Medway NHS Foundation Trust

Papers for the Trust Board Meeting in Public

Wednesday, 08 January 2020 at 12:30

In the Trust Boardroom, Postgraduate Centre, Medway NHS Foundation Trust

Windmill Road, Gillingham, Kent, ME7 5NY

NHS Medway NHS Foundation Trust

Agenda

Trust Board Meeting in Public

Date: Wednesday, 08 January 2020 at 12.30pm - 3pm

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

Subject		Presenter	Page	Time	Action
Patient Story		Chief Nurse	Verbal	12:30	Note
1.	**Preliminary Matters**				
1.1	Chair's Welcome and Apologies	Chairman	Verbal	12:55	Note
1.2	Quorum	Chairman	Verbal		Note
1.3	Conflicts of Interest: i. Register of Interest ii. Declaration of Interest	Chairman	3 Verbal		Note
2.	**Minutes of the previous meeting and matters arising**				
2.1	Minutes of the previous meeting held on 7 November 2019	Chairman	7	12:57	Approve
2.2	Matters arising and actions from last meeting	Chairman	17		Discuss
3.	**Standing Reports**				
3.1	Chair's Report	Chairman	Verbal	13:00	Note
3.2	Chief Executive's Report	Chief Executive	19		Note
4.	**High Quality Care**				
4.1	Integrated Quality and Performance Report	Chief Nurse/Medical Director/COO	23	13:10	Note/ Discuss
4.2	Quality Assurance Committee Assurance Report	QAC Chair/Chief Nurse	Verbal		Note
4.3	Infection Prevention and Control	Medical Director	53		Note
4.4	Responding to Deaths	Medical Director	Verbal		Discuss
4.5	Safe Staffing Review	Chief Nurse	59		Note
5.	**Innovation**				
5.1	Transformation Programme Update	Director of Transformation	63	13:40	Note
6.	**Integrated Health Care**				
6.1	STP and ICP Update	Deputy Chief Executive	Verbal	13:50	Discuss
6.2	Communications and Engagement Report	Director of Communications and Engagement	71		Note

Agenda

7.	**Financial Stability**				
7.1	Finance Report - Month 8	Director of Finance	75	14:00	Note
7.2	Finance Committee Assurance Report	Finance Committee Chair	79		Note
8.	**Our People**				
8.1	Workforce Report	Director of HR & OD	81	14:10	Note
8.2	Inclusive Recruitment	Director of HR & OD	91		Approval
9.	**Governance**				
9.1	Integrated Audit Committee Assurance Report	Chair of Integrated Audit Committee	97	14:25	Note
9.2	Standing Financial Instructions	Director of Finance	99		Approve
10.	**Policies for approval**				
10.1	Emergency Preparedness Resilience and Response Policy	Chief Operating Officer	165	14:40	Approve
10.2	Business Continuity Policy	Chief Operating Officer	179		Approve
10.3	Risk Management Policy and Strategy	Deputy Chief Executive	189		Approve
11.	**Annual Reports**				
11.1	Emergency Preparedness Resilience and Response Annual Assurance Report	Chief Operating Officer	225	14:50	Assurance
12.	**Other Business**				
12.1	Council of Governors' Update	Lead Governor	Verbal	14:55	Discuss
12.2	Any other business	Chairman	Verbal		Note
12.3	Questions from members of the public	Chairman	Verbal		Discuss
13.	**Date and time of next meeting: Thursday, 5 March 2020, 12.30pm-3pm, Trust Boardroom**				

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TRUST BOARD REGISTER OF INTERESTS

NOVEMBER 2019

Name	Position	Organisation	Nature of Interest
Stephen Clark	**Chairman**	Marshalls Charity	Chairman
		3H Fund Charity	Chairman
		Nutmeg Savings and Investments	Non-Executive Director
		Henley Business School	Member Strategy Board
		Access Bank UK Limited	Non-Executive Director
		Brook Street Equity Partner LLP	Chairman Advisory Council
		Medway NHS Foundation Trust	Chairman
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Jon Billings	**Non-Executive Director**	Fenestra Consulting Limited	Director
		Healthskills Limited	Associate
		FMLM Applied	Associate
		University of Kent	Wife is Professor of Applied Health Research, Centre for Health Service Studies
		Medway NHS Foundation Trust	Chair Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Ewan Carmichael	**Non-Executive Director**	Medway NHS Foundation Trust	Chair of Charitable Funds Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Name	Position	Organisation	Nature of Interest
Mark Spragg	**Non-Executive Director**	Marcela Trust	Trustee
		Sisi and Savita Charitable Trust	Trustee
		Mark Spragg Limited	Director
		Faculty of Medical Leadership and Management	Lay Trustee/ Director
		Medway NHS Foundation Trust	Chair Integrated Audit Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Adrian Ward	**Non-Executive Director**	Bella Moss Foundation	Trustee
		Veterinary Sciences Limited	Director of Award
		National Midwifery Council	Chair Fitness to Practice Panel
		RCVS Preliminary Investigation Committee	Member
		BSAVA Scientific Committee	Member
		Medway NHS Foundation Trust	Member of the Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Joanne Palmer	**Non-Executive Director/ Senior Independent Director**	Lloyds Gresham Nominee1 Limited	Director
		Lloyds Gresham Nominee2 Limited	Director
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
James Devine	**Chief Executive**	London Board for the Healthcare People Management Association	Member
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Ian O'Connor	**Executive Director of Finance**	Essex Partnership Trust	Spouse is a Senior Manager
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Name	Position	Organisation	Nature of Interest
Karen Rule	**Executive Director of Nursing**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Dr David Sulch	**Executive Medical Director**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Leon Hinton	**Executive Director of HR and OD**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

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Minutes of the Trust Board of Directors Meeting in Public

Thursday 7 November 2019 at 12.30pm, in the Trust Boardroom, Postgraduate Centre, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members	Name	Job Title
Voting:	Mr Stephen Clark	Chairman
	Ms Joanne Palmer	Non-Executive Director and Senior Independent Director *(up to item 7.2)*
	Mr Adrian Ward	Non-Executive Director *(up to item 4.1)*
	Mr Ewan Carmichael	Non-Executive Director
	Mr Jon Billings	Non-Executive Director
	Mr Mark Spragg	Non-Executive Director
	Mr James Devine	Chief Executive
	Mr Ian O'Connor	Executive Director of Finance
	Dr David Sulch	Executive Medical Director
	Mr Leon Hinton	Executive Director of HR and OD
Non-Voting:	Ms Glynis Alexander	Executive Director of Communications and Engagement
	Mr Harvey McEnroe	Chief Operating Officer
	Mr Gary Lupton	Executive Director of Estates and Facilities
	Mr Jack Tabner	Executive Director of Transformation
Attendees:	Ms Simone Hay	Divisional Director of Nursing, Planned Care
	Ms Brenda Thomas	Company Secretary (minutes)
	Mr Glyn Allen	Lead Governor
Apologies:	Gurjit Mahil	Deputy Chief Executive
	Karen Rule	Executive Director of Nursing
	Ms Morfydd Williams	Executive Director of IT Transformation
Observers:	Ms Catherine McDonald	Director of Intensive Support, NHS England and NHS Improvement - South East
	Katy White	Governor
	Doreen King	Governor
	1 member of the public	

Patient Story
James Devine, Chief Executive, told the patient story on behalf of the patient, Richard, who was unable to attend the meeting. Richard, now 35 had his most recent treatment for cancer at Medway NHS Foundation Trust (MFT) two years ago. He had recovered from a rare form of cancer at the age of eight. Twenty-five years later, aged 33, he was diagnosed with bowel cancer. Richard opted to have his surgery and chemotherapy treatment at MFT and has been very positive about his experience in the hospital. A combination of excellent care and a positive attitude helped him through the grueling treatment. Richard is getting on with life, and now has a new job and a partner. However, he was moved three times during his time in hospital, which was unsettling for him and his family and the side effects of the treatment were not communicated to him - lessons the Trust can learn from.

The Board raised the following points:

a) Staff not getting too detached from the emotional turmoil that patients face.
b) To present the challenge that the person centered aspect, as adopted in the Quality Strategy (as distinct from patient experience) is being taken account of.
c) To resolve without much cost, IT issues around bandwidth to improve on patient experience.
d) Improvements required on communication to patients/ families, which has been a recurring theme in patient stories.
e) Improvements required on informing patients about medications and their side effects. David Sulch, Executive Medical Director took an action to raise awareness on this matter on the ground rounds. **Action: TB/2019/036.**
f) Thought to be given to diversifying/ capturing patient stories in other forms, for instance, creating videos, which could be a reusable resource. Glynis Alexander, Executive Director of Communications and Engagement noted that videos have been created for some of the patient stories, but would review as part of the wider review of patient story. **Action: TB/2019/037.**

01/19 Preliminary Matters

1.1 Welcome and Apologies for absence

1.1.1 The Chairman apologised for starting the meeting late and welcomed everyone to the meeting, particularly Glyn Allen to his first meeting as Lead Governor and Catherine MacDonald, Director of Intensive Support, NHS England and NHS Improvement - South East, who was attending the meeting as an observer.

1.1.2 Apologies for absence were noted as recorded above.

1.2 Quorum

1.2.1 The Chairman confirmed the meeting was quorate.

1.3 Register of Interests

1.3.1 There were no declarations of interest in relation to items on the agenda.

1.3.2 The Chairman reminded members to review their interests and contact the Company Secretary should there be any change in their interests.

1.3.3 The Register of Interests was noted.

02/19 Minutes of the previous meeting and Matters Arising

2.1 Minutes of the previous meeting

2.1.1 The minutes of the previous meeting held on 5 September 2019 were **APPROVED** as an accurate record of the meeting, subject to changing *pet dogs* to *Pets as Therapy (PAT) dogs* under item 11.1.1.

2.2 Matters Arising and Action Log

2.2.1 The following actions were agreed to be closed: **TB/2019/028; TB/2019/031; TB/2019/033 and TB/2019/034**.

2.2.2 **TB/2019/032** - it was agreed that this action remains open until a more definitive position is reached.

TB/2019/035: Phlebotomy - Glyn Allen, Lead Governor reported that Doreen King, Governor visited the phlebotomy department with the Executive Director of HR and OD, where they established that the problem seemed to be with the orange bags, which was swiftly resolved. Harvey McEnroe, Chief Operating Officer provided assurance that a review has been carried out on the phlebotomy management team structure and the Phlebotomy Lead now sits on

the Management Board. He added that no contaminated blood samples have been recorded since this matter was raised at the last meeting. Harvey was requested to follow this up separately at the Quality Assurance Committee (QAC). **Agreed to close.**

03/19 Standing Reports

3.1 Chair's Report

3.1.1 The Chairman welcomed members of the public and governors and expressed thanks for taking a keen interest in the Trust's progress. He updated the board on key points of interests which included:

i. the establishment of the transformation team and Programme Management Office (PMO) over the last 12 months, which had led to much greater staff engagement, with many clinical leaders involved in developing and delivering these improvements.

ii. Awards: the Trust was awarded the Patient Flow Programme of the Year Award; staff from the Emergency Department (ED) were shortlisted for two prestigious Nursing Times awards; and the Trust was shortlisted for the Health Service Journal (HSJ) awards for the nursing recruitment in the workforce initiative of the year. The Kent and Medway Sustainability and Transformation Plan (STP) submission had been highly commended. The Chairman, on behalf of the Board congratulated and conveyed thanks to all the teams involved.

iii. Winter: frontline staff who do a great job in challenging circumstances every day would be supported. Over the last three years, more than 1,800 separate incidents of violence and aggression to staff were reported in the Trust. The most recent NHS staff survey showed that more than 14 per cent of staff experienced violence from patients, their relatives or the public in the last 12 months. The offensive comments staff receive include racially-based abuse. The Chairman noted that this behaviour was intolerable, reminding everyone of the zero tolerance campaign that was launched a few months ago which relates to verbal and physical abuse.

iv. Expressing gratitude to the local community who show support for the hospital by getting involved in diverse ways. A particular family whose son, Gary died in the hospital recently at the age of 33, raised £1,500 for the Intensive Care Unit as a show of their gratitude for the care shown by staff to Gary and the entire family. The Chairman, on behalf of the Board, conveyed appreciation to staff.

3.1.2 Discussing racial abuse, the Board gave its commitment to support the zero tolerance campaign. It was flagged that there is a gap in triangulating some of these issues. A People Committee, reporting into the Nominations and Remuneration Committee, to take forward the People Strategy, is required. **Action: TB/2019/038.**

3.2 Chief Executive's Report

3.2.1 James Devine, Chief Executive presented the report which was taken as read. He highlighted the following key issues:

a) Preparation for the winter period, with good engagement with system partners as work is done to expand the provision.

b) Over 50 per cent of staff have had their flu jabs so far. Last year, the Trust had 75 per cent compliance rate. The national target for this year is 80 per cent. Completion rate for the staff survey to date is 33 per cent. Incentives have been introduced for staff survey completion and increase uptake of flu jab.

c) The transformation programme has significantly evolved, with a delivery unit set up, albeit more to be done for consistent delivery.

d) The Waking Up Medway campaign has been well received with positive impact.

e) The Stop! Gel! Go!, a campaign about infection control has been launched.

f) The Rapid Relief Team, a community based charity that support the emergency services were thanked for providing a meal to staff in October. More than £1,300 was raised for the Medway Hospital Charity.

g) The Annual Members Meeting held on 19 September was very successful, with good engagement from the local community. Two bids, one from the Smoking Cessation Team to visit their counterpart in Canada and the other from Dr Samantha Black for her work in hypnosis in paediatric preparation for surgery, were successful for the Chief Executive's Scholarship for Brilliance award.

h) The Trust staged a CPR'athon in October to help highlight the importance of life-saving cardiopulmonary resuscitation (CPR).
i) All eight Kent and Medway Clinical Commissioning Groups (CCGs) have agreed to form a single CCG as part of system changes to go live from April 2020. No change to patient access to care will occur as a result.
j) The Trust has taken steps to reduce the use of single-use plastics in the restaurant, which resonates with the announcement made by the NHS chief executive on this issue.
k) The Care Quality Commission (CQC) has published its State of Health Care and Adult Social Care in England 2018/19.
l) The planned visit by Lord Carter of Coles to the Trust in November.

04/19 High Quality Care

4.1 Integrated Quality and Performance Report (IQPR)

4.1.1 Simone Hay, Divisional Director of Nursing, Planned Care, introduced the report with input from David Sulch and Harvey McEnroe, highlighting operational and quality performance across key performance indicators for September 2019.

a) No further MRSA bacteraemia was recorded (still at three, with a trajectory of no more than four). The current position on c-difficile shows this is now on trajectory and there is increased vigilance, with focus on antimicrobial stewardship. Good feedback has been received on the gel stations at the front entrance. Falls remain below the mean rate for falls per occupant bed days.
b) Pressure ulcers and reducing same sex accommodation breaches remain challenging. There is joined up work with NHS Collaborative around pressure ulcer management, with good outcome seen recently. Training for pressure ulcer prevention and management continues to be provided on a monthly basis and ad hoc. The main area of focus for same sex accommodation is critical care which is being addressed through the Best Flow Programme.
c) The Friends and Family Test (FFT) response rate has improved. VTE (Venous thromboembolism) performance improved, but below the 95 per cent compliance. However, it is anticipated that compliance will be met and sustained with the actions in place and good leadership. The Fractured Neck of Femur (#NOF) performance was impacted by another period of increased demand for trauma and orthopaedic services.
d) Constitutional standards: the emergency care pathway remained off plan with type one achieving 74.44 per cent (off trajectory by 6 per cent) and all types achieving 86 per cent (off trajectory by 4.4 per cent). Type three position achieved 98.38per cent. The ongoing work with Medway Community Healthcare (MCH) to support its improvement continued to ensure good delivery. The baseline trajectory for recovery of standard has been re-established, to be approved.
   Elective position: The referral to treatment (RTT) 18 weeks position was 81.46 per cent (off trajectory by 6 per cent), with a sustained zero breach on 52 weeks wait. The key challenges around RTT remain the specialty groups, with high referral rate continued to be seen, despite the CCG-led outpatient programme in place. However, a trajectory has been re-established via the Best Access Programme to recover the RTT position in year. DM01 reported 98.89 per cent (2.2 per cent off plan). Endoscopy has been impacted by the pensions tapering issue. Actions are being taken to mitigate this risk. The October reporting position shows compliance against standard. The cancer two week waits and 62 day performance exceeded trajectories at 94.02 per cent and 85.06 per cent respectively. The Best Access is now underway with a clear mandate of improving the Trust's constitutional standards and improving care across outpatients, Cancer, DM01, theatres and engagement.
e) Ambulance handover continue to be under trajectory. A 21 per cent increase has been seen in private and non-private ambulance arrivals within the last six weeks of reporting. Work is ongoing with ambulance partners to achieve an improved position.

4.1.2 The Board:

a) Queried infection prevention and control (IPC), noting that despite the range of actions taken, the output is a breached position. In addition, the Board queried when the Trust will get back on trajectory. The Board was assured that the actions in place are starting

to deliver. Consistent awareness raising is key particularly through senior presence at board rounds, with antimicrobial stewardship monitored carefully. It was requested that an IPC focussed report is presented at the next Board meeting. **Action: TB/2019/039.**

b) Queried the inconsistent VTE performance despite the actions taken. The Board was assured that the improved VTE performance since October 2018 has been sustained, albeit below 95 per cent, which is expected to be achieved by end November 2019.

c) Received assurance that a series of actions has been agreed to refocus work on step down on same sex accommodation, which forms part of the Best Flow programme. Trajectory is being set for critical care step down, which would be presented at the next Board meeting.

d) Queried the electronic discharge notification (EDN) completion, which continued to be a challenge at suboptimal level, with further additions to the existing backlogs, despite the actions being taken. It was noted that steps are being taken as part of an assurance process to refocus medical leadership and revised the process of working with clinical leads and care group leads to agree additional interventions, with support received from the Regulators. It was agreed to take this discussion to the QAC, with an assessment of the quality and safety implications and mitigating actions and report back to the Board. **Action: TB/2019/040.**

e) Noted the need to constantly monitor mandatory training, despite the improved position

f) Queried the escalation beds open, which is the highest it has been all year. The Board was assured that this forms part of the escalation bed plan for winter, which Regulators have been made aware of.

4.1.3 **The Board noted the Integrated Performance and Quality Report, highlighting the need for further thoughts to be given to the issues raised ahead of the next Board meeting**.

4.2 Quality Assurance Committee Assurance Report

4.2.1 Jon Billings, Non-Executive Director (NED) presented the report which was taken as read. The Committee focussed on the same sex accommodation breaches, IPC and discussion on using the IQPR as a tool. The Deputy Chief Executive would work on a plan to reformat the IQPR. The assurance rating for IPC on the report was amended to amber-red from green, to reflect an accurate position of IPC. The Committee had an in-depth review of the quality risks on the Board Assurance Framework. A six monthly review of performance against the quality objectives will be undertaken at the next QAC, the output of which will be reported to the next Board.

4.2.2 **The Board noted the Quality Assurance Committee Assurance Report.**

4.3 Quality Assurance Committee Terms of Reference

4.3.1 Jon Billings presented for approval, the Quality Assurance Committee Terms of Reference, noting that the substantive changes were to reflect the executive structure and attendance of governors at meetings. The objectives and programme of activities of the Committee remain unchanged. Following approval, Jon will be writing to the members and attendees to draw attention to the terms of reference and reinforce the importance of the Committee.

4.3.2 **The Board APPROVED the Quality Assurance Committee Terms of Reference.**

4.4 Responding to Deaths

4.4.1 David Sulch presented the report which was taken as read, highlighting key areas. The hospital standardised mortality ratio (HSMR) for the period to August 2019 was 104 which is within expected range. Preliminary investigation suggests that this may be due to improvement in mortality of patients admitted on a weekday compared to the weekend, particularly frail patients. Mortality for frail patients admitted over the weekend has neither worsened nor improved. The reasons for this remain unclear. A review of patients who died following admission over the weekend is now being done by the Therapies and Older Persons Care Group. One piece of information emerging from the data is that frail patients who are admitted over the weekend and are not cared for by geriatricians are more at risk than those patients admitted at the weekend who are cared for by geriatricians. Further discussion is expected with the Therapies and Older Persons Care Group at the Mortality and Morbidity Committee. Improvements have been seen in HSMR for acute cerebrovascular disease and pneumonia. Concern has been raised about the impact of the

palliative care coding change on mortality rate and whether the improvements seen in HSMR are genuine. These concerns would be further explored with the Regulators. The expected mortality for the Trust is currently around 6 per cent for non-elective admissions, which is above the national median of 5.6 per cent. The total number of deaths in the most recent 12 months is 150 less than the number of deaths in the 12 months to September 2018.

4.4.2 Responding to the query on the decision framework in relation to outputs from specialty reviews, Harvey McEnroe advised that the decision tree is clinically led and signed off, supplied by full capacity model via the STP. It was noted that the number of speciality mortality review meetings appears to be increasing; however, a request was made to have a denominator going forward. **Action: TB/2019/041.** Further request was made to look into the possibility of recruiting an Abdominal Nurse, in relation to mortality. **Action: TB/2019/042.**

05/19 Innovation

5.1 Transformation Programme Update

5.1.1 Jack Tabner, Executive Director of Transformation talked through the highlights of the Trust's 'Better, Best, Brilliant' transformation portfolio, including:

- **Large, cross-hospital transformation programmes**: These are good delivery structure for complex change, which are discussed via the Transformation Assurance Group.
  a) BEST Flow: work continues to gather pace, and the Trust was delighted to win the Patient Flow Programme of the Year Award 2019 at the Executive Patient Flow Summit. Its objective is to enable the Trust to deliver improved 4hour ED waits performance. Harvey McEnroe was thanked for his leadership on this piece of work.
  b) BEST Access: adopting the same approach as the Best Flow Programme, this programme coordinates improvement work across four areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/Referral to Treatment (RTT) management. The infrastructure for the RTT recovery programme has been worked through and the Trust is working closely with the CCG on what this looks like (a recovery programme in year). This will inform the next business planning process.
- **The Cost Improvement Programme (CIP):** As at month six, the Trust has delivered £7.2 million in CIP. Year to date, this is adverse to the operational plan (monitored internally) by £786,000, largely due to theatres closure and outpatients utilisation, which the Best Access programme seeks to correct and mitigate against future under-delivery. £15.8million is the most likely scenario with work ongoing to identify further opportunities to close the gap on the £18.0million target. Funding of £1.2million for the urology robot has been confirmed. For next year's CIP, a target of £12.0million (4.3 per cent) based on current calculations of control total deficit in 2020/21 is being planned. Balance will begin to shift from incremental transactional improvements to transformational work. Divisional control processes have improved during the last period with weekly divisional meetings to review off-plan schemes.
- **Quality and Continuous Improvement:** The huddles continue, supported by the transformation team. The white belt and yellow belt trainings will be paused during the winter to allow staff to focus on core operations and review training offer.
- **Development of an Innovation Institute:** As the Kent and Medway Medical School becomes an increasingly real prospect, the Trust will launch in quarter four 2019/20, an Institute for Innovation and Improvement [working title]. Led by three newly appointed Clinical Directors of Innovation and Improvement, this will create a 'one stop shop' for clinicians looking to conduct research studies and improvement projects. There is good support from stakeholders and the target launch date is 1 February 2020.

5.1.2 The Board:

- Queried the level of assurance that the most likely scenario of £15.8million will be achieved. The Board was advised of a number of red and amber schemes for which quality impact assessments (QIA) are yet to be carried out, and which could deliver. £16.5 million is the most likely position at month six from a PMO perspective, which includes the urology robot.

- Noted that the Finance Committee is in support of the transformation programme, even though delivery will not be achieved in the current year. This is the right decision for the Trust in the medium term.

5.1.3 **The Board noted the Transformation Programme Update.**

06/19 Integrated Health Care

6.1 Sustainability and Transformation Partnership Update

6.1.1 James Devine commented that the main issue at hand is the response to the Long Term Plan which the Board has considered and supported the draft submission on 12 November, with a number of caveats to be fed back to the STP. Further submission is scheduled for early 2020.

6.2 Communications and Engagement Report

6.2.1 Glynis Alexander, Executive Director of Communications and Engagement, presented the report, which set out a number of examples of activity since the last report was presented to the Board. Various channels of communication are being used. Internally, monthly newsletter and staff briefing to raise awareness on constitutional standards; transformation programme; Quality Strategy (ongoing piece of work to embed within the Trust), for which there is a highly structured communications plan which has been delivered in many respects; and CQC inspection. There is also a specific communications plan for the CQC preparation. The other specific campaigns include the Stop! Gel! Go! Campaign and promoting the Freedom to Speak Up Guardian role.

6.2.2 There has been a focus on getting out positive messages externally, with more coverage on TV, news website and community radios. There were more than 30 interactions with local, regional and national media. Good progress has been seen on social media accounts since the last update, with a continued growth in followers across our three main channels: Twitter, Facebook and Instagram. Governor and community engagement continued, with some engagement with harder to reach groups like Gypsy Traveller Action Group (GTAG), through Kent Police. The Community Engagement Officer engaged with local schools and community groups to get their involvement in Allied Health Professionals (AHP) day. The next Member event is scheduled for 19 November in the hospital, with a focus on pharmacy and medicines. Christmas events will be widely publicised.

6.2.2 **The Board noted the Communications and Engagement Report**.

07/19 Financial Stability

7.1 Finance Month Six Report

7.1.1 Ian O'Connor, Executive Director of Finance, presented the report. At month six, the Trust reported a year to date (YTD) deficit of £27.2 million, excluding Provider Sustainability Funds (PSF), Marginal Rate Emergency Tariff (MRET) and Financial Recovery Funds (FRF). This is adverse to the current operational plan by £2.1million. Against the declared plan with Regulators, the Trust reported £10,000 favourable variance, recognising a £0.6million contribution from the contingency fund. CIP delivery was £1.3million in month, adverse to plan by £0.8million in month. Two areas flagged as concerns include the increase in pay spend (actions are being taken to address this); and the level of elective activity. Capital expenditure year to date is £8.3million, which is ahead of plan and is encouraging. The Trust remains on track to deliver against its control total at the end of the financial year.

7.1.2 The Board:

a) Queried whether all of the known knowns have been included in the forecast outturn position. Ian O'Connor advised the Board that swiftly addressing the increase in pay spend is key. The forecast has a range of numbers (the five different scenarios was presented to the Finance Committee), with £27million noted as the worst case scenario
b) Commended the style and approach of the report.

7.1.3 **The Board noted the Finance Month Six Report.**

7.2 Finance Committee Assurance Report

7.2.1 Jo Palmer, Senior Independent Director took the report as read, noting that the areas highlighted within the report have been covered elsewhere during the course of the meeting.

7.2.2 **The Board noted the Finance Committee Report.**

7.3 Finance Committee Terms of Reference

7.3.1 Ian O'Connor presented for approval the Finance Committee terms of reference which have been approved by the Finance Committee. The single material change allows for Governors on the Committee to appoint a deputy in their absence.

7.3.2 James Devine encouraged executive directors to escalate if they feel they should be members of particular committees.

7.3.3 **The Board APPROVED the Finance Committee Terms of Reference.**

08/19 Our People

8.1 Workforce Report

8.1.1 Leon Hinton, Executive Director of HR and OD presented the September workforce report. The reporting format has been revised with headings aligned to deliverables on the People Strategy. There was a net increase of: 10 full time equivalent (FTE) registered nurses and midwives and one substantive clinical support worker. Over the next six months, the Trust will embark on a large scale approach to clinical support worker recruitment. Over 190 international nurses have commenced the recruitment pipeline, of which 176 new starters are anticipated over the next 12months. As at month six, the Trust had 41 FTE vacant consultant posts and 53 FTE vacant sub-consultant level posts. However, the Trust is exceeding the establishment for doctors, when bank and temporary staff are included within the numbers. Turnover rate and sickness absence were largely stable from previous months; with doctors sickness absence now being held centrally. The Trust appraisal rate stands at 88.22per cent down 2.56per cent, but above the Trust target of 85per cent. Statutory and mandatory training recorded 90.53 per cent (up 0.61per cent) and meeting the Trust target of 85per cent, with all divisions across the Trust meeting the target. Compared to August, the percentage of pay bill spent on: substantive staff stood at 85per cent, an increase of 1per cent; agency at 3per cent, an increase of 1per cent; and bank staff at 12per cent, a decrease of 2per cent. Agency cap breaches across all staff groups remained stable at an average of 30 breaches per week across the month, with the Trust spending just over £5million below the Regulators' agency ceiling cap target. Overall, there is largely sustained registered nursing workforce stability. Focus remains on 'You are the Difference' cultural change programme following completion of phase two.

8.1.2 Discussing temporary staffing, the Board was informed that commissioned contract staff do not feature in the care groups and safe staff numbers and are not included in the staff numbers, as these staff are contracted separately. Information about the total workforce is included as part of the ICP five year plan. It was agreed to take this discussion offline, using the stroke services with MCH as an example. **Action: TB/2019/043.** Discussing consultancy vacancies, it was noted that thought be given to how to make the Trust more attractive to fill these vacancies; how many of those vacancies are needed and how many are covered with locum staff. A review of this is required with benchmarking to be done, highlighting gaps and actions being taken to address the gaps. **Action: TB/2019/044.** A breakdown of the apprenticeship spend was requested, in addition to safe staffing against temporary spend versus field rate. **Actions: TB/2019/045 and TB/2019/046.**

8.1.3 **The Board noted the Workforce Report.**

09/19 Policies

The Board APPROVED the following policies, which have been reviewed and signed off by the Executive Team and recommended to the Board for approval:

a) **Corporate Policy: Serious Incident Investigation and Management Policy**
b) **Corporate Policy: Duty of Candour Policy**
c) **Corporate Policy: Information Governance and Framework**
d) **Corporate Policy: Human Resources and Organisational Development Policy**

10/19 Other Business

10.1 Council of Governors' Update

10.1.1 Glyn Allen, Lead Governor gave his first report, highlighting as follows:

a) NHS Providers delivered a training session on effective challenge for NEDs and governors in October.
b) Additional governors have been appointed to attend the Board Committees, with further work to be done on the sub-group, once the revised committee structure is approved.
c) Glyn attended the Deloitte Annual Seminar for Lead Governors on 13 October, which covered a number of topics including financial updates, integrated care systems, assessment of public services, including the NHS. The survey showed the NHS remains the public's number one priority for government spending.
d) Signage issues - incorrect/ redundant signage in some areas, causing difficulty for patients. Gary Lupton assured the Board that this is in hand.

10.2 Any Other Business

10.2.1 League of Friends: The Trust is working with the League of Friends Charity on a refurbished coffee shop in the reception area by late spring/ early summer of 2020. The League of Friends Charity recently donated £250,000 to the hospital, which will soon be publicised.

10.2.2 Appointment of Associate NED: The Kent and Medway Medical School (KMMS) has requested that each of the Trusts appoints an Associate NED, which is an academic appointment. The University of Kent (UoK) and Canterbury Christ Church University (CCCU) are the two sponsors of the Medical School. Maidstone and Tonbridge Wells NHS Trust (MTW) has appointed Professor Karen Cox, Vice-Chancellor and President of UoK; East Kent University Hospital NHS Foundation Trust (EKUHFT) has appointed Professor Chris Holland, Founding Dean of KMMS. MFT has been asked to appoint Professor Rama Thirunamachandran, Vice Chancellor at CCCU who has a wealth of experience to take on the role of Associate NED at MFT. He will be a great addition to the Board, plugging the gap in the area of education. The Chairman assured the Board of its authority to make the appointment without going through a formal recruitment process and that Professor Rama would be subject to the fit and proper persons test (FPPT).

10.2.3 **The Board APPROVED the appointment of Professor Rama Thirunamachandran as Associate Non-Executive Director to Medway NHS Foundation Trust Board, as part of the requirement of the Kent and Medway Medical School.**

10.2.4 The Chairman noted this was the Company Secretary's last meeting and thanked her for her contribution during her time at the Trust.

10.3 Questions from members of the public

10.3.1 There were no questions from the member of the public.

11/19 Date and time of next meeting

11.1 The next Board Meeting in Public will be held on Wednesday, 8 January 2020 at 12.30pm in the Trust Boardroom, Post Graduate Centre, Medway NHS Foundation Trust.

11.2 The meeting closed at 3.58pm.

These minutes are agreed to be a correct record of the Trust Board Meeting in Public of Medway NHS Foundation Trust held on Thursday, 7 November 2019

Signed …….. Date …….
Chair

Board of Directors in Public
Action Log

Agenda Item: 2.2
Date: Wednesday,08 January 2020

Actions are RAG Rated as follows:

Off trajectory - The action is behind schedule	Due date passed and action not complete	Action complete/ propose for closure	Action not yet due

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
05-Sep-19	TB/2019/030	**Patient Story** Put in place a better codified way of responding to patients with rare conditions, building on the UK Strategy for Rare Diseases.	05-Mar-20	David Sulch Executive Medical Director	In the light of current pressures relating to flow and quality issues, this item has been slipped to March 2020.	
05-Sep-19	TB/2019/032	**Patient Story** Follow up the information about major train companies offering heavily discounted train travel to children/ young adults with chronic diseases.	08-Jan-20	Gurjit Mahil Deputy Chief Executive	**It was agreed to leave this item open until a definitive position is reached.** Southeastern was contacted and their response was that they have no specific policy on this issue and would look at all such applications on a case by case basis. Should the Trust have patients who might be in need of subsidised travel, details should be sent to Southeastern who would look into the matter. Patients however may be able to claim a refund of travel costs under the Healthcare Travel Costs Scheme.	
07-Nov-19	TB/2019/036	**Patient Story** Raise awareness at ground round about informing patients about medications and their side effects.	08-Jan-20	David Sulch Executive Medical Director	Information has been shared at various teaching and other clinical forums in the Trust	Green
07-Nov-19	TB/2019/037	**Patient Story** As part of the wider review of patient story, give consideration to diversifying/ capturing patient stories, for e.g., creating videos, which could be a reusable resource	08-Jan-20	Glynis Alexander Executive Director of Communications & Engagement		
07-Nov-19	TB/2019/038	**Chair's Report** Creation of a People Committee to report into the Nominations and Remuneration Committee, to take forward the People Strategy	05-Mar-20	Leon Hinton Executive Director of HR & OD	Due in March 2020	
07-Nov-19	TB/2019/039	**Integrated Quality & Performance Report** Present an Infection Prevention and Control focussed report at the next Board meeting	08-Jan-20	David Sulch Executive Medical Director	On the agenda	Green
07-Nov-19	TB/2019/040	**Integrated Quality & Performance Report** Discuss electronic discharge notification at the Quality Assurance Committee, with an assessment of the quality and safety implications and mitigating actions and report back to the Board.	08-Jan-20	David Sulch Executive Medical Director/ Harvey McEnroe Chief Operating Officer	EDN will have been discussed at QAC on December 20 and an update will be provided verbally to the Board	Green

Board of Directors in Public
Action Log

Agenda Item: 2.2
Date: Wednesday,08 January 2020

Actions are RAG Rated as follows:

Off trajectory - The action is behind schedule	Due date passed and action not complete	Action complete/ propose for closure	Action not yet due

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
07-Nov-19	TB/2019/41	**Responding to Deaths** Have a denominator for the number of speciality mortality review meetings going forward.	08-Jan-20	David Sulch Executive Medical Director/	The number of meetings is 18	Green
07-Nov-19	TB/2019/42	**Responding to Deaths** Look into the possibility of investing in an Abdominal Nurse, in relation to mortality	08-Jan-20	David Sulch Executive Medical Director/ Karen Rule Executive Director of Nursing	This is being investigated by Planned Care as part of the National Emergency Laparotomy Audit (NELA) action plan (and will have been discussed in more detail at the Mortality and Morbidity Committee on December 20)	
07-Nov-19	TB/2019/43	**Workforce Report** Discuss outside the meeting, temporary staffing including commissioned contract staff who do not feature in the care groups and safe staff numbers	08-Jan-20	Leon Hinton Executive Director of HR & OD	Forms part of the ICP reports	
07-Nov-19	TB/2019/44	**Workforce Report** Review consultancy vacancies, with benchmarking highlighting gaps and actions to be taken to address the gaps - how many of those vacancies are needed and how many are covered with locum staff.	05-Mar-20	David Sulch Executive Medical Director	Due in March 2020	
07-Nov-19	TB/2019/45	**Workforce Report** Produce a breakdown of the apprenticeship spend	08-Jan-20	Leon Hinton Executive Director of HR & OD	Included in the workforce report	Green
07-Nov-19	TB/2019/46	**Workforce Report** Produce a report on safe staffing against temporary spend versus field rate.	08-Jan-20	Leon Hinton Executive Director of HR & OD		

Chief Executive's Report – January 2020

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

We were delighted to welcome the Care Quality Commission (CQC) back to the Trust in December to inspect our core services.

The inspection provided us with an important opportunity to showcase our numerous achievements since their last inspection. The Trust has only received initial feedback so far but I'm delighted that the CQC acknowledged how passionate our staff are about improving care for our patients.

They will return on 15 and 16 January to carry out their review of how well-led we are, which also contributes to the overall rating.

We won't be complacent and we don't know what the final report will say (due in March 2020) but it is clear that the inspection team saw signs of progress and the delivery of excellent care in many areas.

Transformation

As part of our continued focus on improving flow through the organisation we were delighted to launch our new Full Capacity Protocol. This is a really important step for our patients and the resilience of the Trust when under pressure.

Our Best Flow and Best Access programmes remain the key transformation projects to improve care both now and for the longer term.

NHS Staff Survey

This year's NHS Staff Survey is now complete and I am pleased to say that we achieved a 43 per cent response rate, which is an improvement on previous years. It's really important for our development as an organisation to hear from our staff on a regular basis about the good and less positive aspects of working at Medway. We look forward to receiving the report in the coming months.

Welcoming a special guest

At the time of writing we were very much looking forward to a visit by Her Royal Highness The Princess Royal in December. The Princess Royal is patron of The Royal College of Midwives and the Royal College of Emergency Medicine and was due to visit both our maternity unit and our emergency department.

Developing our partnership with the League of Friends

The Trust has agreed a 10-year lease with the League of Friends for the former outpatient kiosk space (directly opposite the existing Friends shop).

They will be building a brand new modern barista style coffee shop in this area (don't worry the existing Friends shop will remain) for patients, staff and visitors, and all profits from sales will be donated to the Trust to benefit patients and visitors to the Trust.

We are so grateful for the support of the Friends and I am delighted that we are able to strengthen our partnership with the development of this fantastic new coffee shop.

Work will begin in the near future and we expect it to be completed by the summer.

More success for our staff

Congratulations to our Procurement Team who won the Hospital Procurement Award at the Health Business Awards; I'm delighted that their impressive work has been recognised. Congratulations also to our Finance Team who were commended but sadly did not win; still a great achievement to get that far though!

We also celebrated two nominations at the Nursing Times awards in November. The first was for Cliff Evans in the Nurse Leader of the Year category and the second for the Emergency and Critical Care Team of the Year. Although, we didn't win it was a huge achievement to make it to the national stage! Well done.

Celebrating Christmas with our community

This year we once again held a very successful Christmas Fair for our staff, patients and community. I would like to thank all those involved in hosting stalls, plus Town Crier Mike Billingham, Hospital Radio Medway, Chatham Grammar Choir and the Rainham Ladies Choir for making it such a special event.

The fair raised more than £1,500 for the hospital charity, to be spent on improving the experience of our patients.

Launch of innovative clinics for diabetes patients

We were delighted to launch an innovative scheme for our patients with type 2 diabetes. Led by Dr Tara Rampal and Amanda Epps, the 'Perioperative Diabetes Optimisation Clinics' will provide our patients with a personalised and integrated

diabetes management plan, combining care from our brilliant pharmacy and prehabilitation teams.

Using technology to support delivery of brilliant care

In November we saw the launch of our new electronic document and records management system (EDRMS). The system, named Cito, allows us to see more information electronically, including the digitisation of patient records

It is initially being piloted across our Sleep Service, before being rolled out fully next year. Although it is early days with the implementation, this is a really positive step forward and shows our commitment to leading the way in the use of innovative and digitally enabled technology to support the delivery of brilliant care

Further afield

Judicial review into stroke services

The judicial review hearing into stroke services concluded at the beginning of December, although a ruling was not made. The judge said that she recognised the need to reach a quick resolution to the case, and that we could expect a ruling in the New Year.

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Integrated Quality and Performance Report**	**Agenda Item**	**4.1**
Lead Director	Karen Rule, Executive Director of Nursing		
Report Author	Executive Team		
Executive Summary	This report informs Board Members in the form of a dashboard report of November 2019 quality and operational performance across key performance indicators. **Safe** Our Infection Prevention and Control performance for November shows that the Trust has had 0 MRSA bacteraemia cases since July 2019. The Trust is on trajectory for *C. difficile* infections and the antimicrobial stewardship group activity will assist in ensuring controls against this are effective. The updated August HSMR figure now sits at 102, which is not a national outlier. A further independent review will take place in November by NHSI. **Caring** Reducing our same sex accommodation breaches remains challenging. The main area of focus is Critical Care which is being addressed through the Best Flow Programme. Electronic Discharge Notification (EDN) performance remains below trajectory, recent deep dive analysis with the teams has been completed and refreshed trajectories and resources have been clarified to ensure completion within 24 hours. A clinically led Task and Finish Group has also been set up to coordinate this work. **Effective** VTE performance fell in the first half of the 2018/19 year, but a continued improvement in performance and VTE compliance is evident, climbing consistently since October 2018 and stabilising in the first quarter of 19/20, due to better engagement, stronger leadership and constant monitoring, review and flexing of process to amend issues as they arise, but remaining below the target of 95 percent. The Fractured Neck of Femur (#NOF) performance has been impacted by another period of increased demand for trauma services and orthopaedic services. Plans are being implemented to create additional trauma lists and evening orthopaedic lists to meet demand. **Responsive** The Trust did not meet the four-hour performance standard. Eighteen weeks Referral To Treatment (RTT) performance remains steady at 83 percent, with zero 52-week breaches but below trajectory. A stable performance for Diagnostics was seen at 95 per cent. Cancer performance has significantly improved in October to 95 per cent (two-week wait) and a slight downward performance off 74 per cent for 62-day due to endoscopy capacity.		

	Well Led Appraisal completion rate, at 87.48 per cent has increased from October (2.05 percent) and remains above the Trust's target (85 per cent). Statutory and Mandatory training compliance is at 92.11 per cent, showing an increase of 0.65 per cent and this remains above the Trust's target of 85 per cent.	
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care	☒
	Finance: We will deliver financial sustainability and create value in all we do	☒
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Committees or Groups at which the paper has been submitted	Executive team (content discussed, not entire report) Division and Programme leadership teams (content discussed, not entire report).	
Resource Implications	Nil	
Legal Implications/Regulatory Requirements	Nil	
Quality Impact Assessment	Not Applicable	
Recommendation/ Actions required	The Board is asked to discuss and note the report.	

Approval	**Assurance**	**Discussion**	**Noting**
☐	☐	☒	☒

Appendices	None

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EXECUTIVE SUMMARY

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Executive Summary

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EXECUTIVE SUMMARY

Safe
Our Infection Prevention and Control performance for November shows that the Trust has had 0 MRSA bacteraemia cases since July 2019. The Trust is on trajectory for C. difficile infections with 27 cases against trajectory of 29, and the antimicrobial stewardship group activity will assist in ensuring controls against this are effective. The updated August HSMR figure now sits at 102, which is not a national outlier. A further independent review will take place in November by NHSI.

Caring
Reducing our same sex accommodation breaches remains challenging. The main area of focus is Critical Care which is being addressed through the Best Flow Programme. Electronic Discharge Notification (EDN) performance remains below trajectory, recent deep dive analysis with the teams has been completed and refreshed trajectories and resources have been clarified to ensure completion within 24 hours. A clinical led Task and Finish Group has also been set up to coordinate this work.

Effective
VTE performance fell in the first half of the 18/19 year, but a continued improvement in performance and VTE compliance is evident, climbing consistently since October 2018 and stabilising in the first quarter of 19/20, due to better engagement, stronger leadership and constant monitoring, review and flexing of process to amend issues as they arise, but remaining below the target of 95%. The Fractured Neck of Femur (#NOF) performance has been impacted by another period of increased demand for trauma services and orthopaedic services. Plans are being implemented to create additional trauma lists and evening orthopaedic lists to meet demand.

Responsive
The Trust did not meet the 4 hour performance standard. 18 weeks Referral to treatment (RTT) performance remains steady at 83%, with 0 52 week breaches but below trajectory. A stable performance for Diagnostics was seen 95%. Cancer performance has significantly improved in October to 95% (2week wait) and a slight downward performance off 74% for 62 day due to endoscopy capacity.

Well Led
Appraisal completion rate, at 87.48% has increased from October (2.05%) and remains above the Trust's target (85%). StatMan compliance at 92.11% shows an increase of 0.65% and remains above the Trust's target of 85%.

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SAFE

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Safe

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SAFE

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	12M
Harm Free Care	Falls Per 1000 Bed Days	6.6	#	4.48	5.2	7	4.56	4.73	4.74	5.01	4.22	4.15	5.12	4.88	4.03	**4.83**
	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	1.0	#	0.12	0.24	0	0	0.2	0.06	0	0	0	0.13	0	0.06	**0.07**
Incident Reporting	Never Events	0.0	#	0	0	0	0	0	0	0	0	1	0	0	0	**1**
	No of SIs on STEIS	90.0	#	6	7	6	4	5	20	8	11	10	12	7	10	**106**
	% of SIs Responded To In 60 Days	-	%	100	100	100	100	100	100	100	100	100	100	100	100	**100**
Infection Control	MRSA Bacteraemia (Trust Attributable)	4.0	#	1	0	0	0	0	1	1	1	0	0	0	0	**4**
	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	43.0	#	-	-	-	-	3	2	7	5	1	1	7	1	**27**
	C-Diff: Hospital Onset Hospital Acquired (HOHA)	-	#	-	-	-	-	3	2	1	2	1	1	6	0	**16**
	E-coli (Trust Acquired) Infections	30.0	#	4	4	7	3	5	4	6	6	9	5	5	2	**60**
Mortality	Crude Mortality Rate	2.5	%	1.14	1.29	1.51	1.92	1.5	1.9	1.78	1.42	1.53	1.34	1.3	-	**1.49**
	HSMR (All)	100.0	%	110.73	108.95	106.25	107.35	107.43	107.33	107.39	105.06	102.06	-	-	-	**106.94**
	HSMR (Weekday)	100.0	%	110.09	107.02	103	103.09	103.97	103.43	102.98	100.19	96.6	-	-	-	**103.35**
	HSMR (Weekend)	100.0	%	111.64	113.45	115.11	119.24	116.61	117.46	119.09	118.5	117.3	-	-	-	**116.48**
	SHMI	1.0	#	1.1	1.1	1.09	1.09	1.07	1.09	1.11	1.11	1.12	-	-	-	

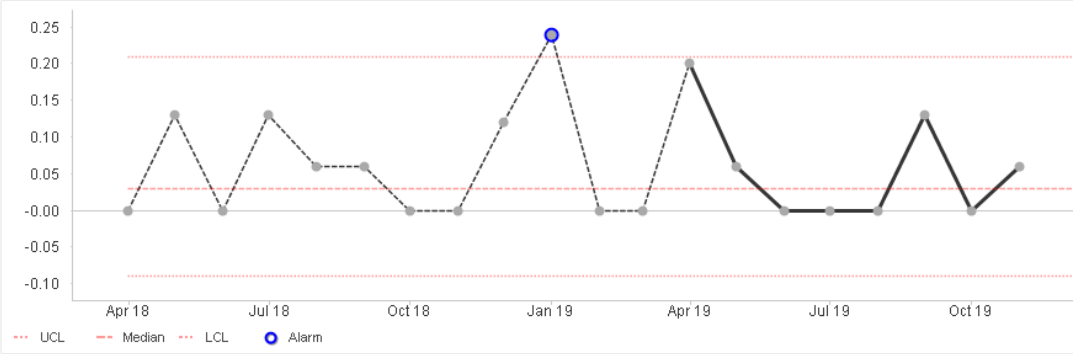
Safe Commentary:

We remain within trajectory for C.difficile infections and are working through antimicrobial stewardship initiatives to provide controls around this. The new protocol for the management of loose stools has been successfully launched. There have been three cases of MRSA this year, we have an MRSA improvement plan which is being worked through. Work has been completed to obtain information on sources of the E.coli BSI's improvements are being planned.

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

Safe – Pressure Ulcers Per 1,000 Bed Days Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19
Harm Free Care	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	1.0	#	0.12	0.24	0	0	0.2	0.06	0	0	0	0.13	0	0.06



Pressure Ulcer Definition:

The number of pressure ulcers acquired in the hospital and resulting in moderate or high harm divided by the number of occupied bed days. Pressure ulcers are injuries to the skin and underlying tissue primarily caused by prolonged pressure on the skin.

Commentary	Risks & Mitigating Actions
In November the total number of hospital acquired pressure ulcers was 18. There was 1 moderate Harm in November for an acquired unstageable pressure ulcer. Across both directorates there were a total of • 10 category 2 PU • 5 Deep Tissue Injury PU • 2 Unstageable PU • 1 category 3 PU (not a moderate harm due to anatomical location) In November our highest incident wards were Harvey and Milton. There was a total of 32 lessons learnt across both directorates for pressure ulcers. We have breached the occupied bed data target for this month We are above our trajectory target by 14 Pressure ulcers	Tissue Viability continue to carry out a point prevalence and ASSKINg audit every month. ASSKINg audit results in November were 70.8% - **Target 95%** Training for pressure ulcer prevention and management is available on a monthly basis – Total of 23 members of staff attended in November Pressure ulcer panel meeting is carried out on a monthly basis, all pressure ulcers that have acquired that month are discussed with an overarching trust pressure ulcer improvement plan attached to this to discuss learning.

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CARING

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	12M
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	248	234	252	147	85	107	97	139	100	138	80	73	**1700**
	MSA %	0.0	%	1.64	1.48	1.75	0.94	0.59	0.7	0.67	0.9	0.65	0.96	0.53	0.48	**0.94**
	% of EDNs Completed Within 24hrs	100.0	%	76.05	74.89	76.56	75.53	75.95	77.63	74.93	73.21	70.66	74.1	75.05	74.65	**74.86**
	Inpatients Friends & Family % Recommended	85.0	%	81.98	85.05	76.33	85.59	85.6	84.41	83.66	88.01	85.26	86.55	88.97	86.18	**85.1**
	Inpatients Friends & Family Response Rate	22.0	%	19.45	19.69	12.1	20.64	15.83	18.51	20.65	20.72	22.67	22.04	22.08	21.55	**19.78**
ED Care	ED Friends & Family % Recommended	85.0	%	71.97	72.05	72.18	75.56	73.34	73.14	72.58	72.9	77.85	84.55	78.14	77.72	**75.9**
	ED Friends & Family Response Rate	22.0	%	14.01	13.99	13.23	13.42	10.64	12.35	13.45	12.96	15.3	14.38	14.23	13.85	**13.57**
Maternity Care	Maternity Friends & Family % Recommended	85.0	%	95.19	97.64	99.6	99.66	100	100	99.6	99.29	98.77	99.64	99.65	99.19	**99.19**
	Maternity Friends & Family Response Rate	22.0	%	28.15	32.81	38.67	31.78	29.77	28.88	11.01	23.56	18.51	19.86	22.77	20.58	**24.02**
Outpatients Care	Outpatients Friends & Family % Recommended	85.0	%	91.63	90.28	89.48	91.14	89.23	89.77	89.42	89.9	91.51	91.2	90.96	91.33	**90.54**
	Outpatients Friends & Family Response Rate	22.0	%	13.06	14.78	14.83	14.15	10.32	12.87	12.75	12.91	15.04	15.09	15	15.11	**13.84**

Caring Commentary:

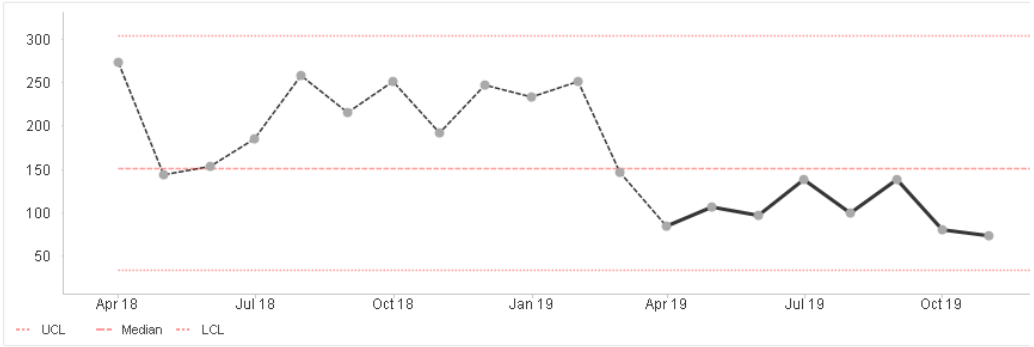
The Inpatients 'would recommend' rate follows a positive trend for the last 5 months. The response rate is 0.53% lower than the previous month. There will soon be a trial of providing patients with written information about the Friends and Family Test within the TTO bag in the hope that it will boosts responses.
Postnatal community data is lacking in November which brings the overall figure down for maternity.
The response rate for ED is shown as red, however compared to the data available nationally (October) ED is 1.25% higher than the national average.
The response rate for Outpatients is shown in red, however this is not measured nationally and therefore no comparison is available. However, our data does show an increase in patients responding to the survey in comparison with the early part of the year.

Overall, the focus is on improving the 'would recommend' rates for all categories.
Some areas have introduced paper surveys which could have a negative impact on patients responding to the text and telephone message. Paper surveys, with the exception of maternity services, are not counted as the information is not provided to our current supplier and they are therefore discouraged.

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

Caring – Mixed Sex Accommodation Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	248	234	252	147	85	107	97	139	100	138	80	73



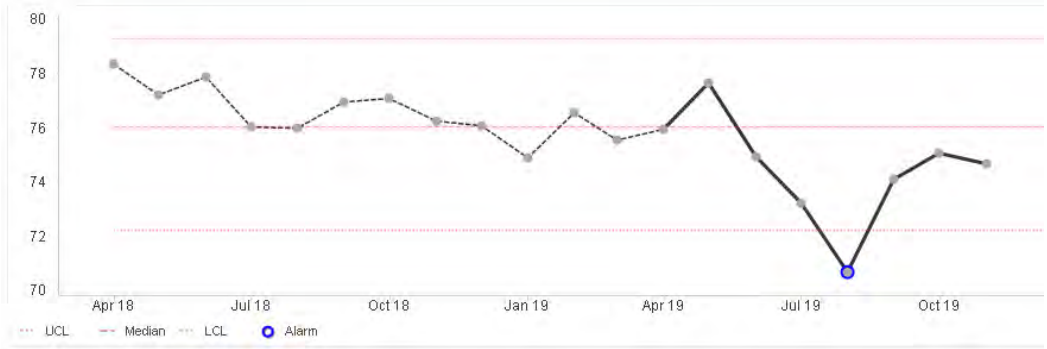
Commentary	Risks & Mitigating Actions
Breaches of Same Sex Accommodation continue downward trend. 73 breaches in month. 71 days of breaches in critical care wards with 36 patients affected. • ICU – 21 breaches affecting 10 patients. • MHDU – 27 breaches affecting 16 patients • SHDU – 22 breaches affecting 11 patients. • The longest wait for a stepdown bed was 7 days in ICU. 2 breaches occurred in Bronte with patients requiring specialised nursing interventions.	Continued scrutiny of SSA breaches in site meetings with patients fit for stepdown to ward areas being allocated in line with admissions. Critical care reviewing processes and validating all breaches within their wards with a view to moving patients to avoid breaches where possible. BI team working to refine system capture to eliminate errors in reporting. Weekly validation meetings continue for all areas with SSA breaches.

Mixed Sex Accommodation Definition:

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

Caring – Electronic Discharge Notification (EDN) Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19
Admitted Care	% of EDNs Completed Within 24hrs	100.0	%	76.05	74.89	76.56	75.53	75.95	77.63	74.93	73.21	70.66	74.1	75.05	74.65



Commentary
Risks & Mitigating Actions

EDN reporting has been reviewed by Medical Director and Deputy Chief Executive and EDN reporting has been amended to exclude some areas where patients do not necessarily need an EDN completed. The EDN completion rate has now been amended on IPQR. There is not much progress in the trend of completion of EDN. Hence a EDN Improvement Task and Finish group has now been set up. Purposes of this group include: redesigning the EDN, streamline content to be more clinically relevant and useful , improve the ease and quality of completion and improve the timeliness of their being sent to the GPs. Membership of the group has been agreed and meetings have been put in place with a view to formulate action plan. This group will be accountable to Medical Director and regular progress report will be provided to MD. Analysis of the data shows that the acute medical wards and the paediatric units are completing over 85% of EDN's within 24 hours. Surgery in general is at over 80% - the main issue is within specialist medicine which is running below 70%.

Electronic Discharge Notification Definition:

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

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Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	12M
Best Practice	7 Day Readmission Rate	10.0	%	4.56	4.31	4.49	4.21	4.64	4.39	4.6	4.57	5.6	5.29	5.7	-	**4.76**
	30 Day Readmission Rate	10.0	%	10.46	9.25	9.97	9.37	10.48	9.41	9.71	10.15	10.77	10.86	11.17	-	**10.15**
	Discharges Before Noon	25.0	%	17.2	15.42	16.21	16.11	14.19	14.82	14.59	14.96	15.36	14.69	14.23	13.97	**15.15**
	Fractured NOF Within 36 Hours	100.0	%	46.9	45.5	71.4	85.7	75	61.7	60	58.1	52.2	58.8	64.7	-	**61.82**
	VTE Risk Assessment % Completed	95.0	%	50.57	74.47	88.67	90.46	95.3	92.68	90.32	93.04	92.23	95.04	94.92	93.38	**87.95**
Maternity	Elective C-Section Rate	13.0	%	9.66	13.2	12.97	11.6	13.26	13.59	13.04	14.56	13.32	15.91	13.07	12.02	**13.05**
	Average occupancy	15.0	%	20.37	20.05	21.45	21.39	17	15.53	16.91	18.14	18.34	18.76	18.84	17.39	**18.68**
	Total C-Section Rate	28.0	%	30.03	33.25	34.41	32.99	30.26	29.13	29.95	32.7	31.66	34.68	31.91	29.41	**31.73**
	Number of Deliveries (Count of Mothers)	-	#	383	409	401	388	347	412	414	419	398	421	398	391	**4781**
	12+6 Risk Assessment	90.0	%	85.19	82.52	82.47	87.21	83.15	81.82	81.58	84.88	85.53	-	-	-	**83.76**
Stroke	Stroke SSNAP Rating *	B	-	E	D	D	D	D	D	D	-	-	-	-	-	
	% of Pts Seen by Stroke Cons in 24 Hours *	95.0	%	41.25	31.13	31.13	31.13	30.51	30.51	30.51	-	-	-	-	-	**31.91**
	Stroke Pts Scanned Within 1 hour *	90.0	%	48.75	42.45	42.45	42.45	50	50	50	-	-	-	-	-	**46.68**

Effective Commentary:

Readmissions: nationally the Trust is not an outlier for readmissions at 28 days. For non elective patients the risk of readmission is lower than the overall national performance, having steadily improved over the last 12 months.

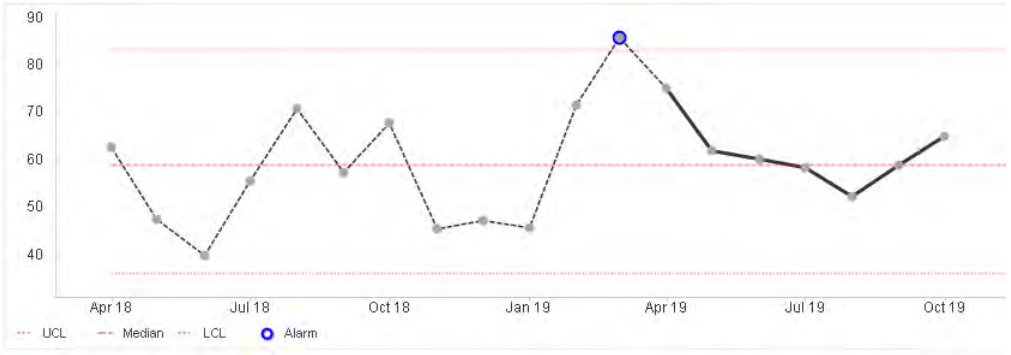
Fractured femur: see subsequent slide

Stroke: there have been intermittent improvements in some aspects of the SSNAP ratings particularly in respect of therapy input, and in time to review by a stroke consultant. Access to the stroke unit remains inconsistent and is affected by the general issues with bed capacity. The ongoing delays to the introduction of the Kent and Medway planned solution for hyperacute care represent a significant risk to the sustainability of services from a workforce viewpoint. This risk is regularly reviewed at the Kent and Medway Stroke Programme Board.

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

Effective – Fracture Neck of Femur Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Best Practice	Fractured NOF Within 36 Hours	100.0	%	46.9	45.5	71.4	85.7	75	61.7	60	58.1	52.2	58.8	64.7



Fractured NOF in 36 Hours Definition:

The NICE guidance states that patients admitted with a fractured neck of femur (NOF) should have surgery within 36 hours of admission. This lowers overall mortality risk and aids in the patient's return to mobility. A Best Practice Tariff (BPT) is associated with this indicator to encourage prompt surgery.

Commentary
Risks & Mitigating Actions

Following significant improvement to March 2019, performance in respect of time to theatre for patients with fractured neck of femur (and therefore achievement of Best Practice Tariff) has deteriorated. Over the last four months approximately 60% of patients undergo surgery within 36 hours of admission.

The principal reason why patients are not operated within the required timescales relates to lack of capacity. This has led to 51% of the delays in the last three months, and to 66% of delays for patients who missed the 36 hour timeline in May.

ACTIONS AND TIMESCALES

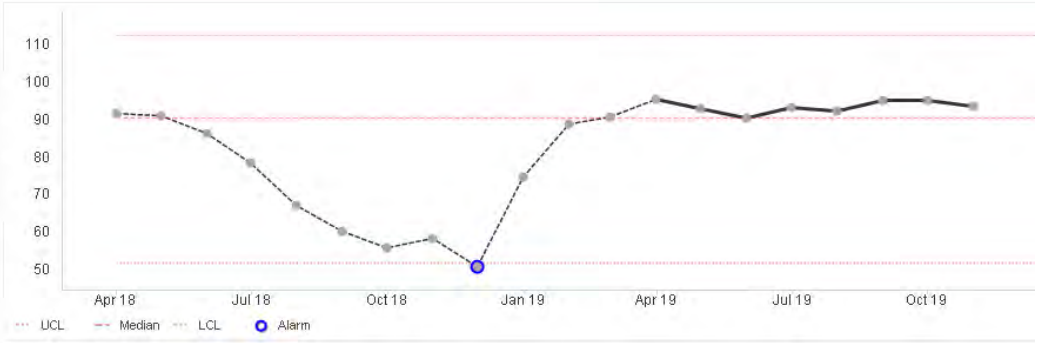
Short term mitigations including the use of 'dropped lists' are being introduced over December and January (when the holiday period generally leads to increased availability of 'ad hoc' lists for fractured neck of femur patients)

A formal review of capacity needed (personnel and theatre) to deliver increasing trauma workload (90th centile of daily activity) will be completed by the end of January 2020.

Work also continues on facilitating prompt discharge of medically optimised patients (delay of 4-5 days at present between date of medical optimisation and discharge date). This includes maintenance of seven day therapy services, and a review of community bed capacity for non weight bearing rehabilitation.

Effective – VTE risk Assessment Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19
Best Practice	VTE Risk Assessment % Completed	95.0	%	50.57	74.47	88.67	90.46	95.3	92.68	90.32	93.04	92.23	95.04	94.92	93.38



VTE Risk Assessment Definition:

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

Commentary	Risks & Mitigating Actions
VTE performance fell in the first half of the 18/19 year, but a continued improvement in performance & VTE compliance is evident, climbing consistently since October 18 and stabilising in the first quarter of 19/20, due to better engagement, stronger leadership and constant monitor, review and flexing of process to amend issues as they arise. The VTE target was achieved in September and October 2019 and is at 93.58% for November. The VTE nurse continues her efforts to improve the performance and hit the 95% compliance rate. **Examples of Improving Practices:** • Lister ward has improved compliance • Engagement of the consultants and junior medical team increased through Trust Induction and Ward visibility of VTE nurse	**Risks:** • VTE deliver and performance recording relies on a single point of failure – the Ward Clerk • Availability of Ward Clerks has continued to be a challenge, due to a high number of vacancies and lack of bank availability for additional shifts • Paediatric Ward engagement is a continued issue. **Mitigations/actions taken:** • Training sessions have been delivered for all Ward Managers and Ward Clerks for the completion & entry of VTE risk assessments • Specific training sessions have been completed on both Lister and on the Paediatric wards • VTE nurse is working hard on maintaining performance in areas where staffing is limited • Dr Bijral has been appointed as the lead for Hospital Transfusion and Thrombosis

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Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	12M
Bed Management	Bed Occupancy Rate	92.0	%	88.6	90.59	91.38	88.52	83.73	84.9	87.07	88	84.03	84.8	84.94	88.07	**87.03**
	Average Elective Length of Stay	5.0	#	2.48	2.02	2.25	2.15	2.24	2.79	2.1	2.09	2.46	2.66	2.14	1.87	**2.27**
	Average Non-Elective Length of Stay	5.0	#	8	9.23	8.79	8.61	8.72	8.56	8.43	8.39	8.27	8.6	8.54	8.5	**8.56**
	Escalation Beds Open Point Prevalence in Month	0.0	#	340	775	700	775	750	775	182	162	319	192	392	437	**5799**
	Delayed Transfer of Care Point Prevalence in Month	-	#	302	228	243	321	373	347	281	341	344	212	320	-	**3312**
	% of Delayed Transfer of Care Point Prevalence in Month	3.5	%	1.88	1.36	1.59	1.95	2.45	2.16	1.83	2.11	2.13	1.39	1.98	-	**1.89**
	Medically Fit For Discharge Point Prevalence in Month	-	#	2991	3211	3345	3663	3379	3060	2829	3114	3104	3222	3312	3277	**38507**
	% Medically Fit For Discharge Point Prevalence in Month	7.0	%	18.61	19.21	21.89	22.26	22.22	19.07	18.4	19.31	19.23	21.13	20.47	19.73	**20.11**
ED Access	ED 4 Hour Performance All Types	95.0	%	84.75	80.35	75.41	76.84	78.8	79.77	81.21	79.97	81.69	85.84	80.06	77.02	**80.11**
	ED 4 Hour Performance Type 1	95.0	%	75.96	69.14	66.29	67.78	70.14	70.7	71.1	73.82	73.2	75.74	68.16	67.81	**70.81**
	ED 12 hour DTA Breaches	0.0	#	1	5	16	1	7	48	11	4	1	2	0	0	**96**
	Median Time to ED Clinician (60mins)	60.0	#	40	48	53	48	37	38	36	36	27	29	33	43	
	Median Time to Ambulance Assessment (15mins)	15.0	#	3	3	4	4	4	4	4	4	4	4	5	5	
	30 Mins Ambulance Handover Delays	0.0	#	315	364	449	423	346	408	450	378	439	432	591	540	**5135**
	60 Mins Ambulance Handover Delays	0.0	#	72	192	212	133	105	98	108	66	90	78	108	100	**1362**
	Number of ED arrivals by Ambulance	-	#	3500	3475	3088	3346	3391	3379	3302	3577	3174	3144	3406	3232	**40014**
	ED Conversion Rate	20.0	%	24.74	22.15	20.3	21.78	24.74	24.8	25.2	21.38	20.98	22.21	23.25	23.4	**22.89**

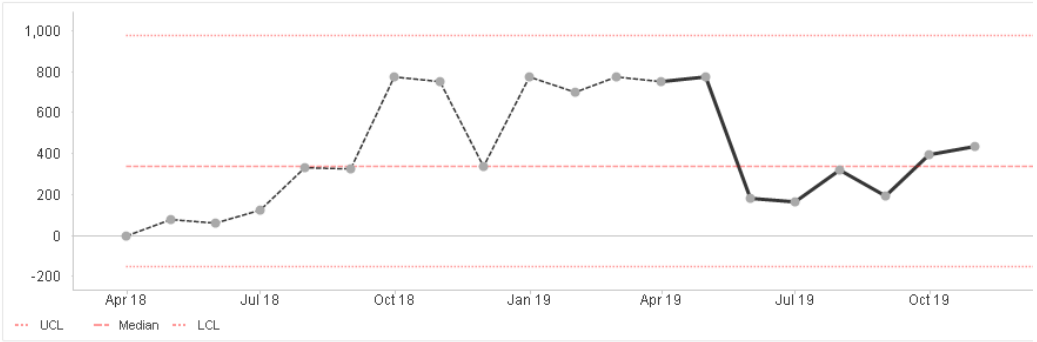
Responsive – Non-Elective Commentary:

Bed occupancy % is not correct so careful inference to flow parameters. Bed occupancy is regularly >100% driven by high LOS in Older Persons care who are dependent on MFFD process to create capacity. MFFD is continually 20-22% of bed capacity (70 – 110 people) and work is ongoing with IDS to improve outflow process. Non-admitted ED performance is in region of 88 – 94% but admitted performance is <10% as a result of exit-block. GIRFT indicates we are worst in country for Aggregate Patient Delay (APD) however there is a downward trend noted as part of the BestFlow programme. Ambulance handover performance is also impacted by high occupancy and we have exceeded our planned threshold for 60 minute breaches for 4 months consecutive. This is also in tandem with ambulances >500 conveyances over plan. ED remain the top performer in region for TTT metric .

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

Responsive – Escalation Beds Open Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19
Bed Management	Escalation Beds Open Point Prevalence in Month	0.0	#	340	775	700	775	750	775	182	162	319	192	392	437



Commentary	Risks & Mitigating Actions
Flex (escalation) capacity has been operated through M6 due to bed occupancy levels of >100% and high MFFD levels ranging from 72 – 114 patients	Dickens ward transferred to Site Operations with direct Divisional oversight. Will commence as temporary respiratory ward under Acute Medicine from 6th January 2020. 16 beds remain as cost pressure with 1:8 nursing ratio and HCA support Safari ward rounds continue. 8 beds opened at end of M8 and remains at 24 into M9 as a cost pressure. These will be funded from the 6th January with funding from NHSI.

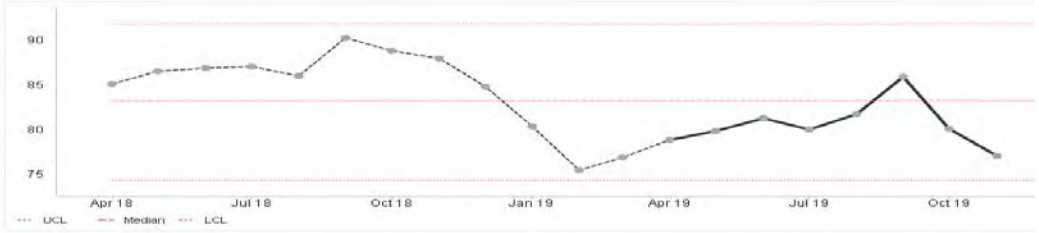
Escalation Beds Definition:

An escalation ward is defined by the NHS as a temporary ward or bed used by a Trust to support capacity in times of high demand to create additional capacity. It is acknowledged that patients "boarded" on an escalation ward are more likely to have poorer experience and high delays in discharge. These wards are not funded and staffed from a planned annual budget.

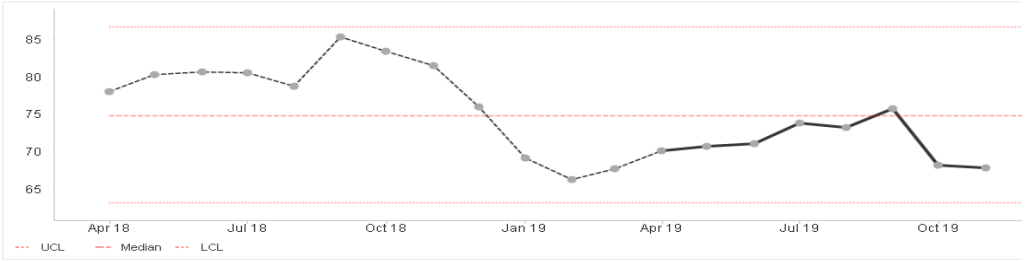
Responsive – ED 4 Hr Performance A

Types and Type 1 Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19
ED Access	ED 4 Hour Performance All Types	95.0	%	84.75	80.35	75.41	76.84	78.8	79.77	81.21	79.97	81.69	85.84	80.06	77.02



Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19
ED Access	ED 4 Hour Performance Type 1	95.0	%	75.96	69.14	66.29	67.78	70.14	70.7	71.1	73.82	73.2	75.74	68.16	67.81



ED 4 Hour Local Trajectory

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
ED - 4 Hours Type 1	Actual	68.10%	68.87%	68.85%	74.09%	76.96%	74.46%	67.16%	67.81%
	Planned	68.13%	77.21%	82.28%	83.22%	82.35%	88.98%	87.07%	88.10%
	Variance	-0.03%	-8.34%	-13.43%	-9.13%	-5.39%	-14.52%	-19.91%	-20.29%
ED - 4 Hours All Types	Actual	79.66%	80.77%	80.60%	86.66%	82.38%	86.16%	78.63%	77.02%
	Planned	79.66%	83.05%	87.76%	90.00%	90.00%	90.00%	90.00%	90.00%
	Variance	0.00%	-2.28%	-7.16%	-3.34%	-7.62%	-3.84%	-11.37%	-12.98%

Commentary

In November from a total of 11,884 attendees (2.5% up on October). Despite streaming more patients to SDEC (over 191) than previous months the number sent to majors increased to nearly 34% due a reduction in patients streamed to MedOCC (1.9% down to 31%).

The majority of the additional attendees (over 200) were seen in majors, which is a marker of increased acuity.

SDEC 'hot' activity continues to increase with an average of over 30 patients seen every weekday that would have been in ED.

The ability to refer and move into AAU and thus improving performance remains constrained by back end flow. Acute medicine has consistently discharged 30% of the acute patients yet AAU has remained full due to 45-60% of beds filled with speciality patients waiting moves.

Lack of consistent flow continues to inhibit completion of care within ED due to lack of appropriate space to see and treat patients. Waiting room patients that could receive timely emergency care are unable to access majors bays.

Risks & Mitigating Actions

- Risk remains late time of day of flow and regular periods with delays of realising agreed moves and allocating beds. Surges in attendances (ambulance and walk ins) regularly occur 12-1500, the majority of moves occur after 1600. Space in ED will allow for improved performance due to increased capacity to see and treat within ED.

Best Flow programme to mitigate through improvements in process. Revision of FCP to facilitate earlier moves from ED via consideration of +1 on query discharges.

- The lack of an established GPAU through new bed model and bedding reduces the ability to refer and move patients, thus increasing performance

The decision to reinstate and ringfence GPAU will improve flow from ED and SDEC

Responsive – Elective

NHS Medway NHS Foundation Trust

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Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	12M
Diagnostic Access	DM01 Performance	99.0	%	97.4	96.85	98.92	98.7	95.41	93.72	92.03	95.87	98.84	98.49	97.87	95.88	**96.57**
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	80.97	80.84	80.25	80.75	83.08	83.27	82.5	82.35	81.36	81.46	83.41	-	**81.81**
	18 Weeks RTT Over 52 Week Breaches	0.0	#	13	20	27	37	8	5	3	3	1	0	0	-	**117**
	Daycase Rate	85.0	%	63.11	67.28	68.15	65.17	65.31	65.75	66.06	65.24	62.84	63.79	64.67	65.23	**65.23**
	DNA Rate	10.0	%	8.75	8.5	8.05	7.78	7.8	7.76	8.13	7.92	7.81	7.95	8.15	8.27	**8.08**
	First to Follow Up Ratio	-	#	1.2	1.16	1.19	1.18	1.19	1.15	1.14	1.14	1.18	1.15	1.15	1.18	**1.17**
Theatres & Critical Care	Operations Cancelled By Hospital on Day	0.0	#	52	46	51	14	41	15	29	26	11	21	25	22	**353**
	Cancelled Operations Not Rescheduled < 28 days	0.0	#	22	23	22	17	8	7	2	1	-	-	4	4	**110**
	Urgent Operations Cancelled for the 2nd Time	0.0	#	0	0	0	0	0	0	0	0	0	0	0	0	**0**
	Critical Care Occupancy Rate	92.0	%	94.55	98.78	94.95	95.44	84.83	88.99	89.54	86.21	84.09	87.93	88.21	85.17	**89.88**

Responsive – Elective Commentary:

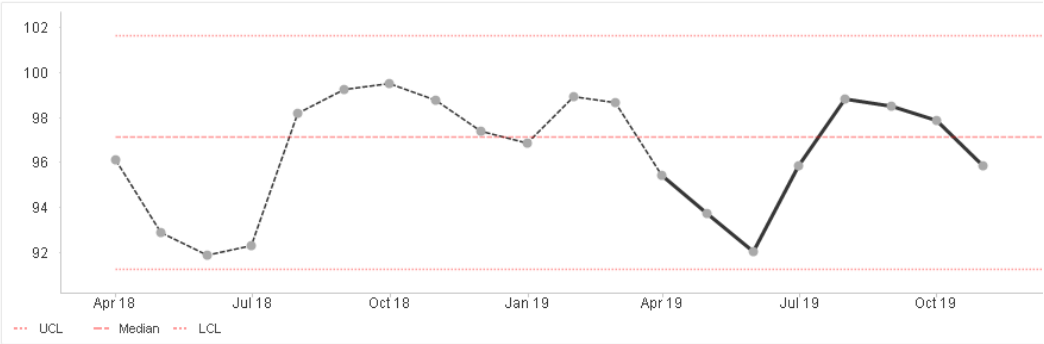
The Trust reported an overall RTT 18 week position of 82.48% for the month of November with zero 52 week breaches across the Trust. The total number of patients on the waiting list has increased to 22500 patients with increases mainly in most specialties. The longest waits remain in NEUROLOGY.

Our DNA position still remains within target and further improvements are expected.

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

Responsive – DM01 Performance Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19
Diagnostic Access	DM01 Performance	99.0	%	97.4	96.85	98.92	98.7	95.41	93.72	92.03	95.87	98.84	98.49	97.87	95.88



DM01 Local Trajectory:

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
DM01- 6 Weeks	Actual	95.41%	93.72%	92.03%	95.87%	98.84%	98.49%	97.87%	95.88%
	Planned	99.20%	99.60%	99.80%	99.40%	99.80%	99.80%	99.70%	99.20%
	Variance	-3.79%	-5.88%	-7.77%	-3.53%	-0.96%	-1.31%	-1.83%	-3.32%

Commentary

DM01 performance had risen steadily over the third quarter of 2019, however performance has begun to decline in some areas due to lack of capacity which is insufficient to manage demand.

The number of MRI requests has seen a sharp increase in volume, driven predominantly by one referring location only and a change in their referring criteria & process.

Unfortunately due to significant capacity issues in Endoscopy it will remain challenging to deliver the expected KPI of 99% until a long term solution to the capacity issues in this service are realised (for Gastroscopy & Colonscopy).

Enhanced processes have been introduced for the management DM01 performance e.g.

- Weekly DM01 report for validation for undated/ forecastable breaches + joint PTL meeting + weekly Exec Review Meeting
- Monthly action report for breeches < 2 weeks notice of end of month

Risks & Mitigating Actions

Risks:

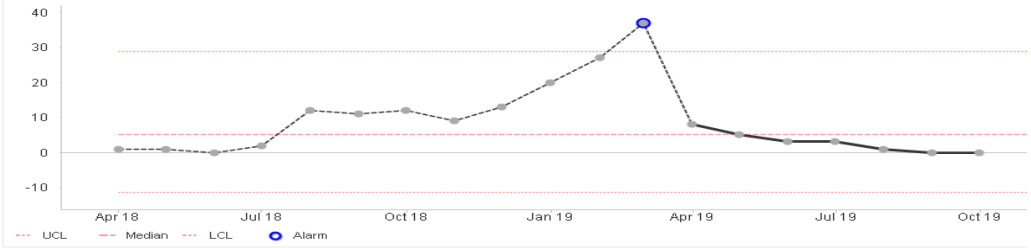
- Capacity (Routine)
  - MRI
  - Gastro (Upper and Lower GI)
- Consultant vacancy – Endo / Colo
- Pensions Tax Issue affecting willingness to undertake adhoc sessions (Endo)
- Reporting capacity within Radiology (cross sectional)

Mitigations:

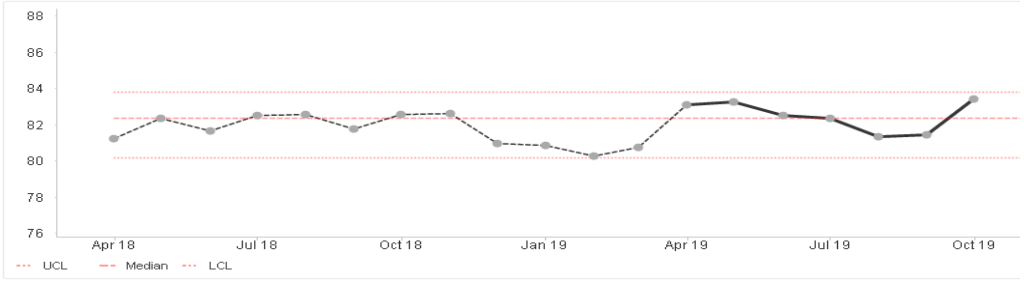
- A Review and refresh of interventions as per IST model in all specialties for 19 - 21, in line with clinical strategy and RTT for each DM01 area
- Increase of MRI Van capacity mobile from 7 to 14 days **(contract to commence Jan 20) /** purchase of mobile MRI
- Source NHS Locum Gastroenterologist to undertake lists OOH / undertake clinics to release substantive Consultants to complete lists
- Advertise and recruit Consultant Radiologists (Locum & Perm)
- Lower GI amending triage and acceptance criteria at WATC
- Colorectal amending STT pathway/triage process – this may impact other diagnostic & RTT performance
- Purchase of capacity at KIMS, subject to acceptance criteria, for routine MRI

Responsive – RTT Performance Spotlight Report

Domain	KPI Name	Target		Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Elective Access	18 Weeks RTT Over 52 Week Breaches	0.0	#	9	13	20	27	37	8	5	3	3	1	0	0



Domain	KPI Name	Target		Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	82.62	80.97	80.84	80.25	80.75	83.08	83.27	82.5	82.35	81.36	81.46	83.41



RTT Local Trajectory :

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19
RTT - 18 Weeks	Actual	83.08%	83.27%	82.50%	82.35%	81.36%	81.46%	83.41%	82.48%
	Planned	82.85%	84.98%	85.73%	86.76%	87.66%	87.76%	89.28%	89.45%
	Variance	0.23%	-1.71%	-3.23%	-4.41%	-6.30%	-6.30%	-5.87%	-6.97%
RTT - 52 Week Breaches	Actual	8	5	2	3	1	0	0	0
	Planned	27	6	4	2	0	0	0	0
	Variance	-19	-1	-2	1	1	0	0	0

Commentary	Risks & Mitigating Actions
The Trust reported an overall RTT 18 week position of 82.48% for the month of November with zero 52 week breaches across the Trust. The total number of patients on the waiting list has increased to 22500 patients with increases mainly in most specialties. The longest waits remain in NEUROLOGY. The Trust have agreed a 88% compliance trajectory with our partners which will be managed via best access programme.	Best Access programme which also includes theatres and outpatients is now fully in place with working groups for each element. Rheumatology at DVH has returned to the Trust from DVH hospital. The data is now fully validated and within the these numbers. With the increased pressure on flow we have seen an increase in the number of elective cancellations due to medical outliers. The number of clinics has also decreased. The day surgery unit has also been re-opened overnight and at weekends due to flow. which has decreased the opportunity within the unit.

Responsive – Cancer & Complaints

NHS Medway NHS Foundation Trust

RESPONSIVE

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	12M
Cancer Access	Cancer 2ww Performance	93.0	%	88.35	72.87	73.01	61.66	83.39	88.69	90.12	91.61	94.09	94.86	95.18	-	**84.59**
	Cancer 2ww Performance - Breast Symptomatic	93.0	%	44.3	7.61	6.33	41.51	70.67	89.19	84.93	59.46	88.71	94.55	92.41	-	**59.63**
	Cancer 31 Day First Treatment Performance	96.0	%	95.51	89.31	87.5	95.45	94.62	94.59	92.59	97.5	95.9	100	99.18	-	**94.5**
	Cancer 31 Day Subsequent Treatments (Surgery)	94.0	%	89.47	75.76	75	73.91	82.61	73.91	100	93.33	100	100	95.45	-	**85.78**
	Cancer 31 Day Subsequent Treatments (Drugs)	98.0	%	100	100	100	100	100	100	96.08	94.74	91.67	100	100	-	**98**
	Cancer 62 Day Treatment - GP Refs	85.0	%	83.64	79.75	67.42	75	76.69	71.67	82.14	75.21	83.7	83.16	74.38	-	**77.37**
	Cancer 62 Day Treatment - Screening Refs	90.0	%	71.79	51.52	42.86	92.31	94.59	100	90.48	100	57.14	64.71	74.07	-	**77.22**
	Cancer 62 Day Treatment - Cons Upgrades	-	%	81.82	67.65	84.38	80.77	73.33	86.96	68.42	85	88	82.14	78.79	-	**79.78**
	104 Day Cancer Waits	0.0	#	6	5	8	9	5	7	6	4	3	3	4	-	**60**
Complaints Management	Number of Complaints	41.0	#	64	67	69	71	57	81	62	74	62	67	72	85	**831**
	% Complaints Responded to Within 30 Days	85.0	%	84.48	94.83	98.08	65.52	56.86	71.19	66.67	73.97	56.25	78.72	74.63	73.21	**74.25**

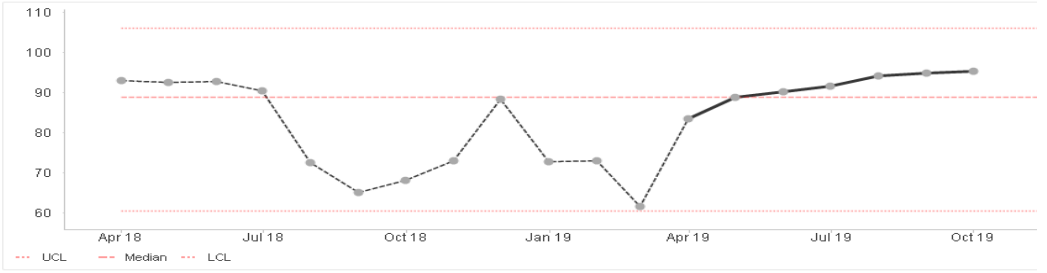
Responsive – Cancer & Complaints Commentary:

- The Cancer 62 day treatment operational standard is 85% this was not achieved in September with trust performance at 83.16%. The following tumour sites did not meet the operational standard H&N 50% (2/1/1) Patient delay to OPA and diagnostic tests, LGI 25% (4/1/3) further investigations prior to oncology treatment, Lung 75% (4/3/1) Imaging report delays and UGI 42.86%(3.5/1.5/2) Further immuno testing & prison delays
- The Cancer 62 day Screening referrals operational standard of 90% was not achieved with trust performance at 64.71%. Breast 64.71% (8.5/5.5/3) (2 of the 3 breaches were patients of DVH and not MFT patients. The 1x MFT breach was due to further staging investigations being required)- Gynaecology No patients, LGI No patients,
- The number of patients beyond day 104 treated in September was 3 this was equal to the lowest in-month total over the last 12 months. The aspirations of the Cancer department is to have 0 patients on the PTL at day 100+ (for anything other than medical reasons).

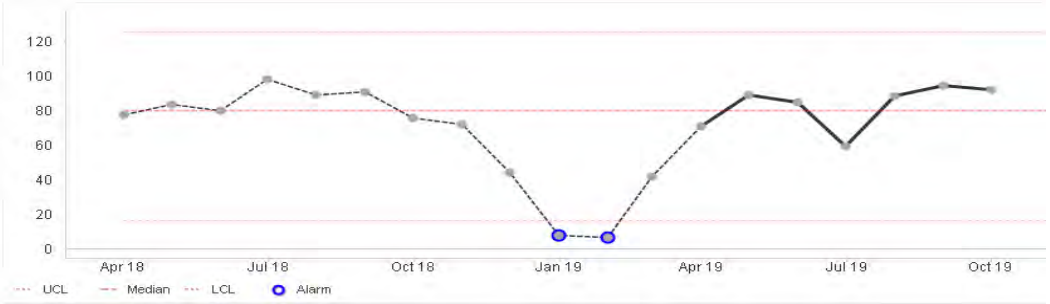
RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Responsive – 2 Week Wait Performanc Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Cancer Access	Cancer 2ww Performance	93.0	%	88.35	72.87	73.01	61.66	83.39	88.69	90.12	91.61	94.09	94.86	95.18



Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Cancer Access	Cancer 2ww Performance - Breast Symptomatic	93.0	%	44.3	7.61	6.33	41.51	70.67	89.19	84.93	59.46	88.71	94.55	92.41



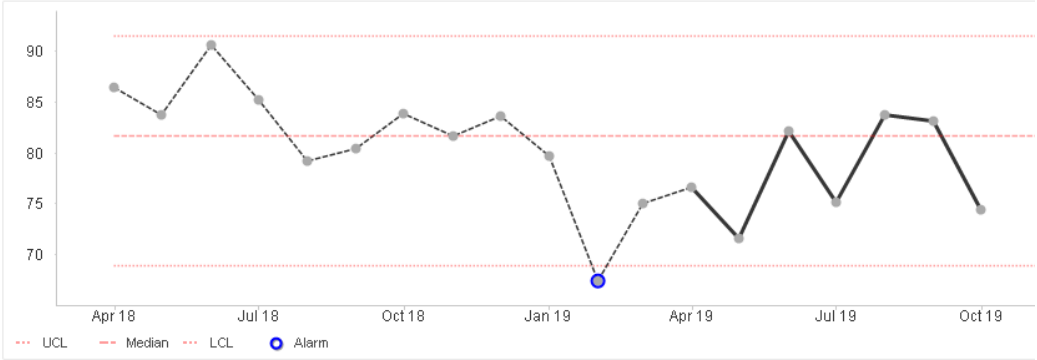
2 Week Wait Definition:

The percent of patients seen by a specialist within 14 days of an urgent GP referral for suspected cancer.

Commentary	Risks & Mitigating Actions
2WW Performance has risen steadily since March 2019 and was above the operational Standard of 93%. Performance for September 94.86%. The introduction of shadow reporting for the 28d FDS has had a positive impact on the 2WW performance. Breast Symptomatic 2 WW performance was at 94.55% for September above the operational Standard of 93%, this has been improving month on month since July. The Breast team are currently reviewing their processes to ensure that there is sufficient capacity to see the symptomatic patients. As this is an on-going project the expectation is that this position will continue to improve.	**Risks** Some specialities are still below the operational standard and work will continue to get these to the 93% standard. • Colorectal Surgery – 91.5% • Gastro – 91.95% • Gynaecology – 92.55% **Mitigating Actions** Cancer Services will be working with each Speciality to get 1st OPA to day 7 and or under in preparation for the FDS.

Responsive – 62 Day Wait GP Performance Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19
Cancer Access	Cancer 62 Day Treatment - GP Refs	85.0	%	83.64	79.75	67.42	75	76.69	71.67	82.14	75.21	83.7	83.16	74.38



Cancer Local Trajectory :

		Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19
Cancer - 62 Days	Actual	76.69%	71.67%	82.14%	75.21%	83.70%	83.16%	74.94%
	Planned	77.10%	77.80%	86.50%	81.40%	78.60%	74.80%	75.70%
	Variance	-0.41%	-6.13%	-4.36%	-6.19%	5.10%	8.36%	-0.76%
Cancer - 2 Week Waits	Actual	83.39%	88.69%	90.12%	91.61%	94.09%	94.86%	95.18%
	Planned	87.10%	89.10%	93.90%	93.80%	93.00%	88.90%	85.90%
	Variance	-3.71%	-0.41%	-3.78%	-2.19%	1.09%	5.96%	9.28%

Commentary	Risks & Mitigating Actions
Cancer 62 day performance was reported at 83.16% which was below the operational standard of 85%. 4 of the 8 tumour sites that we recorded treatments for in September were below the 85% operational standard. H&N 50% (2/1/1) Patient delay to OPA and diagnostic tests, LGI 25% (4/1/3) further investigations prior to oncology treatment, Lung 75% (4/3/1) Imaging report delays and UGI 42.86%(3.5/1.5/2) Further immuno testing & prison delays The Cancer performance impacted by 8 breaches and a low number of in-month treatments.	**Risks** That future performance is detrimentally impacted by the endoscopy back-log patients receiving positive diagnoses and requiring treatment. **Mitigating Actions** The Endoscopy back log should be cleared by end of December. Cancer Services to work closely with Endoscopy to ensure that patients are booked in line with the required timeframes for delivery of 28d and 62d compliance. Upper and Lower GI are the most challenged speciality sites and work is currently underway to optimise the diagnostic aspect of the pathway. Delays are largely due to lack of capacity in Endoscopy but processes are currently under revision and need for additional capacity is being reviewed.

NHS
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WELL-LED

Best of care
Best of people

Well Led

NHS Medway NHS Foundation Trust

WELL-LED

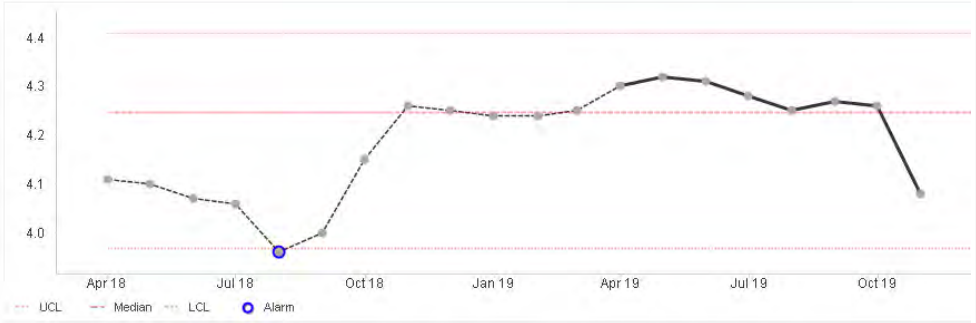
Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19	12M
Staff Experience	Staff Friends & Family - Recommend Place to Work	62.0	%	-	47.33	47.33	47.33	53.07	53.07	53.07	-	-	-	-	-	50.07
	Staff Friends & Family - Recommend Care of Treatment	79.0	%	-	64.15	64.15	64.15	66.62	66.62	66.62	-	-	-	-	-	65.33
Workforce	Appraisal % (Current Reporting Month)	85.0	%	81.3	82.8	83.2	84.43	88.66	90.59	91.41	91.43	91.43	88.22	85.43	87.48	87.22
	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	4.25	4.24	4.24	4.25	4.3	4.32	4.31	4.28	4.25	4.27	4.26	4.08	4.25
	Short Term Sickness Rate (Current Reporting Month, FTE%)	1.5	%	1.97	1.96	1.98	1.93	1.93	1.93	1.92	1.93	1.9	1.91	1.94	1.88	1.93
	Long Term Sickness Rate(Current Reporting Month, FTE%)	2.5	%	2.28	2.28	2.26	2.32	2.37	2.4	2.39	2.35	2.36	2.36	2.32	2.2	2.32
	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0	%	12.02	12.34	12.21	12.52	11.73	12.36	12.57	12.44	12.04	11.97	11.74	11.85	12.15
	Contractual Staff in Post (FTE) (Current Reporting Month)	-	#	3768	3765	3798	3786	3681	3701	3764	3896	3874	3893	3938	3943	
	StatMan Compliance (Current Reporting Month)	85.0	%	76.88	77.75	81.32	82.55	83.96	85.81	88.86	89.7	90.12	90.53	91.46	92.11	86.26
	Agency Spend as % Paybill (Current Reporting Month)	4.0	%	5.61	3.69	3.69	4.06	4	2.82	3.09	3.77	2.14	2.88	3.57	4.08	3.62
	Agency Spend as % Paybill (Financial Year YTD)	4.0	%	4.63	5.68	5.5	5.37	5.29	5.11	3.3	3.42	3.17	4.3	3.18	3.26	4.36
	Bank Spend as % Paybill (Current Reporting Month)	9.0	%	11.86	12.77	12.77	10.93	13.26	12.13	10.93	11.71	14.37	12.27	13.55	13.8	12.53
	Bank Spend as % Paybill (Financial Year YTD)	9.0	%	12.34	11.95	12.03	12.15	12.88	12.54	12.11	12	12.48	12.2	12.58	12.64	12.33
	Temp Staffing Fill Rate – Nurse & Midw ifery (Current Reporting Month)	75.0	%	79	74	78	79	79	76	71	74	74	76	72	74	75.5
Financial Position	Variance from Plan	0.0	%	-8.6	-18.4	-16.4	13	17.8	-4.5	-1.9	-5	-5.3	-16.3	-28.4	0.3	
	Liquidity Ratio	2.0	#	0.47	0.42	0.42	0.32	0.36	0.4	0.41	0.37	0.34	0.31	0.38	0.36	
	Cash Actual (in $m)	1.4	#	13.7	7.5	8.2	10.8	17	29.2	26.4	26.2	24.6	20.6	34.9	32	
	Overall Underlying Financial Surplus / Deficit (in £m)	0.0	#	-36	-42	-43.6	-46.8	-4.6	-8.3	-12.2	-16.8	-22.8	-27.7	-29.1	-34.4	
	Capital Spend Vs Plan	0.0	%	70.9	72.1	72.8	63.3	0	-15.3	7.1	0.1	-26.5	-72.5	-24.1	-20.2	
	Cost Improvement Plans (CIPS) - Var to Plan YTD (in £'000)	0.0	#	1020	894	423	0	-68	74	69	-121	-325	-787	-1288	-1294	

Well-led:

Appraisal completion rate, at 87.48% has increased from October (2.05%) and remains above the Trust's target (85%).
Overall Sickness absence rate at 4.08% has decreased by 0.18% but remains above the tolerance level of 4%. Short term sickness absence at 1.88% has decreased (0.06%).Long term sickness absence, at 2.20% has also decreased (0.12%). The ratios of long-term sickness to short-term sickness remain broadly even.
Voluntary Turnover at 11.85% has increased slightly on October and remains above the tolerance level of 8%.
StatMan compliance at 92.11% shows an increase of 0.65% and remains above the Trust's target of 85%
YTD Agency spend (as a percentage of pay bill) is 3.26%. The Trust continues to meet its agency ceiling cap. Ongoing work to reduce use of agency workforce remains in place and focus on converting agency staff into substantive and or bank assignments continues.
YTD Bank spend (as a percentage of pay bill) is 12.64%. Total YTD temporary spend is at 15.90% which is above the Trust's target of 11.00%
Temporary staffing fill rate for Nurse and Midwifery at 74% was below the YTD average.

Well Led – Total Sickness Rate Spotlight Report

Domain	KPI Name	Target		Dec 18	Jan 19	Feb 19	Mar 19	Apr 19	May 19	Jun 19	Jul 19	Aug 19	Sep 19	Oct 19	Nov 19
Workforce	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	4.25	4.24	4.24	4.25	4.3	4.32	4.31	4.28	4.25	4.27	4.26	4.08



Commentary	Risks & Mitigating Actions
Overall Sickness absence rate at 4.08% has decreased but remains above the Trust's tolerance level of 4%. Short term sickness absence has decreased to 1.88% whilst long term absence has reduced to 2.20% The ratios of long-term sickness to short-term sickness remain broadly even.	

Sickness Rate Definition:

The *absence rate* is the *ratio* of workers with absences to total full-time wage and salary employment.

Safe Staffing

NHS Medway NHS Foundation Trust

		Day		Night		CHPDD	SAFE CARE	VACANCY %	
WARD	CC	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Average fill rate - registered staff (%)	Average fill rate - care staff (%)	Overall	Escalations	RN	CSW
Arethusa Ward	SS133000	97%	84%	97%	107%	6.13	0	6.58%	14.44%
Bronte Ward	AA143000	99%	89%	102%	108%	7.24	0	20.98%	25.19%
Byron Ward	AA800000	89%	84%	100%	90%	6.44	2	-0.97%	-1.27%
CCU	AA156000	100%	94%	100%		12.38	0	22.83%	-16.28%
Delivery Suite	WV226000	100%	100%	100%	97%	24.23	1	1.93%	0.00
Dickens Ward	AA810000	45%	61%	75%	97%	9.25	0	n/a	n/a
Dolphin (Paeds)	WN102000	93%	104%	97%	117%	12.51	0	12.73%	5.85%
Harvey Ward	AA802000	113%	75%	123%	111%	8.10	2	15.13%	5.34%
ICU	AA152000	76%		79%		24.42	0	14.33%	0.00%
Keats Ward	AA132000	93%	78%	108%	84%	6.48	0	24.27%	2.72%
Kent Ward	WV226000	100%	98%	100%	100%	9.82	0	1.93%	0.00
Kingfisher SAU	SS253000	98%	107%	96%	122%	18.11	0	27.16%	12.91%
Lawrence Ward	AA302000	95%	116%	100%	104%	8.32	0	16.48%	12.69%
Lister Assessment Unit	AA100000	79%	95%	101%	101%	8.59	6	38.21%	9.88%
McCulloch Ward	SS453000	104%	99%	105%	118%	6.45	0	12.66%	17.90%
Medical HDU	AA102000	95%		95%		15.24	0	7.20%	40.37%
Milton Ward	AA803000	86%	72%	94%	98%	6.59	0	28.32%	18.50%
Nelson Ward	AA202000	85%	89%	101%	100%	5.57	0	12.90%	14.02%
NICU	WN202000	94%	38%	88%	0%	10.32	0	9.88%	28.03%
Ocelot Ward	WV102000	85%	119%	100%	113%	7.61	0	14.99%	26.54%
Pearl Ward	WV226000	100%	100%	101%	100%	5.88	2	1.93%	0.00
Pembroke Ward	SS113000	96%	129%	97%	149%	8.31	0	31.78%	10.06%
Phoenix Ward	SS513000	98%	83%	100%	102%	5.96	0	-1.29%	19.86%
Sapphire Ward	AA812000	97%	73%	100%	107%	6.97	1	100.00%	0.00
SDCC	ST303000	69%	91%	95%	87%	7.63	0	35.20%	18.33%
Surgical HDU	AA153000	89%		96%		11.83	0	15.22%	-13.64%
Tennyson Ward	AA807000	94%	90%	101%	121%	6.89	1	31.39%	-0.63%
The Birth Place	WV226000	95%	99%	96%	87%	24.42	0	1.93%	0.00
Victory Ward	SS433000	68%	77%	73%	76%	5.95	2	26.82%	19.03%
Wakeley Ward	AA103000	89%	67%	100%	89%	6.65	0	12.34%	13.68%
Will Adams Ward	AA122000	98%	79%	109%	98%	6.85	0	17.10%	3.48%
Trust total		**90.17%**	**86.90%**	**96.12%**	**103.36%**	8.34	19	13.61%	17.09%

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Infection Prevention and Control Quarterly Update 2019/20 - Quarter Three**	**Agenda Item**	4.3
Report Author	Kris Khambhaita – Deputy Director and Head of Infection Prevention and Control		
Lead Director	Dr David Sulch – Director of Infection Prevention and Control, Medical Director		
Executive Summary	NHS providers are obliged to ensure the Board is sighted on performance against Infection Prevention and Control within the Trust on at least a quarterly basis, this report is intended to address this. At the time of writing this report the data included within for December 2019 is not validated.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance of performance against targets on infection controls		
Committee Approval:	Name of Committee: Infection Prevention and Control Date of approval: 16th December 2019		
Executive Group Approval:	Date of Approval:		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Essential Steps to Safe Clean Care, Code of Practice for the Control and Prevention of Infections; Health and Social Care Act 2008.		
Resource Implications	-		
Legal Implications/Regulatory Requirements	Statutory requirement to meet the regulations listed within Code of Practice for the Control and Prevention of Infections; Health and Social Care Act 2008.		
Quality Impact Assessment	N/A		

Recommendation/ Actions required	The board is asked to note the contents of this report and MFT performance			
	Approval ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒
Appendices	None			

1 Executive Overview

1.1 This report is intended to provide a summary update of progress, challenges and incidents for the months of April – December 2019. The next summary report will be provided at the end of quarter four 2019/20; prior to the formal Annual Report in June 2020. Details of anything contained in summary on this report are available on request. It should be noted that December data included within the report is unvalidated at the time of submission.

1.2 NHS Improvement, NHS England, in collaboration with representatives from local Clinical Commissioning Groups undertook a focused inspection on infection prevention and control, providing a report of findings in April 2019, and a follow up visit in November 2019, a further visit is planned for January 2020. Challenges and shortfalls identified during these inspections have been captured and progressed via action plans, of which progress has been monitored via the monthly Infection Prevention and Control Committee (IPCC) with exceptions into Quality Assurance Committee (QAC). In-between these visits, CCG representatives for IPC have worked two days a week with the IPC team for four months, conducted monthly follow up visits and held a number of supervision and support meetings. The Trust has facilitated and extended invitations for CCG to partake in all post infection review panels, and been an active member of the collaborative IPC forum across Kent and Medway to ensure networks and shared learning, collaborative working, learning from others.

1.3 One of the key recommendations for the Trust was to undertake a self-assessment against the Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance. Only two criterions the Trust can currently demonstrate a high level of compliance (criterion 5 and criterion 10) which relates to prompt identification of patients at risk of an infection; and practices in Occupational Health to reduce the risk to staff in relation to infections. Progress against the remaining criterion is captured in an action plan which is monitored by the IPCC. Over the last three months improvements have been noted but the pace is of concern as the Trust is unlikely to complete all the open actions by the end of 2019/20. This risk is captured in the Trust risk register and reviewed monthly.

2 Performance against Mandatory Reportable Infections - MRSA

2.1 In 2018/19 there were 9 cases of MRSA BSI, some of these cases the investigation and reporting were delayed or not carried out at the time. Since April 2019, MFT have aligned to the Public Health England (PHE) and NHS Improvement (NHSI) investigation timelines and process. There have been three cases year to date for MRSA BSI in 2019/20, and all have been declared as a serious incident, been fully investigated with incident reports completed. These cases have been sighted by the CCG and they have been invited to and involved in the post infection review process. This is a considerable improvement when compared to the 2018/19 performance, and we are confident the new standard operating procedure and toolkit will continue to assist in ensuring this is sustained.

2.2 There have been no contaminated blood cultures of MRSA in 2019/20 which is a positive improvement this fiscal year. This is related to the working completed in this reporting period around analysing contaminants monthly and providing this feedback to the clinical staff who obtains samples, and also

working with practice development teams to reinforce competencies and good practices locally. Additional observational audits have been completed and feedback from these has assisted in practitioners having greater insight and ensuring best practice is implemented around aseptic non-touch technique.

2.3 2019/20 year to date MFT has had four confirmed cases of MRSA BSI. Three cases are felt to have been preventable and lessons learnt have been cascaded via Clinical Council, Nursing and Midwifery Grand Round and discussed within divisional forums. The fourth case is under investigation having been detected 20th December 2019.

2.4 Figure 1 below shows the monthly performance of case numbers from 2018/19 - present. It is recommended that the Trust prioritise the Order Comms project which was identified as a solution for all three cases above where there were sample and laboratory case record issues, and investment is made in readymade sterile blood culture kits rather than locally produced kits made in-house.

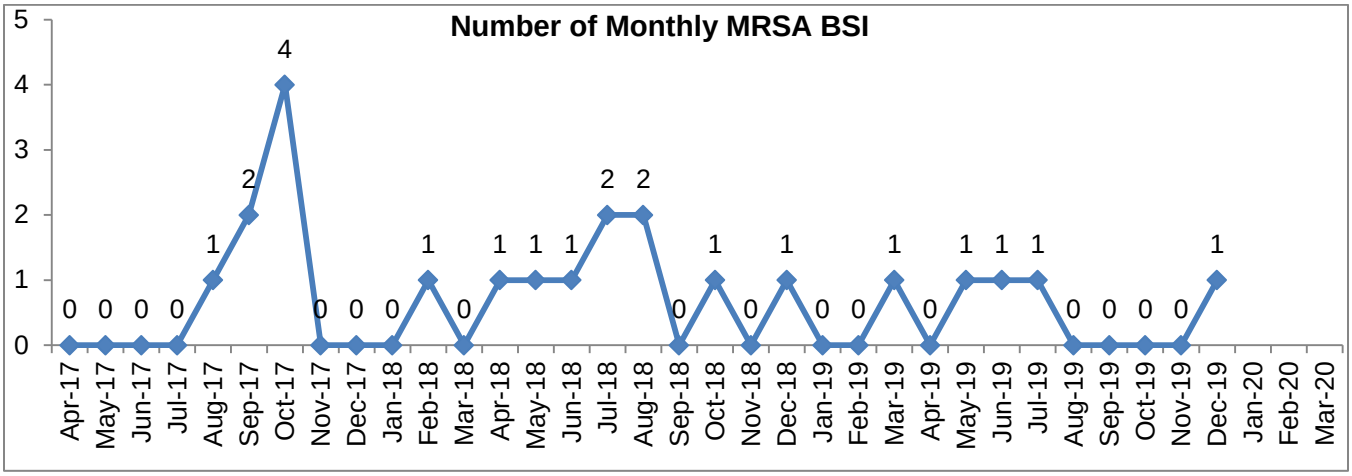


Figure 1: 2019/19 and 2019/20 MRSA BSI performance

3 PERFORMANCE AGAINST MANDATORY REPORTABLE INFECTIONS – *CLOSTRIDIUM DIFFICILE* (C.DIFF)

3.1 There have been changes to the *C. difficile* Infection (CDI) reporting algorithm

• addition of a prior healthcare exposure element for community onset cases

• reducing the number of days to apportion hospital-onset healthcare associated cases from three or more (day 4 onwards) to two or more (day 3 onwards) days following admission.

For 2019/20 cases reported to the healthcare associated infection data capture system will be assigned as follows:

• hospital onset healthcare associated: cases that are detected in the hospital two or more days after admission

• community onset healthcare associated: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous four weeks

• community onset indeterminate association: cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the trust reporting the case in the previous 12 weeks but not the most recent four weeks.

• community onset community associated: cases that occur in the community (or within two days of admission) when the patient has not been an inpatient in the trust reporting the case in the previous 12 weeks.

3.2 Acute provider objectives for 2019/20 from NHS Improvement have been set using hospital onset healthcare associated and community onset healthcare associated aggregated. MFT threshold for 2019/20 is no more than 43 cases in the 12 months.

3.3 *C. difficile* Infection (CDI) incidence overall has declined however controls continue to be a challenge associated particularly to appropriate timely sampling and antimicrobial agent use/overuse. During this reporting period there have been 18 cases of hospital associated CDI against an annual threshold of no more than 43 cases.

3.4 Although within trajectory, and the risk under control, more work is needed around sampling and testing of stools, application of antimicrobial stewardship more robustly. The Antimicrobial Stewardship Group has been reconvened with monthly meetings set, the TOR in place and audit work planned. This group report into the IPCC and are held accountable by DIPC.

3.5 Figures 2 and 3 below provide the breakdowns of performance against trajectory. Ten cases of C. diff in the last five months compared to 17 cases in the first four months of the year. With no cases for five weeks between November and end of December, although at the time of writing this report there have been a further two potential HOHA cases for January, which would bring the total to 29 cases year to date including the new potential cases.

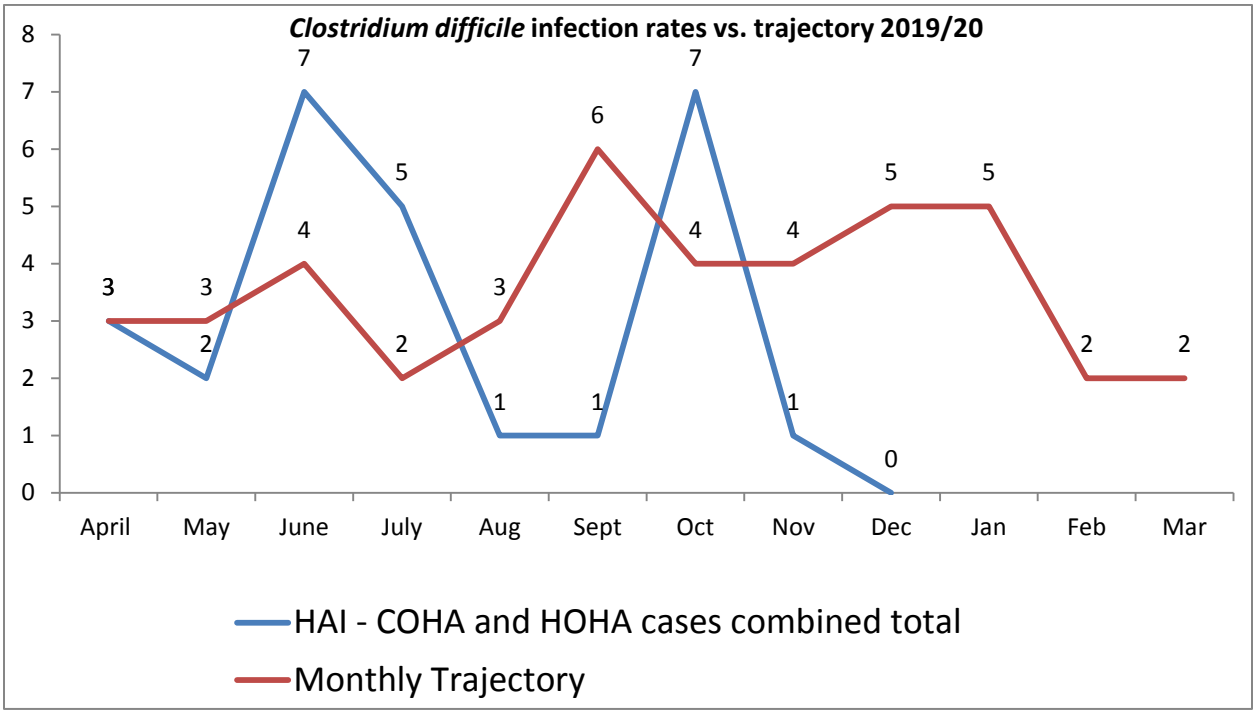


Figure 2: 2019/20 monthly C.diff performance

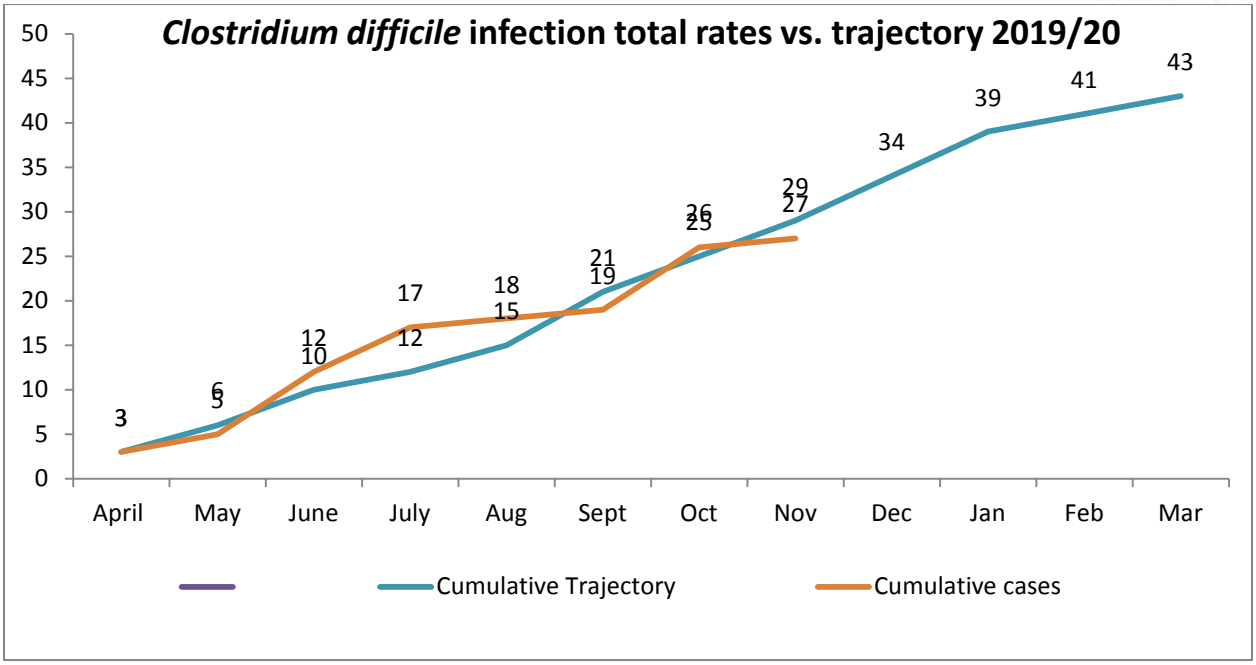


Figure 3: 2019/20 monthly C.diff performance

4 Conclusion and Next Steps

4.1 The Trust Board are asked to note and gain assurance from this paper. Ongoing monitoring of the implementation of the Trust Wide Improvement Plan will be through the Infection Prevention and Control Committee and Quality Assurance Committee with regular updates to the Board for assurance of progress. The annual work plan for IPC was presented to and agreed by IPCC and the Trust Board (September 2019), which will be the framework to seek continuous improvements in MFT.

NHS Medway NHS Foundation Trust

Briefing Report to the Board of Directors

Date: Wednesday, 08 January 2020 Item No: 4.5

Title of Report	**Safe Staffing Nurse Establishment - Review Update**
Prepared By:	Kelly Pickles, Nursing Workforce Facilitator Hayley Jones, Operational Lead Nursing Workforce Julie Murray, Associate Director of Nursing
Lead Director	Jane Murkin on behalf of Karen Rule, Director of Nursing
Committees or Groups who have considered this report	Nursing and Midwifery Operational groups
Executive Summary	The purpose of this paper is to provide the Board of Directors with an update on progress to date of the recent nurse establishment review.
Resource Implications	Recommendations on required staffing levels and costings will be provided in the full board report.
Risk and Assurance	• The paper provides assurance that the Trust has undertaken a nurse establishment assessment of all adult inpatient wards utilising NICE recommended Safer Nursing Care Tool (SNCT). • Failure to comply with safe staffing levels impacts on delivery of safe high quality patient care. • Nurse establishments that are inadequate to deliver against the acuity and dependency recommended establishment can place additional workload on our nursing teams. Potentially impacting on staff retention
Legal Implications/Regulatory Requirements	To ensure safe staffing levels in line with RCN/RCM/NICE guidelines and NHSI recommendations.
Improvement Plan Implication	Failure to provide safe staffing levels will impact on patient safety and quality of care.
Quality Impact Assessment	Failure to support any additional staffing will impact on quality and safety.
Recommendation	None at present
Purpose & Actions required by the Board :	**Approval** ☒ **Assurance** ☒ **Discussion** ☐ **Noting** ☐

Report to the Board of Directors

1 INTRODUCTION

1.1 The following briefing paper has been commissioned by the Director of Nursing, providing the Board of Directors with a progress update in relation to the recent nurse establishment review. The establishment review covers adult inpatient wards. A detailed report including nurse establishment recommendations will be presented to the Trust Executive Team on 15 January 2020.

2 PURPOSE OF THE BRIEFING PAPER

2.1 As an organisation it is imperative that we demonstrate safe staffing levels; the right numbers of nurses with the right skills and knowledge, in the right place at the right time. Without safe staffing levels in place, nursing staff are not able to provide patients with high quality, safe effective and person centred care.

2.2 The briefing paper outlines the process undertaken to ensure the Trust is compliant with national recommendations regarding establishment reviews.

2.3 There is an expectation that all Trust Boards receive papers on establishment reviews every six months, using an evidence based tool alongside multi professional judgement when setting nursing, midwifery and care staff establishments.

2.4 The paper gives assurance the Trust has undertaken a nurse establishment assessment of adult inpatient wards utilising NICE recommended Safer Nursing Care Tool (SNCT).

3 METHODOLOGY

3.1 The review was completed in line with the NHS Improvements (2018) recommendations. Acuity and dependency of all patients on the adult inpatient wards was undertaken between 23 September and 23 October 2019. The timeframe allowed data to be recorded for each ward area using the Safer Nursing Care Tool (SNCT). This is a digital tool that calculates nurse staffing requirements based on the acuity and dependency of the patients on a ward.

3.2 The data was captured on the Safe Care tool, incorporated into the Trust Health Roster. This data is collected each shift by the nurse in charge, however for the purpose of the review there was a further validation process completed by the corporate nursing workforce team.

Report to the Board of Directors

4 Risks and Issues

4.1 Failure to comply with safe staffing levels impacts on delivery of safe high quality care.

4.2 Nurse establishments that are inadequate to deliver against the acuity and dependency recommended establishment can place an additional workload on our nursing teams. Potentially impacting on staff retention.

5 Next Steps

5.1 Each patient was reviewed for acuity and dependency scores against the SNCT criteria. The tool reviews acuity and dependency to give recommended nurse staffing to align with actual care requirements of our patients.

5.2 The divisions will be provided with a detailed breakdown of the review on a ward by ward basis. This will be modelled against previous safe staffing reviews and budgeted nurse establishments. This will allow a professional judgement model and challenge to be applied to the review.

5.3 Once the review is completed and the establishments agreed finance will cost any adjustments and this will be incorporated into the detailed report to be presented to the Executive Team in January 2020.

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Transformation Update**	**Agenda Item**	**5.1**
Lead Director	Jack Tabner, Executive Director of Transformation		
Report Author	Jack Tabner, Executive Director of Transformation		
Executive Summary	The report provides an update on the Trust's 'Better, Best, Brilliant' transformation portfolio, including: • **Large, cross-hospital transformation programmes.** Activity within the Trust's core transformation programmes continues to gather pace: o **BEST Flow:** the Programme has been re-focused on a set of simple activities and measures to support clinical and operational teams manage operational pressures throughout the busy winter period. o **BEST Access:** this programme is coordinating improvement work across 4 areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/RTT management. **The Cost Improvement Programme (CIP).** As at Month 8, the Trust has delivered £11.4million in CIP. Year to date, this is adverse to the operational plan monitored internally by £1.3million. We are forecasting an outturn position of £16.6million - £17.0million CIP delivery against the Trust's requirement of £19.5million. • **Delivering the quality strategy.** As part of the Trust's Quality and People Strategies, we have now trained over 100 staff in Lean-based improvement science and have implemented huddle boards in over 30 clinical and non-clinical areas. Improvement projects are being delivered by frontline staff in 90-day cycles, which align directly to the Trust's strategic objectives. **The development of an Innovation Institute.** As the Kent and Medway Medical School becomes an increasingly real prospect, the Trust will launch in Q4 of this financial year, an Institute for Innovation and Improvement.		
Link to strategic Objectives 2019/20 ***(Please choose ALL that applies - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒

	High Quality Care: We will consistently provide high quality care	☒
Committees or Groups at which the paper has been submitted	Transformation Assurance Group (fortnightly) Finance Committee (latest CIP report – 19 December 2019)	
Resource Implications	N/A	
Legal Implications/Regulatory Requirements	Failure to deliver the Cost Improvement Programme target and the Trust's agreed financial control total could result in the Trust being placed in a Financial Special Measures regime.	
Quality Impact Assessment	QIAs must be completed for all change projects including individual Cost Improvement Programme schemes. The Medial Director and Director of Nursing are required to sign-off all QIAs. For significant projects, QIAs are subject to more detailed discussion and potentially review by the wider Executive Team.	
Recommendation/ Actions required	The Board is asked to note the contents of this report.	

Approval	**Assurance**	**Discussion**	**Noting**
☐	☒	☒	☒

Appendices	N/A

1 Executive Overview

1.1.1 The report provides an update on the Trust's 'Better, Best, Brilliant' transformation portfolio, including:

1.1.2 **Large, cross-hospital transformation programmes.** Activity within the Trust's core transformation programmes continues to gather pace:

- BEST Flow: the Programme has been re-focused on a set of simple activities and measures to support clinical and operational teams manage operational pressures throughout the busy winter period.
- BEST Access: this programme, coordinating improvement work across 4 areas: Theatres and Day Case, Diagnostics, Cancer and Outpatients/RTT management, is now fully up and running. The work has helped secure the Trust's contractual settlement with our commissioners and provide a detailed plan to reduce elective waiting times between now and the end of this financial year.

1.1.3 **The Cost Improvement Programme (CIP).** As at Month 8, the Trust has delivered £11.4million in CIP. Year to date, this is adverse to the operational plan monitored internally by £1.3million. We are forecasting an outturn position of £16.6million - £17.0million against the Trust's requirement of £19.5million. We now focus efforts next year's Cost Improvement Programme, working with clinical and operational teams to prioritise schemes that improve tax payer value for money and deliver efficiencies through improved quality, safety and experience. We are working towards a challenging target of 4.4 percent of expenditure, £12million - £14million.

1.1.4 **Delivering the quality strategy.** As part of the Trust's Quality and People Strategies, we have now trained over 100 staff in Lean-based improvement science and have implemented huddle boards in over 30 clinical and non-clinical areas. Improvement projects are being delivered by frontline staff in 90-day cycles, which align directly to the Trust's strategic objectives. Training pauses during the winter to allow staff to focus on core operations but coaching is always on offer from the Transformation Team.

1.1.5 **The development of an Innovation Institute.** As the Kent and Medway Medical School becomes an increasingly real prospect, the Trust will launch in Q4 of this financial year, an Institute for Innovation and Improvement. Led by three newly appointed Clinical Directors of Innovation and Improvement, this will create a 'one stop shop' for our clinicians looking to conduct research studies and improvement projects. It will combine the best of our currently disparate teams under one new sub-brand. It will serve to provide a single point of entry for the many external agencies that exist to help scale and spread innovation, for instance Academic Health Science Networks and the local Universities.

2 TRANSFORMATION PROGRAMMES

2.1 The Transformation Assurance Group continues to oversee the delivery of the priority cross-hospital transformation programmes agreed by the Executive Team for this year: 1) BEST Flow and 2) BEST Access.

2.2 **BEST Flow:**

2.2.1 The Best Flow programme is a large-scale transformation programme to improve patient flow through each step of the emergency access and inpatient pathways.

2.2.2 This represents the Trust's flagship transformation programme in 2019/20, as well as a key system priority as outlined in the local economy's System Recovery Plan. We have therefore partnered with expert operational improvement consultancy, Transformation Nous, to support

this work. In the last update to the Board, we reported that the Trust was awarded the Patient Flow Programme of the Year 2019, out of 70 Trusts nationally who submitted an application.

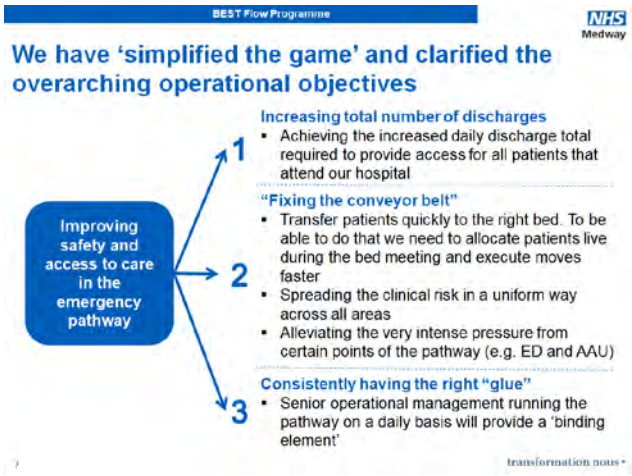
2.2.3 Best Flow's objective is to enable the Trust to deliver improved four-hour ED waits performance. We recognise that this metric is a proxy for safe, effective, high-quality, efficient care in an orderly hospital within which our staff have time to care. This is not however an ED turnaround plan; it is much more than that. We have set out to reduce bed occupancy and achieve an earlier time of day of discharge with a more consistent and predictable discharge profile across the week and during the weekend.

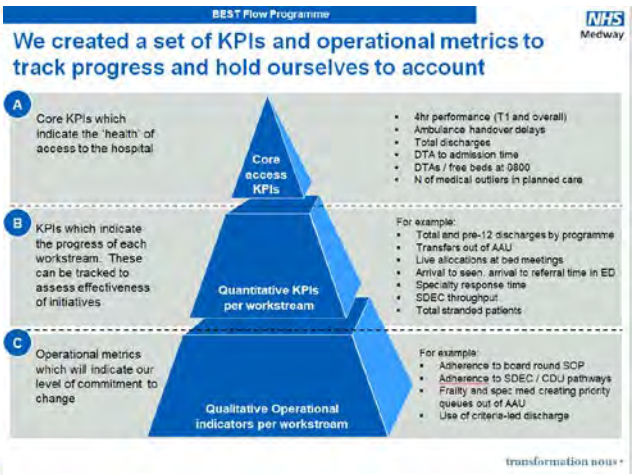
2.2.4 The programme, run jointly with system partners Medway CCG and Medway Community Healthcare, comprises 4 parts: 1) a 'one version of the truth' analytical suite; 2) changes to our medical model, ie. the configuration and location of both medical beds and staff; 3) improved operational discipline; and 4) engagement, leadership and capabilities.

2.2.5 During the operationally pressured winter months, the programme is currently focusing on three simple objectives day-to-day: increasing safe discharges every day to get patients home more quickly; transferring patients to the right beds first time and speeding up this process to reduce crowding and pressures in the Emergency Department; and ensuring Senior Operational Management can focus on this core business every day, freed up from other responsibilities. See below.

2.2.6 As part of a refresh of the programme's governance arrangements, we have clarified the core Key Performance Indicators (KPIs) we use to measure our success and monitor progress. Aligned to a working group structure, these KPIs are all displayed in Dashboard format and reviewed at each Programme Board. Also see below.

2.2.7 We continue to work with Medway Community Healthcare to develop system-wide plans for a Transfer of Care Collaborative; a development of our current Integrated Discharge Team.





2.3 BEST Access:

2.3.1 The overall aim of this programme is to build and sustain operational resilience to deliver safe services, improve quality and patient experience in Cancer Care, Outpatient Services, Diagnostics and Elective Surgery (Inpatient and True Day Case), ensuring economy and efficiency.

2.3.2 The programme is resourced by an internally established Delivery Unit. This is a co-sourced, high-performing internal consultancy, established to support the Trust's most pressing and complex problems.

2.3.3 The programme's key objective is to ensure compliance with all Cancer, RTT, DM01 Constitutional Standards, including the incoming 28 day FDS for Cancer. Other supporting objectives are as follows – the programme will:

- Improve Imaging and Pathology turnaround times across all modalities.
- Improve in-session Endoscopy productivity and address avoidable downtime.
- Seek to achieve the efficiency opportunity in our operating theatres derived from 1) increasing the average case per session, 2) reducing the DNA rates and on the day cancellations and 3) making use of currently fallow capacity in theatres.
- Review the scheduling of all Outpatient appointments, evaluating DNA rates and our Demand and Capacity and Patient Notification Systems. The joint working with the CCG on referral management is also governed by this Programme internally.
- Identify – within the Cancer Workstream – savings and additional income through a review of chemotherapy drug wastage, reduction in the number of fourth and fifth line regimens, through clinical review, Multi-Disciplinary Team (MDT) discussion tariffs and contract reviews.

2.3.4 As well as small improvements already to Theatres efficiency (utilisation / knife to skin time), Day Surgery rates and RTT performance, key achievements include:

- End-of-year financial and contractual settlement position clarified with commissioners
- Plan to reduce elective waiting lists agreed with Regulators
- Plan to reduce the universal wait-time for elective care to 26-weeks developed
- Deployment of Consultant Connect – a tool to allow GPs to seek timely advice from a Consultant in an attempt to reduce avoidable attendances and admission

2.3.5 There has also been extensive work to improve the effectiveness of internal meetings to review Patient Tracking Lists (PTLs) and ensure we do everything we can to avoid breaching our constitutional standards.

3 COST IMPROVEMENT PROGRAMME

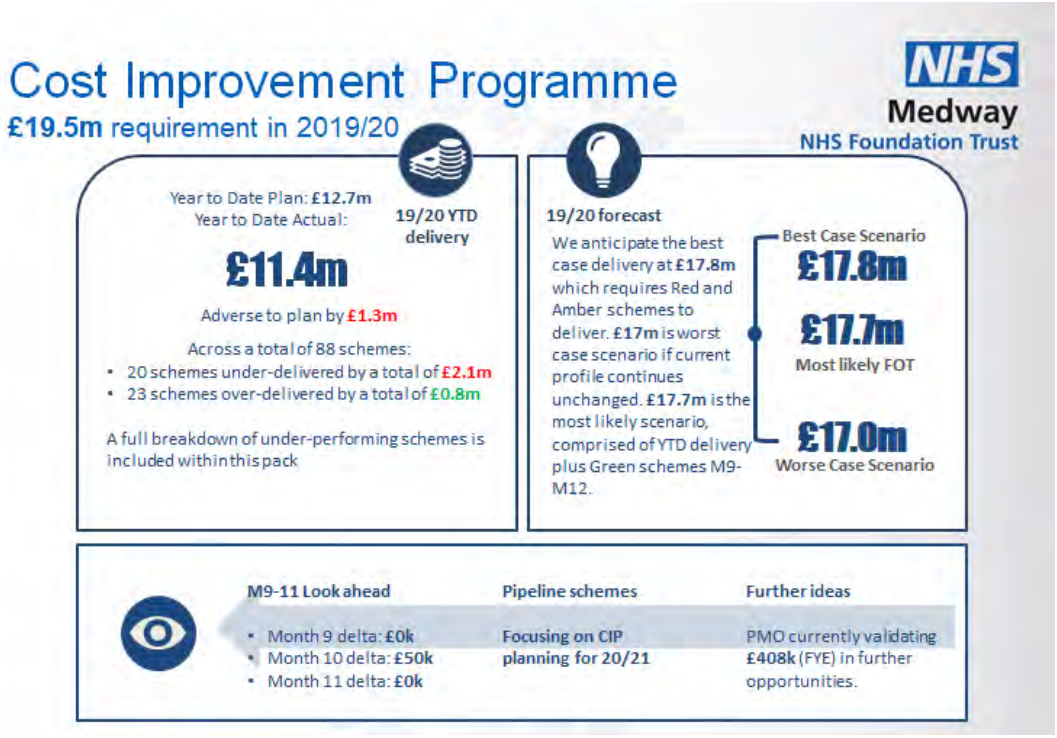
3.1 We continue to work towards our challenging £19.5million Cost Improvement Programme requirement. Our plan comprises around 80 schemes currently, all looking to make MFT more efficient by: improving expenditure control and budget management; reducing waste; optimising our processes and clinical pathways; improving the quality and efficacy of care provided; and reducing our dependency on temporary workers through the investment in recruiting substantive staff.

3.2 As at Month 8, £11.4million has been delivered in cost improvements. While this is an enormous achievement by Divisional staff, this is adverse to our operational plan of £12.7million, by £1.3million.

3.3 Two significant schemes have been the main drivers of under-performance: Theatres closure (£1.4million Full Year Effect) and Outpatients utilisation (£1.2million Full Year Effect). These schemes have now been removed from the plan and represent an 'unidentified' gap within the CIP programme.

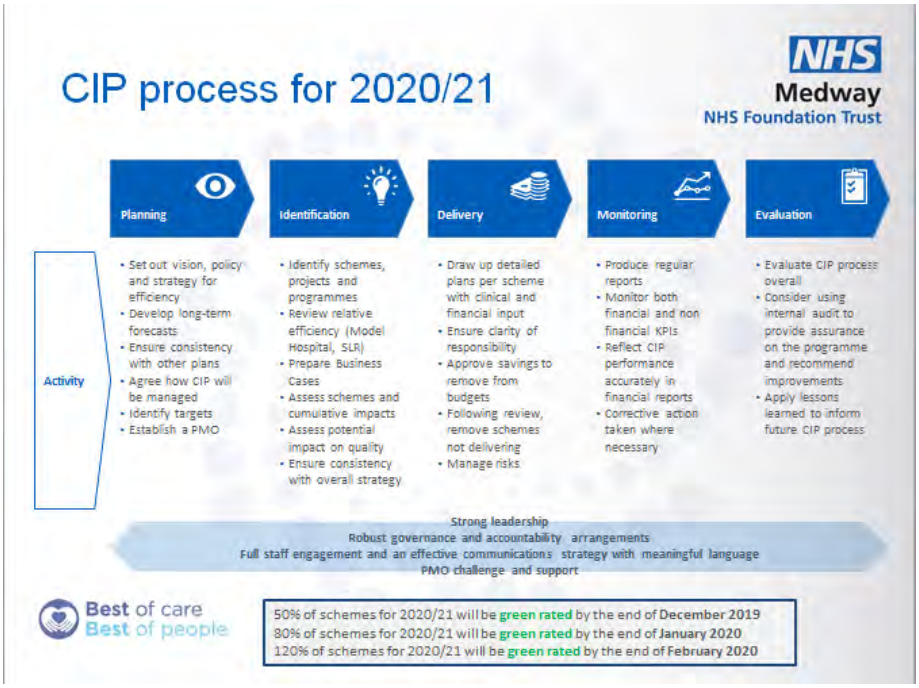
3.4 At Month 8, we anticipate the best case delivery at £17.0million which includes 'Red' and 'Amber' schemes and additional pipeline PYE impact. £16.6million is worst case scenario if current profile continues unchanged.

3.5 According to latest forecasts, we will not deliver against our full £19.5million requirement, falling short by £2.5million-£3million. We are therefore working closely with our finance team to consider potential use of our contingency fund to ensure we deliver our control total set for 2019/20.



3.6 The Programme Management Office continues to work with finance and operational teams to find additional schemes for the 2019/20 CIP programme. Over the coming weeks, we are further reviewing data from the Model Hospital to identify any additional CIP opportunities.

3.7 During the next period, in conjunction with business planning, we will begin planning for next year's Cost Improvement Programme. We are planning for a target of £12million-£14million (4.4 per cent of expenditure). The PMO offers support to colleagues with completing Quality Impact Assessments for the pipeline of new schemes. No schemes are added to the plan unless they have been subject to review and approval by the Medical Director and Director of Nursing.



4 DELIVERING THE QUALITY STRATEGY

4.1 The Quality Strategy highlighted that the first year, of the three year strategy the priorities will be:

- 4.1.1 Focus on making immediate quality improvements
- 4.1.2 Embedding continuous quality improvement into business as usual
- 4.1.3 Assessing our core services and Going for Good - aiming to be awarded a rating of "good" in our next Care Quality Commission (CQC) inspection

4.2 Therefore, quality improvement methodology is being embedded within the organisation through improvement huddles and improvement science training.

4.3 We have now trained more than 100 staff in Lean-based improvement science and have implemented huddle boards in over 30 clinical and non-clinical areas. More than 100 small improvement projects have been delivered by frontline staff, which aligns directly to the Trust's strategic objectives.

4.4 Throughout the pressured winter months, some training is paused to allow staff to prioritise operational care delivery. Coaching is still always available from the Transformation Team for staff undertaking 90-day projects.

5 INNOVATION INSTITUTE

5.1 As the Kent and Medway Medical School becomes an increasingly real prospect, the Trust will launch in Q4 of this financial year, an Institute for Innovation and Improvement [working title].

5.2 Led by three newly appointed Clinical Directors of Innovation and Improvement, this will create a 'one stop shop' for our clinicians looking to conduct research studies and improvement projects. It will combine the best of our currently disparate teams under one new sub-brand. It will serve to provide a single point of entry for the many external agencies that exist to help scale and spread innovation, for instance Academic Health Science Networks (AHSN) and the local Universities.

5.3 We are working collaboratively with the Medway Innovation Hub (Medway CCG) and the Kent, Surrey, Sussex AHSN to ensure this is an Institute that benefits the whole region and not just the acute trust.

5.4 The Trust will be working over the next quarter to develop the sub-brand and launch formally in the New Year. There will be co-design workshops throughout December and January to allow teams to contribute to what will be an exciting development for Medway.

6 A FORWARD LOOK

6.1 In the next period, we will:

- 6.1.1 Continue to focus intensively on delivering the objectives of Access and Flow
- 6.1.2 Progress the design phase of the Innovation Institute, supported by a small creative agency, Tillie Harris Associates.
- 6.1.3 Work alongside CCG partners to develop our Joint Programme Management Office, to support the development and submission of our 5-year efficiency and transformation plan to NHS England and NHS Improvement.

7 Conclusion and Next Steps

7.1 The transformation portfolio continues to gather pace across the Trust. There is an enormous amount of work happening within clinical and corporate teams to support the pace and scale of change required. The Board is asked to note the contents of this report.

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Communications and Engagement**	**Agenda Item**	**6.2**
Lead Director	Glynis Alexander, Director of Communications and Engagement		
Report Author	Glynis Alexander, Director of Communications and Engagement		
Executive Summary	This report details some of the communications and activity since the last Board meeting, including initiatives to ensure staff, patients and stakeholders are aware of and involved in our transformation programme.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	None		
Resource Implications	None		
Legal Implications/Regulatory Requirements	None		
Quality Impact Assessment	Not applicable		
Recommendation/ Actions required	The board is asked to note the report.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	None		

1 EXECUTIVE OVERVIEW

1.1 This report details some of the communications and engagement activity since the last Board meeting, including initiatives to ensure staff, patients and stakeholders are aware of and involved in our transformation programme.

1.2 It also includes feedback from recent engagement with our community.

2 ENGAGING COLLEAGUES;

2.1 We have continued to engage staff in transformation projects to improve care for patients under the slogan Making Medway Brilliant. This includes reducing the length of stay for patients, improving flow, and delivering improved access to outpatient services.

2.2 A programme of communications was put in place to support staff as they prepared for the Care Quality Commission inspection in December. A showcase document was shared as a reminder of all the achievements over the past year that staff can feel very proud of, and two videos highlighted improvements – one featuring patients describing their care, and the other interviewing staff about projects they are involved in.

2.3 There were also posters, screensavers and regular messages to ensure staff were aware of what to expect during the visit.

2.4 In contrast to previous years, weekly messages embedding aspects of quality had been in place for many months, so there was more of a focus on high quality care being 'business as usual' rather than actions to prepare for an inspection.

2.5 Staff focus groups held by the CQC were promoted, with attendees encouraged to talk about the progress services have made as well as the challenges being overcome.

2.6 Handbooks were prepared for staff, for Board members and for the inspectors giving practical guidance.

2.7 Communications also supported the NHS staff survey, ensuring that staff were aware of the importance of providing feedback on their experiences at the Trust. The response rate of 43 per cent was an improvement on the previous year.

2.8 A new communications initiative was developed to ensure that staff are aware of the Full Capacity Protocol/OPEL status at all times, helping the organisation to anticipate and react to surges in patient demand.

2.9 The Communications Team has continued to develop its video production capability with the production a recruitment video for the Head of Access role which has led to a number of applications.

2.10 The Trust's Christmas Decoration Challenge and Christmas Fair helped generate a festive atmosphere for staff (and patients of course). The fair raised more than £1,500 for the hospital charity.

2.11 Communications supported the successful pilot launch of EDRMS in the Sleep Clinic. The system, named Cito, allows staff to access more information electronically, including the digitisation of patient records.

3 MEDIA

3.1 During November and December the Communications Team dealt with more than 15 interactions with local, regional and national media. These include reactive responses to media queries and proactive approaches by the team to promote good news stories.

3.2 Positive news included excellent coverage both in the printed media and on television (ITV Meridian) of the Trust's new diabetes clinic. There was also coverage of an award received for the Best Flow initiative.

3.3 The team facilitated filming for a positive piece on the Urgent Treatment Centre which was shown on the regional news in Jersey, a documentary piece on overseas nurses for Sky News and filming for the Trust's Little Journey project.

3.4 On a less positive note, local media covered the inquest into the death of a patient at the hospital, mixed sex ward breaches, waiting times in the Emergency Department and delayed transfers of care.

3.5 Press releases were issued about the royal visit, members' events, Each Baby Counts and the charity Christmas fair.

4 SOCIAL MEDIA

4.1 We have made further progress with our social media accounts since the last update, and remain as Kent's most-followed acute Trust on both Twitter and Instagram.

4.2 Our social media channels were used to share news updates and key messages on a range of topics, including the launch of the 'DIAL-M' programme (Diabetes and Lifestyle Management Medway) – specialist diabetes clinics helping patients prepare for surgery and adopt a healthier lifestyle; alternative treatment options for those considering visiting our Emergency Department during periods of increased pressure; the national 'Patient Flow Programme of the Year Award' presented to staff at a ceremony showcasing excellence in healthcare; and regular events hosted by our Charity and Fundraising Team such as the Christmas Fair.

4.3 Regular videos produced in-house by the Communications Team were seen by almost 10,000 social media users, covering staff awareness-raising activities for International Stop Pressure Ulcer Day and World Osteoporosis Day, along with the work of the Medway Hospital Charity.

4.4 Our messages on social media again received a significant number of views since the last update – approximately 130,600 on Facebook and 161,300 on Twitter. This compared to 475,000 on Facebook and 244,800 on Twitter last time. (Reduced numbers are due to a shorter reporting period).

4.5 Medway's social media account followers now total 5,478 on Twitter (up from 5,320 at the last update), 7,467 on Facebook (up from 7,277) and 1,866 on Instagram (up from 1,768).

5 COMMUNITY ENGAGEMENT

5.1 Governors

5.1.1 Governors met constituents at various community locations over the last quarter, when patients raised queries about their experiences at the hospital.

5.1.2 Examples included a long wait in the Emergency Department and frustrations over parking.

5.1.3 Our Community Engagement Officer and Governors attended Gillingham's Ahmaddiya Mosque open day where they were able to network with members of the Muslim community. Governors said they found this an interesting and informative evening and hope to attend future events.

5.2 Community engagement and Patient Engagement

5.2.1 We are increasingly being approached by schools to get involved with their career aspiration programmes. One recent request came from Chattenden Primary School in the Hoo area. The Trust's Community Engagement Officer attended the school's careers afternoon and answered questions about opportunities at the hospital.

5.2.2 We were delighted to be invited to Medway African and Caribbean Association (MACA) Windrush exhibition launch. This was a very informative event where we able to see the contribution the community made, particularly to the NHS. This networking opportunity has helped enhance links with MACA, with members expressing increased interest in being involved in the Trust.

5.2.3 We continue to attend Kent police's Gypsy Traveller Action Group. The issue of immunisation take-up for children within Gypsy Traveller communities has been raised and is the subject of ongoing discussions.

5.2.4 We are in the process of arranging cultural awareness training for our staff to work with the Gypsy Traveller community when admitted into hospital.

5.2.5 At the Medway Dementia Action Alliance meeting improvements made to provide good care for dementia patients were highlighted, including the creation of the Butterfly Garden and proposals for a café on Sapphire ward, as well as the wider vision for the frailty service.

5.3 Member engagement

5.3.1 Our November members' event dedicated to the role of the pharmacy and medicines department was well attended and feedback was excellent.

5.3.2 Through the interactive stands members learnt about medications, the operation of the pharmacy department and what goes on behind the scenes to ensure patients receive the medicines they need.

5.3.3 The next member event will focus on Qualities Priorities and will be held on Wednesday 5 February 2019, 6pm to 8pm, Postgraduate Medical Centre, Medway Maritime Hospital.

5.3.4 Members will be invited to discuss their priorities for patient care and what safe, effective and person centred care means them.

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Finance Report November 2019**	**Agenda Item**	**7.1**
Lead Director	Ian O'Connor, Executive Director of Finance		
Report Author	Paul Kimber, Deputy Director of Finance		
Executive Summary	This paper reports the November 2019 financial position for the Trust and delivery against financial targets.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Finance Committee, 19 December 2019		
Resource Implications	Not applicable		
Legal Implications/Regulatory Requirements	Month 8 year to date favourable to NHSI control total by £55,000.		
Quality Impact Assessment	Confirm and challenge sessions and additional cost improvement opportunities continue to be developed and managed through established Quality Impact Assessment Framework.		
Recommendation/ Actions required	The Board is asked to note the financial performance to 30 November 2019, being £55,000 favourable against the financial plan.		
	Approval ☐	**Assurance** ☐	**Discussion** ☐	**Noting** ☒
Appendices	Appendix 1: Finance dashboard		

1 Executive Overview

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

1.2 The finance dashboard report setting out key performance indicators is attached at Appendix 1. It reports a series of individual metrics designed to show progress over time, assessing the risks associated with operational performance and impact on the Trust's financial performance and position.

2 Income and expenditure

2.1 To the end of November 2019 the Trust is reporting a year to date deficit of £34.4million, excluding Provider Sustainability Funds (PSF), Marginal Rate Emergency Tariff (MRET) and Financial Recovery Funds (FRF). This is favourable to the plan submitted to NHSI by £55,000 as shown in the table below.

2.2 November's in month performance is a deficit of £3.5million excluding PSF, MRET and FRF, being £42,000 favourable to plan. This performance arises as a result of the year end contract value agreed with the Trust's main commissioners and through use of contingency.

2.3 The Trust continues to forecast a year end deficit of £22.2million including PSF, MRET and FRF.

2.4 PSF, MRET and FRF income to 30 November 2019 is £17.9million and is on plan; a further £0.6million of PSF has been received and relates to additional income received for achieving the 2018/19 control total. This additional sum is cash-backed but will not provide a benefit in measuring financial performance against 2019/20 control totals, hence is removed in the table below.

	Month 8			Year to Date		
	Plan £'000	**Actual £'000**	**Variance £'000**	**Plan £'000**	**Actual £'000**	**Variance £'000**
Clinical Income	22,089	21,857	(232)	175,135	174,318	(817)
Other Income	1,998	1,947	(51)	15,737	16,198	461
Pay	(16,608)	(17,597)	(989)	(137,320)	(139,387)	(2,067)
Non pay	(9,742)	(8,585)	1,157	(77,699)	(76,166)	1,533
EBITDA	**(2,263)**	**(2,378)**	**(115)**	**(24,147)**	**(25,036)**	**(889)**
Non Operating Expenses	(1,322)	(1,166)	156	(10,350)	(9,406)	944
Surplus/(Deficit) before PSF/MRET/FRF	**(3,585)**	**(3,543)**	**42**	**(34,497)**	**(34,442)**	**55**
PSF/MRET/FRP	2,910	2,910	0	17,922	17,922	0
Surplus/(Deficit)	**(675)**	**(633)**	**42**	**(16,575)**	**(16,520)**	**55**
18/19 Additional PSF	0	0	0	0	580	580
Surplus/(Deficit) Per ledger	**(675)**	**(633)**	**42**	**(16,575)**	**(15,940)**	**635**

3 Cost Improvement Programme

3.1 The cost improvement programme has delivered financial benefit of £11.4million in the year to date, being adverse to the targeted value of £12.7million. This is in large due to delays and slippage against the theatres and outpatients transformation together with the workforce redesign.

3.2 The PMO has implemented a series of check and challenge sessions, led by the Chief Operating Officer, to maximise delivery of existing schemes and/or identify mitigating schemes and actions where applicable.

4 Capital

4.1 Capital expenditure year to date is £12.5million, which is ahead of plan. As detailed schemes are finalised it is likely that the plan will need to be re-profiled at scheme level but will remain within the overall annual plan of £23.7million as agreed and submitted to NHS Improvement.

	Current Month			Year To Date		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000
Backlog Maintenance	350	208	142	3,400	2,243	1,157
Routine Maintenance	0	(25)	25	0	11	(11)
Plant/Equip/Trans/Fits/Other	180	(147)	327	1,480	416	1,064
Fire Safety	1,400	1,952	(552)	3,148	4,456	(1,308)
IT	200	(86)	286	1,400	2,101	(701)
ED	500	955	(455)	1,000	3,304	(2,304)
Capital Programme Totals	**2,630**	**2,857**	**(227)**	**10,428**	**12,531**	**(2,103)**

5 Working capital

5.1 The Trust relies on deficit cash loans each month. The cash held is managed by ensuring these funds are drawn in line with the planned deficit and that loans are not requested (hence incurring interest charges) ahead of when the cash is needed. This follows a standard monthly cycle and is actively managed by the financial control team. The strategy of obtaining earlier payment of contracted values from the Clinical Commissioning Group (CCG) is yielding benefit.

6 Conclusion and Next Steps

6.1 The Board is asked to note the financial performance to 30 November 2019, being £55,000 favourable against the financial plan.

Appendix 1 – Finance dashboard

I&E Deficit EXCLUDING PSF YTD (£m)

	Aug	Sep	Oct	Nov	RATING
Plan	(3.7)	(1.6)	(0.8)	(0.7)	
Actual	(3.8)	(2.1)	(0.8)	(0.6)	
Variance	(0.1)	(0.5)	0.0	0.1	

The Trust delivered a positive variance for Month 8 of £0.1 million on a planned deficit of £0.7 million. This position includes £2.9 million of additional income from the adjustment to the block contract. This month, to offset some of the adverse variances within the divisions, it has been necessary to use £0.5 million of the contingency reserve; the year to date provision for optimism bias is £1.9 million.

Capital Expenditure YTD (£m)

	Aug	Sep	Oct	Nov	RATING
Plan	(4.1)	(4.8)	(7.8)	(10.4)	
Actual	(5.2)	(8.3)	(9.7)	(12.5)	
Variance	(1.1)	(3.5)	(1.9)	(2.0)	

19/20 Capital Expenditure is still overall ahead of plan. There is no indication of overspending as some works have simply commenced earlier than originally expected.

CIP Delivery YTD (£m)

	Aug	Sep	Oct	Nov	RATING
Plan	1.6	1.8	2.3	2.3	
Actual	1.4	1.3	1.7	2.3	
Variance	(0.2)	(0.5)	(0.6)	(0.0)	

CIP Delivery is on plan at £2.3 million, this is an increase from last month of £0.6 million mainly due to income of £0.8 million for the Urology Robot covering the period of April to November; adjusting for this the normalised in month CIP delivery is £1.6 million. The CIP plan includes the impact of the unidentified balances that were phased into the final 6 months of the year.

Cash Actual £m

	Aug	Sep	Oct	Nov	RATING
Plan	5.0	5.0	5.0	5.0	
Actual	24.6	20.6	34.9	32.0	
Variance	19.6	15.6	29.9	27.0	

The Trust cash balance at month 8 is £32m; this is ahead of plan due to a revised payment profile agreed with the main commissioners. The revised profile involves prepayment of an additional months contract payment in May and October, then nothing in February and March. This will reducing borrowing costs for the Trust.

Normalised Monthly Pay

	Aug	Sep	Oct	Nov	RATING
Plan	(17.1)	(17.1)	(16.7)	(16.6)	
Actual	(17.4)	(17.6)	(17.8)	(17.6)	
Variance	(0.3)	(0.5)	(1.1)	(1.0)	

Normalised pay expenditure in month is £17.6 million and is £1.0 million adverse to plan. The £0.2 million decrease in cost since prior month is mainly due to a reduction of bank staff expenditure in the Unplanned Care Division, these temporary staff were required to cover 1:1 nursing and sick leave. Included within the adverse position are the CIP schemes relating to pay reductions that have not been achieved.

Normalised Monthly Agency Expenditure (£m)

	Aug	Sep	Oct	Nov	RATING
Plan	(0.6)	(0.6)	(0.5)	(0.6)	
Actual	(0.4)	(0.5)	(0.6)	(0.7)	
Variance	0.2	0.1	(0.1)	(0.1)	

Agency Spend is £0.6 million and adverse to plan by £0.1m. This is mainly due to specialising costs within the inpatient services.

Better Payment Practice Code (BPPC by Volume (%)

	Aug	Sep	Oct	Nov	RATING
Plan	95.0	95.0	95.0	95.0	
Actual	46.1	47.6	48.9	50.6	
Variance	(48.9)	(47.5)	(46.1)	(44.5)	

BPPC is gradually improving after a brief period of deterioration associated with the implementation of the new system. Finance are currently working with operational departments to resolve invoicing delays in certain areas with a view to improving the BPPC result, but there could be a number of reasons both inside and outside of our control why we do not meet it the target in the next financial year.

All Aged Creditors 60+ Days (£m)

	Aug	Sep	Oct	Nov	RATING
Actual	4.7	5.8	5.5	6.1	

Over 60 day aged Creditors has increased slightly due to:
- £3.7m of outstanding queries with 5 NHS and NON-NHS Providers. Finance are actively working with operational teams to resolve and clear these balances.
- £2.4m / 1,800 invoices without a valid or correct purchase order matching what has been billed. Due to the volume and the need to work with operational teams clearance of which can be a slow, lengthy process.

All Aged Debtors 60+ Days (£m)

	Aug	Sep	Oct	Nov	RATING
Actual	13.8	14.3	12.3	12.9	

Over 60 day debtors has increased slightly due to the build up of 19/20 HCD invoices; Optum has now verified these and we expect payment from our main CCGs in due course.
Finance continues to work with debtors to resolve queries to clear these long standing debts.

Key:

	Adverse to Plan
	Favourable to Plan

Going in the right direction

Going in the wrong direction

s,

I&E	Income and Expenditure
EBITDA	Earnings Before Interest, Tax, Depreciation and Amortisation
CIP	Quality Cost Improvement Programme
YTD	Year-to-Date

Meeting of the Board of Directors in Public

Wednesday, 08 January 2020

Assurance Report from Committees

Title of Committee:	**Finance Committee**	**Agenda Item**	**7.2**
Committee Chair:	Joanne Palmer		
Date of Meeting:	Thursday, 28 November 2019		
Lead Director:	Ian O'Connor, Director of Finance		
Report Author:	Ian O'Connor, Director of Finance		

The key headlines and levels of assurance are set out below, and are graded as follows:

Assurance Level	Colour to use in 'assurance level' column below
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

Key headlines and assurance level	
Key headline	**Assurance Level**
1. Finance Month 7 Report The Committee discussed the Month 7 figures for the Trust and for both Unplanned and Integrated Care and Planned Care. There is some work to be done within the Unplanned and Planned Care Divisions to reduce Pay Costs.	**Green**
2. Finance Risk Register The Committee reviewed the Finance Risk Register and noted the risks and mitigations, together with current scores within the papers.	**Amber**
3. Cost Improvement Programme (CIP) The Committee received a report on the month 7 CIP position. Half way through the year and PMO remains concerned at the continued adverse variance to plan. As at Month 7, the CIP has delivered £9.1million, adverse to plan by £1.3million. 18 schemes under delivered by a total of £2.0million. In contrast 25 schemes over-delivered this month, resulting	**Amber**

in the £0.7million delta. Delivery to date (£9.1million) and add that to the green rated schemes we are forecasting to deliver from November onwards (£16.1million) this warns of a potential under achievement against the plan of £1.9million. Almost 80 percent of this continues to be attributable to just two schemes (theatres and outpatients). PMO continues to actively monitor and support this work as well as working with scheme owners of other materially off plan schemes. The team will continue to report externally against the plan submitted in April 2019.	
4. Capital Plan 2019/20 The Committee was given an update on the Capital programme for 2019/20. This included the following; Current status of Capital, Progress against key projects and Next Steps The Committee noted the progress and additional capital funds which have been made available. The original total capital allocation submitted plan for 2019/20 is £23.7million, and a further £4.1million has been made available directly from DoH for diagnostic and medical equipment. A further bid for Estates backlog of £2.5million is being sought, which potentially results in a total capital plan value of circa £30.3million for 2019/20. In parallel, Trust Board has approved proceeding with a bid for an additional £7.44m for fire, spread across 20/21 and 21/22. Risks: whilst capital projects are over performing against planned capital spend (£9.7million to month 7), a further £21million worth of capital spend will be required in the final 5 months, to achieve the circa £30.3million target, if all bids are received. Trust capital teams are now under significant pressure to deliver within the remainder of the year. External resources are being utilised to assist.	**Green**
5. Model Hospital The Committee asked that this becomes a standing item at monthly meetings.	**Green**
5. Project Updates <u>EDRMS</u> The Committee was given an update on the software application, system and development of the Medial Records Business Case. The system has gone live and the test run will be with 65 patients per week, this will help the team to understand how it will work at scale. The Committee asked that more work is done on this project including some consideration on legal documentation and that a report comes back in January 2020. <u>Outpatients Redesign – Deep Dive Report</u> The Committee was submitted an extensive report and decided to give the project/paper more time at the next Committee meeting in December 2019.	**Green**
Further Risks Identified All risks are captured within the risk register and the BAF.	
Escalations to the Board or other Committee None	

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Workforce Report**	**Agenda Item**	**8.1**
Lead Director	Leon Hinton, Executive Director of HR and OD		
Report Author	Elizabeth Nyawade, Deputy Director of HR and OD		
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The Trust's recruitment campaigns, including national, local and international have delivered 640 candidates to date; 211 of these candidates have commenced in post over the last 12 months. Trust turnover has decreased to 12.10 percent (-0.11 percent) from 12.21 percent, sickness absence at 4.15 percent (-0.08) compared to the month of September is above the Trust's tolerance level of 4 percent, and appraisal compliance has decreased to 88.13 percent (-0.09 percent from 88.22 percent) and is above Trust target of 85 percent. Statutory and Mandatory training is at 92.12 percent (+1.59 percent from 90.53 percent) and is meeting the Trust target of 85 percent. The percentage of pay bill spent on substantive staff in October at (83 percent) decreased (-2 percent) compared to the month of September. The percentage of agency usage at 4 percent increased (+1 percent from 3 percent) compared to the month of September. The percentage of pay bill spent on bank staff at 13 percent (+1 percent from 12 percent) has increased compared to September.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Executive Group Human Resources and Organisational Development Senior Team.		

Resource Implications	Not applicable
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. • 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. Update on medical and dental; allied health professional; and, scientific, technical and therapeutic professional recruitment. 3. Ensuring a robust temporary staffing service 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway 5. Agency/Temporary Staffing Work stream as part of the 2019/20 cost improvement programme
Quality Impact Assessment	Not applicable
Recommendation/ Actions required	The Board is asked to note the content of this report.

Approval	**Assurance**	**Discussion**	**Noting**
☐	☒	☐	☒

Appendices	None

1 Introduction

1.1 This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance those robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The report to Board is aligned to the objectives and deliveries associated with the Trust's People Strategy.

Best of People

We aim to transform ourselves through innovative staff-led improvements that meet the needs of our patients now and in the future

2 Recruitment

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During October 2019, 29 FTE registered nurses and midwives joined the Trust (net increase +18 FTE) on a substantive basis, alongside 5 FTE substantive clinical support workers/maternity care assistants (net increase +4 FTE, table 2).

2.2 In October 2019, 18 international nurses arrived in the Trust. To date a total of 167 international nurses have taken the Objective Structured Clinical Examination (OSCE) exam. The Trust has a first attempt pass rate of 82 percent and an overall success rate of 99 percent.

2.3 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Nine Cpl international nurses have commenced in post. 53 HCL nurses have also commenced in post. 5 candidates remain in the pipeline with offers being processed.

2.4 The Trust is also working with eight additional permanent nursing recruitment agency providers: We Solutions, Ascend, Cromwell Medical Recruitment, Medline, Kate Cowhig, HealthPerm, Santuary Healthcare and Xander Hendrix. The agency partners are working with the Trust on developing a pipeline of nurses for the financial years 2019/20 and 2020/21.

2.5 To support the Trust in achieving its recruitment targets, new international campaigns are being launched with a select number of agencies: Medline, We Solutions, Ascend, Kate Cowhig, Sanctuary Personnel, MSI and Cromwell Medical Recruitment.

Table 1 below summarises the Trust's nursing recruitment pipeline as at end of October 2019:

Commenced	Pipeline	Agency total	Anticipated new starters over the next 12-months from pipeline
211	161	640	156

(Table 1: Nurse recruitment pipeline as of October 2019)

Table 2 below summarises offers made, starters and leavers for the month of October 2019:

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses and midwives	44 (33 NHS Jobs/open days & 11 international nurses via skype)	27	9
Clinical support workers/Maternity Care Assistants	26 (Clinical Support Workers)	5	1

(Table 2: Nursing starters and leavers October 2019)

2.6 During October a total of 49 medical staff, including 36 junior doctors in training and two MTIs, joined the Trust. Focussed discussions on recruitment of medical staff takes place regularly within divisions during the vacancy control panel (VCP) meetings that are chaired by the divisional directors. Out of the 33 medical staff leavers in October, 27 were junior doctors in training taking up placement posts in other NHS Trusts. At present consultant recruitment is taking place for the following specialities Acute Medicine, Cardiology, Gastroenterology, Geriatrics, Otolaryngology, Paediatrics and Haematology. As at end of October 2019 the Trust had 36.75 FTE vacant consultant posts and 54.04 FTE vacant non-consultant posts.

Table 3 below summarises offers made, starters and leavers for the month of October 2019:

Role	Offers made in month	Actual starters	Actual leavers
Consultants	2	0	2
Junior doctors (including doctors in training)	19	49	31

(Table 3: Medical staff starters and leavers October 2019)

2.7 During October three Allied Healthcare Professionals (AHP) (Physiotherapists, Occupational Therapists, Radiographers and Dieticians) joined the Trust. Prior to filling vacancies with like for like replacement, discussions take place regarding use of alternative roles including apprentices and new roles including assistant physiotherapy/occupational therapy especially when filling difficult to recruit to posts.

Table 4 below summarises offers made, starters and leavers for the month of October 2019

Role	Offers made in month	Actual starters	Actual leavers
Physiotherapists	0	0	2
Therapy Assistant Practitioner	1	0	0
Occupational Therapists	0	0	0
Dieticians	0	0	0
Radiographers	0	2	0
Sonographer	0	1	0

(Table 4: AHP starters and leavers October 2019)

2.8 During October three Scientific, Technical and Therapeutic (ST and T) staff (including, but not limited to, Pharmacy staff, Operating Department Practitioners) joined the Trust. Prior to filling vacancies with like for like replacement, discussions take place regarding use of alternative roles including apprentices and new roles including assistant practitioners especially when filling difficult to recruit to posts. Pharmacy department is currently in discussions with local community providers to develop joint rotational posts that will help fill some of the vacancies and providing learning in the different settings.

Table 5 below summarises offers made, starters and leavers for the month of October 2019:

Role	Offers made in month	Actual starters	Actual leavers
Pharmacy Technicians	0	0	0
Pharmacy Assistant	4	1	0
Pharmacists	5	1	0
Operating Theatre Practitioners / Theatre Nurses	0	0	2
Assistant Practitioner (Theatres)	0	1	0

(Table 5: ST&T starters and leavers October 2019)

3 Trust and Divisional Metrics

3.1 The table below (table 6) shows performance across five core indicators by the divisions. Turnover, at 12.10 percent (-0.11 percent from 12.21 percent), remains above the tolerance level of 8 percent. HR Business Partners 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 implementing service specific retention plans. Sickness absence at 4.15 percent (-0.08 from 4.23 percent) is above the tolerance level of 4 percent. Employee Relations are proactively carrying out analysis to support managers to manage sickness and reviewing trends for interventional support.

3.2 The Trust appraisal rate stands at 88.13 percent (-0.09 percent from 88.22 percent) and is above the Trust target of 85 percent, all divisions are meeting the appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings have been included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics.

3.3 Statutory and Mandatory training stands at 92.12 percent (+1.59 percent from 90.53 percent) and is meeting the Trust target of 85 percent. All divisions across the Trust are meeting the Statutory and Mandatory training target. Approximately 15,000 learning interventions need to occur during 2019/20 for the Trust to be compliant. These interventions occur across e-learning, classroom-based learning and also blended learning opportunities. SMEs provide sufficient capacity to provide face-to-face opportunities to meet the demand.

		MFT			Corporate			Estates & Facilities			Planned Care			Unplanned & Integrated Care		
	Trust Target	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend
Turnover rate (Voluntary, 12-month rolling)	8.0%	12.1%	▼		13.3%	▼		6.8%	▲		11.9%	▼		13.5%	▲	
Vacancy rate	12.0%	12.5%	▼		7.7%	▼		11.9%	▼		12.4%	▲		14.2%	▼	
Sickness rate (12-month rolling)	4.0%	4.1%	▼		2.5%	▲		6.1%	▼		4.4%	▼		3.8%	▼	
Statutory & Mandatory Training	85.0%	92.1%	▲		97.0%	▲		91.5%	▲		92.2%	▲		91.2%	▲	
Medway Appraisal	85.0%	88.1%	▼		89.5%	▲		87.6%	▼		89.4%	▼		86.3%	▲	
Agency costs (as % of total paybill)	11.0%	3.2%	▲		2.5%	▲		0.6%	▲		1.5%	▼		5.4%	▲	
Bank costs (as % of total paybill)		13.5%	▲		3.1%	▲		13.3%	▲		11.8%	▼		17.7%	▲	
Substantive costs (as % of total paybill)	89.0%	83.3%	▼		94.4%	▼		86.1%	▼		86.6%	▲		76.9%	▼	
Stability Index (12-month rolling, >12M)	85.0%	83.3%	▲													
Leavers citing "Work/Life Balance" 12m rolling	n/a	80.4	▼													

(Table 6: Key Workforce Metrics)

3.4 The table below (table 7) shows the compliance with StatMan on a divisional and care group basis:

Division >> Care Group	Compliance %
Corporate	**96.24%**
Communications Directorate	100.00%
Finance	97.88%
Human Resources & Organisational Development	97.14%
IT	98.11%
Medical Directorate	92.58%
Nursing	93.65%
Strategy, Governance and Performance	98.66%
Transformation	95.56%
Trust Executive & Board	93.33%
Facilities and Estates	**91.92%**
Facilities and Estates Management	100.00%
Hard FM	96.26%
Soft FM	91.13%
Planned Care	**90.91%**
Cancer Services	93.91%
Peri-operative & Critical Care	92.42%
Planned Care Infrastructure	89.25%
Surgical Services	86.89%
Women's & Children's Health	91.73%
Unplanned and Integrated Care	**89.62%**
Diagnostics & Clinical Support Services	92.55%
Specialist Medicine	87.61%
Therapies & Older Persons	92.10%
Unplanned & Integrated Care Management	88.95%

(Table 7: StatMan compliance profile)

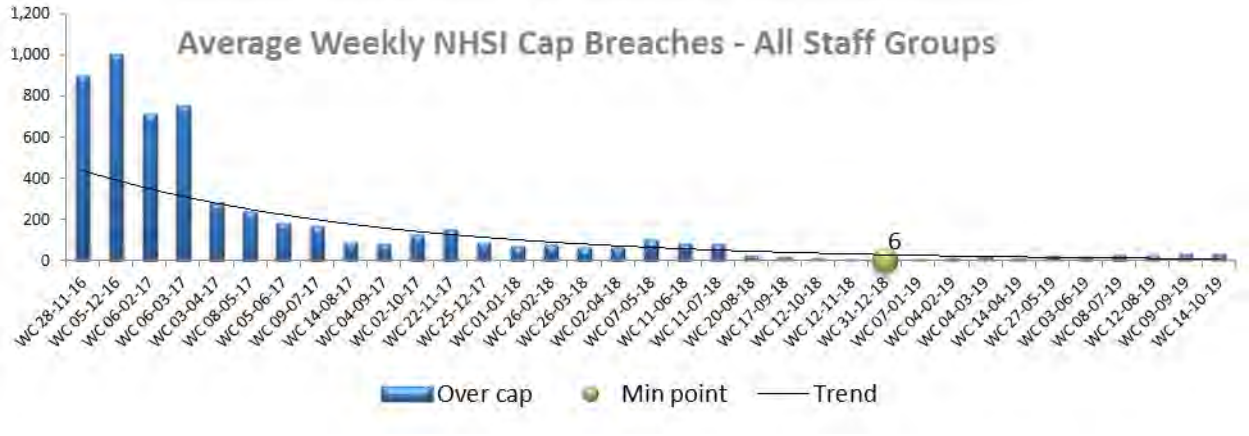
4 Temporary Staffing

4.1 Table 8 below demonstrates that temporary staffing expenditure increased in October 2019 compared to September 2019.

		Mar 17	Mar 18	Mar 19	Apr 19	Jun 19	Jul 19	Aug 19	Sept 19	Oct 19
Spend	Agency	£3,890,198	£2,597,697	£783,127	£684,291	£527,624	£648,395	£373,481	£506,702	£634,482
	Bank	£920,473	£2,329,768	£2,105,055	£2,267,819	£1,865,800	£2,011,274	£2,507,089	£2,160,649	£2,371,903
	Substantive	£13,611,458	£13,542,990	£16,377,676	£14,152,087	£19,446,639	£14,520,349	£14,561,728	£14,934,938	£14,756,923
% of pay bill	Agency	21%	14%	4%	4%	3%	4%	2%	3%	4%
	Bank	5%	12%	11%	13%	11%	12%	14%	12%	13%
	Substantive	74%	74%	85%	84%	86%	84%	84%	85%	83%

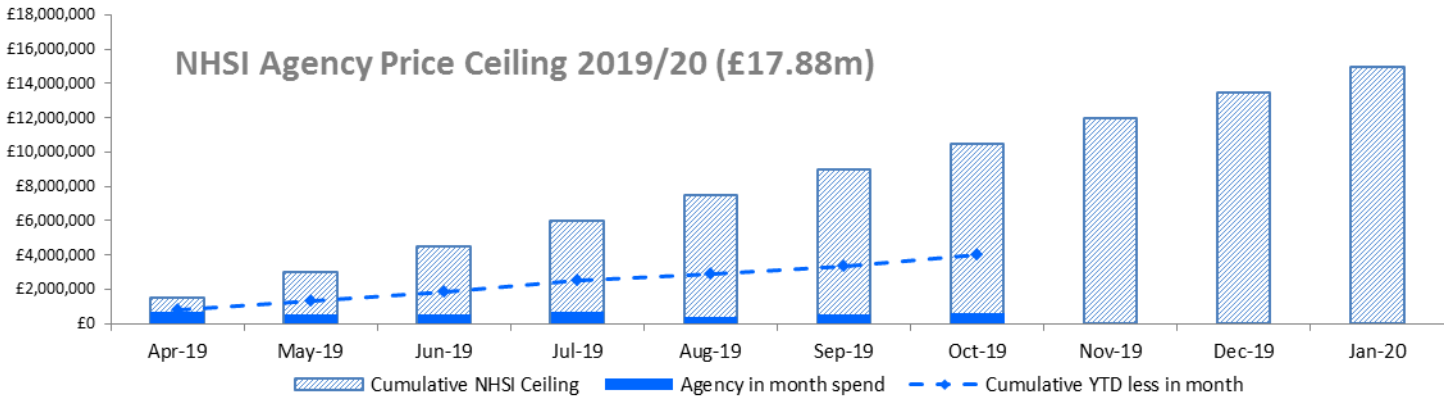
(Table 8: Contractual profile)

4.2 The agency cap breaches across all staff groups have remained stable as illustrated in chart 1 below. During the month of October 2019 the Trust reported an average of 32 breaches per week across the month.



(Chart 1: NHSI cap breaches)

4.3 The Trust's NHSI annual agency spend celling remains the same for 2019/20 at £17.88million. Based on month 7 agency spend, the Trust is £5.8million below the NHSI agency ceiling cap target as illustrated in the chart and table below.



(Chart 2: NHSI agency ceiling)

4.4 Table 9 below shows NHSI agency ceiling performance:

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sept-19	Oct- 19
Cumulative NHSI ceiling target	£1,490,000	£2,980,000	£4,470,000	£5,960,000	£7,450,000	£8,940,000	£10,430,000
Agency in month actual spend	£684,291	£497,825	£527,624	£648,359	£373,481	£506,702	£634,482
Cumulative below ceiling	£805,709	£1,182,116	£2,638,842	£3,601,865	£4,596,966	£5,073,562	£5,801,300

5 (Table 9: NHSI agency ceiling performance)

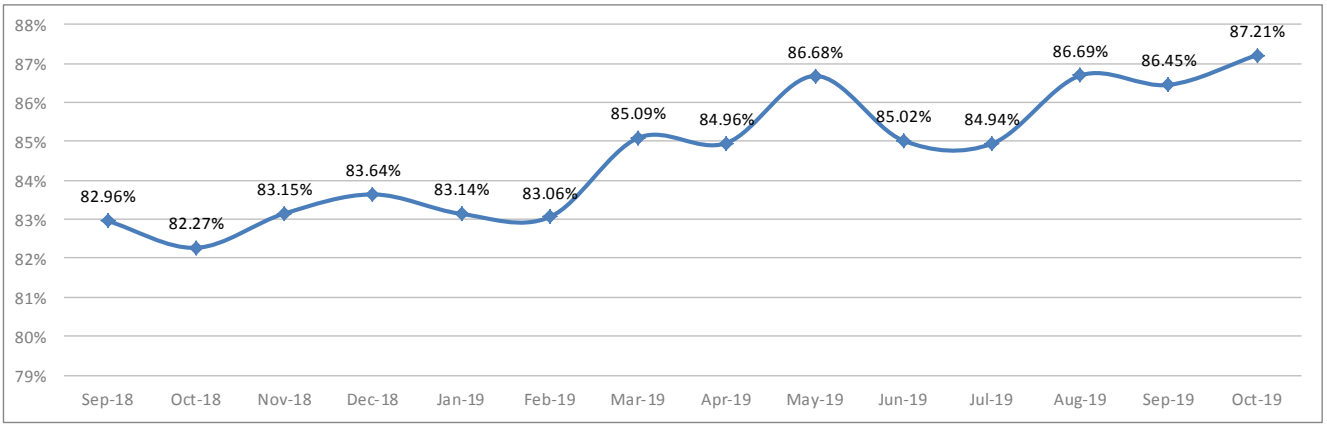
5.1 Temporary nursing demand increased in October 2019 compared to September 2019 (8,919 shift requests in October 2019 compared to 8,537 shift requests in September 2019). The fill rate remained 72 percent. Medical locum demand decreased in October 2019 compared September 2019 (1,043 shift requests in October 2019 compared to 1,278 shift requests in September 2019). The fill rate for medical locum remains stable at 85 percent.

6 NHSI Nursing Retention

6.1 The following retention initiatives have been implemented this financial year for nursing staff; it is acknowledged that some of these retention initiatives will also be beneficial to other staff groups within the organisation. The Trust submitted the below listed retention initiatives to NHSI/E in October 2019.

1. Practice Development Nurse Support on all ward areas;
2. Staff Support, Recognition and Health and Wellbeing support;
3. Flexible Retirement Options for nursing staff.

6.2 Table 10 below shows nursing and midwifery stability index rate over the last 12 months. Overall, there is a significant and largely sustained and positive direction of registered nursing workforce stability. This will continue to be monitored and reported as part of the programme.



(Table 10: Nursing stability index)

Best Culture

We aim to have a culture of openness and transparency, values that staff live by, and quality-led actions across our entire workforce

7 Staff Survey 2019

7.1 On 23 September the Trust commenced participation in the annual NHS Staff Survey 2019 for a period of 10 weeks ending on 29 November 2019. Initial recordings, awaiting verification from our staff survey provider - Quality Health, show that the Trust had a completion rate of 43 percent. The findings from the staff survey 2019 will be released to the Trust at the start of the calendar year 2020.

7.2 The chart below shows completion rate by divisions.

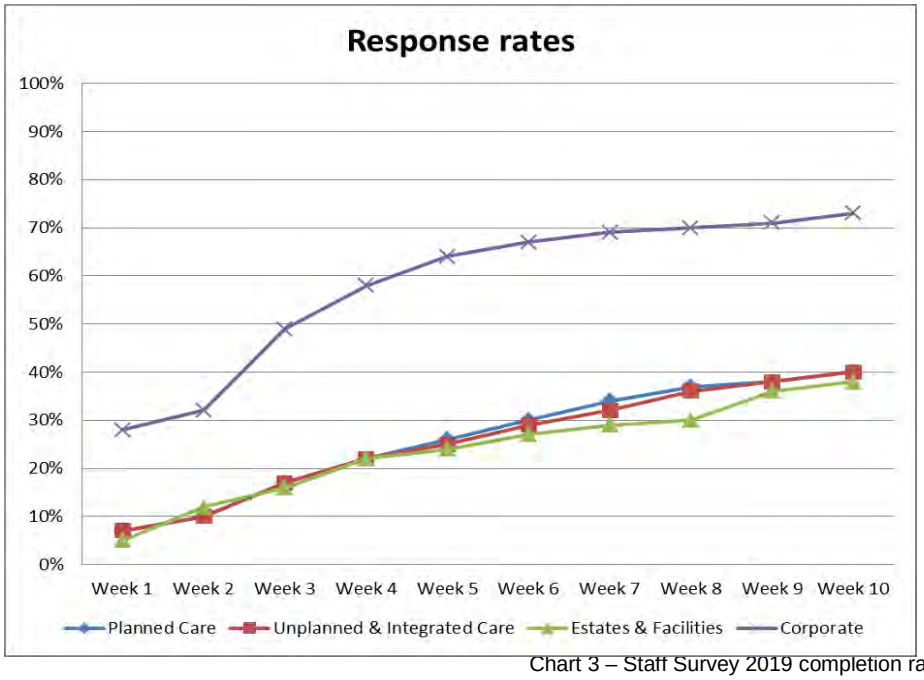


Chart 3 – Staff Survey 2019 completion rate by Divisions

Best Future

We will deliver a workforce ready for the future, supported with the right skills to deliver quality care and to allow us to reach our full potential

8 Apprenticeships update

8.1 The Trust's annual apprenticeship levy stands at £1,669.059 with £330,258 spent in the last 12 months. The Trust currently has 116 monthly learners (against a target of 101). The Trust has not spent its full allocation since August 2019; work with the Kent and Medway Sustainability and Transformation Partnership is being undertaken to support allocation.

8.2 Table 11 below shows the expired levy funds.

Month	Levy Funds in	Expired Levy funds
August 2019	£73,411.82	£2,800.29
September 2019	£76,780.92	£0
October 2019	£75,217.75	£93,687.25
November 2019	£77,153.31	£54,242.96

Table 11 – Expired levy funds

8.3 The Trust currently has 19 different apprenticeship opportunities with courses including nurse associates and MBA programmes. Further apprenticeship opportunities are currently in the procurement stage.

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Inclusive recruitment**	**Agenda Item**	**8.2**
Lead Director	Leon Hinton, Executive Director of Human Resources and Organisational Development		
Report Author	Alister McClure, Head of Equality and Inclusion		
Executive Summary	Three additional opportunities that have arisen since the Trust published its Workforce Race and Disability Equality Schemes in July. These are: the NHS Inclusive Recruitment Toolkit; the Disability Confident scheme; and the 'Valuable 500', which provides organisations with resources, peer support and a community of practice to help Boards lead on disability inclusion. The latter two schemes require Board engagement as part of the eligibility criteria.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	Senior HR & OD team Executive Group		
Resource Implications	Not applicable		
Legal Implications/Regulatory Requirements	Supports the Equality Act 2010 and the NHS Standard Contract by providing additional opportunities for inclusive recruitment.		
Quality Impact Assessment	Not applicable		
Recommendation/ Actions required	It is recommended that the Board give approval to the Trust signing up to the Disability Confident and Valuable 500 schemes, as set out in Sections 4.2 and 5.2.		
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☐
Appendices	Appendix I: Becoming a Disability Confident Employer		

1 Introduction

1.1 This report sets out three additional opportunities that have arisen since the Trust published its Workforce Race and Disability Equality Schemes in July. The opportunities are: a new NHS Inclusive Recruitment Toolkit; the government's Disability Confident scheme; and the 'Valuable 500', which provides organisations with resources, peer support and a community of practice to help Boards lead on disability inclusion. The latter two schemes require Board engagement as part of the eligibility criteria.

2 Background

2.1 The NHS Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES), help NHS organisations to review their data against a set of indicators, including whether there is equality in the recruitment process, from shortlisting to appointment, and to produce action plans for improvement.

2.2 As reported in July 2019, the Trust's performance statistics show that, in 2018/19 (the first year for the WDES) non-disabled people were 1.15 times more likely than disabled staff to be appointed. 20 percent of disabled people and 23 percent of non-disabled people were appointed after shortlisting. This is close to parity, but nevertheless shows a marginal disadvantage for disabled people. And, in terms of race equality the performance statistics show that White people shortlisted for interview were 1.33 times more likely than Black and Minority Ethnic (BME) people to be appointed. In 2018/19 the Trust appointed 26 percent of White candidates shortlisted, and 20 percent of BME candidates shortlisted. Although this was a significant improvement from 2015/16, when White candidates were 2.58 times as likely as BME candidates to be appointed, the Trust still aims for equality of opportunity in the appointments process, and has redesigned management and recruitment training to include training on unconscious bias.

2.3 These statistics illustrate that there is still work to do. However, in addition to the actions agreed as part of the WRES and WDES reports in July 2019, a number of opportunities have arisen during the year, which is brought to the Board's attention now, as the Board has a formal role in scrutinising performance against the WRES and WDES, and equal opportunity in general.

3 NHS Inclusive Recruitment Resources

3.1 NHS Employers have developed a new employer toolkit, a series of videos, and a health passport to help Trusts attract and retain disabled talent. These resources have been created with the input from NHS leaders along with the views of disabled staff. The interactive toolkit focuses on: supporting managers to prepare appropriate and accessible recruitment materials; supporting Trusts to widen their talent pools; and improving the holistic support services available to staff to help them develop their careers.

3.2 Although the toolkit focuses principally on disabled people, it has wider application in the recruitment process. The toolkit has already been linked to TRAC; the recruitment system used by the Trust, for managers' use, and will be incorporated in the Trust's recruitment training programme.

4 The Disability Confident Scheme

4.1 The Disability Confident Scheme is a national initiative, established by the Department of Work and Pensions, to make the most of the talents of disabled people in the workforce, including recruiting more disabled people to the workforce. The scheme largely replaces the Two Ticks recruitment scheme (under which disabled applicants for a post would be guaranteed an interview, provided they met the essential recruitment criteria), and goes beyond Two Ticks by providing support and guidance to employers to develop disabled people within the talent pool.

4.2 The scheme has three levels: Disability Confident Committed; Disability Confident Employer; and Disability Confident Leader (as set out in appendix 1, attached). Organisations must work through one level before proceeding to the next. To become Disability Confident Committed, an organisation must have inclusive and accessible recruitment and communicate vacancies, as well as having a guaranteed interview scheme for disabled people. They must also provide reasonable adjustments and be supporting existing disabled employees. The Trust is already committed to these principles, and is eligible to apply for Level 1 status now.

5 Disability and the role of the Board

5.1 "The Valuable 500" is a scheme, initially set up by the auditors KPMG, to enable Boards to lead on equal treatment of and participation by disabled people. The Trust has the opportunity to join the scheme, which offers leaders the opportunity to become a community of practice, exchanging experience and ideas. There are currently 97 Valuable 500 Organisations, and more than 300 currently signing up.

5.2 The scheme has five recommended commitments:

5.2.1	Taking disability as an agenda item for a minimum of one Board meeting each year.	Already achieved
5.2.2	Appointing a Board-level champion who us accountable for disability issues	To be identified, January 2020
5.2.3	Signing up to the Disability Confident scheme	Achieved, subject to agreeing recommendation 6.3 below
5.2.4	Becoming an advocate and promoting disability issues to suppliers, extended networks and external audiences (e.g. through contracts and partnership agreements requiring disability inclusive policies and practices)	To be developed as part of Valuable 500 Membership March 2021
5.2.5	Considering external partnerships with campaigns and bodies that specialise in disability issues, to boost understanding within the organisation and accelerate change programmes, with regard to disability and access.	To be developed as part of Valuable 500 Membership March 2021

6 Conclusion and next steps

6.1 These three opportunities provide the Trust with practical guidance and tools without additional cost, helping to become not only a more equitable employer, but to show leadership by influencing other organisations and, most importantly, improving patient access and experience.

6.2 The NHS Inclusive Resources are already available to all Trusts, so requires no decision from the Board. Joining the Disability Confident scheme and the Valuable 500 both require agreement from the Board, as Board engagement is one of the eligibility criteria. The Valuable 500 scheme is only open to expressions of interest until 24 January 2020.

6.3 It is recommended that approval be given to the Trust signing up to the Disability Confident and Valuable 500 schemes, as set out in Sections 4.2 and 5.2 above.

6.4

Appendix I: Becoming a Disability Confident Employer

The scheme has three levels designed to support organisations at every step on their Disability Confident journey. Employers must complete each level before moving on to the next.

Level 1: Disability Confident Committed

To be recognised as Disability Confident Committed simply requires employers to agree to the Disability Confident commitments and identify at least one action that you'll carry out to make a difference for disabled people.

The commitments are:

- inclusive and accessible recruitment
- communicating vacancies
- offering an interview to disabled people
- providing reasonable adjustments
- supporting existing employees

The activities (of which employers must identify at least one) include:

- work experience
- work trials
- paid employment
- apprenticeships
- job shadowing
- traineeships
- internships
- student placements
- sector-based work academy placements

The trust already offers disabled people work experience, paid employment, apprenticeships, traineeships and student placements, and is, therefore eligible to be recognised as Disability Confident Committed.

Once an employer has signed up as Disability Confident Committed they receive a certificate in recognition of their achievement, a badge for the website and other materials for three years, and a self-assessment pack to help continue the journey to becoming a Disability Confident Employer.

Level 2: Disability Confident Employer

Once an employer has signed up for level 1 they can progress to level 2, a Disability Confident Employer, by self-assessing organisation around 2 themes:

- getting the right people for your business
- keeping and developing your people

Disability Confident Employers are recognised as going the extra mile to make sure disabled people get a fair chance. Having confirmed completion of the online self-assessment, employers can be registered as a Disability Confident Employer for three years, and will receive.

- a certificate in recognition of achievement
- a badge for the website and other materials for three years
- information on how to become a Disability Confident Leader

The Trust can begin the process of self-assessment as soon as the Disability Confident Committed has been issued. This should be achievable in 2020.

Level 3: Disability Confident Leader

A Disability Confident Leader, will be acting as a champion within your local and business communities, and requires employers to:

- have their self-assessment validated by someone outside of your business (not including DWP employees in jobcentres)
- provide a short narrative to show what they have done or will be doing to support their status as a Disability Confident Leader
- confirm they are employing disabled people
- report on disability, mental health and wellbeing, by referring to the scheme's Voluntary Reporting Framework.

This process can begin as soon as the Disability Confident Employer Certificate has been issued, most likely in 2021 at the latest.

Once recognised as a Disability Confident Leader, the Trust will be sent:

- a certificate in recognition of achievement
- a badge for your website and other materials for three years

Meeting of the Board of Directors in Public

Wednesday, 08 January 2020

Assurance Report from Committees

Title of Committee:	**Integrated Audit Committee**	**Agenda Item**	**9.1**
Committee Chair:	Mark Spragg		
Date of Meeting:	Thursday, 28 November 2019		
Lead Director:	Ian O'Connor, Director of Finance		
Report Author:	Ian O'Connor, Director of Finance		

The key headlines and levels of assurance are set out below, and are graded as follows:	
Assurance Level	**Colour to use in 'assurance level' column below**
No assurance	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partial assurance	Amber/ Red - there are gaps in assurance
Assurance	Amber/ Green - Assurance with minor improvements required
Significant Assurance	Green – there are no gaps in assurance
Not Applicable	White - no assurance is required

Key headlines and assurance level	
Key headline	**Assurance Level (use appropriate colour code as above)**
1. Internal Audit Report and Local Counter Fraud Reports Eight new recommendations were raised since the last Committee meeting on 22.08.19, currently there are eleven overdue, which are being followed up. The Committee asked that the recommendations are submitted on a monthly basis to the Executive Group, quarterly to the Committee and escalated to Trust Board if need be. Realistic deadlines must be set by management and kept. RAG Ratings: *Procurement*: amber/green *Performance Management*: amber/green *Data Assurance Framework*: amber/red	**Green**

2. External Audit Report Grant Thornton presented their External Audit Report. There has been investigative work/workshops with key members of the Finance Team and documenting key business processes. The full audit plan will be submitted to the next Committee meeting in February 2020. This will confirm what the focus will be and any conclusions to date.	**Green**
3. Board Assurance Framework The Committee noted that this document is a work in progress and will be updated and re-submitted to the Committee in February 2020. There has been no material change to it. The issue with the document is the Executive review and the scoring. If scoring has not changed then what is the mitigation on this.	**Green**
4. Risk Management and Policy Strategy The Committee **APPROVED** the Risk Management Policy and Strategy with some minor changes.	**Green**
5. Losses and Special Payments The Committee was informed that in accordance with Trust Standing Financial Instructions all losses and special payments must be reported to the Committee via Finance and are also reported by the Trust in its Annual Accounts. To date in 2019/20 Medway NHS Foundation Trust has incurred costs of £7,975.70 in relation to losses and special payments. Finance is moderately assured that all such payments have been reported as required. To raise this level of assurance the standard operating procedure for reporting such transactions has been refreshed for The Committees approval. The Committee **APPROVED**.	**Green**
6. Standing Financial Instructions The Committee **APPROVED** the Standing Financial Instructions with some minor changes. The policy will be amended and approved outside of the Committee meeting (digitally) and will be submitted to the Trust Board in January 2020. The Committee asks the Trust Board for delegated authority to be given to the IAC.	**Green**
7. 2019/20 Annual Accounts Plan The Committee asked that the team get ahead of schedule and the first review of the annual accounts plan is at the February 2020 Committee meeting. An additional Committee meeting is in the diary for 21 May 2020 for the official sign off of the plan.	**Green**
Further Risks Identified All risks are captured within the risk register and the BAF.	
Escalations to the Board or other Committee 1) Standing Financial Instructions – The Committee asked that this item was added to the Trust Board meeting, the report sits with the Financial Director. The Committee asks for delegated authority to be given to the IAC.	

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Standing Financial Instructions (SFIs) including scheme of delegation**	**Agenda Item**	**9.2**
Lead Director	Ian O'Connor, Director of Finance		
Report Author	Paul Kimber, Deputy Director of Finance Isla Fraser, Financial Controller		
Executive Summary	The annual review of the SFIs has been completed. There are some minor narrative changes together with an update to the scheme of delegation limits to reflect operational processes.		
Link to strategic Objectives 2019/20 ***(Please choose ALL that applies - this could be more than one)***	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☐
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☐
Committees or Groups at which the paper has been submitted	These have been agreed at the Finance Committee.		
Resource Implications	None.		
Legal Implications/Regulatory Requirements	None.		
Quality Impact Assessment	None.		
Recommendation/ Actions required	The Board is asked to approve the SFIs **and** delegate future authority for such approval to the Finance Committee.		
	Approval ☒	**Assurance** ☐	**Discussion** ☐	**Noting** ☐
Appendices	Appendix 1: Standing Financial Instructions		

1 Executive Overview

1.1 The annual review of the Trust's Standing Financial Instructions (SFIs) has been completed by various stakeholders. The policy remains largely unchanged, limited principally to some wording and presentation refinement.

1.2 There is a significant proposed change to the Trust Scheme of Delegation. This has been amended to reflect the revised structure of the organisation and empower staff in the purchasing of goods and services where purchasing policies have been followed.

2 SFI review

2.1 The SFIs have been fully reviewed by the Financial Controller, Deputy Director of Finance and the Associate Director of Procurement.

2.2 The draft revised SFIs were also shared with IT and Estates & Facilities colleagues for review.

2.3 Amendments are as agreed with the Director of Finance and the Finance Committee.

3 Scheme of Delegation Amendments

3.1 **Roles**

The scheme has been amended in accordance with the revised executive structure and grouping has been applied to simplify the table.

3.2 **PO/stock and non-PO**

Differential expenditure control limits are proposed for expenditure via purchase order (PO) or without a purchase order (non-PO).

The proposed changes recognise that purchases made through Trust PO systems are from approved suppliers, are contractually reviewed by procurement and therefore undergo value for money checks, plus the Trust and supplier are protected by a legally binding document.

Increasing the limits will:

- Speed up the buying process for goods and services ordered in the correct way.
- Empower staff whilst still being held to account for any overspending through budgetary control procedures.

Whilst the Trust operates a process of "No PO/No payment", the scheme recognises this may still need to occur in pre-approved circumstances and with reduced financial limits.

Examples of pre-approved non purchase order expenditure are:

- Where the supplier does not accept PO's/requires payment up front or by credit card.
- Where another approved control system is in place, e.g. temporary staffing.
- Where the supply is not easily quantified for a PO, e.g. utilities.

Departments work this through with Finance and Procurement - if there is not a PO solution or raising a PO would be materially inefficient, approval will be granted. A register of approvals is maintained.

Any purchases made via non-PO that are not pre-approved will be reported as a breach of purchasing policy through the Integrated Audit Committee.

3.3 **Contracts and expenditure limits**

Two changes have been made to these limits:

- Associate Director of Procurement - the expenditure and contract authorisation limit for this role have been increased to improve purchasing flow.
- Financial Controller – a £5k limit has been introduced for this role (previously nil); this is to enable urgent payments and other miscellaneous payments to be made faster.

All Amendments have been agreed with the Director of Finance and the Finance Committee.

4 Conclusion and Next Steps

4.1 The Board is requested to approve the revised SFIs.

4.2 Once approval is given the policy will be published in full (accompanied by a summary version) and a compliance message will be sent out to all staff to ensure they are aware of their financial responsibilities.

4.3 Regular Finance training containing SFI awareness will also be made available by Finance.

4.4 The Board is also requested to delegate authority for approval of the SFIs on an annual basis to the Finance Committee.

Corporate Policy – Standing Financial Instructions

Author:	Isla Fraser, Financial Controller
Document Owner:	Ian O'Connor, Director of Finance
Revision No:	3
Document ID Number	
Approved By:	Trust Board
Implementation Date:	January 2020
Date of Next Review:	One year from approval

Corporate Policy – Standing Financial Instructions

Document Control / History	
Revision No	**Reason for change**
1	Annual SFIs review and update
2	Add Instructions for in year SFI amendments
3	Amend Tender receipt process
3	Make Scheme of Delegation changes to • Reflect revised Executive Team structure and grouping of roles. • Recognise differential limits for PO/Stock v Non PO expenditure limits. • Reflect contract authorisation limits. • Increase limits across the board to: o Empower staff who are accountable for financial control in their area. o Improve payment performance.

Consultation
Deputy Director of Finance
Associate Director of Procurement

Director of Estates and Facilities
Director of IT

Corporate Policy – Standing Financial Instructions

Table of Contents

Corporate Policy – Standing Financial Instructions

To be read in conjunction with any policies and Standing Operating Procedures listed in Trust Associated Documents.

1 Introduction

1.1 General

1.1.1 Medway NHS Foundation Trust (the "Trust") became a Public Benefit Corporation on 1st April 2008 following authorisation by the Independent Regulator pursuant to the 2006 Act.

1.1.2 These Standing Financial Instructions detail the financial responsibilities, policies and procedures adopted by the Trust. They are designed to ensure that the Trust's financial transactions are carried out in accordance with the law and with Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Matters reserved to The Board and the Scheme of Delegation approved by The Board of Directors.

1.1.3 These Standing Financial Instructions identify the financial responsibilities, which apply to everyone working for the Trust and its constituent organisations including Trading Units. The financial responsibilities also apply to service organisations providing financial services on behalf of the Trust. They do not provide detailed procedural advice and should be read in conjunction with the detailed departmental and financial procedure notes. The Director of Finance (DoF) must approve all financial procedures.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the Standing Financial Instructions then the advice of the Director of Finance must be sought before acting.

1.1.5 **Failure to comply with Standing Financial Instructions can be regarded as a disciplinary matter that could result in dismissal.**

1.1.6 All members of The Board and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Director of Finance as soon as possible.

1.1.7 Overriding of Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance including justification and circumstances around which non-compliance arose shall be reported to the next formal meeting of the Integrated Audit Committee for referring action or ratification.

Amendments to Standing Financial Instructions outside of the annual review process should be requested using SFIa1 form available on the Intranet. Amendments will be considered and either approved or rejected by The Board.

1.2 Terminology

1.2.1 Any expression, to which a meaning is given in Acts of Parliament, or in the Financial Directions made under such Acts, shall have the same meaning in these instructions.

(a) "Trust" means Medway NHS Foundation Trust.

(b) "Board of Directors" means The Board of Directors as constituted in accordance with the constitution of the Trust.

(c) "Assembly of Governors" means the Assembly of Governors as constituted in accordance with the constitution of the Trust.

(d) "Budget" means a resource, expressed in financial terms, proposed by The Board for the purpose of carrying out, for a specific period, any or all of the functions of the Trust.

(e) "Budget Holder/Manager" means the director or employee with delegated authority to manage finances (Income and Expenditure, or capital where applicable) for a specific area of the organisation.

(f) The "Chief Executive" (CE) and "Accounting Officer" means the Chief Executive Officer of the Trust.

(g) "Director of Finance" (DoF) means the Chief Financial Officer (CFO) of the Trust.

(h) "Legal Adviser" means the properly qualified person appointed by the Trust to provide legal advice.

(i) "NHS Improvement" means the sector regulator for health service providers in England.

(j) "The Chair" is the Chair of the Trust.

(k) "The Medway Hospital Charity" shall mean those funds which the Trust holds at its date of Authorisation, receives on distribution by statutory instrument or chooses subsequently to accept under powers derived under S.47(2)(c) of the NHS Act 2006, as amended.

(l) 'Virements' means an administrative transfer of funds from one part of a budget to another.

1.3 Responsibilities and Delegation

1.3.1 **The Board** exercises financial supervision and control by:

(a) Formulating the financial strategy;

(b) Requiring the submission and approval of budgets within approved allocations/overall income;

(c) Defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money);

(d) Defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation (SD); and

(e) Ensuring that the duties of the Chief Executive as Accounting Officer are performed.

1.3.2 **The Board** has resolved that certain powers and decisions may only be exercised by The Board in formal sessions. These are set out in the 'Schedule of Matters Reserved for The Board' document. All other powers have been delegated to such other committees as the Trust has established.

1.3.3 **The Board** will delegate responsibility for the performance of its functions in accordance with its constitution, the SOs and the Scheme of Delegation adopted by the Trust. The extent of the delegation shall be kept under review by The Board.

1.3.4 Within the SFIs it is acknowledged that the Chief Executive is accountable to The Board, and to Parliament as Accounting Officer.

1.3.5 The Chief Executive Officer is the Accounting Officer of the Trust and as such has the following principal responsibilities:

(a) To ensure there is a high standard of financial management within the Trust;

(b) To ensure financial systems and procedures promote the efficient and economical conduct of business and safeguard financial propriety and regularity throughout the Trust; and

(c) To ensure financial considerations are fully taken into account in decisions on Trust policy proposals.

1.3.6 The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.7 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these Instructions.

1.3.8 The Director of Finance is responsible for:

(a) Implementing the Trust's financial policies and for co-ordinating any corrective action necessary to further these policies;

(b) Maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions; and

(c) Ensuring that sufficient records are maintained to show and explain the Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Trust at any time.

1.3.9 Without prejudice to any other functions of directors and employees to the Trust, the duties of the Director of Finance include:

(a) The provision of financial advice to other members of The Board of Directors, the Assembly of Governors and Trust employees;

(b) The design, implementation and supervision of systems of financial control to provide reasonable assurance as to the probity and regularity of transactions;

(c) The preparation and maintenance of such accounts, certificates, estimates, records and reports as the Trust may require for the purpose of carrying out its statutory duties; and

(d) Deciding at what stage to involve the police in cases of misappropriation and other irregularities not involving fraud or corruption.

1.3.10 All directors and employees, severally and collectively, are responsible for:

(a) The security of Trust property;

(b) Avoiding loss;

(c) Exercising economy and efficiency in the use of resources; and

(d) Conforming to the requirements of the Constitution, Standing Financial Instructions, Financial Procedures and the Scheme of Delegation.

1.3.11 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Director of Finance.

1.3.12 Any contractor or employee of a contractor who is empowered by the Trust to commit the Trust to expenditure or who is authorised to obtain income shall be

covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of their duties under these SFIs.

2 Audit

2.1 Integrated Audit Committee

2.1.1 In accordance with the Constitution of the Trust, The Board of Directors shall formally establish an Audit Committee, with clearly defined and approved terms of reference which includes approving the appointment of the internal auditors. This Committee will, amongst other things:

(a) Provide an independent and objective view of integrated governance, risk management and internal control systems across the whole of the Trust's activities (both clinical and non-clinical);

(b) Monitor and review the effectiveness of Internal and External Audit services;

(c) Review financial and information systems and monitor the integrity and quality of the financial statements and review significant financial reporting judgments;

(d) Ratify schedules of losses, compensations, and settlements with staff, as approved through sub-committee; review and monitor the effectiveness of the Local Counter Fraud Service; and

(e) Review the arrangements in place to support The Board Assurance Framework process prepared on behalf of The Board and advising The Board accordingly.

2.1.2 Where the Integrated Audit Committee feels there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chair of the Integrated Audit Committee should immediately inform the Chief Executive and raise the matter at the next meeting of The Board. Exceptionally, the matter may need to be referred to NHS Improvement after seeking the advice of Chair/Company Secretary/DoF.

2.1.3 It is the responsibility of the Director of Finance to ensure an adequate internal audit service is provided and the Integrated Audit Committee shall be involved in the selection process when an internal audit service provider is changed. It must ensure a cost-effective service is provided, in compliance with the contracting procedures herein.

2.2 Countering Fraud, Bribery and Corruption

2.2.1 The Board recognises that fraud and bribery is a hugely damaging practice that undermines competition and the reputation of public and private bodies involved.

It is The Board's policy to act with integrity, and bribery and corruption will not be tolerated in any form.

2.2.2 An Anti-Fraud and Bribery Policy is in place that sets out procedures designed to prevent everyone associated with the Trust from undertaking acts of fraud, bribery or corruption.

2.2.3 **'Fraud'** - any person who dishonestly makes a false representation to make a gain for himself or another or dishonestly fails to disclose to another person, information which he is under a legal duty to disclose, or commits fraud by abuse of position, including any offence as defined in the Fraud Act 2006.

2.2.4 **'Bribery'** - Inducement for an action which is illegal, unethical or a breach of trust. Inducements can take the form of gifts, loans, fees, rewards or other advantages.

This can be broadly defined as the offering or acceptance of inducements, gifts, favours, payment or benefit-in-kind which may influence the action of any person. Bribery does not always result in a loss. The corrupt person may not benefit directly from their deeds; however, they may be unreasonably using their position to give some advantage to another.

It is the criminal offence of bribery to bribe the holder of a public office and it is similarly an offence for the office holder to accept a bribe.

2.2.5 In line with their responsibilities, the Trust Chief Executive and Director of Finance shall monitor and ensure compliance with the NHS Standards for Providers on Fraud, Bribery and Corruption issued by the NHS Counter Fraud Authority (NHSCFA).

2.2.6 The Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the NHS Standards for Providers on fraud, bribery and corruption. The Director of Finance is responsible for ensuring that the Police are notified at an appropriate stage in any investigation. This shall be following advice from the NHS Counter Fraud Authority.

2.2.7 If any employee suspects or discovers any act of fraud or bribery, they must inform the Local Counter Fraud Specialist or the Director of Finance immediately. Employees can also call the NHS Fraud and Corruption Reporting Line on Freephone 0800 028 40 60 or fill in an online form at www.reportnhsfraud.nhs.uk.

2.2.8 The Local Counter Fraud Specialist shall report to the Trust Director of Finance and shall work with staff in the NHS Counter Fraud Authority in accordance with the NHS Standards for Providers and NHS Anti-Fraud Manual.

2.2.9 The Local Counter Fraud Specialist will provide a written report to the Integrated Audit Committee, as required by the Committee, on counter fraud work within the Trust.

2.2.10 The Trust will ensure that policies and procedures for all work related to fraud are implemented. The Trust will consider the major findings of investigations and respond accordingly.

2.2.11 The Trust will enable the Local Counter Fraud Specialist to attend the Integrated Audit Committee meetings. The Trust shall receive Local Counter Fraud Specialist reports at these meetings.

2.2.12 All conflicts of interest, gifts and hospitality should be reported in accordance with Trust procedures, all incidences that do not comply will be reported to the Trust Counter Fraud Specialist.

2.3 Director of Finance responsibilities with regard to audit

2.3.1 The Director of Finance is responsible for:

(a) Ensuring there are arrangements to review, evaluate and report on the effectiveness of internal financial control including the establishment of an internal audit function.

(b) Ensuring that the internal audit is adequate and meets the NHS mandatory audit standards.

(c) In conjunction with the Local Counter Fraud Specialist (LCFS), Local Security Management Specialist (LSMS) and/or the NHS Counter Fraud Authority, as appropriate, deciding at what stage to involve the Police in cases of misappropriation and other irregularities.

(d) Ensuring that an annual internal audit report is prepared for the consideration of the Integrated Audit Committee and The Board in line with relevant guidance. The report must cover:

(ii) A clear opinion on the effectiveness of internal control in accordance with current and relevant assurance framework guidance issued;

(iii) Major internal financial control weaknesses discovered;

(iv) Progress on the implementation of internal audit recommendations;

(v) Progress against plan over the previous year;

(vi) Strategic audit plan covering the coming three years; and

(vii) A detailed plan for the coming year.

2.3.2 The Director of Finance and/or designated auditors are entitled without necessarily giving prior notice to require and receive:

(a) Access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

(b) Access at all reasonable times to any land, premises or employees of the Trust;

(c) The production of any cash, stores or other property of the Trust under an employee's control; and

(d) Explanations concerning any matter under investigation.

2.4 Role of Internal Audit

2.4.1 Internal Audit, as an independent and objective appraisal service commissioned by the Trust, will review, appraise and report upon:

(a) The extent of compliance with, and the financial effect of, relevant, established policies, plans and procedures;

(b) The adequacy and application of financial and other related management controls;

(c) The suitability of financial and other related management data;

(d) The extent to which the Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

(i) Fraud and other offences;

(ii) Waste, extravagance, inefficient administration;

(iii) Poor value for money or other causes.

(e) Internal Audit shall also independently provide assurance on the Assurance Statements.

2.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.4.3 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Director of Finance must be notified immediately.

2.4.4 The Head of Internal Audit will normally attend Integrated Audit Committee meetings and has a right of access to all Integrated Audit Committee members, the Chairman, Chief Executive, and all non-executive directors of the Trust.

2.4.5 The Head of Internal Audit shall be accountable to the Chairman of the Integrated Audit Committee. The reporting system for internal audit shall be agreed between the Director of Finance, the Integrated Audit Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Standards.

2.5 External Audit

2.5.1 The external auditor is appointed and removed by the Council of Governors at a general meeting of the Council of Governors in accordance with the appointment process set out in the Audit Code for NHS Foundation Trusts as issued by the Independent Regulator from time to time.

2.5.2 The Trust must ensure that the external auditor appointed by the Council of Governors meets the criteria included by the Independent Regulator within the Audit Code for NHS Foundation Trusts at the date of appointment, and on an on-going basis throughout the term of their appointment.

2.5.3 The Trust will provide the external auditor with every facility and all information which he may require for the purposes of his functions under the 2006 Act.

2.6 Security Management

2.6.1 In line with their responsibilities, the Chief Executive will monitor and ensure compliance with directions issued by the Secretary of State for Health on NHS security management.

2.6.2 The Trust shall nominate a suitable person to carry out the duties of the LSMS.

2.6.3 The Chief Executive has overall responsibility for controlling and coordinating security. However, key tasks are delegated to the Director of Estates and Facilities as the Security Management Director (SMD) and the appointed LSMS.

2.6.4 The Chief Executive and the Executive Director with designated responsibility for Security Management matters will ensure that the Local Security Management Specialist:

(a) Keeps full and accurate records of any breaches, or suspected breaches, of security:

(b) Reports to the Integrated Audit Committee, any weaknesses in security-related systems or any other matters which may have implications for security management for the Trust;

(c) Has all necessary support to enable them to efficiently, effectively and promptly carry out their functions and responsibilities, including working conditions of sufficient security and privacy to protect the confidentiality of the work;

(d) Receives appropriate training and support, and

(e) Participates in activities which NHS Improvement directs, relating to national security management measures

3 Business Planning, Budgets, Budgetary Control and Monitoring

3.1 Preparation and Approval of Business Plans and Budgets

3.1.1 The Chief Executive will compile and submit to The Board an operational plan, a strategic plan, and an annual revenue and capital operating plan, together forming the Trust's Business Plan which will take into account financial targets, forecast limits of available resources and clinical governance requirements. The Business Plan will be developed in line with guidance issued by NHS Improvement and will contain:

(a) The key objectives of the Trust;

(b) A statement of the significant assumptions on which the plan is based;

(c) Details of major changes in clinical activity, delivery of services or resources required to achieve the plan, including any impact on the Trust's continuity of services risk rating;

(d) An annual revenue plan which the Director of Finance shall prepare. This shall detail expected income by main purchaser and the main expenditure headings; and

(e) An annual capital plan which should:

(ii) Identify all sources of funding, including charitable, for both capital and revenue,

(iii) The allocation of this funding to major capital schemes, rolling replacement and individual schemes and budgets where appropriate.

3.1.2 Prior to the start of each new financial year the Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by The Board.

Such budgets will:

(a) Be in accordance with the aims and objectives set out in the annual Business Plan;

(b) In line with activity and workforce plans;

(c) Be produced following discussion with appropriate budget holders;

(d) Be prepared within the limits of available funds; and

(e) Identify potential risks;

3.1.3 The Board shall monitor performance against the budget and the business plan.

3.1.4 All budget holders must provide information as required by the Director of Finance to enable budgets to be compiled. All budget holders must sign up to their allocated budgets before the commencement of each financial year.

3.1.5 The Director of Finance has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders to help them manage successfully.

3.2 Budgetary Delegation

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities. This delegation must be in writing and be accompanied by a clear definition of:

(a) The amount of the budget;

(b) The purpose of each budget heading;

(c) Individual and group responsibilities;

(d) Authorities to exercise virement;

(e) Achievement of planned levels of service; and

(f) Provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by The Board.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive, as advised by the Director of Finance.

3.3 Budgetary Control and Reporting

3.3.1 The Director of Finance will devise and maintain systems of budgetary control. These will include:

(a) Monthly financial reports to The Board in an approved form containing:

(ii) Income and expenditure to date showing trends and forecast year-end position;

(iii) Performance on cash, accounts receivable, capital expenditure against plan, and accounts payable payment performance;

(iv) A statement of financial position and investment information;

(v) Actual and forecast financial risk ratings as required by NHS Improvement's Risk Assessment Framework;

(vi) Capital project spend and projected out-turn against plan;

(vii) Explanations of any material variances from plan;

(viii) Details of any corrective action where necessary and the Chief Executive's and/or Director of Finance's view of whether such actions are sufficient to correct the situation; and

(ix) Identify potential risks.

(b) The issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible.

(c) Investigation and reporting of variances from financial, activity and manpower budgets.

(d) Monitoring of management action to correct variances.

(e) Arrangements for the authorisation of budget transfers within the limits set out in the scheme of delegation.

3.3.2 Each budget holder is responsible for ensuring that:

(a) They deliver their budgets as agreed in the Business Plan;

(b) Any likely overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of The Board;

(c) The amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement;

(d) Employees are not appointed without the approval of the Chief Executive or delegated officer other than those provided for in the budgeted establishment as approved by The Board, and that all recruitment is approved through the Trust's vacancy control process; and

(e) Cost improvements, cost savings and income generation initiatives are identified and implemented.

3.4 Capital Expenditure

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure (The particular applications relating to capital are contained in Section 11).

3.5 Monitoring Returns

3.5.1 The Chief Executive is responsible for ensuring that appropriate systems are in place in order for the Trust to meet its licence conditions and any other compliance requirements as issued by NHS Improvement, any other legal or other mandated obligations and any contractual obligations of the Trust.

3.5.2 The Chief Executive, or delegated officer, shall ensure appropriate information is submitted to The Board of Directors, in a format agreed by The Board of Directors, to enable The Board to monitor compliance against its obligations and to enable The Board to certify that appropriate and adequate performance management systems are, and will remain in place to meet its obligations.

4 Annual Accounts and Reports

4.1 Annual Financial Accounts

4.1.1 The Chief Executive, Accounting Officer is responsible for the preparation and submission of annual accounts in respect of each financial year in such form as NHS Improvement may require. The annual accounts are approved prior to submission to NHS Improvement by those deemed by The Board to be 'charged with governance'

4.1.2 The Director of Finance, on behalf of the Trust, will:

(a) Prepare financial returns in accordance with the accounting policies and guidance given by NHS Improvement, the Trust's accounting policies, and International Financial Reporting Standards; and

(b) Submit financial returns to Parliament and NHS Improvement for each financial year in accordance with the timetable prescribed by NHS Improvement.

4.2 Annual Quality Accounts and Report

4.2.1 The Chief Executive, as Accounting Officer, shall ensure that the Trust prepares, in respect of each financial year, annual quality accounts and report in such form as NHS Improvement, and the Department of Health and Social Care direct.

4.2.2 In preparing its annual quality accounts and report, the Trust shall comply with any directions given by NHS Improvement and the Department of Health and Social Care as to the presentation and content to be included.

4.3 Annual Report

4.3.1 The Trust will publish an annual report, in accordance with guidelines issued by NHS Improvement and present it to a public general meeting of the Assembly of Governors.

4.4 General

4.4.1 The Chief Executive shall ensure that the Annual Accounts, the Annual Quality Accounts and Report, the Annual Report and any report of the Auditor are submitted to The Board of Directors for its adoption and thereafter, together with any report of the Auditor on these are laid before Parliament and submitted to NHS Improvement on dates prescribed by NHS Improvement and, in respect of Quality Accounts, the Department of Health and Social Care.

4.4.2 The Board of Directors will present the adopted Annual Accounts and Reports, and shall arrange for the Auditor to present his/her report on said statements to a general meeting of the Assembly of Governors by no later than 30th September of the financial year end to which the accounts and report relate.

4.4.3 The Company Secretary shall ensure that the Annual Accounts and Reports are made available to the membership of the Trust and to the wider public

4.5 Annual Plans

4.5.1 The Chief Executive shall ensure that the Trust prepares an annual plan for each financial year, the form and minimum contents of which are to be consistent with those prescribed by NHS Improvement.

4.5.2 In preparing the Annual Plan, The Board of Directors shall have regard to the views of the Assembly of Governors.

4.5.3 The Board of Directors shall submit the Annual Plan together with its agreed self-certification statements of compliance as required by NHS Improvement, to NHS Improvement at a time specified by NHS Improvement.

5 Bank and Government Banking Service (GBS) Accounts

5.1 General

5.1.1 The Director of Finance is responsible for managing the Trust's banking arrangements and for advising the Trust on the provision of banking services and operation of accounts. This advice will take into account guidance and directions issued from time to time by NHS Improvement and or The Department of Health and Social Care.

5.1.2 The Board shall approve the banking arrangements.

5.2 Commercial Bank and GBS Accounts

5.2.1 The Director of Finance is responsible for:

(a) Commercial bank accounts and GBS accounts;

(b) Establishing separate bank accounts for the Trust's non-exchequer funds;

(c) Reporting to The Board all arrangements made with the Trust's bankers for accounts to be overdrawn;

(d) Ensuring payments made from bank or Government Banking Service accounts do not exceed the amount credited to the account except where arrangements have been made.

5.3 Banking Procedures

5.3.1 The Director of Finance will prepare detailed instructions on the operation of bank and GBS accounts which must include:

(a) The conditions under which each bank and GBS account is to be operated.

(b) Those authorised to sign cheques or other orders drawn on the Trust's accounts;

(c) Those authorised to use any credit facility i.e. credit cards associated with Trust accounts.

(d) The limit to apply to any overdraft

5.3.2 The Director of Finance must advise the Trust's bankers in writing of the conditions under which each account will be operated.

(a) The names of all officers and directors authorised to release money from and draw cheques on and payable orders on, each bank account of the Trust and shall notify promptly the cancellation of any such authorisation

(b) Cheques drawn on a named payee over the value of £25,000 shall require two authorised signatories

5.3.3 All cheques are to be treated as Controlled Stationery, in the charge of the Director of Finance or designated officer controlling their issue

5.3.4 All funds shall be held in accounts in the name of the Trust. No officer other than the Director of Finance shall open any bank account in the name of the Trust or relating to the activities of the Trust. The Director of finance will inform The Board at the earliest opportunity of details of such accounts.

5.3.5 No officer or Director may open a bank account bearing a name or description that includes the name or description of any of the Trust's hospitals, wards or departments, or in any way that may indicate the bank account is an official account of the Trust.

5.3.6 If any bank accounts or funds held are discovered they will be immediately ceased by The Trust and reported to the Trust Counter Fraud Specialist.

5.4 Tendering and Review

5.4.1 The Board will review the commercial banking arrangements of the Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Trust's banking business.

5.4.2 Competitive tenders should be sought at least every five years. The results of the tendering exercise should be reported to The Board.

5.5 Public Dividend Capital

5.5.1 The amount that was the Public Dividend Capital (PDC) immediately prior to becoming an NHS Foundation Trust continues as the PDC of the Trust.

5.5.2 The dividend paid by the Trust is to be the same as that payable by NHS Trusts in England in pursuance of section 9(7) of the 1990 Act (dividend on public dividend capital) and must be authorised by the Director of Finance.

5.5.3 Any amount paid to the Secretary of State by the Trust by way of repayment of public dividend capital is to be paid into the Consolidated Fund.

5.6 External Borrowing

5.6.1 The Director of Finance will advise The Board concerning the Trust's ability to pay interest on, and repay, both the originating capital debt and any proposed new borrowing.

5.6.2 The Director of Finance is also responsible for reporting periodically to The Board concerning the originating debt and all loans and overdrafts.

5.6.3 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and the Director of Finance.

5.6.4 Any short-term borrowing and leases must be with the authority of two members of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

5.6.5 All short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position.

5.6.6 All long-term borrowing including leases must be consistent with the plans outlined in the current Business Plan.

5.6.7 The Trust also has freedom to access short-term working capital facilities, subject to an overall limit agreed with NHS Improvement. All such short term borrowings should be kept to the minimum period of time possible, consistent with the overall cash flow position.

5.7 Investments

5.7.1 The Trust will comply with any relevant guidance and best practice advice issued by NHS Improvement regarding the management of cash surpluses and the making of investments including for the avoidance of doubt, Managing Operating Cash in NHS Foundation Trusts and Risk Evaluation for Investment Decisions by NHS Foundation Trusts.

5.7.2 The Director of Finance is responsible for advising The Board on investments and shall report periodically to The Board concerning the performance of investments held.

5.7.3 An Investment policy will be formulated by the Director of Finance in conjunction with Investment Committee and approved by The Board of Directors. The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

6 Income and Security of Cash and Cheques and Other Negotiable Instruments

6.1 Income Systems

6.1.1 The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 The Director of Finance is also responsible for the prompt banking of all monies received.

6.1.3 Invoicing outside of the systems set up by The Director of Finance will be reported to Trust Counter Fraud.

6.2 Fees and Charges

6.2.1 The Trust shall follow the relevant guidance in setting prices for services or the equivalent regime for Foundation Trusts.

6.2.2 The Director of Finance is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the NHS or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the DH's "Commercial Sponsorship – Ethical standards in the NHS" shall be followed.

6.2.3 All employees must inform the Director of Finance promptly of money due arising from transactions which they initiate and/or deal with, including all contracts, leases, tenancy agreements, research income, private patient undertakings and other transactions.

6.2.4 Approval to enter into Non-NHS contracts may be delegated in accordance with the scheme of delegation.

6.3 Debt Recovery

6.3.1 The Director of Finance is responsible for the appropriate recovery action on all outstanding debts.

6.3.2 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.3.3 The Director of Finance shall establish procedures for the write off of debts after all reasonable steps have been taken to secure payment.

6.3.4 Income not received should be dealt with in accordance with the losses procedures.

6.4 Security of Cash, Cheques and Other Negotiable Instruments

6.4.1 The Director of Finance shall be responsible for:

(a) Approving the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

(b) Ensuring arrangements are in place for the ordering and secure control and storage of any such stationery;

(c) The provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

(d) Prescribing systems and procedures for handling cash, cheques and negotiable securities on behalf of the Trust.

6.4.2 Money owned by the Trust and kept at any of its premises shall not under any circumstances be used for the encashment of private cheques or "IOUs".

6.4.3 All cheques, postal orders, cash, etc., shall be banked intact. Disbursements shall not be made from cash received, except under arrangements approved by the Director of Finance.

6.4.4 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Trust from responsibility for any loss.

6.5 Money Laundering Regulations

6.5.1 Under no circumstances will the Trust accept cash payments in excess of 10, 000 Euros (converted to sterling at the prevailing rate at the time) in respect of any single transaction. Any attempts by an individual officer to effect payment above this amount shall be notified immediately to the Director of Finance.

7 Tendering and Contracting Procedures

7.1 Duty to comply with Standing Orders and Standing Financial Instructions

7.1.1 The procedure for making all contracts by or on behalf of the Trust shall comply with these Standing Orders and Standing Financial Instructions (except where Standing Order No. 3.13 Suspension of Standing Orders is applied).

7.2 EU Directives Governing Public Procurement

7.2.1 Directives by the Council of the European Union prescribing procedures for awarding all forms of contracts shall have effect as if incorporated in these Standing Orders and Standing Financial Instructions.

7.3 Reverse eAuctions

7.3.1 The Trust should have policies and procedures in place for the control of all tendering activity carried out through Reverse eAuctions. For further guidance on Reverse eAuctions refer to www.ogc.gov.uk

7.4 Capital Investment Guidance

7.4.1 The Trust shall consider the guidance "Risk Evaluation for Investment Decisions by NHS Foundation Trusts" and such other guidance as may be issued by the Independent Regulator from time to time in respect of capital investment and estate and property transactions.

7.5 Formal Competitive Tendering

7.5.1 General Applicability

The Trust shall ensure that competitive tenders are invited for:

- The supply of goods, materials and manufactured articles;
- The rendering of services including all forms of management consultancy services (other than specialised services sought from or provided by the DH);
- For the design, construction and maintenance of building and engineering works (including construction and maintenance of grounds and gardens); for disposals

7.5.2 Health Care Services

Where the Trust elects to invite tenders for the supply of healthcare services these Standing Orders and Standing Financial Instructions shall apply as far as they are applicable to the tendering procedure and need to be read in conjunction with Standing Financial Instruction No. 8.

7.5.3 Exceptions and instances where formal tendering need not be applied

Formal tendering procedures **need not be applied** where:

(a) The estimated expenditure or income does not, or is not reasonably expected during the total period of the contract to exceed £ 24,999;

(b) Where the supply is proposed under special arrangements negotiated by the DH in which event the said special arrangements must be complied with. This includes the use of DH procurement frameworks for the construction of healthcare facilities;

(c) In transactions involving the disposal of assets Standing Financial Instructions No. 14 does not require formal competitive tendering;

Formal tendering procedures below the OJEU threshold (or any subsequent legislation) **may be waived** in the following circumstances:

(d) In very exceptional circumstances where the Chief Executive decides that formal tendering procedures would not be practicable or the estimated expenditure or income would not warrant formal tendering procedures, and the circumstances are detailed in an appropriate Trust record;

(e) Where the requirement is covered by an existing contract;

(f) Where national framework agreements are in place.

(g) Where a consortium arrangement is in place and a lead organisation has been appointed to carry out tendering activity on behalf of the consortium members;

(h) Where the timescale genuinely precludes competitive tendering but failure to plan the work properly would not be regarded as a justification for a single tender;

(i) Where specialist expertise is required and is available from only one source. This would include specialist original equipment manufacturer (OEM) parts, maintenance and repairs

(j) When the task is essential to complete the project, and arises as a consequence of a recently completed assignment and engaging different consultants for the new task would be inappropriate;

(k) There is a clear benefit to be gained from maintaining continuity with an earlier project. However in such cases the benefits of such continuity must outweigh any potential financial advantage to be gained by competitive tendering;

(l) Where the market has been tested and insufficient number of tenders have been received

(m) Where the provider is available via a national framework but the Trust is able to negotiate better commercial terms.

(n) For the provision of legal advice and services that are not available via a national framework providing that any legal firm or partnership commissioned by the Trust is regulated by the Law Society for England and Wales for the conduct of their business (or by the Bar Council for England and Wales in relation to the obtaining of Counsel's opinion) and are generally recognised as having sufficient expertise in the area of work for which they are commissioned.

The waiving of competitive tendering procedures should not be used to avoid competition or for administrative convenience or to award further work to a consultancy originally appointed through a competitive procedure

Where it is decided that competitive tendering is not applicable and should be waived, the fact of the waiver and the reasons should be documented and recorded in an appropriate Trust record and reported to the Integrated Audit Committee at each meeting.

7.5.4 Fair and Adequate Competition

Where the exceptions set out in these standing financial instructions do not apply, the Trust shall ensure that invitations to tender are sent to a sufficient number of firms/individuals to provide fair and adequate competition as appropriate, and in no case less than three firms/individuals, having regard to their capacity to supply the goods or materials or to undertake the services or works required.

7.5.5 List of Approved Firms

The Trust shall ensure that the firms/individuals invited to tender (and where appropriate, quote) are among those on approved lists or approved by pre-qualification, unless through open invitation to tender consistent with EU directives. Where in the opinion of the Director of Finance it is desirable to seek tenders from firms not approved, the reason shall be recorded.

A manager nominated by the Chief Executive shall on behalf of the Trust maintain lists of approved firms from who tenders and quotations may be invited. These shall be kept under frequent review. The lists shall include all firms who have applied for permission to tender and as to whose technical and financial competence the Trust is satisfied. All suppliers must be made aware of the Trust's terms and conditions of contract.

For building and engineering construction works and consultancy costs, invitations to tender shall be made only to firms included on the approved list of tenders compiled in accordance with this instruction or on the separate maintenance lists compiled and who are listed on the Construction line Supplier List for the relevant scope and value of works/services being procured.

Firms included on the approved list of tenders shall ensure that when engaging, training, promoting or dismissing employees or in any conditions of employment, shall not discriminate against any person because of colour, race, ethnic or national origins, religion or sex, and will comply with the provisions of the Equality Act 2010 and any amending and /or related legislation.

Firms shall conform at least with the requirements of the Health and Safety at Work Act and any amending and /or other related legislation concerned with the health, safety and welfare of workers and other persons, and to any relevant British Standard Code of Practice issued by the British Standard Institution. For building and engineering construction works, firms must provide to the appropriate manager a copy of its safety policy and evidence of the safety of plant and equipment, when requested.

7.5.6 Financial Standing and Technical Competence of Contractors

The Director of Finance may make or institute any enquiries he/she deems appropriate concerning the financial standing and financial suitability of approved contractors. The Director with lead responsibility for clinical governance will similarly make such enquiries as is felt appropriate to be satisfied as to their technical/medical competence.

7.5.7 Exceptions to using Approved Contractors

If in the opinion of the Chief Executive and the Director of Finance it is impractical to use a potential contractor from the list of approved firms/individuals (for example where specialist services or skills are required and there are insufficient suitable potential contractors on the list), or where a list for whatever reason has not been prepared, the Chief Executive should ensure that appropriate checks are carried out as to the technical and financial capability of those firms that are invited to tender or quote.

An appropriate record in the contract file should be made of the reasons for inviting a tender or quote other than from an approved list.

7.5.8 Items which subsequently breach thresholds after original approval

Items estimated to be below the limits set in this Standing Financial Instruction for which formal tendering procedures are not used which subsequently prove to have a value above such limits shall be reported to the Chief Executive, and be recorded in an appropriate Trust record.

7.6 Contracting/Tendering Procedure

7.6.1 Invitation to tender

(a) All invitations to tender shall be issued on the Trust's e-tendering platform and shall state the date and time as being the latest time for the receipt of tenders.

(b) All invitations to tender shall state that no tender will be accepted unless they are submitted via the e-tendering platform

(c) Every tender for goods, materials, services or disposals shall embody such of the NHS Terms and conditions for the supply of goods and services as are applicable.

(d) Every tender for building or engineering works (except for maintenance work, when Estate code guidance shall be followed) shall embody or be in the terms of the current edition of one of the Joint Contracts Tribunal Standard Forms of Building Contract or Department of the Environment (GC/Wks) Standard forms of contract amended to comply with Concode; or, when the content of the work is primarily engineering, the General Conditions of Contract recommended by the Institution of Mechanical and Electrical Engineers and the Association of Consulting Engineers (Form A), or (in the case of civil engineering work) the General Conditions of Contract recommended by the Institute of Civil Engineers, the Association of Consulting Engineers and the Federation of Civil Engineering Contractors, or in the case of contracts entered into using DH frameworks the rules and regulations regarding this procurement route. If the Trust deems appropriate these documents shall be modified and/or amplified to accord with Independent Regulator guidance and, in minor respects, to cover special features of individual projects.

7.6.2 Opening tenders and Register of tenders

(a) As soon as practicable after the date and time stated as being the latest time for the receipt of tenders, they shall be opened on the e-tendering platform.

(b) The rules relating to the opening of tenders will need to be read in conjunction with any delegated authority set out in the Trust's Scheme of Delegation.

(c) The 'originating' Department will be taken to mean the Department sponsoring or commissioning the tender.

(d) An electronic record shall be maintained on the e-tendering platform to show for each set of competitive tender invitations despatched:

i) The name of all firms or individuals invited;

ii) The names of firms individuals from which tenders have been received;

iii) The date the tenders were opened;

iv) The price shown on each tender;

(e) Incomplete tenders, i.e. those from which information necessary for the adjudication of the tender is missing, and amended tenders i.e., those amended by the tenderer upon his own initiative either orally or in writing after the due time for receipt, but prior to the opening of other tenders, should be dealt with in the same way as late tenders.

7.6.3 Admissibility

(a) If for any reason the designated officers are of the opinion that the tenders received are not strictly competitive (for example, because their numbers are insufficient or any are amended, incomplete or qualified) no contract shall be awarded without the approval of the Chief Executive.

(b) Where only one tender is sought and/or received, the Chief Executive and Director of Finance shall, as far as practicable, ensure that the price to be paid is fair and reasonable and will ensure value for money for the Trust.

7.6.4 Late tenders

Tenders received after the due time and date, but prior to the opening of the other tenders, may be considered only if the Chief Executive or his nominated officer decides that there are exceptional circumstances i.e. despatched in good time but delayed through no fault of the tenderer.

7.6.5 Acceptance of formal tenders

(a) Any discussions with a tenderer which are deemed necessary to clarify technical aspects of his tender before the award of a contract will not disqualify the tender.

The most economically advantageous (MEAT) tender, shall ordinarily be accepted unless there are good and sufficient reasons to the contrary. Such reasons shall be set out in either the contract file, or other appropriate record. The process of determining the lowest net cost, or the highest net value, should ensure that optimum value for money is achieved and should therefore assess the factors of economy, effectiveness and efficiency of the tendered goods or services. Other qualitative factors affecting the success of specific projects should also be assessed and include the:

i) Experience and qualifications of the supplier team member;

ii) Understanding of client's needs;

iii) Feasibility and credibility of proposed approach;

iv) Ability to complete the project or deliver the service within the required timescale

(b) Where other factors are taken into account in selecting a tenderer, these must be clearly recorded and documented in the contract file, and the reason(s) for not accepting the lowest tender clearly stated.

(c) If only one tender is received and this is in the range of the initial estimate then the contract can be awarded to that tenderer.

(d) No tender shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with these Instructions except with the authorisation of the Chief Executive.

(e) The use of these procedures must demonstrate that the award of the contract was:

i) Not in excess of the going market rate / price current at the time the contract was awarded;

ii) That best value for money was achieved.

(f) All tenders should be treated as confidential and should be retained for inspection.

7.6.6 Tender reports to the Trust Board

Reports to the Trust Board will be made on an exceptional circumstance basis only.

7.7 Quotations: Competitive and non-competitive

7.7.1 General Position on quotations

Competitive quotations are required where formal tendering procedures are not adopted and where the intended expenditure or income during the total period of the contract is reasonably expected to exceed £24,999.

7.7.2 Competitive Quotations

(a) Written Quotations or Tenders as appropriate should be obtained from at least 3 suppliers from £24,999 to £49,999, 4 from £50,000 to £249,999 and a minimum of 5 over £250,000, based on specifications or terms of reference prepared by, or on behalf of, the Trust.

(b) Quotations should be in writing on company letter headed paper or from a company email address.

(c) All quotations should be treated as confidential and should be retained for inspection.

(d) The Chief Executive or his nominated officer should evaluate the quotation and select the quote which gives the best value for money. If this is not the lowest quotation if payment is to be made by the Trust, or the highest if payment is to be received by the Trust, then the choice made and the reasons why should be recorded in a permanent record.

7.7.3 Non-Competitive Quotations

Non-competitive quotations in writing may be obtained in the following circumstances

(a) The supply of proprietary or other goods of a special character and the rendering of services of a special character, for which it is not, in the opinion of the responsible officer, possible or desirable to obtain competitive quotations;

(b) The supply of goods or manufactured articles of any kind which are required quickly and are not obtainable under existing contracts;

(c) Miscellaneous services, supplies and disposals;

(d) Where the goods or services are for building and engineering maintenance the responsible works manager must certify that the first two conditions of this SFI (i.e.: (a) and (b) of this SFI) apply.

7.7.4 Quotations to be within Financial Limits

No quotation shall be accepted which will commit expenditure in excess of that which has been allocated by the Trust and which is not in accordance with Standing Financial Instructions except with the authorisation of either the Chief Executive or Director of Finance.

7.8 Authorisation of Tenders and Competitive Quotations

Providing all the conditions and circumstances set out in these Standing Financial Instructions have been fully complied with, formal authorisation and awarding of a contract may be decided by those with delegated authority.

The total value of the contract should be determined by reference to the total period to which the contract relates

Formal authorisation must be put in writing. In the case of authorisation by the Trust Board this shall be recorded in their minutes.

7.9 Instances where formal competitive tendering or competitive quotation is not required

Where competitive tenders or competitive quotations are not required because the amounts are less than those specified in 7.7 the Trust should adopt one of the following alternatives:

(a) The Trust shall use NHS Supply Chain or other national collaborative agreement for the procurement of goods and services unless the Chief Executive or nominated officers deem it inappropriate. The decision to use alternative sources must be documented.

(b) If the Trust does not use the NHS Supply Chain or other national collaborative agreement - the Trust shall procure goods and services in accordance with procurement procedures approved by the Director of Finance.

(c) Where a schedule of rates for work has already been approved via a minor / major construction framework agreement.

7.10 Private Finance for capital procurement

The Trust should normally market-test for PFI (Private Finance Initiative funding) when considering a capital procurement. When The Board proposes, or is required, to use finance provided by the private sector the following should apply:

(a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector.

(b) Where the sum exceeds delegated limits, a business case must be referred to the appropriate Independent Regulator for approval or treated as per current guidelines.

(c) The proposal must be specifically agreed by The Board of the Trust.

(d) The selection of a contractor/finance company must be on the basis of competitive tendering or quotations.

7.11 Compliance requirements for all contracts

The Board may only enter into contracts on behalf of the Trust within the statutory powers delegated to it by the Secretary of State and shall comply with:

(a) The Trust's Constitution, Terms of Authorisation, Standing

(b) Orders and Standing Financial Instructions;

(c) EU Directives and other statutory provisions;

(d) Any relevant directions including the Capital Investment Manual, Estate code and guidance on the Procurement and Management of Consultants;

(e) Where appropriate contracts shall be in or embody the same terms and conditions of contract as was the basis on which tenders or quotations were invited.

(f) In all contracts made by the Trust, The Board shall endeavour to obtain best value for money by use of all systems in place. The Chief Executive shall nominate an officer who shall oversee and manage each contract on behalf of the Trust.

7.12 Personnel and Agency or Temporary Staff Contracts

The Chief Executive shall nominate officers with delegated authority to enter into contracts of employment, regarding staff, agency staff or temporary staff service contracts.

7.13 Disposals

Competitive Tendering or Quotation procedures shall not apply to the disposal of:

(a) Any matter in respect of which a fair price can be obtained only by negotiation or sale by auction as determined (or pre-determined in a reserve) by the Chief Executive or his nominated officer;

(b) Obsolete or condemned articles and stores, which must be disposed of in accordance with the supplies policy of the Trust;

(c) Items to be disposed of with an estimated sale value of less than £1,000, this figure to be reviewed on a periodic basis;

(d) Items arising from works of construction, demolition or site clearance, which should be dealt with in accordance with the relevant contract;

7.14 In-house Services

7.14.1 The Chief Executive shall be responsible for ensuring that best value for money can be demonstrated for all services provided on an in-house basis. The Trust should ensure from time to time that benchmarking takes place.

7.14.2 In all cases where The Board determines that in-house services should be subject to competitive tendering the following groups shall be set up:

(a) Specification group, comprising the Chief Executive or nominated officer/s and specialist.

(b) In-house tender group, comprising a nominee of the Chief Executive and technical support.

(c) Evaluation team, comprising normally a specialist officer, a supplies officer and a Director of Finance representative. For services having a likely annual expenditure exceeding £500,000, a non-officer member should be a member of the evaluation team.

7.14.3 All groups should work independently of each other and individual officers may be a member of more than one group but no member of the in-house tender group may participate in the evaluation of tenders.

7.14.4 The evaluation team shall make recommendations to The Board.

7.14.5 The Chief Executive shall nominate an officer to oversee and manage the contract on behalf of the Trust.

7.15 Applicability of SFIs on Tendering and Contracting to funds held in Trust

These Instructions shall not only apply to expenditure from Exchequer funds but also to works, services and goods purchased from the Trust's Charity and private sources

8 NHS Contracts for the Provision of Healthcare Services

8.1 Commissioning

8.1.1 Contracts with NHS providers for the supply of healthcare services shall be drawn up in accordance with the latest guidance available from the Department of Health and Social Care and administered by the Trust.

8.1.2 The Chief Executive, as the Accounting Officer, is responsible for ensuring the Trust enters into suitable contracts with service commissioners for the provision of NHS services. This responsibility has been delegated to the Director of Finance who is responsible for commissioning NHS service agreements for the provision of services to patients in accordance with the Business Plan, and for establishing the arrangements for non-contracted activity. In carrying out these functions, the Director of Finance will pay due regards to:

(a) Costing and pricing of services;

(b) Payment terms and conditions;

(c) Amendments to NHS contracts and contracted activity; and

(d) License conditions and any other guidance issued by NHS Improvement and or NHS England.

8.2 Contract Pricing and Reporting

8.2.1 NHS contracts should comply with the most recent guidance from the DH and be so devised as to minimise risk whilst maximising the Trust's opportunity to generate income. NHS contract prices should comply with Costing and Payment by Results guidelines and the latest guidance published by NHS England and conform with any license conditions and other guidance issued by NHS Improvement.

8.2.2 The Director of Finance will need to ensure that regular reports are provided to The Board detailing actual and forecast income from the contract. This will include information on costing arrangements; any pricing of NHS contracts at marginal/subsidised cost must be undertaken by the Director of Finance and reported to The Board.

8.3 Content of Contracts

8.3.1 All contracts should aim to implement the agreed priorities contained within the Plan and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account the latest relevant guidance available from NHS Improvement and NHS England, including:

(a) The standards of service quality expected;

(b) The relevant national service framework (if any);

(c) The provision of reliable information on cost and volume of services; and

(d) The NHS National Performance Assessment Framework.

8.3.2 Approval of contracts must be in accordance with the scheme of delegation.

9 Employment and Terms of Service including staff expenses

9.1 Remuneration and Terms of Service

9.1.1 In accordance with the trust constitution, The Board shall establish a Non-Executive led nomination and rremuneration committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting. (See guidance contained in the Higgs report.)

9.1.2 The Remuneration Committee is a committee of The Board and fulfils the role of the Personnel and Remuneration and Terms of Service Committee described in the NHS 2006 Act.

9.1.3 The Remuneration Committee reviews and makes recommendations to The Board of Directors (BoD) on the composition, balance, skill mix and succession planning of The Board. It recommends to the BoD the appointment of Executive Directors. It is responsible for setting the overall remuneration and benefits for the Chief Executive, the Executive Directors and other senior managers reporting directly to the Chief Executive. In carrying out this role it has the specific duty to:

(a) Regularly review the composition and effectiveness of the BoD and to make recommendations to The Board to improve its own governance and effectiveness.

(b) Ensure that appraisals are undertaken for all members of the BoD

(c) Regularly review the structure, size and composition (including the skills, knowledge and experience of The Board of Directors) and make recommendations to The Board with regard to any changes and appropriate process.

(d) To ensure a succession plan is in place and appropriate actions are taken to ensure the continued leadership of the Trust for the most senior leaders (including consultants) of the Trust.

(e) To ensure an appropriate process is in place for the appointment of the Chief Executive, Executive Directors, senior managers and consultants to and recommend the appointment of Executive Directors to the BoD and the Chief Executive to the Council of Governors (CoG).

(f) In conjunction with the CoG Appointment committee and the Council of Governors, ensure that the process for appointing the Trust Chair and Non-Executive Directors, and the process for appointing the Chair, Executive, Executive Directors, senior managers and consultants are aligned.

(g) To advise and make recommendations to the BoD about appropriate remuneration and terms of service for the Chief Executive, the Executive, senior managers reporting directly the Chief Executive and consultants which will include:

- All aspects of salary (including any performance related element/bonuses)

- Provision for other benefits, including pensions and cars

- Agreement of contracts of employment and if applicable terms of office

- Arrangements for termination of employment and other contractual terms, including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

- Clinical Excellence Awards

(h) To consider a report annually from the Chair on the performance of the Chief Executive and from the Chief Executive on the performance of Executive Directors and consultants and determine any adjustment to salary and PRP.

(i) To agree the policy and strategy for remuneration for all staff.

9.1.4 The minutes of the Remuneration Committee shall be submitted to The Board or, where this is not appropriate due to a confidentiality issue, a report or extract from the minutes will be submitted to The Board. The Chair of the Committee shall draw the attention of The Board to any issues that require disclosure to the full board, or require executive action.

9.1.5 The Board will be required to consider and to approve proposals presented by the Chief Executive for the setting of remuneration and conditions of service for those employees and officers not covered by the Committee.

9.2 Funded Establishment

9.2.1 The workforce plans incorporated within the annual budget will form the funded establishment, as approved by The Board.

9.2.2 The funded establishment of any department can only be varied if its cost remains within the approved budget for pay and changes are within approved virement levels. Any amendment to establishments must obtain prior approval from the Vacancy Control Panel.

9.3 Staff Appointments

9.3.1 No officer or Member of the Trust Board or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless:

(a) They are duly authorized to do so by the Chief Executive; and

(b) The changes are within the limit of their approved budget and funded establishment;

9.3.2 The Board will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

9.4 Agency Nurses

9.4.1 Agency nursing staff will only be appointed to fill gaps in the approved establishment up to safe minimum operating levels. The appointment of agency nursing staff will only be approved by officers who have been delegated the authority to do so, and in accordance with the Trust's mandatory processes for recruiting temporary staff.

9.5 Processing Payroll

9.5.1 The Director of Finance and the Director of HR and OD are jointly responsible for arranging the provision of an appropriate payroll service. Together with the service provider, The Director is responsible for:

(a) Specifying timetables for submission of properly authorised time record and other notifications;

(b) The final determination of pay and allowances including the verification that rates of pay and other relevant conditions of service are in accordance with the current agreements as approved by The Board;

(c) Making payment on agreed dates;

(d) Agreeing method of payment;

(e) Determining the correct tax status of any payment made;

9.5.2 Together with the payroll service provider, the Director of Finance and the Director of HR and OD will issue instructions in compliance with the standard operation of the national NHS Electronic Staff Record System and in compliance with the procedures of the relevant payroll service provider regarding:

(a) Certification and documentation of data;

(b) The timetable for receipt and preparation of payroll data and the payment of employees and allowances;

(c) Maintenance of subsidiary records for superannuation, income tax, national insurance and other authorised deductions from pay;

(d) Security and confidentiality of payroll information;

(e) Checks to be applied to completed payroll before and after payment;

(f) Authority to release payroll data under the provisions of the Data Protection Act;

(g) Methods of payment available to various categories of employee and officers;

(h) Procedures for payment by cheque, bank credit, or cash to employees and officers;

(i) Procedures for the recall of cheques and bank credits;

(j) pay advances and their recovery;

(k) Maintenance of regular and independent reconciliation of pay control accounts;

(l) A system to ensure the recovery from those leaving the employment of the Trust of sums of money and property due by them to the Trust.

9.5.3 Managers authorised under the Scheme of Delegation have delegated responsibility for:

(a) Submitting time records, and other notifications, in accordance with agreed timetables;

(b) Completing time records and other notifications in accordance with the Director of HR and OD instructions and in the form prescribed by the Director of HR and OD;

(c) Submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's or officer's resignation, termination or retirement. Where an employee fails to report for duty or to fulfil obligations in circumstances that suggest they have left without notice, the Director of HR, OD and Developments must be informed immediately;

(d) Submitting change of detail forms regarding both employment and personal data as soon as information is available.

9.5.4 Regardless of the arrangements for providing the payroll service, the Director of Finance and the Director of HR and shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures, and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

9.6 Contracts of Employment

9.6.1 The Board shall delegate responsibility to the Director of HR and OD for:

(a) Ensuring that all employees are issued with a Contract of Employment in a form approved by The Board and which complies with employment legislation;

(b) Dealing with variations to, or termination of, contracts of employment.

9.7 Staff Expenses

9.7.1 The Director of Finance and Director of HR and OD are jointly responsible for establishing procedures for the management of expense claims submitted by Trust employees.

They shall arrange for duly approved expense claims, which are in accordance with the Trust's expense policy, to be processed through the Trust's payroll system Expense claims shall be authorised in accordance with the Scheme of Delegation.

9.7.2 The Director of Finance and Director of HR and OD shall refer to the Trust's general policies on staff expenses and may reject expense claims where there are material breaches of Trust policies. In this regard the Director of Finance shall liaise with the Chief Executive where appropriate.

10 Non Pay Expenditure

10.1 General

The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

10.1.1 The Chief Executive will set out:

(a) The list of managers who are authorised to place requisitions for the supply of goods and services;

(b) The maximum level of each requisition and the system for authorisation above that level.

10.1.2 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

10.1.3 Where appropriate the Director of Finance will ensure that relevant statutory and guidance notes are followed. This will include the requirements in relation to the construction industry certificates.

10.1.4 Choice, Requisitioning, Ordering, Receipt and Payment for Goods and Services (see overlap with Standing Financial Instruction No. 7)

10.2 Requisitioning

The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Trust. In so doing, the advice of the Trust's adviser on supply shall be sought. Where this advice is not acceptable to the requisitioner, the Director of Finance (and/or the Chief Executive) shall be consulted.

10.3 System of Payment and Payment Verification

The Director of Finance shall be responsible for ensuring there is a system and associated procedures in place for the prompt payment of supplier invoices and charges. Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with **national guidance.**

10.3.1 The Director of Finance will:

(a) Advise The Board regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be incorporated in Standing Orders and Standing Financial Instructions and regularly reviewed;

(b) Prepare procedural instructions or guidance within the Scheme of Delegation on the obtaining of goods, works and services incorporating the thresholds;

(c) Be responsible for the prompt payment of all properly authorised accounts and claims;

(d) Be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

(ii) A list of employees (including specimens of their signatures) authorised to certify invoices.

(iii) Certification that:

- Goods have been duly received, examined and are in accordance with specification and the prices are correct;

- Work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;

- In the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;

- Where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- The account is arithmetically correct;
- The account is in order for payment.

10.3.2 A timetable and system for submission to the Director of Finance of accounts for payment; provision shall be made for the early submission of accounts subject to cash discounts or otherwise requiring early payment.

10.3.3 Instructions to employees regarding the handling and payment of accounts within the Finance Department.

10.3.4 Prepayments

Prepayments are only permitted where the Trust is contractually obliged as part of a contract approved within the Scheme of Delegation.

(a) The appropriate Director must provide, as part of the Business Case, all relevant circumstances of the purchase. The report must set out the effects on the Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments:

(b) The Director of Finance will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold):

(c) The budget holder is responsible for ensuring that all items due under a prepayment contract are received and they must immediately inform the appropriate Director or Chief Executive if problems are encountered.

(d) Payment in respect of training courses and book purchases, maintenance contracts and leases where appropriate may be paid in advance of the receipt of the goods or services.

10.4 Official orders

10.4.1 Official Orders must:

(a) Be consecutively numbered;

(b) Be in a form approved by the Director of Finance;

(c) State the Trust's terms and conditions of trade;

(d) Only be issued to, and used by, those duly authorised by the Chief Executive.

10.4.2 Duties of Managers and Officers

Managers and officers must ensure that they comply fully with the guidance and limits specified by the Director of Finance and that:

(a) All goods, services, or works must be ordered on an official order.

(b) All contracts (except as otherwise provided for in the Scheme of Delegation), leases, tenancy agreements and other commitments which may result in a liability are notified to the Director of Finance in advance of any commitment being made;

(c) Contracts above specified thresholds are advertised and awarded in accordance with EU rules on public procurement;

(d) No order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than:

- Isolated gifts of a trivial character or inexpensive seasonal gifts, such as calendars;

- Conventional hospitality, such as lunches in the course of working visits;

This provision needs to be read in conjunction the principles outlined in the national guidance contained in HSG 93(5) “Standards of Business Conduct for NHS Staff”, Specifically all orders shall be issued in compliance with the Trust’s standards of business conduct policy, ensuring that no director or employees benefit from contracts with the Trusts suppliers or obtain private use of the Trust’s assets, goods or services

(e) No requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Director of Finance on behalf of the Chief Executive;

(f) Verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order and clearly marked "Confirmation Order";

(g) Where consultancy advice is being obtained, the procurement of such advice must be in accordance with guidance issued by NHS Improvement;

(h) Orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

(i) Goods are not taken on trial or loan in circumstances that could commit the Trust to a future uncompetitive purchase;

(j) Changes to the list of employees and officers authorised to certify invoices are notified to the Director of Finance;

(k) Purchases from trust petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Director of Finance; No single petty cash payment may exceed £50 without finance department approval.

(l) Purchases from charitable funds petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Charitable funds committee; No single petty cash payment may exceed £100 and be in accordance with the delegations agreed by the Trustees.

(m) The trust will not reimburse personal expenses or petty cash payments for items that have a formal contract and should have been ordered through an official purchase order.

(n) Petty cash records are maintained in a form as determined by the Director of Finance.

(o) The Director of Finance or designated officer may authorise advances on the imprest system for petty cash and other purposes as required. He/she may make supplementary advances in excess of the imprest where, through special circumstances, the amount of an officer's imprest is temporarily insufficient to meet outgoings.

(p) It is the responsibility of budget holders to ensure that accruals of expenditure are notified to Finance and that they are fully and accurately reflected within monthly financial reports and records.

10.4.3 The Chief Executive and Director of Finance shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with best practice. The technical audit of these contracts shall be the responsibility of the relevant Director.

10.5 Joint Finance Arrangements with Local Authorities and Voluntary Bodies

10.5.1 Payments to local authorities and voluntary organisations made under the powers of section 256 of the NHS Act 2006 shall comply with procedures laid down by the Director of Finance which shall be in accordance with these Acts.

11 External Borrowing

11.1 External Borrowing and Public Dividend Capital

11.1.1 The Director of Finance will advise The Board concerning the Trust's ability to pay dividends and repay Public Dividend Capital together with any proposed new borrowing, within the limits set by the Terms of the Authorisation and reviewed annually by the Independent Regulator (the "Prudential Borrowing Code"). The Director of Finance is also responsible for reporting periodically to The Board concerning Public Dividend Capital debt and all loans, overdrafts and associated interest.

11.1.2 Any application for new borrowings will only be made by the Director of Finance or by an employee acting on their behalf and in accordance with the Scheme of Delegation as appropriate.

11.1.3 The Director of Finance must prepare detailed procedural instructions concerning applications for new borrowings which comply with the instructions issued by the Independent Regulator from time to time.

11.1.4 Assets protected under the Terms of Authorisation shall not be used or allocated for borrowing. Non-protected assets will be eligible as security for loans.

11.1.5 The Board will agree the list of employees (including specimens of their signatures) who are authorised to make short term borrowings on behalf of the Trust. This must include the Chief Executive and the Director of Finance.

11.1.6 Any short-term borrowing must be with the authority of two Directors of an authorised panel, one of which must be the Chief Executive or the Director of Finance. The Board must be made aware of all short term borrowings at the next Board meeting.

11.1.7 The Director of Finance will produce an investment policy in accordance with any guidance issued by the Independent Regulator from time to time, for approval by The Board.

11.1.8 The Board will report to the Independent Regulator on any proposed major investments that could affect their financial risk rating, as part of the annual planning process or in year, prior to financial closure. In determining whether any investment decision is to be reported to the Independent Regulator the Trust will take into account guidance issued by the Independent Regulator "Risk Evaluation for Investment Decisions by NHS Foundation Trusts" as amended from time to time. Temporary cash surpluses must be held only in such investments as authorised by The Board and within the terms of guidance as may be issued by the Independent Regulator from time to time.

11.1.9 The Director of Finance is responsible for advising The Board on investments and shall report periodically to The Board concerning the performance of investments held. The Director of Finance will prepare detailed procedural instructions on the operation of investment accounts and on the records to be maintained.

12 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets

12.1 Capital Investment

12.1.1 The Chief Executive shall:

(a) Ensure that there is an adequate appraisal and approval process in place for determining capital expenditure, including leasing, priorities and the effect of each proposal upon Business Plans;

(b) Be responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

(c) Ensure that the capital investment is not undertaken without appropriate authorisation and confirmation of purchaser(s) support, and resources to finance all revenue consequences, including depreciation and interest payable.

For every significant capital expenditure proposal the Chief Executive shall ensure:

(a) That a business case, prepared to a standard format as determined by The Board of Directors, is produced setting out:

(ii) An option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs;

(iii) The involvement of appropriate Trust personnel and external agencies;

(iv) Appropriate project management and control arrangements;

(b) That the Director of Finance has certified professionally to the costs and revenue consequences detailed in the business case for capital schemes where the contracts stipulate stage payments; the Chief Executive will issue procedures for their management, incorporating the recommendations of “Estate code”.

12.1.2 The Director of Finance shall assess on an annual basis the requirement for the operation of the construction industry tax deduction scheme in accordance with Inland Revenue guidance.

12.1.3 The Director of Finance shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

12.1.4 The approval of the annual capital plan shall not constitute approval for expenditure on any scheme within that plan.

12.1.5 The approval of annual programmes of maintenance, renewal or similar works shall constitute approval for schemes within that programme under the responsible supervision of the trust capital group.

12.1.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with "Estate code" guidance, the Trust's Standing Orders and any guidance issued by the Independent Regulator.

12.1.7 The Director of Finance shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes. Escalation thresholds for approving variations to authorised capital programmes are set out in the Scheme of Delegation.

12.2 Private Finance

12.2.1 The Trust should normally test for PFI when considering capital procurement. When the Trust proposes to use finance which is to be provided other than through its internally generated funds or formal borrowing, the following procedures shall apply:

(a) The Director of Finance shall demonstrate that the use of private finance represents value for money and genuinely transfers significant risk to the private sector.

(b) Where the sum involved exceeds delegated limits, the business case must be referred to the Independent Regulator or in line with any current guidelines.

(c) The proposal must be specifically agreed by The Board.

12.3 Asset Registers

12.3.1 The Chief Executive is responsible for ensuring procedures are in place for the maintenance of registers of assets, taking account of the advice of the Director of Finance concerning the form of any register and the method of updating, and arranging for a physical check of assets against the asset register to be conducted once a year.

12.3.2 The Trust shall maintain a publicly available property asset register recording protected property in accordance with the guidance issued by the Independent Regulator.

12.3.3 The Trust may not dispose of any protected property assets without the approval of the Independent Regulator. This includes the disposal of part of the property or granting an interest in it.

12.3.4 The Director of Finance shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on protected property asset registers.

12.3.5 Additions to the fixed asset register must be clearly identified to an appropriate budget holder and be validated by reference to:

(a) Properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

(b) Stores, requisitions and wages records for own materials and labour including appropriate overheads;

(c) Lease agreements in respect of assets held under a finance lease and capitalised.

12.3.6 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

12.4 Security of Assets

12.4.1 The overall control of fixed assets is the responsibility of the Chief Executive.

12.4.2 Asset control procedures (including fixed assets, cash, cheques, negotiable instruments and donated assets) must be approved by the Director of Finance. This procedure shall make provision for:

(a) Recording managerial responsibility for each asset;

(b) Identification of additions and disposals;

(c) Identification of all repairs and maintenance expenses;

(d) Physical security of assets;

(e) Periodic verification of the existence of, condition of, and title to, assets recorded;

(f) Identification and reporting of all costs associated with the retention of an asset;

(g) Reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

12.4.3 All discrepancies revealed by verification of physical assets to fixed asset register shall be notified to the Director of Finance.

12.4.4 Whilst each employee and officer has a responsibility for the security of property of the Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by The Board. Any breach of agreed security practices must be reported in accordance with agreed procedures.

12.4.5 Any damage to the Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

12.4.6 Where practical, assets should be marked as Trust property.

13 Stores and Receipt of Goods

13.1 General

13.1.1 Stores, defined in terms of controlled stores and departmental stores (for immediate use) should be:

(a) Kept to a minimum practical level;

(b) Subjected to regular stock take –perpetual and/or annual;

(c) Valued at the lower of cost and net realisable value; and

(d) Be kept as secure as practically possible.

13.2 Control

13.2.1 The Director of Finance is responsible for the systems of control and stores.

13.2.2 The day to day responsibility will be delegated to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Director of Finance. The control of Pharmaceutical stocks shall be the responsibility of a designated pharmaceutical officer; and the control of fuel oil and coal to a designated estates manager.

13.2.3 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager/pharmaceutical officer. Wherever practicable, stocks should be marked as Trust property.

13.2.4 The Director of Finance shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, stocktaking and losses.

13.2.5 Stocktaking arrangements shall be agreed with the Director of Finance and there shall be a physical check covering all items in store at least once a year.

13.2.6 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Director of Finance.

13.2.7 The designated manager/pharmaceutical officer shall be responsible for a system approved by the Director of Finance for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated officer shall report to the Director of Finance any evidence of significant overstocking and of any negligence or malpractice. Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

13.3 Goods supplied to the Trust

13.3.1 For all goods supplied to the Trust, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note before forwarding this to the Director of Finance, or delegated representative, who shall satisfy himself that the goods have been received before accepting the recharge.

14 Bankruptcy, Liquidations and Receiverships

14.1 Responsibility of The Finance Director

14.1.1 **The Director** of Finance should make every effort to become aware, at the earliest point possible, of the bankruptcy, liquidation or receivership of any supplier.

14.1.2 When a bankruptcy, liquidation or receivership is discovered, all payments should be ceased pending confirmation of the bankruptcy, etc. As a matter of urgency, a statement must be prepared listing the amounts due to and from the Trust.

14.1.3 The Director of Finance must ensure that:

- Any payments due to the Trust are made to the correct person;
- Any claim by the Trust is properly lodged with the correct party and without delay.

15 Disposals and Condemnations, Losses and Special Payments

15.1 Disposals and Condemnations

15.1.1 The Director of Finance must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

15.1.2 When it is decided to dispose of a Trust asset, the head of department or authorised deputy will determine and advise the Director of Finance of the estimated market value of the item, taking account of professional advice where appropriate.

15.1.3 All unserviceable articles shall be:

(a) Condemned or otherwise disposed of by an employee authorised for that purpose by the Director of Finance; and

(b) Recorded by the Condemning Officer in a form approved by the Director of Finance which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Director of Finance.

15.1.4 The Condemning Officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Director of Finance who will take the appropriate action.

15.2 Losses and Special Payments

15.2.1 The Director of Finance must prepare procedural instructions on the recording of and accounting for losses, and special payments.

15.2.2 In cases involving suspected fraud, the Director of Finance must also prepare a 'fraud response plan' that sets out the action to be taken both by persons detecting a suspected fraud and those persons responsible for investigating it.

15.2.3 Any employee or officer discovering or suspecting a loss of any kind must immediately inform their line manager, who must immediately inform the Head of Department.

Depending of severity, circumstance and materiality of the loss the Chief Executive, Director of Finance or an officer charged with responsibility for responding to concerns involving loss must be informed. This officer will then appropriately inform the Director of Finance and/or Chief Executive.

Where a criminal offence is suspected, the Director of Finance must immediately inform the police if theft or arson is involved. In cases of fraud and corruption or of

anomalies which may indicate fraud or corruption, the Director of Finance must inform the Trust's Local Counter Fraud Specialist and the NHS Counter Fraud Authority in accordance with the NHS Standards for providers.

15.2.4 The Director of Finance must notify the Counter Fraud and Security Management Services (CFSMS) and the External Auditor of all frauds.

15.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial, the Director of Finance must immediately notify:

(a) The Board, and

(b) The External Auditor.

15.2.6 Write offs and losses not associated with Fraud are approved within the scheme of delegation The Director of Finance shall be authorised to take any necessary steps to safeguard the Trust's interests in personal and company insolvencies.

15.2.7 For any loss, the Director of Finance in conjunction with the Company Secretary should consider whether any insurance claim can be made.

15.2.8 The Director of Finance shall maintain a Losses and Special Payments Register in which write off action is recorded, including bad debt written off. The register should show:

(a) The nature, gross amount (or estimate where an accurate value is unavailable), and cause of each loss;

(b) The action taken, total recoveries and date of write-off where appropriate; and

(c) The category in which each loss is to be noted.

15.2.9 All Losses and special payments must be reported to the Integrated Audit Committee on a regular basis; at least annually.

16 Information Technology

16.1 Controls

16.1.1 The Chief Executive will nominate a Senior Information Risk Owner (SIRO) who is responsible for the accuracy and security of the computerised data of the Trust, shall;

(a) Devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Trust's data, programs and computer hardware from accidental or intentional disclosure to unauthorised persons, deletion or

modification, theft or damage, having due regard for the Data Protection Act, Human Rights Act and Freedom of Information Act;

(b) Ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness and timeliness of the data, as well as the efficient and effective operation of the system;

(c) Ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment; and

(d) Ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews as may be considered necessary are being carried out;

16.1.2 The Director of IT Transformation shall:

(a) Prepare and maintain an IT strategy for regular approval by The Board; and

(b) Ensure that all purchases of hardware/software are in compliance with the Trust's IT strategy.

16.1.3 The Director of Finance shall ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy must be obtained from them prior to implementation.

16.1.4 The Chief Executive shall ensure that the Trust shall publish and maintain a Freedom of Information (FOI) Publication Scheme, or adopt a model Freedom of Information Publication Scheme approved by the information Commissioner.

16.2 System Development

16.2.1 The Chief Executive Officer shall satisfy themselves that new computer systems and amendments to current systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

16.2.2 In the case of computer systems which are proposed General Applications (i.e. normally those applications which the majority of Authorities/Trusts in the cluster or nationally wish to sponsor jointly) all responsible Directors and employees will send to the Director of Finance:

(a) Details of the outline design of the system; and

(b) In the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

16.2.3 Contracts for Computer Services with other health bodies or outside agencies

16.2.4 The Director of Finance shall ensure that contracts for computer services for financial applications with another health organisation or any other agency/party shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

16.2.5 Where another health organisation or any other agency provides a computer service for financial applications, the Director of Finance shall periodically seek assurances that adequate controls are in operation.

16.3 Risk Assessment

16.3.1 The Director of Finance shall ensure that risks to the Trust arising from the use of IT are effectively identified and considered and appropriate action taken to mitigate or control risk. This shall include the preparation and testing of appropriate disaster recovery plans.

16.4 Requirements for Computer Systems which have an impact on corporate financial systems

Where computer systems have an impact on corporate financial systems the Director of Finance shall need to be satisfied that:

(a) Systems acquisition, development and maintenance are in line with corporate policies such as an Information Technology Strategy;

(b) Data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

(c) Staff as delegated by the Director of Finance have access to such data; and

(d) Such computer audit reviews as are considered necessary are being carried out.

16.5 Data Security and Integrity as it relates to Financial Systems

16.5.1 The Director of Finance shall ensure that appropriate controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system.

16.5.2 Where another health organisation or any other agency provides a computer service for financial applications, the nominated Executive Director shall periodically seek assurances that adequate controls are in operation

17 Patients Property

17.1 Responsibilities

17.1.1 The Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

17.1.2 The Chief Executive is responsible for ensuring:

(a) That patients or their carers, as appropriate, are informed before or at admission by:

(ii) Notices and information booklets; (notices are subject to sensitivity guidance);

(iii) Hospital admission documentation and property records; and

(iv) The oral advice of administration and nursing staff responsible for admissions.

(b) That the Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patients' property record is obtained as a receipt.

17.1.3 The Director of Nursing must provide detailed written instructions on the collection, custody, safekeeping, collection or disposal of patients' property. This should include the transfer of valuables for safekeeping to Finance where applicable.

17.1.4 The Director of Finance must provide detailed written instructions on the custody, recording, safekeeping, and disposal of patients' valuables (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patient valuables. Due care should be exercised in the management of patients' money in order to avoid loss.

17.1.5 In all cases where property of a deceased patient is of a total value in excess of £5,000 (or such other amount as may be prescribed by any amendment to the Administration of Estates, Small Payments, Act 1965) the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of the property is £5,000 or less, forms of indemnity shall be

obtained, and the authority of the Director of Finance received to release the property.

17.1.6 Staff should be informed, on appointment, by appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients, detailed in the patient's property policy and procedure.

17.1.7 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

18 Funds Held on Trust – The Medway Hospital Charity

The Medway Hospital Trust Charity receives gifts, donations and endowments held on trust for purposes relating to services provided by the Trust.

18.1 Corporate Trustee

18.1.1 The Trust has responsibilities as a corporate trustee for the management of funds it holds on trust and will comply with the Charities Commission latest guidance and best practice.

18.1.2 The responsibilities of the Trust acting as corporate trustee are distinct from its responsibilities for exchequer funds and may not necessarily be discharged in the same manner, but there must still be adherence to the overriding general principles of financial regularity, prudence and propriety. Trustee responsibilities cover both charitable and non-charitable purposes.

18.1.3 The Charitable funds manager on authority from the Trustees of the Charitable Funds shall ensure that each trust fund which the Trust is responsible for managing is managed appropriately with regard to its purpose and to its requirements.

18.2 Accountability to Charity Commission and Secretary of State for Health

18.2.1 The Trustee responsibilities must be discharged separately and full recognition given to the Trust's dual accountabilities to the Charity Commission for charitable funds held on trust and to the Secretary of State for all funds held on trust.

18.2.2 The Schedule of Matters Reserved to The Board and the Scheme of Delegation make clear where decisions regarding the exercise of discretion regarding the disposal and use of the funds are to be taken and by whom. All Board members and Trust officers must take account of that guidance before taking action.

18.3 Applicability of Standing Financial Instructions to funds held on Trust

18.3.1 In so far as it is possible to do so, most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

18.3.2 The over-riding principle is that the integrity of each Trust must be maintained and statutory and Trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

18.3.3 Specific differences in SFIs or their application are explicitly set out in the relevant section.

19 Acceptance of Gifts by Staff and Link to Standards of Business Conduct

19.1 The Trust's policy on acceptance of gifts and other benefits in kind by staff is embodied in the Trust's Policies on Anti-Fraud and Bribery and Standards of Business Conduct Policy. The Standards of Business Conduct policy follows the guidance from DH, in particular Health Circular HSG (93) 5 'Standards of Business Conduct for NHS Staff' which is deemed to be an integral part of these SFIs.

19.2 The Company Secretary shall ensure that a Code of Conduct and arrangements and procedures for the declaration and registering of interests of members of both The Board of Directors and the Council of Governors and other senior management as determined by The Board of Directors are in place.

20 Retention of Records

20.1 The Chief Executive shall be responsible for the management of all NHS records by the Trust, regardless of the media on which they are held.

20.2 The Chief Executive shall be responsible for ensuring that all records required to be retained in accordance with the requirements of the Data Protection Act 1998 and the Freedom of Information Act 2000 and taking into account the guidance contained in Records Management: NHS Code of Practice (2010).

20.3 The records held in archives shall be capable of retrieval by authorised persons in accordance with the provisions of the Records Management Code.

20.4 Records held shall only be destroyed at the express instigation of the Chief Executive and details shall be maintained of records so destroyed.

21 Risk Management and Insurance

21.1 Programme of Risk Management

21.1.1 The Chief Executive shall ensure that the Trust has a programme of risk management, in accordance with current Independent Regulator requirements (if any), which must be approved and monitored by The Board.

The programme of risk management shall include:

(a) A process for identifying and quantifying risks and potential liabilities;

(b) Engendering among all levels of staff a positive attitude towards the control of risk;

(c) Management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

(d) Contingency plans to offset the impact of adverse events;

(e) Audit arrangements including; Internal Audit, clinical audit, health and safety review;

(f) A clear indication of which risks shall be insured;

(g) Arrangements to review the Risk Management programme.

The existence, integration and evaluation of the above elements will assist in providing a basis to create the Annual Governance Statement (AGS) within the Annual Report and Accounts.

Insurance brokers may be appointed if required in accordance with the Trust's SFIs governing tendering and contracting procedures, to affect such insurance cover.

21.2 Insurance: Risk Pooling Schemes administered by NHS RESOLUTION

The Board shall decide if the Trust will insure through the risk pooling schemes administered by the NHS Resolution, commercial insurers or self-insure for some or all of the risks covered by the risk pooling schemes. Any decision not to use the risk pooling scheme administered by the NHS RESOLUTION for any of the risk areas (clinical, property and employers/third party liability) covered by the scheme should be reviewed annually.

21.3 Insurance arrangements with commercial insurers

21.3.1 Insurance cover for the Trust's assets (except income generation activities and motor vehicles) shall as a minimum be provided through the Property Expenses Scheme (PES) operated by the NHS Resolution.

21.3.2 The Trust is free to enter into appropriate insurance arrangements with commercial insurers. Insurance to cover the risk of legal action against the Trust's

directors shall be arranged in line with guidance set out in the NHS Foundation Trust Code of Governance.

21.2 Arrangements to be followed by The Board in agreeing Insurance cover

Where The Board decides to use the risk pooling schemes administered by the NHS Resolution the Company Secretary shall ensure that the arrangements entered into are appropriate and complementary to the risk management programme. The Company Secretary shall ensure that documented procedures cover these arrangements.

21.2.1 Where The Board decides not to use the risk pooling schemes administered by the NHS Resolution for one or other of the risks covered by the schemes, or to source commercial insurance for those risks, the Company Secretary shall ensure that The Board is informed of the nature and extent of the risks that are self-insured as a result of this decision. It shall be for The Board of Directors to decide if the cost of insuring assets to a greater extent than the PES is warranted.

21.2.2 The Trust's nominated Claims Manager will draw up formal documented procedures for the management of any claims arising from third parties and payments in respect of losses which will not be reimbursed.

21.2.3 All the risk pooling schemes require Scheme members to make some contribution to the settlement of claims (the 'deductible'). The Director of Finance should ensure documented procedures also cover the management of claims and payments below the deductible in each case

22 Credit Finance Arrangements Including Leasing Commitments

22.1 There are no grounds where any employee of the Trust can approve any contract or transaction which binds the Trust to credit finance commitments without the clear prior authority of the Director of Finance. This includes all Executive Directors of the Trust as well as all officers. The Board has provided the Director of Finance with sole authority to enter into such commitments, although these powers can be delegated by him/her to appropriate officers under his/her organisational control.

22.2 This instruction applies to leasing agreements and Hire Purchase undertaking which must be sent to the Director of Finance for prior approval. No officer of the Trust outside the organisational control of the Director of Finance has any powers to approve such commitments.

23 Delegated Matters

23.1 Delegated matters in respect of decisions which may have a far reaching effect must be reported to the Chief Executive.

23.2 All items concerning Finance must be carried out in accordance with Standing Financial Instructions.

23.3 The Scheme of Delegation can be amended by the Chief Executive at any time providing there is no change to the Standing Financial Instructions.

23.4 The level of authority to authorise delegated matters is contained within the Scheme of Delegation – Financial Authorities document.

23.5 The table of delegated matters below is the lowest level to which authority is delegated. Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Officers as appropriate.

24 Scheme of Delegation – Financial Authorities

Medway Foundation trust	Expenditure			Contracts	Disposal/ Write off of assets	Write off of Debt	Losses & Special Payments
	General		Capital				
	PO/Stock	Non PO					
Trust Board	£500k+	£500k+	£1m+	£500k+	£500k+	£500k+	£500k+
Chief Executive	£500k	£500k	£1m	£500k	£500k	£500k	£500k
Director of Finance	£500k	£500k	£1m	£500k	£500k	£500k	£500k
Deputy Chief Executive	£250k	£50k		£250k	£150k	£150k	£150k
Associate Director of Procurement	£250k	£50k		£50k			
Chief Operating Officer	£150k	£25k		£50k			
Executive Director of Estates and Facilities	£150k	£150k	£150k	£50k			
All other voting Executive Board Members	£100k	£10k		£50k			
All other Executive Directors	£50k	£10k					
Directors of Clinical Operations	£50k	£10k					£10k
Chief Pharmacist	£50k	£10k					
Deputy Directors of Finance	£50k	£50k		£50k	£50k	£50k	£50k
Deputy Director of HR	£50k	£5K					
Deputy Director of Estates and Facilities	£50k	£50k	£50k				
Heads of Service /General Manager Budget Holders - including Head of Temporary Staffing	£20k	£5K			£5k		£5k
Company Secretary	£10k	£5K					
Other Budget Holders & Qualified Pharmacy Buyers	£10k	£0					
Financial Controller	£5k	£5k			£5k	£5k	

Limits can be delegated downwards during periods of absence by completing SFIa forms available on the intranet or from Finance.
Limits can be delegated upwards or sideways by using vacation rules in the Finance ledger.

Note:

PO/Stock relates to all goods and services ordered through Trust approved procurement and stock replenishment systems (finance, catering, pharmacy and temporary staffing systems) including goods supplied by NHS Supply Chain.

Non PO purchases are exceptional purchases approved with Finance. Purchase commitments made in this way without Finance approval will be reported as a breach of SFIs.

Non PO limits are set lower than PO/Stock limits in recognition of Trust NO PO/NO PAY policy

Charitable funds	All spend
Charitable funds committee	£15k+
Chief Executive	£15k[4]
Financial Controller	£5k[5]
Charity & Fundraising Manager	£2k

Notes:

[4] Countersigned by Committee Chair

[5] In conjunction with Fund Manager

End of document

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Emergency Preparedness, Resilience and Response Policy**	**Agenda Item**	**10.1**
Lead Director	Harvey McEnroe, Chief Operating Officer		
Report Author	Steve Arrowsmith, Head of Emergency Preparedness, Resilience and Response (EPRR)		
Executive Summary	The EPRR Policy sets out the Trust arrangements for the management of EPRR and associated governance to ensure compliance with the regulatory		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: n/a Date of approval: n/a		
Executive Group Approval:	Date of Approval: 8 August 2019		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): NHS E EPRR Framework under the Civil Contingencies Act (2004)		
Resource Implications	None		
Legal Implications/Regulatory Requirements	The sighting of this paper at Executive and Board level supports the Trusts obligations under the Civil Contingencies Act (2004).		
Quality Impact Assessment	Not applicable		
Recommendation/	The report is presented for Approval		

Actions required	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	None			

Emergency Preparedness, Resilience and Response (EPRR) Policy

Author:	EPRR Manager
Document Owner:	Chief Operating Officer
Revision No:	6.1
Document ID Number	POLCOM045
Approved By:	Executive Group
Implementation Date:	August 2019
Date of Next Review:	August 2021

Policy

Document Control / History		
Revision No	**Date**	**Reason for change**
0.1		Detail the arrangements of the Trust in relation to the Local Health Resilience Partnership (LHRP) and Kent Resilience Forum (KRF).
1.0		Reference to include National Risk Register 2014
2.0		Change of Organisational leads.
3.0		Streamlined into Corporate Trust Policy for Board approval. Responsibilities of the Board and EPRR Group added. References to supporting documents added.
4.0		Change of author, owner, Accountable Executive and update of Trust Logo
5.0		Role and Responsibility of Non-Executive Director with EPRR Portfolio Trust Annual Report requirement
6.0	August 2019	Revision of terminology in line with the NHS England EPRR Standards and update of roles in place. Critical Plan referenced superseding the Significant Incident Plan, Structure

Consultation
Divisional Management Board – Planned and Unplanned

Table of Contents

Policy

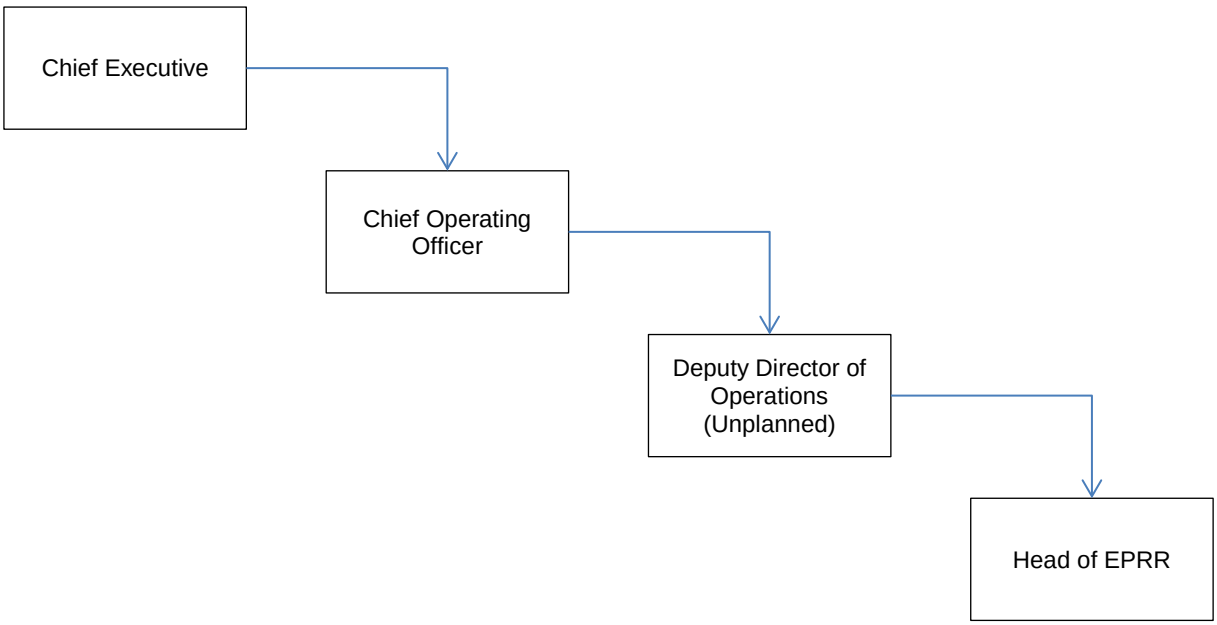
To be read in conjunction with any policies listed in Trust Associated Documents.

Introduction

1.1 All NHS-funded organisations must meet the requirements of;

- the Civil Contingencies Act (2004),
- the NHS Act (2006) as amended by the Health and Social Care Act (2012),
- the NHS standard contract,
- the NHS England Core Standards for EPRR; and
- NHS England Business Continuity Management Framework.

1.2 EPRR Structure



Purpose / Aim and Objective

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

2.2 The Civil Contingencies Act (2004)

- The Civil Contingencies Act (2004) and accompanying non-legislative measures, deliver a single framework for civil protection in the United Kingdom capable of meeting the challenges of the twenty-first century. The Act is separated into two substantive parts: local arrangements for civil protection (Part 1) and emergency powers (Part 2).

- Part 1 of the Act and supporting Regulations and statutory guidance Emergency Preparedness establish a clear set of roles and responsibilities for those involved in emergency preparation and response at the local level. The Act divides local responders into two categories, imposing a different set of duties on each.
- Those in Category 1 are those organisations at the core of the response (e.g. emergency services, local authorities, NHS bodies).

2.3 The Civil Contingencies Act (2004), requires Category 1 responders to:

- assess the risk of emergencies occurring and use this to inform contingency planning
- put in place emergency plans
- put in place business continuity management arrangements
- put in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency
- share information with other local responders to enhance co-ordination
- co-operate with other local responders to enhance co-ordination and efficiency
- provide advice and assistance to businesses and voluntary organisations about business continuity management (local authorities only)

2.4 Emergency Preparedness Framework

The Trust Policy is to ensure the requirements set out in the NHS England EPRR Framework are met. NHS funded organisations are required to submit evidence of their conformity to the required EPRR standards via the completion of a pro-forma template and the provision of a statement of EPRR Conformity. The Trust Board is responsible for reviewing and approving the submission annually.

2.5 The National Health Service Standard Contract.

The NHS Standard contract requires that the Trust have a clear reporting process and assess the impact and recovery of Elective Care in relation to Major Incident.

2.6 Business Continuity

The Trust Policy is to ensure that business continuity arrangements are aligned to ISO 22301. This International Standard specifies requirements for setting up and managing an effective Business Continuity Management System (BCMS) thereby.

- Understanding the organisation’s needs and the necessity for establishing business continuity management policy.

- Implementing and operating controls and measures for managing an organisation's overall capability to manage disruptive incidents
- Monitoring and reviewing the performance and effectiveness of the BCMS
- Continual improvement.

2.7 Trust Objectives

EPRR supports the Trust objectives by ensuring the continuous improvement and rolling programme of Business Continuity and Emergency Preparedness across the organisation and at all appropriate levels of staffing by ensuring that its people are trained and exercised in EPRR best practice with the support to carry out the skills required when required.

2.8 On Call

Medway NHS Foundation Trust ensures it can receive notifications relating to business continuity incidents, critical incidents and major incidents by employing a resilient and dedicated on-call mechanism, which is supported by the Head of EPRR.

This function has both 24/7 senior manager and director level robust availability and capability. On-call staff are trained and competent to perform their role, and are in a position of delegated authority on behalf of the Chief Executive Officer. The Identified Individuals;

- Are trained according to the NHS England EPRR competencies (National Occupational Standards
- Can determine whether a Major, Critical or Business Continuity incident has occurred
- Has a specific process to adopt during decision making
- Is aware of who should be consulted and informed during decision making
- Should ensure appropriate records are maintained throughout

2.9 Testing and Exercising

Exercising schedule should incorporate the response needed for Major, Critical and Business Continuity Incident, whilst considering local risks and meeting the needs of the organisation in the form of;

- Six-monthly communications cascade test
- Annual Table top
- Live Exercise; and a
- Command post exercise

2.10 Incident Control

The Incident Control Centre currently resides in the Clinical Site office with the secondary site being the Australia Room 1, Brown Zone.

The completion of incident SitReps reportable to NHS England can be found within the appendices of the Major Incident Plan.

In and out of hours Loggist support can be sourced via switch board

2.11 Business Continuity Management System (BCMS)

The organisation has a system to evaluate BCMS and this is part of the 2019/20 programme of work which will include the monitoring and evaluation of Business Continuity arrangements against KPIs, Support arrangements and Emergency Ward boxes.

Definitions

3.1 Not applicable

(Duties) Roles & Responsibilities

4.1 Trust Board

Responsible for;

- Approving the Trust's Corporate Policy for EPRR.
- Reviewing and approving the annual report to the Board on EPRR arrangements.
- Understanding the statutory framework and assuring itself on the adequacy of the Trust arrangements for meeting requirements.

4.2 Chief Executive

Department of Health Guidance (2005) dictates the Chief Executive is named as the person accountable for Emergency Preparedness, Resilience and Response. To support this arrangement an Executive is designated to take responsibility for Emergency Preparedness on behalf of the organisation.

4.3 Non-Executive Director (responsible for EPRR)

The Trust has an identified, active Non-executive Director representative who formally holds the EPRR portfolio for the organisation.

The Non-executive Director Representative will;

- Be publicly identified via the public website and annual report
- Be a regular and active member of the Board/Governing Body
- Be briefed via a formal and establish process on the progress of the EPRR work plan outside of Board meetings and via an update following the EPRR Group

4.4 Chief Operating Officer

The Chief Operating Officer is the designated Executive for EPRR and the delegated Accountable Emergency Officer with responsibility for ensuring that the Trust has;

- Resources committed and funds available,
- Plans and policies in place to fulfil the requirements of the statutory framework; and
- Commitment from staff and Senior Leadership towards Emergency Planning, Business Continuity and Training and Exercising

They will;

- Attend the Local Health Resilience Partnership Executive Group,
- Ensure that the Trust has published both the results of the NHS EPRR Assurance process, and the named Non-Executive Director in the Trust Annual Report.
- Discharge their responsibility to provide EPRR reports to the board no less frequently than annually, the reports must go to board, and as a minimum, include an overview on;
  - Training and exercising undertaken by the organisation
  - Summary of any business continuity, critical incidents and major incidents
  - Summary of lessons identified from Incidents and exercises
  - The organisations compliance position in relation to the latest NHS England EPRR Assurance process

4.5 Emergency Preparedness, Resilience and Response Group

This group is established to assist the Trust Board in fulfilling its responsibilities in relation to the Civil Contingencies Act 2004. It will fulfil its purpose by having responsibility for oversight of the Trust EPRR Policies, Procedures and the NHS England EPRR Framework to assess adequacy and identify where improvements need to be made.

4.6 Head of Emergency Preparedness Resilience and Response

The Emergency Preparedness, Resilience and Response Manager is responsible for discharging agreed work plan objectives and ensuring that documents listed in Trust Associated Documents are subject to a programme of maintenance and renewal to ensure that they continue to meet regulatory requirements.

They will ensure that assessments of EPRR risks are shared across the organization and that High level risks are escalated to the Corporate Risk register. In consultation with the EPRR Group, action plans will inform the EPRR Work plan for the following year using a risk-based approach.

4.7 Directors, General Managers and Service Managers

Directors, General Managers and Service Managers will;

- Agree the Trust Core Functions and Critical Dependencies for their areas and undertake detailed Service and IT System Business Impact Assessments following the Trust Management of Business Continuity Policy,
- In line with the EPRR Training Needs Analysis release staff accordingly for training.
- Release staff to undertake Exercises to test EPRR Plans.

- Directors, General Managers and Service Managers who are aligned to the Trust on call Rota's will evidence attendance at Commander training ensuring an up to date EPRR portfolio is kept.

4.8 Incident Response Leads of the Emergency Department.

Responsible for Departmental staff training for a Major Incident response.

4.9 Communications Team

Responsible for Trust Communications for during an incident and liaison with external communication partners

4.10 Head of Infection Control

Responsible for supporting the EPRR agenda via communications with and direction from the Health Protection Agency or other Agencies as required.

4.11 Head of Health & Safety and Compliance

Is responsible for ensuring that Business Impact Assessments are completed with consultation with the EPRR Manager for any planned Operational Estates or Project work that may disrupt the Organisation.

They will ensure that Fire Response is aligned to the Critical Incident Plan and responding staff are trained to work within a multiagency response.

4.12 The Head of IT

- Will ensure that there is a Disaster Recovery Plan (Covering loss of physical assets and recovery with a recovery time objective)
- Will ensure that the Trust can demonstrate Cyber Security (as outlined within https://www.gov.uk/government/publications/10-steps-to-cyber-security-advice-sheets

4.13 Associate Director of Procurement

Will ensure that a system is in place to request and obtain business continuity plans from providers that the organization commissions and any sub-contractors have arrangements in place.

4.14 Switchboard Supervisor

Will maintain the contact details of staff on 'on-call rotas'
Will test the Incident Response cascade 6 monthly.

4.15 Consultant Nuclear Medicine

Will ensure that the Radiation Monitoring Devices from the Emergency Department (RAMGENE) are adequately assured on an annual basis via an approved Appointed Person.

4.16 Chemical, Biological, Radioactive and Nuclear (CBRN) Leads of the Emergency Department.

The CBRN Leads of the Emergency Departments will be responsible for maintaining the CBRN Standard (LHRP, 2013) covering:

- Risk Assessment.
- Equipment
- Training
- Management of CBRN and Radiation Monitoring trained Staff.

Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	First review in one year and then every three years	Author		Where gaps are recognised action plans will be put into place
NHS EPRR framework – compliance with the core standards	EPRR Group – Each meeting	EPRR Manager	Executive Group, Trust Board	Where gaps are recognised, action plans will be put into place
EPRR work plan	EPRR Group – Each meeting	EPRR Manager	Executive Group	Where gaps are recognised, action plans will be put into place
Learning from exercises	EPRR Group – Each meeting	EPRR Manager	Executive Group	Where gaps are recognised, action plans will be put into place

Training and Implementation

6.1 A training needs analysis is prepared as part of the annual work plan and its adequacy is reviewed by the EPRR Group.

Equality Impact Assessment Statement & Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide “evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]”.

Policy

The policy owner must insert here a statement to summarise how they have assessed the policy for impact on the protected characteristics under the Equality Act 2010. Guidance on how to do this can be found in the Guidance Note on Equality Impact Assessment [AGN00168 - Equality Impact Assessment guidance note]. Key issues to include are:

- An assessment of how relevant the policy is to equality and diversity
- The key informants (e.g. data and/or consultees) of the assessment
- What, if anything, was learnt, and any actions that need to be taken to ensure that the policy can be delivered equitably.
- Where the impact assessment can be located (e.g. available from the document author)

References

Document	Ref No
References:	
Civil Contingencies Act 2004 Part 1 and 2	
Emergency Preparedness, Resilience and Response Framework (NHS England, 2015)	
NHS England Core Standards for Emergency Preparedness, Resilience and Response (NHS England, 2015)	
The Health and Social Care Act, 2012	
Trust Associated Documents:	
Major Incident Plan	
Chemical, Biological, Radiological and Nuclear CBRN Incident Plan	
Kent and Medway – Information Sharing Agreement	
Kent and Medway Local Health Resilience Partnership – Mutual Aid Agreement	

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Business Continuity Policy**	**Agenda Item**	**10.2**
Lead Director	Harvey McEnroe, Chief Operating Officer		
Report Author	Steve Arrowsmith, Head of Emergency Preparedness, Resilience and Response		
Executive Summary	As a category 1 responder, as identified in the Civil Contingencies Act (2004), Medway NHS Foundation Trust has a responsibility to have comprehensive Business Continuity Plans in place to ensure that they can continue to exercise their functions in the event of an emergency so far as is reasonably practicable. Business Continuity Management (BCM), including processes for recovery and restoration, should be considered by NHS organisations as part of everyday business processes and should follow a designed programme of activity.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: n/a Date of approval: n/a		
Executive Group Approval:	Date of Approval: 8 August 2019		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): NHS E EPRR Framework under the Civil Contingencies Act (2004)		
Resource Implications	None		
Legal Implications/ Regulatory Requirements	The sighting of this paper at Executive and Board level supports the Trusts obligations under the Civil Contingencies Act (2004)		
Quality Impact Assessment	Not applicable		
Recommendation/	The report is presented for Approval		

Actions required	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	None			

Business Continuity Policy Policy

Author:	Head of Emergency Preparedness, Resilience and Response (EPRR)
Document Owner:	Chief Operating Officer
Revision No:	4.1
Document ID Number	POLCOM031
Approved By:	Executive Group
Implementation Date:	August 2019
Date of Next Review:	August 2021

Policy

Document Control / History		
Revision No	**Date**	**Reason for change**
1		To ensure that IT System Managers accountability is clearly defined.
2		Update to link to (Significant Incident) Business Continuity Plan
3		Change of Trust Policy Template with creation of two Standard Operating Procedures
4.1	August 2019	Layout revision and update of roles within the plan. Amendment to the Critical incident from Significant incident

Consultation
Directorate Management Group – Planned and Unplanned

Contents

Policy

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

Introduction

1.1 As one of the Key Priorities for the NHS within the NHS Operating Framework, Business Continuity in relation to preparing to respond in a state of emergency is owned at Board level in each NHS organisation.

1.2 As a category 1 responder, as identified in the Civil Contingencies Act 2004, Medway NHS Foundation Trust has a responsibility to have comprehensive Business Continuity Plans in place to ensure that they can continue to exercise their functions in the event of an emergency so far as is reasonably practicable.

1.3 Business Continuity Management (BCM), including processes for recovery and restoration, should be considered by NHS organisations as part of everyday business processes and should follow a designed programme of activity.

1.4 Risks to the organisation can be from the external environment (for example, power failures, severe weather, pandemic surge) or from within an organisation (for example, systems failures, loss of key staff).

Purpose / Aim and Objective / Scope

2.1 The primary aim of the Business Continuity Policy is to establish the underlying principles of Business Continuity.

2.2 The secondary aim is to confirm the Business Continuity Management Programme and detail the management and governance activities to be undertaken and monitored to maintain the programme as aligned to the Trust to the requirements of the International Standard ISO 22301:2012, which is laid out via the NHS England EPRR Framework.

2.3 Medway NHS Foundation Trust will be able to give adequate Business Continuity Management assurance; which instils confidence in all stakeholders of the ability of the Trust to protect its brand and reputation by planning for challenges and responding appropriately to an incident.

2.4 This policy does not guide staff in what to do during an instance of Business Continuity, for this, service or organisational plans should be followed.

Definitions

3.1 **Business Continuity** - Strategic and tactical capability of the organisation to plan for and respond to incidents and business disruptions in order to continue business operations at an acceptable pre-defined level.

3.2 **Critical Incident** - any localised incident where the level of disruption results in the organisation temporarily or permanently losing its ability to deliver critical services, patients may have been harmed or the environment is not safe requiring special measures and support from other agencies, to restore normal operating functions.

3.3 **Business continuity management programme. (BCMP**) The management and governance process supported at the Executive level which is resourced to ensure that the organisation has the ability to identify the impacts of potential loss, maintain viable recovery strategies and plans, training, exercising, revisions following lessons identified and review.

3.4 **Strategic Business Impact Analysis** is a document which sets out the Trust Strategy/Recovery Plan and associated programmes to identify essential activities and the impact of disruption as to where priority must be given and where programs can be scaled down if necessary.

3.5 **Critical Incident Plan** designed as an overarching plan that holds information on the process for activation of an incident response, identification of the Trust Core and Critical Functions, Recovery methodology and a Communication Strategy.

3.6 **Service Business Continuity Plans** pull together the response of the Service Department to an incident. The components and content of a Service Level BCP will vary from department to department and will have a different level of detail based on the essential functions identified.

3.7 **IT System Business Continuity Plan** pulls together the response of the Service Department to an information Technology Asset incident. The components and content of an IT System BCP will vary from department to department and will have a different level of detail based on the essential functions identified across any dependency on that system.

3.8 **Core functions and critical dependencies** - Defined as those which must be undertaken to deliver the key activities and objectives

3.9 **Exercise -** The activity of rehearsing in part or as a whole, to ensure that plan/s produce the desired outcome when put into action.

3.10 **Recovery time objective**. Is the period of time following an incident within which an activity must be resumed.

3.11 **Maximum tolerable period of disruption** - Is the time frame during which a recovery must be affected before an outage compromises the ability to achieve the Trust's business objectives and/or survival.

3.12 **Stakeholders** - Those with an interest in the organisations achievements; financial and political.

(Duties) Roles & Responsibilities

4.1 **Trust Board** The Trust Board will ensure resources are directed appropriately and request assurance against the Business continuity management programme to safeguard the interests of its key stakeholders, reputation, brand and value creating activities.

4.2 **Chief Executive** The requirement for the Chief Executive as defined in the Department of Health NHS Resilience and BCM Guidance, 2008 gives the Chief Executive Officer of each NHS Organisation responsibility for ensuring that their organisation has a BCM process in place that will address the requirements for ensuring business continuity as required by the CCA 2004'.

4.3 **Chief Operating Officer** as Executive Lead for Emergency Preparedness, Resilience and Response has overall delegated responsibility from the Chief Executive for Business Continuity:

- Ensuring that the Trust meets the requirements of CCA 2004 and have evidence to support NHS England Core Standards and Assurance Indicators.

4.4 **Head of Health & Safety and Compliance** is responsible for:

- Monitoring compliance with the agreed Business Continuity Management Programme
- Acting on escalation from the EPRR Manager where a risk of non-compliance remains unresolved.

4.5 **EPRR Manager** is responsible for:

- Supporting the Trust in meeting the CCA requirements and enacting the Business Continuity Management Programme.

- Maintaining a live Trust Strategic Business Impact Analysis which is reflective of the Trust Strategy and Recovery Programme.
- Providing the general principles to guide Directors in developing their Service BCPs Scope and train identified staff accordingly; via an ongoing programme for BCM training and awareness.
- Providing the Standard Operating Procedures and generic templates to be used for the writing of BCPs. The template being fit for purpose as a Business Impact Analysis, Activation, Resilience and Recovery Plan.
- Ensuring that the Trust has an agreed and ratified overall corporate Trust Critical Incident Plan.
- Assist Directors to undertake a deep dive Exercise of any Directorate Plans as identified to the Annual EPRR Work Plan.

4.6 **Directors are responsible for:**

- Agreeing the Trust Strategic Business Impact Analysis for their own Directorate and reviewing that document on an annual basis with the EPRR Manager
- Identifying the Scope of the Plans required for their own areas of the business aligned to their Core Functions and Critical Dependencies.
- Thereby Identifying the correct:
  - Staff to be trained by the EPRR Manager to create and maintain and exercise Service Business Continuity Plans for the Directorate.
  - Identifying the IT System Asset Owners to create and maintain and exercise IT System Business Continuity Plans for the Directorate.
- Ensure that robust BCPs are in place that are agreed and remain as live documents which are reviewed and revised no less than annually.
- Identify and enact a continuity review programme; In the event of a service re-structure or change to a working practice or venue that Service Business Continuity Plans are to be evaluated and realigned.
- Directors are responsible for identifying any plan to fit into the Trust EPRR Work Plan, within the annual scoping review which requires an exercise over and above that undertaken by the Directorate locally.

4.7 **The Associate Director for Procurement will:**

- Ensure that procurement contracts are aligned to the principles of ISO22301:2012 and contracted suppliers can evidence a Business Continuity Plan.
- Ensure that there is an identification process of alternative capable suppliers.
- Consider the appropriateness of Insurance Bonds which could be used within large contracts to mitigate the risk of a contractor going into liquidation; which would have a financial impact on the Trust. This type of contract is signed off by the Chief Executive

Monitoring and Review

What will be monitored	How/ Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Reviewed yearly	Author	EPRR Group	Where gaps are recognised action plans will be put into place
Designated Staff Training and competency	Monthly Reporting to Directorate	Author	EPRR Group	Where gaps are recognised action plans will be put into place
Master list of compliancy	Monthly Reporting to Directorate	Author	Directors	RAG rated for action by Directors
Annual Program Compliance	Annual Report to Board	Author	EPRR Group	Action plans to recover to compliant level.

Training and Implementation

6.1 Directors (via their programme leads) will identify the correct staff to be trained by the EPRR Manager as identified by their Directorate BCP Scope and confirm they are to be released for training.

Staff will be trained by the EPRR Manager either:

- Within a formal classroom setting
- Through team workshop sessions

6.2 A scope review will take place annually via the EPRR Group following the Annual Assurance Process review.

- The Annual EPRR Report to Board will detail compliance and non-compliance against the Business Continuity Management programme.
- This will be supported by the annual peer review / and or audit carried out by partner organisations across Kent

Equality Impact Assessment Statement & Tool

All public bodies have a statutory duty under The Equality Act 2010 (Statutory Duties) Regulations 2011 to provide “evidence of analysis it undertook to establish whether its policies and practices would further, or had furthered, the aims set out in section 149(1) of the [Equality Act 2010]”.

The policy owner must insert here a statement to summarise how they have assessed the policy for impact on the protected characteristics under the Equality Act 2010. Guidance on how to do this can be found in the Guidance Note on Equality Impact Assessment [AGN00168 - Equality Impact Assessment guidance note]. Key issues to include are:

- An assessment of how relevant the policy is to equality and diversity
- The key informants (e.g. data and/or consultees) of the assessment

- What, if anything, was learnt, and any actions that need to be taken to ensure that the policy can be delivered equitably.
- Where the impact assessment can be located (e.g. available from the document author)

References

Document	Ref No
References:	
Health and Social Care Act, 2012	
ISO 22301:2012 Business Continuity	
NHS Commissioning Board Business Continuity Management Framework 2013	
Business Continuity Management Toolkit,	
Civil Contingencies Act, 2004	
NHS England Emergency Preparedness, Resilience and Response Framework. February 2016	
Freedom of Information Act 2000	
General Data Protection Regulation	
Trust Associated Documents:	
IT System Business Continuity Plans	
Service Business Continuity Plans	
Trust Critical Incident Plan	
Trust Major Incident Plan	

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Corporate Risk Management Strategy and Policy**	**Agenda Item**	**10.3**
Lead Director	Gurjit Mahil, Deputy Chief Executive		
Report Author	Tracy Kelly, Assistant Head of Corporate Governance and Legal Paul Mullane, Head of Corporate Governance and Legal		
Executive Summary	A full review of risk management has taken place. The procedure describes in full the management and escalation process. Risk pathways established for both corporate divisions and clinical divisions.		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☒
	Finance: We will deliver financial sustainability and create value in all we do		☒
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☒
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: - Date of approval: -		
Executive Group Approval:	Date of Approval: 18 December 2019		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): Yes		
Resource Implications	None		
Legal Implications/ Regulatory Requirements	The Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver its strategic and operational plans and comply with the registration requirements of the quality regulator. This includes systematically assessing and managing its risks. These include financial, corporate		

	and clinical risks. For Foundation Trusts, this also includes risks to compliance with the terms of authorisation. The Trust Board is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives.			
Quality Impact Assessment	n/a			
Recommendation/ Actions required	The Board is asked to review and approve the content.			
	Approval ☒	Assurance ☐	Discussion ☐	Noting ☐
Appendices	Appendix 1: Corporate Risk Management Strategy and Policy Appendix 2: Risk Management Standard Operating Procedure			

1 Executive Overview

1.1 The Corporate Risk Management Strategy and Policy is presented at appendix 1.

1.2 The Risk Management Standard Operating Procedure is presented at appendix 2.

1.3 The Corporate Risk Management Strategy and Policy was due for review in June 2019. There was a delay due to structural changes in Corporate Governance and the review has now taken place to incorporate these changes.

1.4 The strategy and policy fundamentally stay the same but additional emphasis on the roles and responsibilities of the committees and senior management have been identified and added. Detailed escalation pathways and risk appetite have been included.

1.5 The Risk Appetite Statement outlines the risk tolerances for various areas of the organisation's business. The Trust Board are to review the Risk Appetite at a Risk Board Training Session scheduled for February 2020, so this may be subject to change at a later date.

1.6 The corporate risk register is reviewed and updated every two months.

2 CORPORATE RISK STRATEGY AND POLICY

2.1 The policy outlines the roles and responsibilities for all staff and the collective responsibility for the management of all risks across the Trust by individual specialised committees. Detailed escalation routes have been provided to clearly outline where the risks must be discussed.

2.2 Monitoring and review table outlines what will be monitored, by whom and how often.

2.3 Training for all staff has been identified.

3 RISK APPETITE STATEMENT

3.1 The Risk Appetite is defined as "The levels and types of risk the Organisation is prepared to accept in pursuance of its objectives. This informs all planning and objective setting, as well as underpinning the threshold used when determining the tolerability of individual risks".

3.2 A Trust Board training session with NHS Providers will be scheduled for February 2020. The Board will be asked to review the current risk appetite and therefore this may be subject to change. The Standard Operating Procedure will be updated accordingly.

4 Corporate Risk Register and Reporting

4.1 Corporate Risk register and summary report provided detailing risks and their movements over the last six months will be presented to the Executive Team every two months and Trust Board every six months.

5 Training

5.1 In line with the policy annual board level training is to be arranged with external trainers.

5.2 In-house training for the governance teams and risk owners to be organised.

6 Conclusion and Next Steps

6.1 The final draft of the Corporate Risk Management Strategy and policy will be presented at the Executive Group for approval and then final ratification from Trust Board.

6.2 Training session for board members to take place.

6.3 Review of all risks to ensure they are up to date will take place monthly.

6.4 Risks over 15 will be reviewed and linked to the Corporate Risk Register.

6.5 Meetings scheduled with Executive Risk Accountability Owners and Assistant Head of Corporate Governance to update the Corporate Risk Register.

6.6 The Corporate Risk Register to be presented to Executive Group and Trust Board.

6.7 Update Risk Management Standard Operating Procedure if Risk Appetite changes.

Medway NHS Foundation Trust
Corporate Risk Management Strategy and Policy

Author:	Tracy Kelly and Paul Mullane – Assistant Head of Corporate Governance & Legal and Head of Corporate Governance & Legal
Document Owner	Deputy Chief Executive – Gurjit Mahil
Revision No:	9
Document ID Number	POLCGR028
Approved By:	
Implementation Date:	
Date of Next Review:	

Medway NHS Foundation Trust
Risk Management Strategy and Policy

Document Control / History	
Revision No	**Reason for change**
7	Combined Risk Strategy & Policy
8	Page 8 - Detail added regarding training levels across the Trust
9	Reviewed – more detail added regarding reporting structures

Consultation
Executive Group, Integrated Audit Committee,

Medway NHS Foundation Trust
Risk Management Strategy and Policy

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Medway NHS Foundation Trust
Risk Management Strategy and Policy

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

1 Introduction

1.1 All activities contain inherent risks. Risk management and internal control is central to the effective running of any organisation. At its simplest, risk management is good management practice. It should not be seen as an end in itself, but as part of an overall management approach. Medway NHS Foundation Trust (MFT) will ensure that decisions made on behalf of the organisation are taken with consideration to the effective management of risks.

1.2 Although the key strategic risks are identified and monitored by the Trust Board, operational risks are managed on a day-to-day basis by staff throughout the organisation. In order that progress in managing all risks can be acknowledged, the Trust has a Standard Operating Procedure in place for Risk management (SOP0064), enabling provision of a record of all risks to the organisation via an electronic platform Risk Assure.

1.3 At the heart of the Trust Risk Management Strategy and Policy is the desire to learn from events and situations in order to continuously improve management processes. Where necessary, and where appropriate, changes will be made to the Trust's systems to enable this to happen.

2 Purpose / Aim and Objective

2.1 **Risk Management Strategy and Policy Statement**

Risk management is the key system through which strategic, clinical (Quality & Safety), operational, corporate and financial risks are managed by all staff to their reasonable best for the benefit of patients, staff, visitors and other stakeholders. It is through this system of internal control and accountability the Chief Executive fulfils their responsibility as accountable officer and the Board fulfils its responsibility of stewardship. Key systems will be fully embedded at every level of the organisation and will ensure compliance with current and future risk management related standards and legislation; these systems are described within SOP0064 Standard Operating Procedure for Risk Management.

2.2 Assurances will be provided to the Trust Board through an agreed scheme of delegation according to principles and systems which will allow the Board to be able to make accurate judgements as to the degree to which risks to its objectives are being managed effectively and efficiently. This Board Assurance Framework will contribute to the ability of the Trust to be able to confidently sign the Annual Governance Statement, Annual Accounts and Annual Quality Account and it is through this process MFT monitors adherence to the requirements of the Care Quality Commission and other regulators. SOP0165 Medway NHS Foundation Trust Procedure for the Board Assurance Framework describes the assurance process.

3 Definitions

3.1 **Risk** is an uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives.

3.2 **Risk management** is the assessment, analysis and management of risks. It is a way of recognising which events (hazards) may lead to harm in the future and minimising their potential consequence(s) and likelihood of occurrence.

3.3 **Risk Appetite** - The levels and types of risk the Organisation is prepared to accept in

pursuance of its objectives. This informs all planning and objective setting, as well as underpinning the threshold used when determining the tolerability of individual risks.

4 (Duties) Roles & Responsibilities

4.1 **The Trust Board** is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives. The Board Assurance Framework (BAF) is described in a Standard Operating Procedure SOP0165.

4.1.1 The Board will receive a Corporate Risk Register for consideration and adoption, as recommended by the Integrated Audit Committee & Performance Committee every six months. The Board will also receive a quarterly Board Assurance Framework, proposed by the Trust Secretary. The Board will use both of these documents to guide its agenda setting, further information and assurance requests and to inform key decision making, particularly about the allocation of financial and other resources.

4.1.2 To this end, both the Corporate Risk Register and the BAF will be sent to

4.1.2.1 the Finance and Performance Committee to inform financial decision making and budget setting

4.1.2.2 the Integrated Audit Committee to inform the planning of audit activity

4.1.2.3 the Workforce and Organisational Development Committee to inform human resources and training and development decisions

4.2 **Non-Executive Directors** have responsibility for reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical). This supports the achievement of quality and the organisation's objectives. Members of the Integrated Audit Committee will review the adequacy of the Risk Management Strategy, Policy and procedures and receive regular monitoring information against the management of risks judged as significant and provide verification to the Trust Board through the Board Assurance Framework on the systems in place for the management of risk within the Trust.

4.3 **The Chief Executive** is the Accountable Officer and is accountable for ensuring:

- The Trust's Principal Strategic Objectives are agreed.
- Sound systems of internal control exist, which are based on an ongoing management process designed to identify the principal risks to the achievement of the organisation's objectives; to evaluate the nature and extent of those risks; and to manage them efficiently, effectively and economically.
- Systems of internal control exist which are underpinned by compliance with the core controls assurance standards of Governance, Financial Management and Risk Management.
- Internal Audit Plans are aligned to risk areas and review the effectiveness of the system of internal control

The Trust Board Sub Committees are the principal means by which these responsibilities are discharged and through which effectiveness of risk management systems is monitored.

4.4 **The Deputy Chief Executive** is the Executive with responsibility for ensuring that the Trust has robust risk management resources and systems. They are responsible for ensuring that

mechanisms for risk management are robust so as to assure the Trust Board that risks are being managed and that the Trust complies with the risk management standards.

4.5 **Trust Secretary** has the responsibility for developing and implementing the Board Assurance Framework.

4.6 **The Head of Corporate Governance and Legal** reports to the Deputy Chief Executive and is responsible for overseeing the development and implementation of a robust Risk Management Strategy and Framework, working with Executive Directors, Chief Operating Officer and Divisional Governance Managers to embed good practice at all levels of the Trust and ensure that the Trust's commitment to managing risk is co-ordinated, systematic, transparent and evident.

4.7 **Assistant Head of Corporate Governance and Legal**

4.7.1 Is responsible for the management of the Trust's electronic Risk Management platform – Risk Assure.

4.7.2 Responsible for training managers on the Risk Assure system

4.7.3 Providing training sessions for staff and developing presentation materials.

4.7.4 Assists in the review of the Strategy, Policy and SOP and Health Assure training materials.

4.8 **The Director of Finance** is accountable to the Trust Board and Chief Executive for the Trust's financial risk management activities and has close working arrangements with other Executive Directors with regard to ensuring that Financial Planning and Financial Risk Management integrates with the Trust's Clinical and Organisational Risk Management activities and is closely involved in consideration of the recommendations of the Integrated Audit Committee and the Quality Assurance Committee. The Director of Finance seeks the Internal Auditor's Opinion on the effectiveness of Internal Control and Internal Financial Control.

4.9 **The Medical Director** has responsibility for identifying with the **Director of Nursing**, the principal risks to the Clinical Governance arrangements and through working with the appropriate Directors of Clinical Operations, Clinical Directors, Clinical Leads, senior managers and clinicians, ensures risks identified through risk profiling / assessment are effectively managed, eliminated or reduced. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management Standard Operating Procedure through to Executive and Trust Board where appropriate

4.10 **The Executive Director of Human Resources and Organisational Development, The Director of Communications, Information Technology, and the Trust Secretary** are responsible for the management of risks within their areas of operational responsibility. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management Standard Operating Procedure through to Executive and Trust Board where appropriate. They are responsible for ensuring that there are nominated individuals in their teams with explicit risk management responsibilities.

4.11 **The Directors of Clinical Operations and The Director of Estates and Facilities** are responsible for ensuring that the Trust's risk management processes are fully implemented within their services, risk registers are maintained and ensuring that principal risks to the Trust's objectives are systematically managed i.e. identified, evaluated, eliminated or reduced. They are responsible for ensuring that risks are appropriately escalated according to the Trust Risk Management Standard Operating Procedure through to Executive and

Trust Board where appropriate. They are responsible for ensuring that there are nominated individuals in their teams with explicit risk management responsibilities

4.12 **The Chief Operating Officer and Divisional Governance Teams** - are responsible for managing their Divisional Risk register, utilising the agreed process and methodology, ensuring that it is regularly reviewed in appropriate governance meetings across the divisions and at the Divisional Management Board meetings.

4.13 **The Integrated Audit Committee** has a responsibility to provide to the Board assurance that in respect of Governance, Risk Management and Internal Control, effective systems across the whole of the organisation's activities (both clinical and non-clinical), support the achievement of the organisation's objectives.

4.14 **Executive Committee / Quality Assurance / Nominations and Remuneration/ Financial and Sub Board Committees**

4.14.1 **All committees** have a responsibility to provide to the Board assurance that in respect of Risk Management and Internal Control, effective systems across the whole of the organisation's activities (both clinical and non-clinical), support the achievement of the organisation's objectives and report to the Board.

4.14.2 **All to ensure they act on lessons learnt from risks incidents and they review the risk reports and key issue reports on a quarterly basis.**

4.15 **Wards and Departments**

4.15.1 To identify, assess and monitor risks as they arise or are anticipated in accordance with the Risk Assessment Policy. Risks may be identified as a result of

4.15.1.1 Incidents

4.15.1.2 Complaints

4.15.1.3 Claims

4.15.1.4 Serious Incidents Requiring Investigation and Never Events

4.15.1.5 Risk Assessments

4.15.1.6 External and internal reviews, inspections and assessments

4.15.1.7 External and internal audit activity

4.15.2 All such risks will be referred to and recorded on Divisional Risk Registers, which will then be used to ensure the effective management of those risks.

4.15.3 Risks will also be reported using the Key Issues Report to ensure the information is cascaded up.

4.16 **All Trust Staff** - Risk management is everyone's responsibility and it is important that potential risks are identified within all levels of the organisation; however it is also important that risks are articulated, recorded and acted upon appropriately and systems have been put in place to facilitate this as described in the Risk Management Standard Operating Procedure (SOP0064) which all staff are required to abide by.

5 Risk Appetite

5.1 See Risk appetite statement – Appendix 1

5.2 Risk appetite can be defined as the amount of risk, on a broad level, that an organisation is willing to accept in the pursuit of its strategic objectives.

5.3 Risk appetite is a core consideration in any corporate risk management approach. No organisation, whether in the private, public or third sector can achieve its objectives without taking a risk. The question for the decision-makers is how much risk do they need to or are prepared to take.

5.4 The UK Corporate Governance Code states that "the board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic decisions". As well as meeting the requirements imposed by corporate governance standards, organisations are increasingly being asked to express clearly the extent of their willingness to take risk to meet their strategic objectives.

5.5 Risk appetite, correctly defined, approached and implemented, should be a fundamental business concept that makes a difference to how organisations are run. The strategy will be to develop an approach to risk appetite that is practical and pragmatic, and that makes a difference to the quality of decision-making, so that decision-makers understand the risks in any proposal and the degree of risk to which they are permitted to expose the organisation while encouraging enterprise and innovation.

5.6 The Trust's risk appetite is expressed in two key ways. Firstly, through the score attributed to particular risk impacts, and secondly through the approach to risks which have specific overall risk scores.

5.7 The Trust uses a risk matrix which is common across the NHS and globally recognised standard for risk measurement and management.

5.8 Good Governance Institute – Risk Appetite Descriptions – see appendix 2

5.9 Risk Appetite Summary Table – see appendix 3

6 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Every year	Head of Corporate Governance & Legal	Executive Group and Trust Board	Where gaps are recognised action plans will be put into place
Compliance with the Trust's Risk Management standard operating procedure.	Managed via the outputs of the divisional governance groups monthly	Divisional Governance Teams	Executive Group and Trust Board	Where gaps are recognised action plans will be put into place
The Integrated Audit Committee	Oversight of Risk Management and systems of control	Chair of the Audit Committee	Trust Board	Where gaps are recognised action plans will be put into place

7 Training and Implementation

7.1 To support the implementation and embedding of the risk management policy and procedures the following training is available.

7.1.1 Every two years Risk Management training is provided by an external company to the Board.

7.1.2 A more in depth risk training presentation, Risk Management for Governance Staff, is delivered by the Assistant Head of Integrated Governance for staff in Governance roles.

7.1.3 As a result of in depth Risk Register Reviews by the Assistant Head of Integrated Governance, bespoke training is available to all staff teams, tailored to their specific needs and includes advice and guidance on the management of risk in their area and support with development of risk registers.

8 Equality Impact Assessment Statement & Tool

A screening process has been carried out and this policy does not require a full impact assessment.

9 References

Document	Ref No
References:	
Trust Associated Documents:	
Standard Operating Procedure for Risk Management	SOP0064
Medway NHS Foundation Trust Standard Operating Procedure for the Board Assurance Framework	SOP0165
Risk Assure Procedure	SOP0166

10 APPENDIX 1 - Risk Appetite Statement

The Trust Board has considered and agreed the principles regarding the risks that Medway NHS Foundation Trust is prepared to seek, accept or tolerate in the pursuit of its objectives.

The Trust Board has taken a cautious view regarding the risks that it is prepared to take in terms of risks to quality and patient safety, compliance and regulation, reputation, workforce and external stakeholders.

In recognition of a challenging financial climate, the Trust Board has taken a view to reduce its risk appetite for financial controls.

In all these areas the Trust expresses a preference for safe delivery options that have a low degree of risk and which may only have a limited potential for reward.

Alternatively, the Trust Board has set a high appetite for innovation, indicating an open approach and willingness to consider all potential delivery options while also providing an acceptable level of reward, (value for money).

This Statement sets out the Board's strategic approach to risk-taking by defining its boundaries and risk tolerance thresholds therefore supporting delivery of the Trust's Risk Management Strategy and Policy.

The Board understands that there is a balance to be maintained between key risk areas and that sometimes risks in some areas will need to be taken to manage risks to an acceptable level in other areas. The Trust's risk management framework requires that where the Trust's risk appetite is exceeded the risk review governance process includes:

- scrutinising the adequacy of mitigating actions and controls
- agreeing the timeline for bringing the risk within the acceptable risk tolerances
- monitoring progress
- determining any further actions and escalation routes if needed

Finance

Until such times as financial sustainability is re-established, the Trust's strategy will be based mainly on low-risk opportunities and on a highly controlled basis. The Trust is cautious in accepting the possibility of some limited financial loss. Value for money is still a primary concern.

Compliance and Regulation

The Trust has been, and continues to be under regulatory scrutiny, having been rated "Requires Improvement" by the Care Quality Commission. The Trust is keen to move at pace on its "Better Best Brilliant" Programmes of improvement, as this is key to optimising quality and financial sustainability and the Trust takes a minimal or avoidance approach to risks that will compromise this.

The potential for non-compliance with legal and statutory requirements undermines public and stakeholder confidence in the Trust and therefore the Trust has minimal appetite in relation to these risks. The Trust has a preference for safe delivery options rather than risk breaching legislative and regulatory obligations.

Innovation

The Trust has greatest appetite to pursue innovation and challenge current working practices in terms of its willingness to take opportunities where positive gains can be anticipated and it supports the use of systems and technology developments within service delivery. The Trust is eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risks). The Trust is supportive of innovation, with demonstration of commensurate improvements in management control. It supports the use of information and patient management systems and technological developments being used to enhance operational delivery of current operations.
The Trust will consider risks associated with innovative technology and research and development approaches to enable the integration of care, development of new models of care and improvements in clinical practice to support sustainability.

Reputation

The Trust recognises that patient confidence and trust in the organisation is important for good outcomes. The Trust therefore has a moderate appetite for risks that may cause reputational damage and undermine public and stakeholder confidence. The Trust's tolerance for risks relating to its reputation is limited to those events where there is little or no chance of **significant** repercussions for the organisation.

The Trust will maintain high standards of conduct, ethics and professionalism and will not accept risks or circumstances that could cause reputational damage to the Trust and/or the wider NHS.

Quality and Patient Safety

The Trust is responsible for ensuring the quality and safety of services it delivers. The provision of high quality services is of the utmost importance to the Trust and the Trust has low appetite for risks that impact adversely on quality of care. The Trust is strongly adverse to risks that could result in non-compliance with standards of clinical or professional practice, unintended outcomes or poor clinical interventions. The Trust has low appetite for options that impact on patient safety, the Trust will avoid taking risks that will compromise patient safety.

Workforce

The Trust will not accept risks associated with unprofessional conduct, underperformance, bullying, or an individual or a team's competence to perform roles or tasks safely, nor any incidents or circumstances which may compromise the safety of any staff member or group.

The Trust will only tolerate lower substantive staffing levels where there is visible competent leadership, a robust management plan is in place and prevailing shortages of staff are supported by trained and competent temporary staffing to keep within safe staff numbers.

For patient safety, quality care and service and financial sustainability reasons the Trust is willing to consider risks associated with the implementation of non-NHS standard terms and conditions of employment, innovative resourcing and staff development models.

External Stakeholders

The Trust has a greater appetite to seek out opportunities and take greater inherent risks for higher rewards in pursuit of partnership development and collaborative working where this is considered advantageous to the Trust or wider health economy through implementing sustainability and transformation plans.

11 APPENDIX 2 - Good Governance Institute – Risk Appetite Descriptions

Appetite Level	Described as:
None	**Avoid**: the avoidance of risk and uncertainty is a Key Organisational objective.
Low	**Minimal** (as little as reasonably possible): the preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential.
Moderate	**Cautious**: the preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward.
High	**Open**: willing to consider all potential delivery options and choose, while also providing an acceptable level of reward (and Value for Money).
Significant	**Seek**: Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). **Mature**: Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

12 APPENDIX 3 - Risk Appetite Summary Table

The diagram below summarises the Trust's risk appetite across these domains.

Domain	Appetite	Consequence	Likelihood	Score (trigger level)
Quality and Patient Safety	Low	2	2	4
Financial/Value for money	Moderate	2	3	6
Compliance and regulation	Moderate	2	2	4
Workforce	Moderate	2	2	4
Reputation	Moderate	3	2	6
External Stakeholders	Moderate	3	2	6
Innovation	High	3	3	9

Standard Operating Procedure for Risk Management

Relevant to:

Trust Wide

Purpose of SOP:

Risk assessment is a systematic and effective method of identifying risks and determining the most cost-effective means to minimise or remove them. It is an essential part of any risk management programme, and it encompasses the processes of risk analysis and risk evaluation. The Trust is required to have in place efficient assessment processes covering all areas of risk. It is also a legal requirement that all NHS staff actively manage risk.

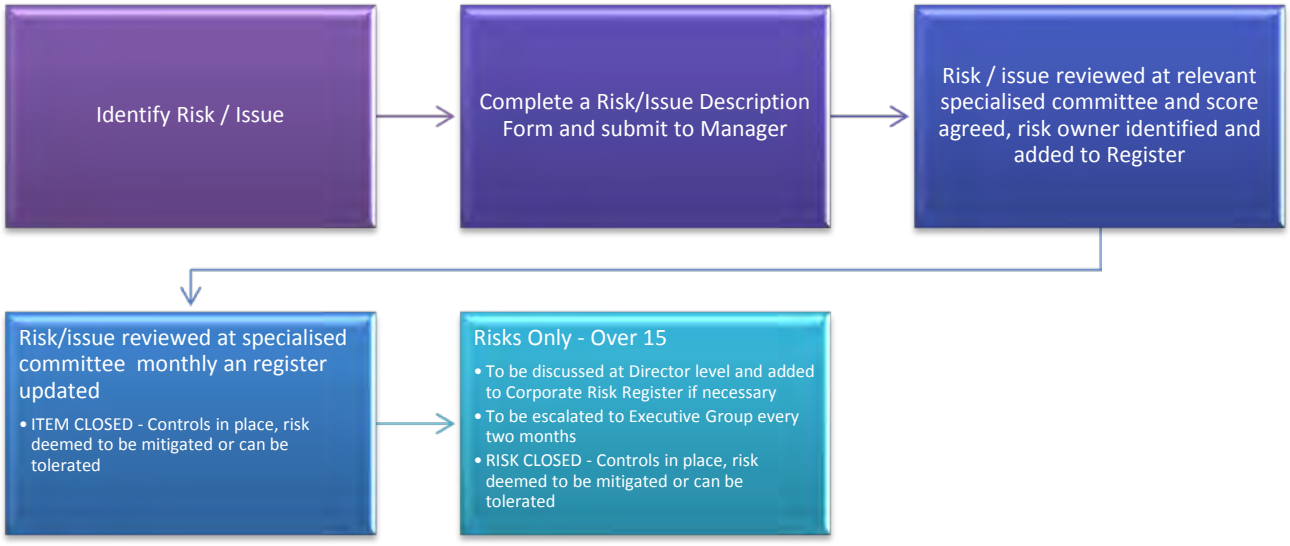
To separate those risks that are unacceptable from those that are tolerable, risks should be evaluated in a consistent manner. Risks are usually analysed by combining estimates of consequence (also described as severity or outcome) and likelihood (frequency or probability) in the context of existing control measures. In general, the magnitude or rating of a given risk is established using a two-dimensional grid or matrix, with consequence as one axis and likelihood as the other (see appendix A).

The purpose of this document is to describe how risks will be identified, assessed, recorded, mitigated and escalated within Medway NHS Foundation Trust (MFT).

This procedure describes the governance systems in place at MFT to ensure that risk is managed at appropriate levels within the organisation and escalated appropriately.

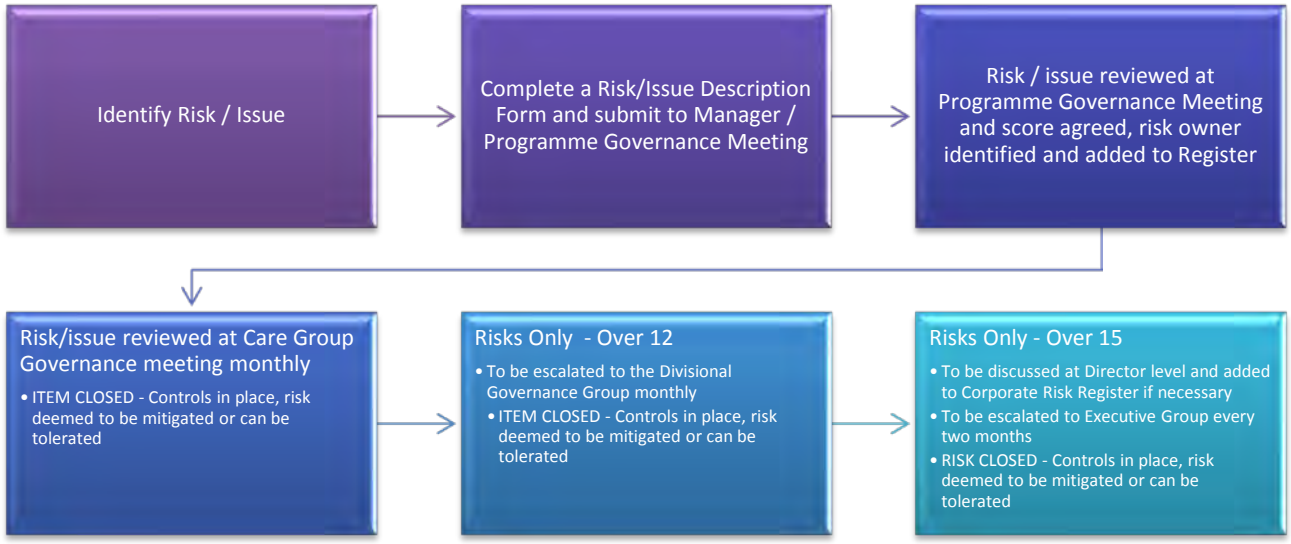
Procedure to Follow:

CORPORATE DIVISIONS – HR/OD, FINANCE, IT, COMMS, ESATES & FACILITIES, CORPORATE GOVERNANCE & LEGAL, NURSING & MEDICAL DIRECTOR



Standard Operating Procedure for Risk Management

PLANNED CARE & UNPLANNED & INTEGRATED CARE DIVISIONS



Accountability and Ownership

1) Accountability Sponsor and Owner

The Accountability Sponsor is the person with overall responsibility for the risk, controls and actions. This will be any one of the Directors of Clinical Operations, Executive Directors, Chief Executive, Deputy Chief Executive or the Chair and within Risk Assure there is a drop down list from which one of these posts can be selected.

The Accountability owner is the person with overall management responsibility for the risk, controls and actions of the risk owner.

2) Risk Owner

The risk owner is the person responsible for the overall management of that risk, they may delegate control actions to other members of staff and these can be identified within Risk Assure when adding the control measures as the person responsible for a particular control measure.

Management of the Division risk register

Risks which have been accepted to be inputted on Risk Assure to form part of the Division Risk Register must be reviewed on a regular basis.

At Care Group level, the divisional risks and issues identified as being assigned to the particular Care Group are reviewed on a monthly basis. This review includes all elements of the risk, i.e. description, score, have the mitigating actions been completed, can the present score be reduced or does it need to be increased, are further mitigating actions required, is escalation required.

At Division Board all risks and issues scoring over 12 on the Divisional risk register are reviewed where possible and Care Group management teams will be required to report on the effectiveness of mitigating actions.

At Division Board level, the decision is made whether to assign further mitigating actions, escalate the risk as a corporate level risk (for example its impact extends beyond the division), or close risks which have been appropriately mitigated.

Within Corporate Divisions, such as Finance and Human Resources, a similar process is followed, whereby risks are identified, assessed and mitigated at management level meetings and ultimately considered for inclusion on the Division risk register, escalation or closure at Division level meetings.

Management of the Corporate Risk Register

Risks will be added and linked from the Directorate risk register that score over 15. A new corporate risk score will be calculated by the Executive Risk Accountability Owner and Sponsor. The Assistant Head of Corporate Governance & Legal will input the risks onto Risk Assure.

Risks which have been accepted to be inputted on Risk Assure to form part of the Corporate Risk Register must be reviewed on a regular basis (approximately every two months).

A meeting with the Assistant Head of Corporate Governance & Legal and Executive Risk Accountability Owners to review and update the corporate risk register will take place.

Identification of risk

When identifying a risk, consideration should be given to what could pose a potential threat (or opportunity) to the achievement of objectives within the context of the organisation.

Risks and issues often get confused and a useful way of remembering the difference is;

Risks are things that **might happen** and stop us achieving objectives, or otherwise impact on the success of the organisation.

Issues are things that **have happened that** were **not planned** and require management action.

Risks and issues are identified on Risk Assure by using **R** for Risks and **RI** for Risk Issues within the reference number.

Once identified, the risk needs to be described clearly to ensure that there is a common understanding by all stakeholders of the risk.

The recommended format for risk descriptions is to identify:-

- the cause (i.e. the source of the risk),
- the risk event (what could happen) and
- the effect (the impact of the risk)

Processes have been put in place across the organisation to ensure that risks and issues are identified, appropriately articulated, recorded and escalated appropriately.

This process is described in the Risk Register and Escalation section and summarised in Appendix C.

3) Risk Reference number

Each risk on the risk register is identified by a unique reference number, this is made up as follows;

Important Must Do

R or RI	Initials indicating R for risk, RI for Risk Issue,
UPIC	The Division e.g. UPIC for Unplanned and Integrated Care and PC for Planned Care, then if a Care Group risk, this is identified by 3 or 4 letters,
2019	The year expressed as YYYY, followed by a
01	Sequential number.
	For example within the Emergency Medicine Care Group, the first risk identified in 2019 would have the reference
	R - UPIC – EMP - 2019-001 and next one R - UPIC –SMP - 2019-002
	If the risk has happened and classed as a risk issue it would read
	RI - UPIC – EMP - 2019-001 and next one RI - UPIC –SMP - 2019-002

Risk assessment and scoring

4) Consequence score

It is vital that all risks are assessed in an objective and consistent manner if they are to be managed, and to guide operational resource allocation.

When undertaking a risk assessment, the consequence or 'how bad' the risk being assessed is must be measured. In this context, consequence is defined as: the potential outcome of an event. Clearly, there may be more than one consequence of a single event.

Consequences can be assessed and scored using qualitative and quantitative data. Wherever possible, consequences should be assessed against objective definitions across different types (see appendix A table 1) to ensure consistency in the risk assessment process. Despite defining consequence as objectively as possible, it is inevitable that scoring the consequences of some risks will involve a degree of subjectivity and it is important to take a group approach to arrive at the most appropriate consequence score.

Choose the most appropriate type for the identified risk from the left hand side of the risk scoring matrix (appendix A table 1), then work along the columns in the same row to assess the severity of the risk on the scale of 1–5 to determine the consequence score, which is the number given at the top of the column.

Important Must Do

It is very important for reporting purposes to choose the correct type for the following risk / issues across the divisions. This will enable specialised managers i.e. Health and Safety Manager to run reports detailing all risks across all divisions.

Type	Risk / Risk Issue Types	Target
Patient Safety	Health and Safety & Infection Control	**Quality / Patient**
Business Objectives / Projects	Project budgets only	**Finance / Reputation**
Finance	Budget	**Finance / Reputation**
Quality / Audit	Failure to meet standards	**Quality / Patient**
Complaints / Claims	Legal issues	**Compliance / Regulation**
HR	Staff morale	**Workforce**
Organisational development	Training	**Workforce**
Staffing Competence	Staffing levels	**Workforce**
Compliance / audit / governance	Non-compliance against policies / breaches	**Compliance / Regulation**
Adverse publicity / reputation	Media stories	**Finance / Reputation**
Service / business interruption	Loss of service – downtime	**Finance / Reputation**
Environmental	Environmental impact	**Compliance / Regulation**
Agreed targets	Failure to meet national target	**Innovation**
Fire Safety / General Security	Fire and Security	**Compliance / Regulation**
IT / Information Governance	IT and IG	**Compliance / Regulation**
External Stakeholders	Partnership development and collaborative working implementing sustainability and transformation plans.	**External Stakeholders**

5) Likelihood Score

Once a specific area of risk has been assessed and its consequence score agreed, the likelihood of that consequence occurring can be identified by using Appendix A table 2. As with the assessment of 'consequence', the likelihood of a risk occurring is assigned a number from '1' to '5': the higher the number the more likely it is the consequence will occur.

When assessing likelihood, it is important to take into consideration the context of the risk being assessed. The likelihood score is a reflection of how likely it is that the adverse consequence described will occur.

Appendix A table 2 gives an indication of qualitative and quantitative descriptions for frequency, by considering how often the adverse consequence being assessed will be realised. For example, when assessing the risk of staff shortages on a ward, the likelihood of occurrence could be assessed as expected to occur daily or even weekly depending on staffing levels. However, if staff shortages are unlikely it could be graded as expected to occur annually.

However, frequency is not a useful way of scoring certain risks, especially those associated with the success of time-limited or one-off projects such as a new IT system that is being delivered as part of a three-year programme or business objectives. For these kinds of risks, the likelihood score cannot be based on how often the consequence will materialise. Instead, it must be based on the probability that it will occur at all in a given time period. In other words, a three-year IT project cannot be expected to fail 'once a month', and the likelihood score will need to be assessed on the probability of adverse consequences occurring within the project's time frame.

With regard to achieving a national target, the risk of missing the target will be based on the time left during which the target is measured. The trust might have assessed the probability of missing a key target as being quite high at the beginning of the year, but nine months later, if all the control measures have been effective, there is a much reduced probability of the target not being met.

6) Calculate the Risk Score

Calculate the risk score by multiplying the consequence by the likelihood: C (consequence) × L (likelihood) = R (risk score).

7) Target Risk Score / Risk Appetite

The target risk scores are based on the Risk Appetite levels which have been agreed by the Trust Board.

Risk appetite is the level of risk an organisation is prepared to tolerate in pursuit of its objectives and will be different for different categories of risk.

As the risk appetite indicates the tolerance level, it also indicates the level at which the risk can be moved to the closed risk register i.e. when the controls in place have reduced the risk to a level the Trust deems tolerable.

The Trust Board has approved a Risk Appetite Statement, identifying the risk appetite and so target score as below:-

Risk Type	Target Risk Score
Quality / Patient Safety	4 (2x2)
Compliance / Regulation	4 (2x2)
Workforce	4 (2x2)
Finance / Reputation	6 (2x3)
External Stakeholders	6 (2x3)
Innovation	9 (3x3)

In order to guide staff on the appropriate target risk score, the Target Score section on RiskAssure has been updated to include the Trust risk target scores in line with the table above.

8) Action planning

Following completion of the risk assessment, consideration must be given to whether the risk requires further management actions that ideally minimise the likelihood and/or impact of a threat (or maximise the likelihood of opportunities). For each risk an identification of mitigation action plans to eliminate or minimise the risk is required, in order to reduce the risk to an acceptable or tolerable level i.e. target score.

The implementation of the action plan and the level of risk must be kept under review. Where implementation of action plans is not producing the anticipated results, the risk should be re-assessed and a revised action plan agreed as necessary.

Risk Register and Escalation

Risk management is everyone's responsibility and it is important that potential risks are identified within all levels of the organisation; however it is also important that risks are articulated, recorded and acted upon appropriately and systems have been put in place to facilitate this. Please see Appendix B.

9) Identification of potential new or reoccurring risks

When a potential risk has been identified, the first action is to complete a risk description form, which is given at Appendix C. The form prompts information on risk description, initial scoring, potential mitigation or mitigation in place, post mitigation scoring, the date the risk was identified, the risk raiser and the potential risk owner. Complete as much is this information as you are able, seeking advice where appropriate.

This form is then given to the most appropriate person, depending on the risk raiser's role. Front line staff members should submit this form to their line managers. Line managers in turn review the potential risk and either feed back to the staff member if the potential risk is already being managed, or submit the form to the relevant next level, e.g. in the case of the Clinical Divisions, to the Care Group Board.

At Care Group Board, risk register description forms are reviewed, any additional information added in the manager's review section and where possible further action identified. If deemed appropriate, the risk should be added to the Care Group risk register on the Trust's electronic risk management platform – Risk Assure. If the matter identified is an operational issue rather than a risk, this must be managed at operational level. Issues are still recorded on the risk register.

At Care Group level and below, if the identified risk is deemed to score 15 or above or the risk is perceived as urgent, then the risk description form must be sent to the Division Senior Management and Governance Teams and the matter discussed at the first opportunity.

10) Action to Take

Very low and low risks (1-8)

Most risks will be graded into these less serious categories and can normally be managed through local action by line managers and local risk registers.

Risk	Further Action	By Whom
Very low	Acceptable	All staff

Score 1-3	• Inform all appropriate stakeholders • Take action to reduce risk where necessary and within authority • Complete the risk form and pass to manager	
Low **Score 4-8**	Acceptable risk. As above plus: • Discuss whether any further action should be taken to reduce future risk • Report to care group governance group for management	Departmental Lead/Supervisor/Ward Manager/Team Leader

Moderate risks

Those risks classed as moderate will be addressed by a Clinical Director of the service area, Deputy Directors or Associate Directors. Where risks are complex, separate risk assessments and action plans must be recorded on Health Assure for all identified moderate risks to determine the most appropriate way of dealing with the risk. This will be reported to the appropriate group e.g. Divisional Governance Group using the key issues reports. Further action may also include a requirement to discuss the risk at the Trust Integrated Audit Committee.

Risk	Further Action	By Whom
Moderate **Score 9-12**	Considerable risk • For complex risks, complete and record full risk assessment and action • Inform all appropriate stakeholders • Take action to reduce risk within authority • Discuss further actions to be taken to reduce risk • Report to Divisional Governance Group for management via key issues report • Place on to risk register • Risk to be managed/monitored at divisional governance group • Risks to be discussed with the Divisional Management Team on a monthly basis	Executive Directors Clinical Director of Operations Clinical Directors

High risks (15+)

All high risks will be recorded on the corporate risk register and reported 2 times per year by the Deputy Chief Executive to the Board and Integrated Audit Committee to approve action plans and monitor progress.

Risk	Further Action	By Whom
High **Score 15-25**	Significant risk. As above plus: • Reviewed by Executive Group bi-monthly • Corporate risk register will be reviewed 2 times a year at Integrated Audit Committee • Corporate risk register will be reviewed by the Trust Board 2 times a year.	Executive Directors Division Directors/Management Team Deputy/Associate/Clinical Directors Director of Corporate Governance and Legal Deputy Chief Executive

Implications of not following procedure

Unmanaged risk is a threat to the Trust achieving its Strategic and Operational objectives.

Useful Contacts:

Paul Mullane – Head of Corporate Governance & Legal
Tracy Kelly – Assistant Head of Corporate Governance & Legal

Monitoring the Process:

This process has been agreed and approved and adherence will be monitored via the Integrated Audit Committee, Executive Group and Trust Board.

National Definitions:

Risk is an uncertain event or set of events that, should it occur, will have an effect on the achievement of objectives.

Issue is an event or set of events that have occurred and have an effect on the achievement of objectives.

Risk management is the assessment, analysis and management of risks. It is simply a way of recognising which events (hazards) may lead to harm in the future, and minimising their likelihood of occurrence (how often?) and consequence(s) (how bad?).

Risk Cause is a description of the source of the risk, i.e. the situation that gives rise to the risk.

Risk Event is a description of the area of uncertainty in terms of the threat or the opportunity.

Risk Effect is a description of the impact that the risk would have on the organisational activity should the risk materialize.

Risk Proximity is the time factor of risk, i.e. the occurrence of risks will be due at particular times and the severity of their impact will vary depending on when they occur.

Acceptable/tolerable risk is defined based on the following principles.

- Tolerability does not mean acceptability. It refers to a willingness to live with risk to secure certain benefits, but with the confidence that it is being properly controlled. To tolerate risk does not mean to disregard it, but rather that it is reviewed with the aim of reducing further risk.
- No person should be exposed to serious risk unless they agree to accept the risk.
- It is reasonable to accept a risk that under normal circumstances would be unacceptable if the risk of all other alternatives, including nothing, is even greater.

Reference Material & Associated Documents:

Management of Risk (MoR®): Guidance for Practitioners 2010 Edition.

National Patient Safety Agency (NPSA) A risk matrix for risk managers (January 2008)

Approval Signatures:

Revision No:	**8**	**ID No:**	**SOP0064**
Distribution:	**Intranet**		
Date Approved:			
Approved By:	**Integrated Audit Committee, Executive Group and Trust Board**		
Review date:			
Author	**Assistant Head of Corporate Governance & Legal** **Head of Corporate Governance & Legal**		
Person responsible for review / Owner:	**Deputy Chief Executive**		

Appendix A Risk Rating Guidance

Table 1	Consequence score (severity levels) and examples of descriptors				
Type	**1**	**2**	**3**	**4**	**5**
	Negligible	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on Health and Safety of Patients, Staff, Visitors	Minimal injury requiring no / minimal intervention or treatment. No time off work	Minor injury/illness requiring minor intervention Time off work <3 days Increase in LOS by 1-3 days Affects 1-2 people	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay 4-14 days RIDDOR/agency reportable incident An event which impacts on a small number of patients Affects (3-15) people	Major injury leading to long-term incapacity/disability >14 days off work Increase in LOS by >15 days Mismanagement of patient care with long term effects An event which impacts on moderate numbers (16-50)	Death Multiple permanent injuries or irreversible health effects An event which impacts on large numbers (>50)
Business objectives / projects	Insignificant cost increase / schedule slippage.	<5% over project budget	5-10% over budget	10-25% over budget	>25% over budget
Finance	Small loss <£10,000	Loss of greater than £10,000 and less than 0.25 % of turnover.	Loss of 0.26-0.5% of budget	Loss of 0.51-1.0% of budget Uncertain delivery of key objectives Purchasers failing to pay on time	Loss of >1% of budget Non-delivery of key objectives Failure to meet specification/ slippage Loss of contract/service/payment by results

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

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

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

Table 1	Consequence score (severity levels) and examples of descriptors				
Type	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
	this Risk Type	Fail to meet National target 1 quarter	Fail to meet National target 2 qtrs. Amber light	Fail to meet National target > 2 quarters Red light	Failure to meet National target > 2 quarters, by more than 20%
Fire Safety/General Security	Minor short term (<1day) shortfall in fire safety system Security incident no adverse outcome	Temporary (<1 month) shortfall in fire safety system / single detector etc. (non-patient area) Security incident managed locally Controlled drug discrepancy accounted for	Fire code non-compliance / lack of single detector – patient area etc. Security incident leading to compromised staff / patient safety. Controlled drug discrepancy – not accounted for	Significant failure of critical component of fire safety system (patient area) Serious compromise of staff / patient safety	Failure of multiple critical components of fire safety system (high risk patient area) Infant / young person abduction
Information Governance / IT	Breach of confidentiality – no adverse outcome. Unplanned loss of IT facilities < half a day Health records / documentation	Minor breach of confidentiality – readily Resolvable Unplanned loss of IT facilities < 1 day Health records incident /	Moderate breach of confidentiality – complaint initiated Health records documentation incident – patient care affected with short term consequence	Serious breach of confidentiality – more than one person Unplanned loss of IT facilities >1 day but less than one week Health records /	Serious breach of confidentiality – large Numbers Unplanned loss of IT facilities >1 week Health records / documentation incident

Table 1	Consequence score (severity levels) and examples of descriptors				
Type	1	2	3	4	5
	Negligible	Minor	Moderate	Major	Catastrophic
	incident – no adverse outcome	documentation incident – readily resolvable		documentation incident – patient care affected with major consequence	– catastrophic consequence
External Stakeholders					

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

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

Standard Operating Procedure for Risk Management

Appendix B Organisation Process for Risk Escalation and Management

Risks Only - Over 15	•Requires review by Executive Group every two months, Trust Board and Integrated Audit Committee every six months
Risks Only - Over 12	•Requires review by Divisional Governance Groups or specialised committee (every month)
HR /OD Risks / Issues	•Requires review by Strategy Workforce Group and escalated to the Executive Group if over 12
Finance Risks / Issues	•Requires review by Executive Group and escalated to the Finance Committee if over 12
IT Risks / Issues	•Requires review by IG committee and escalated to the Executive Group if over 12
Governance, Legal, Comms, Trust Secretary Risks / Issues	•Requires review by Executive Group and escalated to Integrated Audit Committee if over 12
Infection Control Risks / Issues	•Requires review from the Infection Prevention and Antimicrobal Stewardship and escalated to Executive Group if over 12
Quality Risks / Issues	•Requires review by the Quality and Patient Safety Steering Group and escalated to Executive Group if over 12
R & D Risks / Issues	•Requires review from the Research and Innovation Group and escalated to Executive Group if over 12
Nursing Risks / Issues	•Requires review from Nursing and Midwifery Group and escalated to Executive Group if over 12
Medicines Management / Drugs Risks / Issues	•Requires review from the Medicines Management Committee and escalated to Quality and Patient Saftey Group and escalated to Executive Group if over 12
Safeguarding Risks / Issues	•Requires review by the Safeguarding Committee and escalated Division Governance and Nursing and Midwifery Strategy Group and escalated to Executive Group if over 12

Appendix C Risk Description Form

Risk Description Form - DOC.dotx

Meeting of the Board of Directors in Public
Wednesday, 08 January 2020

Title of Report	**Emergency Preparedness, Resilience and Response (EPRR) Assurance Assessment report**	**Agenda Item**	**11.1**
Lead Director	Harvey McEnroe, Chief Operating Officer		
Report Author	Steve Arrowsmith, Head of Emergency Preparedness, Resilience and Response		
Executive Summary	Medway NHS Foundation Trust is subject to an annual assurance process for Emergency Planning under the NHS England EPRR Framework as stipulated by the Civil Contingencies Act (2004). Medway NHS Foundation Trust were Assurance audited by NEL on behalf of Medway Clinical Commissioning Group		
Link to strategic Objectives 2019/20	**Innovation:** We will embrace innovation and digital technology to support the best of care		☐
	Finance: We will deliver financial sustainability and create value in all we do		☐
	People: We will enable our people to give their best and achieve their best		☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership		☐
	High Quality Care: We will consistently provide high quality care		☒
Due Diligence	To give the Trust Board assurance, please complete the following:		
Committee Approval:	Name of Committee: EPRR Group Date of approval: 6 November 2019		
Executive Group Approval:	Date of Approval: 20 November 2019		
National Guidelines compliance:	Does the paper conform to National Guidelines (please state): NHS E EPRR Annual Assurance Process		
Resource Implications	None		
Legal Implications/ Regulatory Requirements	The sighting of this paper at Executive and Board level supports the Trusts obligations under the Civil Contingencies Act (2004)		
Quality Impact Assessment	Not applicable		
Recommendation/	The report is presented for Assurance		

Actions required	Approval ☐	Assurance ☒	Discussion ☐	Noting ☐
Appendices	Appendix 1 – Partially Complaint Standards			

Medway Foundation Trust

EPRR Assurance Assessment Report

September 2019

Samantha Proctor, NEL BR team

September 2019

Document revision history

Date	Version	Revision	Comment	Author
16.09.19	V1			SP
26.09.19	Final	Addition of paragraph re staffing resources provided by NS as discussed with SA		

Document Approval history

Date	Version	Revision	Comment	Author
26.09.19	Final	Agreed by Nigel Scott and Steve Arrowsmith		

Assurance Visit

NEL Business Resilience team and CCG Commissioners visited Medway Foundation Trust to conduct an assessment of their Emergency Planning Response and Recovery [EPRR] preparedness against the NHS England EPRR Core Standards.

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

Assessment Details	
Date of assessment	3 September 2019
Locations of assessment	Medway Maritime Hospital
Assessors	Nigel Scott, Assistant Director – Corporate Services, DGS and Swale CCGs Samantha Proctor, Head of Business Resilience, NEL Vince Mott, Senior Business Resilience Lead, NEL
Provider Representatives	Steve Arrowsmith, Head of EPRR, MFT

Areas Investigated

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

EPRR Core Standards

Deep Dive – Severe Weather response /Long term adaptations planning

Assessment Results

Medway Foundation Trust were able to demonstrate to provide evidence to demonstrate the following rates of compliance

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Governance	6	5	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	14	10	4	0
Command and control	2	2	0	0
Training and exercising	3	3	0	0
Response	7	7	0	0
Warning and informing	3	3	0	0
Cooperation	4	4	0	0
Business Continuity	9	7	2	0
CBRN	14	13	1	0
Total	64	56	8	0

Deep Dive	Total standards applicable	Fully compliant	Partially compliant	Non compliant
Severe Weather response	15	12	3	0
Long Term adaptation planning	5	4	1	0
Total	20	16	4	0

Overall assessment:	Partially compliant

Full assessment results are appended to this report, along with resulting action plan.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100 percent compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99 percent compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88 percent compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76 percent or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

Assessment Narrative

The year 2018/19 was a challenging one for Medway Foundation Trust in relation to EPRR. In July 2018 their longstanding and experienced Head of EPRR left for pastures new. Despite 2 recruitment rounds a new substantive Head of EPRR did not come into post until May 2019. This gap in focussed specialist resource has impacted upon the Trust and its levels of compliance being reported this year.

To ensure that this situation cannot re-occur and that future standards are maintained the Board should consider available options to consider wider succession planning and/or enhance cross

organisational support so as to mitigate this potential single point of failure. Since coming into post the new Head of EPRR has undertaken a detailed assessment of the EPRR baseline of the trust and prioritised his work programme to ensure that all key requirements could be met.

The commissioning CCG has been aware of this ongoing situation and as such requested that the Trust were subject to a face to face EPRR Assurance assessment visit this year, in order to explore with the Trust its current position and agree a collaborative way forward for any resulting action plan.

The face to face assessment visit was undertaken on the 3 September and considered all evidence provided in detail. This meeting agreed that this year MFT had achieved Partial compliance against the NHS England EPRR Assurance Framework Standards.

The commissioners of this provider can be assured that the trust has in place the required measures to respond to both internal disruptions and external major incidents. However, it should be noted that there is still work required to get the compliance back to their former levels. Full assessment results are appended to this report, along with resulting action plan.

Examples of good practice

During the assessment a number of items of good practice were identified, these are shown below:

- Annual EPRR Work plan – the annual work plan does not only show the details of the work items required to be achieved across the annual cycle, but is also 'time costed'. This has allowed the head of EPRR to identify that additional man hours were required in order to achieve the work required. This has resulted in the Trust AEO to allocate extra staff hours to support the EPRR agenda. This includes the following:
    - Emergency Dept. Assistant Manager being put forward to do the DipHep training, thus expanding the specialist knowledge resource at the trust
    - 1 day per week of ED Operational Management time working with the Head of EPRR on dedicated work areas
    - 2 ED staff trainers focussing on the CBRN training requirements of ED staff. [2 days per month]

  Initial feedback from the wider Emergency Department staff is that this closer collaborative working arrangement is proving very positive. Response staff are feeling greater levels of confidence in their roles and responsibilities.

Item 11.1
Appendix 1
Medway Foundation Trust EPRR Assurance Assessment – Partially compliant standards

Ref	Domain	Standard	Detail	Assurance Score	Management Action Plan	Responsible officer	Date
3	Governance	EPRR board reports	The Chief Executive Officer / Clinical Commissioning Group Accountable Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board / Governing Body, no less frequently than annually. These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process.	Partially compliant	Submit report to board as soon as assurance process has ended	Head of EPRR, MFT	Apr – 20
17	Duty to maintain plans	Mass countermeasures	In line with current guidance and legislation, the organisation has effective arrangements in place to distribute Mass Countermeasures - including arrangement for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. CCGs may be required to commission new services to support mass countermeasure distribution locally, this will be dependent on the incident.	Partially compliant	new document to be added and specific organisational action to be taken added to the Major incident Plan	Head of EPRR, MFT	Nov-19
19	Duty to maintain plans	Mass Casualty - patient identification	The organisation has arrangements to ensure a safe identification system for unidentified patients in an emergency/mass casualty incident. This system should be suitable and appropriate for blood transfusion, using a non-sequential unique patient identification number and capture patient sex.	Partially compliant	Documents in the Decon Shed to be updated to non-sequential numbering	Head of EPRR, MFT	Jan-19
20	Duty to maintain plans	Shelter and evacuation	In line with current guidance and legislation, the organisation has effective arrangements in place to shelter and/or evacuate patients, staff and visitors. This should include arrangements to shelter and/or evacuate, whole buildings or sites, working in conjunction with other site users where necessary.	Partially compliant	Plan to be reviewed and agreed via the EPRR Group	Head of EPRR, MFT	Jan-19

Ref	Domain	Standard	Detail	Assurance Score	Management Action Plan	Responsible officer	Date
22	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond and manage 'protected individuals'; Very Important Persons (VIPs), high profile patients and visitors to the site.	Partially compliant	Document to be refreshed as part of the EPRR Group review	Head of EPRR, MFT	Nov - 19
48	**Business Continuity**	**BCMS scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented.	Partially compliant	BC Policy to be reworked to ensure Scope of the BC Policy includes a section on scope	Head of EPRR, MFT	Dec-19
52	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	Partially compliant	Plan to monitor Training, Trained Loggists, BC Plans in date and Decon trained staff	Head of EPRR, MFT	Dec-19
67	**CBRN**	**HAZMAT / CBRN trained trainers**	The organisation has a sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.	Partially compliant	Although Trained the CBRN trainers will join the Kent Wide Training programme as trainers run by MTW to ensure CPD is held and able to be evidenced.	Head of EPRR, MFT	Nov-19

Deep Dive Standards

Ref	Domain	Standard	Detail	Assurance Score	Management Action Plan	Responsible officer	Date
5	Severe Weather response	Discharge	The organisation has polices or processes in place to ensure that any vulnerable patients (including community, mental health, and maternity services) are discharged to a warm home or are referred to a local single point-of-contact health and housing referral system if appropriate, in line with the NICE Guidelines on Excess Winter Deaths	Partially compliant	Direct evidence to be obtained from IDS as to checks carried out at home	Head of EPRR, MFT	Dec-19
8	Severe Weather response	Flood prevention	The organisation has planned preventative maintenance programmes are in place to ensure that on site drainage is clear to reduce flooding risk from surface water, this programme takes into account seasonal variations.	Partially compliant	SOP to be obtained for PPMP	Head of EPRR, MFT	Dec-19
15	Severe Weather response	ICT BC	The organisations ICT Services have been thoroughly exercised and equipment tested which allows for remote access and remote services are able to provide resilience in extreme weather e.g. are cooling systems sized appropriately to cope with heatwave conditions, is the data centre positioned away from areas of flood risk.	Partially compliant	IT network Failure table top planned for March/April 2020	Head of EPRR, MFT	Apr-20
19	Long term adaptation planning	Flooding	The organisations adaptation plans include modifications to reduce their buildings and estates impact on the surrounding environment for example Sustainable Urban Drainage Systems to reduce flood risks.	Partially compliant	Invite the Capital project team to the EPRR Group to explain this subject further	Head of EPRR, MFT	Dec-19