counted against the hospital statistics due to the date of discharge. NHSI are working with the Trust on the coding of palliative care.

10.19 TM noted that one could consider the HSMR data and think that the Trust is an organisation in denial and justifying all OK. He requested that the index is reported along with the way that the coding works and relevance to patients. His second observation is that pneumonia is getting worse and asked if the relative risk of people dying at Medway is higher than other hospitals. DS responded that it seems to be and is considering the reasons and ensuring that the data is consistent. DS noted the general anxiety of the Board and is accelerating all he can do to give confidence.

10.20 Board requested an update at the next Board.

ACTION: Update on Mortality and Morbidity at the January Board meeting.

11. Performance

11a) Finance Report

11.1 RB noted that the Month 6 position is ahead of plan and the second half of the year is a big step with targets more difficult to achieve.

11.2 Noted that have plans in place and lot of cash as the Trust takes a long time to pay creditors. The deficit needs funding and the Trust needs to make sure that it is spending on the right things and deliver the control total. The Turnaround Team are not just looking at this year.

11.3 SC noted that there is no complacency on the scale of what needs to be done. The position has been scrutinised by Finance Committee.

11.4 JD noted the importance of managers managing their budgets and that turnaround and achieving financial targets is not the job of Finance. The Trust can support people who need development to manage budgets and enable them to be efficient through clinical strategy and transformation work.
11.5 SC noted the will to change is key to the success of the transformation team.

11b) Board Assurance Framework
11.6 SA presented the BAF and said that it needs a thorough review by the Board at the next Board Development Day. LD highlighted that the Execs do consider this on a regular basis.

11c) Corporate Policy – Information Governance
11.7 LH presented the policy and highlighted the changes and that it includes access to Data Security and Protection and assurance from NHS Digital.
11.8 SC noted that this is an update to an existing policy that has been place in for some time.
11.9 The Board APPROVED the Information Governance Policy.

11d) Communications Report
11.10 GA highlighted the current communications with staff and patients in the Frailty Unit as we approach winter. There have been some communications on flow and these have been discussed in detail with staff on the Exec walkabout – this will be shared with patients and the public.
11.11 There are a lot of posters and stories to highlight the importance of getting a flu jab.
11.12 GA noted the success of the ‘You are the Difference’ programme and that the Trust will make the pledges and commitments public to maintain positive commitment.
11.13 The Teddy Bear Hospital has been launched and is helping to reduce the fear of hospital for children
11.14 The Diabetes Team has been named Diabetes Healthcare Professionals of the Year at the Quality in Care Diabetes Awards.
11.15 The Trust responds to media on specific negative stories and the key ones at the moment are pathology and the dermatology service.
11.16 Governor engagement is ongoing with meetings for constituents in a few locations and a member event focused on quality improvements in nursing and midwifery.
11.17 The Trust is continuing with the programme to meet with harder to reach people in our area.

12. People

12a) Workforce Report
12.1 LH asked the members and attendees to take the report as read.
12.2 LH highlighted international and national recruitment for nursing, and new consultant starters and doctors on rotation from the Deanery.
12.3 Flu vaccinations are ahead of where need to be to achieve 100% target. NHSI best management self-assessment checklist has been reviewed and the Trust is confident it is performing well.
12.4 EAP issued last month and is an opportunity for employees to be supported.
12.5 JB asked about the NHSI checklist and LH confirmed this is only in relation to the flu campaign.

12.6 NHSI has been running a collaborative for the retention of nursing. The Trust has been accepted on this and will be able to better understand whether recruitment is replacing staff or achieving a higher staff base.

12b) Corporate Policy – HR and Organisational Development

12.7 LH highlighted that the policy has been updated for issues such as Modern Slavery.

12.8 The Board APPROVED the HR and Organisational Development Policy.

13. Quality Assurance Committee Report

13.1 JB referred to the fact that many items covered by the Committee have already been covered in the agenda of this meeting.

13.2 There were no questions.

14. Finance Committee Report

14.1 TM highlighted the challenge to generate real cash savings to the bottom line, which is a big ask. The cost recovery plan has been reviewed by the finance and transformation teams. There is a renewed ownership attitude with all feeling it is the right thing to do. The Board asked for more detail about cost improvement and TM noted that some is from an ongoing basis, not one offs. The Trust needs recurrent savings, not just in-year savings. The Trust needs to review and reaffirm its commitment to the financial plan by December. This may require virtual consultation with Board. The plan will reflect all activity and costs forward to next year.

14.2 SC highlighted the confidence level coming from the ground and difference between in-year and ongoing cost savings and the need to split out what can control and deliver compared with issues outwith the Trust’s control. Cultural side is important for transformation. It is good that finances are over performing on the first six months of savings. Need to keep regulators informed and they seem to be more supportive than in other years. TM not spending too much time on revenue line as paid on basis of block contract therefore energy can focus on what the Trust is spending.

14.3 JL noted that the Trust has already started 2019/20 business planning and met with clinical directors to determine what objectives might look like. SC asked whether making progress in integrated care and DHF said that successful workshops had occurred and partners are engaged. DHF and JL working with contracts and seeking to maximise revenue and this work is feeding into contract talks. LD noted good position from the base that we have built and moving forward.

14.4 JB asked about skills to model predictions. JD said this is an area that is improving. The CCG often raise issues as the Trust is in a shadow contract because of the block contract. There is currently better understanding and the Trust is not just reporting data as there are links between the front line and contracting team. The modelling is considering how to understand data and how this is derived/validated.
14.5 JL commended the data assurance framework and data available to service this along with the better working to understand issues. Moved to one data warehouse. SC stated that the big thing has been to engage clinical directors to get things right.

15. Council of Governors’ Update
15.1 DK thanked LD for the time that she has been here and taken the Trust into a position of trust from the public perspective. LD was wished well.
15.2 SC was reminded of the need to resume four weekly meetings with governors to keep them up to date.

16. Any Other Business
16.1 There was no other business.

17. Questions from members of the public
17.1 Question about what the Trust is doing about Brexit and the surrounding risk. LH responded on the Trust’s Brexit planning, which includes workforce, reciprocal healthcare, medicines, research and innovation. The Trust is looking upwards for support from NHS Providers and also working with partners where it can.
17.2 There were no further questions from the public.
17.3 SC mentioned the Christmas Market and Lights on 7 December and that on 20 November the new ED will be opened.
17.4 SC provided his thanks to all those in attendance and closed the meeting.

The next Public Board will be held on Thursday 10th January 2019 at 12.30pm. Venue: Boardroom, Post Graduate Centre, Medway NHS Foundation Trust.

The meeting closed at 3.11pm.

Stephen Clark: Date: 
Chair
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<td>Update on Mortality and Morbidity to be brought to the public Board meeting in January</td>
<td>10/01/2019</td>
<td>Update to be provided</td>
<td>Medical Director</td>
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Chief Executive's Report – January 2019

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

I am very proud to have taken over from Lesley Dwyer as Chief Executive in November 2018 and I look forward to working with our community, staff and stakeholders to continue to build on our recent achievements.

2018 was on the whole, a positive year for the hospital, and we saw teams and individuals recognised locally and nationally for achievements. Our operational performance is improving and we have stronger grip and control on our finances; that said, we recognise that we are still too inefficient in some areas and this again must be a focus over the next 12 months.

I have been clear with our staff across the hospital in saying that quality of care must remain our number one priority, and despite our operational and financial challenges, we will not compromise quality. There is more to do as we look to take the next step in our ‘Better, Best, Brilliant’ improvement journey but whilst there are many challenges ahead of us, there are many opportunities too.

We have worked well as a health and social care system this year to have good protocols and escalation processes in place, and as I write this note, I know that many of our staff are working incredibly hard over the Christmas and New Year period as we see an increased number of patients, and an increased acuity across the hospital.

As we start 2019, we must maintain momentum and take our hospital to the next level.

I believe the future is bright for Medway and I am delighted to lead this fantastic organisation on our continued pursuit of brilliance.

Transformation

Work to deliver the improvements we need to become efficient and effective continues at pace.

The programme on safe and appropriate discharge continues, with a focus on elderly care wards initially. We have seen a reduction in our overall length of stay, but sustaining this will be the critical success factor. The safe and appropriate discharge also includes flow through the front door (emergency department), which again we are seeing some improvement in both ambulance handover times, and rapid assessment. Whilst the new emergency
department will go some way to helping flow, it is phases 2 and 3 of the build that will really support us providing high quality care, in a high quality environment, and subsequently a sustained improvement in the 4 hour access standard.

Our cost improvement programme is progressing well this year. Over 130 schemes are being worked through as we strive to achieve the directed target of £21m for 2018/19. We have also commenced plans for 2019/20.

It is encouraging to see transformation in action around the Trust, with improvement projects underway to create a better experience for our patients and make us more efficient. Huddles are now taking place in a number of teams several times a week to involve staff in identifying where improvements are needed to enhance the quality of care while making our services more sustainable. We are also better utilising those staff who have undertaken white belt and yellow belt training in some of the key transformation programmes.

The Trust has also launched the ‘We’re Making Medway Brilliant’ campaign; this features our staff showcasing the work they have done to make improvements in their areas.

Culture programme

The ‘You Are The Difference’ culture programme, in which the Trust is looking to address and redefine the culture at Medway, has continued with great success.

Since the launch in October 2018, senior manager sessions have taken place with more than 400 managers attending. The feedback has been extremely positive, with managers making their commitment to working to improve the culture within the Trust. In addition, more than 700 staff have attended sessions. You Are The Difference gets to the heart of staff being ‘the best of people’. In delivering the best of care to our patients, they really are the difference.

All attendees are asked to sign a pledge to ‘being the difference’, and these are being placed around the hospital.

Developing our clinical strategy

I am pleased to say that we have commenced the work on our clinical strategy – setting out a clear direction for Medway. At the same time, we are bringing together other key strategies which really look to provide a clear vision for our staff; alongside the clinical strategy, these include the (1) system financial recovery plan, (2) the quality strategy and (3) the workforce strategy.

We have also set out the enablers which underpin the delivery. These are; (1) continuous improvement, (2) transformation programme, (3) You Are The Difference culture programme, (4) integrated partnerships, (5) digital transformation, and (6) estates plan.

It is hoped that this by bringing this together, we can set out a five year vision for Medway.

Within five years we want to:

- Be designated as a specialist emergency centre with associated designated specialties and one of the specialist women’s and children’s centres for Kent and Medway.
- Become a university hospital, delivering first class education and research.
- Routinely exceed national standards and access targets.
• Work with our partners to ensure that the hospital site is used optimally to provide services that meet the needs of the local people many of whom are among the most deprived in Kent.

Crucially, we will also be financially sustainable, going beyond financial balance so that we can reinvest to provide even better patient care.

The clinical strategy was presented to senior managers and staff for the first time in December and we are now seeking feedback.

Health Secretary praises improvements at the Trust

We were delighted to welcome Secretary of State for Health and Social Care, Matt Hancock MP to the Trust in November. He toured our new Emergency Department, Maternity Unit and Pre-habilitation Unit, and met with staff.

It was a really positive acknowledgment of the hard work of our staff, and also of the way we are now working across the system in Medway and Swale – with the ambulance service, community services, social care, primary care and mental health provider, as well as local health commissioners

UNICEF awards baby-friendly status

Our maternity unit has been awarded the prestigious Baby Friendly Award, achieving international recognition from UNICEF. The Baby Friendly initiative was set up by UNICEF and the World Health Organisation to improve the care provided for all mothers and babies. By achieving this award, our maternity unit has demonstrated that we offer the highest level of care and support for mothers in forming strong and loving relationships with their babies and this is fantastic news for the mothers of Medway and Swale.

We are now an accredited Institute of Leadership and Management training centre

The Institute of Leadership and Management (ILM) is the UK’s leading provider of leadership, coaching and management qualifications and training and I am delighted that we have been successful in our application to become an approved centre to deliver ILM-accredited courses and qualifications. Being an approved centre means that we can now provide training and leadership courses that lead to nationally recognised qualifications.

Strengthening ties with Canterbury Christ Church University

We were proud to sign a document that reaffirms our working relationship with the university. We already enjoy a close relationship, and the signing of this document establishes our partnership and commitment to working together to promote general and higher education.

We share a common interest in the development of research, scholarship, learning and teaching and we are excited where this special relationship is leading us, as we look forward to the medical school, and pursue our ambition to become a university teaching hospital.

Radiology ISAS Accreditation

Our radiology service was recently re-inspected by ISAS (Imaging Services Accreditation Scheme Accreditation) and passed with flying colours. They will now automatically transition
to the revised ISAS standards that are being implemented. This is no mean feat and identifies us as providing a high quality, efficient and effective service for patients.

**Reinstatement of pharmacy training posts**

Following a visit from Health Education England last year, our pre-registration pharmacists were reallocated to another training site with the posts being withdrawn with immediate effect. This was very disappointing news for the Trust.

I’m delighted to say that after a follow-up visit, Health Education England has reinstated our training posts, with an intake of new pre-registration trainees planned for August 2019.

The visiting panel witnessed numerous examples of how the Trust and the pharmacy leadership team had made a significant improvement to the culture, the educational infrastructure and governance within the department, providing confidence and assurance that future trainees could expect a great training experience in Medway. The team also heard from all of the current junior pharmacists who were able to describe the improvement journey.

**Christmas celebrations**

The Trust really got into the Christmas spirit with a number of festive activities. The inaugural Christmas Fair was a brilliant success – bringing the community together and raising £1,500 for the Trust’s charity. We were delighted to welcome the Mayor to switch on our Christmas lights as well as carol singers from local schools.

Staff also took part in the Medway Christmas Decoration Challenge, bringing some colour and cheer to the site. Finally, we held a very special Christmas carol concert to thank our volunteers for their ongoing support.

**Beyond Medway**

**Review into overprescribing**

A national review into overprescribing has been announced, to be led by Chief Pharmaceutical Officer Dr Keith Ridge.

Estimated total NHS spending on medicines in England has grown from £13 billion in 2010 to £18.2 billion in 2017 to 2018. This is an average growth of around five per cent a year – with 1.1 billion prescription items dispensed in primary care by GPs and pharmacists. Health Survey England 2016 found that nearly half of over 75-year-olds surveyed were taking five or more medicines, with this percentage rising the older people get.

**English language tests**

The Nursing and Midwifery Council (NMC) has accepted proposed changes to the requirements for overseas nurses and midwives taking the International English Language Test System (IELTS).

There will still be a requirement of an overall 7 for international registration, however from December 2018, the NMC began to accept level 6.5 in writing, alongside a level 7 in reading, listening and speaking.
Candidates with IELTS results less than two years old that meet the new requirements will be considered by the regulator.

The NMC has said that the change is in line with its commitment to better, safer care and will ensure that only nurses and midwives with the right skills, knowledge and command of English are able to register to work in the UK.

**SECAmb chief executive**

The chief executive of South East Coast Ambulance Service NHS Trust (SECAmb) Darren Mochrie has announced that he is to leave the organisation in the spring to take up a new role in the north west. A recruitment process is underway to appoint his successor.

**Patient Safety Directors**

All NHS trusts will be expected to appoint patient safety directors working at a senior level within a new national structure, it has been announced.

The new national patient safety director, Aidan Fowler, has set out his emerging vision for patient safety policy in the NHS, which will sit alongside the NHS long-term plan, but will not be finalised until March 2019, after a consultation with the NHS. Among his proposals is for NHS Improvement to become “more directive” over the 15 English patient safety collaboratives to deliver national programmes for improvement. Each of the new NHS regions will also have a safety structure under the national patient safety team.

**CCG budget cuts**

Clinical commissioning groups are to have their administration budgets cut by 20 per cent in the coming year.

A letter sent to all CCGs from NHS England said the CCGs must make the full recurrent savings by 2020-21. The letter added each CCG will have “administration limits” placed on it for the next financial year, with new “resource allocations” for each one issued next month.
Executive Summary

Transformation is gathering pace around the Trust. Many Better, Best, Brilliant projects underway and delivering improvements. New posters and other communication materials to be rolled out to raise awareness and celebrate achievements.

This set of papers includes updates on the following 4 improvement programmes:

1. Cost Improvement Programme
   - As at Month 8 (November), £12.1m has been delivered in Cost Improvement Plans Year to Date (YTD). This is £1.5m favourable to the phased plan of £10.6m at this point in the Financial Year.
   - Of this £12.1m, £6.6m is recurrent savings (54%) and £5.5m is non-recurrent (46%).
   - Further work is ongoing to identify non-recurrent savings which can be reflected in budgets for subsequent years.
   - The confirm and challenge rhythm of Programme-level assurance meetings continues, to be supplemented by Star Chambers in Months 9-12 to assure delivery right up to the end of the financial year.
   - As at Month 8, we are forecasting total 18/19 CIP delivery ranging from £18.2m (base case) to £20.8m (upside). This represents a decrease from the Month 7 forecast, ranging from £18.5m-£21.5m, due to slippage in a small number of schemes.
   - During the last month, significant progress has been made to scope the Cost Improvement Programme for FY2019/20. This includes the development of an efficiency strategy: Best in Class.

2. Clinical Strategy & Portfolio of Services Review
   - A Trust clinical strategy has been developed and
communicated with all staff setting out our ambition to become a designated specialist emergency centre, as defined by the Keogh Review.

- Against this backdrop, the work of the Portfolio of Services Review working group continues, conducting deep dive data reviews of services in waves, identifying both services not compatible with the strategy as well as services we wish to grow and develop into tertiary services.
- This forms a rolling work programme as services are identified through the Spring and notice served collaboratively to commissioners.
- Contractual notice has been served to our commissioner on first tranche of services and demobilisation and/or re-design work is in train in collaboration with system partners.

3. **Best Flow Programme, including Frailty**

- The Best Flow Programme of work on flow enters its next phase, with a refreshed set of workstreams, leads, objectives/KPIs and under a new Oversight Group.
- As part of the Best Flow Programme, a new set of site processes have been introduced to better manage the aggregate bed balance of the hospital and improve the ways of working between the wards and the Site Operational Centre.
- This work aligns to the Full Capacity Protocol which has been approved and now provides staff with clear directions as to how to respond to the OPEL status of the site.
- A further MADE event was held on 18 and 20 December focusing on complex patients with the aim of discharging them safely home before Christmas – this was under the No Place like Home communications campaign.
- The Sapphire Acute Frailty Unit was formally opened by Dr Matt Thomas, Consultant Geriatrician from Poole Hospital, as part of the ongoing development of the frailty pathway at MFT. The frailty team have ambitious plans to create a centre of excellence for frailty at Medway within a “village” model whereby patients are cohort based on complexity and acuity.

4. **Culture Programme – You Are the Difference**

- The Trust’s YATD culture programme continues, as the staff sessions and Manager follow up sessions are completed.
- This work moves into its next phase of work which will include the following:
### Purpose & Actions required by the Board:

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- Include YATD in Trust induction and medical induction
- Develop and agree a culture strategy for the Trust
- Create a culture programme board
- Formally launch Ambassador

### Resource Implications

N/A

### Risk and Assurance

Detailed review of the Transformation Programme and the monitoring of risks/issues takes place within the Transformation Assurance Group which last met on 18 December.

### Legal Implications/Regulatory Requirements

Non-delivery of the financial control total could result in the Trust being placed in a financial special measures regime.

### Improvement Plan Implication

The Transformation programme is a critical enabler of the Trust’s improvement and system recovery.

### Quality Impact Assessment

Improvement projects are all subject to Quality and Impact Assessments.

### Recommendation

To note the contents of this report
Transformation programme update
10th January, Trust Board

James Devine
Chief Executive

Jack Tabner
Associate Director of Transformation
Transformation in progress
Transformation programme
10th January, Trust Board report

Month 8 CIP report and Model Hospital

- Clinical strategy & Portfolio of Services Review
- Best Flow Programme
- Culture programme – You Are the Difference
Cost Improvement Programme at Month 8

Year to date position

£12.1m

£1.5m favourable to plan
Up from £10.4m in M7

Month 8 Position

18/19 CIP Forecast

Year end CIP forecast, based on YTD delivery and forecast delivery of existing schemes

£20.8m

Upside forecast

£18.2m

Base Case Scenario

We are identifying more schemes in 18/19 to ensure we mitigate a) any slippage and b) cost pressures / budgetary overspend

1. DC rates
2. Outpatient productivity
3. KIMS Repatriation
4. PPIB Savings
5. Reducing Medicines waste

18/19 Ideas

Based on the current plan the Full Year Effect of recurrent 18/19 schemes that will deliver in FY 19/20 is

£6.2m

19/20 CIP plan

We have an additional 21 schemes forecasting a target of £4m in next year’s plan – further validation and quantification required
Year-to-date delivery is £1.5m favourable to plan – YTD the Trust has delivered £12.1m against a £10.6m target

2018/19 CIP Forecast vs Target Month 8

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<th>Planned Care (£’000)</th>
<th>Corporate (£’000)</th>
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<td>% Identified to Target</td>
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- YTD delivery at Month 8 of CIP is £1.5m favourable to plan – YTD the Trust has delivered £12.1m against a £10.6m target.
- The £12.1m delivered is made up of £5.5m in non-recurrent savings (46%), £6.6m in recurrent savings (54%). The £21m plan is split 71% recurrent and 29% non-recurrent.
- £2.9m of the £12.1m delivered YTD is in recording of YTD vacancies as non-recurrent savings. However, at Programme-level, many of these vacancies may be reflected in the budgets in subsequent years.
We are forecasting CIP delivery of £18.2m-£20.8m.

- **Plan**: £21m NHS I target, phased over 12 months.
- **Upside Forecast**: £20.8m. YTD actuals banked + future months forecast for all schemes including Amber and Red schemes.
- **Base case scenario**: £18.2m total, YTD actuals banked + future months forecast only for schemes that are Green in Planning.
- **Average CIP delivery (Months 1-8)** forecast through Months 9-12 – £18.1m total, based on current delivery profile.
Years 2 and 3 of the transformation programme need to address the drivers of the deficit via quality and safety improvement.

Year 1
- Demonstrating **grip and control** of delivery
- **Raising the profile** of CIP and efficiency within the Trust
- **Pay spend controls** and temporary staffing daily reporting
- **Transactional** efficiencies e.g. holding vacancies
- Establishment of Transformation Team, new governance processes and **Confirm & Challenge cadence**

Years 2
- A focus on **quality, safety and the patient experience** – from which the money falls out
- Fewer schemes, **more transformational** in nature e.g. re-design
- Genuinely **clinically-led** delivery, driven down to the lowest level possible
- Creating a culture that **incentivises and rewards efficiency**
- Transformation Team support **prioritised** by scale of opportunity
‘Best in Class’

1. Top 5 hurts
   - Quality and safety → efficiency & Happy staff → productivity
   - Quality priorities → system savings

2. Model Hospital
   - ‘Move a metric’ projects delivered by MH champions
   - Improved governance and link to GIRFT
   - Exemplar Trust

3. BIC Partners
   - Mutually beneficial partnerships with other organisations we can learn from
   - E.g. TFL, Debenhams, BA, BAE, Arsenal

4. £10k challenge
   - Behavioural nudges, awareness campaigns
   - E.g. Save TED, “Did you know…?” programme, 10 small things

5. Headspace
   - Week-long programme of development for Junior Docs and Registrars to K-O an improvement project/sprint
Model Hospital data has been updated to include 2017-18 Reference Costs

Model Hospital Productivity Cost per (WAU) for Medway Foundation Trust has decreased by 9% from £3852 to £3520.

2016-17 MFT Cost Per WAU

2017-18 MFT Cost Per WAU
Transformation programme
10th January, Trust Board report

Month 8 CIP report and Model Hospital

Clinical strategy & Portfolio of Services Review

Best Flow Programme

Culture programme – You Are the Difference
A Trust **clinical strategy** has been developed and communicated with all staff setting out our ambition to become a designated specialist emergency centre, as defined by the Keogh Review.

Against this backdrop, the work of the **Portfolio of Services Review working group** continues, conducting deep dive data reviews of services in waves, identifying both services not compatible with the strategy as well as services we wish to grow and develop into tertiary services.

This forms a rolling work programme as services are identified through the Spring and notice served collaboratively to commissioners.

**Contractual notice** has been served to our commissioner on first tranche of services and demobilisation and/or re-design work is in train in collaboration with system partners.
Briefing to Senior Managers and staff
Transformation programme
10th January, Trust Board report

Month 8 CIP report and Model Hospital

Clinical strategy & Portfolio of Services Review

Best Flow Programme

Culture programme – You Are the Difference
Best Flow programme update

• The **Best Flow Programme** of work on flow enters its next phase, with a refreshed set of workstreams, leads, objectives/KPIs and under a new Oversight Group – some impacts from the flow improvement programme are shown on the slides on the next few pages

• As part of the Best Flow Programme, a new set of **site processes** have been introduced to better manage the aggregate bed balance of the hospital and improve the ways of working between the wards and the Site Operational Centre

• This work aligns to the **full capacity protocol** which has been approved and now provides staff with clear directions as to how to respond to the OPEL status of the site

• A further **MADE event** was held on 18 and 20 December focusing on complex patients with the aim of discharging them safely home before Christmas – this was under the No Place like Home communications campaign. At time of writing, impact not yet known

• The **Sapphire Acute Frailty Unit** was formally opened by Dr Matt Thomas, Consultant Geriatrician from Poole Hospital, as part of the ongoing development of the frailty pathway at MFT. The frailty team have ambitious plans to create a centre of excellence for frailty at Medway within a “village” model whereby patients are cohorted based on complexity and acuity
<table>
<thead>
<tr>
<th>Best Flow Group</th>
<th>Objective</th>
<th>KPI(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UTC and Streaming</strong></td>
<td><strong>Objective</strong></td>
<td><strong>KPI(s)</strong></td>
</tr>
<tr>
<td>Lead: Simon Collins &amp; Cliff Evans</td>
<td>1. Instigate joint and regular review of MedOCC streaming rates</td>
<td>1. No’s streamed to MedOCC</td>
</tr>
<tr>
<td></td>
<td>2. Establish and monitor a process to avoid patients being</td>
<td>2. Reduced in no. patients ‘bounced back’ to ED</td>
</tr>
<tr>
<td></td>
<td>‘bounced back’ to ED</td>
<td></td>
</tr>
<tr>
<td><strong>ED clinical re-design</strong></td>
<td><strong>Objective</strong></td>
<td><strong>KPI(s)</strong></td>
</tr>
<tr>
<td>Lead: Andrew Stradling</td>
<td>1. Complete the clinical redesign of ED</td>
<td>1. Ambulance Handover target (&lt;15 minutes) achieved consistently</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. 0 Red chair breaches</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Support achievement of Emergency Access Target trajectory (95%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>target by March 19) by maintaining non admitted performance at</td>
</tr>
<tr>
<td></td>
<td></td>
<td>98%</td>
</tr>
<tr>
<td><strong>Medical Model</strong></td>
<td><strong>Objective</strong></td>
<td><strong>KPI(s)</strong></td>
</tr>
<tr>
<td>Lead: Paul Kitchen</td>
<td>1. Complete redesign of Medical rota to optimise patient flow</td>
<td>1. No. of job plans reviewed</td>
</tr>
<tr>
<td></td>
<td>2. Fully implement single clerking</td>
<td>2. No. of PA’s dedicated to supporting Flow</td>
</tr>
<tr>
<td></td>
<td>3. Instigate medical triage within ED</td>
<td>3. Reduced time to SDM</td>
</tr>
<tr>
<td><strong>Pull Pathways</strong></td>
<td><strong>Objective</strong></td>
<td><strong>KPI(s)</strong></td>
</tr>
<tr>
<td>Lead: Tzvetka Tenecheva-Stoencheva &amp;</td>
<td>1. Establish and maintain 24-hour speciality assessments areas</td>
<td>1. Increased flow to in-patient beds</td>
</tr>
<tr>
<td>Gurjit Mahil</td>
<td>2. Resilient assessment areas</td>
<td>2. Reduced LOS in assessment areas</td>
</tr>
<tr>
<td></td>
<td>3. Introduction of Frailty Assessment Area</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4. Complete roll out off digital take lists</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5. Establish Area 8 as co-located AEC and SAU units</td>
<td></td>
</tr>
<tr>
<td><strong>Effective Discharge Planning</strong></td>
<td><strong>Objective</strong></td>
<td><strong>KPI(s)</strong></td>
</tr>
<tr>
<td>Lead: Simon Weeks &amp; Tarina Phillips</td>
<td>1. Improve effectiveness of ward and board rounds</td>
<td>1. Increase no. patients discharged before 12pm)</td>
</tr>
<tr>
<td></td>
<td>2. Implement CLD, R2G, EDN completion, TTOs</td>
<td>2. Increase No. eDNs completed day before discharge</td>
</tr>
<tr>
<td></td>
<td>3. Running regular MADE events for complex discharges</td>
<td>3. Increase No. of complex discharges facilitated by MADE events</td>
</tr>
<tr>
<td></td>
<td>4. Complete IDT Review</td>
<td></td>
</tr>
<tr>
<td><strong>Frailty village</strong></td>
<td><strong>Objective</strong></td>
<td><strong>KPI(s)</strong></td>
</tr>
<tr>
<td>Lead: Sanjay Suman &amp; Alison Streatfield</td>
<td>1. Complete re-design of Frailty bed base (SAFU &amp; Ambulatory, Acute Frailty, Post-Acute long-stay ward, Medically Fit setting, EoL pathway)</td>
<td>1. Increase 0 LOS or same day discharges</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Reduce average LOS (Days)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Increase % Discharges before noon</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Reduction in Frailty Outliers</td>
</tr>
<tr>
<td><strong>Site &amp; Flow</strong></td>
<td><strong>Objective</strong></td>
<td><strong>KPI(s)</strong></td>
</tr>
<tr>
<td>Lead: Korron Spence &amp; Michelle Mackie</td>
<td>1. New processes embedded</td>
<td>1. Reduction in No. of outliers</td>
</tr>
<tr>
<td></td>
<td>2. Instigate and maintain behaviour change programme</td>
<td>2. Reduction in average time for DTA admissions</td>
</tr>
<tr>
<td></td>
<td>3. Address staffing and capacity issues</td>
<td>3. No 12 hour breaches</td>
</tr>
</tbody>
</table>
Our Emergency Access Pathway Improvement Plan is supporting a whole hospital approach to meeting the 4 Hour constitutional target.
Improved SECAmb Performance 30 Minute Handover Performance

Medway currently has the highest percentage of <15 minute ambulance handovers in the SECAmbs Region (over 63% of handovers <15 minutes).
Reducing Ambulant Patient Breaches

Our ‘Majors Lite’ area has been developed to stop ambulant patients not requiring further assessment breaching the 4 Hour target.
Effective streaming and the management of ambulatory patients within ED which is delivering excellent Non-Admitted performance.

Admitted Performance is however 40% lower than last year (YTD). Sustained improvement in flow through the hospital is required to enable us to consistently meet our 4 hour Emergency Access target.
### Flow Improvement

#### Impact

<table>
<thead>
<tr>
<th>Before SITE huddles</th>
<th>Since SITE huddles</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Graph showing discharges by hour, before SITE huddles" /></td>
<td><img src="image2" alt="Graph showing discharges by hour, since SITE huddles" /></td>
</tr>
</tbody>
</table>

- **Peaky d/c profile throughout the day**
- **Smother d/c profile throughout the day**
- **Peak time of d/c has moved forward by 1 hour**

*Note: Images show bar charts comparing discharges by hour before and after the implementation of SITE huddles.*
MADE@MFT- #noplacelikehome4xmas

MADE impact

Impact of MADE

Delayed transfers & long stay patients (7+ days) in acute beds

56% of bed base

% Long stay patient (7+ Days)

Beds occupied by delayed transfers

Transforming Medway
medwayft transformationteam@nhs.net
Matron & Lead Nurse actions (example)

Actions apply for Unplanned and Planned Care unless otherwise specified

- Attending board rounds where appropriate with a focus on providing challenge to wards below their discharge target e.g. ward with high drop-offs or consistently below target
- Following up that key actions on wards or at the huddles have been completed and expedite definite discharges to the discharge lounge and act as a point of escalation for the conversion of queries
- Attendance at huddles, providing challenge for delays

- Attending all wards and providing challenge where appropriate at board rounds on wards which are consistently below their discharge target or have many drop-offs
- Following up on the wards that key actions have been completed
- Actively looking for patients to sit out and escalating discharge dependant diagnostics & procedure lists for today and tomorrow
- Act as a point of escalation in liaising with consultants to solve medical issues (if consultant is not scheduled to be on the ward)
- Lead nurse to meet with Medical/Surgical Matrons at 1130 in CCC room to discuss & escalated issues on wards and confirm actions identified.
- Attend and provide challenge at all huddles (including 1500 for medicine)

- Reviewing transport need for discharges
- Working with DoN in walking MDT to unblock delays and expedite discharge

‘Proposed’ Schedule of meetings:

0800 Med huddle
0900 Walking MDT of Medical wards with Co DoN and DDoN & Therapies to expedite discharges
1015 Surg huddle
1130 Matron meeting in CCC to discuss & escalated issues on wards and confirm actions completed
1200 Med huddle
1500 Med huddle
SAFU Official Opening
13th December, 2018

By
Dr Matt Thomas
(Consultant Geriatrician,
Poole NHS Foundation Trust)
Sapphire Acute Frailty Unit: Impact Metrics

SAFU Pre-noon discharges = 38.7%* (vs Trust 19.4%*)
Aim: Getting Frail patients home earlier in the day (especially in Winter)

SAFU Av LOS (Nov) : 6.2 days (vs. FBB avg LOS of 12.11 days)
Aim: Reducing unnecessarily long lengths of stay (ALOS) for Frail patients

* For period up to 11/12/18

#noplacelikehome
Sapphire Acute Frailty Unit: Impact Metrics

223 patients discharged over 10 weeks (up to 11/12/18).
Aim: Reducing acute length of stay (ALOS) for Frail patients

Actual Discharges

Daily discharge goal = 8

#noplacelikehome
Acute Frailty Unit: Developments since June 2018

- **Frailty Bed Base**
  - June 2018
  - Established Milton, Byron, Tennyson as Frailty bed base
  - Dedicated Multidisciplinary Team
  - Consultant Led
  - Focus areas:
    - Criteria Led Discharge
    - Effective Board Round
    - Prompt EDN completion
    - ↑ Discharges before mid-day

- **ED / Medical Assessment Unit**
  - September 2018
  - MDT Embedded: Front Door Therapist, Frailty Specialist Nurses, Pharmacist
  - Identifying Frailty in ED (Clinical Frailty Scale applied)
  - Consultant led pathway: 7 days, 12 hours
  - Comprehensive Geriatric assessment commenced in ED
  - Frail Patients streamed to Acute Frailty Unit or Frailty Bed Base depending on Expected Date of Discharge

- **Sapphire Acute Frailty Unit (SAFU)**
  - October 2018
  - Dedicated Multidisciplinary Team (Nursing, Medical, Therapies, Pharmacy, Discharge Team)
  - Consultant-Led Unit
  - Focus areas:
    - Rapid turnaround (<48 hours)
    - Improvements to the physical space befitting of a frailty unit i.e. Enablement Café, Dementia-friendly garden

- **Establishment of CCG commissioned Frailty Unit “hot clinics” for access to Specialist support from primary care**
  - Same day MDT and diagnostic intervention
  - Proactive care approach to support admission avoidance
  - SAFU post – mobilisation “stocktake” (Jan 2019) and culture programme commencement
  - Implementation of formal Continuous Improvement approach
Transformation programme
10th January, Trust Board report

- Month 8 CIP report and Model Hospital
- Clinical strategy & Portfolio of Services Review
- Best Flow Programme

Culture programme – You Are the Difference
Medway’s context:

17/18 Staff Survey

- Staff survey 2017/18 and staff engagement
  - 17/18 staff survey response rate of 40 per cent.
  - Engagement index score of 3.66.
  - Heat map revealed areas with low engagement
  - Levels of engagement appear to have reduced across the Trust.

CQC highlighted some challenging cultural trends

- The culture throughout the organisation was a mixed picture.
- Some staff worked in silos and staff satisfaction was mixed.
- "That’s not my patient…"
- Other teams worked well with staff in and out of the hospital.
- They did not feel empowered to raise concerns.

Culture is regularly cited as an inhibitor or an accelerator

- Change programmes historically have failed to address long-standing cultural challenges and behaviours.
- Experience from other organisations shows cultural change is a long-game and we now need to make this part of our strategic priorities.
Purpose Of The Programme

To Provide The Tools To Help Everyone To Take A Proactive Approach In Developing A New Culture, Which Is Positive, Inclusive, And Delivers The Values Of The Trust
### Evaluation – so far

Following the sessions:

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>65%</td>
<td>Of staff that attend YATD sessions <strong>Very Strongly Agree</strong> that they now recognise their own responsibility for improving the culture at MFT</td>
</tr>
<tr>
<td>41%</td>
<td>Of staff that attend YATD sessions <strong>Very Strongly Agree</strong> that they have the ability and tools to improve the culture at MFT (compared to 18% before attendance)</td>
</tr>
<tr>
<td>66%</td>
<td>Of staff that attend YATD sessions <strong>Very Strongly Agree</strong> with the belief that our values/behaviors directly affect our patients' results</td>
</tr>
<tr>
<td>69%</td>
<td>Of staff that attend YATD sessions <strong>Very Strongly Agree</strong> that positivity at work leads to better outcomes &amp; I am committed to helping MFT create a positive culture</td>
</tr>
<tr>
<td>89%</td>
<td>Agreed that the session was engaging, interesting and useful</td>
</tr>
</tbody>
</table>
We need to now

We must keep YATD alive and evolving

Be clear that changing culture can't happen overnight – it takes time, support and reinforcement

Create a connected programme of work across the trust to

- **Keep** doing the great things
- **Stop** doing other “initiatives”
- **Start** our focussed cultural change programme of work

Make YATD be the core of everything we do

Create a **collective leadership** of YATD everywhere at all levels
## Proposed work plan for YATD

### November/December 2018
- Complete staff sessions & Manager follow up sessions.
- Agree how we will roll out YATD to remaining staff.
- Agree plans for YATD 2019/20
  - Trust wide
  - Localised
  - Built into current work streams to join up / align YATD ethos/behaviours
- Agree how we will use Ambassadors

### January – March 2019
- Include YATD in Trust induction and medical induction.
- Develop and agree culture strategy for the Trust.
- Create a culture programme board.
- Formally launch Ambassador support.
- Review staff survey results and create an ambitious work plan with culture change at the core.
- Create focus groups to define what brilliant culture looks like for us.
- Define leadership expectations to deliver YATD in their areas.
- Include YATD in staff recognition programmes.

### March – September 2019
- Assess leadership capability/competence.
- Create leadership development interventions to support YATD.
- Review performance review process to ensure behaviours are discussed/reviewed.
- Localise YATD programme to specific areas / teams / projects.
- Create series of supporting toolkits.
- Introduce quarterly pulse checks.
- Review recruitment process to include recruitment for behaviour/attitude.
Report to the Board of Directors
Board Date: Thursday, 10 January 2019

Title of Report: Integrated Quality Performance Dashboard - Update

Prepared By: Associate Director of Business Intelligence

Lead Director: Director of Nursing

Committees or Groups who have considered this report: Draft to Quality Improvement Committee

Executive Summary:
To inform Board Members in the form of a flash report of September’s performance across all functions and key performance indicators. A full report will be presented to the next Board.

Key points are:

• The Trust did not achieve the **four hour ED target** in the month but performance has improved from 88.82% in October to 89.01% in November.

• There were no **12 hour breaches** in November.

• **HSMR** data reported in this month’s IQPR is for the period from October 2017 to September 2018. This is currently 116.56, which is higher than the expected range.

• This month saw a 23.2% decrease in the number of **Mixed Sex Accommodation** breaches, which totalled 192 in November. An IT system has been launched to support the wards in accurately recording and reviewing MSA breaches.

• **RTT** performance has increased to 82.59% from 81.77%. This is below the national standard of 92% but above the trajectory for the month.

• 31-day **Cancer targets** for first and subsequent surgical cancer treatments did not meet the national standards at 94.77% and 92.59% respectively. The 2-week wait
and 62-day targets have not been met. The 2-week wait symptomatic breast performance has decreased by 14.98% to 75.76%. The 62-day GP performance was not achieved in October, with performance increasing by 2.94% to 68.13%. The 62-day screening standard was also not achieved in October, and performance has decreased by 5.8% to 83.33%.

54 complaints were reported in the month, a decrease from October’s 65. There were 5 complaint returners in November.

<table>
<thead>
<tr>
<th>Resource Implications</th>
<th>n/a</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk and Assurance</td>
<td>See report</td>
</tr>
<tr>
<td>Legal Implications/Regulatory Requirements</td>
<td>n/a</td>
</tr>
<tr>
<td>Improvement Plan Implication</td>
<td>Supports the Improvement Programme in the following areas: Workforce, Data Quality, Nursing, Finance</td>
</tr>
<tr>
<td>Quality Impact Assessment</td>
<td>See report appropriate</td>
</tr>
<tr>
<td>Recommendation</td>
<td>n/a</td>
</tr>
<tr>
<td>Purpose &amp; Actions required by the Board :</td>
<td>Approval</td>
</tr>
<tr>
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<td>☐</td>
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</tbody>
</table>
Integrated Quality and Performance Report

December 2018

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Constitutional Target Trajectories

ED 4 Hour Trajectory Commentary:

We continue to move towards the national 4 hour target with a 0.25% increase against last years performance. We have seen an increase in walk-in patient attendance compared to last year an increase of 2500 YTD. ED Non-Admitted performance remains to be strong with a monthly average of 92.78% compared to the average Admitted performance which is struggling at 16.71%, a decrease from last year of 29.37% average. The Ambulance handover process changed in August where MFT were given the availability to input ambulance crew pins. November saw the opening of RAU and a new ambulance handover process was put into practice.

RTT Trajectory Commentary:

The Trust remains on trajectory for RTT performance against the trajectory agreed with NHSI, however not meeting the National Standard. Dermatology remains an area of concerns from an RTT perspective. The team are currently working with DMC to ensure patients are being seen on time. Without Dermatology the performance for November would be 86.5%.
Constitutional Target Trajectories

Cancer Trajectory Commentary:
The Trust has improved the 62 day performance in October 2018 to 83.85%, however still not compliant against the national standard or trajectory. 38 day shadow reporting puts the Trust as compliant. Action plans are in place to address this performance.

DM01 Trajectory Commentary:
MFT continues to improve performance of the DM01 against both the agreed improvement trajectory (October – 2.14 above trajectory) and the national standard (October – 0.54% above standard).
The achievement of the national standard was achieved seven months ahead of plan, driven through robust, weekly meetings, close and responsive leadership and delivery expectation, combined with education and training for staff at all levels and professional group.
SAFE
Safe Commentary:
We reported 63 falls in November, two of these falls resulted in harm. An improvement action plan is in place. The key actions are to improve recording of lying and standing blood pressure and comply with the NICE guidance relating to neurological observations post fall.

Of the four (check total once Kath & Louise have agreed the data) post 72 hour cases in October and November we have had finalised three out of four PIR’s. Two cases were unavoidable. Year to date we have reported three level 3 lapses of care against our CDiff acquisitions. The MRSA bacteremia reported in October although trust attributable was unavoidable and likely to be a transient bacteremia. There was no focus of infection.

E.coli: The IPCT carry out surveillance on all gram negative bacteremia and analysis shows the majority of cases are secondary to gastrointestinal / hepatobiliary conditions, however there are cases where a urinary catheter is the source of the infection and evidence of good catheter management is insufficient. Both acute and CCG IPC teams are working collaboratively to make the required improvements in the reduction of GNBSIs across the Kent & Medway system and new Kent and Medway guidelines for the care of patients with urinary catheters are nearly finalised. A working group is being convened to lead the improvement actions, the first meeting is scheduled to take place in January 2019.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red
Safe – Never Events
Spotlight Report

Commentary

Incident date: 16/10/2018
Date identified: 05/11/2018

The nature of the incident was a retained swab post birth. As soon as incident identified the swab was removed, an ultrasound performed and a course of antibiotics prescribed. No lasting harm to the patient.

The investigation found that the swab count was documented as being correct but there was no documentary evidence that the post repair swab count was checked with a colleague as per unit guidance.

There were missed opportunities to identify and remove the swab when the patient was seen by her community midwife and GP.

Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

Risks & Mitigating Actions

This incident has been presented to the programme governance board. Actions taken in response are:

- Update Operative Vaginal Delivery Guideline. This is to be linked with and acknowledged in the Standard Operating Procedure for swab, needle and instrument count
- Update swab, needle and instrument count SOP to include obstetric delivery rooms
- Update documentation to reflect NatSSIPS National Safety Standards
- Highlight incident to all midwifery and nursing teams working in delivery suite by involving the NatSSIPS simulation team.

The Trust last reported a never event in November 2017.
The Trust HSMR continues to climb, and has now risen to 116.6. Work carried out by the mortality committee during 2018 has identified key contributors to this, including:

- Reduction in expected mortality rates largely related to a reduction in palliative care coding
- Patients discharged from the Trust and dying at the Wisdom Hospice still counting as Trust deaths (whereas HSMR should only relate to deaths occurring in hospital)

In contrast the SHMI has gradually reduced over the last 18 months (this measure covers deaths occurring up to 28 days after hospital discharge and specifically excludes palliative care patients).

It has been agreed with the CCG and NHSI that the Z51.5 palliative care code will in future be applied to all patients who receive care from the Trust End of Life Care Team as well as those seen by the Palliative Care Team. Work is ongoing within coding to address the issue of the Wisdom Hospice patients. An estimate of HSMR if those changes are made is being prepared: previous work with NHSI and Dr Foster has suggested that the Trust HSMR would stand at around 102 after the changes to palliative care coding are made. However it must also be noted that the continued rise in HSMR is associated with a recent (six month) increase in both crude mortality and in observed deaths. Pneumonia has been flagged as an outlier diagnosis and the results of a deep dive into pneumonia mortality will be available for review at the Mortality Committee later in January. As a response to the continuing rise in HSMR the Medical Director is leading a focused task and finish group to review the underlying issues that may be contributing to HSMR, both from a data quality and a clinical and operational viewpoint. This review will report to the Executive Committee at the beginning of February.

### Commentary

<table>
<thead>
<tr>
<th>Domain</th>
<th>KPI Name</th>
<th>Target</th>
<th>Apr 18</th>
<th>May 18</th>
<th>Jun 18</th>
<th>Jul 18</th>
<th>Aug 18</th>
<th>Sep 18</th>
<th>Oct 18</th>
<th>Nov 18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortality</td>
<td>HSMR (All)</td>
<td>100.0 %</td>
<td>112.9</td>
<td>114.15</td>
<td>114.06</td>
<td>113.3</td>
<td>112.87</td>
<td>113.82</td>
<td>115.95</td>
<td>116.59</td>
</tr>
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</table>

### Highest observed exceeding expected

<table>
<thead>
<tr>
<th>Title</th>
<th>Rel. risk</th>
<th>Vol</th>
<th>Obs</th>
<th>Exp</th>
<th>O-E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pneumonia</td>
<td>124.6</td>
<td>1711</td>
<td>278</td>
<td>223.1</td>
<td>54.9</td>
</tr>
<tr>
<td>Diagnostic imaging (except heart)</td>
<td>117.0</td>
<td>7680</td>
<td>359</td>
<td>306.8</td>
<td>52.2</td>
</tr>
<tr>
<td>Diagnostic imaging of heart</td>
<td>154.5</td>
<td>1560</td>
<td>106</td>
<td>66.6</td>
<td>37.4</td>
</tr>
<tr>
<td>Septicemia (except in labour)</td>
<td>103.3</td>
<td>1265</td>
<td>222</td>
<td>203.0</td>
<td>19.0</td>
</tr>
<tr>
<td>Aspiration pneumonia, food/aspirate</td>
<td>130.2</td>
<td>166</td>
<td>67</td>
<td>51.5</td>
<td>15.5</td>
</tr>
</tbody>
</table>
Safe – Falls Per 1,000 Bed Days
Spotlight Report

We reported 63 falls in November, two of these falls resulted in harm:

- Hip fracture (Severe harm) Harvey Ward
- Ankle fracture (moderate harm) Arethusa Ward

An improvement action plan is in place. The key actions are to improve completion of falls risk assessment and post fall care, including use of the flat lift kit, and correct monitoring of neurological observation.

Falls Definition:
The number of falls that occur in the Trust divided by the number of occupied bed days. Inpatient falls can be classified into three categories: accidental falls (derived from extrinsic factors, such as environmental considerations), anticipated physiologic falls (derived from intrinsic physiologic factors, such as confusion), and unanticipated physiologic falls (derived from unexpected intrinsic events, such as a new onset syncopal event or a major intrinsic event such as stroke).
Caring Commentary:

The current focus of our FFT work is working with the PMB leads to improve the response rate and would recommend rate for FFT for outpatients, inpatients and ED. Actions to date include:

- Establishing a working group to review and address the operational barriers to the FFT.
- We have a leaflet called ‘ways in which we seek your feedback’ which alerts patients to the FFT contact they will receive once discharged. All patients are given the leaflet on discharge with the aim that they are more likely to respond if they know why we request their feedback and how we use it to make positive changes for future patients.
- Representatives from BI and IT are working with the Trust Patient Experience manager to implement a process to collate the FFT feedback from patients before they are discharged for the calendar month of February to see if that impacts positively on the scores.
- The PE manager is supporting Senior Sisters to review their FFT data including ‘you said we did’ and negative feedback reports.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red
November showed an improved position reporting 192 breaches, a fall of 44 breaches from the 236 reported in October.

This improvement is largely due to increased diligence with validation of data.

We remain challenged in placing critical care patients fit for ward based care into ward beds and in placing patients requiring assessment, short stay or specialist care, contributing to the majority of the breaches.

The critical factor to achieving our trajectory is successful delivery of the Emergency Pathway and LOS improvement plans.

- IT system developed for validation of MSA breaches
- MSA breaches discussed at Trust Clinical Site meetings
- Daily report MSA to management teams
- Weekly validation meeting commence January 2019
- Met with CCG Dec 2018 to review position and request additional support for Harvey ward

**Mixed Sex Accommodation Definition:**

The number of patient breaches by day of mixed-sex accommodation (MSA). This includes all sleeping accommodation where it is not deemed best for the patient’s care, patient choice or the patient has not consented to share mixed sex accommodation. This measure excludes A&E.
Electronic Discharge Notification (EDN) Spotlight Report

EDN completion remains at a suboptimal level. A number of pieces of work were carried out in 2018, particularly a review of the completion of EDN’s for deceased patients. However these actions have not made any noticeable difference to the EDN completion rate. The completion rate is Directorate and Programme dependent, with excellent completion rates in Perioperative and Critical Care and very poor rates in Specialist Medicine – consistently below 30%. Issues contributing to this include some problems with scarce junior doctor resource on some of the downstream medical wards – Keats and Will Adams being particularly affected by this.

Electronic Discharge Notification Definition:
The Electronic Discharge Notification (EDN) is required to be completed and sent to a patient’s GP within 24 hours of discharge. The discharge summary provides information to the GP of the reason for admission and any post-discharge plans.
Effective

The stroke SSNAP rating is E. This is related to three key issues, alongside delays in data entry which have affected the Trust’s audit score.

Consultant input – in terms of early review and delivery of thrombolysis
Access for stroke patients to beds on Harvey Ward
Inadequate therapy staffing

The impact of the decision not to site a HASU at Medway will affect the potential to recruit additional therapists, although options for shared appointments with DGT and MTW are being reviewed. An internal review of consultant working patterns may enable some adjustments to be made which will improve the consultant aspect of the SSNAP scores, and bed management decisions are continually reviewed to try and ensure that appropriate patients are admitted to the correct ward area (not just in stroke).

The Trust continues to face the challenge of the maintenance of stroke services until spring 2020 as this is the timescale within which DGT and MTW will be in a position to deliver the HASU / ASU models.

* Stroke metrics available quarterly from 2018/19

Effective Commentary:

The stroke SSNAP rating is E. This is related to three key issues, alongside delays in data entry which have affected the Trust’s audit score.

Consultant input – in terms of early review and delivery of thrombolysis
Access for stroke patients to beds on Harvey Ward
Inadequate therapy staffing

The impact of the decision not to site a HASU at Medway will affect the potential to recruit additional therapists, although options for shared appointments with DGT and MTW are being reviewed. An internal review of consultant working patterns may enable some adjustments to be made which will improve the consultant aspect of the SSNAP scores, and bed management decisions are continually reviewed to try and ensure that appropriate patients are admitted to the correct ward area (not just in stroke).

The Trust continues to face the challenge of the maintenance of stroke services until spring 2020 as this is the timescale within which DGT and MTW will be in a position to deliver the HASU / ASU models.
Effective – Fracture Neck of Femur
Spotlight Report

T&O have struggled with # NOF activity within 24 hours. In part because of:
• the flow/attendance profile
• trauma theatre utilisation/management
• complex patients who require significant working up prior to surgery
• variation in anaesthetic support/confidence in managing frail patients requiring surgery
• Vacancies in the Trauma Coordinator role

Re-established the # NOF working group under the clinical leadership of Mr Paras Mohanlal
Agreement to profile # NOF as golden on the Trauma list
Explicit focus within team on the target led by the Trauma Coordinator
New Clinical Lead
Physician Associate focus 1st thing in the morning on prepping # NOF for theatre
Review of other trusts performance on management of # pathway. Plan to visit Swindon Hospital
Profile and improvement action plan will be discussed at Surgery Programme Board and in the Orthopaedic Team Meeting to ensure awareness of performance
Performance and targets fed back through the daily Trauma meeting.

Fractured NOF in 24 Hours Definition:
The NICE guidance states that patients admitted with a fractured neck of femur (NOF) should have surgery within 24 hours of admission. This lowers overall mortality risk and aids in the patient’s return to mobility. A Best Practice Tariff (BPT) is associated with this indicator to encourage prompt surgery.
Effective – VTE risk Assessment
Spotlight Report

Commentary

Small improvement noted from last month

Trust process for data collection changed in April 2018 to Ward Clerk to input data.

Trust wide training completed.

Reduction in Data inputting and scrutiny following VTE specialist nurse vacancy.

(August 2018)

Round table/SWARM event held in November 2018 with internal stakeholders transformation team and Professor Hughes to discuss immediate actions and risk review.

Risks & Mitigating Actions

- VTE specialist nurse recruited commences 7th January 2018.
- Task and finish group in place.
- Updated training and education sessions planned for all ward clerks and senior sisters in January 2019.
- Data to be included on Nursing and Midwifery report.
- Daily BI reporting Ward by Ward for oversight.
- Harm review- Dip test – random review of 20 sets of notes to be completed by end January 2019.
- All admitted/ acquired VTE now reported on Datix.

VTE Risk Assessment Definition:

A venous thromboembolism (VTE) risk assessment should be carried out on all patients admitted to the Trust both electively and as an emergency. A VTE is a condition where a blood clot forms in a vein. This is most common in a leg vein but a blood clot can form in the lungs.
Responsive – Non-Elective

Bed occupancy has continued to improve for 3 consecutive months with a reduction in LOS, areas identified as most improved are Byron and SAFU, both with a reduction of 5 days. Areas for improvement are Milton and Tennyson with an average of 3 days increase.

Requirement for escalation beds increased in the month of November, usage was the highest YTD. Ambulance handovers continues to improve. ED performance remains below trajectory.

### RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

<table>
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<tr>
<th>Domain</th>
<th>KPI Name</th>
<th>Target</th>
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<th>May 18</th>
<th>Jun 18</th>
<th>Jul 18</th>
<th>Aug 18</th>
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<td>75</td>
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<td>Delayed Transfer of Care Point Prevalence in Month</td>
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<td>% of Delayed Transfer of Care Point Prevalence in Month</td>
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</tbody>
</table>
Responsive – Escalation Beds Open

Spotlight Report

November has seen a significant decrease in the use of escalation beds

Financial Impact. Additional controls in place to manage staffing challenges, vacancy gaps, absenteeism or the need for additional capacity.

**Escalation Beds Definition:**

An escalation ward is defined by the NHS as a temporary ward or bed used by a Trust to support capacity in times of high demand to create additional capacity. It is acknowledged that patients “boarded” on an escalation ward are more likely to have poorer experience and high delays in discharge. These wards are not funded and staffed from a planned annual budget.
ED performance remains below trajectory largely due to flow. 89.71% improvement on previous month – Majors light down from 82% to 89% being treated within the 4 hours standard. MEDOCC activity remains static. ED attendances were down 207 on the previous month. Increase in conveyances of 125 on the previous month.

Implementing an escalation process for ED and MEDOCC in order to manage the throughput in the department which includes MEDOCC, Secamb and Hospital capacity and demand.

ED 4 Hr Performance Definition:
The four-hour A&E waiting time target is a pledge set out in the NHS Mandate. The operational standard is that at least 95% of patients attending A&E should be admitted, transferred or discharged within four hours. The All Types metric refers to all ED department attendances in Type 1 (on site ED) and Type 3 (MedOcc, and WICs) departments across the Trust’s footprint area.
Responsive – Elective

Diagnostic access standards remain on target. Elective access targets – Although the Trust is not meeting the 18 weeks national standard of 92%, the Trust is compliant against the trajectory agreed. There has been an increase in 52 week breaches, and this has been driven by the long waits within Dermatology, this is being addressed through additional capacity.

Theatres – In November the Trust had 24 patients cancelled on the day of their operation, this was due to patient snot being well on the day of procedure and also due to site pressures around flow.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red
This measure looks at the percent of patients waiting for a diagnostics test in nationally specified modalities that have waited less than 6 weeks from referral to test.

DM01 Performance Definition:
This measure looks at the percent of patients waiting for a diagnostics test in nationally specified modalities that have waited less than 6 weeks from referral to test.

DM01 Performance has continued to improve against national standard and trajectory, out performing expectation.

Services meet weekly to review performance and discuss issues, risks and mitigations required, with agreed plan for improvement/delivery over next four weeks.

A TCI report is delivered weekly, enabling teams to review TCI dates vs current wait and mitigate breeches and unexpected long waits, enabling frequent and regular validation also.

The majority of services are delivering the expected standard, with the exception of Colorectal Surgery and Gastro.

Issues across all services remain and are driven by:
- Capacity (routine)
- Consultant Led clinics
- GA capacity

The DM01 & RTT meetings have now joined to ensure pathways are appropriately supported

<table>
<thead>
<tr>
<th>Commentary</th>
<th>Risks &amp; Mitigating Actions</th>
</tr>
</thead>
</table>
| DM01 Performance has continued to improve against national standard and trajectory, out performing expectation. | **Risks:**
- Capacity (Routine)
  - MRI
  - Respiratory
  - Gastro
- GA capacity
- Consultant Led Clinic capacity |
| Services meet weekly to review performance and discuss issues, risks and mitigations required, with agreed plan for improvement/delivery over next four weeks. | **Mitigations:**
- Additional MRI capacity purchased (4 weeks), with plan for monitoring breeches
- Capacity and Demand review to be completed – plan for capital group submission re MRI capacity on medium to long term basis
- Additional lists running in Cardiophys for sleep studies on regular basis
- Review of sleep studies location due to ward closure (Dickens)
- Care UK contract signed for Gastro
- Additional GA & Paed lists running for MRI
- Additional GA lists running for Gastro |
The number of 52 week breaches as a Trust has increased.

This has been driven in the main by the long waiting time within the Dermatology service. Additional capacity has been sought by the Trust.

Weekly meetings are in place to review the RTT patient tracking list.

The lists are reviewed and patients are tracked through their pathways to ensure safety and quality.

All patients that breach the 52 week standard have a clinical harm review completed by the clinical team. This is then reviewed at Directorate level.

A 52 week breach occurs at the point a patient has been waiting 365 days from when a Trust receives a referral for a new condition to when the patient commences their first treatment or a pathway clock is stopped.
Responsive – Cancer & Complaints Commentary:

Cancer – Unfortunately the Trust did not meet the 2 week wait standard. This has been mainly driven by an increase wait for Dermatology. Plans are in place and we are now seeing an increase in compliance. The 62 day performance is on an upward trajectory and shadow reporting places the Trust as compliant.

The Planned Care directorate achieved their trajectory of 100% compliance with complaint response rates in October. This was maintained in November and the directorate had zero complaints re-opened (returners). The directorate complaint process is being carefully managed within the Governance team to ensure deadlines are met, and as such, a marked improvement in performance has been seen over the past few months, and is expected to continue. An escalation process has been established to include an email from the Clinical Governance Lead, which is proving effective in ensuring comments are returned in a timely manner.

It has been more challenging to deliver improvement in complaints performance in the Unplanned and Integrated Care directorate. This is largely due to the higher number of ‘backlog’ of complaints. In November Unplanned and Integrated Care received 25 new complaints with 4 complaints re-opened in November. Overall the Directorate closed 53 complaints and are progressing to clear the historic backlog of breach complaints (currently 24 outstanding breach complaints across the Directorate) by the end of January in addition to ensuring ongoing complaints are completed within the trust deadline. Trajectories have been set to monitor each Programme ensuring compliance against upcoming complaint response timeframes occurs in addition to identifying a cohort of historic breached complaint responses are closed. Methods of escalation have been established by the Deputy Director of Nursing and Deputy Medical Director.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red
Responsive – 2 Week Wait Performance Spotlight Report

2 WW performance has declined particularly in the Dermatology service. The service had an increased waiting time, and is now booking at 13 days.

Demand and capacity has been carried out for Dermatology and additional clinics were allocated for 2 WW patients.

Patients are being tracked carefully through the pathway to ensure all data is validated in a timely fashion.

All tumour groups that are non compliant will be having deep dive pathway process mapping completed with the clinical team to ensure that the pathways are streamlined and clear.

2 Week Wait Definition:
The percent of patients seen by a specialist within 14 days of an urgent GP referral for suspected cancer.

62 day performance continues to improve in October 2018, however does not meet the national standard of 85%.

38 day shadow reporting does place the Trust as complaint against the standard.

Specific work is being carried out in the tumour groups that are non compliant to reduce the time patients are waiting.

All tumour groups that are non compliant will be having deep dive pathway process mapping completed with the clinical team to ensure that the pathways are streamlined and clear.

**Commentary**

62 day performance continues to improve in October 2018, however does not meet the national standard of 85%.

38 day shadow reporting does place the Trust as complaint against the standard.

Specific work is being carried out in the tumour groups that are non compliant to reduce the time patients are waiting.

All tumour groups that are non compliant will be having deep dive pathway process mapping completed with the clinical team to ensure that the pathways are streamlined and clear.

**62 Day Wait GP Definition:**

The percent of patients treated by a specialist within 62 days of an urgent GP referral for first definitive cancer treatment.
Following the annual nationally mandated clinical coding audit in 2017/18 it was identified that the Trust met all international standards of coding (over 90% accuracy for diagnosis and procedure codes compared to the target of 80% for both). However, multiple audits carried out in 2017/18 with internal consultants and the clinical coding team have identified challenges with patient record documentation. The team will expand the current coding training session so it is tailored to each specialty with support from national subject matter experts.

**Risks:**
- HSMR negative impact through reduced expected deaths following no diagnosis recording of some spells
- Challenges in 2019/20 contract planning as baseline data affected.
- Commissioner data Quality challenges
- Potential £1.8m FYE loss of income due to specialised commissioning activity not coded.
- Non-compliance with a number of Information Governance toolkit standards

**Mitigating Actions:**
- Clinical documentation review to be undertaken by national experts subject to receipt of an acceptable proposal.
- Enhanced training programme implementation following workforce redesign project.

**Depth of Coding Definition:**
‘Depth of coding’ is defined as the number of secondary diagnosis codes for each record (inpatient admission) in the data. A higher mean depth of coding may indicate a higher proportion of patients with multiple conditions and/or comorbidities, but may also be due to differences in coding practices between trusts.

**Domain**
- Data Quality & Coding

**KPI Name**
- Clinical Coding - Depth of Coding

**Target**
- 6.5

**Values**
- Apr 17: 6.21
- May 17: 6.07
- Jun 17: 6.15
- Jul 17: 6.08
- Aug 17: 6.18
- Sep 17: 6.12
- Oct 17: 6.38
- Nov 17: 6.34

**Domain**
- KPI Name

**Programme**
- ACUTE MEDICINE
- CANCER, DIAGNOSTICS & CLINICAL SUPPORT SERVICES
- PERIODICATIVE & CRITICAL CARE
- SPECIALIST MEDICINE
- SURGICAL SERVICES
- WOMENS & CHILDREN'S HEALTH

**Values**
- Apr 17: 6.05, 6.12, 5.00, 6.08, 6.14, 6.54, 6.26, 6.34
- May 17: 6.22
- Jun 17: 6.15
- Jul 17: 6.08
- Aug 17: 6.18
- Sep 17: 6.12
- Oct 17: 6.38
- Nov 17: 6.34

**Domain**
- KPI Name

**Values**
- Apr 17: 6.13, 3.31, 3.35, 3.67, 3.41, 3.91, 4.35, 4.69
- May 17: 6.22
- Jun 17: 6.22
- Jul 17: 6.27
- Aug 17: 6.11
- Sep 17: 6.49
- Oct 17: 5.7
- Nov 17: 9.47

**Domain**
- KPI Name

**Values**
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- May 17: 3.29
- Jun 17: 3.22
- Jul 17: 3.18
- Aug 17: 3.35
- Sep 17: 3.31
- Oct 17: 3.26
- Nov 17: 3.21
Well Led

Well Led Commentary:

StatMan has dropped over the last 3 months due to migration from Mollie to OLM platform. Agency spend as a percentage of the paybill has dropped in November compared to October and is reflective of ongoing work to increase bank. Bank spend as a percentage of the paybill has dropped in November compared to October. Temporary Staffing fill rate for nursing and midwifery increased in November compared to October.

RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red
Sickness absence has gone up in November compared to October by +0.11

**Sickness Rate Definition:**
The *absence rate* is the ratio of workers with absences to total full-time wage and salary employment.
## Safe Staffing

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<th>VARD</th>
<th>Beds</th>
<th>Day Total monthly planned staff</th>
<th>Day Total monthly actual staff</th>
<th>Night Total monthly planned staff</th>
<th>Night Total monthly actual staff</th>
<th>Average full time %</th>
<th>Average fill rate %</th>
<th>Average full time - Care staff (%)</th>
<th>Average fill rate - Care staff (%)</th>
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<td>990</td>
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<td>The Birth Place</td>
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<td>1068</td>
<td>1012</td>
<td>1000</td>
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<td>Will Adama Ward</td>
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<td>1068</td>
<td>134</td>
<td>93 of 184</td>
<td>1013</td>
<td>1068</td>
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<tr>
<td><strong>Trust total</strong></td>
<td></td>
<td><strong>659</strong></td>
<td><strong>6646</strong></td>
<td><strong>49,528</strong></td>
<td><strong>29,468</strong></td>
<td><strong>29,468</strong></td>
<td><strong>29,468</strong></td>
<td><strong>29,468</strong></td>
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</table>
Report to the Board of Directors
Board Date: Thursday, 10 January 2019    Agenda Item: 6.1

<table>
<thead>
<tr>
<th>Title of Report</th>
<th>Finance Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared By:</td>
<td>Ian O’Connor, Director of Finance (Interim)</td>
</tr>
<tr>
<td>Lead Director</td>
<td>Ian O’Connor, Director of Finance (Interim)</td>
</tr>
<tr>
<td>Committees or Groups</td>
<td>Executive Group</td>
</tr>
<tr>
<td>who have considered</td>
<td>Finance Committee</td>
</tr>
<tr>
<td>this report</td>
<td></td>
</tr>
<tr>
<td>Executive Summary</td>
<td>Summary report attached.</td>
</tr>
<tr>
<td>Resource Implications</td>
<td>None</td>
</tr>
<tr>
<td>Risk and Assurance</td>
<td>BAF compliance and Risk assessments undertaken.</td>
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<tr>
<td>Legal Implications/</td>
<td>At Q3 it is likely there will be a need to reforecast</td>
</tr>
<tr>
<td>Regulatory Requirements</td>
<td>the net year end deficit. Regulators have been</td>
</tr>
<tr>
<td></td>
<td>informed and are working closely with the Trust</td>
</tr>
<tr>
<td></td>
<td>on plans to limit any deficit and deliver the</td>
</tr>
<tr>
<td></td>
<td>best possible position.</td>
</tr>
<tr>
<td>Improvement Plan</td>
<td>Additional cost improvements will be required and a</td>
</tr>
<tr>
<td>Implication</td>
<td>continuation of the grip and control processes</td>
</tr>
<tr>
<td></td>
<td>already in place.</td>
</tr>
<tr>
<td>Quality Impact</td>
<td>Resources are not being starved to front line</td>
</tr>
<tr>
<td>Assessment</td>
<td>provision. Confirm and challenge sessions and</td>
</tr>
<tr>
<td></td>
<td>additional cost improvement opportunities continue</td>
</tr>
<tr>
<td></td>
<td>to be developed and managed through the established</td>
</tr>
<tr>
<td></td>
<td>Quality Impact Assessment Framework.</td>
</tr>
<tr>
<td>Recommendation</td>
<td>The Board is asked to note this report and consider</td>
</tr>
<tr>
<td></td>
<td>any further delegated action it might want to</td>
</tr>
<tr>
<td></td>
<td>delegate through the finance committee.</td>
</tr>
</tbody>
</table>

| Purpose & Actions     | Approval | Assurance | Discussion | Noting |
| required by the Board |          |           |            |        |
|                      | ☐        | ☐         | ☐          | ☒      |
Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 This report is intended to represent a summary of the more detailed report provided to the Finance Committee. It is intended to provide the Board with assurance, knowledge and insight into the Trust’s financial standing.

1.2 Appendix 1 of this report sets out a series of individual metrics designed to show progress over time and assess the risks associated with operational performance and the impact on the Trust’s financial position.

2 INCOME AND EXPENDITURE

2.1 To the end of November the Trust is reporting a year to date deficit of £33.0m (excluding income from the Provider Sustainability Fund). This is favourable to the planned deficit by £8k. November’s in month performance is a deficit of £3.0m although this is supported by £0.7m of non-recurrent adjustment.

2.2 PSF income in November is £0.9m adverse to plan by £0.4m due to the Trust not meeting the A&E performance target. PSF income is predicated on hitting the planned financial position at the end of every quarter. It is anticipated the Trust will achieve the control total at the end of December yet will start to move away from this plan in the final quarter. This will require a review of our forecast once the Quarter 3 position is known.

2.3 The forecast year end position at Month 8 reported to NHSI excluding PSF is a deficit of £46.9m and including PSF is £38.1m adverse to plan by £3.8m due to the A&E performance target not being met. These are best case forecasts and it is likely there will be a need to vary the forecast at the end of Quarter 3 in line with the most likely outturn scenario.

<table>
<thead>
<tr>
<th></th>
<th>Month 8</th>
<th>Year to Date</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Budget</td>
<td>Actual</td>
<td>Variance</td>
</tr>
<tr>
<td>Clinical Income</td>
<td>20,700</td>
<td>22,265</td>
<td>1,565</td>
</tr>
<tr>
<td>Other Income</td>
<td>1,984</td>
<td>2,026</td>
<td>42</td>
</tr>
<tr>
<td>Pay</td>
<td>(15,473)</td>
<td>(16,664)</td>
<td>(1,192)</td>
</tr>
<tr>
<td>Non-pay</td>
<td>(9,017)</td>
<td>(9,240)</td>
<td>(223)</td>
</tr>
<tr>
<td>EBITDA</td>
<td>(1,806)</td>
<td>(1,613)</td>
<td>193</td>
</tr>
<tr>
<td>Non Operating Expenses</td>
<td>(1,193)</td>
<td>(1,389)</td>
<td>(196)</td>
</tr>
<tr>
<td>Surplus/(Deficit) before STF</td>
<td>(2,999)</td>
<td>(3,002)</td>
<td>(3)</td>
</tr>
<tr>
<td>PSF</td>
<td>1,266</td>
<td>885</td>
<td>(381)</td>
</tr>
<tr>
<td>Total Surplus/(Deficit)</td>
<td>(1,733)</td>
<td>(2,117)</td>
<td>(384)</td>
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</tbody>
</table>
Report to the Board of Directors

3 COST IMPROVEMENT PROGRAMME

3.1 The targeted cost improvement programme overall is reported ahead of plan at the end of November by £1.4 million. This has been offset by number of pressures across divisions, although of most significance in unplanned care.

3.2 Cumulatively to the end of November these offset the over-performance on the cost improvement programme with a net £8,000 favourable variance before the Provider Sustainability Fund is applied.

4 CAPITAL

4.1 The capital plan for 2018/19 was ambition with expenditure of £31.2 million anticipated. Current forecasts are that around £18.3 million will be spent however there is some concern that this is also ambition with £6 million being spent in the first 8 months of 2018/19, according to the table below.

<table>
<thead>
<tr>
<th></th>
<th>Month 8</th>
<th></th>
<th>Year To Date</th>
<th></th>
<th>Annual</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Plan (£’000)</td>
<td>Actual (£’000)</td>
<td>Variance (£’000)</td>
<td>Plan (£’000)</td>
<td>Actual (£’000)</td>
<td>Variance (£’000)</td>
</tr>
<tr>
<td>Backlog Maintenance</td>
<td>400</td>
<td>120</td>
<td>(280)</td>
<td>4,210</td>
<td>1,490</td>
<td>2,720</td>
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<tr>
<td>Plant/Equip/Trans/Fits/Other</td>
<td>120</td>
<td>70</td>
<td>(50)</td>
<td>700</td>
<td>1,160</td>
<td>(460)</td>
</tr>
<tr>
<td>Fire Safety</td>
<td>1,327</td>
<td>362</td>
<td>(965)</td>
<td>7,100</td>
<td>1,585</td>
<td>5,515</td>
</tr>
<tr>
<td>IT</td>
<td>200</td>
<td>390</td>
<td>190</td>
<td>1,190</td>
<td>1,530</td>
<td>(340)</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>370</td>
<td>0</td>
<td>(370)</td>
<td>5,020</td>
<td>0</td>
<td>5,020</td>
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<tr>
<td>Original Plan Total</td>
<td>2,417</td>
<td>942</td>
<td>(1,475)</td>
<td>18,220</td>
<td>5,765</td>
<td>12,455</td>
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<td>FUNDED - Wifi Enhancements</td>
<td>130</td>
<td>100</td>
<td>(30)</td>
<td>130</td>
<td>100</td>
<td>30</td>
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<tr>
<td>Total</td>
<td>2,547</td>
<td>1,042</td>
<td>(1,505)</td>
<td>18,350</td>
<td>5,865</td>
<td>12,485</td>
</tr>
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</table>

5 WORKING CAPITAL

5.1 The Trust relies on deficit cash loans each month. The cash held is managed by ensuring these funds are drawn in line with the planned deficit and that loans are not requested (hence incurring interest charges) ahead of when the cash is needed. This follows a standard monthly cycle and is actively managed by the financial control team.
6 FINANCE AND USE OF RESOURCES METRICS

6.1 The rating at Month 8 is a 3. With the changing forecast, the Trust will move away from a score of 2, to a score of 4 for distance from financial plan. However, at the end of the financial year, the overall Use of Resources Rating will remain at 3 due to the excellent agency rating of 1.

![Summary Metrics: Finance and Use of Resources](image)

7 CONCLUSION

7.1 The Board is asked to note the position in this report in particular the likelihood for a need to reforecast the financial position once the Q3 position is known.

Ian O’Connor
Interim Director of Finance
December 2018
<table>
<thead>
<tr>
<th>Title of Report</th>
<th>Board Assurance Framework</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared By:</td>
<td>Brenda Thomas, Company Secretary</td>
</tr>
<tr>
<td>Lead Director</td>
<td>James Devine, Chief Executive</td>
</tr>
<tr>
<td>Committees or Groups who have considered this report</td>
<td>Board Development Session Executive Group</td>
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**Executive Summary**

The Board Assurance Framework (BAF) was discussed at the Board development Session on 6 December 2018 and subsequently reviewed by the Executive Directors at the Executive Group meeting on 19 December 2018.

This report summarises the above discussion and review, which resulted in the presentation of a new BAF, revised risk scoring and new risks raised.

There are 11 risks on the BAF with risk threshold of 12 or higher.

**Resource Implications**

None at this time.

**Risk and Assurance**

As per Risk Management Strategy and Policy.

**Legal Implications/Regulatory Requirements**

The Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver its strategic and operational plans and comply with the registration requirements of the quality regulator. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks.

For Foundation Trusts, this also includes risks to compliance with the terms of authorisation.

The Trust Board is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives.

**Improvement Plan Implication**

Not applicable.

**Quality Impact Assessment**

Not required at this stage.
The Trust Board is asked to:

i. Review the BAF, provide necessary scrutiny and provide feedback on the risks;

ii. Note that the BAF is still work in progress; and

iii. Approve the new BAF format.

**Purpose & Actions required by the Board:**

<table>
<thead>
<tr>
<th>Approval</th>
<th>Assurance</th>
<th>Discussion</th>
<th>Noting</th>
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</thead>
<tbody>
<tr>
<td>☒</td>
<td>☒</td>
<td>☒</td>
<td>☒</td>
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</tbody>
</table>
1 EXECUTIVE SUMMARY

1.1 At the Trust Board Development session on 6 December 2018, members of the Board reviewed the Board Assurance Framework (BAF). Subsequently, Executive Directors, at the Executive Group meeting on 19 December 2018, reviewed their individual strategic risks and a new BAF format. The new BAF format, which brings reporting of strategic risks in line with other Foundation Trusts, was agreed by the Executive Group on 19 December 2018.

1.2 Risks have been revised and new strategic risks raised. Risk description now includes a title, cause and effect and impact of the risk on the Trust. In addition, what the key controls are and assurances on these controls.

1.3 Summary of the review is presented under heading two and the full BAF, which is still work in progress, presented as Appendix 1.

2 BOARD ASSURANCE FRAMEWORK REVIEW

2.1 The agreed revisions to the strategic risks and their scorings are summarised below:

2.1.1 Finance risks: (Link to Strategic Objective Three - Financial Stability)

Previous BAF

There were three strategic risks on the previous BAF:

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk</th>
<th>Current Risk</th>
<th>Target Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Going Concern</td>
<td>16 (4x4)</td>
<td>16 (4x4)</td>
<td>6 (2x3)</td>
</tr>
<tr>
<td>Unable to deliver our financial control total</td>
<td>16 (4x4)</td>
<td>16 (4x4)</td>
<td>6 (2x3)</td>
</tr>
<tr>
<td>Risk that central funding is not made available as required to support the deficit, capital investment, and loan repayments that fall due</td>
<td>16 (4x4)</td>
<td>8 (4x2)</td>
<td>6 (2x3)</td>
</tr>
</tbody>
</table>

New BAF

There are now four strategic risks on the BAF (refer to the full BAF in Appendix 1):

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk</th>
<th>Current Risk</th>
<th>Target Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery of financial control total</td>
<td>16 (4x4)</td>
<td>20 (4x5)</td>
<td>12 (4x3)</td>
</tr>
<tr>
<td>Investment</td>
<td>16 (4x4)</td>
<td>12 (4x3)</td>
<td>12 (4x3)</td>
</tr>
<tr>
<td>Failure to achieve longer term financial sustainability</td>
<td>16 (4x4)</td>
<td>25 (5x5)</td>
<td>12 (4x3)</td>
</tr>
<tr>
<td>Going Concern</td>
<td>16 (4x4)</td>
<td>8 (4x2)</td>
<td>8 (4x2)</td>
</tr>
</tbody>
</table>
2.1.2 Workforce risks: (Link to Strategic Objective Four: Our People)

Previous BAF
There was a single strategic risk on the previous BAF:

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk</th>
<th>Current Risk</th>
<th>Target Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recruit/ Retain sufficient qualified staff</td>
<td>initial risk = 16 (4x4); current risk = 12 (4x3); target risk = 4 (2x2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

New BAF
There are now three strategic risks on the BAF (refer to the full BAF in Appendix 1):

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk</th>
<th>Current Risk</th>
<th>Target Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing levels including recruitment and retention</td>
<td>initial risk = 16 (4x4); current risk = 8 (4x2); target risk = 8 (4x2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Engagement</td>
<td>initial risk = 12 (3x4); current risk = 12 (3x4); target risk = 6 (3x2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Best staff to deliver the best of care</td>
<td>initial risk = 12 (3x4); current risk = 12 (3x4); target risk = 6 (3x2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.1.3 System Integration risks: (Link to Strategic Objective One - Integrated Health Care)

Previous BAF
There were three strategic risks on the previous BAF:

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk</th>
<th>Current Risk</th>
<th>Target Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure of partnership and integration</td>
<td>initial risk = 16 (4x3); current risk = 9 (3x3); target risk = 6 (2x3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brand failure</td>
<td>initial risk = 12 (4x3); current risk = 9 (3x3); target risk = 6 (2x3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Collaborating with partners</td>
<td>initial risk = 16 (4x4); current risk = 9 (3x3); target risk = 6 (2x3)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

New BAF
There is now a single strategic risk on the BAF, which incorporates the three previous risks (refer to the full BAF in Appendix 1):

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk</th>
<th>Current Risk</th>
<th>Target Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure of partnership working to deliver systems integration, stability and better patient services via the formation of an Integrated Care Partnership (ICP).</td>
<td>initial risk = 16 (4x4); current risk = 12 (4x3); target risk = 6 (3x2)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Board Assurance Framework

2.1.4 Innovation risks: (Link to Strategic Objective Two: Innovation)

Previous BAF
There were three strategic risks on the previous BAF:

<table>
<thead>
<tr>
<th></th>
<th>Initial Risk</th>
<th>Current Risk</th>
<th>Target Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovation Strategy</td>
<td>16 (4x4)</td>
<td>12 (4x3)</td>
<td>9 (3x3)</td>
</tr>
<tr>
<td>Capability</td>
<td>9 (3x3)</td>
<td>9 (3x3)</td>
<td>4 (2x2)</td>
</tr>
<tr>
<td>Funding</td>
<td>9 (3x3)</td>
<td>9 (3x3)</td>
<td>4 (2x2)</td>
</tr>
</tbody>
</table>

New BAF
Risk titles largely remained the same, with the exception of risk 1 - ‘Strategy’ being removed from ‘Innovation Strategy’.

<table>
<thead>
<tr>
<th></th>
<th>Initial Risk</th>
<th>Current Risk</th>
<th>Target Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Innovation</td>
<td>16 (4x4)</td>
<td>16 (4x4)</td>
<td>12 (4x3)</td>
</tr>
<tr>
<td>Capability</td>
<td>9 (3x3)</td>
<td>12 (4x3)</td>
<td>9 (3x3)</td>
</tr>
<tr>
<td>Funding</td>
<td>9 (3x3)</td>
<td>9 (3x3)</td>
<td>9 (3x3)</td>
</tr>
</tbody>
</table>

2.2 The above proposed changes have been reflected in the BAF attached as Appendix 1.

3 NEXT STEPS
3.1 Should the Board approve the new BAF, subsequent reporting will include highlight report showing movement on the risk scoring (if any) for the past three meetings.

4 APPENDICES
4.1 Appendix 1- Board Assurance Framework (new format)
4.2 Appendix 2 - Risk Matrix
## APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

### COMPOSITE RISK: Finance

**EXECUTIVE LEAD:** Director of Finance

**LINKS TO STRATEGIC OBJECTIVE:** Objective Three - We will deliver financial sustainability and create value in all we do

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk Rating</th>
<th>KEY Controls</th>
<th>KEY Assurances on Controls</th>
<th>Saps in Controls and Actions to address</th>
<th>Current Risk Rating</th>
<th>Target Risk Rating</th>
<th>Target Date</th>
</tr>
</thead>
</table>
| **TITLE:** Delivery of financial control total | 4 (major) X 4 (likely) = 16 [Extreme] | 1. Monthly reporting of financial position to finance committee and Board, demonstrating:  
- agency usage has reduced and bank usage increased – continuing to focus on this, and to address bank rate differentials  
- improving run rate during the year. | 1. Heightened Grip and Control processes (Q4 2018/19) | 1. Establishment and prosecution of system wide recovery plan  
2. Understanding of shifts in reference costs and model hospital between years  
3. Setting of revised forecast (Q3 2018/19) | 4 (major) X 3 (almost certain) = 12 [High] | 4 (major) X 3 (possible) = 12 [High] | 31/03/2019 |
| **CAUSE AND EFFECT:** There is a risk that the Trust may be unable to establish financial sustainability within the required timeframe due to inability to realise efficiencies. |  |  |  |  |  |  | |
| **IMPACT:** This may lead to inability to return to balance position and deliver the financial control total leading to a reputational impact. |  |  |  |  |  |  | |
| **TITLE:** Investment | 4 (major) X 4 (likely) = 16 [Extreme] | 1. Governed entirely by the availability of cash, obtaining loans for significant investment in new technologies will require business cases to be signed off by regulators unless affordable within the existing capital programme or through a revenue stream. (Note: Risk not fully mitigated from the Trusts perspective until it starts to generate a cash surplus). | 1. Development of standard business case process and 6 month review point by Finance Committee (Q4 2018/19). | 4 (major) X 3 (possible) = 12 [High] | 4 (major) X 3 (possible) = 12 [High] | 31/03/2019 |
| **CAUSE AND EFFECT:** If there is insufficient cash to invest in new technologies, there is a risk to the transformation plan. |  |  |  |  |  |  | |
| **IMPACT:** Non-delivery of transformation plan. |  |  |  |  |  |  | |
### APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

**COMPOSITE RISK: Finance**

**EXECUTIVE LEAD:** Director of Finance

**LINKS TO STRATEGIC OBJECTIVE:** Objective Three - We will deliver financial sustainability and create value in all we do

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Strategic Risk Rating</th>
<th>KEY Controls</th>
<th>KEY Assurances on Controls</th>
<th>Saps in Controls and Actions to address</th>
<th>Current Strategic Risk Rating</th>
<th>Target Strategic Risk Rating</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CAUSE AND EFFECT:</strong> Achieving financial sustainability is a statutory responsibility. Improving the position will lead to enhanced reputation leading to an improved capability for recruitment into key roles.</td>
<td>2. Benchmarking material available from model hospital and other sources</td>
<td>2. Programme for the development of service line information and its migration to service line management processes to be established (Q4 2018/19) (IOC).</td>
<td>2. Development of service line and Patient Level Information and Costing System (PLICs).</td>
<td>3. Closer scrutiny at PRMs</td>
<td>4 (major) X 2 (unlikely) = 8 [High]</td>
<td>4 (major) X 2 (unlikely) = 8 [High]</td>
<td></td>
</tr>
<tr>
<td><strong>IMPACT:</strong> This may lead to further regulatory action.</td>
<td>3. Reporting of identified pressures alongside CIP and budgetary delivery to Finance Committee on a regular basis (M8 2018/19 and ongoing) (IOC)</td>
<td>4. Developing planning tools to better triangulate resources with activity. (Linked Capacity, Activity, Financial and Workforce plans) (IL)</td>
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<td></td>
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<tr>
<td>5. Development of system wide financial narrative and joint plans with commissioners and other key stakeholders. (IOC)</td>
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</tr>
<tr>
<td><strong>TITLE:</strong> Going Concern</td>
<td>4 (major) X 4 (likely) = 16 [Extreme]</td>
<td>1. Interaction with regulators for loans to support deficit and capital requirements has mitigated this risk.</td>
<td></td>
<td></td>
<td>4 (major) X 2 (unlikely) = 8 [High]</td>
<td>4 (major) X 2 (unlikely) = 8 [High]</td>
<td></td>
</tr>
<tr>
<td><strong>CAUSE AND EFFECT:</strong> There is a risk that the Trust's Going Concern assessment is at risk given the proportionality of the continued and sustained deficit.</td>
<td></td>
<td>(Note: Risk may increase with a national context with working capital needing to be managed effectively to maintain the supply chain).</td>
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<tr>
<td><strong>IMPACT:</strong> This could lead to further licence conditions and potential regulatory action.</td>
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</tbody>
</table>
## APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

**COMPOSITE RISK:** Workforce

**EXECUTIVE LEAD:** Director of Human Resources and Organisational Development

**LINKS TO STRATEGIC OBJECTIVE:** Objective Four - We will enable our people to give their best and achieve their best

### Workforce

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk Rating</th>
<th>KEY Controls</th>
<th>KEY Assurances on Controls</th>
<th>Gaps in Controls and Actions to address</th>
<th>Current Risk Rating</th>
<th>Target Risk Rating</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>TITLE: Staffing levels including recruitment and retention</td>
<td>4 (major) X 4 (likely) = 16 [Extreme]</td>
<td>1. Strategy: Workforce Strategy in place to address current workforce pressures, link to strategic objectives and national directives.</td>
<td>Workforce strategy in place from April 2018 to 31 March 2019</td>
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<td></td>
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</tbody>
</table>
| CAUSE AND EFFECT: There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function | | 2. Vacancy Reporting: Bi-monthly reporting to Board demonstrating:  
- Current contractual vacancy levels (workforce report)  
- Sickness, turnover, starters leavers (IQPR) Monthly reporting to services or all HR metrics and KPIs via HR Business Partners. | | Talent management to support the Trust’s successional planning process due to form part of revised Workforce Strategy alongside culture programme. [April 19] | 4 (major) X 2 (unlikely) = 8 [High] | 4 (major) X 2 (unlikely) = 8 [High] | March 2020 |
| IMPACT: This may lead to an impact on patient experience, quality, staff morale and safety | | 3. Monitoring controls:  
- Monthly reporting of vacancies and temporary staffing usage at PRMs;  
- Daily temporary staffing reports to services and departments against establishment;  
- Daily pressure report during winter periods for transparency of gaps. | 1. Trust vacancy rate at 17.5%.  
2. Sickness rate 4.1%  
3. Substantive workforce 82.4% | Launch of retention programmes across Trust from [January 2019]. | |
| Attraction: Resourcing plans based on local, national and international recruitment. Progress on recruitment reported to Board. Employment benefits expanded. | | 1. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing.  
2. Temporary staffing and daily pressure/gap report in operation. | | | |
| Temporary staffing delivery:  
- NHSI agency ceiling reporting to Board;  
- Weekly breach report to NHSI;  
- Reporting to Board of substantive to temporary staffing paybill. | | 1. Number of substantive nurses currently at highest point since 2015. C.450 international nursing offers in place. | | | |
| Operational:  
- Operational KPIs for HR processes and teams reported monthly. | | 1. £3.4m favourable to ceiling;  
2. Averaging 14 breaches per week compared to c1000 in 2016  
3. Agency workforce 5%  
4. Bank workforce 12% | | | |

84 apprentices of 101 target

85% of operational HR KPIs met
### APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

**COMPOSITE RISK: Workforce**

**EXECUTIVE LEAD:** Director of Human Resources and Organisational Development

**LINKS TO STRATEGIC OBJECTIVE:** Objective Four - We will enable our people to give their best and achieve their best

### Risk Description | Initial Risk Rating | Key Controls | Key Assurances on Controls | Gaps in Controls and Actions to address | Current Risk Rating | Target Risk Rating | Target Date
--- | --- | --- | --- | --- | --- | --- | ---
**Title:** Staff Engagement  
**Cause and Effect:** Should there be a deterioration of staff engagement with the Trust due to lack of confidence, this may lead to worsening morale and subsequent increase in turnover.  
**Impact:** This may lead to an impact on patient experience, quality, safety and risk the Trust’s aim to be an employer of choice  

| 3 (moderate) X 4 (likely) = 12 [High] | 1. Strategy; Workforce Strategy in place to address the underlying cultural issues within the Trust, to ensure freedom to speak up guardians are embedded and deliver the ‘Best Culture’.  
2. Culture Intervention: The Trust has engaged with specialist to deliver ‘You are the difference’ culture programme to instil tools for personal interventions to workplace culture and a parallel programme for managers to support individuals to own change.  
3. Staff Communications:  
   - Weekly Chief Executive communications email;  
   - Monthly Chief Executive all staff session (December 2018 onwards);  
   - Senior Team briefing pack monthly.  
4. Staff Survey results: Annual report to Board demonstrating:  
   - Trust scores across key domains;  
   - Comparative results from previous years and other organisations;  
   - Heat maps for targeted interventions.  
   - Local survey action plans to address key concerns.  
5. Leadership development programmes:  
   - Implemented to ensure leadership skills and techniques in place.  
6. Policies, processes and staff committees in place:  
   - Freedom to speak up guardian route to Chief Executive;  
   - Promoting professionalism pyramid for peer messaging concerns, actions and behaviours;  
   - Respect – countering bullying in the workplace policy;  
   - Joint staff (JSC) and local negotiating committees (JLNC) to engage with the workforce.  
7. Well-being interventions in place:  
   - Employee assistance programme and counselling;  
   - Advice and health education programmes;  
   - Connect 5 training front line staff to help people improve mental wellbeing and signpost to specialist support.  
8. Values embedded into the Trust and culture:  
   - Values-based recruitment (VBR) in place for medical and non-medical positions;  
   - Values-based appraisal in conjunction with performance. | 1. Workforce strategy in place from April 2018 to 31 March 2019.  
2. You are the difference (YATD) commenced in Q2 18/19, baseline and progress to be assessed [Feb. 2019];  
3. YATD Ambassador programme implemented to further embed ethos locally and sustain the programme.  
4. Communications routes well-established in Trust.  
5. Trust has become an ILM accredited centre;  
6. Programme in fourth year;  
7. Henley Business School MA leadership programme launched in Q4 18/19.  
8. Freedom to speak up guardians in place;  
9. Promoting professional pyramid in place, training for peer messengers continuing;  
10. Respect policy in place;  
11. JSC and JLNC in place.  
12. Employee assistance programme launched and live;  
14. VBR in place since June 2018;  
15. Qualitative and quantitative values-based appraisal in place since April 2018. | 3 (moderate) X 4 (likely) = 12 [High] | 3 (moderate) X 2 (unlikely) = 6 [Moderate] | March 2021

- Pulse surveys to be implemented to enable continuous feedback.  
- Values-based recruitment to be reviewed in March 2019.  
- Lower than average staff engagement score (staff survey 2017) of 3.66.  
- Solid and sustained engagement score (staff survey 2018) of 3.79.  
- Lower than average staff engagement in March 2019.  
- Average (3.79) - lower than average (3.79)
### APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

**COMPOSITE RISK: Our People**

**EXECUTIVE LEAD:** Director of Human Resources and Organisational Development

**LINKS TO STRATEGIC OBJECTIVE Four - We will enable our people to give their best and achieve their best**

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk Rating</th>
<th>KEY Controls</th>
<th>KEY Assurances on Controls</th>
<th>Gaps in Controls and Actions to Address</th>
<th>Current Risk Rating</th>
<th>Target Risk Rating</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE:</strong> Best staff to deliver the best of care</td>
<td>3 (moderate) X 4 (likely) = 12 [High]</td>
<td>1. Strategy: Workforce Strategy in place to address the underlying cultural issues within the Trust to deliver the 'Best Culture' with the best of people. 2. Right skills: The Trust has a fully-mapped competency profile for each position within the Trust and monitored against individual competency. Overall StatMan (statutory and mandatory training) compliance report to Board (bi-monthly) and internally weekly. 3. Right attitude and values: • Values-based recruitment (VBR) in place for medical and non-medical positions; • Values-based appraisal in conjunction with performance; • Promoting professionalism pyramid for peer messaging concerns, actions and behaviours; • Respect – countering bullying in the workplace policy.</td>
<td>Workforce strategy in place from April 2018 to 31 March 2019</td>
<td>Competency profile in place for all positions.</td>
<td>3 (moderate) X 12 [High]</td>
<td>3 (moderate) X 6 [Moderate]</td>
<td>March 2021</td>
</tr>
<tr>
<td><strong>TITLE:</strong> Continuity of care: The Trust monitors its substantive workforce numbers and recruits permanently whilst retaining flexibility of need and acuity: • Current contractual vacancy levels (workforce report) • Monthly reporting of vacancies and temporary staffing usage at PRMs; • Reporting to Board of substantive to temporary staffing paybill.</td>
<td></td>
<td>1. Trust vacancy rate at 17.5%; 2. Substantive workforce 82.4%; 3. Monthly PRM including discussion on workforce, vacancies, recruitment plan and temporary staffing.</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TITLE:</strong> Leadership development programmes implemented to ensure leadership skills and techniques in place.</td>
<td></td>
<td>1. Trust has become an ILM-accredited centre; 2. Programme in fourth year; 5. Henley Business School MA leadership programme launched in Q4 18/19.</td>
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</tr>
</tbody>
</table>

**COMPOSITE RISK: System Integration to deliver sustainable future system model of care**

**EXECUTIVE LEAD:** Director of Planning and Partnerships

**LINKS TO STRATEGIC OBJECTIVE: One - Integrated Health Care: We will work collaboratively with our local partners to provide the best of care and the best patient experience**

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk Rating</th>
<th>KEY Controls</th>
<th>KEY Assurances on Controls</th>
<th>Gaps in Controls and Actions to Address</th>
<th>Current Risk Rating</th>
<th>Target Risk Rating</th>
<th>Target Date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE:</strong> Failure of partnership working to deliver systems integration, stability and better patient services via the formation of an Integrated Care Partnership (ICP).</td>
<td>4 (major) X 4 (likely) = 16 [Extreme]</td>
<td>1. Establishment of fortnightly Medway &amp; Swale Transformation Board. &gt;Chair alternates between the CCG AO and MFT CEO. &gt;Membership is made up of executive from all provider and commissioning organisation &gt; System recovery is a standing agenda item. &gt;CIP &amp; QIPP plans as well as commissioners key transformational programmes monitored via the Board. 2. Systems wide strategic vision written in partnership with all sector partners. 3. Agreed Intergraded Care Partnership model in place with systems partners actively working to mobilise key collaborative elements. 4. A formal Strategy &amp; Planning Function has been established up within the Acute Trust.</td>
<td>1. Progress against system recovery and integration plans monitored independently via NHS England and NHS Improvement bi-monthly Assurance meetings. 2. Regular updates against milestones submitted to Executive and Board of Directors meetings. 3. Collaborative agreements drafted with corporate governance best practice utilised. 4. Legal advice procured regarding agreements. NHS England and NHS Improvement new models of care teams utilised for advice and guidance on process.</td>
<td>1. Unsure planning guidance form NSHE/I as to future models. 2. No formal legal vehicle in existence to facilitate alternative forms. 3. Patient and staff side engagement strategy needs to be further developed.</td>
<td>4 (major) X 12 [High]</td>
<td>3 (moderate) X 6 [Moderate]</td>
<td>March 2020</td>
</tr>
<tr>
<td><strong>TITLE:</strong> Patient and staff side engagement to facilitate alternative forms.</td>
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</table>

**NOTE:** The above table only includes risks rated 3 (Moderate) or above.
### APPENDIX 1: BOARD ASSURANCE FRAMEWORK - December 2018

**COMPOSITE RISK: Innovation**

**EXECUTIVE LEAD: Director of Finance**

**LINKS TO STRATEGIC OBJECTIVE:** Objective Two - Innovation: We will embrace innovation and digital technology to support the best of care

<table>
<thead>
<tr>
<th>Risk Description</th>
<th>Initial Risk Rating</th>
<th>KEY Controls</th>
<th>KEY Assurances on Controls</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>TITLE: Innovation</strong></td>
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<tr>
<td></td>
<td></td>
<td>1. Organisational structure devised to ensure services aligned and encourage innovation. Further work in progress on colocation of services to assist best working practices.</td>
<td>Development of longer term Innovation Strategy</td>
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<td></td>
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<td>2. Working with Getting it Right First Time (GIRFT) to improve efficiency and effectiveness of surgical pathways.</td>
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<tr>
<td><strong>CAUSE AND EFFECT:</strong></td>
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<td></td>
</tr>
<tr>
<td><strong>IMPACT:</strong></td>
<td>4 (major)</td>
<td>=</td>
<td>16 (Extreme)</td>
<td>4 (major)</td>
<td>4 (likely)</td>
<td>=</td>
<td>16 (Extreme)</td>
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<tr>
<td><strong>TITLE: Capability</strong></td>
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<td></td>
<td></td>
<td>1. Innovative front door model streaming to Primary Care (MEDOCC), ambulatory emergency centre and assessment areas. £1m capital investment received for Urgent Care Front Door.</td>
<td>IT Capability ▪ development of tender</td>
<td></td>
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<tr>
<td><strong>CAUSE AND EFFECT:</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>IMPACT:</strong></td>
<td>3 (major)</td>
<td>=</td>
<td>9 (High)</td>
<td>3 (major)</td>
<td>3 (possible)</td>
<td>=</td>
<td>9 (High)</td>
</tr>
<tr>
<td><strong>TITLE: Funding</strong></td>
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<tr>
<td></td>
<td></td>
<td>1. Trust investment in the R&amp;D department which has shown success attracting NHS and private funding for trials. Ensuring communication and engagement with patients eligible for trials so they are aware of opportunities to join trials.</td>
<td>Develop reporting mechanism to appropriate committees.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>2. Partnering arrangements being secured for managed services in a number of areas to enable cost of innovation to be spread over the life, as well as ensuring there is sufficient expertise for optimum implementation and adoption.</td>
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<td>3. IT project office has a programme for delivering a number of digital solutions in the year.</td>
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<td>4. Working across the STP on digital plan for interoperability between partners.</td>
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<tr>
<td><strong>CAUSE AND EFFECT:</strong></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IMPACT:</strong></td>
<td>3 (major)</td>
<td>=</td>
<td>9 (High)</td>
<td>3 (major)</td>
<td>3 (possible)</td>
<td>=</td>
<td>9 (High)</td>
</tr>
</tbody>
</table>
Appendix 2 - Risk Matrix

This chart shows the level of risk a risk represents and sets out the priority which should be given to each risk:

<table>
<thead>
<tr>
<th>Consequence</th>
<th>1 Rare</th>
<th>2 Unlikely</th>
<th>3 Possible</th>
<th>4 Likely</th>
<th>5 Almost Certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 Catastrophic</td>
<td>5 Moderate</td>
<td>10 High</td>
<td>15 Extreme</td>
<td>20 Extreme</td>
<td>25 Extreme</td>
</tr>
<tr>
<td>4 Major</td>
<td>4 Moderate</td>
<td>8 High</td>
<td>12 High</td>
<td>16 Extreme</td>
<td>20 Extreme</td>
</tr>
<tr>
<td>3 Moderate</td>
<td>3 Low</td>
<td>6 Moderate</td>
<td>9 High</td>
<td>12 High</td>
<td>15 Extreme</td>
</tr>
<tr>
<td>2 Minor</td>
<td>2 Low</td>
<td>4 Moderate</td>
<td>6 Moderate</td>
<td>8 High</td>
<td>10 High</td>
</tr>
<tr>
<td>1 Negligible</td>
<td>1 Low</td>
<td>2 Low</td>
<td>3 Low</td>
<td>4 Moderate</td>
<td>5 Moderate</td>
</tr>
</tbody>
</table>
## Title of Report
Communications and Engagement report

## Prepared By:
Glynis Alexander

## Lead Director
Glynis Alexander, Director of Communications and Engagement

## Committees or Groups who have considered this report
NA

## Executive Summary
In the past two months we have stepped up communications and engagement around our transformation and culture programmes. We have developed communications to raise awareness of our clinical strategy, beginning with a staff briefing. Externally we continue to engage with community groups to create opportunities to discuss improvements at the hospital, and to hear what’s important to patients and public. Our Governors have played an important role in engaging with local residents by holding events in Medway and Swale.

## Resource Implications
NA

## Risk and Assurance
NA

## Legal Implications/Regulatory Requirements
NA

## Improvement Plan Implication
Communications and engagement activity is aligned with the Better, Best, Brilliant transformation plan.

## Quality Impact Assessment
NA

## Recommendation
The Board is asked to note the report.

## Purpose and Actions required by the Board:

<table>
<thead>
<tr>
<th>Approval</th>
<th>Assurance</th>
<th>Discussion</th>
<th>Noting</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>

113 of 136
EXECUTIVE OVERVIEW

1.1 In the past two months we have stepped up communications and engagement around our transformation and culture programmes.

1.2 We have developed communications to raise awareness of our clinical strategy, beginning with a staff briefing.

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

1.4 Our Governors have played an important role in engaging with local residents by holding events in Medway and Swale.

ENGAGING COLLEAGUES

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

2.2 We have launched the ‘Making Medway Brilliant’ campaign to showcase some of the fantastic work taking place across the Trust to transform the care provided by the Trust.

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

2.4 In December, we launched a new monthly staff briefing and James Devine’s first briefing session was attended by more than 300 staff. The new briefings will also feature the presentation of the employee and team of the month awards. To support this, the Communications Team has relaunched the awards to encourage staff members to nominate colleagues.

2.5 The Trust clinical strategy was introduced at a senior manager and all staff session; staff have been encouraged to provide feedback.

2.6 Communications to promote awareness of the ‘You are the Difference’ culture led to significant number of bookings to the sessions from both managers and staff.

2.7 The Communications and Organisational Development teams have worked together to promote the NHS staff survey.

2.8 We have continued to implement the flu vaccination campaign and we are pleased to see that uptake for the vaccination has been good.

2.9 The team provided communications support for a number of festive activities, including the Christmas fair, staff song and Christmas card.
Report to the Board of Directors

3 MEDIA

3.1 Since the beginning of November this year the communications team has dealt with 22 interactions with local, regional and national media.

3.2 There was significant coverage of the opening of our new Emergency Department, with the event being the running theme for the entirety of BBC Radio Kent’s breakfast programme on the day through a live broadcast. BBC South East, ITV Meridian, the Medway Messenger and KMTV also covered the opening.

3.3 The visit by the Secretary of State for Health and Social Care generated a real buzz around the hospital, with staff in the Emergency Department, maternity and the prehabilitation unit showcasing their improvements. This led to significant media coverage.

3.3 Other positive stories have included a number of donations and Christmas visits to our children’s wards; the formal ‘ribbon-cutting’ of the Emergency Department; and three interviews with Trust staff by the Medway Messenger after their nomination for the local ‘Pride in Medway’ awards.

4 SOCIAL MEDIA

4.1 Since the last update Medway has retained its position as Kent’s most-followed acute Trust on both Twitter and Instagram, owing to an increased following across all social media channels.

4.2 Several key announcements were shared across our social media accounts in this period, resulting in more than 100,000 people viewing our posts throughout November and December (33,101 on Facebook and 86,900 on Twitter).

4.3 Medway’s social media account followers now total 4,435 on Twitter (up from 4,339 at the last update), 6,220 on Facebook (up from 6,038) and 1,151 on Instagram (up from 1,053).

4.4 Our social media channels notably raised awareness of a visit to the Trust by Health and Social Care Secretary Matt Hancock; the departure of former Chief Executive Lesley Dwyer; the opening of our new £11.5 million Emergency Department building; a special musical Christmas video message from our staff to the local community (which reached 20,000 people alone on Facebook); the success of the Christmas Fair which helped to raise money for the Medway Hospital Charity; our regular members’ and Governor events; and alternative treatment options for those considering visiting our Emergency Department during periods of increased pressure and throughout the winter period.
5 COMMUNITY ENGAGEMENT

5.1 Governors

5.1.1 We continue to actively engage with our local community. The majority of the people we are talking to are very complimentary of hospital services and the care our staff provide.

5.1.2 Since our last report the Trust’s Community Engagement Officer and governors held engagement stands at Sittingbourne Memorial Hospital and Sheppey Community Hospital.

5.1.3 Constituents welcomed the opportunity to speak with governors, asking questions about how services are commissioned and the Emergency Department and Walk in Centre.

5.1.4 They expressed concerns about hospital wastage and the training of overseas staff.

5.1.5 Our Governors and Chief Executive met members, patients and the public at Rainham Healthy Living Centre.

5.1.6 Here our community wanted reassurance that staff were receiving regular customer care training and are wearing their yellow name badges so that they can be easily identified.

5.1.7 Concerns were also raised over hospital access for emergency patient particularly at peak times.

5.1.8 Our governors were able to be part of Oasis Academy Dementia Café. The school runs regular café for local nursing home residents with Dementia.

5.1.9 The recent café was filmed by Songs of Praise and will be aired on Sunday 13 January 2019.

5.2 Members

5.2.1 We are regularly communicating with members. Our messages include the Chair’s update, Membership and Governor Engagement events and information about Trust fundraising activities.

5.2.2 We continue to hold membership recruitment events within the hospital.

5.2.3 Going forward we intend to increase our use of healthy living centres and community hospitals to engage with our local community and recruit members, as well as talking to people within the hospital.

5.3 Reaching out to less engaged audiences

5.3.1 In collaboration with the voluntary sector we have started to engage with victims of domestic violence.
5.3.2 Following the success of our Teddy Bear Hospital, we will be inviting children from local primary schools to the four planned Teddy Bear Hospital Sessions.

5.3.3 We have developed a good relationship with the NHS retirement fellowship and have been invited to give a presentation to their members in 2019.

5.4 Other engagement

5.4.1 We continue to support the organ donation committee to raise the awareness of organ donation among the BAME community.

5.4.2 In 2019 we will focus on how we can support BAME communities to promote this in their communities.
**Report to the Board of Directors**  
**Board Date: Thursday, 10 January 2019**  
**Agenda item: 7.1**

<table>
<thead>
<tr>
<th>Title of Report</th>
<th>Workforce Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepared By:</td>
<td>Elizabeth Nyawade, Deputy Director of HR &amp; OD</td>
</tr>
<tr>
<td>Lead Director</td>
<td>Leon Hinton, Executive Director of HR &amp; OD</td>
</tr>
<tr>
<td>Committees or Groups who have considered this report</td>
<td>Senior HR Team</td>
</tr>
</tbody>
</table>

**Executive Summary**

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

The Trust’s recruitment campaigns, including national, local and international have delivered 475 candidates to date – 50 candidates supplied to us by Cpl Healthcare and 165 candidates provided by HCL. The original Philippines recruitment plan for nursing continues with a total of 74 candidates being processed for posts at MFT.

Trust turnover has increased at 12.60% (+0.30%) from 12.30%, sickness absence at 4.20% (+0.10% from 4.10%) is above the Trust's tolerance level of 4%, and appraisal compliance has increased to 81.30% has remained the same compared to October and is below Trust target of 85%. Statutory and Mandatory training is at 74.39% (-0.32% from 74.71%) and is below Trust target of 85%.

The percentage of pay bill spent on substantive staff in November at (82%) remained the same compared to the month of October. The percentage of agency usage at 6% (+1% from 5%) is up compared to the month of October. The percentage of pay bill spent on bank staff at 12% in November is the same compared to October.

**Resource Implications**

None

**Risk and Assurance**

- Nurse Recruitment
- Temporary Staffing Spend

The following activities are in place to mitigate this through:

1. Targeted campaign to attract local and national nurses
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 Work stream as part of the 2018/19 cost improvement programme
Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators.

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).

Not applicable

Not applicable

<table>
<thead>
<tr>
<th>Purpose &amp; Actions required by the Board :</th>
<th>Approval</th>
<th>Assurance</th>
<th>Discussion</th>
<th>Noting</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐</td>
<td>☒</td>
<td>☐</td>
<td>☐</td>
<td>☒</td>
</tr>
</tbody>
</table>
1 INTRODUCTION

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

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During November 2018, 15 FTE registered nurses and midwives joined the Trust on a substantive basis, alongside 1 FTE substantive clinical support worker.

2.2 The initial international campaign in the Philippines continues. Harvey Nash, our international recruitment partner agency working on Filipino nurse recruitment campaign is continuing to process 74 of the Filipino nurses that remain engaged in the process. Six Filipino nurses have commenced in post via Harvey Nash. A further 15 Harvey Nash candidates have recently passed their International English language Test (IELTS); Seven of the candidates are expected to commence in post in the early part of 2019.

2.3 A total of 67 international nurses have undertaken the OSCE exam since April 2018 and 66 have passed. Five international nurses successfully undertook the OSCE exam in November 2018 and are now working in their allocated ward areas.

2.4 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Four Cpl international nurses have commenced in post, with 50 in the pipeline. Twenty four HCL nurses have also commenced in post, with a further 165 candidates with offers being processed.

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

2.6 To support the Trust in achieving its targets new campaigns are being launched with a select number of agencies: Medline, We Solutions, Ascend and Cromwell Medical Recruitment.
Report to the Board of Directors

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

<table>
<thead>
<tr>
<th>Agency Provider</th>
<th>Commenced</th>
<th>Pipeline</th>
<th>Agency total</th>
<th>Anticipated new starters over the next 12 months from pipeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harvey Nash</td>
<td>6</td>
<td>74</td>
<td>80</td>
<td>(10%) 7</td>
</tr>
<tr>
<td>Cpl Healthcare</td>
<td>4</td>
<td>50</td>
<td>54</td>
<td>(20%) 10</td>
</tr>
<tr>
<td>HCL</td>
<td>24</td>
<td>165</td>
<td>189</td>
<td>(26%) 43</td>
</tr>
<tr>
<td>Person Anderson</td>
<td>24</td>
<td>0</td>
<td>24</td>
<td>(100%) 0</td>
</tr>
<tr>
<td>Cromwell Medical</td>
<td>17</td>
<td>72</td>
<td>89</td>
<td>(28%) 20</td>
</tr>
<tr>
<td>Recruitment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSI Group</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>(20%) 1</td>
</tr>
<tr>
<td>Xander Hendrix</td>
<td>3</td>
<td>13</td>
<td>16</td>
<td>(54%) 7</td>
</tr>
<tr>
<td>We Solutions</td>
<td>4</td>
<td>43</td>
<td>47</td>
<td>(46%) 20</td>
</tr>
<tr>
<td>Blue Thistle</td>
<td>0</td>
<td>8</td>
<td>8</td>
<td>(0%) 0</td>
</tr>
<tr>
<td>Medline</td>
<td>0</td>
<td>37</td>
<td>37</td>
<td>(40%) 15</td>
</tr>
<tr>
<td>HealthPerm</td>
<td>0</td>
<td>7</td>
<td>7</td>
<td>(86%) 6</td>
</tr>
<tr>
<td>IELTS Medical</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>(100%) 1</td>
</tr>
<tr>
<td>EPSN</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>(100%) 0</td>
</tr>
<tr>
<td>Total</td>
<td>86</td>
<td>475</td>
<td>561</td>
<td>130</td>
</tr>
</tbody>
</table>

(\text{Table 1: Nurse recruitment pipeline as of November 2018})

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

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

<table>
<thead>
<tr>
<th>Role</th>
<th>Offers made in month</th>
<th>Actual starters</th>
<th>Actual leavers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered nurses &amp; midwives</td>
<td>66 (33 NHS Jobs/open days &amp; 8international nurses via skype)</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td>Clinical support workers</td>
<td>5</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

(\text{Table 2: Nursing starters and leavers November 2018})

2.8 During November 7 non-training medical staff joined the Trust including 1 ED SAS, 1 MTI and 5 Trust Grade doctors’ backfilling vacant trainee posts.
3 DIRECTORATE METRICS

3.1 The table below (table 3) shows performance across five core indicators by the directorate. Turnover, at 12.60% (+0.30% from 12.30%), remains above the tolerance level of 8%. HR Business Partners will work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let’s work together commissioned by Health Education England) and staff survey results to implement service specific retention plans. Sickness absence at 4.20% (+0.10% from October) is above the tolerance level of 4%. Employee Relations are proactively carrying out analysis to support managers to manage sickness and reviewing trends for interventional support.

3.2 The Trust appraisal rate stands at 81.3% same as October and is below the Trust target of 85%, two directorates (Corporate and Estates and Facilities) are meeting the appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings have been included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics. Statutory and Mandatory training stands at 74.39% (-0.32% from 74.71%) and is below Trust target of 85%.

<table>
<thead>
<tr>
<th>Metric</th>
<th>Trust</th>
<th>Corporate</th>
<th>Estates &amp; Facilities</th>
<th>Planned Care</th>
<th>Unplanned &amp; Integrated Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Turnover rate (Voluntary, 12-month rolling)</td>
<td>8.0%</td>
<td>12.6%</td>
<td>16.0%</td>
<td>5.8%</td>
<td>11.8%</td>
</tr>
<tr>
<td>Vacancy rate</td>
<td>12.0%</td>
<td>17.4%</td>
<td>15.6%</td>
<td>17.7%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Sickness rate (12-month rolling)</td>
<td>4.0%</td>
<td>4.2%</td>
<td>2.7%</td>
<td>6.1%</td>
<td>4.3%</td>
</tr>
<tr>
<td>Statutory &amp; Mandatory Training</td>
<td>85.0%</td>
<td>74.4%</td>
<td>86.0%</td>
<td>58.8%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Medway Appraisal</td>
<td>85.0%</td>
<td>74.4%</td>
<td>86.0%</td>
<td>58.8%</td>
<td>75.7%</td>
</tr>
<tr>
<td>Agency costs (as % of total payroll)</td>
<td>4.0%</td>
<td>4.2%</td>
<td>0.2%</td>
<td>3.4%</td>
<td>5.3%</td>
</tr>
<tr>
<td>Bank costs (as % of total payroll)</td>
<td>12.4%</td>
<td>2.8%</td>
<td>8.9%</td>
<td>9.9%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Substantive costs (as % of total payroll)</td>
<td>83.6%</td>
<td>93.0%</td>
<td>91.2%</td>
<td>86.8%</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

(Table 3: Key workforce metrics)
Report to the Board of Directors

4 TEMPORARY STAFFING

Table 4 below demonstrates that temporary staffing expenditure increased in November compared to October 2018.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Spend</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td>3,890,198</td>
<td>943,419</td>
<td>1,502,866</td>
<td>1,003,597</td>
<td>895,452</td>
<td>799,288</td>
<td>968,606</td>
<td>881,163</td>
<td>988,934</td>
</tr>
<tr>
<td>Bank</td>
<td>920,473</td>
<td>2,307,191</td>
<td>2,003,992</td>
<td>1,939,086</td>
<td>2,914,663</td>
<td>1,441,538</td>
<td>2,231,622</td>
<td>2,145,475</td>
<td>2,068,000</td>
</tr>
<tr>
<td>Substantive</td>
<td>13,611,458</td>
<td>13,904,703</td>
<td>14,328,856</td>
<td>14,032,556</td>
<td>14,112,477</td>
<td>14,916,485</td>
<td>13,681,072</td>
<td>14,213,731</td>
<td>14,283,166</td>
</tr>
<tr>
<td><strong>% Pay bill</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Agency</td>
<td>21%</td>
<td>5.5%</td>
<td>8%</td>
<td>6%</td>
<td>5%</td>
<td>6%</td>
<td>5%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Bank</td>
<td>5%</td>
<td>13.5%</td>
<td>11%</td>
<td>11%</td>
<td>16%</td>
<td>8%</td>
<td>13%</td>
<td>12%</td>
<td>12%</td>
</tr>
<tr>
<td>Substantive</td>
<td>74%</td>
<td>81%</td>
<td>81%</td>
<td>83%</td>
<td>79%</td>
<td>87%</td>
<td>81%</td>
<td>82%</td>
<td>82%</td>
</tr>
</tbody>
</table>

(Table 4: Workforce profile based on contractual arrangement)

4.1 The agency cap breaches across all staff groups continues to decrease as illustrated in chart 1 below. During the month of November 2018 the Trust reported an average of 12 breaches per week.

4.2 The Trust’s NHSi annual agency spend ceiling has decreased from £21.6m in 2017/18 to £17.88m (corrected ceiling based on Model hospital figures) in 2018/19. Based on cumulative agency spend YTD, the Trust is £3.94m below the NHSi agency ceiling cap target as illustrated in the chart and table below.
Report to the Board of Directors

Table 5 below shows NHSI agency ceiling performance

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Cumulative NHSI ceiling target</td>
<td>£2,980,000</td>
<td>£4,470,000</td>
<td>£5,960,000</td>
<td>£7,450,000</td>
<td>£8,940,000</td>
<td>£10,430,000</td>
<td>£11,920,000</td>
</tr>
<tr>
<td>Agency in month actual spend</td>
<td>£1,502,866</td>
<td>£1,003,597</td>
<td>£895,452</td>
<td>£799,288</td>
<td>£986,606</td>
<td>£881,163</td>
<td>£988,934</td>
</tr>
<tr>
<td>Cumulative below ceiling</td>
<td>£539,882</td>
<td>£1,020,285</td>
<td>£1,620,833</td>
<td>£2,311,544</td>
<td>£2,832,938</td>
<td>£3,441,775</td>
<td>£3,942,842</td>
</tr>
</tbody>
</table>

4.3 Temporary nursing demand in November 2018 decreased compared to October 2018 (8,675 shift requests in October 2018 compared to 7,937 shift requests in November 2018). The fill rate increased to 79% (+5%). Medical locum demand increased in November 2018 compared October 2018 (1,137 shift requests in October 2018 compared to 1,704 shift requests in November). The fill rate increased to 93%.

5 RETENTION PROGRAMME

5.1 Retention of the workforce at MFT remains a focus given a turnover rate of 12.60% as at end of November 2018. It is vital to understand what matters to staff, if we are to retain them. To demonstrate added focus, the Trust recently signed up for the retention direct support programme cohort 4 by NHS Improvement in October 2018; whilst this support for retention is directed at nursing staff the initiatives suggested can be applied to all staff groups.
Appendix I lists out the delivery plan for the forthcoming year with regards to understanding and improving turnover and includes actions for each stage of the employee journey:

- Attraction to Medway;
- Post offer to hire;
- Induction to Medway;
- Staying at Medway;
- Leaving Medway.

Retention direct support programme by NHSI cohort 4: The aim of the direct support programme is for Trusts to develop a retention plan over a 120 day period. This programme should be clinically led and it is targeted at improving nursing retention. The support offered includes:

- Identified lead for the Trust to help develop the action plan during the 120 days;
- Access to NHSI retention resources portal with details of initiatives used by other NHS organisations;
- A detailed pack for MFT, source ESR, for trends in our Turnover rates, reasons for leaving and age profile.

NHSI recommends focussing on 3 main actions, listed below, that have had demonstrable success and caution that it will take at least 12 months’ for organisations to see impact:

- Early years’ careers support;
- Internal rotation programme;
- Pastoral care support for new starters and qualified nurses joining the Trust at the start of their careers.

The measures of success of this programme of work will be measured by improved stability rate; lower turnover rate for specific staff groups; a reduction in the cost of temporary staffing; improved metrics for quarterly friends and family test and staff survey; qualitative stories collated from staff about their experiences of working at MFT and shared with existing and applicants.

NMC LANGUAGE TEST REQUIREMENTS

Changes to language test requirements for nurses and midwives:

With effect from 5 December 2018, the NMC will accept level 6.5 score in writing for overseas nurses taking the International English Language Test System (ILETS) test instead of a level 7 score. However, a level 7 score will still be required for the reading, listening and speaking tests. The change is in line with the nursing regulators' commitment to 'better, safer care and will ensure that only nurses and
midwives with the right skills, knowledge and command of the English are able to register to work in the UK’. NHS Employers welcomed the change stating that it will increases access for much needed nursing talent. This change means that candidates who took the test and attained a level 6.5 score can submit their results to the regulator, if these are less than two years old. It is the expectation that MFT will benefit by seeing an increase in the number of candidates coming through the international recruitment pipeline.

7 ILM ACCREDITATION

7.1 Institute of Leadership and Management accreditation:

In November 2018, the Trust achieved accreditation from the Institute of Leadership and Management (ILM) for the in-house delivered level 5 Certificate in Leadership and Management course. Staff undertaking level 5 Certificate in Leadership and Management course, aimed at colleagues in bands 5-7, will now be awarded with a certificate from the ILM. In addition, the Trust will be able to generate income by offering this leadership programme to neighbouring organisations. Future plans following receipt of the accreditation include the Trust applying to City and Guilds to convert the level 5 Certificate in Leadership and Management course into an apprenticeship to enable drawing down funds from the levy. This will result in increased income generation that can be used to invest in developing further leadership courses for our staff. The accreditation is testament to the quality of the in-house developed and delivered leadership course.

End
### APPENDIX I: RETENTION PROGRAMME DELIVERY PLAN

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Description</th>
<th>Stage</th>
<th>Q4 18/19</th>
<th>Q1 19/20</th>
<th>Q2 19/20</th>
<th>Q3 19/20</th>
<th>Q4 19/20</th>
<th>Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHSI focus</td>
<td>NHSI recommends focussing on 3 main actions, listed below, that have had demonstrable success and caution that it will take at least 12 months’ for organisations to see impact: Early years’ careers support; Internal rotation programme; Pastoral care support for new starters and qualified nurses joining the Trust at the start of their careers</td>
<td>throughout employee journey</td>
<td>Develop</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Stability Index &amp; Staff Survey</td>
</tr>
<tr>
<td>Career Stories</td>
<td>A story for posts advertised – these will help applicants to understand what a day in the life of an employee looks like</td>
<td>Attraction</td>
<td>Develop</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Stability Index</td>
</tr>
<tr>
<td>Values-based recruitment (VBR)</td>
<td>Values-based recruitment (VBR) – this can help to contribute to a reduction in staff turnover by ensuring from the outset that staff recruited fit within the organisation’s values. The Trust implemented VBR in Q2, an assessment of the impact will be carried out at the end of Q4</td>
<td>Recruitment selection</td>
<td>Delivery</td>
<td>Review</td>
<td></td>
<td></td>
<td>Turnover</td>
<td></td>
</tr>
<tr>
<td>Flexible working advertising</td>
<td>Advertising posts stating that flexible working is welcome in the form of part-time, job shares and annualised hours</td>
<td>Attraction</td>
<td>Develop</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Turnover &amp; Staff Survey</td>
</tr>
<tr>
<td>Onboarding portal</td>
<td>Online portal detailing all staff benefits available, values and other orientation material</td>
<td>Onboarding</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Turnover</td>
</tr>
<tr>
<td>Keeping in touch comms</td>
<td>Regular communications throughout the onboarding period (from unconditional offer to hire) detailing one or two specifics about the organisation, about the team, about the future</td>
<td>Onboarding</td>
<td>Develop</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Turnover</td>
</tr>
<tr>
<td>Social media forum</td>
<td>Create a closed social media group for new starters to engage with HR colleagues</td>
<td>Onboarding</td>
<td>Develop</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Turnover</td>
</tr>
<tr>
<td>Meet the Director of Nursing</td>
<td>Inviting newly qualified and new starter nurses to tea with the executive director of nursing; this will demonstrate support for nurses in their new roles</td>
<td>Induction</td>
<td>Delivery</td>
<td>Review</td>
<td></td>
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<td>Stability Index</td>
<td></td>
</tr>
<tr>
<td>Preceptorship development</td>
<td>Develop a robust preceptorship programme full of clinical skills to empower the new nurses at the start of their career journey with the Trust</td>
<td>Induction</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Stability Index</td>
<td></td>
</tr>
<tr>
<td>Preceptor visibility</td>
<td>Provide pin badges for preceptors to wear which highlights to others that the practitioner is in their transitional phase to supporting learning</td>
<td>Induction</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Stability Index</td>
</tr>
<tr>
<td>Stay conversation</td>
<td>What made you join MFT? What would make you stay at MFT? What would make you leave MFT? A quarterly conversation with all new starters in the first 12 months; A six-monthly conversation with staff under 2 years of service but over 12 months; An annual discussion with existing staff – probably incorporating this in the annual appraisal process</td>
<td>Throughout employee journey</td>
<td>Develop</td>
<td>Delivery</td>
<td></td>
<td>Review</td>
<td>Turnover, Stability Index and Staff survey</td>
<td></td>
</tr>
<tr>
<td>Itchy feet discussion</td>
<td>These include having conversations with employees considering leaving but have not made up their mind. Nominate a career development lead for each staff group that can be contacted by staff to discuss professional and personal career development; Introduce career clinics, run on a monthly basis; Implement internal transfer scheme to allow staff to move wards or departments rather than leave the organisation; Invest in a helpline for staff considering to leave to talk to HR staff or other who may be able to advise and address any issues</td>
<td>Throughout employee journey</td>
<td>Develop</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Turnover</td>
</tr>
<tr>
<td>Exit intelligence</td>
<td>Review exit processes across teams to promote exit questionnaires, interviews to improve response rate and intelligence gathered for analysis and feedback to areas.</td>
<td>Exit</td>
<td>Develop</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Delivery</td>
<td>Review</td>
<td>Turnover</td>
</tr>
</tbody>
</table>
8.1

The Quality Assurance Committee (QAC) received an update on progress with the Care Quality Commission (CQC) improvement plan. The QAC expressed some concern at the pace of implementation with six out of 12 must-do recommendations still with evidence of compliance outstanding. Significant progress is expected to be reported at the January meeting of QAC.

The QAC received a detailed presentation from the Medical Director on HSMR and the work to understand what is driving the current upward trend. Discussions continue with NHS Improvement, the CCG and Dr Foster to agree the most appropriate handling and reporting of this issue. However, since the QAC meeting, the Chief Executive has asked the Medical Director to intensify the focus on this work through a four-week review of the data.

The QAC received a draft Safeguarding Adults and Children’s Annual Report 2017 - 2018 and requested additional detail to be included regarding where safeguarding concerns have been raised against the trust. In addition, the Committee also requested that an introduction be added to the report and for the report to be consistent in presentation before submission to board. The report will come for information to a subsequent Board meeting.

Other matters considered by the committee:

- Progress with the new quality dashboard
- Oral update on the process for Quality Impact Assessment (QIA) of service change
- Directorate assurance report – focus on winter preparation
- CQUIN programme 2018/19
### Key decisions made/ actions identified:

- Additional details to be included to the draft Safeguarding Adults and Children’s Annual Report 2017 - 2018.

### Risks:

- Key area discussed was the DIPC report and follow up steps agreed.

### Assurance:

- A regular focus on QIA of service change will provide assurance as the Transformation Programme progresses.
# Key Issues Report

**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.

<table>
<thead>
<tr>
<th>Name and Job Title of Member</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sept</th>
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<tr>
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<tr>
<td>Ewan Carmichael, NED</td>
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<td>Diana Hamilton-Fairley, Director of Strategy</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Karen Rule, Director of Nursing</td>
<td></td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Jon Billings, NED &amp; Chair</td>
<td></td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Adrian Ward, NED</td>
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<tr>
<td>David Sulch, Medical Director</td>
<td></td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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</tbody>
</table>
Matters for escalation

1. Actual deficit figure to be produced in the event the A&E financial target or any of the financial numbers are not achieved.
2. Clarity to be provided on the range of possible deficits that is likely to be acceptable going into the next financial year, for the Committee to assess the Trust’s position within that range.
3. Cost Improvement Programme: Report to be provided on the additional pressures to the required £21m to achieve the control total.
4. Report on the number of plans that make up the integrated Plan.

Other matters considered by the group:

1. Financial position at Month 7 £12k favourable to plan.
2. The forecast year end position has been maintained at £46.9million pre-PSF (Provider Sustainability Funding). Achieving this deficit is considered the best case scenario with the range of possible deficits ranging from £46.9million to £54.8million.
3. At Month 7, £10.48m has been delivered in Cost Improvement Programmes (CIPs) YTD, which is £2.4m favourable to the phased plan of £8.1m. There are additional pressures to the required £21m to achieve the control total.
4. Cash position better than last year’s; with 40% of invoices being paid within 30 days of invoice date and ongoing work to ensure robust processes are in place.
5. A number of facilitated sessions held to discuss the Business Plan. A top-down, bottom-up approach will be taken to identify gaps.
6. Pathology Assurance Group introduced. This will see NEDs in attendance from Dartford and Gravesham and Medway Foundation Trusts, with CEO input.
Key decisions made/ actions identified:

Additional to actions included under matters for escalation.

1. Plans to be shown against the benchmark in the Hospital Model tool. A tool could be chosen during the course of the year for discussion.
2. Report on the CIP and the pressures over the course of the next few months.

Risks:

1. No new risks identified

Assurance:

1. Ongoing discussions at the Executive Group about meeting the trajectory and steps being taken to achieve this.
2. Progress on the deficit is also discussed at the Transformation Assurance Group (TAG).
3. The Quality Impact Assessment (QIA) process to be presented to the Quality Assurance Committee to provide assurance that none of the Trust’s QIPP schemes compromise safety and quality.
**Matters for escalation**

1. Conflicts of Interest Policy to be reviewed, setting out expectation; reissue to staff and review yearly.
2. Non-responses for the five overdue recommendations relating to the Homecare Services to be followed up.
3. Internal auditors to produce a list of the high priority recommendations that had been accepted by the Trust in the last 18 months, with their status.
4. Trust Board to have sight of the Integrated Annual Report and Accounts timetable.
5. More narrative to be provided on the losses and special payments report going forward.
6. Declaration of interest to be a standing item on the agenda going forward.

**Other matters considered by the group:**

1. On internal audit, 16 outstanding recommendations were reported, with eight new recommendations raised since August 2018, and five overdue recommendations. Of the eight new recommendations (which relate to the audits of Adult and Child Safeguarding) four have been accepted and three have been partially accepted. Recommendations which are not yet due for implementation relate to Data Quality, Homecare Services and Nurse Revalidation reviews. The five overdue recommendations relates to the Homecare Services review.

2. Internal Audit reports were presented on Adult Safeguarding and Child Safeguarding. Both received an overall assessment of significant assurance with minor improvement opportunities (amber-green rating). The areas flagged for improvement include mandatory training compliance rates and getting timely updates from the Local Authority since the introduction of the general Data Protection Regulation.

3. On Local Counter Fraud Specialist (LCFS) service, fieldwork has been completed on the invoice fraud review, which led to criminal conviction. The LCFS will work with the communications team to include this information in the LCFS newsletter.

4. On external audit, the Audit Plan is to be presented to the Committee at its meeting in February 2019. The Committee was informed of some accounting standards changes which would pose concern for...
implementation across the NHS, particularly around IFRS 9 (Financial Instruments) and IFRS 15 (Revenue from contract with customers), which became relevant from 1 April 2018.

5. The Committee noted the key dates in relation to the production of the 2018/19 Annual Accounts.

6. The Committee queried the losses and special payments numbers, which appeared to be low compared to the previous year.

7. The Committee received the single tender waiver report and queried the management apprenticeship figure.

8. The Committee was advised that the Board Assurance Framework (BAF) will be reviewed in detail by the Board at its development session.

9. The Committee discussed the self-assessment form. The Non-Executive Directors were satisfied that steady progress has been made on improving processes. However, further improvement is required.

The Committee approved the recommendation to continue to work with the Trust’s current Valuer, District Valuer Services, for 2018/19, to resolve the issues raised by the external auditors for the last two annual audits and therefore defer a change in Valuer until 2019/20, when a full revaluation will be required.

No new risks identified. The BAF was reviewed by the Board at its development session in December 2018.

Assurance was provided on:

1. Progress with the recommendations from audit reports.

2. Reviews of Adult Safeguarding and Child Safeguarding both received an overall assessment of significant assurance with minor improvement opportunities (amber-green rating).

3. Testing the weakness revealed by the invoice fraud and segregation of duties in place for raising invoices through to making payments.

4. Having an online training system commissioned in August 2018 with NHS Elect to assist with mandatory online training.

5. Developing a system to have a summary of the outstanding internal audit actions reviewed by the Executive team on a monthly basis.

6. Committee self-assessment: The Non-Executive Directors were satisfied that the Committee has complied with its obligations and expectations as noted in its terms of reference, with steady progress being made on improving processes. However, further improvement is required.