Agenda

Public Meeting of the Trust Board

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

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

Item	Subject	Presenter	Time	Action	Format
1.	Patient Story	Director of Nursing	12.30pm	Discuss	Paper
Opening of the Meeting					
2.	Chair's Welcome	Chairman	1.00pm	Note	Verbal
3.	Quorum	Chairman		Note	Verbal
4.	Register of Interests	Chairman		Note	Paper
Meeting Administration					
5.	Minutes of the previous meeting held on 18 January 2018	Chairman	1.05pm	Approve	Paper
6.	Matters Arising/Action Log	Chairman		Note	Paper
Main Business					
7.	Chair's Report	Chairman	1.10pm	Note	Verbal
8.	Chief Executive's Report	Chief Executive	1.15pm	Note	Paper
9.	Strategy a) STP Update b) Trust Improvement Plan Better Best Brilliant	Chief Executive Deputy CEO/Executive Director of HR & OD	1.20pm	Note Discussion	Paper Paper
10.	Quality a) IQPR b) CQC Preparedness	Director of Nursing & Medical Director	1.35pm	Discussion	Paper Paper

Agenda

11.	Performance a) Finance Report b) Communications Report	Director of Finance & Business Services Director of Communications	1.45pm	Discussion Discussion	Paper Paper
12.	Governance a) Corporate Governance	Trust Secretary	2.05pm	Assurance	Paper
13.	People a) Workforce Report b) Gender Pay Gap Report	Director of Operational HR	2.10pm	Assurance	Paper
For Approval					
14.	Quality Assurance Committee Terms of Reference	Trust Secretary	2.20pm	Approve	Paper
15.	Audit Committee Terms of Reference		2.25pm	Approve	Paper
16.	Finance Committee Terms of Reference		2.30pm	Approve	Paper
Reports from Board Committees					
17.	Quality Assurance Committee Report	QAC Chair	2.35pm	Assurance	Paper
18.	Integrated Audit Committee Report	IAC Chair	2.45pm	Assurance	Paper
19.	Finance Committee Report	FC Chair	2.55pm	Assurance	Paper
For Noting					
20.	Overview of the process for the 2017/18 Annual Report	Trust Secretary	3.05pm	Note	Paper
21.	North Kent Pathology Service Update	Director of Finance & Business Services	3.10pm	Note	Paper
22.	Council of Governors' Update	Governor Representative	3.20pm	Discussion	Verbal
23.	Any other business	Chairman		Note	Verbal
24.	Questions from members of the	Chairman		Discussion	Verbal

	public				
Close of Meeting					
	Date and time of next meeting: 3 May 2018 Boardroom, Post Graduate Centre, Medway NHS Foundation Trust				

NHS
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MEDWAY NHS FOUNDATION TRUST

REGISTER OF INTERESTS FOR BOARD MEMBERS

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

		• Director of Lloyds Halifax Premises Limited • Director of Lloyds Gresham Nominee1 Limited • Director of Lloyds Gresham Nominee 2 Limited • Director of Lloyds Commercial Properties Limited • Director of Lloyds Bank Properties Limited • Director of Lloyds Commercial Property Investments Limited • Director of Lloyds Target Corporate Services Limited
9.	Karen Rule Director of Nursing	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds.
10.	Mark Spragg Non-Executive Director	• Trustee for the Marcela Trust • Trustee of the Sisi & Savita Charitable Trust • Director of Mark Spragg Limited • Chair of the Medway NHS Foundation Trust Integrated Audit Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
11.	Tracey Cotterill Director of Finance and Business Services	• Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds
12.	Adrian Ward Non-Executive Director	• Trustee of the Bella Moss Foundation • Director of Award Veterinary Sciences Limited • Chair of NMC Fitness to Practice Panel • Member of the RCVS Preliminary Investigation Committee • Member of the BSAVA Scientific Committee • Member of the Corporate Trustee of Medway NHS Foundation Trust Charitable Funds • Member of the Medway NHS Foundation Trust Quality Assurance Committee

Meeting in Public

NHS Medway NHS Foundation Trust

Board of Directors Meeting in Public on 18/01/2018 held at Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members:	Name:	Job Title:	Initial
	Mr S Clark	Chairman	SC
	Mrs L Dwyer	Chief Executive	LD
	Mrs J Palmer	Non-Executive Director	JP
	Mr J Billings	Non-Executive Director	JB
	Mr E Carmichael	Non-Executive Director	EC
	Mr T Moore	Non-Executive Director	TM
	Mr M Spragg	Non-Executive Director	MS
	Dr D Hamilton-Fairley	Medical Director	DHF
	Mrs T Cotterill	Director of Finance and Business Services	TC
	Mr J Devine	Director of HR and OD and Director of Improvement	JD
	Mrs K Rule	Director of Nursing	KR
Attendees:	Ms G Alexander	Director of Communications	GA
	Ms D King	Governor Board Representative	DK
	Mr C Bradley	2020 (item 9b only)	CB
	Ms S Bennett	Patient (presentation only)	SB
	Mr J Lowell	Director of Clinical Operations	JL
	Mrs A Meadows	Assistant Trust Secretary (minute taker)	AM
	Dr D Sulch	Deputy Medical Director for Unplanned Integrated Care	DS
	Mr K Hunt	Liaison	KH
Apologies:	Mr A Ward	Non-Executive Director	AW
	Ms S Murphy	Trust Secretary and Director of Corporate Governance and Legal	SMM
	Mr B Stevens	Director of Clinical Operations	BS

1. Patient Story

1.1 SB attended to provide detailed account of her positive experience at the Birth Place. SB was very grateful to members of staff who cared for her and allayed her fears during child birth. The Board was grateful to SB for sharing such a personal account of her delivery and for such positive feedback of the care provided.

2. Welcome and Apologies for Absence

2.1 The Chairman welcomed everyone to the meeting.

2.2 Apologies for absence were noted as stated above.

2.3 DHF introduced DS who had just joined the Trust as Deputy Medical Director for Unplanned Integrated Care and will also be leading on clinical effectiveness and research programmes. DHF noted that DS is an expert in Stroke and would help in improving the Trust's stroke pathways.

2.4 JD introduced KH from Liaison and noted that the Trust had been working with Liaison on improving the booking systems and the cost base for medical locums in particular.

3. Quorum

3.1 It was confirmed that the meeting was quorate.

4. Register of Interests

4.1 This was noted.

5. Minutes of the Previous Meeting

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

6. Matters Arising and Action Log

6.1 The Board of Directors **RECEIVED** the Action Log

6.2 0392, 0393 and 0394 – It was agreed that these actions should be closed
0395 – It was noted that Deloitte would be coming to assist with the risk statement
0396 – It was noted that the action should be left open - JD to follow up

7. Chair's Report

7.1 SC noted that in the depth of winter, the Trust had faced the same challenges as elsewhere; high levels of attendance, with some very unwell patients. However staff did their best to minimise waits, maintain flow and ensure patients were discharged in a timely way. SC thanked staff for the hard work they do on behalf of the Trust. SC noted ED improvements and thanked LD and the team for their support.

7.2 SC noted there is now flu in the community and there has been a sharp rise in the number of cases nationally. Whilst the Trust's vaccination rate (64 per cent) is a little higher than the national average (59 per cent currently) SC emphasised that this is not as high as the Trust would like and urged everyone who has not had the vaccination to do so especially the frontline staff and all other staff who care for patients.

7.3 .SC noted that the Trust is moving forward in its improvement programme and extended thanks to all members of staff. SC provided updates on the community services review and stakeholder engagement.

7.4 SC made reference to the yellow names badges (Hello, My Name Is…) worn by staff and noted that these are now worn in many countries around the world. SC noted that Chris Pointon was a speaker at a clinicians' Grand Round educational session last week where he impressed on the audience that the patient-centred care that the Trust aspires to means always treating patients with respect, and addressing them as individuals.

8. Chief Executive's Report

8.1 The report was taken as read.

9. Strategy

9a) Sustainability and Transformation Partnership (STP) Update

9.1 DHF highlighted the current STP activities in Medway and the rest of Kent. DHF noted that the development of the clinical strategy, a key piece of work in relation to the future provision of healthcare, is now moving forward.

9.2 In relation to the Stroke Review, DHF noted that consultation on stroke services will take place over the coming months following a long period of review and engagement. The five options going out for consultation are to go live soon and MFT features in three out of five. It was noted that the consultation process is to last between ten to twelve weeks. DHF noted a recent positive meeting where DHF, LD and an officer from the Council had a discussed the consultation sharing the same view on how to respond to it.

9.3 DHF also noted that East Kent is to go out for consultation shortly on the configuration of their emergency services with more details to be provided in the near future on the potential of building a new hospital. Questions were taken. SC thanked DHF.

9b) Trust Improvement Plan

9.4 JD noted the monthly report around the improvement programme and explained that the report focuses on delivery sprint.

9.5 JD mentioned that 16 schemes were identified to bring about financial or efficiency gains focussing on three primary areas; theatres, pre-assessment and radiology.

9.6 It was noted that the report includes the governance process ad timescale being walked through around these particular projects. JD noted that the schemes are led by programmes in the new structure with 2020 helping to improve capabilities.

9.7 CB briefed Board on sustainability noting that the 2020 contract ends in March. CB noted that hand over would ensure work could continue effectively. The vision in the next three months is to develop a plan to run improvement and pass on capabilities.

9.8 JD noted that the aim of the sprints is to improve efficiency and assured Board that work will continue to do so. JD noted that there are a number of work streams but the Executives have decided to focus on 6 streams which will help deliver the other ones.

9.9 Following a query raised by JB in relation to the radiology project and how this could be calibrated, it was confirmed that the Trust has external support to do this work, benchmarking was required to understand how to achieve the national average. Guy's and St. Thomas' Hospital was used as a benchmark and the Trust is also learning from other organisations. TC added that the Trust is looking at a holistic radiology strategy and how it fits into the estates strategy.

9.10 TM made reference to the contract with 2020 which is coming to an end and advised that progress made so far should be measured.

ACTION: KPI on each area 2020 has worked on to be presented to Board to assess progress in March.

10 Quality

10a) IQPR

10.1 The report was taken as read. The Board was asked to note the IQPR for November performance.

10.2 KR made reference to an infection control case reported in November and noted the processes in place for stronger antimicrobial stewardship.

10.3 KR noted that two never events were reported in November. KR explained that the first case is being closely monitored after an initial investigation while the second has been fully investigated with safety alerts immediately circulated before investigations commenced. KR provided assurances that the Trust will continue to monitor safety and quality indicators closely although it has been a really busy period. All escalation areas were open which resulted in additional pressure on staffing. Processes put in place to meet with the high demands of the period were noted.

10.4 KR noted mixed sex accommodation breaches reduced in November but there is a significant increase now due to higher demand. However, patient safety is priority this period following the guidance issued. JL noted that due to the extreme pressure in November/December in ED, the four hour target was a challenge but the Trust coped at 90.45% performance in November. The four hour target issue was linked directly to flow.

10.5 JL noted that with colleagues from across the sector nationally having similar pressure, the period experienced the highest level of escalation. The escalation ward was opened on the 27 of December.

10.6 It was noted that there was focus on delayed transfer of care rate which resulted in more progress compared to past years and one of the best in the country. Other pieces of work being considered are evening calls, executive presence almost 24 hours daily, etc. It was noted that these are well received.

10.7 It was noted that RTT performance slightly decreased to 81.76% from 83.32 %. Four specialties have back logs with Dermatology constituting the highest. The factors responsible were explained and assurances provided that action plans are being prepared to address the back log. It was noted that 52 weeks target went down by 7 - a good trajectory. It was noted that Diagnostics deteriorated slightly.

10.8 It was noted that the Trust is compliant with all the cancer standards. Work has taken place on the trajectory previously set. The support and funding from NHSI was noted. There are daily huddles with discussion around cancer

pathways for individual patients. The cancer improvement plan is also being worked on. Questions were taken.

10.9 JB suggested that debrief on quality and safety could be reported through the quality assurance committee rather than come to Board.

10.10 SC noted Kent wide activities and advised the Trust to bench mark itself with the IQPR reflecting this.

10b) Mortality Report

10.11 The report was taken as read. DHF noted the first edition of the new national framework for NHS Trusts - 'National Guidance on Learning from Deaths' and explained that the focus of the new framework is on the quality of care received by patients (whether or not death is avoidable), improving governance processes around patient death and ensuring the families/carers of patients who have died in care are properly involved at every stage.

10.12 It was noted that the new framework includes new board leadership roles, a new system of 'case record reviews', quarterly reporting of specific information about deaths in care and a new Trust policy on how individual organisations will be implementing all this.

10.13 The Board was asked to note the updated Learning from Deaths Dashboard for Q1 and Q2 which is a national dashboard that has been developed. DHF noted that the revised dashboard is a significant step forward as to how death is investigated. DHF advised that this will be brought to Board quarterly in line with the national requirement.

10.14 DHF noted that the revised Responding to Deaths Policy within the report which incorporates the NHSI/RCP updates was for noting and advised that this would be the Trust's Policy on Mortality.

10.15 The Board **APPROVED** the revised Responding to Deaths Policy as the Trust's Mortality Policy.

10.16 DHF thanked the team.

10c) Annual Report on Safe Working Hours

10.17 DHF noted the annual requirement to provide a report in compliance with the new Junior Doctor contract to the Trust Board. The Board was asked to note the progress made between August 2016 and August 2017 in introducing the new contract. The Board was assured that reporting and management systems that enable compliance with the contract have been implemented. The Board noted that appropriate controls and processes are in place to deliver safe working hours for Junior Doctors.

10.18 It was noted that the report included the number of exception reports, fines levied and issues that have arisen in the introduction of the system. However, all rotas have been adjusted to meet the requirements of the new contract and Junior Doctors have an opportunity to feedback which is taken seriously. It was noted that their training needs were protected. DHF advised that it is important for Board to know the role of the appointed Guardian of Safe Working Hours.

10.19 DHF noted that there is a significantly high level of interaction between the Senior and Junior Doctors. DHF commented that Junior Doctors work very hard and they have also been very flexible. DHF added that there are very few exception reports considering the level of work being done and the number of extra hours they put in. DHF thanked the Junior Doctors and the Human

Resources team. DHF noted that the report would be received quarterly in future.

10.20 SC acknowledged the good development in relation to the new Junior Doctor contract.

11 Performance

11a) Finance Report

11.1 The report which summarised the Month 8 year to date was taken as read. TC in providing highlights stated that in Month performance was reported as a deficit of £5.7m which was slightly adverse to plan. TC explained that at the time (November 2017), forecast outturn was aligned to plan but a number of risks were raised.

11.2 TC noted the factors responsible for the adverse variance one of which was the unresolved contractual issue between the Trust and the main CCG around over-performance. TC explained that there is a gap between the contract value and the planned income in the Trust.

11.3 TC noted that cash remains an issue in the Trust partly because of performance against the income plan.

11.4 It was noted that the Trust is working very hard on financial recovery. The radiology project, theatres and pharmacy were noted as the main transformational projects being worked on. It was noted that work is also ongoing around facilities, catering and a range of areas as part of the recovery plan and to expedite the transformational schemes which will enable the Trust to improve its efficiency.

11.5 It was noted that the Trust maintains a high debt position with the CCG as the biggest debtor. There is a resultant cash issue but assurance was provided that the Trust is working with its regulators to try and expedite some payments as it is required to pay creditors. TC noted that additional income of £4m was received from the Department of Health. However, that did not last long considering the Trust's run rate spend of about £30m monthly.

11.6 TC noted that it has been heard from colleagues, that there will be a reduction in the elective activity as a result of winter pressures. TC noted that this will cause a reduction in income as the Trust beds are all full and generating income. TC advised that the Trust will estimate the impact of that lost income as it progresses against the activity replacing it.

11.7 SC noted that the Trust hopes to resolve the debtor issue with the CCG within the next couple of weeks. Following a query raised by DK around savings including stationery savings, TC noted that the Executives agreed on a range of controls to try and reduce expenditure. TC advised that there is a need to encourage the 'need' culture within the Trust and this is on all levels. The issue of Carillion was raised by DK and TC confirmed that the Trust does not use Carillion.

11b) Communication Report

11.8 The Board noted the report. GA commented that it had been one of the busiest times for the team and there is a risk of overloading staff, patients and the public with messages. The team is trying to do some streamlining in this regard whilst ensuring clarity of message.

11.9 GA noted that in relation to Staff, a whole range of things are going on with an internal staff survey review underway. GA noted the highly successful face to

face staff briefing in December. With such encouraging attendance, GA advised that the team will be doing more of that as it brings messages closer to staff particularly around flow and finance.

11.10 GA noted that the Trust is working more effectively with its partner organisations.

11.11 In relation to financial recovery, GA noted that a full communications and engagement plan had been produced to support the Trust's financial recovery.

11.12 GA noted the good coverage over the Christmas period which gave the Trust an opportunity to raise the profile of charitable funds.

11.13 The forthcoming Unconference around building a brilliant Medway was noted together with the ongoing preparation towards this. GA noted the success around the new app for staff – @MFT (to support training, updates, HR, and useful information) with a commendable number of downloads and visits.

11.14 In relation to Media, GA provided updates including the breast screening, campaign with very good coverage on this. The team is now considering the same for organ donation.

11.15 In relation to community engagement, GA noted tremendous progress made in this area and advised that community engagement activity is now focused on five areas.

11.5 There has been engagement with the medical youth council, raising awareness of organ donation, engagement with local schools, ethnic minority community connections have been made to talk to a group on breast screening. GA noted that significant work is going on with positive feedback.

11.6 SC made reference to the ongoing work to improve features on fire safety and noted that the team would be working with communications on this. SC thanked GA.

11.7 Following a query raised by JB, GA noted that the communications team intends to engage with potential user communities such as the business community and incorporate other audiences also.

12 People

Workforce Report

12.1 The Board noted the report.

12.2 JD noted the metric around sickness and staff turnover and stated that HR Business Partners will work with all existing information sources, system-wide knowledge, staff survey results and in conjunction with outputs from the January unconference and culture workstreams, with the aim to implement a service-specific retention plan through quarter 4 17/18 and quarter 1 18/19.

12.3 On Nurse Recruitment, JD noted that the HR team continues to work with KR's team with 200 nurses recruited in the last few months. JD explained that with there has been an increased turnover rate. However, the retention project will launch in a week so as to improve retention across the organisation starting with nursing.

12.4 JD noted that the organisation has increased the percentage of pay bill spent on substantive staff with a decrease in agency usage and bank usage as part of the financial recovery plan. JD noted more of the organisation's cost is on substantive pay rather than agency and bank adding that this will continue although spend may increase in December due to increased winter pressure and the opening of escalation wards.

12.5 JD referred to the forthcoming Unconference and noted that the facilitator will engage the audience rather than have them sit and listen only. It was also noted that the new quarterly Staff Survey which is different to the NHS Staff Survey will soon be launched.

12.6 JD provided an update on Equality Delivery System (EDS2) noting that the work is back on track to be concluded by March 2018. Finally JD made reference to the story about unite the union and theatre staff noting that the dispute is around working patterns. JD stated that the rota has been reviewed and since the beginning of November, the Trust has been working with the union and ACAS. JD noted that there is a need to move forward around working patterns with staff. JD commented the meetings have been harmonious in the spirit of conversation. Questions were taken.

13 Corporate Safeguarding Policy

13.1 The Corporate Safeguarding Policy was re-presented to Board for approval. The Board had earlier advised that minor adjustment be made so as to make the policy clearer in terms of frontline work and how the Board will be assured that the policy is compliant with statutory requirements and so fit for purpose.

13.2 KR noted that the revised version is now clearer noting the legal requirement to work with partnership agencies.

13.3 The Board **APPROVED** the Corporate Safeguarding Policy

13.4 The Board agreed that all policies for Board approval should be accompanied with front sheets. JD advised that the metric around when policies should be brought would be discussed with SM.

Action- JD to discuss the metric around when policies should be brought for Board approval with SM

14 Corporate Consent Policy

14.1 DHF noted that this is consent in relation to treatment or procedure as required by CQC.

14.2 Discussion ensued; it was suggested that the policy should state why consent is important and that this could be applied to policies generally.

14.3 The Board **APPROVED** the Corporate Consent Policy.

15. Corporate Estate and Facilities Policy

15.1 TC noted that there has been an annual review of the policy which is now presented for Board approval.

15.2 TC noted that the policy is far reaching and covers all the Estates' functions. TC confirmed that the policy is fit for purpose and provides information on levels of accountability and responsibility, implementation of specific policies and procedures, benchmarking and measurement of performance, and reporting mechanisms, in order to provide assurance to Board.

15.3 TC noted that the policy makes provision for annual estates report to Board. TC also noted that the policy refers to the Carter Model Hospital and requires a plan which the new Director of Estates will take forward. In relation to the Annual Compliance Statement, TC noted that she is confident that the organisation has a good compliance reporting policy. In terms of the CQC control mechanisms, TC noted that the Health and Safety Committee meets regularly and is monitoring this.

15.4 The Board **APPROVED** the Corporate Estate and Facilities Policy.

16 Quality Assurance Committee (QAC) Report

16.1 The report was taken as read. JB noted the matters for highlighting which included the internally triggered review into stroke mortality. JB noted that the audit was undertaken by the Trust without being prompted by external bodies and noted that this is an example of a growing quality and safety culture.

16.2 JB also noted that QAC received a report on performance against Medicines Management Checklist and advised that a strong message in relation to compliance was taken back. JB noted that QAC would focus on workforce with a view to considering how the risks associated with this could be mitigated.

17 Integrated Audit Committee (IAC) Report

17.1 MS asked the Board to note the key issues report from IAC.

18 Council of Governors' Update

18.1 DK as Governor Board Representative raised the following queries:

- ED Re-development - What is the estimated open time?
  The estimated open time for phase one is March 2018 and the completed build is October 2018.
- When is CQC coming?
  KR confirmed that an information request came in recently from CQC which will give the Commission an insight as to areas of focus. KR noted that the CQC will write to the Trust giving two to three months' notice of their visit to the Trust.

19. AOB

19.1 SC noted that the next Council of Governors (CoG) was scheduled to be held on Monday, 22 January 2018.

20. Questions from members of the public

20.1 There were no members of the public.

The next Public Board will be held on Thursday, 1 March 2018. Venue: Boardroom, Post Graduate Centre, Medway NHS Foundation Trust

The meeting closed at 3.06pm.

Stephen Clark: Date:
Chair

PUBLIC BOARD ACTION LOG
ITEM 06

NHS Medway NHS Foundation Trust

Action No.	Meeting Raised	Minute Ref	Details	Lead	Progress	Status (RAG)
PUB - 0395	03/11/17	16.1	Risk Appetite Statement to be represented for approval at a subsequent meeting	Acting Deputy Director of Corporate Governance	18-02-18- Work in progress- Deloitte invited to advise	Open
PUB - 0396	03/11/17	20.1	BS to meet with DK and another Governor separately on patient notes and provide feedback to Board.	Director of Clinical Operations – Co-ordinated Surgical	18-02-18 – JD to follow up	Open
PUB- 0397	18/01/18	9.10	KPI on each area 2020 has worked on to be presented to Board to assess progress in March	Deputy CEO/Executive Director of HR and OD		Open
PUB- 0398	18/01/18	13.4	JD to discuss the metric around when corporate policies should be brought for Board approval with SM	Deputy CEO/Executive Director of HR and OD and Trust Secretary		Open

Chief Executive's Report – January 2018

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

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

In and around Medway

Performance – Emergency Department four-hour target

Although we are now at the end of the winter period, our Emergency Department has continued to be challenged. The number of patients being seen, treated and admitted or discharged within four hours has increased but has still not been meeting the target. In fact, towards the end of February the number of attendances rose to similar levels to those seen over the Christmas and New Year period, with higher acuity leading to increased admissions. We continue to have a focus on patient flow to improve patient experience throughout the hospital.

Elective and day case activity

As you will recall, trusts were instructed to pause elective activity during January to help alleviate pressure at the busiest time. We resumed surgical operations at the beginning of February and as a result have seen an increase in the overall position for Referral to Treatment.

We have also seen a further decrease in the number of patients breaching 52 weeks which at the time of writing is down to just one.

Our financial position

As reported at the last Board meeting, our financial challenge is great, and you will hear in the financial report that, unfortunately, it has deteriorated further.

Our deficit is significant and long-standing, and a cause for concern. In order to return the hospital to a sustainable position we need to transform services, tackle overspending on pay, and work closely with commissioners and other partners to provide services the community needs within the available budget.

This is very disappointing, and may require some difficult decisions, but we will not compromise on patient care.

We need to continue to focus on our own efficiency through our Better, Best, Brilliant programme, and it is also important that we receive the right level of income for the services

we provide. We will continue to work closely with commissioners and other partners as this is not just about the hospital but about the healthcare system across Medway and Swale.

We have been open about our financial position, and kept staff informed, encouraging them to think about how they can increase efficiency in their roles and departments. We have also had conversations with a number of key stakeholders including local politicians so there is a shared understanding of the need to make changes across the Medway and Swale system.

Outpatient kiosks

On 19 February, we launched a new booking in system for patients attending Outpatients areas one to three.

Patients are now using tablets located in the main reception to book in for their appointment. This enables them to book in quickly and more easily. It is a simple process but we have staff and volunteers on hand to support anyone having difficulties.

From the first week fewer queues were experienced than with the previous system. We asked patients about their experience of using the tablets, and they fed back that they were easy to use and that the process was smooth.

The outpatient kiosks currently located in the main reception will be permanently closed, with staff redeployed to other areas. We are currently exploring options for the space vacated by the kiosks and have formed a working party with representatives from key stakeholders.

CQC inspection

We are preparing for our next CQC inspection, which will be in the spring. This time we will have an unannounced inspection of four core services, plus an announced well-led review which will follow at a later date.

Six focus groups were held by the CQC for staff groups in mid-February, along with three drop-in sessions. They were well attended and the feedback will feed into the inspection. Two more focus groups are planned.

We have established a CQC assurance group to oversee this, to be chaired by one of our Non-Executive Directors, Jon Billings, and Simone Hay, Deputy Director of Nursing, will lead the operational preparations.

Today we welcome representatives from the CQC who are observing today's Board meeting as part of their review of Medway.

Unconference

We held a highly successful Unconference at the end of January with more than 60 members of staff from across the hospital coming together to discuss how we can move forward as an organisation.

There was a creative buzz as staff worked through solutions to problems that frustrate their work and hinder progress. They also identified a number of 'permissions' that would speed up deliver or cut bureaucracy and some of these are key to unlocking improvements.

The event followed a serious of focus groups held with staff to understand their view of culture at Medway, and what needs to change. Although the room was packed, there was still a huge proportion of staff who were unable to attend; our Organisational and

Professional Development (OPD) Team therefore visited areas of the hospital throughout February to talk to staff and gain feedback on the current culture at Medway.

The feedback from all these, together with the outputs of the Unconference, will now be used to develop a Brilliant Medway culture that we all want to be a part of.

Recent achievements

I am delighted to say we have seen a number of successes recently at Medway.

Lyndsay Walker and Sonya Hinchey of Team Maia were crowned winners of the 'Midwifery Innovation Award' at the inaugural Maternity and Midwifery Festival Awards in London in February. They were praised for 'recognising the need for and the implementation of a dedicated induction of labour team to provide bespoke care and drive forward positive change'. The team, named after the Greek word for midwife, provides specialist care to women before childbirth.

At the same awards, Trude McLaren, a senior sister in the Birth Place was highly commended in the 'Midwifery Management Award' category, with judges praising her 'outstanding commitment to her team and the women they care for'.

Meanwhile, the team on Ocelot ward, one of our gynaecological wards, was nominated for a Pride in Medway award. Ranjit Akolekar, a foetal medicine consultant at the hospital, was also nominated for a Pride in Medway award in January.

Medway CCG Patient Experience event

Medway CCG is hosting the annual patient experience and learning event on Monday 23 April 2018 at Priestfield Stadium in Gillingham. The theme of the event is Medway working in partnership with patients and communities to improve health and develop services.

The event is a great opportunity to showcase the excellence in services across Medway. We have submitted three entries for the awards which will be presented at the event, and are hopeful that our commitment to improving patient experience will be recognised.

Best of People Awards

We have recently refreshed our employee and team of the month awards. Staff are being encouraged to reflect on the things that we do well and nominate colleagues who have gone above and beyond the call of duty for our patients for a Best of People award.

Beyond Medway

New chair for East Kent

A new permanent chairman for East Kent Hospitals has been appointed to replace Dr Peter Carter who has been the interim chair. He is Professor Stephen Smith who is currently a Non-Executive Director for Great Ormond Street Hospital. Several colleagues will have known Stephen in previous roles.

He is a gynaecologist by training and has held prominent positions including as Professor of Obstetrics and Gynaecology at the University of Cambridge before becoming Principal (Dean) of the Faculty of Medicine at Imperial College, London. He led the formation of the UK's first Academic Health Science Centre at Imperial College Healthcare NHS Trust and was the Trust's CEO from 2007 to 2011.

Planning guidance for providers

NHS England has produced the annual planning guidance for 2018/19. Notably the guidance states that Trusts will be expected to meet 90 per cent of ED patients being seen, treated and admitted or discharged within four hours by September 2018, returning to 95 per cent by March 2019.

On the referral to treatment standard, the expectation is that the waiting list should not be any higher in March 2019 than in March 2018, alongside the expectation to halve the number of patients waiting 52 weeks in the same period.

There are changes to the Sustainability and Transformation Fund, and also to the setting up of new care systems.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/03/2018 Agenda item

09a

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

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 The Kent and Medway STP is progressing in a number of areas, both strategically in terms of delivery models, but also in relation to proposed service changes.

1.2 There has been a good deal of work carried out towards developing a clinical strategy.

1.3 Consultation on stroke services is now underway across the county following a long period of review and engagement.

1.4 Initial work on Accountable Care Partnerships has involved engaging GPs.

1.5 Strategic commissioner arrangements have been put in place and will operate in shadow form from April.

2 CLINICAL STRATEGY – QUALITY OF LIFE, QUALITY OF CARE

2.1 The Clinical Strategy project was established to provide a clinically-led strategy for health and care across Kent and Medway.

2.2 So far the project has progressed in four areas:

- 2.2.1 A case for change has been drafted
- 2.2.2 A clinical vision has been produced
- 2.2.3 A care model framework has been agreed
- 2.2.4 A task and finish group has reviewed best practice and analysed demand and performance in urgent and emergency care (a key area of focus).

2.3 The urgent and emergency care task and finish group has looked at national evidence and guidance on different care models to understand the key components, including local urgent care that happens outside the hospital (eg 111, ambulance service, social care, primary care), the emergency department front door, and within the emergency department itself.

2.4 A set of principles has been agreed, such as making sure different parts of the system fit together without gaps or overlaps, and enabling patients to have their needs met on the first point of contact.

2.5 A second task and finish group has been established to agree the outlines for the care models as the next stage of the project.

2.6 Phase two of the clinical strategy will involve sharing the case for change with the public, implementing the urgent care model, and developing other care models for example for prevention, mental health, children and young people, and cancer.

Report to the Board of Directors

3 STROKE CONSULTATION

3.1 A public consultation on the future of urgent stroke services in Kent and Medway is now underway following a lengthy review.

3.2 Currently none of the six hospitals in Kent and Medway is providing a stroke service that meets national standards.

3.3 The consultation asks for views on proposals to establish new 24/7 hyper acute stroke units (HASUs) in Kent and Medway. These units will allow patients to get the best possible care in the vital first few hours and days immediately after a stroke – saving lives and reducing disability.

3.4 A shortlist of five possible options, each including three hospital sites, has been drawn up. Medway Maritime Hospital features in three of the options.

3.5 Public consultation events are being held throughout Kent and Medway during the process, which runs until 13 April.

3.6 There are four events in our areas. The first was held in Minster on the Isle of Sheppey on 21 February, when around 20 people heard more about the proposals and had a lively question and answer session.

3.7 Below are details of the other public events in Medway and Swale:

Monday 5 March, 2pm to 4pm – Rochester Baptist Hall, Moat House, 8 Crow Lane, Rochester ME1 1RF
Tuesday 20 March, 6.30pm to 8.30pm – Kent Ramgarhiadarbur and Community Centre, Gillingham
Thursday 22 March, 6.30pm to 8.30pm Swale Community Centre, Sittingbourne.

3.8 There is a strong case for Medway to host one of the HASUs including the demographics of our population, the co-location of other interdependent services such as interventional radiology, and investment in current stroke services.

3.9 Following the consultation exercise CCGs in Kent and Medway along with two on the borders, will analyse and consider the feedback. A decision on which option will be adopted is expected in the autumn.

3.10 It is important that as many people as possible have their say in the consultation. Through our communications we are encouraging people to complete the online questionnaire, which can be found at **www.kentandmedway.nhs.uk/stroke**

3.11 We have been promoting the consultation extensively internally and externally through our communication channels, including social media, the chief executive's weekly message, and face-to-face briefings.

Report to the Board of Directors

4 ACCOUNTABLE CARE PARTNERSHIPS

4.1 Accountable care partnerships (ACPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved.

4.2 At the Medway, North and West Kent Delivery Board meeting in November, it was agreed that Helen Greatorex (CEO at KMPT) will lead the work around ACP Development in the Medway, North and West Kent.

4.3 Engaging GP federations in this work is a key priority, and an initial overview of ACPs was presented to the Local Medical Committee meeting in December.

4.4 The first meeting about ACP Development was held on 16 February, when five representatives from GP federations attended, along with colleagues from acute trusts, community providers, CCGs, Kent County Council, Medway Council and public and patient representatives.

4.5 Paul Bentley, Chief Executive of Kent Community Health Foundation NHS Trust and lead of the ACP Development work in east Kent, was invited to present a briefing around the experiences in east Kent, both positive and negative. This honest and valuable presentation will help the MNWK work to move at pace, building on the experiences in east Kent.

4.6 It was agreed that three workshop style sessions would be set up to continue the development of the ACP work.

5 STRATEGIC COMMISSIONER

5.1 Since the NHS, Kent County Council and Medway Council set up the STP in 2017, it has become clear that there is a need for the commissioning of some aspects of NHS care to be more joined-up.

5.2 It has been identified that a strategic commissioner is needed with the authority to:

- establish strategic priorities and plans to improve the health and wellbeing for the population of Kent and Medway
- commission services from a small number of health and care partnerships, which would join up the delivery of frontline services
- directly commission some services (both specialised services and services provided at scale) for the whole of Kent and Medway.

5.3 The Clinical Commissioning Groups (CCGs) across Kent and Medway are looking at options for developing a strategic commissioner function that works across multiple CCGs. The aim is to strengthen how CCGs work together, where doing so can drive service improvements that patients need and expect.

5.4 Making strategic commissioning decisions across multiple CCGs is considered to be better because it provides consistency and reduces duplication; it will help improve services for patients by reducing variation in quality and access to care and will drive up standards across all providers.

5.5 A formal proposal to establish a strategic commissioner and share a single senior management team with one accountable officer (chief executive) was considered by CCG governing bodies at meetings in January/February. At the time of writing, six of the eight CCGs had agreed the proposal. South Kent Coast was due to confirm its view following a meeting of the GP membership on 22 February. Thanet CCG is not pursuing a path to be a part of formal arrangements, but will continue to work with the other CCGs on development of the strategic commissioner recognising that there are functions that could be usefully undertaken at a larger geography.

5.6 The strategic commissioner will be established in a shadow form from April 2018.

5.7 To prepare for the new arrangements the accountable officers of the CCGs are taking on additional transitional roles from this month. Ian Ayres, the Accountable Officer of West Kent CCG, has become the Managing Director of Medway, North and West Kent. Caroline Selkirk, the Accountable Officer of Medway CCG, become the Managing Director for East Kent.

5.8 In the coming months the CCGs will be working together to design where the different functions of commissioning need to sit and how to ensure the local voice of clinicians and patients is heard at the strategic level.

5.9 A merger of CCGs is one potential option for the longer-term which will be discussed in the coming months, but it is not the only option and no decisions have been made at this stage.

5.10 A proposal to merge would require all the CCGs involved to seek the support of their membership practices, and NHS England would also have to approve.

Report to the Board of Directors

Board Date: 01/03/2018 Agenda item: 9b

Title of Report	Better, Best, Brilliant – Improvement Programme
Presented by	James Devine, Deputy Chief Executive
Lead Director	Lesley Dwyer, Chief Executive
Committees or Groups who have considered this report	Executive Team
Executive Summary	As part of the Better, Best, Brilliant improvement programme, there are 13 work streams under which improvement is underpinned. The attached slide deck summarises the progress to date; showing either operational improvements or financial savings attributed to the series of improvement programmes and sprints as part of the BBB programme. Improvements have included ED performance, direct engagement for temporary staffing workers, theatre efficiency and outpatient utilisation. The delivery sprints continue, with the fourth starting on Wednesday 28 February 2018 to further focus on the improvement of flow, efficiency and financial recovery primarily. The development of a new transformation team continues with appointments made to commence from April 2018.
Resource Implications	None to note
Risk and Assurance	None to note
Legal Implications/Regulatory Requirements	Regulatory requirements linked to constitutional targets and financial performance/recovery
Recovery Plan Implication	Financial recovery plan
Quality Impact Assessment	QIA are required for several projects, and are reviewed by the Medical Director and Director of Nursing.
Recommendation	The Board are asked to note the report
Purpose & Actions required:	Approval ☐ Assurance ☐ Discussion ☒ Noting ☒

Better, Best, Brilliant

Improvement Programme Update

March 2018

Executive Summary

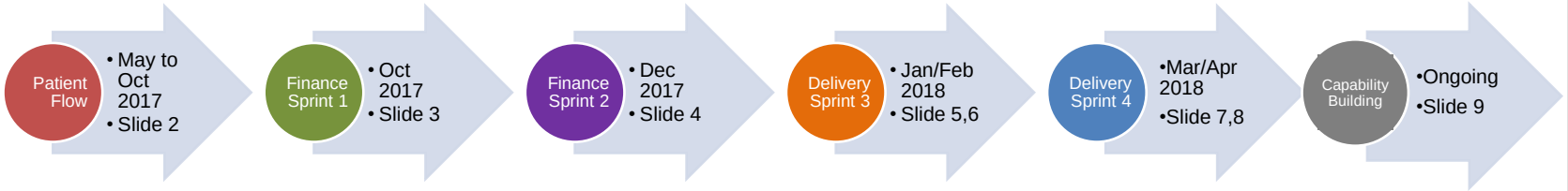
The BBB improvement programme is Medway's approach to becoming Brilliant. It has two overarching outcomes:

Firstly, to create capability, structure and a common language for continuous improvement within the Trust such that benefits may be sustained, and new benefits created.

Secondly, to deliver tangible financial, performance and quality improvement for the Trust, which, in 2017-18 has focused on:

1. Improve patient flow and ED 4-hour performance
2. Support the Financial Recovery of the Trust through finance and delivery sprints, delivering ~£2.7m savings YTD

This short pack is split into six sections outlined below and highlights the achievements to date.



NB: Figures quoted are as of 31/01/2018

Patient Flow

The initial set of projects focused on improving patient flow delivering tangible benefits for the Trust

Better Best Brilliant

Date	Project	Opportunity	Outcome to date	Narrative
May 2017	**Patient Flow – ED Performance**	Improve 4-hour performance from 77% to +90%, triggering Sustainability & Transformation Funding (STF)	ED 4-hour performance up from **77%** in Jan-May 2017, to **~90%** post-May 2017	Improve flow across urgent care pathway through better streaming, policies, discharge, operations management
Oct 2017	**Patient Flow – Escalation Beds**	Reduced need for staffing in escalation areas, thereby reducing cost	Escalation beds reduced from **36** in 2nd week Dec 2016 to **0** in 2nd week Dec 2017. Cost reduction of **~£200k** (assuming 3 months)	Reduce the number of escalation beds
Oct 2017	**Patient Flow – LoS reduction**	Reduced need for staffing in ward, thereby reducing cost	Cost reduction of ~**£1m** DTOC Reduction: **942** delayed days due to NHS in Nov 16 to **64** in Nov 17	Close Sapphire Ward based on reduction in length of stay in other areas. There is more opportunity here
Jun 2017	**Digital**	Supports flow improvement and length of stay reduction work	Improved from **81% to 88%** in 4-weeks	Improve the accuracy of digital bed management system
Jun 2017	**Workforce**	Reduce agency spend across acute care pathway. PYE (17/18): **£109,336 saving** FYE (18/19): **~£267,000 saving**	YTD: **£54,668**	93.13% of locum agency bookings directly engaged vs target of 90%
Sept 2017	**Workforce – Admin and clerical**	Comparison to national median showed conservative £1m opportunity. Benchmarking showed potential savings of ~£4m, if MFT had the same A&C FTEs as Kent, Surrey and Sussex average, scaled by activity.	Ward clerks would only save 1FTE overall so has been de-prioritized.	The Trust's phase 3 redesign of clinical directorates in Q1 18/19 will look at sub-programme management teams. Reviews on A&C in corporate will use latest Model hospital and benchmarking information. Further opportunities exist for A&C staff optimisations in pathway coordinator, reception and other clinical team levels.
Oct 2017	**Single home based team**	Improved patient flow through streamlined discharge processes	N/A	SPEC and H@H working together Next steps to continue work on new structure and efficiencies, assessing how many patients go through this team

~£1.3m

~£1.25m to date

Source: NHSE Statistics 2016-17 and 2017-18

Finance Sprint 1

In Finance Sprint 1, six projects of fifteen delivered >£200k savings so far with the others taken forward to Sprint 2

Project Title	Opportunity	Outcome to date	Narrative
FRP3 Development	A foundation on which to build financial transformation work	**Completed**	Produce a financial recovery plan to identify 'do nothing' scenario and opportunities for recovery
Process definition, escalation & discretionary spend	£485k if spend process fully adopted 2018/19	**£10.4k**	Spending controls fully embedded, and more savings expected through cost avoidance. Next step to develop trend-based KPI to capture savings avoidance
TTOs dispensing from discharge lounge	Direct saving £40k 2016/17. £114 saving per transaction in staff costs. Overall improvement in patient flow	**£15k** Improvement in earlier discharges for patient flow	Mobile dispensing unit implemented in discharge lounge successfully Also included re-using patients drugs rather than re-prescribing Business case is being put together to estimate cost-effectiveness of rolling out across Trust
Remove FP10s	Further £50k 2016/17 £300k 2018/19	**£65k**	FP10s have now been successfully stopped across the Trust. The implication of increased workload for pharmacy is currently being looked into and resolved
Reduce outsourcing	Further £30k 2017/18 £375k FYE	**£45k**	Outsourcing has now fully stopped. Decision required by executive on outsourcing plan next year with projected RTT impact. More capacity to bring outsourcing inhouse will be provided by theatre projects
Continued reduction of medical agency/ locum target	£110k further savings 2016/17	90% target reached, **£110k** saved to date	

Finance Sprint 2

Fifteen projects were worked on in Finance Sprint 2 with some projects carried forward into the Delivery Sprint

Project Title	Opportunity	Outcome to date	Narrative
Reduce agency AHP/HSS spend by 13% by March 2018 by moving to direct engagement model	PYE (17/18): £49,727 FYE (18/19): ~£279,600	YTD: **£826**	Due to issues with the DE system the Trust did not commence booking AHPs via the DE system until mid-December 2017
Procuring staff workers vis a best cost model	MFT was spending c.£3.69m per month on its non-substantive workforce (20% of paybill). Agency paybill for Oct 17 was £1.3m	In Nov and Dec 17, the temporary staffing pay bill reduced by **£1.25m** cumulatively vs Oct 17 baseline.	The project has had a Trust wide impact. Wards and departments have staff who know the organisation. Further quality improvement would target remaining agency staff to take substantive/bank posts
Tail-end management: Effectively manage the 20% of spend that is with 80% of the supply base	TBC	N/A	Suppliers returning indicative savings estimates end of Feb
Inventory management: reduce stock holding to an agreed level and sustain it whilst ensuring operational efficiencies	£3m (non-recurrent) plus £180k 2018/19	Implementation started	Implementation commenced, and will take 3-6 months to complete
Optimise use of ward clerks to best deliver service and normalise spend	1-2 FTE Band 4s	Savings to be delivered from next FY	Survey to the wards has gone out, results need to be collated and an operating model designed and brought in business case.
Implementation of a hybrid mail system to reduce spend on patient communication	FYE (18/19): Phase 1 £50k + Phase 2 £26k	Savings to be delivered from next FY, contract is with supplier for sign off	Once contract is signed and project implemented, there are cost savings for postage, printing, stationary and staff time
	~£1.85m + £3m one-off	**~£1.26m to date**	

Delivery Sprint 3

Sprint 3 started in January into mid-February with ten projects 1/2

Project Title	Opportunity	Outcome to date	Narrative
Theatres: Pre-op assessment	Improved patient experience (less appointments and travel times). Fewer patients will need pre-assessment - staff released will be able to be deployed elsewhere Decreased DNAs	High level pathway has been designed and agreed	Detailed pathway plan and implementation plan are currently underway. Awaiting data from safer sleep in order to estimate number of pre-assessment reductions, and therefore staff and space implications
Theatres: Benchmarking staff	£200k	YTD: **£24k**	Benchmarking to comparative trusts taking place. New model has started to be implemented, with reduced agency costs.
Theatres: Touchtime and Scheduling	Increasing daycase utilisation to 85%: FYE: £240k saving Reducing weekend sessions to 5%: FYE £120k saving Reduce cancelled theatre lists from 8% to 3% (savings likely to be significantly higher, analysis in process by finance)	YTD: **£10k**	Late starts reduced significantly and a marked increase in K2S time (theatre utilisation). This allows the Theatre User Group to establish fuller theatre lists to improve patient experience through faster treatment and reduce RTT. Income will be increased for only a marginal increase in cost (consumables).
Women's case type mix	Estimated savings TBC by finance BP Increased patient experience through reduced waiting times, shorter recovery time	First list scheduled as Outpatient list early-March. Initially, two lists a month will be scheduled	Moving of day surgery cases to outpatients to release theatre capacity. Currently 25/30% of day surgery cases are suitable to be treated in an outpatient setting. This will release theatre space for other specialties and reduce the need for additional sessions respectively.
	£560k+	**£34k to date**	

Delivery Sprint 3

Sprint 3 started in January into mid-February with ten projects 2/2

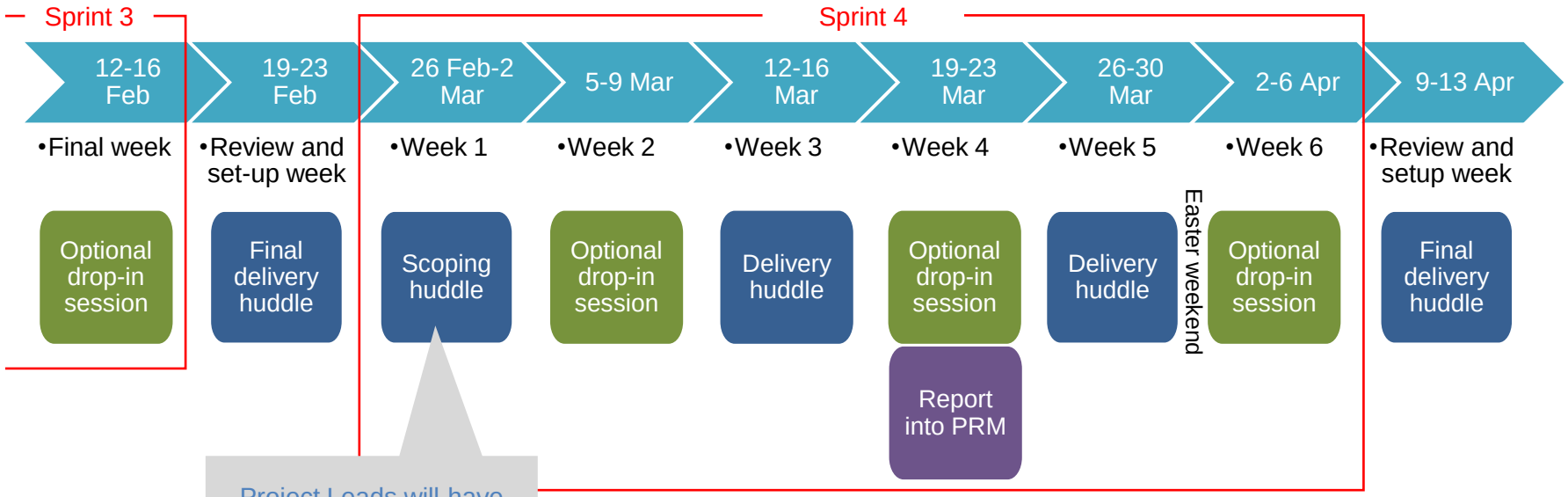
Project Title	Opportunity	Narrative
Outpatient utilisation	3% productivity increase through better clinic utilisation. Loss of 2 FTE once full self-check-in implemented. Repurposing of estates through space vacation.	Project is designed to reduce DNAs through nudge reminders, this increasing utilisation and improving patient experience. Self-check-in launched for areas 1-3 w/c 19/2 releasing estate in reception area for repurposing. Clinic utilisation analysis underway to ensure utilisation at or better than 92%.
Correct ratio of first to follow ups	Estimated savings are £2.6M FYE. Quality improvements: Improved access for patients through streamlined pathways, reduced waiting times, Increased patient experience	Releasing clinic capacity by ensuring correct N:FUP ratio, reducing commissioner penalties
Radiology strategy refresh incl. outsourcing	Out-of-hours reporting outsourcing: £90k FYE X-ray: FYE: ~£458k savings, no PYE in 17/18 CT: no savings attached, business case for short-term outsourced scanning motivated by quality improvement to reduce cancer waiting times and RTT	Strategy identifying financial savings through investment into digital x-ray and 3rd CT scanner, identifying operational productivity improvements.
Sewing room	PYE: £3,344 savings FYE: £40,126 savings	Sewing room closed mid-February. Uniform and equipment stocks to be disposed off, preferably for value.
Catering	PYE: £6,255 savings FYE: £75,060 savings	All savings based on average spend and dependent on Exec decision re continuance of Hospitality and Free Meals

~£3.3m

Delivery Sprint 4

Delivery sprint 4 starts w/c 26/2 and continues the governance from delivery sprint 3 to maintain momentum

GOVERNANCE FOR THE SIX WEEK SPRINT



Project Leads will have met up with their SROs and agreed their six week plan, scope and milestones in advance

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

Delivery Sprint 4

Delivery sprint 4 contains four significant new projects, other projects continue delivery from sprint 3

New projects

Project Name	Opportunity
High-cost drugs and high volume drugs standardisation of dispensing	Large opportunity, with £1m in single theatre drug alone. Review of all high cost and high volume drugs in first 2 weeks, identify 5 key drugs to switch and implement by end of sprint.
Length of stay reduction	Focusing on first five days of stay, Diagnosis of internal aspects of LOS, implementation of key quick win elements e.g. consistent board rounds, early discharges.
PAS clinical functuality	Key enabler for both outpatients and theatre scheduling. Design of new TCI form and outcome form and built into PAS, medical staff given PAS logins and training set up. Implementation plan in place.
Service income identification	Identify through analysis those services for which income is not received, or is insufficient to cover costs, the potential value, and prepare report for Exec discussion on action required.

>£1m

Continuing projects from Sprint 3

- Theatres: Touchtime, Pre-Op assessment, Scheduling
- Outpatient Utilisation
- Correct ratio of first to follow-up appointments
- Radiology
- Dispensary outsourcing

Capability Building

The BBB development programme creates capability, structure, and a common improvement language with 226 attendees so far

Better Best Brilliant

Trust Induction

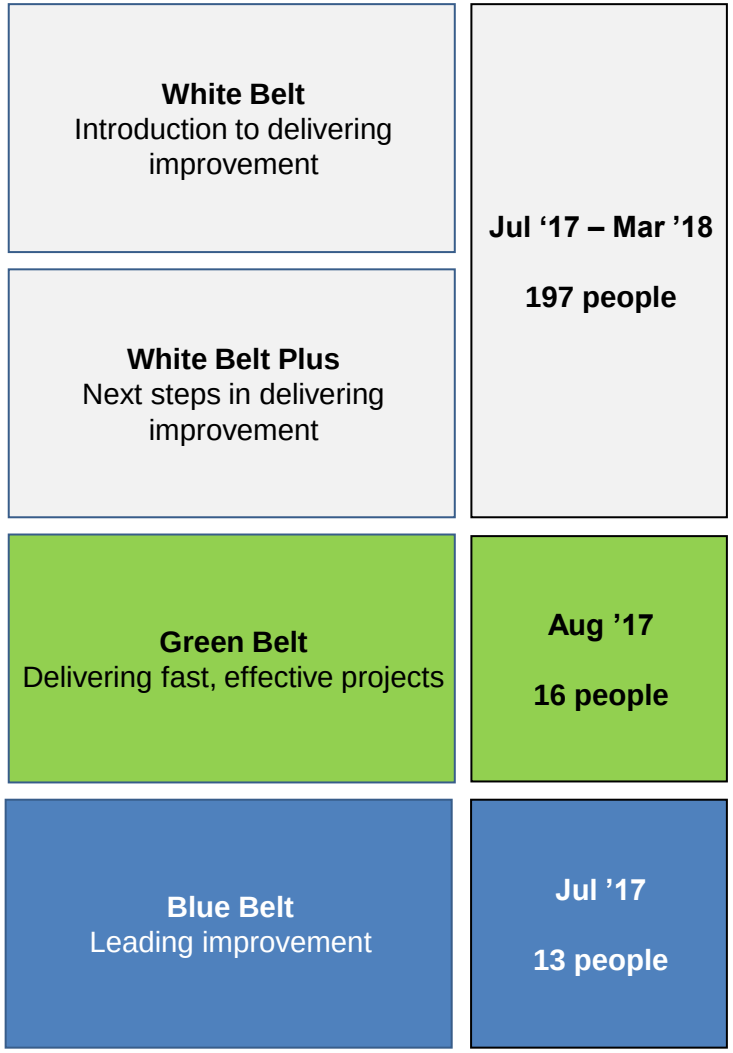
New staff receive a short briefing on improvement in their induction.

After three months, new staff are invited to either a White Belt or White Belt Plus.

Four courses deliver different levels of capability and leadership in core improvement tools.

Further courses are scheduled in a rolling programme.

The incoming Service Transformation Team will be trained at least to Green Belt standard.



The White Belt courses deliver an introduction to five tools which help structure both the process of delivering a project, and also the content which flows through that project. Participants learn the overall improvement methodology and how to run continuous improvement cycles (Plan, Do, Study, Act). White Belt Plus includes time to work on participants' projects, and a deeper look at PDSA.

3 days of training which forms the core of a 5-6 month programme integrating mentoring, group working and vivas, allowing participants to apply tools to a real-life project that is a Trust improvement priority.

Leadership training covering leading change, developing teams and a range of tools to allow senior leaders to support their project leads by providing direction, challenge and expertise.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/03/2018

Agenda item 10a

Title of Report	**Integrated Quality Performance Dashboard - Update**
Prepared By:	Associate Director of Business Intelligence
Lead Director	Executive Team
Committees or Groups who have considered this report	Draft to Quality Improvement Committee
Executive Summary	To inform Board Members in the form of a flash report of December'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** for December but performance has increased from 83.46% in November to 84.41% in December. • There were fifteen **12 hour breaches** in January. • **HSMR** data reported in this month's IQPR is for the period from November 2016 to October 2017. This is currently 103.72, which is within expected range. • This month saw a 0.63% increase in the number of **Mixed Sex Accommodation** breaches, which totalled 159 in January. This is mainly due to winter bed pressures which resulted in opening additional beds in assessment units. • **RTT** performance has decreased to 80.41% from 85.68%. This is below the national standard of 92%, as well as the agreed 90% trajectory. • **Cancer targets** have been achieved apart from the 2-week wait symptomatic breast, the 62-day GP standard and the 62-day screening standard. The 2-week wait

Report to the Board of Directors

	symptomatic breast performance has increased by 4.68 % to 89.39%. Most of the breaches were due to patients being unavailable for their first appointment. The 62-day GP performance was not achieved in December, but has increased by 6.59% to 84.62%. Breaches were predominantly due to complex pathways, diagnostic delays, patient choice and delays in tertiary Trusts. • There was a 11.5% increase in the number of **falls** in January (68) compared to December (61). • 73 complaints were reported in the month, an increase from December's 41. The number of complaint returners has decreased to 2.
Resource Implications	N/A
Risk and Assurance	See report
Legal Implications/Regulatory Requirements	N/A
Improvement Plan Implication	Supports the Improvement Programme in the following areas: Workforce, Data Quality, Nursing, Finance
Quality Impact Assessment	See report as appropriate
Recommendation	N/A
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

NHS Medway NHS Foundation Trust

Integrated Quality and Performance Report

February 2018

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

Best of care
Best of people

Contents

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

Best of care
Best of people

10250 Patients visited our ED , which is a **4.93% decrease** on the previous month, with **84.41%** seen within 4 hours, compared to 83.46% . **1981** Patients were admitted, with a slight **decrease** in conversion rate of **19.33%** compared to 19.35% in December.

There were **5574** total patient admissions in January, and **5569** patients were discharged.

Bed Occupancy **increased** by **1.17%** in January to **94.66%**.

3346 patients arrived at ED via ambulance which is a **8.58% decrease** on last month.

33.8% Of ambulance patients were seen in under 15 minutes.

January's Story....

413 Babies were delivered in the month of December (23 less than December) with Emergency C-Section rate with a **decrease** of **3.33%** from the previous month to **16.67%.**

HSMR is **103.72** and within expected parameters (97.88 – 109.81) compared to 100.21 as reported in December.

83% of staff have had an appraisal compared to **84%** in December.

26011 Patients attended an outpatient appointment with **8.92%** DNA rate which is a decrease of **0.50%** on last month.

There were **68** total falls in January, compared to **61** in December.

RTT Overall Incomplete Pathways for January was **80.41%** which decreased by **5.27%** on previous month. This is below the Trust improvement trajectory. The Trust also reported **3 x 52** week waiters which decreased by **1** compared to December.

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

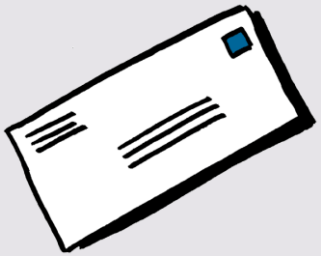
2 Week Wait symptomatic breast was below the target of **93%** in November with performance of **89.39%** - increased by 4.68%.

2 Week Wait cancer performance for December was **95.42%** (reported one month in arrears) . This is a **0.54%** increase from November's performance.

January's Performance....

94.96% of patients waited under 6 weeks for diagnostic tests in the month of January, which has slightly deteriorated by **1.46%** since December's reported performance.

We received **73** complaints in January, increasing from those received in December by **32**. The number of complaint returners decreased to **1** in January.



There were **159** Mixed Sex Accommodation breaches in January which is a **0.63%** increase on December's performance.

Safe Page 10

Legend: Compliant with target; Breaching target

Infection Control
Commentary will be available for the Board submission.

Serious Incidents
As at 31st January 2018 there are a total of 135 open Serious Incidents (SIs) including SIs that are subject to an active investigation (68), SIs that have been submitted for review at the CCG SI Closure Panel and referred back to the Trust for further information (22) and SI investigations that have been completed and are awaiting review at a forthcoming CCG SI Closure Panel (45).

- Open SIs within allocated timeframe – 35
- Open SIs breaching the allocated timeframe – 100
- New SIs reported on STEIS in January 2018 – 10

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

- Report 100% of all serious incidents within 2 working days of the incident being reported on Datix. Trust wide compliance for January 2018 is 40% against a YTD average of 32%.
- Submit a 72 hour report to the Clinical Commissioning Group (CCG) within 3 working days of the SI being reported. Trust wide compliance for January 2018 is 100% against a YTD average of 66%.
- Submit 100% of all serious incident final reports to the CCG within 60 working days. Trust wide compliance for January 2018 is 24% against a YTD average of 26%.

Root Cause Analysis (RCA) training has been in place since July 2017 and there is a regular programme in place through to March 2018. Training dates have been distributed to all Governance Leads and Directorates and are being promoted via global email and Trust intranet. There is currently capacity for training 164 staff; to date, 86 staff have been trained (Planned Care – 59, Unplanned and Integrated Care – 15, Other – 12).

The breakdown of staff trained by staffing group as at 31 January 2018 is as follows:

- Nursing & midwifery - 34
- Medical - 25
- Clinical Support Services - 4
- Management/Administration - 20
- CCG staff - 3

NICE Technology Appraisals (TA)
There were 5 TAs published in January 2018, 5 relating to Cancer Services, 1 relating to Rheumatology and 1 relating to Gastroenterology. These have not been reviewed, and remain within the 90-day standard deadline (April 2018) for assessment.

5 TAs had a deadline for assessment in January 2018. 100% were assessed within the required 90-day deadline.

NICE Clinical Guidelines (CG)
There were 3 CGs published in January 2018, of which 1 was assessed as not applicable to the Trust. The remaining 2 relate to Cancer and ENT. These remain within the 90-day standard deadline (April 2018) for assessment.

4 clinical guidelines were due for assessment in January 2018; 75% (3) were assessed within the required 90-day deadline. 1 clinical guidance relating to Pathology remains not assessed and has breached the 90-day deadline.

NICE Quality Standards (QS)
No QS were published in January 2018.

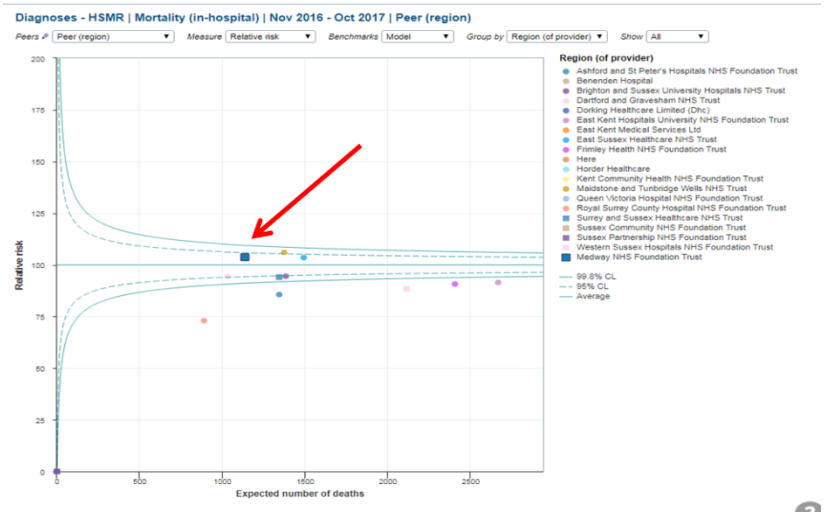
1 quality standard was due for assessment in January 2018, which was assessed within the required 90-day deadline.

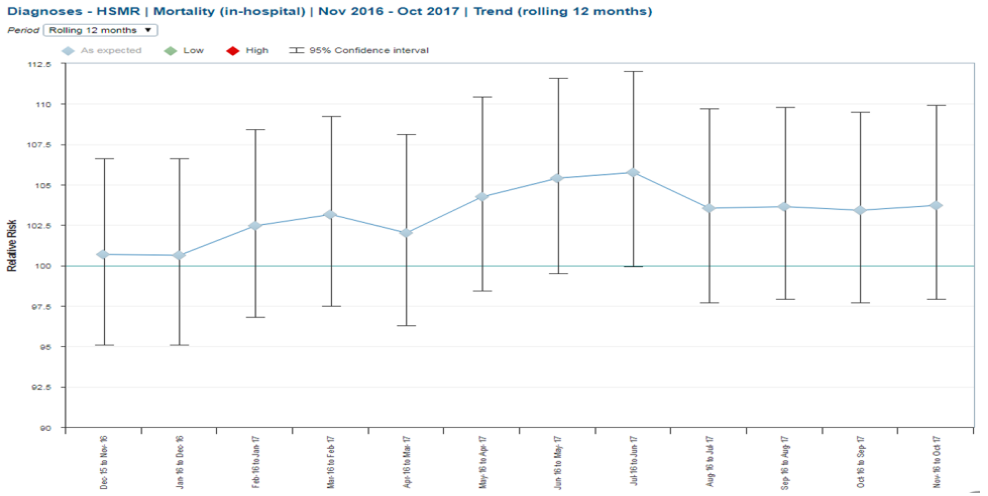
Other news
Since April 2017, 177 guidelines have been published by NICE, 102 of which are applicable to the Trust.

- 77 (75%) have been reviewed, 64 (83%) within the 90-day deadline.
- Of the remaining 25 guidelines awaiting review, 19 remain within their 90 days of publication, and these continue to be escalated to the individual clinicians, specialty leads, governance teams and Directorates.

Mortality

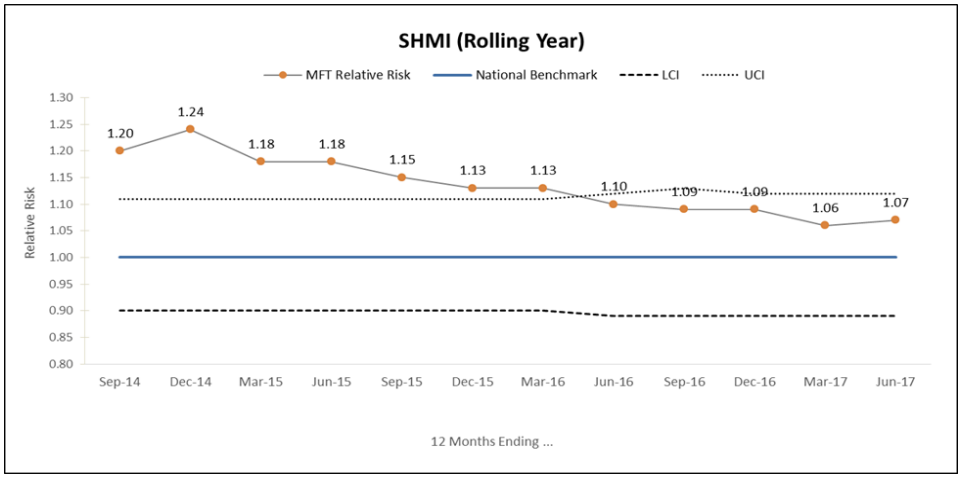
The Hospital Standardised Mortality Ratio (HSMR) is currently 103.72 (for the period from November 2016 to October 2017) which is in line with the national benchmark (100). The current peer comparison and rolling HSMR trend are demonstrated in the following graphs.



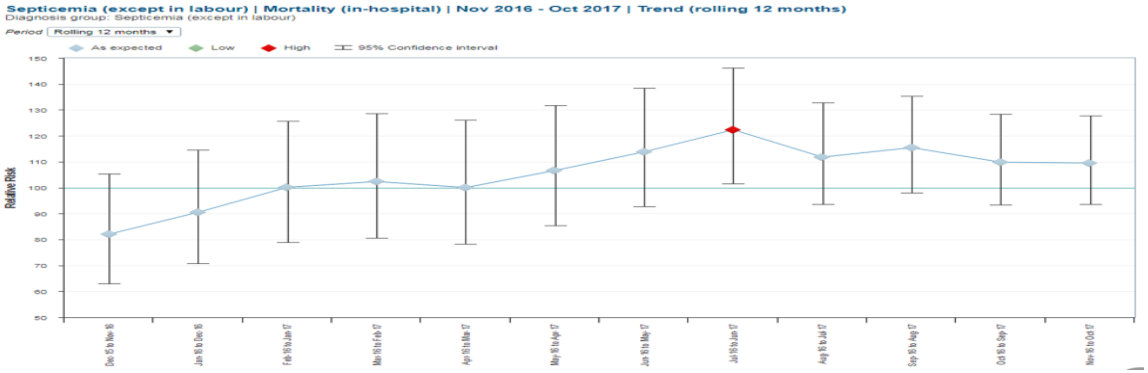


The latest SHMI value for the period July 2016 – June 2017 was published on 14 December 2017. The value has increased slightly to 1.07 from 1.06 in the previous data update (for the period April 2016 – March 2017). However, the SHMI remains within the expected range.

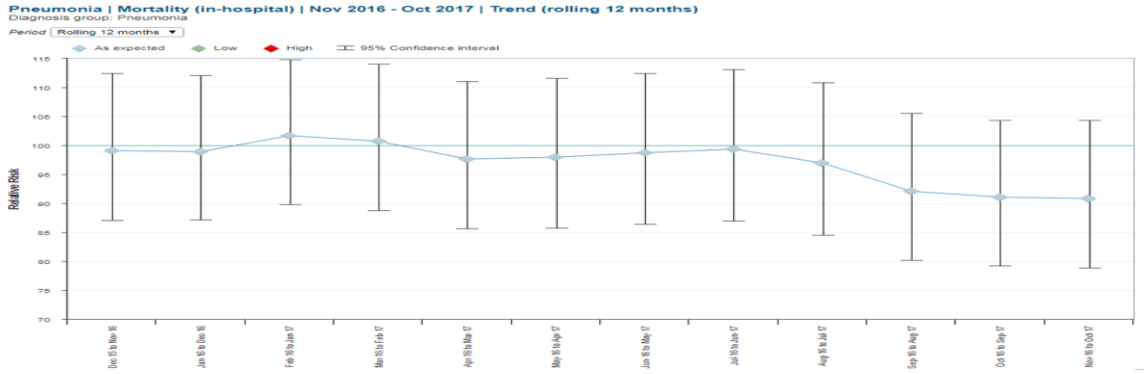
The rolling year trend is illustrated on the right.



The HSMR for Septicaemia is currently 110.07, which is within the expected range.



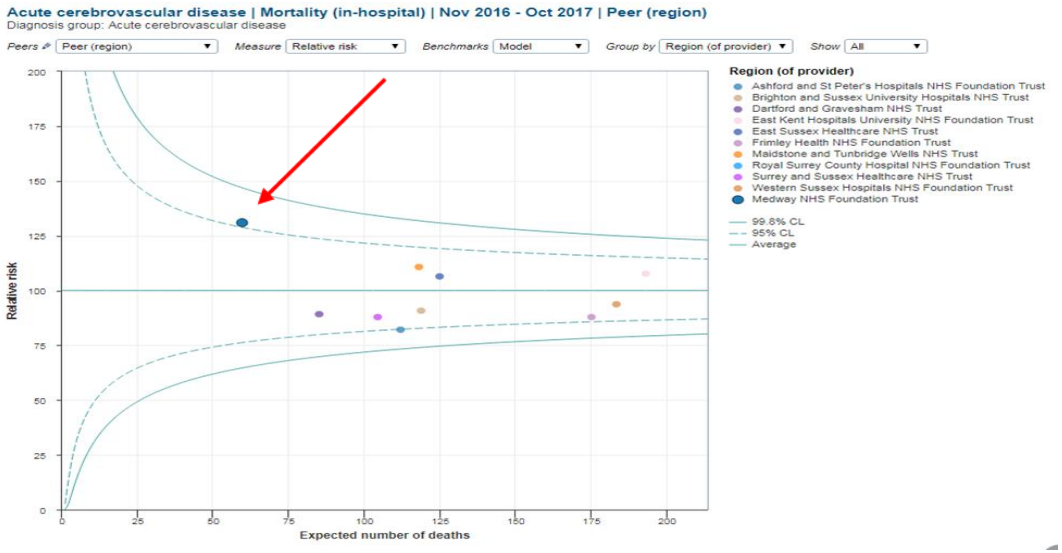
The HSMR for Pneumonia continues to decrease below the national benchmark (100) at 91.01.

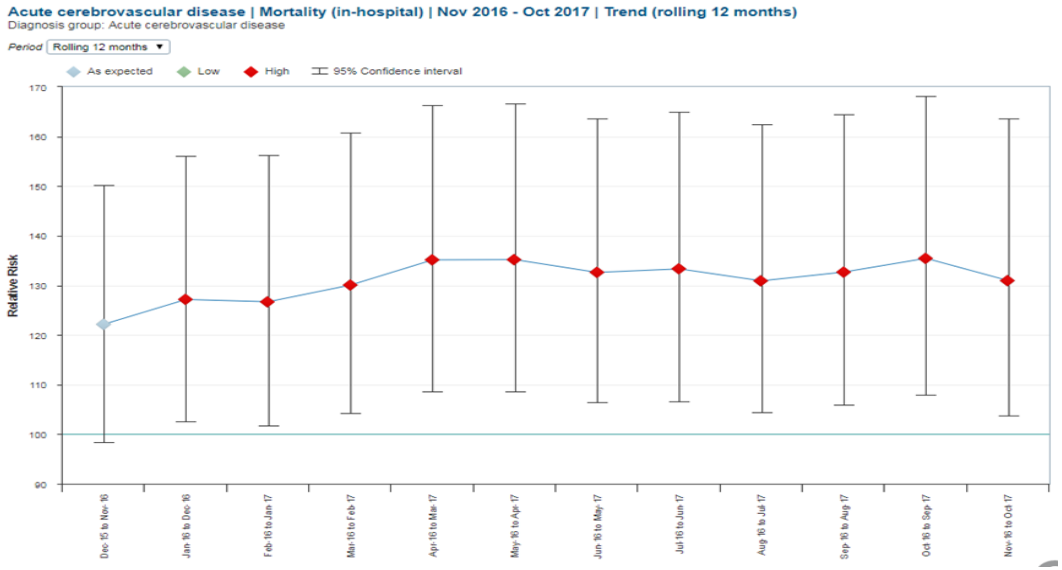


The HSMR for Congestive Cardiac Failure is also currently below the national benchmark (100) at 97.88.

The HSMR for Acute Cerebrovascular Disease has decreased, but remains slightly above the expected range at 131.0. The current peer comparison and rolling trend for this diagnosis group are demonstrated by the graphs.

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



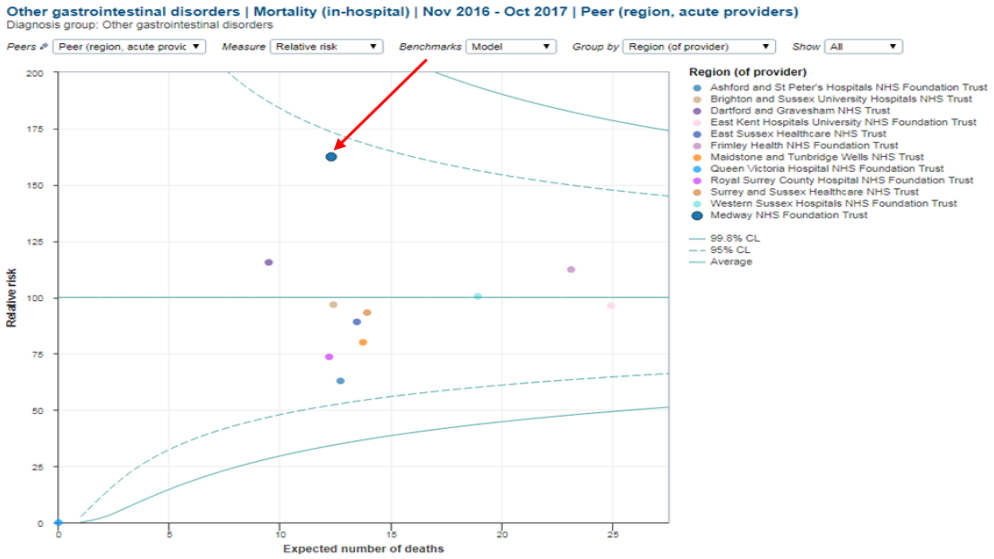


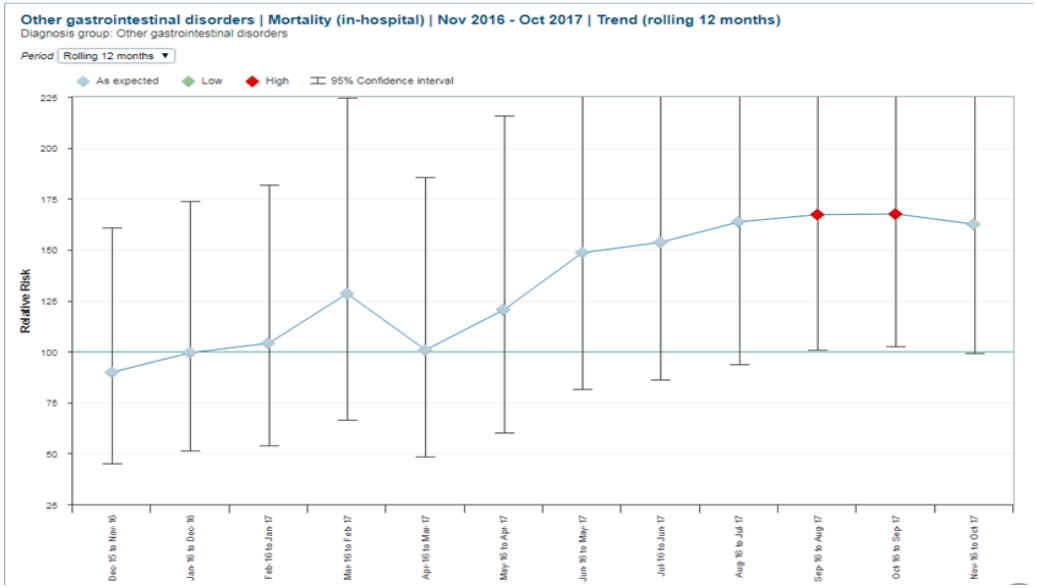
‘Other Gastrointestinal Disorders’ has also been identified as an outlier group in the December 2017 Dr Foster update; however, following the January update this diagnosis group is not alerting for the twelve months from November 2016 to October 2017.

The Head of Clinical Coding undertook a review of the cases assigned to this diagnosis group between October 2016 and September 2017. The main issues highlighted by this are that almost half of the cases reviewed had constipation as the primary diagnosis for their initial FCE. Validation suggests that 75% of these would not have had constipation as their primary diagnosis if they had single FCE spells. It was also highlighted that the cause of bowel perforation is not well documented.

We will continue to monitor this diagnosis group, but as it is not currently flagging up, at this stage no further investigation is required.

The data is correct at the time of compilation – Thursday 01 February 2018.





Effective Page 23

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

Caring Page 24

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

Reporting structures are being agreed in line with the renewed guidance from NHSI and NHSE South East. Recent bed pressures across the organisation have impacted on patient placement and a number of additional beds have been opened in our assessment units. This has caused an increase in the number of mixed sex breaches.

Responsive Page 25

- **RTT**

RTT performance in January deteriorated to 80.41%. The lower performance was expected due to the reduction in elective inpatient and day case activity in January. Normal activity has resumed in February.

Recovery plans have been developed for each speciality, including a revised trajectory to compliance in September and these have been shared with NHSi.

The numbers patients waiting greater than 52 weeks for treatment in January was 3, a reduction of 1 from December and ahead of the trajectory by 7.

Cancer

December performance against the cancer waiting time standards has improved on last month with compliant performance against all the standards with exception of the 2 week wait for symptomatic breast, the 62 day GP referral standard and the 62-day screening standard. The 62 day GP referral performance is non-compliant against the 85% standard and improvement trajectory.

- **2WW** - The Trust is compliant with the GP 2-week wait but not for the symptomatic breast standard.
  - There were 51 breaches in December across a number of tumour sites but only Lower GI were non-compliant.
  - Breaches were predominantly as a result of patients being unavailable for the first OPA, rescheduling booked appointments, prison availability and clinic changes.
  - 12 out of the 19 2-week wait breaches were booked within the target 48 hours from receipt of referral.
  - There were 7 breaches against the symptomatic breast standard due to patients changing appointments.

- **31D** – The Trust is compliant with the first definitive, subsequent drug and subsequent surgery treatments.
  - There were no breaches across all tumour sites.

- **62D** - The Trust failed to achieve compliance with the 62-day GP referral standard and the 62 day screening standard.
  - The 62-day GP standard performance was 84.62%, failing both the 85% standard and the improvement trajectory.
  - The shadow 38-day reporting performance was slightly improved at 85.09% which would result in the Trust being compliant against the 62-day GP standard.
  - There were 9 breaches against the 62-day GP referral standard. These are detailed as 1 Breast, 1 Gynaecology, 1 Haematology, 0.5 Head & Neck, 2 Lung, 1 Skin, 1 Upper GI and 1.5 Urology patients.
  - Pathway breaches were varied due to complex pathways, diagnostic delays, patient choice and delays at tertiary Trust.
  - There were 5.5 breaches over 104 days and 3.5 breaches between 62 and 76 days.
  - The Trust held a Cancer Summit on 14th December, with Clinical Leads presenting performance improvement plans and internal timed pathways which will support a revised CWT improvement trajectory. Additional Cancer Business informatics and management support has also been implemented.

Month	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
Standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
Trajectory	82.0%	83.5%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%	85.1%
Actual	**84.7%**	**74.24%**	**80.00%**	**82.07%**	**80.11%**	**72.29%**	**75.00%**	**78.03%**	**84.6%**			

Diagnostics

- The Diagnostic performance for January was challenged by capacity within the non-obstetric Ultrasound and Audiology modalities, the performance for January has therefore deteriorated and is still below the standard .
- The diagnostic waiting list backlog had continued to increase and is a key area of focus for clinical teams ensuring patients are offered diagnostic procedures at the first available opportunity.
- The Diagnostic PTL meeting is scheduled to begin in February.

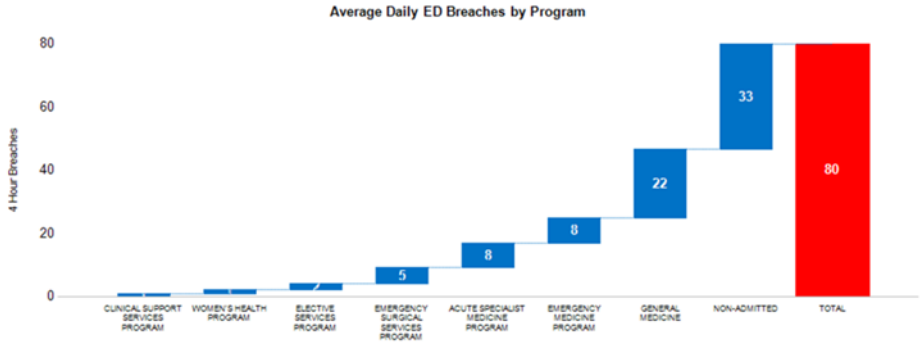
Diagnostic 6 Week Waiting Time Performance Summary												
Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Standard	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%
	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%	1.00%
Trajectory	92.10%	93.20%	94.40%	95.60%	96.80%	98.00%	99.20%	99.80%	99.80%	99.80%	99.80%	99.80%
Actual	95.16%	96.53%	96.13%	97.79%	95.09%	96.17%	97.36%	96.91%	96.42%	94.96%		
	4.84%	3.47%	3.87%	2.21%	4.91%	3.83%	2.64%	3.09%	3.58%	5.04%		

ED

The Trust's performance against the national 4 hour standard for January was 84.41%, December was 83.46%, November was 90.45%

January saw a 0.95% increase in 4 hour performance on December and was 10.59% below the planned trajectory of 95% for the month.

Performance below trajectory for January is primarily through lack of internal flow from the main bed base to discharge. The trust observed an average of 80 4hour breaches each day, a slight improvement of 3, the majority of which are within Medicines and due to bed availability.



- **ED (cont'd)**

The drivers for delay with discharge are multifactorial and span the entire continuum both internal and external to the trust.

There has been a 4.93% decrease in total attendances, though flow out of the ED remained challenged.

Admitted 4 hour performance for January was 34.81%, a slight uplift of 0.42% on the previous month and the Non-admitted pathway was 87.00%, a decrease on December 87.14 %. Minors and ED paediatrics both performed above 98%.

MFT remains consistently one of the top performers' in the region for ambulance handover with 30.8% of offloads within 15 minutes, seeing the largest number of conveyances in the region (3346).

January saw the continuance of the Better, Best, Brilliant (BBB) Flow workstream. The BBB work continued to focus on Delayed Transfers of Care reduction with a sector wide executive level daily teleconference continuing into the month. This consistent focus has been a key element of the sectors winter preparations and featured as a key note speech during the national NHS Benchmarking DToC conference in January.

There continues to be close monitoring of the length of stay on all of the wards to ensure patients spend no more time in an acute hospital setting than is required for their episode of care and that they return to their preferred place of care as soon as practicably possible.

The processes at ward level and the internal systems to support efficient working continued to be a key focus for improving bed availability in the month with a key aim to reduce bed occupancy.

The multi agency coordination of care continued to be a key focus for conversation during the trusts key operational meetings which occur a number of times a day in the trusts 's Clinical Control Centre and January saw the de -escalation of the winter contingency ward which had opened in December 2017.

Well Led Page 26

Voluntary turnover (across all staff groups) has decreased to 11.34% (-0.06%) as a result of a slight net increase of staff (fewer leavers than starters) and remains above the tolerance level of 8%; turnover, as expected, is to plateau/slight decrease over the next three months. Sickness absence at 3.81% is slightly elevated however, remains largely static and below the tolerance of 4%. Ratios of long-term sickness to short-term sickness have both slightly increased over the winter period.

In January, the Trust saw a net increase in staffing (fewer leavers than starters) by 1 FTE; however, January saw higher than average net nurse hires (net +9) and nurse support workers (net +7).

Temporary staff (as a percentage of the Trust's paybill) has increased by 2.87% when compared to December, with a 0.84% increase to agency spend and a 2.03% increase to bank spend. Overall, the Trust's profile of substantive to temporary spend remains positive for 17/18 when compared to 16/17 and works to continue working with suppliers and clinical programmes to reduce agency expenditure are underway. In addition, the Trust continues to actively support staff moving from temporary to substantive posts.

Enablers Page 27

Data Quality Validation Update

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

Emerging work:

The DQ team are supporting the Interim RTT Manager with validation for RTT Open PTL pathways across the specialities. At this stage, work is being scoped to determine how much of the RTT backlog are real data quality or capacity issues. Furthermore, DQ will assist the RTT project, to identify opportunities of supporting specific groups of staff or specialities, who require an enhanced understanding of the RTT Rules and Guidance.

Existing work projects:

- **Cancer PTL Open Pathways update:** the DQ Team continues to support investigations into open cancer pathways on the Infoflex system pre 2015 period. The purpose of the project has been to close historic open pathways in preparation of a new InfoFlex system upgrade in April 2018. The team have investigated **5757** records across multiple tumour groups and closed **5606** patient pathways. Outstanding queries that the DQ team are unable to determine, have been passed to the Cancer Services Team to investigate. Surplus to the historic data project, the DQ team are processing newly identified Bowel Screening patient pathways that require data validation, referring to pre-2015 time period. The Cancer Information System fully supports monitoring of the pathways of suspected cancer patients from receipt of referral until discharge or diagnosis and then on to treatment.
- **E-referral bookings:** DQ team have worked with project team and ensured that all outcomes are correctly linked to the PAS system. The next stage is to look at pathways with old consultants that need to be closed.

Data Quality Training

To date a total of 79 staff members have attended the RTT Decision making training session from an estimated 500 staff that have been identified as having pathway involvement or require 18 week knowledge.

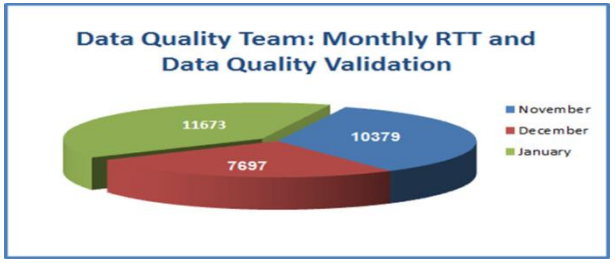
In general, staff have a basic understanding of the RTT 18 week guidelines; however, this varies between job roles and specialities. Reasons for stopping clocks and how to apply guidelines in specific roles and patient groups, is a common theme.

Other DQ Validation Work:

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

Quarterly DQ statistics

The chart below, gives a quarterly overview of combined RTT and DQ related validation of patient records across the clinical directorates that has been carried out by the DQ team between November 2017 and January 2018.



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

Data Quality Validation statistics		
Month	RTT Validation	DQ Validation
Nov	3760	6619
Dec	3204	4493
Jan	4089	6864

3. Safe

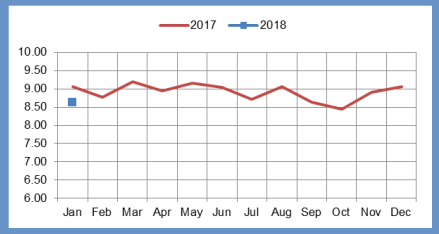
		Monthly Target	RAG Status	Trend Nov-17	Dec-17	Jan-18	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
1.1.3.2	NRLS Organisational Reporting Rate (6 monthly)		G	46.74 (national median 40.14)								
1.1.4	Never events	0	G	2.00	0.00	0.00	⇔	0.1				✓
1.1.4.1	Never Events - Incidence Rate	0.00%	G	0.02%	0.00%	0.00%	⇔	0.0			✓	
1.1.5	Incidents resulting in death	0	R	4.00	4.00	8.00	↑	4.1				✓
1.1.6	Incidents resulting in severe harm (per 1000 bed days)	0.30	G	0.31	0.08	0.13	↑	0.31				✓
1.1.7	Incidents resulting in moderate harm (per 1000 bed days)	2.20	G	0.92	1.07	1.21	↑	1.4				✓
1.1.10	Incidents with moderate or severe harm with duty of candour response	100%	R	15.0%	0.0%	3.4%	↑	0.1				✓
1.1.14	Pressure ulcers (grade 2) attributable to trust	10	R	5.00	4.00	13.00	↑	7.1				✓
1.1.15	Pressure ulcers (grade 3&4)	0	R	0.00	0.00	2.00	↑	0.9				✓
1.1.17	Patient falls with moderate or severe harm (per 1000 bed days)	0.2	G	0.23	0.07	0.19	↑	0.1				
1.1.18	Falls per 1000 bed days	6.63	G	5.46	4.37	4.33	↓	5.0				
1.1.19	Number of falls to fracture (per 1000 bed days)	0.2	G	0.23	0.07	0.13	↑	0.1				
1.1.20	NHS England/NHS Improvement Patient Safety Alerts Outstanding	0	G	0.00	0.00	0.00	⇔	0.0			✓	
1.1.21	% Duty of Candour with first letter	100%	R	0.0%	0.0%	0.0%	⇔				✓	
1.2.2	New VTEs - point prevalence in month	0.36%	G	0.00%	0.21%	0.21%	⇔	0.7%			✓	
1.2.7	Emergency c-section rate	<15%	R	15.1%	20.0%	16.7%	↓	18.8%				
1.3.1	MRSA screening of admissions	95%	R	97.3%	94.2%	84.6%	↓	94%				✓
1.3.2	MRSA bacteraemia (trust – attributable)	0	G	1.00	0.00	0.00	⇔	1			✓	
1.3.3	C-Diff acquisitions (Trust-attributable; post 72 hrs)	2	R	1.00	4.00	3.00	↓	2			✓	✓
1.4.1	Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	103.72 (97.88-109.81)							✓	✓
1.4.1.2	Weekend Hospital Standardised Mortality Ratio (HSMR) (2 months in arrears)	100	G	113.63 (101.59-126.70)							✓	
1.4.2	Summary Hospital-level Mortality Indicator (SHMI)	1	G	1.07 (0.89-1.12)							✓	✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

Safe Staffing – Nursing Update - Highlights

Care Hours per Patient per Day

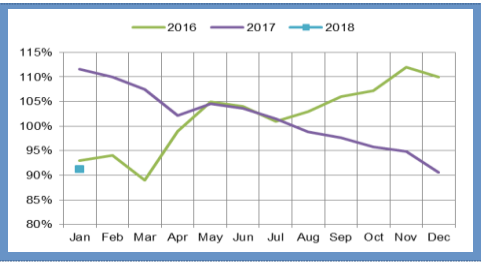
We have continued to see good performance remaining over the target of 8 for January.



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

Safe Staffing

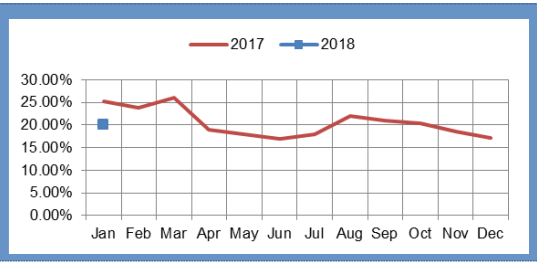
a small dip in the safe staffing occurred due to an increase in demand.



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

Temporary Staffing

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



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

Staffing Levels – Nursing & Clinical Support Workers

		Day				Night				Day		Night		Internal KPIs				
		Registered Staff		Care Staff		Registered Staff		Care Staff										
WARD	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	*Average fill rate - registered staff (%)*	*Average fill rate - care staff (%)*	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Total Planned Hours (registered & care)	Total Actual Hours (registered & care)	Overall fill rate	Difference total Actual vs Planned hs	Difference total Actual vs Planned %
Arethusa Ward	27	1998	1570	1346	1653	1375	1476	1122	1468	*79%*	*123%*	*107%*	*131%*	*5,841*	*6,167*	*106%*	*326*	*6%*
ICU	9	3831	3166	0	0	3488	3059	0	0	*83%*		*88%*		*7,319*	*6,225*	*85%*	*- 1,094*	*-15%*
Kingfisher SAU	14	2402	1802	1149	1405	1705	1677	1023	1012	*75%*	*122%*	*98%*	*99%*	*6,279*	*5,896*	*94%*	*- 383*	*-6%*
McCulloch Ward	29	2495	1354	1186	1580	1705	1716	1023	1145	*54%*	*133%*	*101%*	*112%*	*6,409*	*5,795*	*90%*	*- 614*	*-10%*
Medical HDU	6	1506	1383	405	334	1415	1303	0	138	*92%*	*82%*	*92%*		*3,326*	*3,158*	*95%*	*- 168*	*-5%*
Pembroke Ward	27	2277	1593	1584	1693	1705	1705	1375	1595	*70%*	*107%*	*100%*	*116%*	*6,941*	*6,585*	*95%*	*- 356*	*-5%*
Phoenix Ward	30	2488	1400	1596	1392	1705	1617	1364	1298	*56%*	*87%*	*95%*	*95%*	*7,153*	*5,707*	*80%*	*- 1,447*	*-20%*
SDCC	26	2599	1378	1372	893	682	727	341	440	*53%*	*65%*	*107%*	*129%*	*4,994*	*3,438*	*69%*	*- 1,555*	*-31%*
Surgical HDU	10	2278	2161	374	354	1948	1960	0	11	*95%*	*94%*	*101%*		*4,600*	*4,485*	*98%*	*- 114*	*-2%*
Victory Ward	18	1532	727	0	0	1023	957	0	12	*47%*		*94%*		*2,555*	*1,695*	*66%*	*- 860*	*-34%*
Delivery Suite	15	2889	2856	736	719	2868	2849	408	406	*99%*	*98%*	*99%*	*99%*	*6,901*	*6,829*	*99%*	*- 72*	*-1%*
Dolphin (Paeds)	34	3653	3108	1217	997	2852	2622	357	414	*85%*	*82%*	*92%*	*116%*	*8,078*	*7,141*	*88%*	*- 938*	*-12%*
Kent Ward	24	1060	1056	402	413	660	637	648	648	*100%*	*103%*	*96%*	*100%*	*2,770*	*2,753*	*99%*	*- 16*	*-1%*
NICU	25	3890	3587	150	150	4267	3741	0	0	*92%*	*100%*	*88%*		*8,306*	*7,478*	*90%*	*- 828*	*-10%*
Ocelot Ward	12	909	854	534	823	744	744	372	658	*94%*	*154%*	*100%*	*177%*	*2,559*	*3,079*	*120%*	*520*	*20%*
Pearl Ward	23	1119	1095	604	592	1116	1131	372	372	*98%*	*98%*	*101%*	*100%*	*3,210*	*3,190*	*99%*	*- 21*	*-1%*
The Birth Place	9	1030	1032	372	372	1050	1056	360	360	*100%*	*100%*	*101%*	*100%*	*2,812*	*2,819*	*100%*	*8*	*0%*
Bronte Ward	18	1651	1056	1134	1129	1093	1070	729	763	*64%*	*100%*	*98%*	*105%*	*4,607*	*4,017*	*87%*	*- 589*	*-13%*
Byron Ward	26	1625	1008	2033	1827	1046	1012	1395	1398	*62%*	*90%*	*97%*	*100%*	*6,099*	*5,245*	*86%*	*- 854*	*-14%*
CCU	4	1044	839	0	0	706	706	0	0	*80%*		*100%*		*1,750*	*1,546*	*88%*	*- 205*	*-12%*
Gundulph	25	1983	1374	1577	1508	1364	1358	1364	1329	*69%*	*96%*	*100%*	*97%*	*6,288*	*5,567*	*89%*	*- 721*	*-11%*
Harvey Ward	24	1626	1254	1678	1739	1047	1255	1395	1502	*77%*	*104%*	*120%*	*108%*	*5,746*	*5,749*	*100%*	*3*	*0%*
Keats Ward	27	1708	1050	1230	1518	1024	996	1023	1188	*61%*	*123%*	*97%*	*116%*	*4,985*	*4,751*	*95%*	*- 234*	*-5%*
Milton Ward	27	1663	990	2375	2168	1046	1080	2093	1962	*59%*	*91%*	*103%*	*94%*	*7,177*	*6,200*	*86%*	*- 977*	*-14%*
Nelson Ward	24	1655	1126	1260	1307	1023	962	682	892	*68%*	*104%*	*94%*	*131%*	*4,620*	*4,287*	*93%*	*- 332*	*-7%*
Sapphire Ward	28	1715	695	1276	1375	1023	947	682	1122	*41%*	*108%*	*93%*	*165%*	*4,696*	*4,140*	*88%*	*- 557*	*-12%*
Tennyson Ward	27	1665	997	1968	1807	1046	1061	1390	1305	*60%*	*92%*	*101%*	*94%*	*6,070*	*5,171*	*85%*	*- 899*	*-15%*
Wakely Ward	25	2108	1391	1569	1476	1395	1339	1395	1384	*66%*	*94%*	*96%*	*99%*	*6,467*	*5,589*	*86%*	*- 878*	*-14%*
Will Adams Ward	26	1602	1090	1141	1408	1023	1100	1012	1287	*68%*	*123%*	*108%*	*127%*	*4,778*	*4,884*	*102%*	*107*	*2%*
Lawrence Ward	19	1128	1111	886	911	698	711	698	698	*98%*	*103%*	*102%*	*100%*	*3,409*	*3,430*	*101%*	*21*	*1%*
Trust total	**638**	**59,127**	**44,099**	**31,153**	**31,539**	**43,840**	**42,573**	**22,621**	**24,804**	***74.6%***	***101.2%***	***97.1%***	***109.7%***	**156,741**	**143,015**	**91%**	**-13726**	**-8.8%**

Staffing Levels – Nursing & Clinical Support Workers

	Quality Metrics / Actual Incidents								
WARD	Number of escalations of nurse staffing	Number of hospital acquired Pressure Ulcers grade 2 and above	Number of Falls with moderate to severe harm	Number of patient related medication errors - moderate to	Number of complaints relating to nursing care	Post 72 Hour CDIFF Acquisitions	MRSA Colonisations Post 48 hours	MRSA Bacteraemia Post 48 Hours	Care Hours Per Patient Day Overall
Arethusa Ward	2	1	0	0	0	0	0	0	7.61
Bronte Ward	0	2	0	0	0	0	1	0	7.41
Byron Ward	0	0	0	0	2	0	0	0	6.76
CCU	0	1	0	0	0	0	0	0	12.67
Delivery Suite	3	0	0	0	0	0	0	0	20.51
Dolphin (Paeds)	0	0	0	0	1	0	0	0	16.80
Gundulph	0	1	1	0	0	0	0	0	7.79
Harvey Ward	3	1	0	0	2	0	0	0	8.01
ICU	2	0	0	0	0	0	0	0	24.80
Keats Ward	4	1	0	0	0	0	4	0	6.16
Kent Ward	0	0	0	0	1	0	0	0	7.61
Kingfisher SAU	0	0	0	0	0	0	0	0	19.92
Lawrence Ward	0	1	0	0	0	0	0	0	6.77
McCulloch Ward	0	1	1	0	1	0	1	0	6.82
Medical HDU	1	0	0	0	0	0	0	0	18.46
Milton Ward	0	1	0	0	0	2	0	0	7.81
Nelson Ward	0	0	0	0	0	0	0	0	5.86
NICU	0	0	0	0	0	0	0	0	11.91
Ocelot Ward	0	0	0	0	0	0	0	0	8.72
Pearl Ward	0	0	0	0	0	0	0	0	7.04
Pembroke Ward	0	0	1	0	1	0	0	0	8.15
Phoenix Ward	1	3	0	0	2	0	0	0	6.48
Sapphire Ward	0	1	0	0	0	0	0	0	6.91
SDCC	0	0	0	0	0	0	0	0	8.01
Surgical HDU	0	0	0	0	0	0	0	0	15.15
Tennyson Ward	1	0	0	0	0	0	0	0	6.28
The Birth Place	1	0	0	0	0	0	0	0	18.43
Victory Ward	0	0	0	0	0	1	1	0	3.61
Wakeley Ward	0	0	0	0	2	0	0	0	7.72
Will Adams Ward	1	0	0	0	1	0	1	0	6.17
Trust total	**19**	**14**	**3**	**0**	**13**	**3**	**8**	**0**	16583.00

Safe Staffing– Nursing Update KPIs

		Monthly Target	RAG Status	Trend Nov-17	Dec-17	Jan-18	Movement	YTD avg	Trend	Data Quality
1.5.2	Vacancy Rate (Overall)	*8%*	R	26.47%	26.78%	27.20%	↑	26.58%		
1.5.3	Total Vacancies (WTE)	*TBC*		419.54	419.90	425.79	↑	416.3		
1.5.4	Vacancy Rate (Band 5)	*TBC*		36.32%	36.68%	37.38%	↑	36.64%		
1.5.5	Vacancy Rate (Band 6)	*TBC*		20.92%	21.41%	20.61%	↓	21.76%		
1.5.6	Vacancy Rate (CSW)	*TBC*		13.34%	14.61%	16.42%	↑	15.79%		
1.5.7	Nursing Starters	*TBC*		7	6	16	↑	11.0		
1.5.8	Nursing Leavers	*TBC*		16	28	6	↓	15.5		
1.5.9	CSW Starters	*TBC*		1	8	6	↓	7.3		
1.5.10	CSW Leavers	*TBC*		12	5	4	↓	6.8		
1.5.11	Rolling annual turnover rate	*8%*	R	11.17%	11.47%	11.36%	↓	10.99%		
1.5.16	Safe Staffing	*94.00%*	R	94.9%	90.6%	91.2%	↑	95.3%		
1.5.17	CHPPD	*8.00*	G	8.91	9.07	8.62	↓	8.94		

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

Commentary	Actions

4. Effective

		Monthly Target	Status	Trend						Alignment		
			Status	Nov-17	Dec-17	Jan-18	Movement	YTD avg	Data Quality	Carter	SOF	Locality Account / CQUIN
2.5.4	Emergency Readmissions within 28 days	10%	R	11.84%	12.75%	10.77%	↓	12%			✓	
2.5.4.1	Emergency Readmissions within 28 days Under 65	10%	R	10.51%	10.36%	10.36%	↔	10%			✓	
2.5.4.2	Emergency Readmissions within 28 days 65 +	10%	R	14.43%	17.00%	17.00%	↔	16%			✓	
2.6	Discharges before noon	25%	R	21.30%	17.67%	20.39%	↑	19%			✓	✓

	CQUIN DESCRIPTION	CQUIN LEAD	Value	Reporting Frequency to Commissioners	Q1
1	Improving Health and Wellbeing of Staff	Gemma Nauman, Service Manager, Occupational Health	157,525	Annual report to the CCG on the publication of 2017 (year 1) & 2018 (year 2) staff survey – expected to be released in February 2018 & 2019 respectively	On target. No report required.
2	Healthy food for NHSE staff, visitors and patients	Peter Reeson, Catering Manager	157,525	End of Quarter 4	On target. Although no report is required, the action plan for 2016/17 has been updated to reflect the work that is being achieved to build on the 4 changes from last year.
3	Improving the update of flu vaccinations for front line staff within providers	Gemma Nauman, Service Manager, Occupational Health	157,525	1) Providers to submit cumulative data monthly on the ImmForm website. 2) Final report to the CCG at Q4	On target. No report required.
4	Timely Identification of Seps is in ED and acute inpatient settings	Cliff Evans, Nurse Consultant	118,144	Quarterly reports	An action plan has been agreed. For ED achieved 93%, and for inpatient areas, achieved 55%. Overall, for Q1 achieved 74%.
5	Timely treatment for Sepsis in ED and acute inpatient settings	Cliff Evans, Nurse Consultant	118,144	Quarterly reports	An action plan has been agreed. For ED achieved 67%, and for inpatients 31%. Overall, for Q1 achieved 49%.
6	Antibiotic review	Busola Ade-Ojo, Chief Pharmacist	118,144	1). Monthly audit of a minimum of 30 patients diagnosed with sepsis. Audit data should be submitted to PHE via an online submission portal. 2) Quarterly report on an empiric review of notes as per CQUIN milestones	Quarterly report is expected by 31st July 2017. Awaiting confirmation of monthly data submissions to PHE
7	Reduction in antibiotic consumption per 1,000 admissions	Busola Ade-Ojo, Chief Pharmacist	118,144	1) Quarterly submission of antibiotic consumption data to be submitted to PHE 2) Annual report to the CCG	Awaiting confirmation that Q1 data has been submitted to PHE
8	Improving services for people with mental health needs who present to A&E	Clare Hughes, Lead Matron Emergency Pathways	472,576	1) Quarterly submissions to CCG relating to the milestones set out in the CQUIN. 2) Single annual submission to NHS England Digital.	We are working closely with KMPT and have agreed a shared cohort of 15 patients and agreed baseline of 160. Monthly meetings with KMPT have been scheduled to ensure the CQUIN plan is on track. We are currently planning for audit which is required in Q2.
9	Offering advice and guidance (non emergency A&G)	None identified	472,576	The provider will meet with Commissioners at least quarterly, initially to review the implementation of the A&G service and then to monitor impact through the main indicator.	There is no lead identified for this CQUIN and no report is available for Q1. At Clinical Council on 12th July 2017, at which GPs were in attendance, there was a discussion about an electronic consultation service. It was agreed that MFT and GPs will work together to implement an electronic consultation service.
10	NHS e-referrals	Benn Best, General Manager	236,288	Quarterly reports	On target to achieve. The e-referral project group meets monthly
11	Supporting proactive and safe discharge	Amanda Gibson, Lead Matron for Discharge	472,576	1) Quarterly data using HES data available via NHS Digital 2) Quarterly report to the CCG	No report or update received
12	Preventing ill health by risky behaviours – alcohol and tobacco Tobacco Screening	James Lowell, Director of Operations	11,814	No reports required for 2017/18	This CQUIN is applicable from April 2018.
13	Preventing ill health by risky behaviours – alcohol and tobacco Tobacco brief advice	James Lowell, Director of Operations	47,258	No reports required for 2017/18	This CQUIN is applicable from April 2018.
14	Preventing ill health by risky behaviours – alcohol and tobacco Tobacco referrals and medication offer	James Lowell, Director of Operations	59,072	No reports required for 2017/18	This CQUIN is applicable from April 2018.
15	Preventing ill health by risky behaviours – alcohol and tobacco Alcohol Screening	James Lowell, Director of Operations	59,072	No reports required for 2017/18	This CQUIN is applicable from April 2018.
16	Preventing ill health by risky behaviours – alcohol and tobacco Alcohol brief advice or referral	James Lowell, Director of Operations	59,072	No reports required for 2017/18	This CQUIN is applicable from April 2018.
17	Hospital Medicines Optimisation	Busola Ade-Ojo, Chief Pharmacist	96,000	Quarterly reports	Quarterly report is expected by 31st July 2017.
18	Shared Decision Making	Alistair Lindsay, Director of Operations	Expected to be £120k for a cohort of 400 patients	Quarterly reports	No update has been provided. The value has not been confirmed as the patient cohort has not been identified and shared with NHSE.
19	Complex Device Optimisation	Simon Weeks, General Manager	40,000		CQUIN Lead is speaking with Fiona Mackison at NHSE to get guidance and support.
20	School Age Immunisations	Barbara Jeffery, Lead Nurse for School Health	3,154	Quarterly reports	On target to achieve.

5. Caring

		Monthly Target	RAG Status	Trend Nov-17	Dec-17	Jan-18	Movement	YTD avg	Data Quality	Alignment Carter	SOF	Quality Account / CQUIN
3.1.2	Admitted: Friends and Family Test % extremely likely/likely to recommend	*83%*	G	89.9%	86.2%	87.0%	↑	88%			✓	
3.2.2	A&E: Friends and Family Test % extremely likely/likely to recommend	*65%*	G	81.8%	76.1%	76.6%	↑	82%			✓	
3.3.2	Maternity: Friends and family test % extremely likely/likely to recommend	*79%*	G	99.2%	99.0%	100.0%	↑	99%			✓	
3.1.3	Mixed Sex Accommodation breaches	*15*	R	46.00	158.00	159.00	↑	48.1			✓	
3.4.1	Number of Complaints	*45*	R	62.00	41.00	73.00	↑	67			✓	
3.4.2	Complaint Response Rate <30 days (2 months in arrears)	*85%*	R	55.9%				49%			✓	
3.4.3	Number of complaint returners	↓	G	2.00	2.00	1.00	↓	3.1			✓	

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

6. Responsive

		Monthly Target	Status	Trend						Alignment		
			Status	Nov-17	Dec-17	Jan-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CoLIN
4.1.1	RTT – Incomplete pathways (overall)	92%	R	81.76%	85.68%	80.41%	↓	82.14%			✓	
4.1.2	RTT - Treatment Over 52 Weeks	0	R	8	4	3	↓	27				
4.2.3	A&E 4 hour target (all Types from Nov 2017)	95%	R	90.45%	83.46%	84.41%	↑	86.64%			✓	
4.3.1	Cancer – 2 week wait (1 month in arrears)	93%	G	94.88%	95.42%		↑	85.90%				
4.3.2	Cancer - 2 Week Wait Breast (1 month in arrears)	93%	R	84.71%	89.39%		↑	89.83%				
4.3.3	Cancer - 31 day first treatment (1 month in arrears)	96%	G	98.81%	100.00%		↑	97.01%				
4.3.4	Cancer – 31 day subsequent treatments – surgical (1 month in arrears)	94%	G	100.00%	100.00%		↔	97.11%				
4.3.5	Cancer – 31 day subsequent treatments - drug (1 month in arrears)	98%	G	100.00%	100.00%		↔	97.42%				
4.3.6	Cancer - 62 day consultant upgrade (1 month in arrears)	N/A		75.76%	83.33%		↑	73.93%				
4.3.7	Cancer – 62 day urgent GP referrals (1 month in arrears)	85%	R	78.03%	84.62%		↑	78%			✓	
4.3.9	Cancer – 62 day screening (1 month in arrears)	90%	R	100.00%	75.00%		↓	86%			✓	
4.4.1	Diagnostic waits - under 6 weeks	99%	R	96.91%	96.42%	94.96%	↓	96%			✓	
4.5.8	Patients seen by a stroke consultant within 24 hours (Aug to Nov figures reported)	95%	R	53.90%	53.90%	51.00%	↓	56%				✓
4.6.1	Average elective Length of Stay	<5	G	2.13	2.41	2.66	↑	2.3				✓
4.6.2	Average non-elective Length of Stay	<5	R	6.11	5.27	6.59	↑	7.1				✓
4.6.6	Average occupancy	90%	R	97.58%	93.49%	94.66%	↑	95%				✓

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

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

7. Well led

		Monthly Target	Status	Trend						Alignment		
			Status	Nov-17	Dec-17	Jan-18	Movement	YTD avg	Data Quality	Carter	SOF	Quality Account / CQUIN
5.2.1	Staff Friends and Family – Recommend as place to work (Quarterly)	62%	R		52.7%		↓	58.0%			✓	
5.2.2	Staff Friends and Family – Recommend for care or treatment (Quarterly)	79%	R		66.6%		↓	70.7%			✓	
5.3.7	Rolling annual turnover rate	8%	R	11.2%	11.5%	11.4%	↓				✓	
5.3.7.1	Executive Team Turnover Rate	TBA		6.7%	0.0%	0.0%	↔	3.8%			✓	
5.3.8	Overall Sickness rate	4.0%	G	3.76%	3.74%	3.81%	↑	3.8%				
5.3.9	Sickness rate – Short term	3.0%	G	1.81%	1.78%	1.83%	↑	1.9%			✓	
5.3.10	Sickness rate – Long term	1.0%	R	1.95%	1.96%	1.98%	↑	1.9%			✓	
5.3.11	Temporary staff % of pay bill	15%	R	18.5%	17.1%	20.0%	↑	19.3%			✓	
5.3.14	Starters	N/A		27	33	41	↑	85.1				
5.3.15	Leavers	N/A		56	62	40	↓	69.3				

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

8. Enablers

		Monthly Target	Status	Trend						Alignment		
			Status	Nov-17	Dec-17	Jan-18	Movement	YTD avg	Data Quality	Carter	SDF	Quality Account / CQUIN
7.2.1	APC – NHS number completeness (2 month in arrears)	99%	R	98.9%				98.9%				✓
7.2.8	A&E – Attendance disposal (2 month in arrears)	99%	R	87.4%				93.4%				✓
7.3.8a	RTT large No. of patients with an unknown clock start (1 month in arrears)	11	R	107	160		↑	144.6		✓		✓
7.3.8b	RTT % of patients with an unknown clock start (1 month in arrears)	0	G	0	0		↔	0.0				
7.3.9a	RTT No. cancelled referral, pathway still open (1 month in arrears)	99.25	G	76	70		↓	102.0		✓		✓
7.3.9b	RTT % cancelled referral, pathway still open (1 month in arrears)	1%	G	0.4%	0.3%		↓	0.5%		✓		✓
7.3.10a	RTT No. appt outcome suggest clock stop, pathway still open (1 month in arrears)	103.50	G	8	6		↓	3.86				
7.3.11a	RTT No. deceased patient with an open pathway (1 month in arrears)	0.00	R	1.00	3.00		↑	2.14				
7.3.13a	A&E No. missing breach reason on breached attendances (1 month in arrears)	949	R	1337	2537		↑	1346.0		✓		✓
7.3.13b	A&E % missing breach reason on breached attendances (1 month in arrears)	50%	G	100.0%	100.0%		↔	100.0%		✓		✓
7.3.17	Cancer 2ww invalid NHS Number (1 month in arrears)	0.25	R	0	1		↑	1.6		✓		✓
7.3.21	Cancer 2ww missing breach reason (1 month in arrears)	13.25	G	0	0		↔	0.7		✓		✓
7.3.22	Cancer 2ww % Oasis referral records missing on Infoflex (1 month in arrears)	0.01	G	0.01	0.01		↔	1%		✓		✓
7.3.25	Cancer 31 day missing primary diagnosis (1 month in arrears)	2	G	0	0		↔	3.0		✓		✓
7.3.29	Cancer 31 day missing breach reason (1 month in arrears)	1.25	G	0	0		↔	0.3		✓		✓
7.3.32	Cancer 62 day missing primary diagnosis (1 month in arrears)	1.25	G	0	0		↔	2.9		✓		✓
7.3.36	Cancer 62 day missing breach reason (1 month in arrears)	1	G	1	1		↔	1.1		✓		✓

Commentary	Actions
Please see Executive Summary	Please see Executive Summary

NHS
Medway
NHS Foundation Trust

Report to the Board of Directors

Board Date: Thursday, 01 March 2018 Item No: 10b

Title of Report	**CQC Preparedness**
Prepared By:	Michelle Woodward, Associate Director of Quality
Lead Director	Karen Rule, Executive Director of Nursing Simone Hay, Deputy Director of Nursing/CQC Project Lead
Committees or Groups who have considered this report	The Quality Assurance Committee have received a verbal update in line with the content of this report.
Executive Summary	The purpose of this report is to provide the Trust Board with an overview as to organisational preparedness for the forthcoming Care Quality Commission (CQC) Core Service with Well Led inspection.
Resource Implications	The Trust have engaged some limited external expertise to support the well-led aspect of the inspection. There has been a necessity to divert some staffing resource to support the CQC project Team.
Risk and Assurance	Failure to ensure appropriate arrangements are in place for organisational preparedness for the forthcoming core services with well-led inspection could impact on the CQC rating allocated against each core service with respect to the five key lines of enquiry (KLOE).
Legal Implications/Regulatory Requirements	The Trust is required to comply with the requirements of the following statutory provisions: • The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015 • Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 • Care Quality Commission (Registration) Regulations 2009
Improvement Plan Implication	The arrangements organisational preparedness will benefit the improve plan.

Report to the Board of Directors

Quality Impact Assessment	N/A			
Recommendation	The Board is asked to note the content of this report.			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☐	☒	☐	☒

Report to the Board of Directors

1. Executive Overview

The purpose of this report is to provide the Trust Board with an overview as to organisational preparedness for the forthcoming Care Quality Commission (CQC) Core Service with Well Led inspection.

2. Background

In 2011 and 2012 Medway NHS Foundation Trust was identified as a mortality outlier for both the hospital standardised mortality ratio (HSMR) and the summary hospital mortality indicator (SHMI). Consequently, Professor Sir Bruce Keogh (NHS England National Medical Director) carried out a rapid responsive review of the Trust in May 2013 and the findings resulted in the Trust being placed into special measures in July 2013.

The CQC then undertook two comprehensive inspections of Medway Maritime Hospital in April 2014 and August 2015. The Trust was rated inadequate overall at both of these inspections. In August 2015 the Trust was rated inadequate overall because of concerns relating to patient safety, the organisational culture and governance throughout the trust.

Following this inspection the CQC maintained a heightened programme of engagement. The Trust had formalised a buddying agreement with Guys' and St Thomas' NHS Trust. The Trust was also subject to additional scrutiny and support from the local clinical commissioning groups and NHSI through a monthly Quality Oversight Committee which monitored the implementation of action plans to address the shortcomings identified.
The CQC inspected Medway NHS Foundation Trust in November and December 2016. The inspection was specifically designed to test the requirement for the continued application of special measures at the Trust. Medway NHS Foundation Trust were rated as 'Requires Improvement' overall and removed from the special measures regime.

3. Core service[1] with well-led Inspection

These are annual and involve inspecting the five key questions[2] in at least one core service, followed by an inspection of how well-led a provider is. An additional service[3] may also be inspected. Most core (and additional) service inspections will normally be unannounced.

The inspection of the well-led key question at trust level will follow the core service(s) inspection. This will be announced after the Regulatory Planning Meeting to provide time to

[1] Acute hospital core services include urgent and emergency services, medical care (including older people's care), surgery, critical care, maternity, services for children and young people, end of life care and outpatients.
[2] CQC key lines of enquiry: Is it safe? Is it effective? Is it caring? Is it responsive? Is it well led?
[3] Examples of additional services for Acute Hospitals can include gynaecology, diagnostic imaging, rehabilitation and spinal injuries.

schedule the appropriate interviews. This assessment focuses on well-led at trust level, and draws on the CQC's wider knowledge of quality in the trust at all levels.

4. CQC Engagement Meetings

The Trust has a CQC Inspection Manager who is designated as our relationship holder; regular contact is maintained via monthly engagement meetings which were formally reinstated when the Trust exited special measures. The engagement meetings are held onsite and are attended by members of the Executive Team. The engagement meetings will be expanded to include walkabouts and focus groups.

During the course of the engagement meeting which took place on 9 January 2018, the forthcoming inspection schedule was discussed and the CQC Inspection Manager advised that:

- The Trust will be subject to a core service with well-led inspection
- Following submission of the RPIR the CQC will analyse the data over a period of approximately four weeks
- The Well Led inspection will be held over a 2-3 day period
- The Trust will be given between 8 and 12 weeks written notice of when the Well Led inspection will take place; during this period, a number of core services will be subject to unannounced inspection, in some cases 30 minutes' notice will be given

5. Routine Provider Information Request (RPIR)

The CQC will send a provider information request (PIR) to the Trust's nominated individual approximately once a year. The Trust has three weeks in which to return the information and any supporting documents through an online portal.

In January 2018, the Trust received correspondence from the CQC requesting completion and submission of the following documents:

1. **Trust level request**. This is the main request, which asks the Trust about the quality of our services against the five key questions. This includes any changes in quality or activity since our last inspection. We will also be asked to use the key lines of enquiry for the well-led key question to tell the CQC about our trust's leadership, governance and organisational culture. This will support the assessment of well-led for the trust.
2. **Acute request**. This asks the Trust to report on a limited number of key information items for core services that our trust provides. It is a much shorter list of questions to gather key information that is not available through other national data collections

Report to the Board of Directors

The Trust uploaded all requested documentation and supporting evidence to the CQC portal on Friday 26 January 2018. Following submission, the CQC raised a number of minor points for clarification which have now been addressed.

6. The Quality and Assurance Framework

As part of the programme of routine improvement work, the nursing and midwifery quality assurance framework has been reviewed and strengthened and the following improvement measures have been undertaken.

- The audit programme has been reviewed and an agreed tool that provides information against CQC domains has been developed and will link with the new Trust quality assurance framework. This includes a combination of peer review and inspections. The tool is used at GSTT and has already been through a testing process. In order to ensure the outcomes from the audit are immediately actionable, the tool will be utilised in an electronic format.
- Clinical Friday will be launched from 1 March 2018. A clearly defined SOP will be in place to ensure consistency with expectation including outcome indicators and feedback. The benefits from senior nurses (bands 7 upwards) working clinically once per week is significant as it positively impacts on staff morale, embedding of clinical standards, patient safety, and patients flow on the day and better weekend planning.
- Senior Nurses daily walkabouts and twilight visits programme are being standardised to ensure outcome focus – this is aimed at addressing culture, uniform, attitudes and behaviour, engagement with patients and families
- Monthly surgeries will be opened to all staff between the hours of 18:00 and 21:00 hours.

7. Planning for the CQC Core Service inspection

This section provides an overview of some of the key actions and work streams in place to ensure organisational preparedness for the forthcoming CQC Core Service with Well Led inspection.

i. CQC Project

Simone Hay, Deputy Director of Nursing has been identified as the designated lead for the CQC Project Team and is currently pulling together the operational plan for CQC preparedness.

Briefing with the CQC project team are in place and these will migrate into Scrums to include directorate and other subject matter expert (SME) representatives where

necessary. The Scrums will drive progress with actions required for preparedness; this will be monitored via an agile turndown approach.

ii. CQC Focus Groups

On 13 February 2018 the CQC hosted a number of focus groups aimed at black and minority ethnic (BME), frontline and support staff as well as managers and leaders. There were also a number of drop-in sessions open to all staff. This provided the CQC Inspectors with an opportunity to meet with staff from a diversity of roles within the Trust and hear their views. It also provide a great opportunity for staff to promote the improvements that have been taking place this year to help deliver better care for our patients. Additional focus groups will be held on 1 and 21 March 2018.

iii. CQC Improvement Plan

A refresh of the CQC improvement plan was undertaken in January 2018 in preparation for submission of the NHSI undertakings review. Significant progress has been made and a summary of the current position is as follows:

		Must Do	Should Do
Blue	Action has been completed and there is evidence that the action has been embedded in daily practice	**13**	**17**
Red	The action is off track and unrecoverable within the current timescales. Requires a re-plan	**0**	**0**
Amber	The action is off track and plans are being put in place to mitigate the delay. The action is expected to return to the planned delivery date	**2**	**8**
Green	Action is on track to deliver on time	**1**	**2**

The supporting evidence that underpins the improvement plan is current subject to a rapid review and arrangements are being made to undertake practical testing of the actions that have been implemented; this will be overseen by a party independent of the Trust.

iv. Communications

A draft CQC communications plan has been developed. A review of the staff handbook is underway.

v. Risks

As part of the provider information request (PIR) process, a detailed review of the information submitted was undertaken with oversight from the Executive Leads for Quality. This review has identified a number of areas of risk that will need to be acted

upon and assurance gained that the Trust have the requisite actions in place. The risks have been shared with the Directorates and other relevant leads; the CQC project team will be working with operational teams to monitor progress against addressing these risks. A list of the risks is contained in appendix 1 of this report.

vi. Quality Reviews

A revision of the quality review tools is underway. In addition to the arrangement in place described in point 6 of this report, the Deputy Directors of Nursing will commencing a programme of quality reviews week commencing 26 February 2018.

vii. CQC Assurance Group (CAG)

A bi-monthly CQC Assurance Group is being established. The CAG will be chaired by Jon Billings, Non-Executive Director and membership will include the Chief Executive, Medical Director, Director of Nursing, the CQC project lead and appropriate Directorate Representatives. The purpose of the group will be to ensure requisite progress is being made with organisational preparedness for the forthcoming core services with well led inspection.

viii. Well Led Inspection

The new well-led framework for healthcare providers has a strong focus on financial and resource governance, and was developed jointly by CQC and NHS Improvement. The framework provides a single structure to enable CQC to assess and review the leadership, management and governance of the organisation (including self-review).

The Trust has made arrangements for additional resource from the previous CQC Project Team who will provide valuable expertise in making the necessary preparations for the new style well-led inspection. This is the first time the Trust will be subject to the new style well-led inspection which encompasses the use of resources; this inherently carries a greater risk. Oversight and management of emerging risks will be undertaking via the CQC Assurance Group.

8. Recommendation

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

NHS
Medway
NHS Foundation Trust

Report to the Board

Committee Date: 01/03/2018 Item No. 11a

Title of Report	**Finance Report Month 10**
Prepared By:	Tracey Easton, Deputy Director of Finance
Lead Director	Tracey Cotterill – Director of Finance & Business Services
Committees or Groups who have considered this report	Finance Committee 22nd February 2018
Executive Summary	The purpose of this report is to summarise the M10 year to date (ytd) and forecast financial performance of the Trust against the agreed plan. Key points are : 1. Year to date performance has been reported as a deficit of £47.3m pre STF, which is adverse to plan by £7.6m. 2. Year End Forecast – The forecast outturn was revised at month 9 in line with the agreed NHSI process which restricts adverse changes to forecast to the quarterly reporting cycle. The forecast outturn is now a deficit of £58.2m pre STF. This is an adverse movement to plan of £11.3m. STF income has also reduced in line with the change to the deficit being off plan. STF income will be £2.4m against a plan of £9m. This leaves the overall deficit inclusive of STF at £55.8m, compared to the original plan of £37.8m, an adverse variance of £17.9m. 3. Expenditure – Month 10 ytd expenditure is favourable to plan by £4.3m, £2.6m over spend on pay, £6.4m favourable on non-pay due to reserves and the release of the prior year provision and £0.6m favourable on interest. There are significant pay overspends in most of the Directorates. 4. Income – Clinical income is below plan by £10.5m ytd at month 10, due to the release of the prior year provision, the impact of reduced income for month 10, especially on elective work due to the elective pause, and provision for challenges.

Report to the Board of Directors

	5. Other income – at month 10 other income is below plan by £1.3m. 6. At month 10 CIP delivery is behind plan by £4.1m.This largely relates to the current unidentified CIP target, and the phasing of the plan, as well as savings delivered not yet captured and reported as Non-recurrent CIP. 7. Cash has been drawn down from DH in the form of loans in line with the revenue plan. Pressure on cash will increase due to the increased deficit and loss of STF Income. It has now been agreed that the Trust can access additional cash loans up to the revised deficit position. 8. Capital – The 2 year operational plan submitted in March 2017 included £32m capital spend. The current forecast is for c.£20.4m.
Resource Implications	As outlined
Risk and Assurance	• Contract Work plan – this is a large risk to the organisation as the full value of provider intentions is included in our plan, leading to a system gap. • **The Board is asked to note that all challenges within the contract that cannot be agreed locally will be assessed by Expert Determination.** • CIP Delivery is a risk with a significant level of unidentified CIP. **The Board is asked to note that actions are already being taken to improve the delivery process.** • **2020 are currently supporting the Improvement workstream for Financial Recovery with a round of 6 week "delivery sprints" on transformation schemes, as well as implementation planning of projects that have previously been through the sprint process. This round has had particular focus on larger transformation projects that are aimed at securing efficiency savings for 2018/19.** • **Focus on specialty contribution to highlight target areas for savings – programme level review of**

outlier procedures and high average length of stay.

- **Planning for 2018/19 is also focusing on outturn 2017/18 to identify further savings opportunities.**
- **Expenditure controls enhanced for non-essential non-clinical spend.**
- **Enforcement of the Ordering controls relating to no Purchase order, no payment policy.**
- **Communications across the Trust are now enhanced to reflect the revised financial position and raise awareness, as well as providing opportunity for all staff to contribute ideas for savings.**
- **Additional senior finance resource is working alongside the programmes to develop savings opportunities.**
- **Benchmarking analysis of peer Trusts and the national benchmarking data are being used to identify opportunities and inform planning for 2018/19.**

- Inefficient use of Trust resources remains a risk due to assurance gaps in the financial controls environment. **The Board is asked to note that work has already commenced to enhance the financial controls environment as part of the Trust Financial Recovery Plan and will further roll out through the remainder of the 2017/18 financial year as part of the Trust FRP. The Grip and Control Toolkit provided by NHSI has been completed with actions identified to close gaps and seize opportunities.**
- Trust infrastructure and estate remains a risk due to age and condition, and lack of cash for capital investment. **The Board is asked to note that the capital programme is being managed within the capital limits, with prioritisation criteria for spend being risk based as well as invest to save.**

Report to the Board of Directors

Legal Implications/Regulatory Requirements	Lack of achievement of the agreed control total will lead to Further Regulatory actions. Inappropriate Estate and insufficient Facilities lead to higher than acceptable risk to Patients, visitors and staff and could lead to further regulatory action.
Improvement Plan Implication	Financial Recovery is one of the nine programmes of Phase 2 Recovery. In year, financial stability is one of 4 programmes in Better, Best, Brilliant which includes financial recovery, commercial efficiency and estate planning.
Quality Impact Assessment	All actions will follow an appropriate QIA process
Recommendation	To note the contents of the report
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

Board Report

Month 10

2017/18

Best of care
Best of people

Medway NHS
NHS Foundation Trust

Finance Report for January 2018

1. Liquidity
    a. Cash Flow
    b. Loan Conditions

2. Financial Performance
    a. Consolidated I&E
    b. Run Rate Analysis - Financial
    c. Workforce
    d. Run rate analysis Pay

3. Balance Sheet
    a. Statement of Financial Position
    b. Trade Receivables
    c. Trade Creditors

4. Capital
    a. Capital Summary

5. Cost Improvement Programme
    a. Cost Improvement Programme Summary

6. Use of Resources Metric

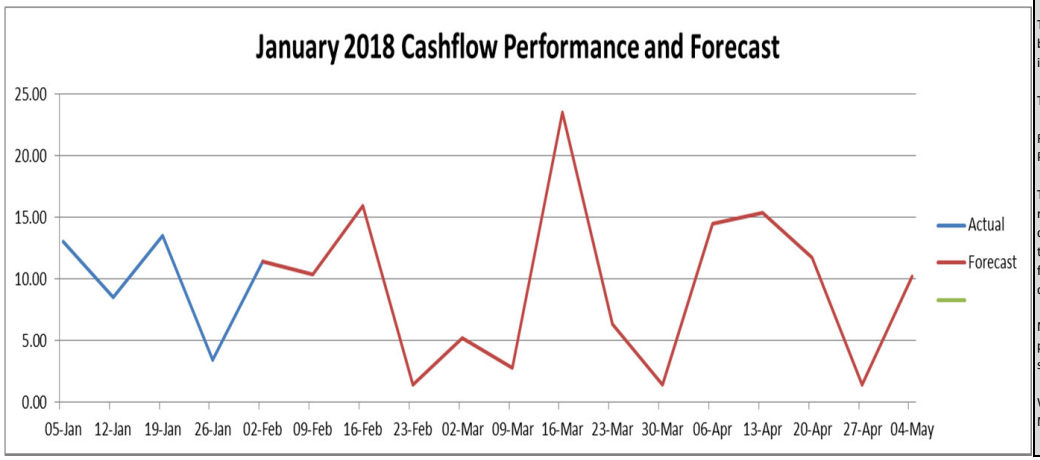
1. Liquidity

1a. Cash Flow

13 Week Forecast

	Actual				Forecast												
Week Ending	05/01/18	12/01/18	19/01/18	26/01/18	02/02/18	09/02/18	16/02/18	23/02/18	02/03/18	09/03/18	16/03/18	23/03/18	30/03/18	06/04/18	13/04/18	20/04/18	27/04/18
BANK BALANCE B/FWD	**3.68**	**13.05**	**8.53**	**13.50**	**3.45**	**11.47**	**10.41**	**15.94**	**1.42**	**5.19**	**2.79**	**23.51**	**6.32**	**1.41**	**14.52**	**15.35**	**11.72**
Receipts																	
NHS Contract Income	9.76	0.02	7.51	0.12	10.01	0.47	7.90	0.00	6.56	0.00	7.88	0.00	0.00	15.40	3.40	0.00	0.00
Other	0.14	0.24	0.33	2.53	0.78	0.34	0.40	0.28	0.40	0.61	0.40	0.28	0.22	0.35	0.73	2.51	0.28
STF Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total receipts	**9.89**	**0.26**	**7.84**	**2.65**	**10.79**	**0.81**	**8.30**	**0.28**	**6.96**	**0.61**	**8.28**	**0.28**	**0.22**	**15.74**	**4.13**	**2.51**	**0.28**
Payments																	
Pay Expenditure (excl. Agency)	(0.50)	(0.31)	(2.77)	(13.27)	(0.42)	(0.39)	(0.40)	(15.47)	(0.41)	(0.40)	(0.40)	(15.47)	(0.41)	(0.40)	(0.40)	(7.18)	(8.62)
Non Pay Expenditure	(0.02)	(4.47)	(3.49)	(2.22)	(0.94)	(1.47)	(1.67)	(2.14)	(1.02)	(2.61)	(2.61)	(3.15)	(1.20)	(2.23)	(2.90)	(2.68)	(1.90)
Capital Expenditure	0.00	0.00	0.00	0.00	(1.42)	0.00	0.00	0.00	(1.75)	0.00	0.00	0.00	(3.52)	0.00	0.00	0.00	0.00
Total payments	**(0.52)**	**(4.78)**	**(6.26)**	**(15.48)**	**(2.78)**	**(1.86)**	**(2.07)**	**(17.61)**	**(3.18)**	**(3.01)**	**(3.01)**	**(18.61)**	**(5.13)**	**(2.63)**	**(3.30)**	**(9.86)**	**(10.52)**
Net Receipts/ (Payments)	**9.37**	**(4.52)**	**1.59**	**(12.83)**	**8.01**	**(1.06)**	**6.24**	**(17.33)**	**3.78**	**(2.41)**	**5.27**	**(18.34)**	**(4.91)**	**13.11**	**0.82**	**(7.35)**	**(10.25)**
Funding Flows																	
FTFF/DOH - Revenue	0.00	0.00	2.57	0.00	0.00	0.00	(0.50)	0.00	0.00	0.00	20.80	0.00	0.00	0.00	0.00	3.84	0.00
STF Advance	0.00	0.00	1.05	0.00	0.00	0.00	(0.21)	0.00	0.00	0.00	(5.34)	0.00	0.00	0.00	0.00	0.00	0.00
FTFF/DOH - Capital	0.00	0.00	0.00	2.79	0.00	0.00	0.00	3.00	0.00	0.00	0.00	1.80	0.00	0.00	0.00	0.00	0.00
Incentive Funding	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Loan Repayment/Interest payable	0.00	0.00	(0.23)	0.00	0.00	0.00	0.00	(0.19)	0.00	0.00	0.00	(0.66)	0.00	0.00	0.00	(0.12)	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
	0.00	**0.00**	**3.38**	**2.79**	**0.00**	**0.00**	**(0.71)**	**2.81**	**0.00**	**0.00**	**15.46**	**1.14**	**0.00**	**0.00**	**0.00**	**3.73**	**0.00**
BANK BALANCE C/FWD	**13.05**	**8.53**	**13.50**	**3.45**	**11.47**	**10.41**	**15.94**	**1.42**	**5.19**	**2.79**	**23.51**	**6.32**	**1.41**	**14.52**	**15.35**	**11.72**	**1.48**

Fig1. Cashflow Forecast



Commentary

The opening cash balance for January 2018 was £3.7m, with a closing balance of £3.9m. This is above the minimum liquidity level (£1.4m) required by DH by £2m. This additional cash balance was due to the timing of creditor payment runs at month end following the late receipt of Q4 training income from Health Education England (£2.2m).

The graph shows the actual cashflow for January and the projected weekly cashflow up to and including w/e 27 April 2018.

Receipts in the month were £22m, plus £6.2m loans & funding, therefore the total cash inflow for January was £28.2m.
Payments, including capital in the month were £28m.

The Trust has received £32.5m of deficit loan funding YTD in the form of an uncommitted revenue loan with a further £4.1m 'working capital' loan received during November. In addition, the Trust has received £2.4m STF for 2017/18 with a further £5.6m in STF advances. The Trust has also drawn PDC of £3.2m and capital loans of £9.5m in relation to the Emergency Department capital project and CT scanner. Following the revision of the Trust's deficit forecast in M9, confirmation has now been received that revenue cash support will be available up to the value of the revised forecast. Taking into account the reclassification of £5.6m currently drawn as STF advances, the Trust will be able to draw a further £15.5m of deficit funding during March.

Monthly payments for 17/18 have so far averaged at £28.2m, with 58% relating to payroll costs. This includes £9.5m per month for direct salary payments and £6.8m in relation to employer costs. Monthly receipts (excluding loans & STF) for 17/18 have averaged at £22.9m, however it should be noted that this includes an additional monthly contract payment received from Medway CCG during April.

Whilst the Trust continues to experience significant cash pressures it is expected that the availability of additional revenue cash support during March will enable creditor payment terms to be returned to more acceptable levels.

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

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

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

2. Financial Performance

2a. Consolidated Income & Expenditure

Consolidated I&E (January 2018)

	Current Month			Year to Date (YTD)			Annual		
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Forecast*	*Plan*	*Variance*
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Revenue									
Clinical income	19,986	20,270	-284	186,198	198,254	-12,056	224,987	238,270	-13,283
High Cost Drugs	1,514	1,650	-136	18,549	17,065	1,484	17,038	20,596	-3,558
Other Operating Income	1,939	2,039	-100	19,054	20,364	-1,310	22,807	24,724	-1,917
Total Revenue	**23,439**	**23,959**	**-520**	**223,801**	**235,683**	**-11,882**	**264,832**	**283,590**	**-18,758**
Expenditure									
Substantive	-14,833	-16,270	1,437	-142,557	-161,977	19,420	-171,008	-194,561	23,553
Bank	-2,575	-191	-2,384	-20,663	-441	-20,222	-23,986	-1,078	-22,908
Agency	-1,130	-919	-211	-12,986	-11,079	-1,907	-15,970	-12,917	-3,053
Total Pay	**-18,538**	**-17,380**	**-1,158**	**-176,206**	**-173,496**	**-2,710**	**-210,964**	**-208,556**	**-2,408**
Clinical supplies	-2,925	-2,963	39	-31,071	-30,687	-384	-36,942	-36,631	-311
High Cost Drugs Expense	-1,700	0	-1,700	-16,279	0	-16,279	0	0	0
Drugs	-1,264	-2,519	1,256	-10,918	-25,188	14,270	-32,401	-30,059	-2,342
Consultancy	-107	-67	-39	-1,393	-825	-569	-1,741	-959	-782
Other non pay	-2,954	-3,434	481	-25,065	-34,375	9,310	-28,516	-41,276	12,760
Total Non Pay	**-8,948**	**-8,984**	**36**	**-84,726**	**-91,075**	**6,349**	**-99,600**	**-108,925**	**9,325**
Total Expenditure	**-27,486**	**-26,364**	**-1,122**	**-260,932**	**-264,572**	**3,639**	**-310,564**	**-317,481**	**6,917**
EBITDA	**-4,047**	**-2,405**	**-1,642**	**-37,131**	**-28,888**	**-8,243**	**-45,732**	**-33,891**	**-11,841**
Post EBITDA									
Depreciation	-803	-808	5	-8,105	-8,077	-28	-9,693	-9,693	0
Interest	-235	-266	31	-2,004	-2,656	652	-2,661	-3,186	525
Dividend	-7	-7	0	-70	-70	0	-81	-81	0
Profit/(loss) on sale of asset	0	0	0	0	0	0	0	0	0
Net (Surplus) / Deficit - Pre STF	**-5,092**	**-3,486**	**-1,606**	**-47,311**	**-39,691**	**-7,619**	**-58,167**	**-46,851**	**-11,316**
STF Income	0	1,051	-1,051	2,409	6,905	-4,496	2,409	9,006	-6,597
Net (Surplus) / Deficit - Pre STF	**-5,092**	**-2,435**	**-2,657**	**-44,902**	**-32,786**	**-12,115**	**-55,758**	**-37,846**	**-17,913**

2b. Run Rate Analysis - Financial

Anaylsis of 15 monthly performance - Financials

	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Revenue															
Clinical income	19.5	18.4	19.7	18.6	22.6	18.5	19.1	19.8	20.0	20.7	19.8	15.6	19.2	13.7	20.0
High Cost Drugs	1.7	1.5	1.8	1.6	1.6	1.7	1.9	1.9	1.8	1.8	1.7	2.2	1.9	1.6	1.5
STF Income	0.7	0.7	0.7	1.0	2.4	0.1	0.9	0.5	0.6	0.4	0.6	0.4	0.9	- 1.9	-
Other Operating Income	1.7	2.0	2.3	2.1	3.0	2.0	1.6	2.1	2.0	2.0	1.9	1.7	1.9	1.9	1.9
Total Revenue	**23.6**	**22.6**	**24.6**	**23.4**	**29.5**	**22.3**	**23.6**	**24.3**	**24.4**	**24.9**	**24.0**	**19.8**	**23.9**	**15.3**	**23.4**
Expenditure															
Substantive	-14.0	-13.6	-13.9	-14.0	-13.6	-14.0	-14.3	-14.3	-14.1	-14.3	-13.9	-14.5	-14.2	-14.1	-14.8
Bank	-0.9	-0.8	-0.7	-0.8	-0.9	-1.1	-1.2	-2.7	-1.8	-2.4	-2.3	-2.4	-2.2	-2.0	-2.6
Agency	-3.8	-3.5	-3.7	-3.6	-3.9	-2.2	-1.9	-0.2	-1.3	-1.6	-1.4	-1.3	-1.1	-0.9	-1.1
Total Pay	**-18.6**	**-17.9**	**-18.3**	**-18.3**	**-18.4**	**-17.3**	**-17.4**	**-17.2**	**-17.2**	**-18.3**	**-17.6**	**-18.2**	**-17.4**	**-17.0**	**-18.5**
Clinical supplies	-2.7	-2.8	-2.9	-3.1	-3.0	-2.7	-3.8	-2.8	-3.1	-3.3	-3.3	-3.2	-3.0	-2.9	-2.9
High Cost Drugs Expense	0.0	0.0	0.0	0.0	0.0	-1.5	-1.5	-1.5	-1.5	-1.5	-9.2	-2.0	-1.9	-1.5	-1.7
Drugs	-2.1	-1.7	-2.4	-2.4	-2.4	-1.0	-1.2	-1.1	-1.1	-1.4	6.3	-2.0	-1.7	1.0	-1.3
Consultancy	0.1	0.0	-0.1	0.0	0.0	-0.2	-0.1	-0.2	-0.2	-0.3	-0.1	0.0	-0.1	-0.1	-0.1
Other non pay	-3.0	-3.0	-3.0	-2.9	-7.0	-3.1	-3.3	-2.0	-4.3	-1.4	-2.6	-3.2	-2.3	0.3	-3.0
Total Non Pay	**-7.8**	**-7.4**	**-8.5**	**-8.4**	**-12.4**	**-8.5**	**-9.9**	**-7.6**	**-10.2**	**-7.9**	**-8.9**	**-10.4**	**-8.9**	**-3.2**	**-8.9**
Total Expenditure	**-26.4**	**-25.3**	**-26.8**	**-26.7**	**-30.8**	**-25.9**	**-27.3**	**-24.8**	**-27.4**	**-26.2**	**-26.5**	**-28.6**	**-26.3**	**-20.1**	**-27.5**
EBITDA	**-2.8**	**-2.7**	**-2.2**	**-3.3**	**-1.3**	**-3.6**	**-3.8**	**-0.5**	**-3.0**	**-1.3**	**-2.5**	**-8.8**	**-2.4**	**-4.8**	**-4.0**
Post EBITDA															
Depreciation	-0.9	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8	-0.8
Interest	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2
Dividend	-0.1	-0.1	-0.1	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fixed Asset Impairment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Profit on sale of asset	0.0	0.0	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	-1.2	**-1.1**	**-1.1**	**-0.9**	**-1.0**	**-1.1**	**-0.9**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**	**-1.0**
Net Surplus / (Deficit)	**-3.9**	**-3.8**	**-3.3**	**-4.2**	**-2.2**	**-4.7**	**-4.7**	**-1.5**	**-4.0**	**-2.3**	**-3.5**	**-9.8**	**-3.5**	**-5.9**	**-5.1**

2c. Workforce

		Current Month						Prior Year In Month	Year to Date			Prior Year YTD
		Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
		WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Substantive	Consultants	192	212	-20	2.39	2.41	-0.02	2.37	24.54	24.10	0.44	23.54
	Junior Medical	356	372	-16	2.08	1.99	0.09	1.95	19.95	19.99	-0.04	19.26
	Nurses & Midwives	1125	1565	-440	4.06	5.40	-1.34	4.01	40.64	54.13	-13.49	39.37
	Scientific, Therapeutic & Technical	425	519	-94	1.27	1.56	-0.29	1.40	13.53	15.56	-2.02	13.84
	Healthcare Assts, etc.	480	595	-115	1.05	1.23	-0.17	0.97	10.35	12.66	-2.31	9.58
	Admin & Clerical	842	949	-107	2.22	2.39	-0.17	2.06	21.88	23.99	-2.12	20.25
	Chair & NEDs	0	7	-7	0.02	0.01	0.00	0.01	0.13	0.13	0.00	0.11
	Executives	6	9	-3	0.14	0.14	0.00	0.09	1.10	1.51	-0.42	1.17
	Other Non Clinical	435	499	-63	0.94	1.00	-0.06	0.89	9.17	9.99	-0.82	9.14
	Pay Reserves	0	0	0	0.66	0.14	0.52	0.00	1.25	-0.09	1.34	0.00
	Substantive Total	**3,861**	**4,727**	**-866**	**14.83**	**16.27**	**-1.44**	**13.75**	**142.55**	**161.98**	**-19.43**	**136.26**
Agency	Consultants	3	0	3	0.08	0.26	-0.18	0.41	1.49	2.72	-1.2	3.37
	Junior Medical	17	0	17	0.26	0.36	-0.10	0.67	2.07	3.56	-1.5	6.03
	Nurses & Midwives	153	0	153	0.72	0.12	0.60	1.92	6.20	1.89	4.3	13.85
	Scientific, Therapeutic & Technical	24	0	24	0.02	0.05	-0.03	0.21	2.06	0.62	1.4	2.54
	Healthcare Assts, etc.	0	0	0	-0.03	0.01	-0.04	0.31	0.10	0.15	0.0	1.29
	Admin & Clerical	5	2	2	0.03	0.09	-0.06	0.47	0.46	1.85	-1.4	4.90
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	18	0	18	0.06	0.03	0.03	0.11	0.61	0.29	0.3	1.18
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Agency Total	**220**	**3**	**217**	**1.14**	**0.92**	**0.22**	**4.10**	**12.99**	**11.08**	**1.91**	**33.16**
Bank	Consultants	15	0	15	0.24	0.00	0.24	0.00	1.84	0.00	1.8	0.00
	Junior Medical	41	0	41	0.58	0.00	0.58	0.00	4.35	0.01	4.3	0.00
	Nurses & Midwives	195	0	195	0.81	0.16	0.65	0.27	5.28	0.01	5.3	2.14
	Scientific, Therapeutic & Technical	22	0	22	0.10	0.00	0.10	0.02	0.53	0.01	0.5	0.52
	Healthcare Assts, etc.	208	0	208	0.52	0.00	0.52	0.30	5.07	0.12	4.9	2.63
	Admin & Clerical	59	4	55	0.18	0.02	0.16	0.12	2.33	0.21	2.1	1.01
	Chair & NEDs	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Executives	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Other Non Clinical	66	1	65	0.14	0.00	0.14	0.07	1.25	0.08	1.2	0.40
	Pay Reserves	0	0	0	0.00	0.00	0.00	0.00	0.00	0.00	0.0	0.00
	Bank Total	**606**	**5**	**600**	**2.58**	**0.19**	**2.38**	**0.78**	**20.66**	**0.44**	**20.22**	**6.70**
	Workforce Total	**4,687**	**4,735**	**-48**	**18.54**	**17.38**	**1.16**	**18.63**	**176.21**	**173.50**	**2.71**	**176.12**

	Current Month						Prior Year In Month	Year to Date			Prior Year YTD
	Actual	*Plan*	*Variance*	*Actual*	*Plan*	*Variance*	*Actual*	*Actual*	*Plan*	*Variance*	*Actual*
Staff Group:	WTE	WTE	WTE	£m	£m	£m	*£m*	£m	£m	£m	*£m*
Consultants	210	212	-2	2.72	2.67	0.05	2.78	27.88	26.83	1.06	26.91
Junior Medical	414	372	42	2.92	2.35	0.57	2.62	26.38	23.56	2.82	25.29
Nurses & Midwives	1,474	1,566	-92	5.59	5.69	-0.10	6.20	52.12	56.02	-3.90	55.37
Scientific, Therapeutic & Technical	471	519	-48	1.39	1.61	-0.22	1.62	16.12	16.18	-0.06	16.91
Healthcare Assts, etc.	688	595	93	1.54	1.24	0.30	1.58	15.53	12.93	2.60	13.50
Executives	6	9	-3	0.14	0.14	-0.00	0.09	1.10	1.51	-0.42	1.17
Chair & NEDs	0	7	-7	0.02	0.01	0.00	0.01	0.13	0.13	0.00	0.11
Admin & Clerical	906	955	-50	2.42	2.50	-0.08	2.65	24.66	26.05	-1.39	26.15
Other Non Clinical	520	500	20	1.14	1.03	0.11	1.07	11.03	10.36	0.67	10.72
Pay Reserves	0	0	0	0.66	0.14	0.52	0.00	1.25	-0.09	1.34	0.00
Workforce Total	**4,687**	**4,735**	**-48**	**18.54**	**17.38**	**1.16**	**18.63**	**176.21**	**173.50**	**2.71**	**176.12**

2d. Run rate analysis pay

		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
		WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE	WTE
Substantive	Consultants	181	180	179	178	179	180	184	187	186	189	189	192	190	193	192
	Junior Medical	329	327	321	321	330	315	320	320	320	348	346	354	339	359	356
	Nurses & Midwives	1,106	1,098	1,118	1,134	1,120	1,087	1,096	1,148	1,148	1,152	1,142	1,161	1,148	1,128	1,125
	Scientific, Therapeutic & Technical	446	450	448	448	446	437	437	426	425	429	442	446	438	433	425
	Healthcare Assts, etc	459	463	455	472	479	470	478	491	489	492	492	492	494	485	480
	Admin & Clerical	809	809	812	821	817	894	889	825	835	840	839	841	831	831	842
	Chair & NEDs	6	6	6	6	5	3	11	7	-2	6	6	1	1	-	-
	Executives	10	6	5	7	7	7	8	8	7	7	6	6	6	6	6
	Other Non Clinical	458	434	433	438	441	440	445	446	445	449	442	441	436	437	435
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Substantive Total	**3,804**	**3,772**	**3,777**	**3,823**	**3,824**	**3,833**	**3,868**	**3,857**	**3,853**	**3,912**	**3,904**	**3,935**	**3,883**	**3,872**	**3,861**
Agency	Consultants	18	18	19	20	28	20	15	14	9	14	10	11	12	4	3
	Junior Medical	61	70	62	53	56	47	40	33	28	24	24	12	23	20	17
	Nurses & Midwives	364	290	366	339	411	168	125	141	102	171	153	153	90	93	153
	Scientific, Therapeutic & Technical	54	63	50	37	35	46	32	38	35	50	46	34	31	32	24
	Healthcare Assts, etc	57	45	82	63	53	1	1	-	-	-	-	-	-	-	-
	Admin & Clerical	57	57	51	47	24	12	8	8	5	4	4	3	3	3	5
	Chair & NEDs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Executives	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Non Clinical	45	45	45	51	47	31	22	26	2	28	21	26	20	19	18
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Agency Total	**656**	**588**	**675**	**611**	**654**	**325**	**243**	**261**	**181**	**291**	**258**	**238**	**179**	**171**	**220**
Bank	Consultants	-	-	-	-	-	-	-	7	11	10	13	14	15	14	15
	Junior Medical	57	57	39	64	107	71	79	97	96	45	41	48	39	32	41
	Nurses & Midwives	-	-	-	1	3	5	22	21	33	137	126	125	124	105	195
	Scientific, Therapeutic & Technical	20	21	6	3	11	1	1	10	12	11	12	12	16	17	22
	Healthcare Assts, etc	124	127	121	134	209	130	142	161	173	249	207	203	195	182	208
	Admin & Clerical	78	59	67	64	52	263	105	84	83	114	74	91	75	58	59
	Chair & NEDs	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Executives	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Other Non Clinical	45	40	41	44	40	37	41	44	47	71	59	65	56	59	66
	Pay Reserves	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
	Bank Total	**324**	**304**	**274**	**310**	**422**	**507**	**390**	**423**	**455**	**637**	**532**	**558**	**518**	**467**	**606**
	Workforce Total	**4,784**	**4,664**	**4,726**	**4,743**	**4,900**	**4,665**	**4,502**	**4,540**	**4,489**	**4,840**	**4,694**	**4,730**	**4,580**	**4,510**	**4,687**

Analysis of 15 monthly performance - £

		Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
		£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m	£m
Substantive	Consultants	2.48	2.34	2.40	2.46	2.19	2.55	2.36	2.55	2.52	2.47	2.37	2.54	2.41	2.40	2.39
	Junior Medical	2.10	1.95	2.01	1.86	2.08	1.84	1.95	2.00	1.90	2.09	1.81	2.22	2.01	2.05	2.08
	Nurses & Midwives	3.91	3.89	3.91	4.14	3.96	3.94	4.03	4.12	4.04	4.13	4.05	4.08	4.07	3.88	4.06
	Scientific, Therapeutic & Technical	1.39	1.40	1.40	1.42	1.36	1.33	1.36	1.34	1.32	1.33	1.37	1.38	1.36	1.36	1.27
	Healthcare Assts, etc	0.96	0.94	1.02	0.97	0.93	1.00	1.05	1.04	1.03	1.03	1.04	1.02	1.05	1.04	1.05
	Admin & Clerical	2.04	2.08	2.06	2.07	2.08	2.26	2.43	2.14	2.20	2.20	2.20	2.15	2.20	2.27	2.22
	Chair & NEDs	0.02	0.00	0.01	0.01	0.04	0.01	0.02	0.02	0.01	0.01	0.01	0.01	0.01	0.01	0.02
	Executives	0.10	0.12	0.09	0.10	0.14	0.17	0.16	0.12	0.11	0.10	0.09	0.09	0.09	0.09	0.14
	Other Non Clinical	0.96	0.85	0.89	0.92	0.91	0.90	0.94	0.93	0.90	0.91	0.92	0.91	0.90	0.90	0.94
	Pay Reserves	0.00	0.00	0.00	0.00	0.00	0.02	0.02	0.07	0.06	0.07	0.07	0.07	0.07	0.07	0.66
	Substantive Total	**13.96**	**13.57**	**13.78**	**13.96**	**13.69**	**14.01**	**14.32**	**14.32**	**14.09**	**14.34**	**13.93**	**14.48**	**14.17**	**14.07**	**14.83**
Agency	Consultants	0.29	0.37	0.41	0.37	0.42	0.37	0.18	0.03	0.14	0.25	0.15	0.18	0.09	0.02	0.08
	Junior Medical	0.62	0.72	0.61	0.64	0.52	0.39	0.24	0.18	0.23	0.21	0.12	0.12	0.21	0.12	0.26
	Nurses & Midwives	1.81	1.43	1.82	1.69	2.03	0.19	1.25	0.37	0.61	0.76	0.69	0.75	0.43	0.44	0.72
	Scientific, Therapeutic & Technical	0.29	0.25	0.21	0.10	0.18	0.29	0.19	0.16	0.23	0.26	0.32	0.20	0.18	0.22	0.02
	Healthcare Assts, etc	0.15	0.13	0.31	0.19	0.14	0.01	0.00	0.00	-0.02	-	-	-	-	-	-0.03
	Admin & Clerical	0.52	0.50	0.49	0.41	0.21	0.13	0.01	0.06	0.04	0.01	0.04	-	0.12	0.04	0.03
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-
	Other Non Clinical	0.08	0.09	0.08	0.16	0.11	0.21	0.07	0.07	0.04	0.08	0.06	0.06	0.05	0.05	0.06
	Agency Total	**3.76**	**3.49**	**3.94**	**3.55**	**3.61**	**1.58**	**1.94**	**0.87**	**1.27**	**1.57**	**1.38**	**1.31**	**1.08**	**0.89**	**1.14**
Bank	Consultants	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.21	0.19	0.21	0.25	0.26	0.22	0.21	0.24
	Junior Medical	0.27	0.31	0.20	0.24	0.29	0.25	-0.03	1.16	0.45	0.59	0.48	0.58	0.47	0.50	0.58
	Nurses & Midwives	0.00	0.00	0.00	0.01	0.05	0.09	0.23	0.50	0.39	0.53	0.61	0.56	0.51	0.44	0.81
	Scientific, Therapeutic & Technical	0.06	0.07	0.02	0.01	0.04	0.00	0.01	0.04	0.04	0.03	0.05	0.05	0.12	0.08	0.10
	Healthcare Assts, etc	0.28	0.27	0.30	0.31	0.58	0.33	0.35	0.81	0.47	0.54	0.57	0.51	0.49	0.48	0.52
	Admin & Clerical	0.14	0.11	0.12	0.15	0.15	0.97	0.58	-0.89	0.21	0.39	0.23	0.28	0.21	0.18	0.18
	Chair & NEDs	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-
	Executives	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	-	-	-	-	-	-
	Other Non Clinical	0.10	0.09	0.07	0.08	0.09	0.07	0.08	0.23	0.09	0.16	0.11	0.14	0.12	0.13	0.14
	Bank Total	**0.85**	**0.85**	**0.71**	**0.80**	**1.20**	**1.70**	**1.21**	**2.05**	**1.84**	**2.45**	**2.30**	**2.38**	**2.15**	**2.02**	**2.58**
	Workforce Total	**18.58**	**17.91**	**18.43**	**18.30**	**18.50**	**17.29**	**17.47**	**17.23**	**17.20**	**18.36**	**17.61**	**18.17**	**17.40**	**16.98**	**18.54**

3. Balance Sheet

3a. Statement of Financial Position

	Last Month Actual £m	Current Month Actual £m	Plan £m	Variance £m
Non current Assets				
Property, Plant and Equipment	181.1	181.8	192.7	-10.9
Trade and Other Receivables: Other	0.3	0.4	0.5	-0.2
Total Non current Assets	**181.4**	**182.2**	**193.3**	**-11.1**
Current Assets				
Inventories	7.3	7.3	6.4	0.9
Trade and Other Receivables: Trade	30.2	30.6	15.0	15.6
Trade and Other Receivables: Accruals	6.9	8.4	4.1	4.3
Trade and Other Receivables: Prepayments	5.1	4.4	2.2	2.2
Trade and Other Receivables: Other	1.6	2.3	1.1	1.2
Cash and Cash Equivalents	3.6	3.9	1.1	2.8
Total Current Assets	**54.7**	**56.9**	**29.8**	**27.1**
Current Liabilities				
Borrowings	-58.3	-58.3	-1.3	-57.1
Trade and Other Payables: Trade	-32.1	-32.1	-21.4	-10.8
Trade and other payables: Accruals	-12.1	-13.0	-8.7	-4.4
Trade and other payables: Other	-5.2	-5.4	-3.6	-1.8
Other liabilities: Deferred Income	-8.7	-9.2	-5.5	-3.7
Provisions	-0.1	-0.1	0.0	-0.1
Total Current Liabilities	**-116.5**	**-118.2**	**-40.5**	**-77.7**
Total Assets Less Current Liabilities	**119.6**	**120.9**	**182.6**	**-61.7**
Non Current Liabilities				
Borrowings	-117.3	-123.7	-176.2	52.5
Provisions	-0.9	-0.9	-0.9	0.0
Total Non Current Liabilities	**-118.2**	**-124.6**	**-177.1**	**52.5**
Net Assets Employed	**1.4**	**-3.7**	**5.5**	**-9.2**
Taxpayers Equity				
Public Dividend Capital	137.7	137.7	138.8	-1.1
Retained Earnings	-172.0	-177.1	-165.5	-11.6
Revaluation Reserve	35.7	35.7	32.3	3.4
Total taxpayers' equity	**1.4**	**-3.7**	**5.5**	**-9.2**

Commentary

Non Current Assets

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

Current Assets

Trade and Other Receivables have been reported over four separate headings to provide further detail:
Trade, these are balances owed to the Trust for trading activities for which sales invoices have been raised and are yet to be paid.
Accruals, these relate to balances owed to The Trust which are yet to be invoiced for. The £1.5m increase relates to NHS income accruals not yet billed.
Prepayments, payments made in advance for purchases such as equipment, software, maintenance. Payments for some of these services are paid annually in advance which is the reason for the current variance on plan. This balance should reduce each month unless additional prepayments are made in the month.
Other, included in other are further RTA debts and VAT Contracted Out Services refunds. The increase relates to VAT Contracted Out Services refunds that will be paid in February 2018.

Cash and Cash Equivalents

A condition of the deficit loans is for The Trust to hold a balance of £1.4m to ensure there is always an adequate balance from which to make emergency payments. The balance as at 31st January 2018 was £3.9m. Please see 1a Cashflow for further detail.

Current Liabilities

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

Trade and Other Payables

Trade, please see note 4c for further information. These balances remain at a fairly constant level due to the Trusts inability to improve working balances without the injection of additional cash. The 2017/18 plan had assumed increased levels of income which would have allowed an improvement in this area, unfortunately this has failed to materialise.
Other, mainly relates to payovers such as Pensions and HMRC costs. Payment to these bodies is required a month in arrears.

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

Non Current Liabilities

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

Taxpayers Equity

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

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

3b. Debtors

Aged Debtors

	Total	Current	31 to 60 Days	61 to 90 Days	91 to 180 Days	6 Months +
NHS						
CCGs and NHS England	24.46	0.61	0.58	10.05	6.24	6.99
NHS FTs	2.28	0.36	0.24	0.19	0.32	1.17
NHS Trusts	1.62	0.26	0.05	0.14	0.38	0.78
Health Education England	0.26	0.02	0.00	(0.02)	0.11	0.13
Special Health Authorities	0.05	0.00	0.00	0.00	0.00	0.05
NDPBs	0.00	0.00	0.00	0.00	0.00	0.00
other DH bodies	0.02	0.00	0.00	0.02	0.00	0.00
Total NHS	**28.68**	**1.25**	**0.87**	**10.38**	**7.06**	**9.12**
Non NHS						
Bodies external to Government	2.21	0.10	(0.09)	0.16	0.31	1.72
other WGA bodies	0.01	(0.00)	0.00	(0.00)	0.00	0.01
Local Authorities	0.14	0.00	0.00	0.05	0.02	0.07
Total Non NHS	**2.36**	**0.10**	**(0.09)**	**0.21**	**0.34**	**1.80**
Bad Debt Provision	(0.46)	0.00	0.00	0.00	0.00	(0.46)
Other Receivables	0.01	0.01	0.00	0.00	0.00	0.00
Total Receivables	**30.58**	**1.36**	**0.79**	**10.59**	**7.39**	**10.46**

Commentary

Total outstanding Trade Receivables as at the 31 January 2018 are £30.58m. This includes a £0.46m bad debt provision.

NHS Debt is £28.68m, £12.4m of this relates to billed overperformance for 2017/18 up to the end of September.

Non NHS Debt is £2.36m, with £0.87m owing from Medway Community Healthcare.

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

Fig 1 Aged Receivables Analysis

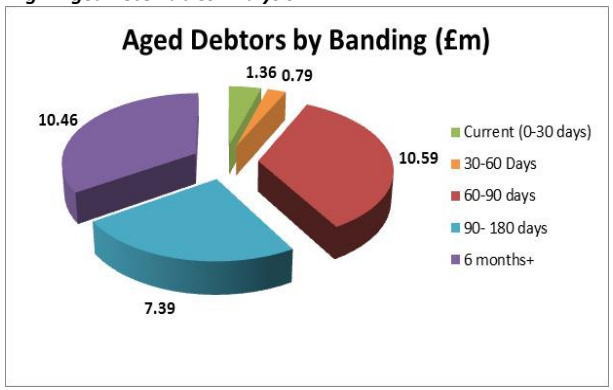


Fig 2 - Debtor Trends

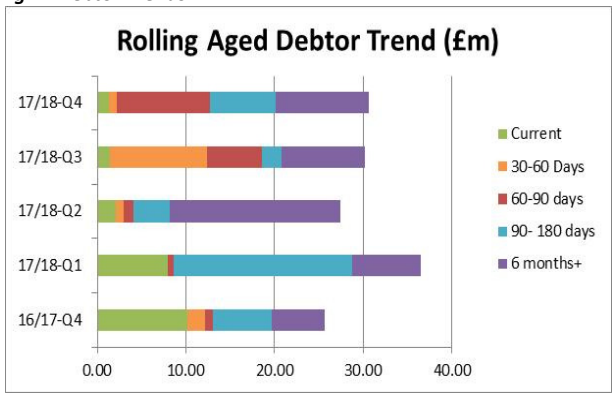


Fig.3 Top Ten Debtors

Top 10 Debtors

		£m
1	NHS MEDWAY CCG	13.56
2	NHS SWALE CCG	5.39
3	NHS DARTFORD GRAVESHAM & SWAL	2.50
4	E.K.HOSP.UNIV.NHS.FOUNDA.TRUST	1.07
5	MEDWAY COMM HEALTHCARE CIC	0.87
6	MAIDSTONE AND TUNBRIDGE WELLS	0.85
7	NHS WEST KENT CCG	0.83
8	QUEEN VICTORIA HOSP. NHS TRUST	0.75
9	DARTFORD & GRAVESHAM NHS TRUST	0.47
10	NHS ENGLAND	0.41

3c. Creditors

Aged Creditors

	Total	Current	31 to 60 Days	61 to 90 Days	91 - 180 Days	6 months +
	£m	£m	£m	£m	£m	£m
NHS FTs	2.40	0.19	0.16	0.25	0.60	1.20
NHS Trusts	3.72	0.42	0.44	0.65	0.74	1.48
Public Health England	0.00	0.00	0.00	0.00	0.00	0.00
CCGs and NHS England	(0.03)	0.00	0.00	(0.03)	0.00	0.00
Special Health Authorities	0.37	0.11	0.13	0.13	0.00	0.00
Other DH bodies	0.65	0.02	0.02	0.02	0.04	0.56
Total NHS Payables	**7.12**	**0.74**	**0.75**	**1.02**	**1.38**	**3.24**
Other WGA bodies	0.22	0.10	0.10	0.01	0.00	0.00
Local Authorities	0.42	0.00	0.00	0.00	0.00	0.42
Bodies external to Government	18.76	4.39	7.48	2.95	1.45	2.49
Total Non NHS Payables	**19.41**	**4.50**	**7.59**	**2.96**	**1.45**	**2.90**
Capital	2.77	2.77	0.00	0.00	0.00	0.00
Payroll	2.82	2.82	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00
Total Other Trade Payables	**5.59**	**5.59**	**0.00**	**0.00**	**0.00**	**0.00**
Total Trade Payables	**32.12**	**10.83**	**8.34**	**3.98**	**2.83**	**6.14**

Commentary

Total outstanding creditors as at 31st January were £32.1m of which 66% (£21.3m) were overdue based on 30 day payment terms.

The Trust is currently paying approved invoices in approx 65 to 70 days from the invoice

There are currently £10.4m of unapproved invoices that are more than 60 days old, unapproval relates to issues with Purchase Orders and inability to validate historical NO PO invoices. The Finance team is working to reconcile these balances with suppliers and with Procurement and Operational Teams to clear the balance down as quickly as possible. Enforcement of NO PO/NO PAY should ensure that such significant balances of aged unapproved invoices do not accumulate in the future.

The Trust has £6.14m creditors over 6 months; Fig. 1 shows aged creditors analysed by ageing category; Fig.2 shows the rolling creditor trend; & Fig.3 provides a list of the top 10 creditors by value.

Fig.1 - Aged Payables Analysis

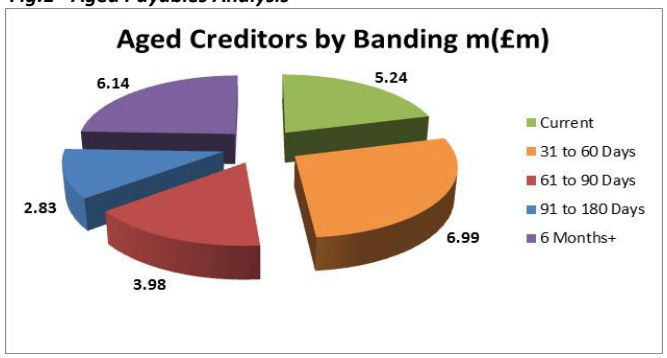


Fig.2 - Creditor Trends

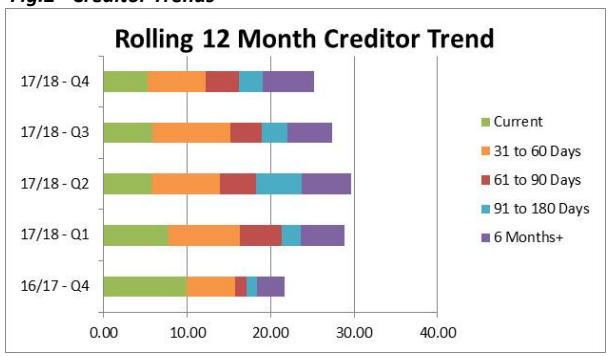


Fig.3 - Top 10 Creditors

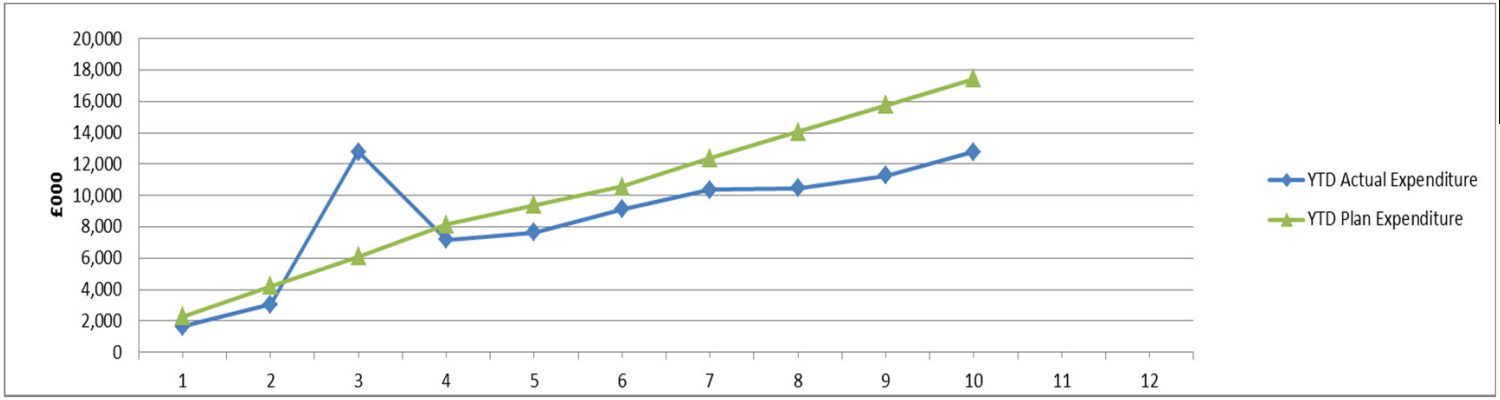
	Top 10 Creditors	£m
1	MAIDSTONE TUNBRIDGE WELLS NHS TRUST	2.12
2	DARTFORD & GRAVESHAM NHS TRUST (RN7)	1.47
3	NHS SUPPLY CHAIN	1.37
4	MEDWAY COMMUNITY HEALTHCARE CIC	1.08
5	KINGS COLLEGE HOSPITAL NHS TRUST (RJZ)	0.79
6	KENT COMMUNITY HEALTH NHS FT (RYY)	0.66
7	EAST KENT HOSPITALS NHS TRUST (RVV)	0.64
8	JOHNSON & JOHNSON MEDICAL LTD	0.63
9	COMMUNITY HEALTH PARTNERSHIPS	0.49
10	MEDWAY COUNCIL	0.42

4. Capital

4a. Capital

Capital Programme Summary

	Current Month			Year to Date			Forecast year end position		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m	Original Plan £m	Forecast Out-turn £m	Forecast Variance £m
Expenditure									
Recurrent Estates & Site Infrastructure	0.70	0.53	0.17	2.98	3.63	-0.65	4.90	4.90	0.00
IM&T	0.11	0.18	-0.07	1.02	1.52	-0.51	2.85	2.85	0.00
Medical & Surgical Equipment	0.00	0.17	-0.17	0.34	1.14	-0.80	1.50	1.50	0.00
Specific Business Cases	0.09	0.15	-0.07	1.12	1.68	-0.56	1.85	1.85	0.00
Transform Projects (ED/AAU)	0.62	0.52	0.10	7.18	8.90	-1.72	10.32	8.32	2.00
Medical Asssessment Unit (MAU)	0.00	0.10	-0.10	0.16	0.05	0.11	0.00	1.00	-1.00
Other Schemes Unfunded							10.00		10.00
Total	**1.51**	**1.64**	**-0.13**	**12.80**	**16.93**	**-4.13**	**31.42**	**20.42**	**11.00**



Commentary

Cumulative capital spend as at Month 10 amounted to £12.80m. This represents an underspend of £4.13m below the original plan of £16.93m.

There is still a material underspend for ED representing £1.72m and this is slippage on Phase 1 of the ED Project.

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

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

Total capital expenditure is still dominated by the ED project and CT Scanner. All programmes are being encouraged to meet their budget allocation for 17/18 wherever possible to avoid having to rebid for funds in 18/19.

5. Cost Improvement Programme

5a. 2017/18 Cost Improvement Programme Summary

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

6. Use of Resources Metric

Finance and use of resources rating	Expected Sign	03PLANYTD Plan 31/01/2018 YTD Number	03ACTYTD Actual 31/01/2018 YTD Number	03VARYTD Variance 31/01/2018 YTD Number	03PLANCY Plan 31/03/2018 Year ending Number	03FOTCY Forecast 31/03/2018 Year ending Number	03VARCY Variance 31/03/2018 Year ending Number
Capital service cover rating	+	4	4		4	4	
Liquidity rating	+	4	4		4	4	
I&E margin rating	+	4	4		4	4	
I&E margin: distance from financial plan	+		4			4	
Agency rating	+	3	1		3	1	

Overall finance and use of resources risk rating	Expected Sign	03PLANYTD Plan 31/01/2018 YTD Number	03ACTYTD Actual 31/01/2018 YTD Number	03VARYTD Variance 31/01/2018 YTD Number	03PLANCY Plan 31/03/2018 Year ending Number	03FOTCY Forecast 31/03/2018 Year ending Number	03VARCY Variance 31/03/2018 Year ending Number
Overall rating unrounded	+		3.40			3.40	
If unrounded score ends in 0.5	+		0.00			0.00	
Plan risk ratings before overrides	+		3			3	
Plan risk ratings overrides:							
Any ratings in table 6 with a score of 4 override - if any 4s "trigger" will show here	Text		Trigger			Trigger	
Any ratings in table 6 with a score of 4 override - maximum score override of 3 if any rating in table 6 scored as a 4	+		3			3	
Control total override - Control total accepted	+		YES			YES	
Control total override - Planned or Forecast deficit	Text		Yes			Yes	
Control total override - Maximum score (0 = N/A)	+		0			0	
Is Trust under financial special measures	Text		No			No	
Risk ratings after overrides	+		3			3	

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/03/2018

Agenda item: 11b

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	The first two months of the year have been particularly busy in terms of communications, both internally and externally. Within the Trust we strive to keep staff informed about developments, and to have their input into improvement plans. As our Better, Best, Brilliant improvement plan has developed, it has been essential to engage staff, particularly in relation to our performance and regarding our financial position. We have had a higher than usual level of media interest, with increased media enquiries during the winter period, but also in response to our proactive approach. Community engagement continues to evolve and grow, and we are working with governors to support their role as an important link with patients and public. We have received feed back about the effectiveness of our community engagement, which is encouraging.
Resource Implications	NA
Risk and Assurance	NA
Legal Implications/Regulatory Requirements	NA

Report to the Board of Directors

Improvement Plan Implication	Communications and engagement activity is aligned with the Better, Best, Brilliant improvement plan
Quality Impact Assessment	NA
Recommendation	The Board is asked to note the report.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 The first two months of the year have been particularly busy in terms of communications, both internally and externally.

1.2 Within the Trust we strive to keep staff informed about developments, and to have their input into improvement plans.

1.3 As our Better, Best, Brilliant improvement plan has developed it has been essential to engage staff, particularly in relation to our performance and regarding our financial position.

1.4 We have had a higher than usual level of media interest, with increased media enquiries during the winter period, but also in response to our proactive approach.

1.5 Community engagement continues to evolve and grow, and we are working with governors to support their role as an important link with patients and public.

1.6 We have received feed back about the effectiveness of our community engagement, which is encouraging.

2 ENGAGING COLLEAGUES

2.1 In recent weeks information about the Trust's finances has been shared with staff and key stakeholders.

2.2 Communications have focused on the Trust's revised year-end financial position with the Chief Executive filming a video message for staff, and addressing many staff at two briefings in the hospital restaurant.

2.3 The Chair and Chief Executive have discussed the situation with local MPs and councillors and other stakeholders, all of whom have offered their support.

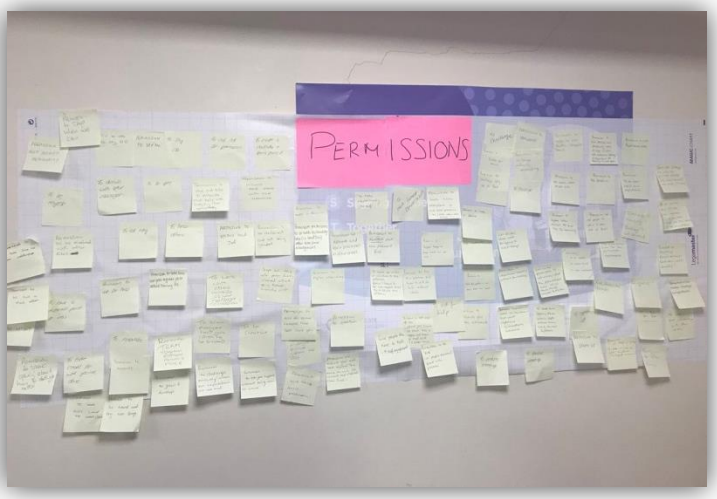
2.4 The aim has been to be open about the current financial position, and to develop understanding about the challenges we face, as well as to explain actions being taken as part of our Better, Best, Brilliant improvement plan and financial recovery.

2.5 Communications also encouraged staff to attend CQC focus groups, which were well attended. Over the coming weeks we will be ensuring that staff are aware of, and engaged with, the CQC inspection which is expected to take place in the spring.

2.6 A communications plan is being rolled out to engage stakeholders in the formal public consultation on urgent stroke services. The aim of the campaign is to provide people with enough information to have their say on the future of stroke services in Kent and Medway.

2.7 Staff, patients and public have been urged to take part in the consultation. Internally managers have been provided with information to ensure their staff are fully informed.

2.8 The Communications team worked with the Organisational and Professional Development Team to organise and promote an Unconference. Around 60 members of staff attended and enjoyed a creative and solution-focused day as part of a cultural change project.



2.9 Other internal communications and staff engagement has been underway to promote the Best Choices Scheme, a new check-in process for outpatients and changes to pathology services.

3 MEDIA

3.1 We responded to 35 separate media enquiries during the past two months. The majority of these were from regional and local media, although there were a number of enquiries from national broadcasters and journals.

3.2 We continued to have regular enquiries from national and local media on winter pressures, including the Trust's OPEL status. While there has been little coverage focusing on the Trust specifically, regional and local press have referenced the Trust in articles about ambulance handovers, surgery cancellations and A&E four-hour performance.

3.3 The stroke services consultation has had significant radio, TV, print and online coverage on regional BBC TV and radio, ITV Meridian, and across a range of Kent newspaper titles. Quotes from our Medical Director have had prominence in the print and online pieces.

Report to the Board of Directors

3.4 Our main local paper, the Medway Messenger, has continued with our joint campaign to raise awareness of breast cancer screening and has published further interviews with members of staff involved in cancer care, including screening for the over 70s and the breast cancer support group that meets regularly at the hospital.

3.5 A wedding on one of our wards between a Trust patient with terminal cancer and his long-term partner received substantial coverage, including on the front page of the Sittingbourne Messenger.

3.6 The Guardian newspaper ran a piece on technological improvements in the NHS, and included a profile of Forward App, an information sharing app which has been developed and trialled by junior doctors at Medway. At the time of writing the BBC is also expected to feature the development, with filming in Medway.

3.7 The Medway Messenger covered the nomination of the team on Ocelot ward, one of our gynaecological wards, for a Pride in Medway award.

Report to the Board of Directors

3.8 The Trust's fundraising activities have also received regular local coverage in recent weeks, with pieces published on the Trust's role as the council's charity partner in the recent 'Big Splash' sponsored swim, as well as the current 'Knit-a-Chick' Easter campaign.

3.9 Details of upcoming member events are now also regularly featured in the local media.

3.10 On a negative note, the Medway Messenger ran two separate pieces over the last two months spotlighting families who had experienced delays in having the bodies of their loved ones released from the mortuary. We apologised to the families in each case.

3.11 A piece ran in the Sheerness Times Guardian about a Sheppey resident whose pacemaker operation at the Trust had been cancelled three times over the winter period.

3.12 A county-wide piece looked at negligence claim pay-outs in Kent hospitals. The piece, which looked at figures obtained by Kent Online, placed Medway comparatively low overall compared to other local Trusts.

3.13 The Trust's Communications team regularly meets editors and correspondents, and has recently received positive feedback from them about the Trust's open and responsive way of liaising with the media.

Report to the Board of Directors

4 SOCIAL MEDIA

4.1 Over a 28-day period we engaged with 58,300 followers on Twitter (11 per cent increase) and 104,492 on Facebook (13 per cent increase).

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

4.3 Trust social media account followers now total 3,401 on Twitter (up from 3,247 at the last update), 5,268 on Facebook (up from 5,061) and 423 on Instagram (up from 316); this represents a steady increase across all channels and reinforces our position as the second-most followed Trust in Kent on both Twitter and Facebook.

4.4 In addition to promoting key news updates, our social media accounts raised awareness of our 'Building a Brilliant Medway Unconference', which received widespread coverage on Twitter thanks to the use of a dedicated hashtag and the online interaction of Trust employees; awards won by our maternity team at the London Maternity and Midwifery Festival 2018; the launch of our new check-in system for Outpatients; numerous charity-led events, including the Big Splash and the Knit-a-Chick Easter Appeal; our advice to the public on how to stay safe and healthy during the extreme cold weather periods; members' events; and two poignant weddings that took place within the hospital involving terminally ill patients.

4.5 The Trust social media accounts have also been used to distribute key messages to the public regarding the consultation on the future of urgent stroke services. So far, the messages have encouraged the public to take part in the consultation and have highlighted why we believe Medway should be the site for a hyper acute stroke unit.

4.6 In future, we plan to post further engaging social media content, including a regular video feature with staff which will highlight a typical day in the life of Trust employees, with filming for this due to take place in the month of February.

4.7 Additionally, we will continue to post regular messages as part of our stroke services social media campaign. We hope this will help us to achieve our goal of becoming the most-followed Kent Trust on Twitter within the coming months.

4.8 We are actively using our staff app @Medway to highlight messages and updates to staff.

5 COMMUNITY ENGAGEMENT

5.1 Governors

5.1.1 The Trust continues to offer support to governors to engage with networks across Medway and Swale.

5.1.2 The next Governor coffee morning will be on Saturday 24 March 2018, at Sittingbourne Memorial Hospital.

5.1.3 The Lead Governor, Stella Dick, attended the Medway Disability Fayre in January, to hear the views of local people. At the same event new members were recruited to the Trust.

5.1.4 Governors are involved in membership recruitment, with stands held on a regular basis in the hospital main entrance. The next recruitment event will be on 22 March.

5.1.5 An awareness campaign will highlight opportunities to become a governor through upcoming elections.

5.2 Members

5.2.1 At a member event held in February around 20 attendees discussed the Trust's quality priorities, including patient safety, patient experience and effective care.

5.2.2 A workshop was held when attendees identified priorities for the coming year.

5.3 Supporting services to engage with patients and public

5.3.1 The Trust has engaged with Brompton Academy and Chatham Girls Grammar School.

5.3.2 The trust that manages both schools has asked the hospital to support the Academy to host clinical information sessions such as talks on diabetes and breast screening.

5.3.3 Local residents including their parents/carers will be invited to attend.

5.3.4 The Trust's Community Engagement Officer is working with BME groups to raise the profile of dementia and organ donation within these communities.

5.3.5 She is also working to support patient engagement within the hospital, such as through programme boards and directorate meetings.

5.4 Reaching out to less engaged audiences

5.4.1 The Trust was invited by the female membership of the Kent Khawateem Association to talk about breast screening. Dr Asma Javed, Breast Screening Lead, gave a presentation to 50 women from this Muslim community.

5.4.2 The Trust has been asked by Medway African and Caribbean Association (MACA) to support with their event to commemorate the 70th anniversary of the arrival of Empire Windrush which landed at Tilbury docks in 1948, the same year the NHS was launched.

5.4.3 They would like to acknowledge and recognise the contribution Black and Ethnic Minority staff made to the NHS at the time of its inception.

5.4.4 The Trust was invited to take part in a Health Open Day by Kent Malayalee Association in February. The agenda included stroke and organ donation, and the association also expressed an interest in the Trust's Governor roles.

5.4.5 We have promoted the NHS Youth Forum to organisations working with young people to encourage them to engage with this online community and share their experience of the NHS and areas of concerns.

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

5.4.7 Since the last report we have made links with Medway Parent Carers Forum, NHS retirement fellowship and Imago charity supporting young carers.

5.5 Engagement in the STP

5.5.1 The current stroke services review is the first service change to be consulted upon across Kent and Medway, and is actively support by the Trust as described above.

5.5.2 The Trust also supported a public engagement event held by Medway CCG in January to discuss a community services review and the Medway Model for local care.

Report to the Board of Directors

5.6 Feedback on our community engagement.

5.6.1 Organisations we have connected with over the past months have been asked to feed back on our approach to community engagement.

5.6.2 85.71 per cent of respondents said they had seen an improvement in the way the hospital engages and communicates with the local community.

5.6.3 79 per cent said they felt more informed about the Trust than they did a year ago.

5.6.4 65 per cent confirmed they knew how they could find out more and have a say in the Trust and future improvements.

5.6.5 However, more than half of those who responded felt there was more the Trust could do to engage with patients and the public. Among the suggestions received was to provide information in GP surgeries and libraries.

5.6.6 It was also felt that further engagement was needed with deprived and/or minority communities.

5.6.7 We will continue to monitor, evaluate and build on our community and patient engagement.

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/03/2018 Item No. 12

Title of Report	Corporate Governance Report
Presented By:	Sheila M Murphy: Trust Secretary: Director of Corporate Compliance and Legal Services
Lead Director	Sheila M Murphy: Director of Corporate Compliance and Legal Services
Committees or Groups who have considered this report	Not Applicable (N/A)
Executive Summary	The report outlines current activity and issues in corporate governance.
Resource Implications	N/A
Risk and Assurance	The report outlines the progress of a number of Trustwide initiatives designed to improve corporate governance arrangements.
Legal Implications/Regulatory Requirements	N/A
Improvement Plan Implication	N/A
Quality Impact Assessment	N/A
Recommendation	The Board is requested to note the report and the assurance and risks stated.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE SUMMARY

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

2 CARE QUALITY COMMISSION

2.1 Simone Hay, Deputy Director of Nursing has been named as the designated lead for the CQC Project Team and will prepare the operational plan for CQC preparedness.

2.2 A CQC Assurance Group (CAG) has been established to be Chaired by Jon Billings, Non-Executive Director with a membership of the Chief Executive, Medical Director, Director of Nursing, CQC project lead and appropriate Directorate Representatives. The Group will be provided with assurance that appropriate action is being taken in preparation for the core services and well led inspections.

2.3 The Well Led inspection will be in the new format developed by CQC and NHSI with a strong focus on financial and resource governance to assess leadership, management and governance of organisations; this is considered to carry a greater risk. An initial meeting has taken place with the Trust's previous CQC Project Team who will provide expert support and knowledge.

2.4 Focus groups have been held with additional ones planned for 1 and 21 March 2018 enabling the CQC Inspectors to meet a broad spectrum of staff.

2.5 CQC Improvement Plan

A summary of the current position is as follows:

		Must Do	Should Do
Blue	Action has been completed and there is evidence that the action has been embedded in daily practice	**13**	**17**
Red	The action is off track and unrecoverable within the current timescales. Requires a re-plan	**0**	**0**
Amber	The action is off track and plans are being put in place to mitigate the delay. The action is expected to return to the planned delivery date	**2**	**8**
Green	Action is on track to deliver on time	**1**	**2**

2.6 Further to submission of the PIR feedback has been received and actioned.

Report to the Board of Directors

3 RISK AND REGULATION ASSURANCE

The Trust was inspected by the Human Tissue Authority (HTA) on Thursday 26 October 2017, this was our first inspection against the revised Codes of Practice and Standards April 2017. The HTA noted the suitability of the Designated Individual, Licence Holder and premises and the inspection resulted in only one minor shortfall against the standards which has subsequently been addressed and the HTA have indicated this in their report published on the HTA website.

This was an extremely successful inspection with many areas of good and innovative practice noted. In particular, the HTA were very impressed with the mortuary quality manual, Standard Operating Procedures, risk assessments, audits and records such as the viewing form and training programs for porters and undertakers, the latter they had not seen in any other establishment. The peer review of consent for paediatric post mortem was considered very good practice.

4 DOCUMENTATION MANAGEMENT

4.1 The table below shows the status of the corporate policies, all have been approved and are available on the intranet and internet.

Corporate Policy	Document Owner	Status
Conflicts of Interest	Company Secretary	Approved; Available on intranet and website
Consent	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Duty of Candour	Medical Director	Requires review – October 2017
Complaints	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Emergency Preparedness, Resilience and Response	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Estates and Facilities	Director of Finance	Approved; Available on intranet and website
Fire Safety	Director of Finance	Approved; Available on intranet and website
Health and Safety	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Human Resources and Organisational Development	Director of Workforce and OD	Approved; Available on intranet and website
Information Governance	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website

Medicines Management	Medical Director	Approved; Available on intranet and website
Risk Management Strategy	Director of Corporate Governance, Risk, Compliance and Legal	Approved; Available on intranet and website
Safeguarding	Director of Nursing	Approved; Available on intranet and website
Serious Incidents	Medical Director	Requires review – October 2017
Standing Financial Instructions	Director of Finance	Approved; Available on intranet and website
Violence, Aggression and Disruptive Behaviour	Security Director (currently Director of Finance)	Approved; Available on intranet and website

5 EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE

NHS England EPRR Assurance Programme 2017

The October Local Health Resilience Partnership was attended by Katy White and Paul Mullane. Medway Clinical Commissioning Group presented the Trust audited NHS England Assurance Programme outcome for 2017. It was confirmed that the Trust were fully compliant with the prescribed core standards and as detailed within the report to Board on the subject have two areas of corrective action in relation to the deep dive on the subject of Governance.

Two additional items were raised in the discussion: ED attendance at the Trust EPRR Group where it was felt on the evidence submitted that the department were not completely committed and that of a Communications Team representative being moved back to the core membership of the group from the additional membership list. These items have been addressed and resolved.

Kent Resilience Forum Seminar

The KRF Seminar was held at the County Showground on 19 October. The theme for this year reflected the National Threat profile of Terrorism. Sessions were received from experts on counter terrorism and those involved in the management and deployment of terrorist attacks and included discussion on the Grenfell Fire response. The learning from this event will be reflected upon to strengthen the Trust position especially in relation to Psychosocial impacts of response on staff.

Shoreham Air Show Mass Fatalities Seminar 27 October, Crawley

Report to the Board of Directors

The EPRR Manager was invited to attend a detailed debrief of the incident by the Coroner Service as part of her work on the Kent Resilience Forum; Mass Fatalities Group. The learning from this will support the Trust in terms of the Disaster Victim Identification Mortuary process via a newly forged alliance with the Mortuary Lead APT from the public mortuary involved as well as the wider resilience programme benefits for Kent and Medway.

NHS E Concept of Operations for managing Mass Casualties – Received 16 November

A gap analysis has been undertaken against the Trust Major Incident Plan.
An update to the Mass Casualty Section of Trust Major Incident Plan will include reference to the document and:

1. The requirement to expand Critical Care Capacity and maintain that for 96 hours
2. An initial planning assumption in relation to casualty dispersal by SECAmb agreed by Mr R Jain and Dr A DaCosta
3. The fact that via Mutual Aid Military Doctors can be requested to enhance the skill set of our Trauma and Orthopaedic Surgeons.

Priestfied Stadium – Safety Advisory Group Exercise 21 November

The recommendation by the EPRR Manager at the Exercise is that Medway Hospital have the graded Fixtures List annually and are privy to the Football Safety Advisory Group Minutes. This will allow for better communication of higher risk attendees at the Stadium and a more robust review of ED Staffing associated with that risk.

Mutual Aid Planning

Following on from NHS England's Exercise Fluctus held on 1st November a task and Finish Group will be hosted by NHS England between Christmas and New Year to review planning assumptions in relation to an ED closure and the impacts across the system that would need to be considered within Mutual Aid. The NHS England local lead is Matthew Drinkwater.

Significant Incident 30 January/ 1 February Failure of ISDN Main Hospital Switchboard 01634 830000 line for Incoming Calls. Both Significant Incident Scale Matrix - Serious, reported to Medway and Swale CCGs/ North Kent CCGs on call.

Stand-alone DDI lines not affected.
31 January incident 13:00 - 23:30 Director Liz Capp- Gray/ Karen Rule out of hours
1 February Incident (Insert time) Director Karen Rule.
Alternative contact details for on call teams shared with CCG for General Practitioners
Trust Communications - Warning/Informing instigated - Internal and External
Debrief Report requested from British Telecom and Daisy in relation to infrastructure.
For Trust debrief with recommendations to Trust EPRR Group 12 February.

Report to the Board of Directors

6 COMPLAINTS AND COMPLIANCE DASHBOARD

6.1 The compliance dashboard gives an overview of performance across a range of corporate governance key performance indicators and is monitored at the monthly Directorate Performance Review Meetings. There is an overarching Trust level dashboard (attached at appendix 1) and each directorate (clinical and corporate) has a dashboard tailored to the relevant KPIs of that service.

Freedom of Information		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
1.1	% of closed FOIs completed in 20 working days	90%	47%	62%	61%	78%	40%	70%	94%	38%	54%	70%	49%	39%	45%
1.2	No. of FOIs overdue	N/A	0	0	93	72	64	43	65	75	56	61	57	52	61

Information Governance		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
2.1	IG Training (>95%)	95%	0%	0%	81%	80%	78%	77%	77%	75%	80%	77%	80%	80%	78%
2.2	No. breaches reported to the ICO	N/A	1	0	1	0	1	1	1	0	0	1	0	0	0

Data Protection		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
3.1	% of closed SARs completed in 40 calendar days	85%	74%	81%	95%	87%	93%	95%	88%	88%	82%	81%	85%	71%	68%

Complaints		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
4.1	Number of complaints received	N/A	N/A	N/A	N/A	52	61	62	66	66	81	73	63	41	73
4.2	% of red assessed complaints with final response within 60 working days	85%	0%	0%	33%	40%	61%	28%	67%	40%	59%	38%	N/A	N/A	N/A
4.3	% of amber assessed complaints with final response within 30 working days	85%	19%	25%	19%	48%	57%	60%	68%	70%	72%	31%	59%	N/A	N/A
4.4	% of green assessed complaints with final response within 10 working days	85%	52%	41%	57%	28%	37%	58%	54%	39%	29%	100%	47%	N/A	N/A
4.5	% complaints acknowledged within 3 working days	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
4.6	Number of referred complaints taken up by the Ombudsman	N/A	1	1	3	1	0	0	0	1	0	0	0	0	1
4.7	Ombudsman Outcomes - upheld	N/A	0	0	0	0	0	0	0	0	0	0	0	0	0
4.8	Ombudsman Outcomes - partially upheld	N/A	0	0	1	0	1	1	0	0	0	0	0	0	0
4.9	Ombudsman Outcomes - not upheld	N/A	0	1	0	2	0	1	1	0	0	0	0	0	0

Serious Incident Reporting		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
5.1	No. of Serious Incidents reported on STEIS in month	N/A	13	20	20	9	24	21	7	13	14	18	0	0	0
5.2	No. of Serious Incidents reported on STEIS within 48 hours of incident date	N/A	2	6	1	2	3	4	5	4	6	5	0	0	0
5.3	48 hour compliance rate	0%	85%	70%	95%	78%	88%	81%	29%	69%	57%	72%	#DIV/0!	#DIV/0!	#DIV/0!
5.4	No. of Serious Incident 72 hour reports due for submission in month	N/A	8	24	19	9	21	25	5	14	11	19	0	0	0
5.5	No. of Serious Incident 72 hour reports submitted in month	N/A	2	6	2	4	15	14	4	13	8	19	0	0	0
5.6	72 hour report compliance rate	0%	75%	75%	89%	56%	29%	44%	20%	7%	27%	0%	#DIV/0!	#DIV/0!	#DIV/0!
5.7	Number of Serious Incident Reports due for Submission (60 Working Day)	N/A	15	6	7	15	16	20	15	20	19	9	0	0	0
5.8	Number of Serious Incidents Reports submitted	N/A	0	2	3	9	9	2	1	1	3	3	0	0	0
5.9	60 Day Report Submission Compliance Rate	0%	100%	67%	57%	40%	44%	90%	93%	95%	84%	67%	#DIV/0!	#DIV/0!	#DIV/0!

Incident Reporting		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
6.1	Number of incidents triggering Duty of Candour	N/A	29	30	30	27	39	35	33	23	28	24	0	0	0
6.2	Number of incidents triggering DOC where this was applied	N/A	2	2	1	1	8	0	2	2	3	1	0	0	0
6.3	Number of incidents awaiting review	N/A	57	58	86	123	209	175	281	395	527	488	0	0	0
6.4	Number of incidents overdue review	N/A	57	58	86	123	209	65	183	272	407	413	0	0	0
6.5	Number of incidents being reviewed and overdue	N/A	182	159	263	243	305	2357	2261	2244	2367	2496	0	0	0
6.6	Awaiting final approval and overdue	N/A	157	310	618	296	280	156	707	1594	2342	2937	0	0	0

Risk		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
7.1	% of risks within review period by Directorate	100%	20%	24%	20%	28%	20%	31%	52%	39%	53%	45%	42%	39%	43%
7.2	% of staff trained on MOLLIE risk management module by Directorate	85%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	53%	45%	42%	39%	43%
7.3	% of risk where current score is less than the initial score by Directorate	85%	35%	38%	36%	35%	41%	37%	25%	28%	27%	29%	28%	29%	25%

Policies		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
8.1	% of Corporate policies in date	95%	0%	0%	85%	85%	85%	86%	86%	87%	79%	79%	81%	81%	94%
8.2	% of other procedural documents in date	95%	N/A	N/A	71%	71%	71%	72%	72%	78%	77%	82%	88%	87%	82%

Central Alerts System		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
9.1	CAS alerts outstanding	0	0	0	0	0	0	0	0	0	0	0	0	0	0

EPRR and Business Continuity Planning		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
10.1	% of Business Continuity Plans overdue	0%	0%	0%	22%	21%	22%	27%	38%	41%	41%	46%	45%	48%	4%
10.2	% Major Incident Training (Gold)	95%	0%	0%	0%	0%	0%	0%	85%	85%	85%	77%	88%	88%	8%
10.3	% Significant Incident Training (Gold)	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	58%	71%	83%	0%
10.4	% Significant Incident Training, Silver	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
10.5	% Major Incident Training, Silver	95%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
10.6	% Major Incident Training, Bronze	95%	0%	0%	0%	0%	0%	14%	14%	14%	14%	9%	18%	18%	0%

Health and Safety		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
11.1	No. reports sent within 10 days and investigated (RIDDOR 2013)	N/A	0	0	1	0	0	1	0	2	1	0	1	0	1
11.2	No. of incidents which were RIDDOR reportable but not sent within 10 days and investigated (RIDDOR 2013)	0	0	0	1	0	0	0	1	0	0	1	0	0	0
11.3	No. manual handling key workers in post	192	72	72	72	69	69	69	69	74	74	74	63	63	67
11.4	No. H&S key workers in post	128	90	90	90	62	62	62	62	62	62	62	55	55	44

11.5	% Fire safety training completed	95%	100%	100%	86%	87%	86%	83%	83%	83%	81%	67%	82%	82%	83%
11.6	% H&S training completed	95%	89%	91%	91%	89%	89%	85%	89%	90%	83%	87%	92%	93%	90%
11.7	% Manual Handling training completed	95%	87%	93%	93%	88%	88%	84%	87%	87%	82%	85%	84%	86%	86%

Legal		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
12.1	No. of inquests	N/A	7	6	4	0	0	0	0	0	7	8	8	8	13
12.2	% of documentation returned to coroner on time	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
12.3	No. Claims Received - Clinical Negligence	N/A	2	4	6	0	0	4	4	8	5	3	2	8	2
12.4	No. Claiims Received - Employers Liability Claims	N/A	0	0	1	2	1	0	0	0	0	0	0	0	1
12.5	No. Claiims Received - Public Liability Claims	N/A	0	0	1	0	0	0	1	0	0	0	1	0	0
12.6	% of documentation returned to NHSLA on time	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

EDN Completion		Target	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
13.1	% completed in 24 hours	100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	80%	81%	81%	74%	74%
13.2	% completed in 48 hours	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	84%	84%	76%	78%	78%
13.3	Backlog - All Outstanding EDNs	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1180	2339	893	1154	1192
13.4	Backlog longest wait time, in days (average for Directorates)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1668	1048	1751	1732	1760

		Q4 (Jan - Mar 17)				Q1 (Apr 17-Jun 17)					Q2 (Jul 17-Sep 17)			Q3 (Oct 17-Dec 17)	
Care Quality Commission		ACCD	CSD	W&CD	Trustwide	ACCD	CSD	F&CSD	Trustwide	ACCD	CSD	F&CSD	Trustwide	ACCD	CSD
13.1	Compliance against Safe domain (as per CQC Assure)	Req Improvement	Good	Req Improvement	Req Improvement	Req Improvement	Req Improvement	Req Improvement	Req Improvement						
13.2	Compliance against Effective domain (as per CQC Assure)	Req Improvement	Req Improvement	Good	Good					Req Improvement					
13.3	Compliance against Caring domain (as per CQC Assure)	Req Improvement	Good	Good	Good										
13.4	Compliance against Responsive domain (as per CQC Assure)	Req Improvement	Req Improvement	Good	Req Improvement										
13.5	Compliance against Well led domain (as per CQC Assure)	Req Improvement	Req Improvement	Good	Good										
13.6	No. of Requirement actions (as per CQC Quality Report 17/3/17)	N/A	N/A	N/A	13	N/A	N/A	N/A	13	N/A	N/A	N/A		N/A	N/A
13.7	No. of Enforcement actions (as per CQC Quality Report 17/3/17)	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A		N/A	N/A
13.8	No. of Warning notices (as per CQC Quality Report 17/3/17)	N/A	N/A	N/A	0	N/A	N/A	N/A	0	N/A	N/A	N/A		N/A	N/A

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/03/2018

Agenda item 13a

Title of Report	**Workforce Report**
Prepared By:	Leon Hinton, acting Director of Operational HR
Lead Director	Leon Hinton, acting Director of Operational HR
Committees or Groups who have considered this report	Executive Team
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the hospital. The Trust's recruitment campaigns, including national, local and international have delivered 45 candidates to-date via Cpl, 47 candidates to-date via HCL and 65 from other partner agency providers. The initial Philippines recruitment plan for nursing continues with a total of 194 nurses being processed for posts at MFT. Trust turnover has decreased to 11.3% (-0.06% from 11.40%) and is likely to plateau for the next three months, sickness remains under 4% (+0.07% from 3.74%) at 3.81%, compliance with mandatory training compliance has slightly deteriorated to 76.9% (-1.1% from 78%) against target of 85% - but remains higher than 2017, achievement review compliance slightly deteriorated to 82.9% (-1.1% from 84%) against target of 85% - and remains on average with 2017. A decrease in the percentage of pay bill spent on substantive staff is reported for January (to 80% by -2.9%) with an increase (of 0.9%) in agency usage and an increase (of 2%) to bank usage. The profile of the organisation remains lower than average temporary staffing spend for 2017/18 compared to 2016/17.
Resource Implications	None

Report to the Board of Directors

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

Report to the Board of Directors

1 INTRODUCTION

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

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During January 15 FTE nurses joined the Trust on a substantive basis, alongside 8 FTE clinical support workers.

2.2 The international campaign in the Philippines continues. Harvey Nash, our international partner agency working on our Filipino nurse recruitment campaign, is continuing to process 194 of the Filipino nurses that remain engaged in the process (26 individuals have withdrawn and 21 individuals have failed to follow-up on the offer). Of those remaining in the process 110 have yet to attempt an IELTS . Harvey Nash is supporting these individuals to undertake their IELTS test. On the 4 January two further nurses (placed on NICU and Byron) arrived in the Trust and joined the new six-week objective structured clinical examination (OSCE) training programme that commenced on 08 January. An additional cohort of nurses are scheduled to arrive in February.

2.3 Further to the collaborative regional procurement approach to International Nurse Recruitment the Trust selected additional partner providers; Cpl Healthcare (Cpl) (48 offers in process and 3 withdrawals), HCL (45 offers in process, 2 arrivals and 13 withdrawals), Person Anderson (35 offers of which 17 are scheduled to arrive in the next 8 weeks, 1 arrival and 4 withdrawals), Imperial MS (20 offers, 1 arrival and 4 withdrawals) and MSI Group (7 offers, 1 arrival and 0 withdrawals).

2.4 The Trust has commissioned the services of HealthSectorJobs (HSJ), a specialist health sector advertising company to undertake a four-week targeted nurse recruitment advertising campaign on behalf of the Trust which is reopening the campaign at the beginning of March.

2.5 The table below summarises offers made, starters and leavers for January 2018. The net positive nurse and clinical support worker hires in January mitigated some of the net leavers from November and December 2017.

Role	Offers made in month	Actual Starters	Actual Leavers
Registered Nurses	30	15	6
Clinical Support Workers	5	8	1

(Table 1: Monthly starters and leavers)

2.6 Six doctors commenced in post in January: one Deputy Medical Director and Consultant Physician; two Medical Trainee Initiative doctors (MTI) and three Trust Grade doctors.

2.7 The first Trust Physician Associate (PA) commenced in Medicine in January 2018 and a second Physician Associate (PA) commences in Trauma and Orthopaedic in February. A further six are currently at conditional offer stage. The Trust will be interviewing for additional newly-qualified PAs from the University of Greenwich in February.

3 DIRECTORATE METRICS

3.1 The table below (table 2) shows performance across five core indicators by the directorate. Turnover, at 11.34% (-0.06% from December), remains above the tolerance level of 8% and is likely to plateau for the next three months. Sickness absence (+0.07% at 3.81%) remains below the tolerance level of 4%. HR Business Partners will work with all existing information sources (exit interview data and face to face interviews), system-wide knowledge (let's work together commissioned by Health Education England) and staff survey results. In conjunction with outputs from the January unconference and culture workstreams, with the aim to implement a service-specific retention plan through quarter 4 17/18 and quarter 1 18/19.

3.2 Trust achievement review rate stands at 82.86% (-1.14%), below the Trust target of 85%, Mandatory training remains below target (at 76.9%, slight deterioration by 1%) but remains higher than 2017 – one directorate is meeting the mandatory training target (Corporate) and two directorates are meeting the achievement review target (Corporate and Planned Care). A revised achievement review (AR) system will be implemented across the Trust from 01 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings will be included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation. The appraisal paperwork will be replaced to streamline the process and reduce the burden of paperwork. The mechanism will also change to support an ongoing performance and objective conversation rather than an annual report and will capture training and development needs for intelligent commissioning.

Report to the Board of Directors

	Planned Care			Unplanned & Integrated Care			Corporate			Estates & Facilities			Trust		
	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend	Rate	Trend from previous month	12-month trend
Turnover rate (8%)	11%	▲		13%	▼		13%	▼		6%	▶		11%	▼	
Vacancy rate (12%)	20%	▲		14%	▼		14%	▲		13%	▼		16%	▼	
Sickness rate (4%)	4%	▲		4%	▲		3%	▲		5%	▼		4%	▲	
Mandatory Training (85%)	82%	▼		76%	▼		89%	▼		52%	▶		77%	▼	
Achievement Review (85%)	87%	▲		79%	▼		95%	▼		78%	▼		83%	▼	

(Table 2: Key workforce metrics)

4 TEMPORARY STAFFING

4.1 Table 3 below demonstrates that temporary staffing expenditure increased in January compared to December. January's £3.7m temporary spend is slightly higher than average compared to previous months.

		Mar-17	Jun-17	Sep-17	Dec-17	Jan-17
Spend	Agency	3,890,198	860,106	1,379,621	891,539	1,129,723
	Bank	920,473	2,046,593	2,307,063	2,014,739	2,575,466
	Substantive	13,611,458	14,326,916	13,920,369	14,073,505	14,833,312
% Pay bill	Agency	21%	4.99%	7.84%	5.25%	6.09%
	Bank	5%	11.88%	13.10%	11.87%	13.89%
	Substantive	74%	83.13%	79.06%	82.88%	80.01%

(Table 3: Workforce profile based on contractual arrangement)

4.2 The agency cap breaches across all staff groups for January has decreased with approximately 86 price cap breaches per week. Based on agency spend to date, the Trust is now on target to be £7.3m below the Trust's 2017/18 NHSi agency ceiling cap of £21.6m.

4.3 Temporary nursing demand increased for the second consecutive month (12,582 shifts requests in Jan compared to 10,146 shifts requests in Dec and 9,892 shift request in Nov). However, the fill rate remained in January remained at 72%. Medical locum fill rate also decreased slightly in January (form 72% in Dec to 69% in Jan). The decrease in fill can be attributed to an increase in demand for medical SpRs.

-End

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Board Date: 01/03/2018

Agenda item 13b

Title of Report	**Gender Pay Gap Report**
Prepared By:	Alister McClure, Head of Equality & Inclusion
Lead Director	Leon Hinton, acting Director of Operational HR & OD
Committees or Groups who have considered this report	Executive Team
Executive Summary	This report sets out the gender pay gap calculations and supporting statement for 2017. It is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The gender pay gap for the Trust is a mean of 30.62% and a median of 19.56%. The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles.
Resource Implications	None identified at this stage
Risk and Assurance	Reputation and Contract Compliance Publication of the gender pay gap along with the supporting statement will remove the risk of non-compliance. Development of an implementation plan will enable the Trust to mitigate the reputational risks associated with a gender pay gap.
Legal Implications/Regulatory Requirements	The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires the Trust publishes its gender pay gap.
Improvement Plan Implication	Workforce equality, including being an employer of choice, is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan.
Quality Impact Assessment	Not applicable
Recommendation	To approve the publication of the Trust's Gender Pay Gap and

Report to the Board of Directors

	supporting statement (as set out is section 6)			
Purpose & Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☒	☐	☐	☐

Report to the Board of Directors

1 EXECUTIVE SUMMARY

1.1 This report sets out the gender pay gap calculations for 2017, together with a supporting statement. The report is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017

1.2 The gender pay gap for the Trust is a mean of 33.32% and a median of 24.24%. The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles. There is some evidence that this pattern is repeated in many other Trusts across the NHS, and relates to professional career paths.

2 BACKGROUND

2.1 Following government consultation, it became mandatory on 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap (GPG). Since the Equality Act 2010 (Specific Duties) Regulations 2011 (SDR) came into force on 10 September 2011, there has been a duty for public bodies with 150 or more employees to publish information on the diversity of their workforce (these are published annually on the Trust website). Although the SDR did not require mandatory GPG reporting, the Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) provided guidance that made it clear that employers should consider including GPG information in the data they already publish. It was evident that not all employers did this, so the government made GPG reporting mandatory by amending the SDR so that all public sector employers with more than 250 employees have to measure and publish their gender pay gaps.

2.2 The new requirement to publish GPG reports is set out in the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The requirements are summarised in section 4 of this report.

2.3 The difference between the gender pay gap and equal pay

2.3.1 **Equal pay** deals with the pay differences between men and women who carry out the same jobs, similar jobs or work of equal value. It is unlawful to pay people unequally because they are a man or a woman.

2.3.2 **The gender pay gap** shows the differences in the average pay, across the whole workforce, between men and women. If a workplace has a particularly high gender pay gap, this can indicate there may a number of issues to deal with, and the individual calculations may help to identify what those issues are. In some cases, the gender pay gap may include unlawful inequality in pay but this is not necessarily the case.

2.4 Although each individual NHS Trust is responsible for its own GPG report, the NHS has a nationwide tool to make the relevant calculations.

3 REPORTING REQUIREMENTS

3.1 Employers with 250 employees and over will need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This includes those under Agenda for Change terms and conditions, medical staff and very senior managers. All calculations must be made relating to the pay period in which the snapshot day falls. For this first year, this will be the pay period including 31 March 2017.

3.2 Employers must:

- calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls;
- calculate the difference between the mean hourly rate of ordinary pay of male and female employees, and the difference between the median hourly rate of ordinary pay of male and female employees;
- calculate the difference between the mean (and median) bonus pay paid to male and female employees (NB this calculation is not relevant to this Trust, as staff are not paid bonuses. Clinical Excellence Awards, for example, are fully incorporated into pay.);
- calculate the proportions of male and female employees who were paid bonus pay (again, this is not relevant to this Trust);
- calculate the proportions of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands by number of employees rather than rate of pay.

3.3 The Trust is also required to publish a supporting narrative (see section 4 below), which must include an assurance statement, agreed by a senior representative of the Trust, and/or the Executive Group and The Trust Board. The calculations and supporting statement must be published on both the Trust website and a Government portal. Once published, employers are required to implement an action plan to address the gender pay gap.

3.4 The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 identify gender as male and female. There is no consideration in the regulations to people to identify as intersex, or gender non-binary. In terms of gender identity (e.g. Transgender status) the advice provided to employers is to ensure that for the purposes of the GPG report, people's gender is recorded according to their HR/Payroll records.

4 GENDER PAY GAP CALCULATIONS

4.1 Mean and Median Hourly Rates (All staff groups)

Gender	Average (mean) Hourly Rate	Median Hourly Rate
Male	21.7437	16.4418
Female	14.4996	12.4556
Difference	7.2441	3.9862
Pay Gap %	33.32%	24.24%

4.2 Number of employees per quartile

Quartile	Female	Male	Female %	Male %
1 (lower)	880	158	84.78	15.22
2 (lower middle)	920	159	85.26	14.74
3 (upper middle)	910	150	85.85	14.15
4 (upper)	690	370	65.09	34.91

4.3 As reported in section 3 above, the calculation on bonuses is not relevant to this Trust, as staff are not paid bonuses. Awards that may be perceived as bonuses (Clinical Excellence Award, for example) are fully incorporated into pay, and under the definitions of the regulation are pay not bonuses.

4.4 Mean and Median Hourly Rates, separating medical and dental roles from non-medical roles.

Medical and Dental		
Gender	Average (mean). Hourly Rate	Median Hourly Rate
Male	36.2115	36.4409
Female	30.0725	27.2668
Difference	6.1390	9.1740
Pay Gap %	16.95%	25.18%

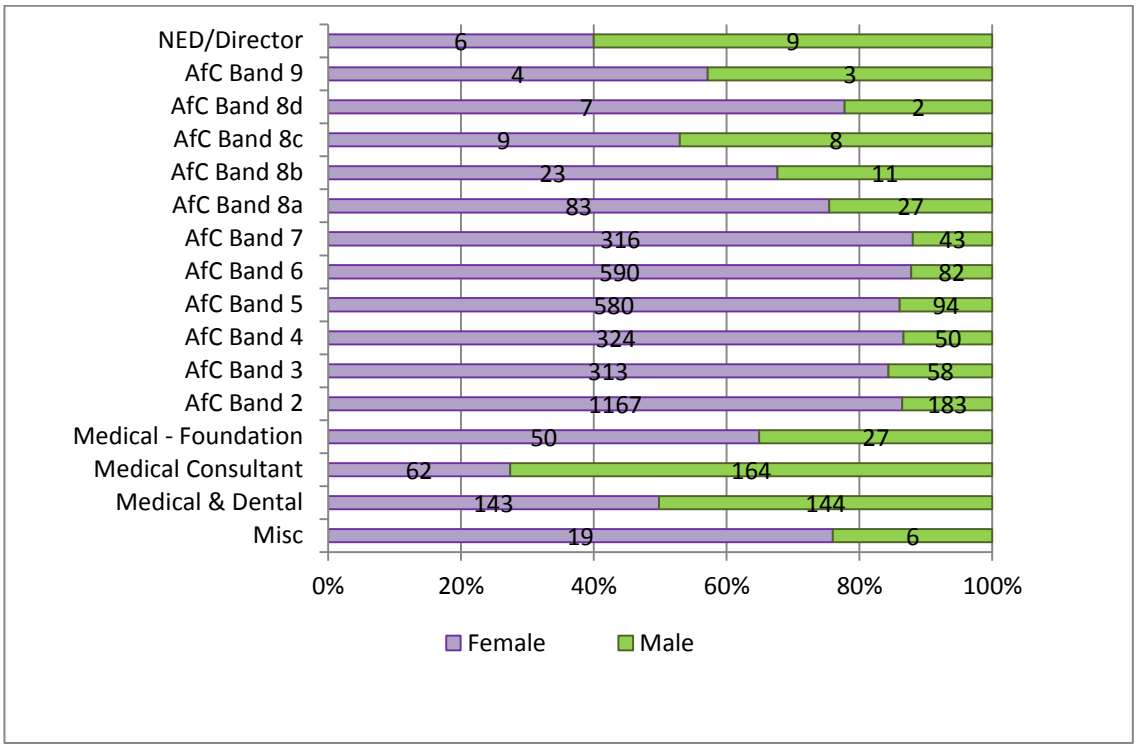
Non-Medical		
Gender	**Avg. Hourly Rate**	**Median Hourly Rate**
Male	14.3136	12.0973
Female	13.5470	11.9526
Difference	0.7666	0.1448
Pay Gap %	5.36%	1.20%

5 SUPPORTING STATEMENT

5.1 The headline calculations for this Trust are a Mean gender pay gap of 33.32% and a Median gender pay gap of 24.24%. However, it is evident that the proportion of men in the workforce increases in the upper quartile, compared to quartiles 1 to 3.

5.2 When calculating the pay gap separately for medical and dental, and non-medical staff, the mean reduces for both groups, and the median reduces for non-medical staff. Indeed, the mean pay gap for non-medical staff (chiefly AfC pay bands) there is very little variation in the mean, at 5.36%, and the median is 1.2%.

5.3 The gender pay gap issue for the Trust comes when we combine medical and non-medical grades, as the number of men in the medical workforce, particularly consultants, is significantly higher than the number of women. The graph below illustrates, from the Trust's workforce demographics report 2017, that amongst medical consultants, men comprise over 75% of the workforce. In Agenda for Change (AfC) pay bands, women form over 80% of the workforce. This means that, compared to women, a greater proportion of men are in higher paid roles. Another potential matter to consider is the fact that the Trust has not outsourced some services, such as catering and housekeeping, which have a higher proportion of women in lower pay bands.



5.4 Discussions with neighbouring trusts and with NHS Employers have revealed that there is a similar pattern across Acute Trusts in England. On the one hand, there is reasonable confidence that, owing to Agenda for Change and medical pay reviews, the NHS is providing equal pay (men and women paid equally to carry out the same jobs, similar jobs or work of equal value). However, it is evident that in medical roles there are significantly more men progressing to the most senior levels resulting in a gender pay gap.

5.5 Further work is needed to understand the reasons for the differences in progression for men and women, especially in medical and dental roles. There is also little that the Trust can do in the short term to remove the gender pay gap, precisely because the issue affects professions that have long term career pathways.

5.6 The important issue with gender pay gap analysis is not only to know the data and understand the reasons for the gaps, but to be able to develop plans to address the gap. Reliable benchmarking with other organisations has not yet been possible, as this is the first year for gender pay gap reports. Noting that the gender pay gap issue is common to many other acute trusts across the NHS, it will be important to explore with partners across the NHS what practical changes can be made. Ideas currently under consideration include:

- Continuing to keep pay structures under proper review, to ensure that equal pay is maintained;
- Improving the professional pathways for women in medical roles to encourage more female medics into consultant and other senior roles;
- Working with Medical Schools/Universities to explore how medical graduates choose the direction of their careers;
- Reviewing the international dimension of medical recruitment, recognising the pattern of male dominance in medical roles across the world. This must include practical steps to encourage more women medics from international recruitment;
- Reviewing how well the Trust manages women's progression after career gaps/maternity;
- Reviewing how well the Trust is managing the progression into senior medical roles for women who work part-time;
- Active promotion of current policies on flexible and family-friendly working, workforce planning and career development opportunities and career pathways for all staff.

5.7 **Assurance statement.** The gender pay gap for Medway Foundation Trust has been prepared using the NHS Electronic Staff Record (ESR) gender pay gap calculator. The Trust has also used the ACAS guidance to calculate and verify the result.

6 PUBLICATION

6.1 Subject to approval by the Trust Board at its meeting in March 2018, the gender pay gap and supporting statement will be published on the Trust website and the Government portal before 31 March 2018. The next steps (set out in 4.5 above) will be developed into an implementation plan.

6.2 It is recommended:

6.2.1 that the gender pay gap (section 4 of this report) together with the supporting statement (section 5), be approved for publication.

6.2.2 that the Trust works with partners across the NHS to develop the next steps (5.5 above) into a detailed implementation plan.

6.2.3 that benchmarking be undertaken with other NHS trusts and with UK employers whose gender pay gap will published on the Government portal.

-End

NHS Medway NHS Foundation Trust

Report to the Board of Directors

Date: 23/02/2018 Agenda item 14-16

Title of Report	Board Committee Terms of Reference
Prepared By:	Trust Secretariat
Lead Director	Sheila Murphy, Trust Secretary
Committees or Groups who have considered this report	The terms of reference have been endorsed by the relevant Board Committees
Executive Summary	The purpose of this report is to present the draft 2018/19 Terms of Reference for approval following their annual review.
Resource Implications	Not applicable
Risk and Assurance	Terms of Reference follow a standard template, ensuring that there is effective coverage of the intended remit of the Quality Assurance Committee, Integrated Audit Committee and Finance Committee
Legal Implications/Regulatory Requirements	None
Improvement Plan Implication	None
Quality Impact Assessment	Not applicable for this particular paper.
Recommendation	The Board is asked to approve the terms of reference
Purpose and Actions required by the	**Approval** **Assurance** **Discussion** **Noting**

Report to the Board of Directors

Committee :	☒	☐	☐	☐

Terms of Reference

Quality Assurance Committee

1. Establishment

1.1. Board of Directors of Medway NHS Foundation Trust (the Trust) hereby resolves to establish a committee to be known as the Quality Assurance Committee (the Committee).

2. Purpose

2.1. The purpose of the Committee is to provide assurance to the Board of Directors that there is an effective system of governance, risk management and internal control across the clinical activities of the trust that support delivery of its strategic objectives and statutory or constitutional requirements for quality, in keeping with its ambition to deliver the Best of Care delivered by the Best of People.

3. Authority

3.1. The Committee is accountable to the Board of Directors and the Chair will report to the Board bi-monthly or as required by the Board

3.2. Any matters requiring Trust Board approval under the Trust's Scheme of Delegation and Reservation will be submitted to the Trust Board by the Chair of the Committee.

3.3. The Committee shall have the delegated authority to act on behalf of the Board of Directors in accordance with the Constitution, Standing Orders, Standing Financial Instructions, and Scheme of Delegation. The Committee is specifically authorised to:

3.3.1. investigate any activity within its terms of reference and seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee;

3.3.2. obtain independent professional advice and to secure the attendance of external personnel with relevant experience and expertise, should it consider this necessary. All such advice should be arranged in consultation with the Trust Secretary; and

3.3.3. carry out any activities which are in line with the terms of reference, as part of the Committee work programme.

3.4. The Chair of the Committee will provide briefings to the Council of Governors on request from the lead governor on issues relevant to the remit of the Committee.

4. Membership

4.1. The members of the Committee shall comprise:

- Three NEDs one of which will be the Chair of the Committee

- Medical Director (Co-director of Quality)
- Director of Nursing (Co-director of Quality)

4.2. The Chair of the Committee will be appointed by the Trust Board from among the Non-Executive Directors (NEDs). In the absence of the Chair for any given meeting, one of the NEDs present will be selected as Chair for that meeting.

4.3. The Trust Secretary (or deputy) will attend all meetings as minute taker and work with the Chair to ensure effective and appropriate conduct of the Committee's business.

5. Attendees

5.1. The chief executive may attend the Committee meeting at their discretion or as invited by the Chair.

5.2. Other Executive Directors, along with any other appropriate attendees, will be invited to attend by the Chair when areas of risk or operation that fall under their responsibility are being considered by the Committee.

5.3. Directorate or programme leadership teams (triumvirates) will be invited to attend periodically in order to present 'deep dive' assurance reports about their area.

5.4. Up to three public governors may attend each meeting, of which one will be in attendance and the others as observers. The lead governor may attend periodically at their discretion.

5.5. Other internal or external people may be invited to attend as deemed necessary and appropriate by the Chair for the effective delivery of the Committee's terms of reference.

6. Quorum

6.1. The meeting will be quorate provided that the Chair of the Committee (or deputy) and two other members are present, one of which must be an Executive Director.

7. Frequency

7.1. Meetings will be held at least six times in each financial year. Meetings will be held on alternate months to Board to ensure there is a formal assurance meeting each month at which quality risks or issues can be considered.

7.2. The Chair of the Committee may request an extraordinary meeting if they consider one to be necessary.

7.3. Development meetings may be held each intervening month for the purposes of developing knowledge of members or allowing more discursive sessions. This may include 'site visits' to meet teams or service users in situ.

8. Objectives and programme of activities

8.1. The overarching objective of the Committee is to obtain assurance that the risks linked with the Trust's provision of excellent care are identified, managed and mitigated appropriately. The Committee will deliver this objective through a work programme which includes, but may not be not limited to:

8.1.1. Overseeing development and maintenance of a corporate quality strategy for approval by the Board;

8.1.2. Ensuring that strategic priorities for quality assurance best support delivery of the Trust's quality ambitions in relation to patient experience, safety and effective outcomes for patients and service users;

8.1.3. Evaluating the effectiveness of corporate and operational governance, leadership and management in delivering quality priorities, and reporting on these to the board and making recommendations for improvements where needed. This will include reviewing and monitoring activities of the various quality governance groups – receiving specific reports and/or minutes from these as needed;

8.1.4. Overseeing in-depth reviews as necessary in areas identified as risks to quality by the Board, the Committee or others;

8.1.5. Ensuring robust arrangements are in place for assessing the impact on quality and safety of planned changes to service delivery, for example resulting from cost improvement measures;

8.1.6. Reviewing the annual Clinical Audit Programme, to ensure it provides a suitable level of coverage for assurance purposes, and receiving reports as appropriate;

8.1.7. Reviewing compliance with regulatory standards and statutory requirements, such as: Duty of Candour, the CQC registration, NHSLA and the NHS Performance Framework;

8.1.8. Reviewing non-financial risks on the Risk Register or Board Assurance Framework which have been assigned to the Committee and satisfying itself as to the adequacy of assurances on the operation of the key controls and the adequacy of action plans to address weaknesses in controls and assurances; and

8.1.9. Reviewing statutory reports ahead of submission to the Board of Directors for approval, for example: Annual Infection Prevention and Control Report, Annual Safeguarding Report and Quality Account.

9. Reporting

9.1. Formal minutes of Committee meetings will be recorded and circulated to members within one month. These will normally be confirmed as accurate at the next meeting of the Committee.

9.2. The full minutes of the Committee will be made available to the Board of Directors via BoardPad or any future system in use. The Chair of the Committee will draw to the attention of the Board to any serious issues that require disclosure to the full Board. A summary of key issues will be presented by the Chair in the public session of the Board Meeting.

10. Review

10.1. These Terms of Reference should be reviewed annually as part of the Committee's review of its performance. Any significant changes to the terms of reference must be subject to approval by the Trust Board.

Terms of Reference *approved by the Trust Board on* insert date of meeting when they were approved.

Terms of Reference

Integrated Audit Committee

1. Purpose

1.1. To provide the Trust Board with an independent and objective review of its financial and non-financial systems, financial and non-financial information and compliance with laws, guidance and regulations governing the NHS.

2. Constitution

2.1. The Integrated Audit Committee (the Committee) is established on the authority of the Trust Board.

3. Authority

3.1. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

3.2. The Committee is also authorised to implement any activities which are in line with its terms of reference.

4. Accountability

4.1. The Committee will report to the Trust Board after each meeting.

4.2. The Committee will provide a report to the Council of Governors periodically/as requested.

5. Chairperson

5.1. The Chair of the Committee will be chosen and appointed by the Trust Board from among the Non-Executives Directors (NEDs); the Deputy Chair will be one of the other NED members.

6. Membership

Membership of the Committee comprises not less than three Non-Executive Directors (the Trust Chairman shall not be a member).

In attendance:

- Chief Executive
- Director of Finance
- Director of Corporate Governance, Risk, Compliance & Legal
- Internal and External Audit representatives
- Counter Fraud representatives
- Executive Directors and other managers may be invited to attend meetings

- Other Non-Executive Directors and Executives can attend with the Chair's consent but will have no voting rights
- Company Secretary (or member of the secretariat) as minute taker

7. Attendance is expected from:

7.1. There is a requirement for members to attend at least 75% of all meetings in one calendar year.

7.2. Other staff may be requested to attend at the invitation of the Chair.

8. Quorum

8.1. Meetings will be quorate when at least two Non-Executive Directors are in attendance.

9. Frequency

9.1. The meetings will be held quarterly.

10. Key responsibilities

10.1. Responsibilities:

Integrated governance, risk management and internal control

10.1.1. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- All risk and control-related disclosure statements;
- The underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any reporting and self-certifications
- The policies and procedures for all work related to counter fraud and security as required by NHS Protect.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

10.1.2. **Internal audit**

The Committee shall ensure that there is an effective internal audit function that meets the Public Sector Internal Audit Standards, 2013 and provides appropriate independent assurance to the Committee. This will be achieved by:

- Considering the provision of the internal audit service and the costs involved
- Reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- Considering the major findings of internal audit work (and the management's response), and ensuring co-ordination between the internal and external auditors to optimise the use of audit resources
- Monitoring the effectiveness of internal audit and carrying out an annual review.

10.1.3 **External audit**

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- Considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the Board when appropriate)
- Discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan.
- Discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee.
- Reviewing all external audit reports, including the report to those charged with governance (before its submission to the Board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

- Ensuing that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

10.1.4 **Other assurance functions**

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, and consider the implications for the governance of the organisation.

10.1.5 **Counter fraud**

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud and security that meet NHS Protect's standards and shall review the outcomes of work in these areas.

10.1.6 **Management**

The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

10.1.7 **Financial Reporting**

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the governing body, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the Board, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the Committee
- Changes in, and compliance with, accounting policies, practices and estimation techniques
- Unadjusted mis-statements in the financial statements
- Significant judgements in preparation of the financial statements
- Significant adjustments resulting from the audit
- Letters of representation
- Explanation for significant variances.

10.1.8 **Whistleblowing**

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensure that any such concerns are investigated proportionately and independently.

10.2. **Duties :**

10.2.1. Report to the Trust Board after each of its meetings;

10.2.2. Report to the Trust Board annually on its work, specifically on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management, and the operation of integrated governance within the Trust.

10.3. Committee papers will be published at least 5 working days before the date of the Committee. Committee minutes will be produced within 5 working days.

11. Process for Monitoring compliance with Terms of Reference

11.1. The Committee will monitor its performance against its TOR annually.

12. Review Date

12.1. All Terms of Reference should be reviewed annually.

Terms of Reference

Medway NHS Foundation Trust

Finance Committee

1. Purpose

1.1. To assure the Trust Board on the review and scrutiny of its financial planning and performance and to scrutinise major business cases and oversee major capital and estates projects.

2. Constitution

2.1. The Finance Committee is established on the authority of the Trust Board.

3. Authority

3.1. The Committee is authorised by the Trust Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Finance Committee

3.2. The Finance Committee is also authorised to implement any activities which are in line with its terms of reference.

4. Accountability

4.1. The Committee will report to the Trust Board bi-monthly.

4.2. The Committee will provide a report to the Council of Governors as required.

5. Chairperson

5.1 The Chair of the Committee will be chosen and appointed by the Trust Board from among the Non-Executives Directors (NEDs); In the absence of the Chair at any given meeting, the members of the Committee will select one of the NEDs present to act as Chair.

6. Membership

- Two NEDs one of which will be the Chair of the Committee
- Director of Finance
- Director of Workforce and OD
- Director of Communications
- Director of Nursing

In Attendance:

- Trust Secretary (or member of the secretariat) as minute taker.
- Chief Executive Officer
- Director of Clinical Operations
- Up to three public governors may attend each meeting, one of which will be in attendance and the others as observers.
- Attendees may contribute at the invitation of the Chair.

6.1 There is a requirement for members to attend at least 75% of all meetings in one calendar year.

6.2 Other staff may be requested to attend at the invitation of the Chair and participate in the financial review.

7. Quorum

7.1. Meetings will be quorate when at least three members, one non-executive and two executives are present.

8. Frequency

8.1. The meetings will normally be held monthly.

9. Key responsibilities

9.1. Responsibilities : To enable the Trust Board to obtain assurance that :

~~9.1.1. There is scrutiny of the Trust's financial performance against plans agreed by the Trust Board.~~

~~9.1.2.~~9.1.1. There is oversight of financial planning in the short and long term.

9.1.2. There is scrutiny of the Trust's financial performance against plans agreed by the Trust Board.

9.1.3. There is review of areas of ~~unmitigated~~ financial risk through the Board Assurance process, and that all appropriate and available mitigations are in place.

9.1.4. There is scrutiny of major business cases, service developments and proposed investment decisions in excess of £~~1m~~ 0.5m on behalf of the Trust Board.

~~9.1.4.~~9.1.5. Post project evaluation and benefits realisation of major investments

9.2. To provide a written or verbal report to the Trust Board that provides this assurance and highlights any areas that are of concern.

9.3. Finance Committee meetings will include the following standing items:

9.3.1. Review of the monthly Finance Report.

9.3.2. Review of Financial Recovery Plan.

9.3.3. Review of Capital Programme.

9.3.4. Review of CIP plans and delivery.

9.3.5. Review of business cases for service developments/changes/contracts in excess of £~~1m~~0.5m.

~~9.3.6. Review of contracts due to be awarded in excess of £1m.~~

9.4. Committee papers will be published at least 5 working days before the date of the Committee.

Committee minutes will be produced within 5 working days.

11. Terms of Reference

11.1. The Committee's terms of reference will be reviewed and approved by the Trust Board annually.

11.2. The Committee will monitor its performance against its terms of reference six monthly.

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Quality Assurance Committee held on 23/02/2018

Report to:	**Trust Board**	**Date of meeting: 1 March 2018**		**1**
Presented by:	**Jon Billings** **Non-executive Director**	**Prepared by:**	**Jon Billings** **Chair, Quality Assurance Committee**	
	The papers and full minutes will be available to review on BoardPad			

Matters for escalation or highlighting	• QAC received a detailed report on the arrangements to ensure the safe transition to the shared North Kent Pathology Service with Dartford and Gravesham NHS Trust. This included an overview of governance arrangements, quality criteria that must be met in order for the service changes to progress and the associated risk register. Having reviewed the report and explored questions with the project team, the Committee felt that the measures in place appear robust and provide sufficient assurance.
Other matters considered by the committee:	• IQPR • Maternity Safety Strategy • Draft Patient Experience Strategy • Medicines Management update • Discussion on links between workforce indicators and quality • Planning the Quality Account • CQC action plan and inspection preparation • Quality strategy update • Draft revised terms of reference for QAC
Key decisions made/ actions identified:	• Work on a quality dashboard to replace IQPR should continue and an update to come to the QAC development meeting in March. • The QAC has commissioned a significant piece of work aimed at helping us relate workforce indicators such as vacancies, turnover etc. to quality indicators. Update on progress will come to the QAC development session in March with a paper coming to April QAC. • QAC endorsed the direction of travel on the Patient Experience Strategy but requested a stocktake of the document to ensure clear messages and coherence with emerging quality strategy. • QAC supported the direction of travel presented on the quality strategy. Next steps will include discussion at Board development session.

	• QAC endorsed draft revised terms of reference to come to Board for approval.
Risks:	• The key quality and safety risks on the risk register mainly relate to workforce – note decision above to have a focused piece of work on this come to future QAC.
Assurance:	Main issue related to North Kent Pathology Service as reported above.

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Integrated Audit Committee held on 22/02/2018

Report to:	**Board of Directors**	**Date of meeting:**	**01/03/2018**
Presented by:	**Mark Spragg. Chair Integrated Audit Committee**	**Prepared by:**	**Tracey Cotterill. Director of Finance & Bus Svcs**

1

Matters for escalation

1. The committee considered the going concern declaration for the annual report and accounts and felt that it would be sensible to seek expert advice to ensure that the Directors were able to make the appropriate statements regarding going concern, reflecting the financial position and the organisational risk.
2. The Information Governance toolkit requires 95% of staff to be IG trained in order to be compliant. The Trust is working with staff to reach this target.
3. Terms of reference were agreed at the committee and will be included in the next Board papers.

Other matters considered by the group:

1. Audit reports were received on Cyber Security (Amber/Green rating), Information Governance Toolkit (Amber/Green rating) and Temporary Staffing (Amber/Red rating). The committee asked for future updates on the trends in adherence to procedures for temporary staffing, recognising the proportion of spend in this area.
2. Progress against the Internal Audit plan was reviewed.
3. Progress against the Local Counter Fraud Services Plan was reviewed. It was noted that the guidance on new standards has been released with only minor changes. This will inform the self-assessment toolkit which is expected imminently. There was an update on cases currently in progress.
4. External Auditors presented the sector development update. It was noted that the Audit report will include more information on use of resources and value for money (vfm) and the Trust performance scores adversely in all the areas. There was considerable discussion about context for the performance, not just relying on deficit to determine vfm.
5. Terms of reference for the committee were considered and approved.
6. Losses & Special Payments for the period 1st November 2017 to 31st January 2018 were presented.

	7. The single tender waivers report was presented for information, and is extended in compliance with the SFIs to report on direct awards from the framework. It was noted that the spend on STWs has increased recently, and the committee were assured that the controls were in place. 8. The quarterly declaration of gifts and hospitality was presented. 9. The reference cost methodology was approved, noting that there is a substantial change for 2017/18 collection to PLICs approach. This will be compulsory from 2018/19 but the Trust has decided to use the 2017/18 collection for its first submission. 10. AOB – item raised re IFRS 16 – lease accounting, and ensuring that any investment decisions reflected on changes 11. AOB – whistleblowing – it was noted that one of the NEDs has been asked to take on this responsibility following the departure of the previous lead, Jan Stephens.
Key decisions made/ actions identified:	1. Approved the proposed approach for the calculation of reference costs. 2. Approved the terms of reference for the committee
Risks:	The risks associated with all items on the agenda were considered, and in particular the risks relating to temporary staffing processes, going concern and value for money in the Audit statement.
Assurance:	Assurance was provided on; 1. Expenditure on waivers and framework awards is being appropriately managed and controlled to minimise risk of fraud. 2. The Cyber Security control framework audit showed that the Trust has appropriate processes in place 3. Information Governance Toolkit audit provided assurance on the design and operation of IG controls in place to support the 17/18 self assessment. 4. Improvements have been made in the control of temporary staffing expenditure, and further enhancements to controls are planned.

Key Issues Report

NHS Medway NHS Foundation Trust

From a meeting of Finance Committee held on 22/02/2018

Report to:	**Board of Directors**	**Date of meeting:**	**01/03/2018**	**1**
Presented by:	**Tony Moore Chair Finance Committee**	**Prepared by:**	**Tracey Cotterill, Director of Finance**	

Matters for escalation

1. Terms of reference were agreed at the committee and will be included in the next Board papers.
2. 2018/19 Planning and the proposed control total will need to be considered by the private Board.

Matters considered by the group:

3. The standard reporting pack was presented and the further planned changes to format discussed. It was noted that the activity information had not yet been incorporated but that this would be resolved by April latest.

   Key items brought to the committees attention included:

   - Forecast remains as reported at M9, with the largest risk being the income challenges from the CCG
   - Cash – additional revenue support has been agreed following the change to the forecast position. This will be drawn down mid March.
   - Very aged NHS debt is an issue and is unprovided. The balance sheet is being reviewed ahead of the year end close.
   - Creditor days have slipped again, but the cash approved for March will greatly assist.

4. Contract performance was discussed, particularly in relation to challenges and the expert determination.
5. The committee were updated on the ED build. Phase 1 is still due to complete early March. The committee were advised that the Director of Clin Ops and the Director of Finance met with IHP earlier in the week and have another meeting on 23rd Feb with clinicians to consider the phasing for the remaining elements of the project.
6. STP. The committee was updated on the back office shared services plans and stroke services. The financial contribution to 2018/19 was discussed, but no information is currently available on the required contribution from the Trust. It was agreed to update the FC on the productivity workstream at the next meeting.
7. The bad debt write off was agreed. There was discussion on the

process for collecting debt relating to overseas visitors and recent changes to the guidance in this area.

8. Procurement performance was reviewed. It was noted that the electronic purchase orders were lower, and that the NonPO spend had increased. There will be further information to the next committee.
9. North Kent Pathology Service update received and noted the intention to enter the Joint Venture with staff transfer date set for 1 March 2018.
10. Board Assurance Framework – The risk relating to CIP delivery was changed. The revised scoring was approved by the committee
11. Terms of reference were discussed and approved subject to the changes considered by the committee
12. AOB – The committee entered private session to consider the papers on planning update and the proposed paper to Board on the loan resolution. There was considerable discussion regarding the control total set for 2018/19 and the Board will need to give careful consideration to this.

Risks:

13. The Income position contains a number of risks including the outcome of arbitration and the challenges being raised by the commissioner. This could also impact income plans for 2018/19
14. Planning for 2018/19 will require considerable CIP and transformation savings in order to meet the control total.
15. The Finance section of the Board Assurance Framework was considered and the revised likelihood score relating to CIP agreed.

Report to the Board of Directors

Board Date: 01/03/2018 Agenda item: 20

Title of Report	**Overview of the process for the 2017/18 Annual Report and Accounts**
Prepared By:	Nike Meadows, Assistant Trust Secretary
Lead Director	Sheila Murphy, Trust Secretary
Committees or Groups who have considered this report	
Executive Summary	The process for producing the 2017/18 Annual Report and Accounts is underway. The working party is meeting on a regular basis and has agreed a timetable. The **key dates** for your information are as follows: • Extra-ordinary Meeting of the Audit Committee to sign off accounts on behalf of Board – **Date TBC (May 2018)** • Deadline for submission of the audited Annual Accounts to NHSI – **29 May 2018** • Annual Report laid before Parliament – **25 June 2018**
Resource Implications	
Risk and Assurance	
Legal Implications/Regulatory Requirements	Annual Report and Accounts are a statutory requirement for Foundation Trusts.
Improvement Plan Implication	
Quality Impact Assessment	

Report to the Board of Directors

Recommendation	To note the process for producing the 2017/18 Annual Report and Accounts and the deadlines set out by the Department of Health for the laying of 2017/18 accounts			
Purpose and Actions required by the Board :	**Approval**	**Assurance**	**Discussion**	**Noting**
	☐	☐	☐	☒

Report to the Board of Directors - Annual Report Timetable

The process for producing the 2017/18 Annual Report and Accounts has commenced with the working group meeting to meet on a regular basis. A timetable

The timetable below has been agreed by the working group with sections of the Annual Report and Accounts allocated to individuals across the Trust. The working group sends out messages regularly to the relevant people as reminders and offering assistance to ensure deadlines are met. Progress is monitored through a central electronic platform set-up by the Trust's Documentation Manager for individuals to update their respective sections. The Documentation Manager will also support with formatting in addition to collation of reports.

It is our intention to provide the Trust Board with sections of the Annual Report at future Board meetings leading up to sign off before 24 May 2018 so that the review process is made easier.

The Annual Financial Accounts will be led by the Financial Controller, under direction from the Director of Finance, and the financial controller will be responsible for the final submission in May.

The Annual Quality Account will be led by the Associate Director of Quality under direction from the Director of Nursing and will be discussed and reviewed at meetings of the Quality Assurance Committee.

The Communications team will support in editing and design, while the final report will be produced externally.

Report to the Board of Directors - Annual Report Timetable

Date	Action	Planned Completion Date	Actual Date
Jan-18	Working Party 1st Meeting	11/01/2018	14/12/2018
Jan-18	Instructions and actions issued to all authors	12/01/2018	11/01/2018
Feb-18	CoG Agenda Item	20/02/2018	20/02/2018
Feb-18	QAC – present paper on the process for the Quality Account	23/02/2018	
Feb-18	Contributions for everything (except the accounts)	31/02/2018	
Mar-18	**TRUST BOARD** – provide overview of the process	01/03/2018	
Mar-18	**Stakeholder Event** to discuss Quality Priorities	08/03/2018	
Mar-18	Contributions for everything (except the accounts)	30/03/2018	
Mar-18	Completion of first draft	30/03/2018	
Apr-18	**TRUST BOARD** – provide an initial draft of the report	05/04/2018	
Apr-18	**TRUST BOARD** – revised sections, where appropriate	05/04/2018	
Apr-18	**QAC** – to review draft Quality Account	27/04/2018	
Apr-18	**QAC** – to review final Quality Account	27/04/2018	
May-18	**TRUST BOARD** – review latest draft	03/05/2018	
May-18	FTC resubmission – date to be confirmed	tbc	
May-18	**AUDIT COMMITTEE MEETING audited accounts signed off**	tbc	
May-18	**TRUST BOARD MEETING**	03/05/2018	
May-18	Audited FTCs	24/05/2018	
May-18	Final Annual report including sign-off by CEO and signed audit opinion	29/05/2018	
Jun-18	Annual report and accounts laid before parliament and published date to be confirmed by Finance	25/06/2018	
	Annual report and accounts - Parliamentary Clerk to approve format – date to be confirmed by Finance	tbc	

NHS Medway NHS Foundation Trust

Report to Public Board

Meeting Date: 01/03/2018 Agenda item 21

Title of Report	**North Kent Pathology Service Update**
Prepared By:	Tracey Cotterill – Director of Finance & Business Services
Lead Director	Tracey Cotterill – Director of Finance & Business Services
Committees or Groups who have considered this report	Finance Committee – 22nd February 2018
Executive Summary	The purpose of this report is to update the Board on the progress of the NKPS programme, and to consider the Joint Venture Consortium Agreement (JVCA). Go live is scheduled for 1st March 2018. The Board approved the original business case on 2nd March 2017 and revisions to the business case on 6th July 2017. There are planned annual savings accruing to the Trust of c£80k year one, progressing to c£300k per annum once the implementation phase is complete. The STP is working collaboratively to provide pathology services across Kent and Medway, and this joint venture is the first stage of that process and does not preclude the JV partners from benefitting from the wider programme. The JV is a commitment until 2025 by both parties. This extended period was required due to the investment cost for new equipment at DVH. The JV will be managed through a Consortium Board with at least 2 directors from each organisation required to be quorate. The Clinical Director also attends the meeting.
Resource Implications	As per the business case and subject to amendments approved by the commercial group.
Risk and Assurance	Risk Register at Appendix 3

Report to the Board of Directors

Legal Implications/Regulatory Requirements	
Improvement Plan Implication	
Quality Impact Assessment	Integration plan includes Safe Handover plan
Recommendation	To note the contents of the report and particularly that the TUPE transfer of staff to the NKPS Joint Venture is scheduled for 1 March 2018.
Purpose and Actions required by the Board :	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

Appendix 1 - NORTH KENT PATHOLOGY SERVICE PROGRESS REPORT: FEBRUARY 2018

1. The business case for pathology integration was approved by both Trust boards in early 2017. Year 1 savings of £831k were attributed £152k to MFT and £680k to DGT, but DGT has agreed abatements of £235k of costs for one year, applicable from 26th Feb 2018, reducing monthly pro-rata thereafter.
2. **Joint Venture Consortium Agreement (JVCA) and Partner Contracts**: Near final draft JVCA and Partner Contracts have been prepared for approval by the Trusts Finance Committees on behalf of Trust boards to enter into the Joint Venture Consortium Agreement before staff are TUPE transferred on 1st March.
3. **Safe handover documents**: Safe handover documents have been prepared for review by the Quality & Safety Committee at DGT on 15 February and Quality Assurance Committee at MFT on 23 February. These documents describe the transition arrangements and planned governance mechanisms.
4. **TUPE Transfer of staff:** Preparations have progressed to TUPE transfer MFT pathology staff to DGT employment overnight between 28th February / 1st March. Arrangements are in place to transfer staff onto DGT's payroll from 1st March. However, at this point some final clarifications about due diligence information provided by MFT to DGT remain outstanding.
5. **Staff levels:** Staffing required to cover rotas in pathology post integration is being further reviewed, within budgetary limits. Locum staff for microbiology have been engaged, recruitment into blood sciences has been successful and some staff are returning from maternity leave.
6. **Training**: Training on equipment, IT and SOPs is continuing and being monitored closely week by week. More staff are being released from each site to undertake training. Efforts are focused on ensuring that at least a 'critical mass' of staff have appropriate training to provide services from 5 March.
7. **Equipment:** An upgraded automated track at DVH and new equipment installs at both sites, are on course to be completed for 5th March 2018.
8. **Validations of new Equipment:** It has come to light that validations of assays on new equipment has fallen significantly behind. This is for a variety of reasons including lack of staff availability and direction. Approaches to speeding up the validations have been explored but there is a risk that some elements of the service will not be ready to transition to NKPS by 5th March. Options to address this are being explored urgently.
9. **IT:** Loading information about MFT GP practices on to Telepath and ensuring that GP practices are able to receive results from Telepath is not yet complete and accelerated arrangements are in place to address this before 5 March. The dedicated inter-site WAN link has not yet been installed and frequent chasing of Virgin media is continuing – mitigation is to continue use of the Coin. IT Interface work is progressing to plan.
10. **AKI data migration:** This migration needs to be completed at go-live. It is currently underway and due for completion by 5 March.

Produced by June Dales, Project Manager, North Kent Pathology Service
to be received by both Trust Finance Committees/Boards.

11. **Information Governance**: Both Trusts have signed off an Information Governance SOP during December 2017. Also, having been briefed about the impact of providing access to DGT's systems for Medway users (hospital, GPs and prisons) in terms of access to information, both Trusts' SIROs and Caldicott Guardians have agreed to accept the risk, subject to mitigations being put in place including accelerating the rollout of electronic order comms results reporting, assurance of IG training levels and toolkit compliance. As at 14th Feb these remain outstanding.

12. **Information Reporting**: Additional work is continuing to ensure that Telepath is able to generate appropriate information reports for MFT to invoice commissioners and keep Trust operational departments informed.

13. **Inter-site transport**: A one-year contract for inter-site transport of samples has been agreed with Delta and is being reviewed for sign-off by DGT DOF. The cost of this service is within business case budget levels. Mobilisation planning has been completed including the number and timing of runs and logistics of loading and unloading at each site.

14. **Transporting Medway GP samples to DVH**: MFT's transport service has agreed to continue pick-ups from MFT GPs and delivery to MMH. The Delta inter-site transport service will be used to transport samples from MMH to DVH. Detailed logistics have been worked through and agreed with Delta.

15. **Mobilisation Planning**: Detailed work is progressing on the practical arrangements for the start date of 5th March.

16. **Decommissioning at MMH:** Detailed planning is progressing to decommission equipment, decontamination of facilities, and stand down licences at MFT.

17. **Communications:** Communications about forthcoming changes are being increased and include hospital and GP users across both DGT and MFT, and other stakeholders including the STP. A dedicated email address for enquiries has been set up.

18. **Risks:** A key risks register is attached at Appendix 4. Key risks to the timetable are ensuring that there are sufficient trained staff in place to deliver the service, the equipment validations are completed and that changes to the Telepath IT system are completed in a timely way.

19. **Project Implementation Costs:** NKPS implementation costs incurred from March 2017 to the end of January have been £183k. Projected costs are £298k to end March 2018 compared to an agreed budget of £318k. Details are provided at Appendix 3.

Appendix 2 - Finance Committee – February 2018

JOINT VENTURE CONSORTIUM AGREEMENT (JVCA)

Version 18 of the JVCA, dated 14th December 2016 was appended to the Business Case for Pathology Integration, approved by Trust Boards in early 2017.

Commercial Principles were agreed between the two Trusts, and in July 2017 it was agreed to progress the JV Pathology partnership without further adjustment to them.

The Trusts agreed to avoid incurring further legal fees and base the JVCA on documents previously drafted by the Trusts' legal advisers. Version 18 of the JVCA has been updated for agreed changes and to include detailed schedules.

The Initial Term of the partnership is until 31 March 2025. Neither Partner can exit the JV during this period unless the JV is demonstrably insolvent or both Trusts agree to terminate it.

Partner Contracts set out the service standards that each Partner expects from NKPS.

The JV will be managed by a Consortium Management Board (CMB), accountable to both Trust Boards. CMB members include the Clinical Director, General Manager and executive directors of both Trusts acting on behalf of both Trusts' boards. It will meet monthly for the first 6 months and at least quarterly thereafter. Details are provided in Schedule 3 of the JVCA.

Finance Committee – Resolutions to enter the JVCA

Schedule 7 of the JVCA sets out the resolutions to enter into the JVCA. The Resolutions needs to be informed by considering:

(a) A near final form of JV Consortium Agreement
(b) Draft Partner Contracts
(c) Information Sharing and Management Agreement

Key Documents

The following documents are of greatest relevance to the Finance Committee in considering the Resolutions to enter the Joint Venture:

- Commercial Principles (V12)

- JVCA Main Document
- Resolutions (JVCA Sched 7)

- Partner Contract DGT (JVCA Sched 14)
- Partner Contract MFT (JVCA Sched 14)
- Information Sharing Agreement signed DGT
- Information Sharing Agreement signed MFT

Additional documents available for information:

- Premises standards MMH (JVCA Sched 10)
- Premises standards MMH (JVCA Sched 10)
- Transferring Employees (JVCA Sched 13 Part A)
- Retained Staff MFT (JVCA Sched 13 Part B)
- Retained Staff DGT (JVCA Sched 13 Part B)
- SLA for ITS (JVCA Sched 13 Part C)
- Service Specification PoCT MMH – Partner Contract Sched 1
- Service Specification PoCT DVH – Partner Contract Sched 1
- Service Specification Microbiology – Partner Contract Sched 1
- Service Specification Central Specimen Reception – Partner Contract Sched 1
- Service Specification Blood Transfusion MMH – Partner Contract Sched 1
- Service Specification Blood Transfusion DVH – Partner Contract Sched 1
- Business Continuity Plan Microbiology – Partner Contract Sched 4
- Business Continuity Plan Biochemistry DVH – Partner Contract Sched 4
- Business Continuity Plan Haematology DVH – Partner Contract Sched 4
- Business Continuity Plan Blood Transfusion MMH – Partner Contract Sched 4
- Business Continuity Plan MMH – Partner Contract Sched 4
- Business Continuity Plan Pathology IT DVH – Partner Contract Sched 4

NORTH KENT PATHOLOGY SERVICE INTEGRATION PROJECT

RISK REGISTER

RED/HIGHEST SCORING RISKS

Version 38 14.2.18

Number	Impact	Identification/Cause	Date	STATUS	S	L	Pre Mitigation	Mitigation plan	S	L	Post Mitigation	Risk Owner
W.1	Quality, service disruption	Problems with recruitment and retention and/or support for the project due to disenfranchised staff Staff giving notice to leave citing reason as uncertainty about future in relation to NKPS. Sickness rates rising. Staff feeling demotivated by uncertainty after having completed a lot of detailed work on integration. Update 09.09.17: Its recently been identified that vacancies and maternity leave are putting at risk the blood Sciences on call services on both sites Update 23.11.17. Mapping exercise to establish if there is sufficient MFT BS staff to cover 24/7 service has identified a significant shortfall due to 50% staff exempt from working nights and inadequate skill mix in Haematology & BT	1.8.16	OPEN	4	4	16	1. Development and implementation of a staff communication plan Update 28.11.16: problems mainly due to self-imposed trust restrictions, but not because of staff being disenfranchised, therefore scores reduced. Update 12.04.17: Continue regular communications with staff about what is happening. Look at implications of each departure and implications for approach to recruitment on a case by case basis. Update 18.05.17: Increase frequency of newsletter to twice monthly; teamworking events planned; CEOs visits planned to each lab to demonstrate commitment and hear questions; preparing to consult staff as soon as practicable within the programme - July 2017 Update 14.6.17: Go-live date now unlikely before Feb 2018. Saff being informed via newsletter and teamworking event. An approach to dealing with vacancies has been agreed with HR leads and General Managers, including permenent recruitment where posts are not under threat/to be competed. Update 28.7.17: 'Vacancy Panel' (via commercial group) to consider proposals and options to address gaps in staffing an ongoing viable service upto 'go live' Update 22.8.17: Go-live confirmed 26 Feb 18. Communications stepped up. Consultation starting September. Staff more motivated, although some who do not wish to be part of integrated service likely to leave. Active monitoring of vacancies and recruitment or secondment being actioned for posts needed in the longer term. Update 11.10.17: Staff consultation on future structure has started (continues until 13.11.17), so staff have greater certainty. Adjustments being suggested by staff are being considered positively, within the integration budget and timeline. A further senior team event was well received. Lab staff have started some cross-site training, helping alleviate anxieties. Enabling works have started in the labs, increasing confidence that integration is happening. The vacancy panel addressing existing gaps is continuing in the context of the future budget and staff structure. Staffing out of hours services remains a concern. Update 16.11.17: Over 120 1:1 meetings with staff have been completed during consultation - indicative of staff concerns. Staff unhappy about management of consultation and proposed structure. Comments received during consultation are being reviewed. Update 23.11.17 may have to consider recruiting night workers in BS or recruiting more locums at MFT or consult on including Band 7's into the 24.7 rota (currently these are exempt). Options appraisal required. Update 06.12.17: Mapping exercise performed on 28.11.17 demonstrates shortfall of night staff @ MFT in BS, however some senior staff who currently volunteer for night work have indicated they can continue to do so post Go Live . Options appraisal possibly required. Further meeting to discuss shortfall due 5.12.17 Update 11.1.18: Staff levels are now below business case expectations. Further analysis being undertaken of extent that the workload can be covered by existing staff following outcome of staff consultation, identifying any possible short-term or 'adding back' of transitional staff required to add resilience to the service in its early months. Update 5.2.18: Recruitment process underway including to 'transitional' posts, rotas published for March, individuals identified for all shifts. Update 14.2.18: Some maternity leave returners and success in recruitment is helping with staffing levels.	4	4	16	Alistair Lindsay / Gurjit Lindsay
G.1	Delay	Implementation takes longer than envisaged due to conflicting work pressures for key managers, short timetable, third party providers unable to meet Trust deadlines & lack of critical information	1.8.16	OPEN	4	4	16	1. Develop detailed and robust plans through the work streams 2. Identify and manage interdependent tasks 3. Early identification and rectification of any internal resource shortfall Update 12.10.17: Bottleneck of internal resource due to leave and concurrent elements of project involving liaison of a few with multiple stakeholders - staff consultation, equipment install, governance & JV agreement work Update 16.11.17: Key managers under intense pressure due to pressure of staff consultation, equipment and IT installations, and staff shortages/leavers/discontent. Senior staff are covering more work due to staff shortages which means they are not available to focus fully on the project and information is not being provided in time with the project plan. Update 11.1.18: Focus on timely implementation, through new General Manager. Escalation of delay risks to identify and address any potential 'show stoppers'. Update 6.2.18: As above	3	3	9	June Dales
G.2	Cost	Implementation costs more than planned (revenue and/or capital)	1.8.16	OPEN	4	5	20	1. Confirm project management costs ASAP 2. Identify all essential capital requirements and submit business cases ASAP 3. update 18.10.16: capital requirements to be confirmed by 21.10.16; some funding allocated by DGT. 4. 16.1.17: Capital costs confirmed subject to final quotations from CSC. Workforce implementation costs assessed and included in the business case. However, an extended implementation timetable will increase project management costs. This will be assessed once the timetable is confirmed by IT. 5. Update 21.3.17: Final quotations will be required to be re-sought for MES and IT suppliers because of delay - quotations only valid for 30 days. However this should be within overall budgets 6. Staff structure, equipment and IT tied back to business case. However longer timescale requires additional project management 7. Delays in implementation leading to uplifts in prices and costs, some of which could be offset by higher savings. Project management budget established and being actively monitored monthly. DOF sign off required for any spend above budget. Current projected underspend against revised budget.	3	3	9	June Dales
G.8	Delay, cost, reputation	Lack of corporate memory leads to re-visiting past decisions - causing delay and higher implementation costs, frustration and uncertainty, mis-trust between partners and possible reputational damage.	29.06.17	OPEN	4	5	20	Brief new colleagues about history of project and reasons for current situation. Anticipate new colleagues' questions and address in workstream meetings and/or 1-2-1 briefings. Monthly updates to Trust Finance Committees. Consortium Management Board to be established in shadow form from October. Consortium Management Board now to meet in November. Consortium Management Board meeting being re-scheduled, however continuity being retained through weekly SRO updates and reverting to key decision- makers in addressing issues.	3	3	9	Leslieann Osborn, Alistair Lindsay, June Dales
W8	Delay, cost	There may be insufficient BMS staff available to validate new MES equipment, due staff leave, numbers, shifts etc.	20.9.16	OPEN	4	5	20	1. Analyse project workload and workforce requirements 2. Develop detailed MES implementation plan (may need dedicated staff) including time of consultants and scientists 3. Discuss at clinical sub group meetings - look at adopting some processes from DVH to reduce the workload 5. Start work early where possible (e.g., haematology validation) 6. Plan staffing resources based on the information now available on the new equipment that will be provided; this may require restricting leave 7. **Update 28.11.16**- may need a locum to carry out this work in biochem at MFT because the person who would normally do this is on A/L. Also need to look at how much staff leave is outstanding and encourage staff to take leave ASAP rather than leaving to the end of the year. 7. **Update 12.04.17**: Plan resources for this in advance including eg managing leave, temporary staff, deploying different staff to complete different tasks eg running samples, number crunching, and analysis. 8. Update 5.2.18: This risk has materialised and reflected on red risk register under W.9 below. Additional resources being mobilised to help speed up validations. 9. Update 14.2.18: Risk uprated. The potential to further speed up validations iand the impact of delay is being assessed urgently.	4	4	16	Gurjit Lindsay & Alistair Lindsay

W9	Quality	Insufficient time between decisions about staffing structure and go-live to train staff (as staff are simultaneously managing business as usual and other aspects of the project such as agreeing test harmonisation, SOPs, JVCA schedules etc) compromises service quality	23.10.17	OPEN	4	4	16	Training plan being implemented. Timing to implement shift working and rostering for shift patterns to be reviewed in relation to number of trained staff available 24/7 Update 17.11.17: Microbiology and Haem/BT high level training commenced 4-6 weeks ago. No plan yet in place for Chemistry or CSR, although exchange visits have started and meetings have been held with training leads. Detailed plans covering IT, equipment, CSR and site-specific induction are being compiled. Update 30.11.17: Microbiology training of MFT staff is on track, no adjustments required. Updated training plan developed for Chemistry and Haem & BT staff by PB & SeW to include the minimum number of staff required from MFT to train up on essential instrumentation prior to go live. Meeting due 6.11.17 @ MFT to discuss plans with operational leads & AL. Telepath training – discussions with MFT IM&T train the trainers 6th Dec 17 & possibility of developing an e-learning module being discussed. Update 4.12.17 detailed training plans with minimum staffing levels required & critical tasks to be performed presented to PB on 29.11.17. Meeting on 6.12.17 has been convened @ MFT to discuss planned training dates with Operational Leads & to identify & mitigate any capacity issues Update 11.1.17: Training plans being reviewed, focusing on training requirements for go-live date, and identifying any short-term cover needed to release staff for training ahead of go-live. Update 5.2.18: Emodule for some training in place, added training dates from equipment supplier, re-focus on releasing staff to train others, 'crib sheets' being developed to support staff, schedule for IT and equipment staff to be available for go-live. Training register being compiled to provide assurance about training levels delivered.	4	3	12	Alistair Lindsay
G.9	Delay	STP strategic planning for future pathology configuration across Kent & Medway or SE London derails / delays NKPS implementation Update 8.9.17: NHSI announcement of 29 pathology networks cuts across vision for future configuration of services in Kent & Medway & may cause STP to review its stance, which may delay NKPS implementation	05.07.17	OPEN	4	4	16	Maintain good communications with STP pathology forums tabout the alignement of NKPS with STP objectives. Focus on delivering NKPS integration to timetable Update 12.07.17: Assurances have been received from MTW, NHSi, NHSe and the Kent & Medway STP that NKPS is consistent with STP planning Update 08.09.17: To make statement to RCPath, NHSI, STP & others about the rationale and commitment to NKPS Update 18.09.17: Statement being prepared / colleagues speaking to STP partners Update 12.10.17: Joint statement submitted to NHSI. Continued participation in STP pathology workstream incl responding to NHSI Networks proposals Update 16.11.17: Made contact with NHSI. Initial briefing suggests no issues, but NHSI seeking reassurance that NKPS does not undermine delivery of networks in future Update 5.2.18: Continued involvement with STP planning via GM and CD. NHSI visited both labs and briefed about NKPS. No delay expected	3	1	3	Leslieann Osborn, Alistair Lindsay

G.7	Reputation	Repeated delays and uncertainty damages the reputation of both Trusts, after 7 years of considering integration.	14.6.17	OPEN	4	4	16	Seek advice from teambuilding facilitator / others on how to remain positive and motivated in circumstances. Escalate resolution of uncertainties. Seek final yes/No decision. Update 28.7.17: Decision on basis to proceed in writing by Chairs and CEOs Risk of delay/reputational damage remains.	3	3	9	Alistair Lindsay / Gurjit Lindsay
C.3	Delay or project failure	The Trusts fail to reach agreement on the Joint Venture Consortium Agreement	1.7.16	OPEN	4	4	16	1. Early establishment of the Commercial Work Stream Group 2. Review of the JVCA undertaken and recommendations presented and agreed at July PB and Trust Boards 3. Revised draft JVCA to be produced by September 2016 4. Update 30.8.16: because the commercial model is still not agreed, the redrafting of the JVCA has been delayed. 5. Update 21.9.16: draft JV to be produced for the October meeting 6. Update 22.11.16: draft JVCA produced for business case and forwarded to MFT for review by Capsticks on 7.11.16; no comments yet received. 7. Update 28.11.16: comments shared. LC/SS t meet to discuss on 7th December 9. Update 16.1.17: revised draft documents produced by Blake Morgan on 16th December. SS to present to Capsticks 10. Update 31.3.17: Principles paper has been agreed by DGT; MFT to comment/agree 11. Update 10.5.17: Commercial worksteam to review JVCA in parallel with the commercial model 12. Update 22.8.17: Trust Boards agreed no further changes to commercial agreement or documentation. Consortium Management Board to review details of schedules to be populated. 13. Update 12.10.17: Detailed drafts being prepared for November CMB 14. Update 17.11.17: Drafts have been prepared for review by commercial wokstream 15. Update 6.12.17: No comments received from commercial workstream 16. Update 5.2.18: Final draft JVCA reviewed by DOFs and SROs and no obvious reasons for not agreeing	4	2	8	June Dales
CQ.10	Quality	We will have early UKAS visits post integration and may not be fully prepared	19.9.16	OPEN	4	4	16	1. Seek clarification of the planned assessment visits 2. Develop plans to prepare for these 3. Application for visits are in hand Quality lead at DGT is leaving, which reduces experience/knowledge available within the department to prepare to meet UKAS requirements. Update 21.11.17, plan to relocate the MFT Quality manager over from MFT to enable a 3/12 handover from DGT Quality & Governance manager on QMS and established UKAS standards & quality processes & procedures Update 30.11.17 Training plan for DGT Q&G manager to facilitate handover of DGT QMS and ISO quality systems to MFT QM to be drafted and circulated Update 5.2.18: Planning for visits underway	4	2	8	Alistair Lindsay
M.20	Delay	The potential delay to the upgrade of laboratory middleware Remisol (due to resolving the requirement for unique sample numbering) could delay the BCUK plan and ultimately delay the project	26.10.17	OPEN	4	4	16	Urgent discussions within the project IT subgroup with 5 possible solutions to achieving unique numbering: 1) Implement DartOCM for all orders (Not achievable in timescale) 2) Investigate if PAS system can provide a barcode which can be read by analysers (initial investigation indicates this may not be possible. Discussions with suppliers indicates that it would take time even to identify whether there is a workable solution. Doesn't deal with paper orders coming in) 3) Discussions with IT subgroup members to see if Laboratory computer system TPath can be adjusted provide a unique laboratory number (This is not possible because of the knock-on adjustments (cost + time + complexity) needed to TPath interfaces with the orders and results systems which would then have to be changed once DartOCM rolled out) 4) Uniquely re-number all BS samples as they arrive in Central Specimen Reception (CSR). Possible but could be labour intensive. With training of new CSR staff imminent; would put extra pressures on the department. Possible approach to achieving this efficiently being reviewed 30/10. A solution based on this approach could be tested out via the BCUK Remisol upgrade testing process (Nov). 5) Upgrade Remisol to V1.9 with "as is" processes and perform UKAS required validation and re-validate once a "to-be" solution to the unique laboratory numbering is found (possible although will potential incur costs and significant staffing resources near to go-live date) **Note: When DartOCM is fully rolled out all samples will have unique numbers and this will no longer be an issue.** Update 17.11.17: Ongoing conversations with BCUK have identified an acceptable solution that does not incur additional cost or ccompromise go-live date, associated with combining changes to IT configuration, changing the deployment of sorting equipment across the sites, and triangulation of patient details, tube cap colour and size. Final details have been agreed 20/11. Note - 2 weeks' loss of time in preparing registry data for Remisol whilst options have been evaluated. Update 11.1.18: Remisol upgrade running according to plan Update 5.2.18: A number of problems have arisen during testing the upgrade which have adversely current operational performance in the lab. Unacceptable to continue to affect performance in this way. Causes unclear. Urgent meeting scheduled with BCUK 7/2/18 to identify action to be taken. Update 14.2.18: Issues with Remisol at DVH site appear to have been addressed but testing is still continuing.	2	2	4	Colin Brisley / Tony White
NEW RISK															
IT.23	Quality	Patient confidentiality could be compromised because of inability to constrain user access to their own results only when they look up results on Telepath iLabWeb internet service. When DartOCM Order Comms is fully rolled out iLabWeb will no longer be needed for results viewing and can be ceased.	10.1.18	OPEN	3	3	9	DartOCM results viewing rolled-out across MFT and DGT on an accelerated programme, thereby controlling user access to results based on their role and location. Cease the use of iLabWeb for results viewing after 6 months Communicate with DGT GP Practices explaining that this is a temporary measure until dartOCM fully deployed. Establish process to confirm information sharing agreements are in place and confirm IG rules for 3rd parties to comply or signatory of Kent & Medway Information Sharing Agreement. Validation of user's IG compliance by the Trust that the user currently accesses results through. Agree enhanced routines for regular audit of usage, analysing samples of usage. Develop standard process for telephone results validation across both laboratory, which is not reliant upon iLAB Web access.	3	2	6	
CLOSED RISKS															
M.19	Delay	Agreement of The Hospital Company to grant license for alterations in hub lab to accommodate the track upgrade is protracted	30.3.17	CLOSED	4	4	16	Convene meeting between BCUK, DGT, Carillion and THC to identify specific proposals Early warning to THC of forthcoming request Update 11.4.17: THC indicate that as BCUK contract is direct with DGT, it will be possible to proceed without going through the process of using Carillion to procure/undertake the works. However, the lead time for other projects around the Trust has been months. Update 10.5.17: Carillion representatives have discussed prospective BCUK proposals with BCUK on a site visit, and THC has been informed that proposals are expected soon and have engaged in identifying the information needed to consider approvals. Update: 12.07.17 There could be an increased risk of delayed as currently Carillion have some commercial challenges, but there has been some assurance that it will not be a problem Update 28.7.17: Briefed Carillion & notified THC. Meeting with Carillion, Dir Estates & equipment supplier & lab survey planned 07.08.17. Update 22.8.17: THC confirmed that deed of indemnity to be granted for works to be carried out by DGT facilitated by Carillion, which should reduce time required for approvals. Update 6.9.17: Compressor upgrade needed to support track, to be installed via Carillion - timeline being clarified. Package of enabling works in lab being reviewed by Trust/THC. Structural survey been requested from Trust's preferred surveyor. Update 18.9.17: Timeline has potential to be compromised but to date is still manageable without compromising timetable. Update 12.10.17: Further delays, increased risk of delaying the install programme Update 23.10.17: THC new funder taking more time to agree changes UPdate 16.11.17: Deed of Indemnity has been granted - CLOSE	4	3	12	June Dales

CQ.8	Quality, delay	Some tests from DVH are currently processed at MFT (i.e. They are not currently part of the DVH repertoire). we may not have accreditation for them at DVH from day 1. ;	23.8.16	OPEN	4	3	12	1. We will identify the tests in this category ASAP Specialist coag- will do for Feb Haem visit; Karen has a list of the biochem tests 2. SW to discuss with UKAS 3. We will ensure they these tests are added to the Main lab repertoire 4. If no UKAS visit then will need to notify customers 5. SeW has spoken to UKAS; DVH has a surveillance visit in biochem in Dec, but everything else will be pushed back to after April 6. Update 26.10.17: Covered by CPA accreditation extension at MFT, subject to inspection 21- 23 Nov 2017 7. Update 25.11.17: CPA inspection successful. Assays now accreditated for CPA until June 2018. Close	4	1	4	Colin Brisley, Kurt Djemal, Shelley Wilson
C.5	Cost	Neither Trust has funding set aside for redundancies; there is a risk that if redundancies result from the restructuring then this will pose significant cost pressures	26.10.16	OPEN	4	4	16	1. Workforce Work Stream to minimise the risk of redundancies 2. Only one potential redundancy identified in the business case and included in the commercial model and agreement.The impact may increase as a result of staff consultation. Note that the number of redundancies might increase following consultation 3. Proposals being put forward to avoid redundancy - remains a risk until outcome known (following consultation). 4. Risk of redundancy avoided through management response to consultation - close risk	3	3	9	Lorraine Clegg Tracey Cotterill
M.21	Delay	Delay in the installation of essential air compressors to support new track and equipment at DVH	24.11.17	OPEN	4	4	16	New compressor (+1) has been sourced by Carillion and quote received and sent to BCUK. BCUK still to accept quote. Compressor still needs to be purchased delivered and installed. Potential delay to go-live. Two potential temporary solutions have not materialised ((1) Carillion unable to quote for temporary solution (2) BCUK possible solution not sufficiently high specification) Urgent meeting convened 27/11 to review options Update: 7.12.17: New compressor now ordered expected delivery 12.01.18 Update 11.1.18: New compressor expected w/c 15 January (latest possible = 29 Jan). Update 5.2.18: New compressor has been installed and tested - close risk.	4	3	12	Colin Brisley / June Dales