Agenda

Trust Board Meeting in Public

Date: Thursday 07 March 2019 at 12.30pm

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

Item	Subject	Presenter	Page	Time	Action
1.	Patient Story	Director of Nursing	Verbal	12:30	Note
2.	**Preliminary Matters**				
2.1	Chair's Welcome and Apologies	Chairman	Verbal	12:50	Note
2.2	Quorum	Chairman	Verbal		Note
2.3	Register of Interests	Chairman	3		Note
3.	**Minutes of the previous meeting and matters arising**				
3.1	Minutes of the previous meeting held on 10 January 2019	Chairman	7	12:55	Approve
3.2	Matters arising and actions from last meeting	Chairman	17		Discuss
4.	**Standing Reports and Updates**				
4.1	Chair's Report	Chairman	Verbal	13:00	Note
4.2	Chief Executive's Report	Chief Executive	19		Note
4.3	Strategy i. Sustainability and Transformation Plan Update ii. Transformation Programme Update	Director of Strategy Associate Director of Transformation/ Chief Operating Officers	23 57		Discuss Discuss
5.	**Quality**				
5.1	Integrated Quality and Performance Report	Director of Nursing/ Medical Director/ Chief Operating Officers	85	13:30	Discuss
5.2	Quality Assurance Committee Assurance Report	Quality Assurance Committee Chair	119		Assurance
5.3	Hospital Standardised Mortality Ratio Update	Medical Director	Verbal		Note
5.4	Safe Working Hours Annual Report	Medical Director	123		Note
5.5	Annual Safeguarding Report	Director of Nursing	139		Approve
6.	**Finance and Performance**				
6.1	Finance Report - Month 10	Director of Finance (Interim)	163	14:15	Discuss
6.2	Finance Committee Report	Finance Committee Chair	169		Note

Agenda

6.	**Finance and Performance**				
6.3	Communications Report	Director of Communications	171		Discuss
7.	**People**				
7.1	Workforce Report	Director of HR and OD	177	14:35	Assurance
7.2	Equality Delivery System	Director of HR and OD	187		Approve
7.3	Gender Pay Gap Report	Director of HR and OD	205		Approve
8.	**Assurance Reports**				
8.1	Integrated Audit Committee Report	Integrated Audit Committee Chair	Verbal	14:55	Assurance
9.	**Policies and Strategies**				
9.1	Corporate Policy: Consent	Director of HR and OD	213	15:00	Approve
9.2	Corporate Policy: Safeguarding	Director of Nursing	225		Approve
9.3	Freedom to Speak Up Strategy	Freedom to Speak Up Guardian	237		Approve
10.	**Other Business**				
10.1	Council of Governors' Update	Governor Representative	Verbal	15:15	Discuss
10.2	Any other business	Chairman	Verbal		Note
10.3	Questions from members of the public	Chairman	Verbal		Discuss
11.	**Date and time of next meeting: 2 May 2019, 12.30pm-3.30pm, Trust Boardroom**				

NHS
Medway
NHS Foundation Trust

MEDWAY NHS FOUNDATION TRUST
TRUST BOARD REGISTER OF INTERESTS
MARCH 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 Solutions	Associate
		Medway NHS Foundation Trust	Chair Quality Assurance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Ewan Carmichael	**Non-Executive Director**	Timepathfinders Ltd	
		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
Anthony Moore	**Non-Executive Director**	Medway NHS Foundation Trust	Chair of Finance Committee
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Mark Spragg	**Non-Executive Director**	Marcela Trust	Trustee
		Sisi & Savita Charitable Trust	Trustee
		Mark Spragg Limited	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**	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

Name	Position	Organisation	Nature of Interest
Ian O'Connor	**Director of Finance (Interim)**	OCOBROWN Health Ltd.	Director
		Essex Partnership Trust	Spouse is a Senior Manager
		Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Karen Rule	**Director of Nursing**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Dr David Sulch	**Medical Director**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee
Leon Hinton	**Director of HR and OD**	Medway NHS Foundation Trust Charitable Funds	Member of the Corporate Trustee

Trust Board Meeting in Public

NHS Medway NHS Foundation Trust

Minutes of the Trust Board of Directors Meeting in Public

Thursday 10 January 2019 at 12.30pm, in the Trust Boardroom, Postgraduate Center, Medway Maritime Hospital, Windmill Road, Gillingham, Kent, ME7 5NY

Members:	Name:	Job Title:	Initial
	Mr Stephen Clark	Chairman	SC
	Ms Joanne Palmer	Non-Executive Director and Senior Independent Director	JP
	Mr Jon Billings	Non-Executive Director	JB
	Mr Tony Moore	Non-Executive Director	TM
	Mr Mark Spragg	Non-Executive Director	MS
	Mr James Devine	Chief Executive	JD
	Mr Ian O'Connor	Director of Finance (Interim)	IOC
	Dr Diana Hamilton-Fairley	Director of Strategy	DHF
	Mr Leon Hinton	Director of HR and OD	LH
	Ms Karen Rule	Director of Nursing	KR
Attendees:	Ms Glynis Alexander	Director of Communications and Engagement	GA
	Mr James Lowell	Director of Planning and Partnerships	JL
	Mr Gary Lupton	Director of Estates and Facilities	GL
	Ms Morfydd Williams	Director of IT Transformation	MW
	Ms Gurjit Mahil	Chief Operating Officer - Planned Care	GM
	Mr Harvey McEnroe	Chief Operating Officer - Unplanned and Integrated Care	HM
	Dr Paul Kitchen	Deputy Medical Director	PK
	Ms Doreen King	Governor Board Representative	DK
	Mr Jack Tabner	Associate Director of Transformation *(Item 4.3b only)*	JT
	Ms Brenda Thomas	Company Secretary (minutes)	BT
	Don Lawrence	Patient Story *(Item 1 only)*	DL
	Sue Lawrence	Patient Story *(Item 1 only)*	SL
Apologies	Mr Adrian Ward	Non-Executive Director	AW
	Mr Ewan Carmichael	Non-Executive Director	EC
	Dr David Sulch	Medical Director	DS
	Mr Alastair Harding	Lead Governor	AH
Observers:	Five members of the public, press and Governors		
	One member of staff		

01/19 Patient Story

1.1 Stephen Clark, Chairman and Karen Rule, Director of Nursing, welcomed Don and his wife, Sue who attended the meeting to give an account of their experience with the Trust, on behalf of Don's mother, Audrey, a 94 year old diabetic patient who was admitted in hospital following a fall. Both Don and Sue are volunteers at the Trust.

1.2 The summary of Don's family's experience was that Audrey was extremely well looked after, with exceptional care and treatment received from admission through to discharge. Staff were compassionate and focussed on Audrey's needs.

1.3 In addition to Audrey's experience, Don's brother required hospital admission whilst his mother was admitted, and received the same level of excellent care and support.

1.4 Notwithstanding this positive experience, the areas highlighted for improvement were communication difficulty with the family and the non-availability of podiatry service. Don's request was for the Trust to give consideration to recruiting a Podiatrist.

1.5 The Chairman noted the importance of the Board hearing patient story first hand irrespective of the nature. He thanked Don and Sue not only for sharing their family's story, but for the many years of volunteering work at the Trust, making a real difference to patients.

02/19 Preliminary Matters

2.1 Welcome and Apologies for absence

2.1.1 The Chairman welcomed everyone to the meeting, in particular Ian O'Connor, Interim Director of Finance; Morfydd Williams, Director of IT Transformation and Brenda Thomas, Company Secretary; who were attending their first Board meeting.

2.1.2 Dr Paul Kitchen, Deputy Medical Director was deputising for Dr David Sulch, Medical Director.

2.1.3 Apologies for absence were received as recorded above.

2.2 Quorum

2.2.1 The Chairman declared the meeting quorate, with one third of members present.

2.3 Register of Interests

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

2.3.2 The Register of Interests was noted.

03/19 Minutes of the previous meeting and Matters Arising

3.1 Minutes of the previous meeting

3.1.1 The minutes of the previous meeting held on 1 November 2018 were **APPROVED** as an accurate record of the meeting.

3.2 Matters Arising and Action Log

3.2.1 There were no matters arising from the last meeting.

3.2.2 The Chairman noted that the single action on the action log relating to mortality and morbidity would be discussed under agenda item 5.1.

04/19 Standing Reports and Updates

4.1 Chair's Report

4.1.1 The Chairman wished everyone a happy New Year, remarking that 2019 is set to be a challenging but exciting year for the Trust. He noted:

a) The departure of Lesley Dwyer as Chief Executive in November 2018 and James Devine taking over the reins. The Board is confident James is the right person to lead the Trust on the journey to brilliance

b) The continued work required to provide consistent quality care, meet statutory targets and achieve financial sustainability; however expressed confidence plans are in place to achieve these
c) The outstanding performance of staff who worked tirelessly over the very busy Christmas and New Year period to ensure patients are well looked after. On behalf of the Board, the Chairman expressed profound gratitude and conveyed thanks to all staff who worked over this period
d) The robust winter plans put in place have worked very well
e) The benefit of partnership working with commissioners, community health, social care and other partners, and noted more work is required to improve patient care
f) The front door streaming model is working well given demand, with more patients being streamed away from emergency department (ED) than last Christmas
g) The progress is being made on the Transformation Plan with good support provided by NHS Improvement (NHSI).

4.1.2 He further noted that patient stories provide a reminder of the whole complete complex nature of the quality of care that needs paying attention to. The presentation showed real evidence of the best of care in action to be replicated and maintained. However, it also demonstrated areas of learning to be progressed.

4.2 Chief Executive's Report

4.2.1 James Devine presented his report and updated the Board on the following matters:

a) The strong foundation Lesley Dwyer, outgone Chief Executive, had left to be built upon, with good progress seen on key indicators
b) The patient story presented was a test for continual consistency of high quality patient care
c) The transformation work to deliver the needed improvements to become efficient and effective continues at pace
d) The great success of the '*You Are The Difference'* culture programme, which aims to address and redefine the culture at Medway. About 1400 staff have gone through the programme so far
e) The work that has commenced on developing the Trust's Clinical Strategy that would set out a clear direction for the Trust
f) The visit of the Secretary of State for Health and Social Care, Matt Hancock MP in November 2018, who positively acknowledged the hard work of staff, and the system working across Medway and Swale
g) The accreditation of the Trust's radiology service by ISAS (Imaging Services Accreditation Scheme Accreditation)
h) The Trust achieving accreditation from the Institute of Leadership and Management (ILM) to deliver in-house leadership, training, coaching and management qualifications. He thanked the Director of HR and OD and his team
i) The festive activities that took place over the Christmas period
j) Clinical Commissioning Groups (CCGs) are to have their administration budgets cut by 20 per cent in the coming year
k) The Nursing and Midwifery Council (NMC) has accepted proposed changes to the requirements for overseas nurses and midwives taking the International English Language Test System (IELTS), accepting scores of 6.5 (initially seven).

4.2.2 He reiterated thanks to all staff who worked over the Christmas and New Year period. Furthermore, he thanked the Board for their support as services are taken to the next level and to make Medway a brilliant organisation.

4.3 Strategy

4.3(a) Sustainability and Transformation Plan Update

4.3.1 Dr Diana Hamilton-Fairley, Director of Strategy, updated the Board on the progress made so far on the Sustainability and Transformation Partnership (STP).

a) The STP Programme Board met to discuss the future structure and governance of the STP. Nationally, STPs would increasingly hold the budget across their footprints. In this regard, an integrated care system is being developed across

Medway with all commissioners merging into a single strategic commissioner. An integrated care partnership is being formed for Medway and Swale

b) GPs are increasingly working as networks, with GP federations formed in Medway and Swale to share services, enabling patients to access GP services for longer hours

c) Commissioners to start to commission across Kent and Medway from April 2020.

4.3.2 In relation to the question on the connection between the Board and the regional level and how the Board could shape discussions, Diana noted that these discussions happen at several other groups feeding into the Programme Board. The size of the Programme Board was highlighted as a challenge for reaching consensus, and there is plan to reduce this. There is greater clarity on the Kent-Medway model and good progress has been made on the productivity workstream.

4.3.3 A request was made for consideration to be given to how the outputs of the Programme Board are formally fed back to the Board. **Action: TB/2019/001.**

4.3.4 **The Board noted the Sustainability and Transformation Plan update.**

4.3(b) Transformation Programme Update

4.3.5 Jack Tabner, Associate Director of Transformation presented the report noting that the transformation programme has maintained pace and updated the Board as follows:

a) Cost Improvement Plans (CIPs): As at month 8, £12.1m has been delivered in CIPs year to date compared to £7m at month 8 in 2017/18. This is £1.5m favourable to the phased plan of £10.6m. The forecast for 2018/19 CIP delivery ranges from £18.2m to £20.8m. Significant progress has been made to scope the 2019/20 CIP, with a focus on quality and safety first and efficiencies with fewer but transformational schemes. Plans to be evenly phased throughout the year.

b) Clinical Strategy: Work continues on the Clinical Strategy which has been developed and communicated with all staff. Against this backdrop, the work of the Portfolio of Services Review working group continues.

c) Best Flow Programme: This focuses on discharge processes and patient flow. One of the main drivers is to reduce length of stay. The main areas of focus have been improving board round effectiveness and running Multi-Agency Discharge Events (MADE). The Sapphire Acute Frailty Unit was formally opened by Dr Matt Thomas, Consultant Geriatrician from Poole Hospital, as part of the ongoing development of the frailty pathway.

d) Culture Programme: The '*You Are The Difference'* culture programme continues to make staff feel empowered and equipped to make decisions for improvement.

4.3.5 In response to Doreen King's request to invite some governors on a regular basis to transformation programme sessions, it was agreed to provide an update on the transformation plan at the Council of Governors meeting in January, with regular updates provided via the communications team.

4.3.6 In relation to the Model Hospital there was an 8% improvement in productivity at the Trust between 2016/17-2017/18, which is a noteworthy step change. The expectation of the Trust in the near future is to move leftwards and upwards on the chart (positive).

4.3.7 In relation to the query on the ED trajectory, James Devine advised that the national target is 95%, which was flagged as a challenge. The Trust's trajectory is currently 90.05% and it has been suggested that this remains unchanged for the rest of 2018/19. Work is underway on next year's trajectory, with NHSI's involvement and discussion happening on a realistic timeframe to get to the 95% national trajectory.

4.3.8 **The Board noted the Transformation Programme update.**

05/19 Quality

5.1 Integrated Quality and Performance Report

5.1.1 James Devine updated the Board on mortality and morbidity, which has seen a slight increase. The Trust's Hospital Standardised Mortality Ratio (HSMR) continues to increase,

in contrast to the Summary Hospital-level Mortality Indicator (SHMI) which has reduced over the last 18 months. The Trust has secured agreement from NHSI and the CCG to use one code for palliative care and end of life care from February 2019. The drive is to attain to accurate reporting. Considerable amount of work has been done via the Mortality Group and Dr David Sulch, Medical Director is carrying out deep dives and would present a detailed report to the Board in March. The Board was assured that this is currently not a cause for concern and the Executives are reviewing and taking proactive steps. Jon Billings added that discussions are happening at the Quality Assurance Committee (QAC), and stressed the importance to bottom out the drivers for HSMR and not make the sole assumption of coding issues. James reiterated that this exercise is about understanding the root cause as opposed to simply reviewing data.

5.1.2 Karen Rule advised that the Integrated Quality and Performance Report (IQPR) has recently been reformatted and would continue to evolve over the next few months. The next stage in the development of the report is to move towards reporting of data using statistical process control (SPC) tool. The Trust Board development session in April 2019 would feature a presentation from Sam Riley, Head of Improvement Analytics, NHS Improvement on her #plotthedots work.

5.1.3 Reflecting on the patient story, Karen noted the role of a strong clinical nurse leader and increased staffing level at Pembroke Ward played in delivering high quality care. She also highlighted the positive impact of the mentoring programme and support for nurses in their leadership development in partnership with Henley Business School.

5.1.4 Karen Rule, Paul Kitchen, Gurjit Mahil and Harvey McEnroe highlighted the indicators within the report, noting as follows:

a) Falls: below national average all year. The Falls Improvement Programme is well established and starting to deliver. The Clinical Lead Nurse has been asked to present at the National Falls Summit again this year, reflecting their hard work.
b) Pressure Ulcers: The level of harm has reduced over the past three years, which is an indication of earlier recognition of deterioration and appropriate intervention.
c) Never Events: the first for the past 12 months was reported, which was a retained swab after childbirth. Investigation has completed, learning obtained and shared.
d) Infection prevention and control: 20 cases have now been reported, one above the targeted 19. Detailed analysis has been done and focusing improvement work within the elderly care and frailty unit.
e) C-difficile rate: the Trust is at par with one of the local partners, but reporting above the other two.
f) MRSA: this remains challenged and no consistent themes have been identified. A Director of Infection Prevention and Control for the STP has been appointed and NHSI has identified three pilot sites, one of which is in Kent to start STP-wide improvement work, which is a positive step.
g) Mixed Sex Accommodation: Challenging to bring numbers down in line with the Trust's trajectory. The Trust is taking necessary steps to make improvements.
h) ED: The Trust struggled to meet the A&E 4-hour trajectory - 77% against a planned 83% for 4-hours type 1 and 89.01% against a planned 90.05% for all type 4-hours ED. The December position is set to deteriorate; however high quality is being sustained. Admitted performance is at sub-optimal level.
i) DM01: trajectory for diagnostic performance was achieved in November (98.76% against a planned target of 95.4%). There is much better oversight, with the same rigour given to cancer.
j) Referral to Treatment (RTT): trajectory achieved in November (82.62% against a planned target of 81.09%).
k) Cancer: 62-day wait achieved 83.85% in October against national standard of 86.10%; whilst 2-week wait achieved 68.13% in October against planned target of 93%, mainly driven by dermatology challenge. This has improved to 73% in November and early indication suggesting further increase in December, due to additional capacity sourced. Four 104days cancer breaches were reported.

5.1.5 During discussion, the Board:

a) Queried how the existing accommodation could be configured to address the challenges of the mixed sex accommodation. The current layout of wards was noted as not conducive for maintaining single sex accommodation. Harvey McEnroe added that occupancy needs to be reduced to 96% with a focus on flow and expediting discharge. Gary Lupton assured the Board that a Plan is being worked up to ensure the right mix of bays. This is a focussed project as part of transformation. It was agreed that a detailed discussion be had at the next QAC. **Action: TB/2019/002.**
b) Received assurance that the Trust is much better prepared for the flu season compared to last year, with teams better organised and work evenly shared. So far, the flu season is better than last year. However, this is the first year that staff have been given the option to opt out, which poses a risk.
c) Received assurance that the palliative care is being taken seriously with in-depth work ongoing. Diana Hamilton-Fairley explained that internal changes were made in January 2016, which led to a change in the palliative care code, with approval from NHSI and the CCG. This change corresponds to the change in trend.
d) Noted, in relation to ED that there were daily calls with NHSI this time last year, which shows an improvement. Getting occupancy down have been much more structured and the Trust is requesting for help when needed.
e) Received assurance that diagnostics is in a better place, with better operational oversight on the DM01 tracking and has the same rigour as cancer and RTT.

5.1.6 **The Board noted the Integrated Quality and Performance Report.**

06/19 Performance

6.1 Finance Report - Month 8

6.1.1 Ian O'Connor, Interim Director of Finance, presented the report, noting that at the end of November, the Trust is reporting a year to date deficit of £33.0m, with a year-end position reported to NHSI of £46.9m deficit (excluding income from the Provider Sustainability Fund (PSF)). However, there is need to revise the forecast to a most likely outturn of £52.1m, £5m off target. Whilst £52.1m is not the desired position, the deficit is showing significant reduction when compared to 2017/18, when the deficit was £66.4m pre-PSF. There is an improvement of 8% per productivity unit between 2016/17-2017-18, with continuing improvement seen over the last few years. Regulators have been informed and are working closely with the Trust on plans to limit any deficit and deliver the best possible position. The Trust is also in discussion with the CCG on a system-wide solution.

6.1.2 The cash position is favourable; however, the capital plan of £31.2m would not be delivered. The overall Use of Resources Rating at the end of 2018/19 would remain at three due to the excellent agency rating of one.

6.1.3 **The Board noted the financial position and the need to reforecast the financial position from £46.9m to £52.1m.**

6.2 Board Assurance Framework

6.2.1 Brenda Thomas, Company Secretary presented the Board Assurance Framework (BAF), noting that it was discussed at the board development session on 6 December 2018, which led to a review of the strategic risks and the BAF format. The refreshed format, which brings reporting of strategic risks in line with other foundation trusts, was agreed by the Executive Group on 19 December 2018. Existing risks have been revised and new strategic risks raised. Risk description now includes in addition to a title, cause and effect and impact of the risk on the Trust. In addition, the key controls and assurances on these controls have been included.

6.2.2 James Devine added that the BAF is in a better position, setting out individual risks rather than having one that captures all within the strategic risks. The Executives would review the BAF every two months and would be presented to the Board on a quarterly basis. Executive Directors would also into introducing a fifth strategic risk on consistent high quality care, as raised at the Board development session.

6.2.3 Jon Billings congratulated the Executive Directors on this piece of work, noting the improvement made in a short space of time, with better clarity, better structure, better articulation of gaps and control and clarity on timeframe.

6.2.4 The Board was supportive of the framework; however agreed to have further detailed discussion at the Board development session in February. **Action: TB/2019/003.**

6.2.5 The Chairman left the meeting at this point. Joanne Palmer, Non-Executive Director and Senior Independent Director chaired the meeting for the remainder of its duration.

6.3 Communications Report

6.3.1 Glynis Alexander, Director of Communications and Engagement, presented the report and highlighted the following:

a) The increased communications and engagement around the transformation and culture programmes since September 2018
b) The Trust Clinical Strategy was introduced at a senior manager and all staff session; staff have been encouraged to provide feedback
c) Staff briefing has been launched on a more regular basis, in a slightly different format. It would also feature the presentation of the employee and team of the month awards
d) The Communications and Organisational Development teams have worked together to promote the NHS staff survey
e) Communications support was provided for a number of initiatives during the Christmas period
f) Interactions with the media continue, with the local media being supportive. There was significant coverage of the opening of the new ED and the Secretary of State's visit. There is also continued engagement with the local community
g) A calendar of events has been produced for governors for 2019 and the refreshed Membership Strategy would be presented to Governors at their meeting in January 2019. The membership survey has been closed and a report would be submitted at a future meeting
h) The team is supporting services to obtain BAME (Black, Asian and Minority Ethnic) patient input and talking to Patient Experience Group to look at ways of collating all patient feedback received and obtain learnings.

6.3.2 **The Board noted the Communications report.**

07/19 Workforce Report

7.1 Leon Hinton, Director of HR and OD presented the report for the month of November and highlighted the following:

a) 15 registered nurses and midwives joined the Trust on a substantive basis, with seven non-training medical staff. 475 nurse recruitment is in the pipeline
b) The turnover of 12.6%, (+0.3% from October). He assured the Board that structured retention programmes are being put in place for the next five quarters and the Trust has signed up for the retention direct support programme cohort 4 by NHSI in October 2018.
c) Sickness absence at 4.20% (+0.10% from October)
d) The appraisal rate stands at 81.3% same as October and is below the 85% target. Statutory mandatory training stands at 74.39% (-0.32% from 74.71%) and is below the 85% target. Actions are being taken to address this and a detailed report would be submitted in March. **Action: TB/2019/004**
e) The Trust is working below the NHSI ceiling cap for agency performance (£3.94m below) with agency spend at 6% and spend on substantive staff at 82%; an 8% positive move in the last 18 months. Agency cap breaches continue to decrease
f) The Trust is now ILM-accredited and the NMC accepted proposed changes to the requirements for overseas nurses and midwives taking the IELTS, as earlier alluded to by the Chief Executive.

7.2 Discussing the proposed national initiative to shorten the length of training for nurses for postgraduates from other disciplines, Karen Rule noted the complex nature and advised

that greater gains could be obtained by looking at running return to practice courses, apprenticeship training levy, career pathways and international recruitment.

7.3 **The Board noted the Workforce report.**

08/19 Reports from Board Committees

8.1 Quality Assurance Committee

8.1.1 Jon Billings noted that the report covered areas already discussed under item 5 and assured the Board that more detailed discussions are happening on quality at QAC.

8.2 Finance Committee Report

8.2.1 Tony Moore highlighted that the predicted deficit this time last year was £52.8m, with the Trust set to deliver £52.1m. In 2017/18, £66.4m deficit was delivered and was the fifth year of increased deficit. From a financial point of view, grip has been shown to deliver result, but not at the expense of quality care. This is an encouraging start for the next financial year to deliver.

8.3 Integrated Audit Committee Report

8.3.1 Mark Spragg reported that the Committee is following its programme of work throughout the year. One of the initiatives taken up is to follow up on the recommendations made by the internal audit throughout the year to ensure that these matters are being adhered to.

8.4 **The Board noted the Committee reports.**

09/19 Items for Noting

9.1 Council of Governors' Update

9.1.1 Doreen King, Governor Board Representative, raised the following:

a) The impact on patient care of the traffic flow into the hospital and the effect of ambulances arriving. Gary Lupton provided assurance that a major review is underway to increase onsite parking space. James Devine added that the Trust is yet to receive any complaints on the above matter

b) Resolution required on the issues faced by discharged patients that are unable to get their prescriptions at the pharmacy due to non-availability, and the difficulty of getting another prescription to take to an offsite pharmacy. It was agreed that Harvey McEnroe liaise with Dr Diana Hamilton-Fairley and provide a definitive response back to Doreen. **Action: TB/2019/005**

c) Congratulated the Board on the board papers, noting that papers are clearer and easy to understand.

9.2 Any Other Business

9.2.1 A process is to be put in place to ensure that questions from the public are submitted in advance of the meeting and responses would be available on the Trust website.

9.3 Questions from members of the public

9.3.1 A member of the public queried the restricted hours currently in operation at the restaurant, which means that staff on late shift are unable to have a sit down hot meal.
Gary Lupton and James Devine advised that the early closure of the restaurant is a temporary situation. The restaurant's normal opening hours are from 7am-6pm, with other good provisions via the coffee shop and league of friends' shop.

9.3.2 A member of the public asked whether the Board is confident with the provision of facilities and the Trust's capacity to deliver the urgent care systems coming in place April 2019, with the closure of walk-in centres. James Lowell advised the Trust is working closely with Medway Community Health and commissioners on the number of patients and matching clinical staff to those numbers. James Devine added that the timescale for the redesign of Balmoral ward is estimated to be July 2019, but would clarify. **Action: TB/2019/006.**

9.3.3 In relation to the question on the pharmacy facility, Gary Lupton advised that the pharmacy dispensary facility is under review.

010/19 Date and time of next meeting

10.1 The next Board Meeting in Public will be held on Thursday, 7 March 2019 at 12.30pm in the Trust Boardroom, Post Graduate Centre, Medway NHS Foundation Trust.

10.2 The meeting closed at 3.16pm.

These minutes are agreed to be a correct record of the Trust Board Meeting in Public of Medway NHS Foundation Trust held on 10 January 2019
Signed …….. Date …… Chair

Board of Directors in Public
Action Log

Agenda Item: 3.2
Date: Thursday, 07 March 2019

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
10-Jan-19	TB/2019/001	**Sustainability and Transformation Plan** Give consideration to how outputs of the STP Programme Board are formally fed back to the Board.	07-Mar-19	Dr Diana Hamilton-Fairley Director of Strategy	On the agenda. **Propose for closure.**	Green
10-Jan-19	TB/2019/002	**Integrated Quality and Performance Report** Detailed discussion at the Quality Assurance Committee on the challenges of mixed sex accommodation and the way forward.	02-May-19	Karen Rule Director of Nursing	Due in May.	White
10-Jan-19	TB/2019/003	**Board Assurance Framework** Detailed discussion on the refreshed format at the board development session in February.	07-Mar-19	Brenda Thomas Company Secretary	Discussed at the Board development session on 7 February, where approval was obtained. **Propose for closure.**	Green
10-Jan-19	TB/2019/004	**Workforce Report** Present detailed report on the statutory mandatory training at the March meeting.	07-Mar-19	Leon Hinton Director of HR and OD	Included as part of the Workforce Report. **Propose for closure.**	Green
10-Jan-19	TB/2019/005	**Council of Governors' Update** Liaise with Diana Hamilton-Fairley and provide a definite response back to Doreen King re: prescription at pharmacy.	07-Mar-19	Harvey McEnroe Chief Operating Officer Integrated and Unplanned Care	Update to be provided at the meeting.	
10-Jan-19	TB/2019/006	**Questions from the public** Clarify timescale for the redesign of Balmoral ward.	07-Mar-19	James Devine Chief Executive	Update to be provided at the meeting.	

Agenda Item: 4.2

NHS
Medway
NHS Foundation Trust

Chief Executive's Report – March 2019

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

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

In and around Medway

With spring now upon us I would like to take this opportunity to reflect on the winter that has passed.

Winter is the busiest time in NHS hospitals and Medway was no exception. We saw a large number of patients who were very unwell and required admission to hospital, and our staff worked hard to prioritise the most unwell and safely discharge those who were able to go home. I would like to thank our staff for their dedication in providing care for our community.

Throughout the winter we saw the majority of those coming to our Emergency Department within four hours – however a small number of patients did experience longer waits than we would have liked. Although these waits can be frustrating for patients, the vast majority were very complimentary of the care they received and understood the pressures faced by our staff. We would like to apologise and thank them for their patience and understanding

Our staff carried out rigorous planning for the winter period, and although things didn't always go exactly how we would have liked, we saw significant improvement in our performance compared to the previous winter.

Now as we head towards the warmer weather we must continue to focus on getting things right for our community; that means ensuring our patients spend less time in the Emergency Department and improving flow throughout the organisation to reduce unnecessary delays.

We still have more to do at Medway but we are heading in the right direction. We put patient care at the heart of everything we do and our aim is to ensure our patients receive brilliant care, from highly trained staff, in the right place and at the right time, every time. It's our duty to achieve this, and I remain confident we will.

<u>Culture programme</u>

The '*You Are The Difference'* (YATD) culture programme, in which the Trust is looking to address and redefine the culture at Medway, has continued with great success.

We have now entered the second phase of the programme with further sessions being made available to staff and managers. It is pleasing to see that the feedback for the first phase of the programme has been very positive with 90 per cent of attendees agreeing that the sessions were useful and engaging.

As part of our commitment to embedding the programme throughout the organisation, we have begun to provide YATD training at all Trust induction sessions. The content mirrors that of the regular staff sessions.

Stroke review

The joint committee of Clinical Commissioning Groups (CCGs) met last month and confirmed their decision to locate hyper acute stroke units at Dartford, Maidstone and Ashford.

Although we are disappointed by this decision our focus must be on working with commissioners and other providers to do the best for our patients, ensuring that we can transfer services to the new Hyper Acute Stroke Units (HASUs) safely. I would like to thank our stroke staff for their professionalism throughout this process. They have remained committed to providing high quality care throughout this very extremely difficult time, and I know that they will continue to do so as we work through the transition period.

North Kent Dermatology Service

From 1 April 2019, all dermatology services currently provided by Medway NHS Foundation Trust will be run by DMC Healthcare.

Medway CCG led the procurement for a new provider on behalf of Medway, Swale and Dartford, Gravesham and Swanley (DGS) Clinical Commissioning Groups.

The new North Kent Dermatology Service will be consultant-led, supported and delivered by a range of healthcare professionals with specialist skills in dermatology.

Care will be provided at an existing network of clinics in Kent ensuring patients can be referred to a location closer to home, rather than having to visit a hospital unnecessarily. Dermatology services will no longer be provided at Medway Maritime Hospital.

Preparations for the start of the new service are well underway and clinical leaders from Medway NHS Foundation Trust, Medway CCG and DMC Healthcare are working closely to ensure that continuity of care for our patients is maintained through any service change.

NHS Staff Survey

Our staff are our most important asset and we take their views very seriously. It is vital that we know what they think and feel about working here. The national staff survey is an important opportunity for us to hear more about what our staff think we do well and identify areas where we need to improve.

The results of the 2018 NHS Staff Survey were published recently and although it isn't possible to make a like-for-like comparison to last year due to changes in the way the results are now collated, we can see that our results improved in some areas, are worse in some, and in some cases stayed the same.

It's clear from the results that there are some areas with great leadership and really positive cultures; it's also clear that in some areas staff do not feel as supported or motivated as we would expect. Our aim now must be to learn from these gold standard areas and ensure they we replicate what works across the entire Trust.

Grow My Brain

We were proud to hold the launch event for the Grow my Brain campaign last month. Grow My Brain was the brainchild of one of our midwives and aims to raise awareness of the importance of bonding with babies in the womb, and the first days/years of a child's life. Studies show that investing in a child's early development is crucial for their future health and wellbeing. Connections built in a child's brain in the first years of life are the building blocks of their future and for them to develop properly children need to be nourished and nurtured from pregnancy right through the early weeks, months, years and beyond.

The campaign has come to fruition thanks to the collaboration of our colleagues at the council and in community health – it is a great example of partnership working between health and care providers. I would also like to thank the Medway Hospital Charity who helped to fund the project.

Darzi Fellow

I am really delighted to say that the Trust has been successful in obtaining sponsorship for a new Darzi fellow. They will be working with partners including with GP leads to create new clinical roles across the Health and Social care system.

We have already seen from the work carried out by Coral Akenzua, our previous Darzi fellow, what great value to the organisation the Darzi fellow can bring. Congratulations to Diana Hamilton-Fairley, Coral and everyone else involved in securing this sponsorship.

Developing a dementia garden

I'm proud to say the Trust is developing a dementia garden for patients, their families and staff. Hospitals are fast-paced, and can feel like scary and daunting. This level of anxiety is often heightened in patients with conditions such as dementia. Studies have shown that time spent in natural environments such as gardens can help reduce these feelings of anxiety. It allows for a calm and quiet space for patients, their families, friends and care givers to relax away from the hectic environment of the clinical setting.

Mothers rate Medway as one of top Trusts for maternity care

Congratulations to our maternity unit which has been ranked by patients as one of the country's best-performing services for women, babies and their families, in the 2018 Maternity Survey. This is an example of the brilliant care we want to offer at Medway. I am so proud to see this national recognition of the fantastic care we already know is provided here.

Freedom to Speak Up Lead Guardians

Our Freedom to Speak Up Guardians form a really important part of our strategy to develop a new open culture at the Trust. We want staff to be able to raise concerns in the knowledge that these will be acted upon without fear of repercussions. I'm delighted to announce that the Trust has now appointed Chloe Saygili, as the Lead Freedom to Speak Up Guardian.

Beyond Medway

Provider Collaboration

The government is making changes to existing secondary legislation to make it easier for the first integrated care providers (ICPs) to be set up.

ICPs are designed to:

- bring care services together through a single contract, so patients' care is coordinated around them
- deliver more care in the community and patients' homes, improving access to services and reducing trips to hospital

The NHS Long Term Plan confirmed that NHS England would make the ICP contract available for use from 2019. The contract is expected to be held by statutory providers, such as NHS foundation trusts.

Meanwhile, in Medway and Swale we are taking the initial steps towards an ICP with our Provider Collaborative, working with Medway Community Healthcare. We now have a joint programme. The first initiative is to create an Integrated Discharge Service,

Kent and Medway NHS and Social Care Partnership Trust

KMPT has announced that its chairman, Andrew Ling, is to step down in the summer after nearly eight years in the role, following a family illness. The recruitment process to find a successor is about to begin.

Report to the Board of Directors

Board Date: Thursday, 07 March 2019 Agenda Item: 4.3(i)

Title of Report	Sustainability and Transformation Plan Update
Prepared By	Diana Hamilton-Fairley, Director of Strategy
Lead Director	Diana Hamilton-Fairley, Director of Strategy
Committees or Groups who have considered this report	Not Applicable
Executive Summary	This update includes the following 1. Proceedings of the Programme Board 2. The Sustainability and Transformation Plan (STP) operational plan and budget for 2019/20 3. The Long Term Plan submission for 2019/20 4. Development of the Integrated Care System / Strategic Commissioner 5. Options for the STP feedback to board going forward.
Resource Implications	STP Budget allocation from Medway Foundation Trust (MFT), via the Director of Finance and Chief Executive.
Risk and Assurance	Not Applicable
Legal Implications/Regulatory Requirements	Not Applicable
Improvement Plan Implication	Not Applicable
Quality Impact Assessment	Not Applicable
Recommendation	The Board to: i. Agree how it would like to receive STP feedback in future; ii. Identify issues it wishes to be represented to the Programme Board.
Purpose & Actions required by the Board :	**Approval** ☐ **Assurance** ☐ **Discussion** ☒ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 This paper includes an update for the board on the following items

a) Proceedings of the STP Programme Board
b) The STP budget and forecast for 2019/20
c) The plans for the long term plan submission for 2019/20
d) The progress on the development of the Integrate Care System (ICS) / Strategic Commissioner
e) Options for STP feedback to the board in the future.

1.2 The board is asked to note the items in this paper and to comment on

1.2.1 The proposed contribution to the STP for 2019/20
1.2.2 The proposal for the long term plan.

1.3 The board is asked to agree on one of the options for receiving updates from the STP.

2 PROCEEDINGS OF THE STP PROGRAMME BOARD

2.1 The meeting was held on 5th February 2018. The items discussed were:

Workforce Transformation Plan

2.1.1 Across Kent and Medway there is a full-time equivalent workforce of approximately 83,800 within over 350 careers across health and social care organisations. However, the workforce supply has decreased for most workforce groups and is significantly behind the national average. This decrease varies across clinical / professional groups. For example, health visitor numbers have increased by 26% (compared to 27% nationally), however GP numbers have decreased by 11% compared to a national reduction of one per cent. The greatest reduction is among mental health therapists in down 47% in Kent and Medway, compared to an average national increase of 83%.

2.1.2 The plan has five key strands:

1. Promoting Kent & Medway as a place to work
2. Maximising supply
3. Lifelong careers
4. Systems leaders & culture change
5. Workforce wellbeing, workload and inclusion to support retention.

2.1.3 The presentation outlined some of the achievements that had been made, two of which included developing a Kent and Medway social care recruitment campaign with over 33,000 views and 94 job applications, and launching the 'Take the Different View' website and social media campaign for hard to recruit roles (https://www.takeadifferentview.co.uk/). There is a comprehensive implementation plan for 2019/20, with a number of activities planned under each strand. The Board was asked to note that the development of a Kent and Medway Academy is being scoped, with full proposal to come back to Programme Board at a later date.

2.1.4 The board discussed the paper and asked that more consideration be given to developing the primary care workforce, social care and public health workforce. Emphasis should be on the attractiveness and advantages of living in Kent to increase recruitment. It was acknowledged that the new Medical School would be a positive factor for the long term stability of the workforce.

2.1.5 The Programme Board agreed the Workforce Transformation Plan, however members wanted to see a fuller implementation plan with some clear goals and actions, and also a dashboard to show progress when the plan returns to a future Programme Board meeting.

Estates Strategy Update and Strategic Capability

2.1.6 The recommendations received from NHS England and NHS Improvement on the Kent and Medway Estates Strategy and STP Wave 4 Capital submissions were presented with outline proposals on how the Estates Workstream is to be resourced.

2.1.7 The Estates Strategy submitted in July 2018 was scored as 'Improving'. This meant that the broad themes of the document are good, however, further detail is required on the implementation of these concepts (i.e. building the ability to deliver) and alignment to clinical strategies. The South East Coast Ambulance Service (SECAmb) were successful in securing £6.5m for their Medway Make Ready Centre but no other KMSTP scheme received capital.

2.1.8 Final release of STP capital will be dependent on estates strategies being assessed as sufficiently robust; the next iteration of the strategy will need to be assessed as 'good' as a minimum in order to access funding.

2.1.9 The Estates workstream priorities for 2019/20 are:

1. Capital Disposals
2. Local Area Asset Reviews
3. Strategic Commissioner Workstream
4. Estates Strategy resubmission
5. Capital Projects Delivery

2.1.10 On capital disposals, the Naylor disposals target set for Kent and Medway was £85m. After the property forecasts from NHS Property Services and local trusts plus receipts already realising, a shortfall of £47m still remains. There is a need to do much more to capture all planned disposals, and also have a common process for valuing assets.
It was highlighted that there was no mention of how private sector developers can be utilised in delivering the Estates strategy.

2.1.11 It was agreed that the STP needs to develop an estates map to identify where investment is needed aligned to clinical priorities.

3 UPDATE ON 2019/20 OPERATIONAL PLAN AND 2019/20 BUDGET

3.1 Michael Ridgwell provided an update on the STP budget development for 19/20 supported

by workstream plans; the STP coordinating approach to NHS Operational Planning and the system response to the Long Term Plan.

3.2 The STP have a role in three aspects of planning:

i. STP 2019/20 plan - the plan to deliver the STP programme 19/20

ii. NHS Operational plan 2019/20 - STP will have a role in supporting NHS organisations with the development of their 2019/20 operational plan (including alignment) as well as aggregating this into a 2019/20 system plan

iii. Long-term plan - the STP response to the Long-term plan for the Kent and Medway system.

3.3 Although these three elements will require separate outputs they will be interrelated.

STP 2019/20 Budget

3.4 The draft STP budget has decreased year on year since 2017/18. The overall budget for the STP programme is £6.6 million, a small reduction on the 2018/19 budget (£6.7m) and significantly less than the 2017/18 budget of £8.1million. The budget for each workstream plus the organisational contribution have been discussed and reviewed by the STP Finance Group and will return to the group for sign off on 8 February.

3.5 Specific points to note included the following:

1. Funding for Children and Young People (a key STP clinical strategy priority) is not yet included in the budget – this is being scoped with the Senior Responsible Officer (SRO), Rachel Jones.
2. The System Transformation Budget and resource plan to be excluded from the central STP budget. There will be a separate discussion with the CCG Managing Directors regarding funding for the workstream team.
3. There is an increase to the communications workstream team of 0.5 WTE (whole time equivalent) to support Stroke workstream, to be funded via the removal of STP contingency budget of £40k.
4. The draft STP budget includes £303,000 NHS England STP funding allocation for STP leadership and the Programme Management Office (PMO) - this income stream is yet to be confirmed by NHS England
5. The draft budget is inclusive of 6.3% increase in employers pension contribution, estimated at approximately £203k. This will be funded by the 18/19 budget surplus.

3.6 The primary care workstream will be funded through GP Forward Plan funds. It was agreed that this should be reflected in the budget.
Programme Board members supported the draft budget, subject to the outcome of the discussion at the STP Finance Group on 8 February 2019. The finance group have approved the draft budget and it is attached. The budget will then be taken to each partners' relevant board or committee for ratification.

3.7 The STP 2019/20 plan and budget is attached as an appendix.

Report to the Board of Directors

4 LONGTERM PLAN

4.1 The Long Term Plan (https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan.pdf) was published on 7 January 2019. Further guidance on the Plan is due to be published over the next few weeks.

4.2 The STP will need to set out how it will deliver against the Long Term Plan themes, namely:

1. A new service model (Primary Care Networks, Multidisciplinary teams (MDTs), Integrated Care Partnerships)
2. Prevention and inequalities (with a particular focus on smoking, obesity, and alcohol)
3. Care quality and outcomes improvement (with a particular focus on children and young people, mental health, autism and learning disability, cancer, cardiovascular disease (CVD), diabetes and respiratory disease)
4. Workforce
5. Digital
6. Finance (including productivity) – five specific tests to be met
7. ICS development.

4.3 It was felt that significant support was required for ICS and Integrated Care Partnerships development, as part of the System Transformation programme in 19/20.
Regarding children and young people (CYP), members felt that in order to align CYP commissioning, a move to the single commissioner is required. This should include specialist CYP commissioning (although this is yet to be devolved from NHS England).

4.4 The board agreed that:

i. a paper on resources for the System Transformation programme covering these items should be brought to the next meeting.

ii. a paper outlining the steps to achieving the ICS should come to Programme Board in March or April.

5 DEVELOPMENT OF THE INTEGRATED CARE SYSTEM / STRATEGIC COMMISSIONER

5.1 A simulation event was held on the 12th February to explore how the ICS for Kent and Medway would function with the current and evolving providers of health care. Representatives from across the county worked through a series of scenarios to explore the roles and responsibilities each element of the system would have and what would be the expectation of each other going forward.

5.2 The ICS will incorporate all the current eight Clinical Commissioning Groups (CCGs) and become the strategic commissioner for Kent and Medway. This may also include some of the specialist services that are currently commissioned by NHS England (South East).

5.3 There is a strong likelihood that there will be four integrated care partnerships – East Kent, West Kent, North Kent, Medway and Swale – although this has not been finally decided. The

partnerships will have some of the functions of the current CCGs and this has yet to be defined or agreed.

5.4 The ongoing development of local care is being aligned with the development of the local care networks which will be aligned to the integrated liaison teams that are starting to meet to discuss and plan for people with complex needs.

6 OPTIONS FOR STP REPORT TO BOARD IN FUTURE

6.1 The board requested that the Director of Strategy put forward options for how the members of the board can be updated on the programme board.

6.2 The Programme Board meets in the same week as the Trust Board and so the update will always be at least three weeks out of date. The Chief Executive, Director of Strategy and Director of Planning and Partnerships all attend the Programme Board and other directors attend the principle workstreams of the STP. It is therefore possible to keep this update as fresh as possible. The board is asked to comment on the structure of this report and whether there are elements that could be improved / requests for inclusion.

6.3 The Chief Executive provides a weekly update for the non-executive directors (NEDs) and it would be possible to report on the programme board in one of these updates.

6.4 The Board is therefore asked to consider whether:

- 6.4.1 The report as presented here is adequate for the members to be kept abreast of developments in the STP
- 6.4.2 Whether they would wish for the programme board note and papers to be included in the weekly briefing to NEDs
- 6.4.3 If the Board prefers the latter option then the board is asked to advise on the future content it would like to see in the STP update paper to board.

Transforming health and social care in Kent and Medway

STP 19/20 plan and budget

February 2019

Transforming health and social care in Kent and Medway is a partnership of all the NHS organisations in Kent and Medway, Kent County Council and Medway Council. We are working together to develop and deliver the Sustainability and Transformation Plan for our area.

Purpose of this pack

This discussion pack summarises the STP plan and budget for 19/20. This is a final version of the pack that was reviewed at the STP Programme Board on 5 February and STP Finance Group on 8 February and covers the following areas:

- STP budget principles
- STP budget for 19/20
- Organisational budget apportionment for 19/20
- STP workstream plans on a page for 19/20

STP 19/20 plan and budget

Progress against 19/20 budget setting plan

- STP budget principles and approach approved by Finance Group (October) and Programme Board (November) **Completed**
- First cut delivery plan and budget developed by workstream leads with PMO support through mid-year workstream review process (submitted to PMO by 09/11) **Completed**
- Review plans at workstream leads meeting on 19/11, Finance Group on 30/11, Clinical & Professional Board on 15/11 (check and challenge) **Completed**
- First review of plan and budget by Programme Board (03/12) **Stood down. Paper circulated. Feedback at January Programme**
- Planning meetings in December with STP CEO for priority areas (TBC) – PMO leads to arrange **Not required**
- Final workstream plans and budgets developed by workstreams with PMO support submitted on 04/01 **Completed**
- 19/20 budget submitted to Finance Group (11/01), Clinical & Professional Board (17/01), and STP Programme Board for support (08/01) **Completed**
- **STP 19/20 plan and budget supported by STP Programme Board and Finance Group at February meetings. To be sent to member organisations for approval**

STP 19/20 budget principles and approach

The STP 19/20 budget has the following objectives

- Support the delivery of the agreed STP priorities
- Support the transition to new system structures that enable the delivery of integrated care

The budget setting process for 19/20 will adhere to the following principles

- Focus resources on priorities
- Workstream resources explicitly linked to realising benefits aligned to the clinical and professional strategy
- Apportion programme costs by the lead organisations involved in the workstream
- Workstream budgets and apportionment of costs agreed and managed at the relevant workstream programme board
- Minimise external support and limit the use of external venues
- Organisations responsible for their internal review and governance through the budget setting steps
- Agreement will be required across all workstreams budgets to sign off the overall STP budget

The 19/20 plan and corresponding budget will be developed by workstreams with PMO support

- Plans and budgets developed by workstreams with PMO support, and approved at the relevant workstream/programme boards
- Check and challenge through workstream leads meetings, Finance Group and Clinical & Professional Board
- Planning meetings with STP CEO for priority areas if needed
- Development of plan and budget reviewed at Programme Board

Overview of the STP workstreams

Theme			
1 Care Transformation	1 Stroke	4 Prevention	7 Children and Young People
	2 Local Care	5 Mental Health	8 Cancer
	3 East Kent	6 Primary Care	9 Urgent and Emergency Care
2 Productivity	10 Productivity		
3 Enablers	11 Estates		
	12 Digital		
	13 Workforce		
4 System Leadership	14 System Transformation		

Annual STP Budgets – 3 Year Period

Programme	19/20 Draft Budget	18/19 STP Budget	17/18 STP Budget
Central STP Functions			
Central STP Team	1,524	1,644	2,135
Comms & Engagement	770	501	912
Contingency	0	150	0
SECAMB contribution	(10)	(10)	(10)
NHSE STP Funding allocation	(303)	(302)	(80)
Central STP Functions Sub Total	***1,981***	***1,983***	***2,957***
Workstreams			
East Kent programme	1,850	1,850	0
Local Care	228	334	1,618
Productivity	533	826	800
Pathology Programme	225		
Stroke	362	723	1,566
Primary Care	0		
System Transformation*	0	63	513
Clinical Strategy	0	226	523
Innovation Collaborative	50	0	0
Mental Health	365	295	80
Prevention	425	61	0
Workforce	118	0	0
Digital	319	156	60
Estates	134	193	15
Workstreams Sub Total	***4,610***	***4,726***	***5,175***
Total	**6,591**	**6,710**	**8,132**

*** Resourcing for the System Transformation programme will be dealt with separately**

19/20 STP Plan and Budget Overview

Workstreams	Budget	RoI	Deliverable
East Kent	1,850		Draft PCBC, clinical senate review & completion of NHSE assurance review
Local Care	228		Deliver and embed “Dorothy Model” inc. U&EC, Home First, care navigators, EOL care
Productivity	533	*8,439*	Identify cost reduction schemes to include in organisational plans for 19/20
Pathology	225		Delivery of SOC
Stroke	362		Completion of Stroke review process and implementation of preferred option
Primary Care	0		Publish a system primary care strategy
Innovation Collab	50		Organising user and citizen innovation sessions to support STP workstreams
Mental Health	365		Promote Mental Wellbeing, Integrating Physical Care & MH Care, deliver MH 5YFV
Prevention	425		Strategic development in response to long term plan and prevention action plan
Sub Total	***4,038***	***8,439***	
Enablers			
Workforce	118		Roll out Workforce strategy and specifically, funding for Med School Educator roles
Digital	319		Delivery of pan STP initiatives such as KMCR, HSCN and HSLI
Estates	134		Assurance and support to deliver waves 3, 4, ETTF capital projects & disposals prog
Sub Total	***571***		
Central STP	**1,981**		Central STP team overseeing delivery & governance of workstreams, Inc. Comms
Total	**6,591**	***8,439***	

*** Workstream plans on a page are included in Appendix 1**

19/20 Draft STP Budget
% Contribution to Central STP Functions

	Commissioners								Providers						
Programme	DGS	Medway	Swale	WK	Ashford	C&C	SKC	Thanet	D&G	EKHUFT	KCHT	KMPT	Medway	MTW	Total
Central STP Functions															
Central STP Team	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	100%
Comms & Engagement	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	100%
Contingency	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	100%
SECAMB contribution	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	100%
NHSE STP Funding allocation	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	100%

19/20 Draft STP Budget
Financial Contribution to Central STP Functions

Programme	Commissioners								Providers						Total
	DGS	Medway	Swale	WK	Ashford	C&C	SKC	Thanet	D&G	EKHUFT	KCHT	KMPT	MFT	MTW	
Overheads															
Central STP Team	109	109	109	109	109	109	109	109	109	109	109	109	109	109	**1,524**
Comms & Engagement	55	55	55	55	55	55	55	55	55	55	55	55	55	55	**770**
Contingency	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
SECAMB contribution	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	(1)	**(10)**
NHSE STP Funding allocation	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	(22)	**(303)**
Total	**141**	**141**	**141**	**141**	**141**	**141**	**141**	**141**	**141**	**141**	**141**	**141**	**141**	**141**	**1,981**

*See Appendix 2 for posts funded directly by Commissioners

19/20 Draft STP Budget
% Contribution to Workstreams

Programme	Commissioners								Providers						Total
	DGS	Medway	Swale	WK	Ashford	C&C	SKC	Thanet	D&G	EKHUFT	KCHT	KMPT	MFT	MTW	
Workstreams															
East Kent programme	0%	0%	0%	0%	20%	20%	20%	20%	0%	20%	0%	0%	0%	0%	**100%**
Local Care	11%	11%	11%	11%	11%	11%	11%	11%	0%	0%	11%	0%	0%	0%	**100%**
Productivity	8%	8%	8%	8%	8%	8%	8%	8%	8%	8%	1%	1%	8%	8%	**100%**
Pathology Programme	0%	0%	0%	0%	0%	0%	0%	0%	25%	25%	0%	0%	25%	25%	**100%**
Stroke	9%	9%	9%	9%	9%	9%	9%	9%	9%	9%	0%	0%	0%	9%	**100%**
Innovation Collaborative	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	**100%**
Mental Health	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	**100%**
Prevention	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	**100%**
Workforce	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	**100%**
Digital	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	**100%**
Estates	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	7%	**100%**

*See Appendix 2 for analysis on the contributions to the productivity workstream budget

19/20 Draft STP Budget
Financial Contribution to Workstreams

Programme	Commissioners								Providers						LA's		
	DGS	Medway	Swale	WK	Ashford	C&C	SKC	Thanet	D&G	EKHUFT	KCHT	KMPT	MFT	MTW	Medway LA	KCC	Total
Workstreams																	
East Kent programme	0	0	0	0	370	370	370	370	0	370	0	0	0	0	0	0	**1,850**
Local Care	25	25	25	25	25	25	25	25	0	0	25	0	0	0	0	0	**228**
Productivity	44	44	44	44	44	44	44	44	41	41	7	7	41	41	0	0	**533**
Pathology Programme	0	0	0	0	0	0	0	0	56	56	0	0	56	56	0	0	**225**
Stroke	33	33	33	33	33	33	33	33	33	33	0	0	0	33	0	0	**362**
Innovation Collaborative	4	4	4	4	4	4	4	4	4	4	4	4	4	4	0	0	**50**
Mental Health	26	26	26	26	26	26	26	26	26	26	26	26	26	26	0	0	**365**
Prevention	30	30	30	30	30	30	30	30	30	30	30	30	30	30	0	0	**425**
Workforce	8	8	8	8	8	8	8	8	8	8	8	8	8	8	0	0	**118**
Digital	23	23	23	23	23	23	23	23	23	23	23	23	23	23	0	0	**319**
Estates	10	10	10	10	10	10	10	10	10	10	10	10	10	10	0	0	**134**
Total	**203**	**203**	**203**	**203**	**573**	**573**	**573**	**573**	**231**	**601**	**134**	**108**	**198**	**231**	**0**	**0**	**4,610**
Less LA contribution	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	(13)	80	100	0
Net Contribution	**190**	**190**	**190**	**190**	**560**	**560**	**560**	**560**	**218**	**588**	**121**	**95**	**185**	**218**	**80**	**100**	**4,610**

Organisational contributions to the STP 19/20 budget

			19/20 Draft contribution	18/19 Planned contribution	Increase/ (decrease)
Commissioners	**West Kent**	**DGS**	**332**	327	5
		Medway	**332**	327	5
		Swale	**332**	327	5
		WK	**332**	327	5
	East Kent	**Ashford**	**702**	697	5
		C&C	**702**	697	5
		Thanet	**702**	697	5
		SKC	**702**	697	5
Providers		**D&G**	**360**	389*	(29)
		EKHUFT	**730**	759	(29)
		MFT	**327**	389	(62)
		MTW	**360**	389	(29)
		KCHFT	**262**	271	(9)
		KMPT	**237**	234	3
Local Authorities		**KCC**	**100**	100	0
		Medway	**80**	80	0
Total			**6,591**	**6,710**	**(119)**

* Following approval of the budget, a revised contribution of £305k was agreed with DGT

Appendix 1: Plans on a page

Local Care: Plan on a page

Deliverables 2019/20

- To fully deliver all the elements of the 'Dorothy model', to embed all components i.e. urgent and emergency care, Home First, care navigation and end of life care
- Mental health: embed into the Dorothy model, including dementia support; develop a menu of services needed to support people; from wellbeing to severe mental illness (across self help /H&WB Services /GP practice/ mental health services, including a strategy for suicide
- Develop the MDT approach for children and young people with complex conditions
- Industrialisation of care navigation / social prescribing: framework for population identification, outcomes, system efficiencies; consistency of offer
- Support for carers: facilitate events with key stakeholders to identify levels of support and links with care navigation / social prescribing; stage 2-3 of carers app development.

Budget

Workstream Lead
Strategic Analyst
Snr Project Manager
Total £228k

Return on Investment

The Local Care Investment Case identified the need for a cumulative investment of c£230m in revenue costs (of which c£192m is recurrent costs primarily for workforce and c£39m is non-recurrent) to deliver Local Care from now until 2020/21.

• This ambition was that this investment would lead to reductions in A&E activity, non-elective admissions, outpatient activity and bed days, generating savings across the four years to 2020/21 of c£491m gross and c£260m net. (The savings were presented as the collective direction of travel with a requirement for local planning to determine the target impact by specific geography. We will collate ,at a K&M level ,the outputs of sub-system modelling currently underway (Whole Systems Partnership in MNWK and E&Y in EK).

2018/19 a total of c£32m has been allocated for investment into Local Care; planning has begun in Q4 2018/19 to identify investment for 2019/20. Local Care is aligning to the Primary Care strategy in order to support Primary Care Network development as a key component of Local Care delivery.

* There will be a need to refresh the investment case in 19/20 alongside our response to the Long Term Plan

Productivity: Plan on a page

Deliverables 2019/20

Working through the Productivity Programme Board to identify cost reduction schemes to include in organisation plans for 19/20 to ensure we can achieve maximum savings.

The initial focus is on the following programmes:

Temporary staffing - Expanding the work to date with **Nursing** agencies to include **Medical** and then **AHPs** delivering collaborative bank solutions and harmonising bank rates.

Medicines - Delivering savings on biosimilar switches, changes to continence products saving, improving transfer of care around medicines & developing a Kent & Medway aseptics strategy.

Pathology - Returning out of county send-away tests back to Kent, contract renegotiations for a managed equipment service (MES), improving clinical effectiveness and standardizing terms and conditions.

From April, we will start to deliver within the following programmes:

Back Office - Combining **legal services** support to reduce external legal advice spend. Driving collaboration on **IT and mobile telephony** procurement through pan K&M buying of devices and "bring your own device to work" scheme. Bids to NHSE for replacement BI system; sharing of Data warehousing capabilities. Developing a Payroll and HR Admin Business case for consolidated service.

Clinical - Standardising pathways across Kent for Trauma & Orthopaedics, developing workforce roles alongside HEE and reviewing specialist activity sent outside the county.

Budget

- The total cost to fund the productivity team for 19/20 is **£532,740**
- For the Pathology programme, the expected costs to deliver the OBC phase is a total of **£225k.** This cost is comparable to other pathology networks OBC costs in England.
- Total: **£757,740**

Return on Investment

Currently, **we have a savings value for 19/20 of £8.4m,** predominantly made up of schemes in the medicines optimisation and pathology programme.

Further opportunities to be scoped for the final planning submissions, mean this opportunity is likely to increase.

Stroke: Plan on a page

Deliverables 2019/20

- A programme plan has yet to be developed for 19/20. This will be in place once the final decision has been made on 14th February.
- Provider business cases have been agreed by all Trust Boards
- A benefits realisation plan has been developed but some aspects may to be costly to evaluate as they require a new information capture system. This will form part of the implementation planning.
- The plans will be aligned with the STP's clinical strategy; however there are further questions regarding the visibility and potential overlap of the East Kent clinical strategy with the wider acute strategy.
- JCCCG will meet on Thursday 14 February to make a final decision

Budget

Stroke Delivery Prog Man	£91k
Dir of Acute Strategy	£131k
Stroke Admin Co-ordinator	£47k
Deputy DoF (0.6wte – f/t wef 1 Jan)	£76k
JCCG Chair (independent)	£18k
Total	**£362k**

Return on Investment

The stroke review will not make an ROI until the model is implemented either partially or in full (2020/2021).
Full financial modelling is available in the DMBC.

The HASU/ASU model is expected to lead to the attainment of national standards of stroke care resulting in improvements in outcomes for patients, with a reduction in mortality and morbidity, as evidenced in London and Manchester.

The new service model is designed to provide better long-term outcomes for stroke patients and therefore have financial benefits to the system. Additional investment (capital and revenue) in stroke services is required, which will provide longer term positive return on investment.

Innovation Collaborative: Plan on a page

Deliverables 2019/20

- Organising user / citizen innovation sessions to support STP workstreams
- Evaluation and Research Network supporting the C&PB including the link with ARC and the Health Analytics Board
- ESTHER training and briefing sessions for DGS and Swale
- Facilitating and administering the Innovation Collaborative
- Care Sector Workforce: facilitating conferences and engagement in the STP Workforce planning
- Innovation facility KMMS: person centred approach and wider involvement (social care, colleges etc.)
- ESTHER and Buurtzorg: EU management and implementation of the new models of care, co-production events
- Medication innovation programme: digital MAR sheets and joint pharmacy programme .
- International and national funding applications: Innovation Lab, Workforce Academy, Digital innovation supporting health and social care (providing Innovation panels bringing Digital SMEs together with Health and Social care agencies)

Budget

£50k this includes:

- venues, refreshments and training for ESTHER,
- Admin, communications and facilities
- EU management and implementation of the new models of care for Buurtzorg

Return on Investment

Improved patient outcomes in delivering new models of care and opportunities for financial return through collaboration and sharing of best practice across networks.

Mental Health: Plan on a page

Deliverables 2019/20

Delivering the Mental Health *Five Year Forward View*

- Satisfy NHSE assurance requirements for performance and delivery
- Add value to improvement and transformation where commissioners or providers are stuck and / or a system (vs place or neighbourhood) view is necessary
- Review CCG investment in mental health services in anticipation of the nationally prescribed audit of Mental Health Investment Standard and additional requirements related to the NHS long term plan
- Produce an STP mental health workforce action plan that is approved by Health Education England and making a strong contribution to services sustainability and transformation

Integrating Physical and Mental Health Care

- Design an outcomes based contract for specialist (secondary care) mental health services
- Develop an urgent and emergency mental health care pathway for people of all ages in Kent and Medway
- Support the integration of mental health into Local Care arrangements – to facilitate consistency in priority populations and common core standards of practice AND foster innovation across Kent and Medway
- Lead the development of a Kent and Medway Mental Health Collective (that is, an informal working alliance of providers of core health and social care mental health services)

Promoting Mental Wellbeing

- Run a Kent and Medway mental wellbeing campaign that amplifies the national one and results in behaviour changes in local people
- Create and test a Mental Wellbeing Impact Assessment toolkit that hardwires mental health in integrated care system arrangements
- Lead on reducing **deaths by suicide**

Budget

0.4 WTE executive clinical leadership (VSM)
0.8 WTE programme director (Band 9)
1.4 WTE programme managers (Band 8B)
2.0 WTE project and business support managers (Band 6-7)

Total: **£365K**

Return on Investment

1. Assure compliance with NHS national planning guidance and MHIS
2. Provide a list of opportunities for financial efficiencies in relation to mental health change and transformation
3. Produce a prioritised plan for delivery

Prevention: Plan on a page

Deliverables 2019/20

- Delivery of the Prevention Workstream Action Plan including sustainability of prevention activity (reduction of reliance on Public Health grant funding) and prevention embedded as a fundamental in all policy, commissioning and delivery of services.
- Strategic development for the NHS Long Term Plan
- Champion midwife, smoking in pregnancy lead for each of the 4 Trusts to support the achievement of LMS targets: 90% CO verification at booking, 90% referral of smokers to stop smoking services, 100% recording of SATOD
- Hypertension outreach work to increase the number of patients diagnosed with hypertension, increasing the completeness of hypertension registers

Budget	
Specialist midwives for smoking cessation [Issue in NHS Long Term Plan]	£218,004
Hypertension outreach 2019/20 [Issue in NHS Long Term Plan]	£100,000
Prevention Workstream Programme Manager: Prevention Workstream Programme Coordination	£62,856
Prevention Workstream Programme Officer: Strategic implementation of Long Term Plan requirements	£44,574
Total	£425,420

Return on Investment

Health and wellbeing: Increasing ascertainment of smoking at time of booking is key to ensuring that pregnant women can be directed to smoking cessation services – giving the best start for a healthy child and healthy life.
Non-communicable disease arising from hypertension is a key factor in both physical and mental quality of life as well as high cost to NHS.

Finance and efficiencies

- Potential for 2000 additional, NHS Health Checks in a year provides in the region of: 50 - 67 diagnoses of hypertension, 10-25 diagnoses of T2 diabetes, 200 -333 persons identified as being at high risk of CVD. The average cost to the NHS of stroke per person in the first 12 months is £13,169.
- Impact of Champion Midwives in East Kent: in 2016 the compliance to CO reading was 52%, and in some areas only 21% of women were being monitored at booking. During the first year 2016—2017, 95% of women had a CO reading at booking.

Primary Care: Plan on a page

Deliverables 2019/20

- Development and sign off of a single primary care strategy with implementation plan, aligning with the response to the Long Term Plan
- Development of a single set of commissioning standards for primary care across all CCGs, including timeline for implementation
- Support to develop primary care networks, working through GP federations, including delivering the GPFV e.g. 10 high impact actions, aligned with local care and system transformation

Budget

Working on the assumption that the national GPFV Implementation Fund will be allocated to the Primary Care Board again in 19/20, therefore no STP budget request, but this may change if national funding isn't committed.

Return on Investment

The primary care strategy will inform the effective investment of increased national primary care funding, and an outcomes framework will be developed to measure the benefits realised from this. The strategy is predominantly being developed using existing resources.

Workforce: Plan on a page

Deliverables 2019/20

Ambition: Kent and Medway: A Great Place to live, work and learn

Key Deliverable: Kent and Medway workforce strategy/ transformation plan- being presented to Programme Board in February 2019.

Key Deliverable: Introduction of a Kent and Medway Academy for Health and Social Care as key mechanism to delivery workforce plan aims.

Key Aims of the Workforce Transformation Plan:

- Promote Kent & Medway as a great place to work;
- Maximise supply of health & social care workforce;
- Create lifelong careers in health & social care;
- Develop our system leaders and encourage culture change;
- Improve workforce wellbeing, inclusion and workload to increase retention.

Deliverables: Deliverables detailed in the Transformation Plan with dashboard in development for monitoring key deliverables

Enabler: Expanded STP team for 19/20 to support workforce transformation plan and STP priorities deliverables

Budget 19/20

- Monies for 19/20 not allocated yet (linked to HEE national spending review, likely to know by end Q1/ early Q2 19/20)
- Expanded team and programmes funded through 18/19 monies for a further year until Mar 2020.
- **Total £118k – funding for Clinical Educator roles at the Medical School**

Return on Investment

Health and wellbeing:

- Workforce wellbeing key focus of workforce strategy
- Making Every Contact Count training delivery 2019
- Carer's app launching with training & development
- OD toolkit rollout and MDT OD support to support PCN maturity
- Workforce resource to support implementation of STP priority programme plans

Care and Quality

- Stroke workforce plan implementation to deliver safe staffing levels in HASUs
- Support system leads to develop East Kent system workforce plan and actions
- Support providers to deliver 498 fte gap in mental health
- Support providers to address cancer gap in workforce
- Support providers to receive 100 medical students each year from 2020

Finance and efficiency

- Evaluation of projects funded in 18/19 to ensure RoI
- Business case for Academy to ensure sustainable workforce funding
- Use of attraction mediums and offers to fill hard to recruit roles inc Take a Different View and recruitment campaigns to reduce need for temp staffing
- Upskill key workforce and improve retention of workforce which will reduce need for recruitment and maximise current supply
- Introduce a Kent & Medway Talent Board for roles to reduce need for interims
- Shared Kent & Medway Leadership & Organisational Development offer to share resources and expertise and develop system leaders
- Support local workforce redesign to address workload and workforce supply issues for STP priority work streams

Digital: Plan on a page

Deliverables 2019/20

- KMCR Stage 2 – award of contract
- Initiation of KMCR Implementation
- As system and clinical transformation schemes move into delivery digital work stream needs to develop appropriate solutions.
- Development the following operational structures
  - An IG framework to support multi organisational shared systems such as KMCR
  - An operating model to configure, maintain and provide first line support
- Update of the Local Digital Roadmap taking account of the long term plan and to reflect
  - ➢ STP Clinical Strategy
  - ➢ East Kent Transformation
  - ➢ Emerging national strategies and priorities
  - ➢ The digital asks from STP clinical transformation work streams
- Process for accessing funding sources such as STP Capital, ETTF, LCHRE, HSLI and others, development of business cases
- KID Transition to Optum
- Development of Informatics work force plan to support Strategic commissioner
- STP will establish a governance group (Digital Board) to oversee the delivery

Budget	
Digital Work stream Lead	**£ 43,000.00**
Interim KID arrangements	**£ 82,000.00**
Programme management & Support	**£ 76,000.00** **£ 47,000.00**
IG Lead	**£ 31,000.00**
Local Digital Roadmap Refresh	**£ 40,000.00**
Total	**£319,000.00**

Return on Investment

Demonstrating return on investment on the digital work stream budget is difficult as the deliverables are predominantly enablers for other elements of the STP which do demonstrate a return of investment. Where the digital work stream initiates projects such as KMCR or SHcAB, these will be supported by business cases that will be expected to show RoI. NB KMCR costs are excluded from this budget as funding has been agreed following approval of the KMCR OBC

Estates: Plan on a page

Deliverables 2019/20

- **Capital Disposals**
  - Develop a Disposals Programme that meets the Naylor Fair Share Target
  - Plan to identify the Deficit
- **Local Area Asset Reviews**
  - To be undertaken within each Locality area to drive efficiency savings
  - Identification of new disposal opportunities following improved utilisation
- **Strategic Commissioner Workstream**
  - Support the WS and act as a pilot for the Transforming Systems Work
- **Estates Strategy resubmission**
  - Next iteration must achieve 'Good' as a minimum
- **Capital Projects Delivery**
  - Provide assurance and support to Bid Sponsors to deliver all Wave 3, 4 and ETTF Projects
  - Update Prioritisation list with Transformational Projects

Budget

Workstream Lead	*£64k*
2 x Locality reviews	*£62k*
Consultancy	*£6k*
Total	*£134k*

Return on Investment

Health & Wellbeing

- Requirements for integrated Health and Social Care Services required going forwards identified by bid sponsors and will be the objective of the capital spend.
- Provide analysis and support to CCG's regarding their vision for joined-up health and social care

Care & Quality

- Properties that are future proofed to be fit for purpose to deliver the services that are required within the locality as the population grows

Finance & Efficiency

- Improved utilisation of the estate driving revenue savings, potential capital receipts, reduction of backlog maintenance
- Assurance that awarded capital funding for Wave 3, 4 and ETTF projects are delivered on time, to budget and do not impact the reputation of the STP negatively.
- Identification and support for Capital Bidding and exploration of financial opportunities available to benefit the Estate and Stakeholders.

East Kent: Plan on a page

Deliverables 2019/20

- Finalise evaluation of the two medium list options
- Draft PCBC
- Clinical Senate Review of PCBC
- Successful completion of the NHS E assurance review
- Consultation
- Post-consultation analysis

Budget

£1,850k

Return on Investment

To be addressed in the PCBC

Appendix 2: Budget notes

Posts funded directly by CCGs

STP Leadership	Glenn Douglas	STP CEO	0.5 wte
STP Leadership	Glenn Douglas	STP CEO PA	1.0 wte
STP Leadership	Glenn Douglas	STP CEO lease car	
System Transformation	Simon Perks	Dir of System Transformation	1.0 wte
STP Leadership	Mike Gilbert	Company Secretary & Asst Accountable Officer	0.5 wte
Digital		KCR Project Costs (50%)	

System Transformation ICPS team including Programme Director, Programme Manager, Project Support Officers, Workforce/Comms/Finance leads, and Admin Support

Organisational contributions to the Productivity budget

The following method was used to calculating organisational contributions to the Productivity budget:

- Productivity workstream savings forecast revised to £8.4m.
- As the benefits of the productivity workstream primarily accrue to the commissioners, the contributions to the productivity budget are shared across commissioners and providers, and based on savings
- The providers' and commissioners' shares of the productivity budget are based on the potential workstream savings of £10.4m, which benefits the commissioners (see Table below)
- The providers' contributions are based on the 18/19 contribution %ages applied to the providers' total share of the 19/20 productivity budget, which is the approach agreed at the Productivity DDOFs meeting
- The commissioners' contributions then uses a similar methodology of an equal split of the commissioners' share of the 19/20 productivity budget

		Commissioners								Providers						Total
		DGS	Medway	Swale	WK	Ashford	C&C	SKC	Thanet	D&G	EKHUFT	KCHT	KMPT	MFT	MTW	
Forecast savings (£k)	Bio	970	947	370	1,672	382	931	772	608	121	664			330	418	**8,186**
	Incontinence	24	19	11	39	25	48	52	36							**253**
	Nursing agency										446	245	88	35	1,146	**1,961**
	Total	**994**	**966**	**381**	**1,711**	**407**	**979**	**823**	**644**	**121**	**1,111**	**245**	**88**	**365**	**1,564**	**10,400**
	Contribution %age	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	7.7%	7.7%	1.4%	1.4%	7.7%	7.7%	**100%**
	Budget contribution	**44.2**	**44.2**	**44.2**	**44.2**	**44.2**	**44.2**	**44.2**	**44.2**	**41.0**	**41.0**	**7.5**	**7.5**	**41.0**	**41.0**	**533**

Report to the Board of Directors

Board Date: Thursday 07 March 2019 Agenda Item: 4.3(ii)

Title of Report	Transformation Programme update
Prepared By	Jack Tabner, Associate Director of Transformation Nick Chambers, Associate Director of Transformation Rita Lawrence, Head of Culture and Engagement
Lead Director	James Lowell, Director of Planning and Partnerships
Committees or Groups who have considered this report	Transformation Assurance Group (TAG)
Executive Summary	The portfolio of transformation programmes continues to gather pace across the Trust. The paper includes updates on the following transformation – programmes: • Continuous Improvement • Culture • Cost Improvement Programme **Continuous Improvement** The aim is Create an ***Army*** of problem solvers equipped with tools and Capability to deliver continuous Improvement aligned to our strategic objectives and generate a focus of quality improvement through an engaged and empowered workforce. Four key initiatives drive this aim:- 1. Continuous improvement embedded throughout the organisation. 2. Specific capability building in 'business skills' needed at management level to deliver our objectives. 3. Creating board to ward alignment and performance management for improvement as business as usual. 4. Embedding Continuous Improvement into the Trust Quality strategy for consistent approaches to our quality improvement projects. Since August 2018 we have Trained 84 staff in our advanced improvement science training and Trained 108 staff in our introduction to improvement science training leading to improvement methodology being spread across our Trust and generating small improvements every day.

Report to the Board of Directors

Training remains on track to deliver a 60% completion rate of successful projects with 90 days as a result of the training.
Further training is planned throughout the year and fully booked until April – future training will also be aligned to strategic projects arising from our core strategies.

Specific capability building

Finance and business case writing sessions have been delivered to date utilising NHS Elect partners to support. Currently 58 managers have attended since December.

We have taken the content from NHS elect to deliver in house for future.
Further training is booked throughout the year to cover key areas of capability improvement.

Creating board to ward alignment and performance management

Process Performance Management boards have been created within Pharmacy, Women and Children, Acute Frailty, COAST and Business Intelligence (BI) teams.

The purpose is to provide transparent performance metrics against our strategic objectives and drive improvement through standard improvement science and problem solving processes.

Embedding Continuous Improvement into the Trust

Improvement huddles are occurring throughout the week within Pharmacy (x3), Theatres (x2), Women and Children (x2), Organisational Development and Research and Innovation.
The pipeline consists of Acute Frailty wards, Therapies, Surgical Wards, Maternity/Gynaecology, BI and Neonatal Intensive Care Unit (NICU).

We are already seeing many improvements cutting across the various areas and being solved at the improvement huddles. Over 40 small improvement and 20 medium improvements to date.

Culture

The second phase of the You Are The Difference Programme launched on the 19th February and will be open to staff to attend through until the 5th April.

For this phase a new approach will be trialled to ensure that the

programme can reach as many staff as possible by running the sessions in shorter sessions over a number of days. This has been a result of feedback from clinical staff who want to attend the programme.

Further work must continue to remind, embed and ensure that the skills and behaviours from the programme are adopted in everyday practice across the Trust.

Cost Improvement Programme

Month 10 report – 2018/19

As at Month 10 (January), Year-To-Date actual CIP delivery is **£16.4m**.

This has increased by 14% from £14.1m, as reported in Month 9 and is favourable to Month 10 plan by £0.7m.

The non-recurrent / recurrent breakdown is as follows:

- Non Recurrent : 26.4% (£4.3m)
- Recurrent: 73.6% (£12.1m)

Forecasting delivery through Month 11 and Month 12 (all Red, Amber, Green schemes included), the total CIP forecast position is £21.0m delivery, achieving the Trust's target.

2019/20 CIP Programme

As part of the Trust's effort to deliver next year's control total, the 2019/20 Cost Improvement target is **£18.0m**. This is a significant undertaking given the 2018/19 delivery profile, and the need to transform the organisation alongside cost reduction and efficiency activity.

As at 21st February, we have identified 79 schemes with a value of **£16.3m** (validation ongoing) – therefore a small shortfall of £1.7m.

Clearly, there is no let-up in the need for financial improvement. As part of the Trust's *Best In Class* strategy, efficiency work with clinical teams must focus first and foremost on quality of care and patient safety.
Governance and reporting of the CIP programme has improved in 2018/19 and we endeavour to continue to improve the joint working between different departments across the Trust: finance, Programme Management Office (PMO), operational directorates. An improved reporting cycle is depicted within the paper.

Report to the Board of Directors

	A Joint PMO has been established with Medway CCG to coordinate the delivery of two large-scale transformation programmes: 1. Flow 2. Outpatients transformation.
Resource Implications	The paper provides an update on the level of CIP identified at the directorate level and has implications for budget setting into next year. The merging demand for improvement capability across the 4 key initiatives is expected to highlight a resource gap dependant on expected delivery timescales. This is not reported within the presentation.
Risk and Assurance	The level of risk attached to individual schemes is monitored daily by the PMO, and the forecast is presented as a range to reflect the nature of this. CIP Delivery is a primary focus of the Director of Financial Improvement currently in post at the Trust as part of our Mandated Support regime. The Continuous Improvement processes are managed within the control of the transformation team; however, a significant part of delivery will also be managed through the quality assurance process within the quality strategy governance.
Legal Implications/Regulatory Requirements	CIP delivery is essential for overall delivery of the Trust's control total. Non-delivery of the control total could result in the Trust being placed into a Financial Special Measures regime. We know the CQC have commented "In those trusts we have rated as outstanding, we have found a culture of quality improvement embedded throughout the organisation" as such the strategy is expected to significantly support our CQC requirements.
Improvement Plan Implication	CIP is a central component of the Trust's Improvement / Recovery plan. Continuous Improvement is a central component of the Trust's Improvement / Recovery plan.
Quality Impact Assessment	All schemes should be assessed for quality impact using the CIP governance and QIA process, overseen by the Medical and Nursing Directors.
Recommendation	To note the contents of the report.
Purpose and Actions required by the Board	**Approval** ☐ **Assurance** ☒ **Discussion** ☒ **Noting** ☒

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Capability Building

The aim of the capability building strategy is to:-

"Create an ***Army*** of problem solvers equipped with tools and Capability to deliver continuous Improvement aligned to our strategic objectives and generate a focus of quality improvement through an engaged and empowered workforce"

Supporting the trust vision to deliver the **best of care** with the **best of people**

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The Capability Strategy aligns to CQC findings and expectations

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"In those trusts we have rated as outstanding, we have found a culture of **quality improvement embedded** throughout the organisation"

"When we visit these organisations, they 'feel' different – there is a palpable focus on quality and patient-centred care, with **engaged staff that are enabled to make improvements to the care they deliver**".

"When QI is used well, it gives us **confidence** about the long-term sustainability of the **quality of care**".

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Capability strategy – Targets and Ambitions

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Continuous improvement embedded throughout the organisation

Train 1000 staff members across our trust and integrated health system as improvement practitioners by the end of 2019 financial year

- To effectively upskill ***our people*** in order to create a ***common language*** of CI & QI methodology that is standard and embedded into business as usual and support the delivery of strategic aligned ***improvements.***

Specific capability building in 'business skills' needed at management level

12 topics trained in 2019 supported by NHS Elect and enabling Medway to train internally.

- Creation of additional specific support training to better equip ***our people*** to deliver the strategic aligned ***improvements.***

Creating board to ward alignment and performance improvement as business as usual

100% of our front line and operational areas utilising the BBB improvement system within their area by end 2019 financial year

- Creation of a ***strategy aligned*** process that enables all staff to engage together to make CI part of ***daily business as usual***.

Quality and Capability strategy aligned with quality improvement projects created within it

Review and improve our services to ensure consistent High Quality Care through engaging our people to deliver the best of care

- All of Our People will be **enabled to deliver *consistent* and high quality care** to our patients through living our values and aligning to our vision

Capability strategy – Since August 2018 we have…

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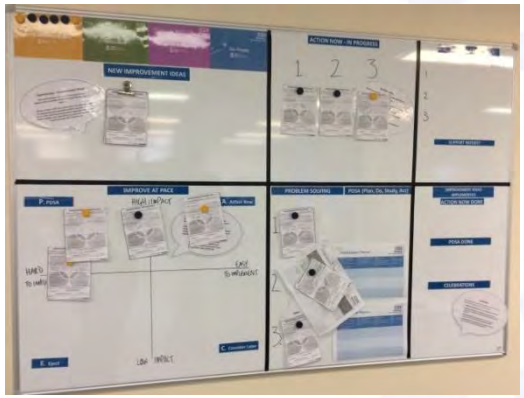
Trained 84 staff in our advanced improvement science training - Resulting in

- 25 improvement projects completed
- 25 further projects being worked through
- 34 projects in the early stages of set up

"I found the training really helpful to consider different ways of planning and implementing a quality improvement"



Introduced **'improvement huddles'** within

- Pharmacy
- Theatres
- Research and Innovation
- Organisational Development
- Paediatrics

"This has given me the knowledge and confidence to make Quality improvements in my area"

Generating and making improvements across the trust

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Trained 108 staff in our introduction to improvement science training - Resulting in:-

- Our improvement methodology being spread across our Trust and generating small improvements everyday.

19/20 Capability and Quality Strategy Milestone plan

NHS Medway NHS Foundation Trust

Milestones

Q4 18/19

Create a centre of excellence using all CI tolls of the BBB improvement system to showcase and support full roll out.

Pharmacy to be the internal centre of excellence

1. White & YB training utilised and showing improvement
2. Improvement huddles system across the whole department
3. Performance Management system in place and in use to drive performance

BBB improvement system live and in place in Main Theatres and Sunderland day case theatre.

Set up BBB system within

- W&C Programme
- Frailty bed base
- Therapies
- Research and Innovation

Q1 19/20

Spread of the BBB improvement system across an entire clinical programme

Complete the roll out for

- W&C Programme
- Frailty bed base
- Therapies

Set up BBB system within

- Endoscopy and cardiac
- Surgical directorate

Align the YB trained individuals to major improvement projects (top down) and create a forum of volunteers to support strategy.

- GIRFT improvement
- Quality Strategy projects
- CQUIN projects

Directorate Performance management process set up within the Planned care directorate.

Q2 19/20

Complete the roll out of the BBB improvement system to

- Frailty bed base
- Therapies

8x Improvement specialists in training under apprenticeship scheme and linked to programmes and transformation projects

Roll out of the BBB improvement system across 2 further clinical areas

Offer YB to our external partners (CCG etc) to bring together a single continuous improvement system.

Trust wide 'Kaizen' workshops to improve large scale pathways using our continuous improvement methodology.

Q3 19/20

Roll out of the BBB improvement system across 2 further clinical programs

YB to be trained by our improvement specialists (start to hand over the training to our improvement specialists)

STP wide 'Kaizen' workshops to improve large scale pathways using our continuous improvement methodology.

Q4 19/20

Roll out of the BBB improvement system across 2 further clinical programs

8x Improvement specialists complete training and will be utilised to manage the capability training and YB cohort in their areas (complete the handover)

Share improvement success and review performance.
Expected output and completion of CQUIN and Quality strategy aligned improvement projects throughout the year.

Trust wide 'Kaizen' workshops to improve large scale pathways using our continuous improvement methodology.

Monthly training in our improvement science modules and 'masterclasses' to build the capability of our staff to deliver the improvements needed to consistently deliver High Quality Care.

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Culture

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You Are The Difference Attendee Evaluation – as of February 2019

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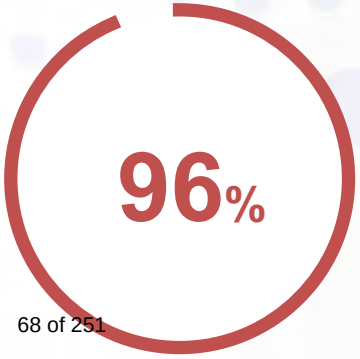
Following the sessions:

Agreed or Very Strongly Agreed that they have the ability and tools to improve the culture at MFT

Agreed or Strongly Agreed that the session was engaging, interesting and useful

Agreed or Very Strongly Agreed that they now recognise their own responsibility for improving the culture at MFT

Agreed or Very Strongly Agreed that positivity at work leads to better outcomes & they're committed to helping MFT create a positive culture



Agreed or Very Strongly Agreed with the belief that our values/behaviors directly affect our patients' results

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Phase 2 Overview

New phase launched on 19th February

- We have a new training room for YATD kindly given to us in sort term by Med Ed colleagues.
- A range of sessions running though 19/2 to beginning of April
- Sessions predominantly made available to **Staff** with further sessions available to **Managers** and **Manager follow up** sessions, with a total capacity to allow for a further 2243 staff.
- **Session promotion** through weekly Trust-wide global message, screen saver and programme boards via HR business partners, and pro-active Ambassador promotion.

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Induction Sessions

You Are The Difference Induction sessions started on **7 January, running weekly.**

These consists of a video presentation hosted by Alf Dunbar whilst utilising a facilitator to take participants through the exercises, sessions last approximately 2.5 hours.

The content mirrors that of the regular staff sessions and to date **153 Inductees** have participated in the sessions

Inductee feedback has been positive with feedback agreeing that Improving the culture of the organisation and making the course part of induction, citing it as **“refreshing”**.

Embedding and Next Steps

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Next Steps include:

- Utilising the YATD Ambassadors to promote and work with staff in their areas to **ensure the maximum uptake** of the programme.
- Support Ambassadors to run YATD **events** within their areas, or areas that need support.
- YATD " on tour" to bring the sessions to wards and depts. in short 30 minute bursts over a few dates utilising team meetings etc. we plan

Challenges:

- Senior Team member's commitment to the **programme is inconsistent**
- Practical elements to enable staff to attend, e.g.– **managers require bank staff cover** to be provided before they send further staff on the sessions.
- Numbers need to be increased on the sessions.

So what now?

- **Continue to run the sessions as planned .**
- **Adopt a range of ways to bring the sessions out to hard to reach areas with the agreement of Executive colleagues.**
- **Start to pull together a range of data to see across the trust how actively engaged areas are in YATD, flu, cqc ratings to decide on appropriate development interventions.**

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Cost Improvement Programme

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2018/19 Cost Improvement Programme headlines

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- Cost Improvement Programme – target of £21m: £15m recurrent, £6m non-recurrent stretch target)
- One of the largest Acute Trust efficiency programmes nationally – 6.9% of operating expenditure (avg. Acute Trust 4.7% in 17/18)
- >130 individual schemes logged on *Aspyre* – significant focus on Temporary Staffing savings and vacancy controls
- Enhanced reporting and documentation, including QIA process
- Confirm & Challenge approach with Financial Improvement Director
- Examples of Model Hospital in action – E&F, Pharmacy

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Month 10 – £16.4m delivered in CIP

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- M10 YTD Actual delivery is **£16.4m**. This has increased by 14% from £14.1m reported in Month 9 and is favourable to Month 10 plan by £0.7m
  - Non Recurrent : 26.4% (£4.3m)
  - Recurrent: 73.6% (£12.1m)
- With M11 + M12 (Red, Amber, Green) forecast delivery, the total CIP forecast position is **£21.0m** delivery, achieving the target.

Activities between now and the end of the financial year:

- Planning for 2019/20 (budget setting, CIP identification, QIA and documentation completion)
- Star Chamber with Director of Finance, HR Director, Director of Financial Improvement on 6th March – to review current non-recurrent savings against vacancies

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Year-to-date delivery is £0.74m favourable to plan

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2018/19 CIP Forecast vs Target Month 10

Directorate Split	Unplanned Care (£'000)	Planned Care (£'000)	Corporate (£'000)	Estates (£'000)	Totals (£'000)
Target	**(10,100)**	**(8,174)**	**(2,021)**	**(726)**	**(21,021)**
CIP Budget as % of Expenditure Budget	7.0%	7.0%		3.1%	6.9%
Identified	**(7,086)**	**(10,330)**	**(2,301)**	**(1,304)**	**(21,021)**
Unidentified	(3,014)	2,156	280	578	**0**
% Identified to Target	**70%**	**126%**	**114%**	**180%**	**100%**
YTD Target	(7,611)	(6,158)	(1,351)	(566)	**(15,686)**
YTD Actual	(6,090)	(7,020)	(2,083)	(1,232)	**(16,425)**
YTD Variance	(1,521)	862	732	666	**739**
YTD % Delivery	**80%**	**114%**	**154%**	**218%**	**105%**

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2019/20 Cost Improvement target = £18.0m

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	NHSI £m	Trust £m
Rebased baseline position excluding PSF	(52.2)	(52.1)
Non recurrent in baseline		(4.6)
Directorate Non Recurrent		(2.6)
£1bn PSF transferred into urgent and emergency prices	6.3	6.3
CNST net change in tariff income and contribution	(4.5)	(4.5)
Other changes	(4.1)	**(13.5)**
Subtotal before efficiency	(54.4)	(70.9)
Other adjustments:		
Additional efficiency requirement up to 0.5%	1.5	
MRET central funding	9.2	9.2
Non recurring PSF allocation	6.6	6.6
Non recurring FRF allocation	14.8	14.8
CIP Programme		**18.0**
Control total	(22.3)	(22.3)

£18m = c.6% of operating expenditure (in line with 6.3% internal target set)

Plan submitted on 12th Feb included **51 schemes, with a value of £13.5m** (+ BTFYE of 18/19 recurrent schemes of £1.4m)

As at 21st February, we have **79 schemes with a value of £16.3m** (validation ongoing) – therefore a shortfall of £1.7m

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We currently have £16.3m identified in CIP schemes for 2019/20

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- **£16.3m identified as potential 19/20 CIP schemes against a £18.0m target. Current shortfall to identify is £1.7m. Note: Important to identify more than £18m in order to deliver £18m.**
- Key scheme in Corporate Directorate currently – relates to net income improvement (£4.0m)
- Significant schemes relate to transformation programmes: Portfolio of Services Review, Outpatients, Flow
- Actions for assuring 19/20 CIP schemes into delivery from 1st April 2019
  - Confirm and challenge meetings with Director of Financial Improvement
  - Scheduled QIA sign offs with Nursing and Medical Directors
  - PMO supporting scheme owners to complete documentation on Aspyre.
  - Finance Business Partners quantifying, phasing, assigning GL codes and signing-off financial assumptions per scheme
  - For many schemes (e.g. savings in agency spend due to substantive recruitment), milestones are being monitored now to ensure delivery from April onwards

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CIP 2019/20 plan profile

(vs. 2018/19 delivery)

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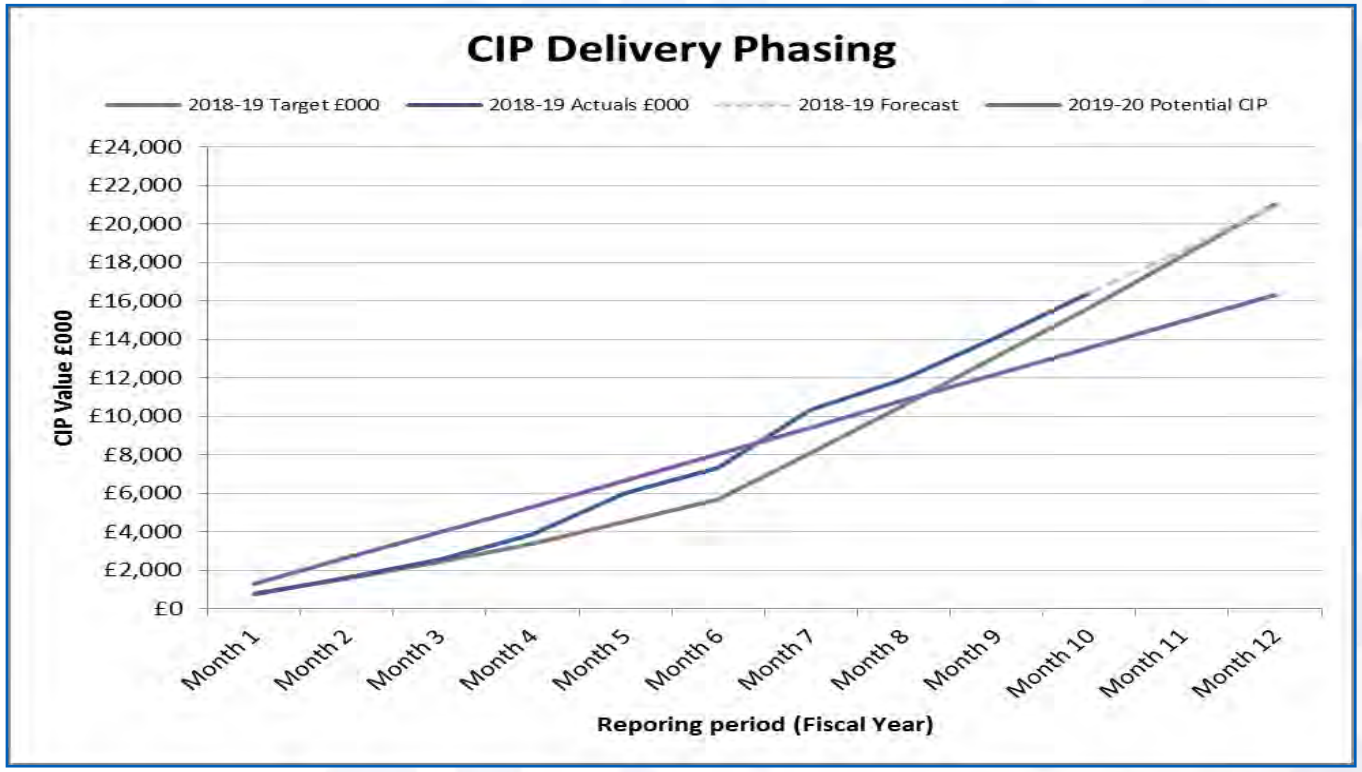

2019/20 'flatter' delivery profile – currently less backended than 2018/19

Requires greater delivery in Q1 of the financial year (£4.0m) – pace must be maintained

18/19 Q1: £2.6m	18/19 Q2: £4.8m	18/19 Q3: £6.8m	18/19 Q4: £6.9m
19/20 Q1: £4.0m	19/20 Q2: £4.1m	19/20 Q3: £4.2m	19/20 Q4: £4.1m

M10 Actual; M11 – M12 forecast

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Planning process

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	1 Set targets	2 Identify opportunity areas and complete QIAs	3 Fully scope CIP schemes and quantify impacts	4 Prioritise effort and set up to deliver	5 Monitor delivery
Activity	• Budget-setting (Finance) • Provide targets at Programme-level: • Apply % to corporate areas • Calculate balance to FYE of 18/19 recurrent schemes	• Hold workshops with Directorates to identify plans • Refresh opportunities in the Model Hospital and share insights tool • Review Aspyre 'ideas' to re-visit • Complete QIAs • Assign owners and clarify roles	• Complete CIP documentation in Aspyre • Milestones, PID, Risks, Programme Board sign-off • Quantify schemes with Finance BP • Phase throughout the year with Finance BP • Assess gaps	• Identify schemes for dedicated support • Identify additional capacity / capability needs • Enter delivery mode and routine reporting cycle	• Confirm & Challenge • Ongoing support – drop in sessions • Monitor slippage / under-delivery • Highlight reports from Aspyre for off-track schemes

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CIP briefing pack

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- We have developed a resource pack to be shared with all Directors, Senior Managers, budget holders and scheme owners
- Interactive PDF format – for reference throughout the year
- Includes key principles, links, jargon buster, detailed QIA process, agreed schemes by Directorate, detailed reporting process, CIP governance, roles and responsibilities, support on offer to deliver targets, FAQs, useful contacts etc.

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Model Hospital

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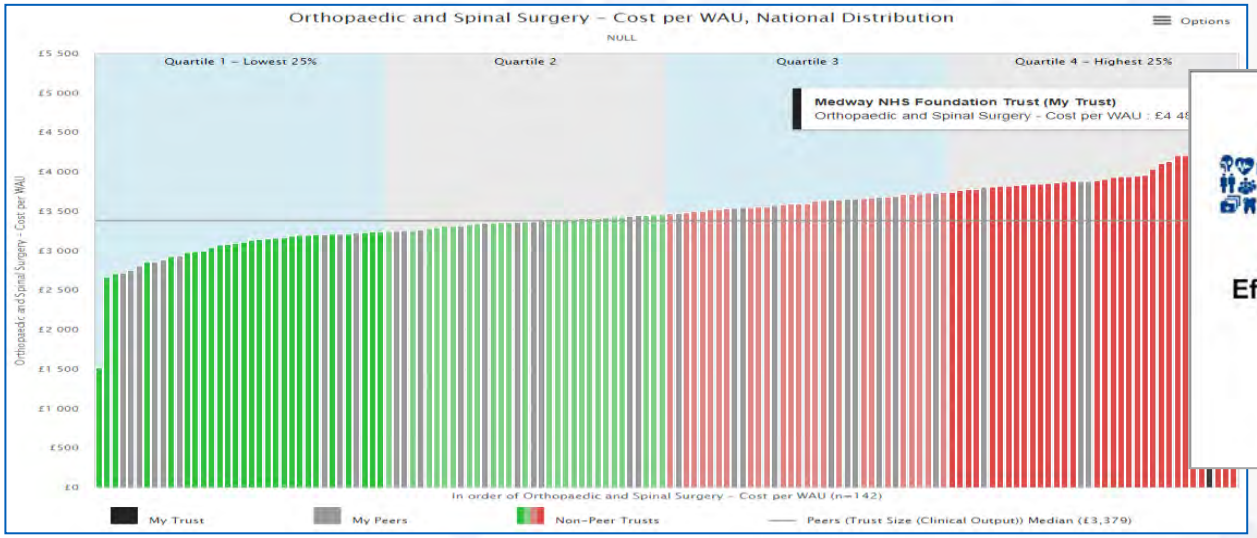

Overall productivity	Data period	Trust value	Peer median	National median	Chart	Actions
Orthopaedic and Spinal Surger...	2017/18	£4,489	£3,379	£3,468		

Cost per WAU by setting	Data period	Trust value	Peer median	National median	Chart	Actions
Cost per WAU - Elective admiss...	2017/18	£3,755	£3,528	£3,490		
Cost per WAU - Non-elective a...	2017/18	£3,540	£3,499	£3,528		
Cost per WAU - Outpatients	2017/18	£9,143	£3,081	£3,337		
Cost per WAU - Day cases	2017/18	£2,546	£3,313	£3,453		
Cost per WAU - Other settings	2017/18	£5,915	£3,443	£3,492		

Identifying potential productivity opportunities through national benchmarking and peer comparison.

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MFT Model Hospital Insights Tool – developed locally

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MFT 2019/20 Potential Productivity Opportunities (PPO) by Model Hospital Clinical Service lines

Clinical Service Line	MFT Cost £	National Average Cost £	MFT Cost Per WAU	Model Hospital National Median WAU	WAU PPO	MFT WAU PPO Cost £	MFT PPO Cost @ (4%)	MFT WAU PPO Cost - MFT PPO Cost @ (4%)	Total MFT PPO Cost £	Total MFT PPO Cost £ % of MFT Actual Cost £
Orthopaedic Surgery	£29,826,700	£23,371,663	£4,487	£3,466	£1,021	£6,786,803	£1,193,068	£5,593,735	£6,786,803	23%
General Medicine	£29,492,322	£41,130,170	£2,521	£3,526	£0		£1,179,693		£1,179,693	4%
Generl Surgery	£29,475,442	£30,611,968	£3,385	£3,518	£0		£1,179,018		£1,179,018	4%
Obstetrics and Gynaecology	£25,827,496	£29,317,530	£3,097	£3,476	£0		£1,033,100		£1,033,100	4%
Emergency Medicine	£22,219,211	£18,260,330	£4,278	£3,533	£745	£3,869,143	£888,768	£2,980,375	£3,869,143	17%
Paediatrics	£22,182,108	£24,286,210	£3,211	£3,539	£0		£887,284		£887,284	4%
Geriatric Medicine	£11,630,976	£12,937,181	£3,161	£3,539	£0		£465,239		£465,239	4%
Ear, Nose and Throat	£10,950,026	£9,082,009	£4,239	£3,417	£822	£2,123,262	£438,001	£1,685,261	£2,123,262	19%
Urology	£10,868,216	£9,526,798	£4,011	£3,490	£521	£1,411,675	£434,729	£976,946	£1,411,675	13%
Cardiology	£6,919,648	£10,518,636	£2,313	£3,523	£0		£276,786		£276,786	4%
Gastroenterology	£6,556,603	£7,405,987	£3,113	£3,505	£0		£262,264		£262,264	4%
Diabetes & Endocrinology	£6,477,434	£7,083,702	£3,215	£3,481	£0		£259,097		£259,097	4%
Rheumatology	£4,183,290	£3,762,589	£3,909	£3,326	£583	£623,886	£167,332	£456,554	£623,886	15%
Vascular	£3,972,040	£3,839,716	£3,637	£3,490	£147	£160,534	£158,882	£1,652	£160,534	4%
Breast Surgery	£3,739,607	£3,669,181	£3,583	£3,418	£165	£172,188	£149,584	£22,604	£172,188	5%
Plastic Surgery and Burns	£3,301,424	£3,068,885	£3,782	£3,444	£338	£295,017	£132,057	£162,960	£295,017	9%
Dermatology	£3,249,825	£3,705,095	£3,084	£3,338	£0		£129,993		£129,993	4%
Stroke	£2,930,623	£3,274,223	£3,147	£3,482	£0		£117,225		£117,225	4%
Respiratory	£2,880,727	£2,167,726	£4,672	£3,500	£1,172	£722,573	£115,229	£607,344	£722,573	25%
Neurology	£2,260,971	£1,942,202	£4,093	£3,362	£731	£403,796	£90,439	£313,357	£403,796	18%
Medical and Clinical Oncology	£2,217,628	£1,788,275	£4,360	£3,538	£822	£418,077	£88,705	£329,372	£418,077	19%
Oral & Maxillofacial	£501,650	£506,098	£3,485	£0	£3,485		£20,066		£20,066	4%
Dentistry	£224,230	£256,634	£3,072	£0	£3,072		£8,969		£8,969	4%
Ophthalology	£0	£0	£0	£0	£0		£0		£0	0%
Neurosurgery	£0	£0	£0	£0	£0		£0		£0	0%
Cardiothoracic Surgery	£0	£0	£0	£0	£0		£0		£0	0%
						£16,986,954	**£9,675,528**	**£13,130,160**	**£22,805,688**	

Data Source: Reference Cost

Data period: 2017-18

* Notes - Clinical Service Lines are based on the Model Hospital Groupings, Cost per WAU is based on the Model Hospital methodology (MFT Cost / (National Average Cost / WAU)).

- Model Hospital Insight Tool (MHIT) has been developed using Reference cost data
- Provides the ability to deep dive into potential productivity opportunities identified through the Model Hospital tool
- MHIT drills down to Service line, Department and Healthcare Resource Group (HRG) level to identify variance to national average costs
- MHIT supports HoOPs, Service Managers and Clinicial Leads to explore areas of potential productivity
- Model Hospital super-users trained to use this tool to support identification of 19/20 CIPs

Shared with Directors, HoOPs , Service Managers, Model Hospital super-users

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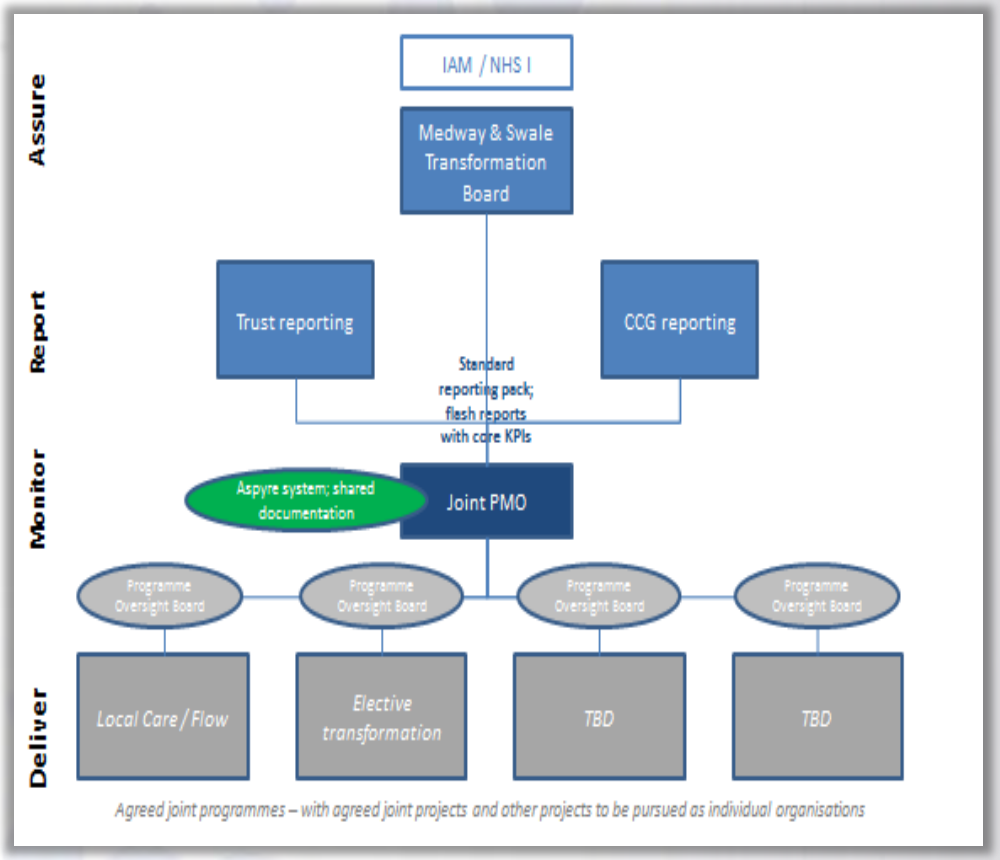
Joint PMO established between MFT and Medway CCG

- Discussion and subsequent planning has commenced to develop a Joint Programme Management Office (PMO) for large, complex change programme to jointly manage and report the system impact of the improvements.
- Led by the Head of PMO (MCCG) and Associate Director of Transformation (MFT) working together and reporting to the Medway & Swale Transformation Board, the purpose of the JPMO will:
  - Account for delivery of cross-system plans across the system
  - Provide updates and reports at programme level
  - Jointly own the delivery of each programme at a Medway-level reporting the benefits for each organisation and understand the impact of the different phases across the system
  - Align, where possible, the reporting practices between local PMOs.
- The two change programmes identified to launch the JPMO are:
  - **Outpatients Transformation Programme**
  - **Flow/Local Care**



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Report to the Board of Directors

Board Date: Thursday, 07 March 2019 Agenda Item: 5.1

Title of Report	Integrated Quality and Performance Report
Prepared By	Karen Rule, Director of Nursing
Lead Director	Karen Rule, Director of Nursing
Committees or Groups who have considered this report	Executive team Directorate and Programme leadership teams
Executive Summary	This report informs Board Members in the form of a dashboard report of January 2019 performance across key performance indicators. January 2019 was an extremely busy month for the Trust. Performance against the 4 hour emergency department (ED) access target deteriorated to 83.06% and the Trust reported five 12 hour breaches. Average bed occupancy rose to 91.11% with Critical Care bed occupancy at 99.56%. Average non-elective length of stay (LOS) was the highest reported this year at 9.28. This reflects the increased demand for inpatient care during an expected winter period. To meet demand escalation beds were open throughout the month. This placed pressure on staffing but all areas were safely staffed by flexing all disciplines across areas. The Trust was supported by system partners to manage demand and to deliver more efficient and effective discharge pathways. The Trust cancelled 48 elective operations on the day of surgery; however, no urgent operations were cancelled for a second time. Clinical patient reviews were undertaken for all cancelled operations and provided assurance that the cancellation did not result in patient harm. The Trust acknowledges and apologises for the detrimental impact this had on patient experience and maintained regular contact with patients to ensure operations were scheduled at the earliest opportunity An increase in patient falls and hospital acquired pressure ulcers were reported in the Unplanned and Integrated Care Directorate. Of particular note, a number of falls were reported in ED which is unusual. Targeted actions were implemented following the immediate reviews to reduce the risk of falling. A focused review on Mortality undertaken by the Executive Medical

Report to the Board of Directors

	director did not identify any clear trends with the possible exception of a correlation but no definite proof of causation of patient placement. This is now the focus of the mortality review work. It is important that we learn quickly when things go wrong or when our patients do not have a good experience when in our care. The directorates have worked hard to investigate incidents and complaints in a timely manner. They have achieved and sustained significant improvements against SI and complaint standards and are now in a position to give more focus to thematic learning and proactive improvement interventions. The Trust has the challenge of maintaining a stroke service for the next 18 months in the light of the confirmed final decision from the Joint Committee of the Clinical Commissioning Group (JCCCG). This is being actively managed by the clinical service with the support of the Executive Medical Director. The Trust has remained compliant against the Referral to Treatment (RTT) and DM01 trajectory as agreed with NHS Improvement (NHSI). The teams continue to ensure that these trajectories are met.			
Resource Implications	Nil			
Risk and Assurance	See report			
Legal Implications/ Regulatory Requirements	Nil			
Improvement Plan Implication	Supports the Improvement Programme by presenting and monitoring key performance indicators.			
Quality Impact Assessment	Not Applicable			
Recommendation	The Board is asked to discuss and note the report.			
Purpose & Actions required by the Board :	**Approval** ☐	**Assurance** ☐	**Discussion** ☒	**Noting** ☒

Integrated Quality and Performance Report

January 2019

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EXECUTIVE SUMMARY

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Executive Summary

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EXECUTIVE SUMMARY

January 2019 has been an extremely busy month for the Trust. Performance against the 4 hour ED access target deteriorated to 83.06% and the Trust reported an increased number of 12 hour breaches. However compliance against the 18 week RTT and DM01 continued to improve with a positive performance against trajectories.

During this period keeping our patients safe was and continues to be of primary importance. With additional support from our system partners during exceptionally busy periods and by adhering to our internal policy and procedures we were able to maintain patient safety. Safe staffing was maintained by flexing staff across areas with decision making supported by Safe Care data. However staffing fill rates fell below planned in a number of ward areas. Despite the increase in activity and patient acuity our staff have responded well and the Trust sickness rate decreased in month for the second consecutive month.

We have reported an increase in patient falls and hospital acquired pressure ulcers in the Unplanned and Integrated Care Directorate. Two areas have reported a significant increase in falls, ED and Arethusa ward (acute admissions). These areas have historically reported low numbers of falls. Initial actions have been implemented to reduce the risk of falling for patients in these areas and the completed incident investigations may identify further interventions to be put in place.

The Medical Director has completed a focused review on Mortality which did not identify any clear trends with the possible exception of the impact of patient placement. This is now the focus of the mortality review work.

The Trust has the challenge of maintaining a stroke service for the next 18 months in the light of the confirmed final decision from JCCCG. Therapy staffing, including funding, remains a significant risk to SSNAP ratings and to the quality of our service.

Detailed commentary is contained within the report, specifically the spotlight reports.

Constitutional Target Trajectories

NHS Medway NHS Foundation Trust

EXECUTIVE SUMMARY

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
ED - 4 Hours Type 1	Actual	71.19%	74.48%	74.43%	73.85%	71.91%	80.53%	77.34%	77.77%	74.52%	66.02%
	Planned	71.18%	74.49%	79.51%	83.37%	82.91%	83.22%	83.06%	83.20%	82.84%	82.68%
	Variance	0.01%	-0.01%	-5.08%	-9.52%	-11.00%	-2.69%	-5.72%	-5.43%	-8.32%	-16.66%
ED - 4 Hours All Types	Actual	85.11%	86.53%	86.95%	87.12%	85.98%	90.32%	88.82%	89.01%	87.39%	83.06%
	Planned	85.06%	86.30%	88.05%	90.04%	90.05%	90.05%	90.04%	90.05%	90.04%	90.05%
	Variance	0.05%	0.23%	-1.10%	-2.92%	-4.07%	0.27%	-1.22%	-1.04%	-2.65%	-6.99%

ED 4 Hour Trajectory Commentary:

The Trust remains behind on the trajectory and national compliance standards for ED performance. The drivers for this remain as poor flow and access to assessment capacity. Flow through the hospital and out into the community was a challenge in month, the MFFD increasing to average position of 121 (up from 88 in Dec). Work is being bought forward with regards to the developments in AEC and short stay medicine to offset the flow issues in ambulatory care.

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
RTT - 18 Weeks	Actual	81.21%	82.38%	81.68%	82.52%	82.55%	81.77%	82.59%	82.62%	80.97%	80.84%
	Planned	81.21%	82.38%	82.12%	81.70%	82.43%	81.16%	81.48%	81.09%	79.84%	80.20%
	Variance	0.00%	0.00%	-0.44%	0.82%	0.12%	0.61%	1.11%	1.53%	1.13%	0.64%

RTT Trajectory Commentary:

The Trust remains compliant against the trajectory set with NHSI, achieving 80.84% against a 80.20% target. The teams continue to ensure compliance in February and March.

Constitutional Target Trajectories

NHS Medway NHS Foundation Trust

EXECUTIVE SUMMARY

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Cancer - 62 Days	Actual	86.42%	83.78%	90.64%	84.81%	79.17%	80.47%	83.85%	81.70%	83.64%
	Planned	86.40%	84.80%	84.00%	85.20%	85.10%	86.10%	86.10%	85.50%	85.70%
	Variance	0.02%	-1.02%	6.64%	-0.39%	-5.93%	-5.63%	-2.25%	-3.80%	-2.06%

Cancer Trajectory Commentary:

The Cancer 62 day performance has improved in December from November. 38 day shadow reporting for December places the Trust at just over 85%, therefore meeting compliance. The Trust still remains behind national compliance. Deep dives are currently in place for each tumour site to allow a thorough review of all the pathways.

		Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19
DM01 - 6 Weeks	Actual	96.11%	92.90%	91.86%	92.30%	98.20%	99.24%	99.54%	98.76%	97.40%	96.85%
	Planned	96.10%	92.90%	91.60%	95.20%	95.80%	95.50%	97.40%	95.40%	97.80%	95.70%
	Variance	0.01%	0.00%	0.26%	-2.90%	2.40%	3.74%	2.14%	3.36%	-0.40%	1.15%

DM01 Trajectory Commentary:

The DM01 trajectory for January 19 was achieved – with 1.15% above target.
There are backlog recovery plans in place for MRI, with performance forecasted to achieve the national KPI in February 19. Upper and Lower GI diagnostics are experiencing challenges in rising demand and brief, but significant loss of capacity in January 19 (driven by short notice unplanned sickness); a plan, with suitable options for demand management and backlog clearance. Urodynamics has a worsening performance and a clear demand and capacity review is being undertaken to ensure these match, with associated growth.

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SAFE

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Safe

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Harm Free Care	Falls (moderate or severe harms)	0.0	#	0	3	1	0	1	2	1	2	4	3	-	-	17	
	Falls Per 1000 Bed Days	0.0	#	3.76	4.76	4.43	4.91	4.02	3.6	3.89	3.97	4.4	5.06	-	-	4.28	
	Pressure Injuries (Low Harm)	0.0	#	20	7	13	18	16	16	16	15	7	20	-	-	148	
	Pressure Injuries (Moderate and High Harm)	0.0	#	0	2	0	2	1	1	0	0	2	4	-	-	12	
	Pressure Ulcer Incidence Per 1000 days (Moderate and High Harm)	-	#	0	0.13	0	0.13	0.06	0.06	0	0	0.12	0.24	-	-	0.07	
	Number of Medication Errors	0.0	#	2	4	2	0	2	0	0	0	0	0	-	-	10	
Incident Reporting	Never Events	0.0	#	0	0	0	0	0	0	0	1	0	0	-	-	1	
	Never Events - Incidence Rate	0.0	%	0	0	0	0	0	0	0	0.06	0	0	-	-	0.01	
	No of SIs on STEIS	0.0	#	10	12	12	13	15	4	10	6	6	7	-	-	95	
	% of SIs Responded To In 60 Days	-	%	50	100	100	100	100	100	100	93.33	83.33	100	-	-	93.14	
Infection Control	MRSA Bacteraemia (Trust Attributable)	0.0	#	1	0	2	1	3	0	1	0	1	0	-	-	9	
	C-Diff Acquisitions (Trust Attributable (Post 72 Hours)	19.0	#	1	2	3	0	2	4	4	1	3	3	-	-	23	
	C Diff Due to Lapses In Care	0.0	#	0	1	1	0	0	1	1	0	0	0	-	-	4	
	MSSA Surveillance (Trust Acquired)	0.0	#	2	4	1	3	1	1	3	3	2	2	-	-	22	
	E-coli (Trust Acquired) Infections	0.0	#	4	6	9	4	4	6	2	4	4	4	-	-	47	
Mortality	Crude Mortality Rate	2.5	%	1.78	1.63	1.49	1.46	1.31	1.44	1.41	1.35	1.14	1.4	-	-	1.43	
	HSMR (All)	100.0	%	113.3	112.87	113.62	116.11	116.45	118.73	116.58	-	-	-	-	-	115.37	
	HSMR (Weekday)	100.0	%	112.35	111.92	113.67	116.26	117.23	118.9	115.69	-	-	-	-	-	115.78	
	HSMR (Weekend)	100.0	%	115.92	115.39	113.04	115.78	114.08	118	119.18	-	-	-	-	-	115.9	
	SHMI	1.0	#	1.03	1.03	1.07	1.07	1.06	1.06	1.06	-	-	-	-	-		

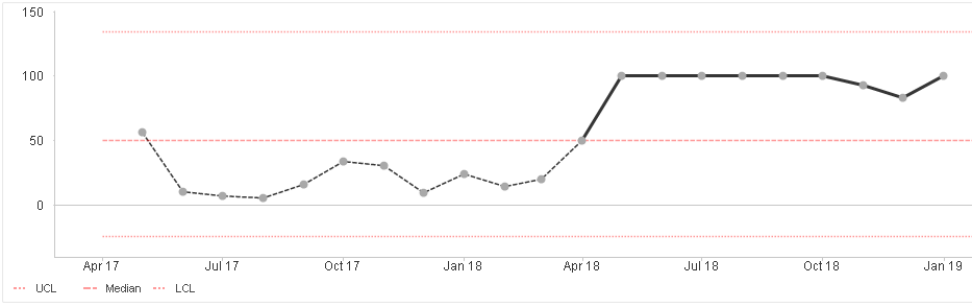
Safe Commentary:

- Pressure Ulcers – increase in low harm pressure ulcers in Unplanned and Integrated Care (UIC). 2 moderate/severe harm pressure ulcers in UIC; both have draft SIs awaiting PU Panel review in March 2019. Mitigation includes increased documentation surveillance by matrons and additional education and support from the TVN team.
- Infection Control – 2 reportable cases of C Diff across the Trust. Initial findings include delay in antibiotic review and delay in sending stool samples, themes already identified from previous cases and being addressed in the directorate improvement plan.
- Falls –an increase in falls with low harm noted across UIC but specific to ED and Arethusa. See spotlight report.

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

Safe – % of SIs Responded to in 60 Days Spotlight Report

Domain	KPI Name	Target	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Incident Reporting	% of SIs Responded To In 60 Days	-	50	100	100	100	100	100	100	93.33	83.33	100



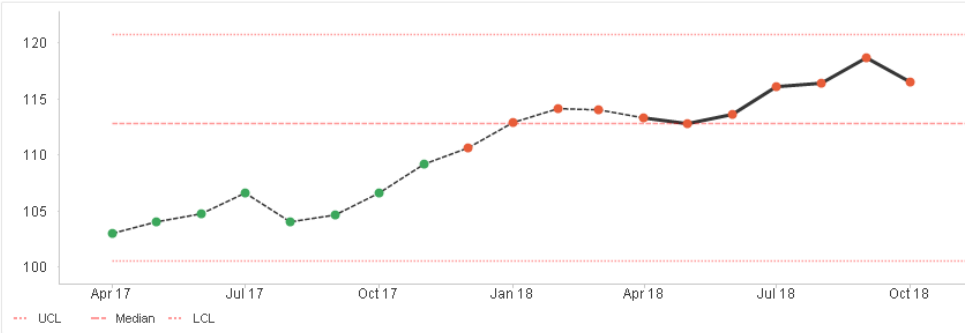
Serious Incidents Definition:

Serious Incidents (SIs) are healthcare events where the consequences to patients, families and carers, staff or organisations are so significant. SIs demonstrates a weakness in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm.

Commentary	Risks & Mitigating Actions
The Trust is required to provide final serious incident investigation reports to commissioners detailing the investigation, findings, recommendations and outlining an action plan within 60 days of the incident being reported on STEIS. All declared Serious Incidents are fully investigated using Root Cause Analysis techniques. The deterioration in performance in November and December 2018 was a result of one SI per month in UPIC not being completed within the 60 day standards. Enhanced scrutiny of the internal management of Sis was applied by the Directorate team and the central patient safety team. Performance improved in January to 100%.	The Central Quality team provides training and support to staff to enable them to fulfil their responsibilities in the investigation of incidents process. Training the Lead Investigators in Root Cause Analysis investigation techniques. Effective collaborative working between the Central Patient Safety Team and the Directorate Governance Teams is in place, along with robust monitoring of the serious incident process against national targets. Compliance Data is reported locally through the Directorate Governance Process and Trust wide via the Quality Steering Group.

Safe – Total HSMR Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18
Mortality	HSMR (All)	100.0	%	113.3	112.87	113.62	116.11	116.45	118.73	116.58



HSMR Total Definition:

The HSMR is a subset of 56 diagnosis group relating to approximately 83% of in hospital deaths in England. A mortality risk for each patient is calculated based upon the admitting diagnosis combined with case mix adjustment factors such as age, admission history, deprivation and secondary diagnoses . The trust uses Dr Foster's methodology and it should be noted that prior period results are refreshed monthly.

Commentary, Risks & Mitigating Actions

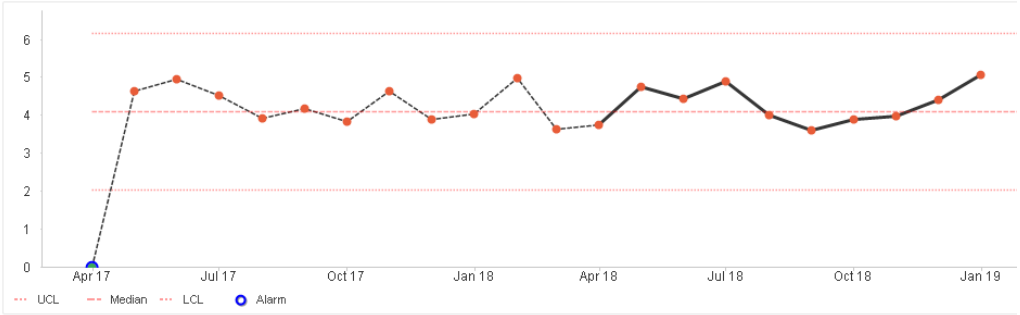
The HSMR for the period November 2017 to October 2018 is 116.6 (95% confidence interval 110.5 – 122.9). This represents a decrease from the previous rolling 12 month value of 118.7 and but highlighted as high for the 13th consecutive month by Dr Foster.

A Task and Finish project has confirmed that a significant component of the current HSMR relates to a) deaths in the community which are being attributed (inappropriately) to Medway and b) a change in palliative care coding relating to increasing referrals to the End of Life Care Team. Adjustment of the HSMR for these factors indicates that Medway will no longer be an outlier in HSMR. Both of these issues have been addressed with a request via NHS Digital to remove the community deaths from Medway's data, and a change in coding for palliative care having been agreed.

The HSMR for Pneumonia is currently 123.2 (95% confidence interval 123.2 – 138.6); this represents a decrease compared to 126.0 for October 2017 – September 2018 but is flagging as high for the sixth consecutive data point. All patients with pneumonia included in Part 1 of their cause of death are currently subject to a Structured Judgement Review. A deep dive is being undertaken looking at patients in this diagnosis group with Pneumonia in part 1 of their death certificate and who are recorded on Dr Foster as having no comorbidities. The preliminary findings will be discussed at the Trust Mortality Meeting in March 2019.

Safe – Falls Per 1,000 Bed Days Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Harm Free Care	Falls Per 1000 Bed Days	0.0	#	3.76	4.76	4.43	4.91	4.02	3.6	3.89	3.97	4.4	5.06



Falls Definition:

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

Commentary	Risks & Mitigating Actions
The Trust reported an increase in total falls at 5.06 per OBD. This is the highest reported all year although still below the national average of 6.63. Of particular note is an increase in falls reported in ED and Arethusa. The Falls Clinical Nurse Specialist and the clinical teams in these areas noted the increasing incidence of falls and intervened early to identify any emerging themes and put o in place interventions to reduce the risk of patients falling.	• ED have implemented yellow assistance bands at initial assessment for those patients identified as at risk of falling. • Additional falls prevention equipment has been supplied to ED such as sensor pads • Additional education for ED staff is being supported by the Falls team. • Arethusa Ward environment and patient placement has been reviewed, to ensure visible bed spaces and cohorting of patients at risk of falls within a bay and provision of enhanced care support • Education regarding lying and standing blood pressure, with PDN support to competence completion.

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CARING

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CARING

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	274	144	154	186	259	216	252	192	248	234	-	-	2159	
	MSA %	0.0	%	1.7	0.9	0.99	1.17	1.6	1.34	1.49	1.21	1.52	1.38	-	-	1.33	
	% of EDNs Completed Within 24hrs	100.0	%	55.44	58.2	52.64	58.6	50.78	54.83	51.4	51.73	51.98	50.18	-	-	53.43	
	Inpatients Friends & Family % Recommended	83.0	%	88.23	87.03	87.33	87.09	83.9	84.45	86.47	86.21	81.98	85.05	-	-	85.91	
	Inpatients Friends & Family Response Rate	25.0	%	22.91	22.14	22.33	21.84	21.71	22.55	21.54	22.7	19.44	19.69	-	-	21.73	
ED Care	ED Friends & Family % Recommended	65.0	%	79.78	76.59	78.92	78.44	77.03	80.65	80.48	78.86	80.61	72.05	-	-	78.28	
	ED Friends & Family Response Rate	25.0	%	15.68	15.01	15.8	14.95	14.08	15.58	14.14	13.94	13.31	13.99	-	-	14.69	
Maternity Care	Maternity Friends & Family % Recommended	79.0	%	99.63	97.81	97.74	100	99.26	98.82	100	100	95.19	97.64	-	-	98.6	
	Maternity Friends & Family Response Rate	25.0	%	34.96	36.03	30.15	28.93	28.32	17.67	22.71	23.62	28.15	32.81	-	-	28.32	
Outpatients Care	Outpatients Friends & Family % Recommended	83.0	%	89.28	89.01	89.85	90.7	89.91	89.12	89.93	90.93	91.63	90.28	-	-	90.1	
	Outpatients Friends & Family Response Rate	25.0	%	-	15.64	14.53	14.41	14.7	14.24	13.56	13.94	13.06	14.78	-	-	14.24	

Caring Commentary:

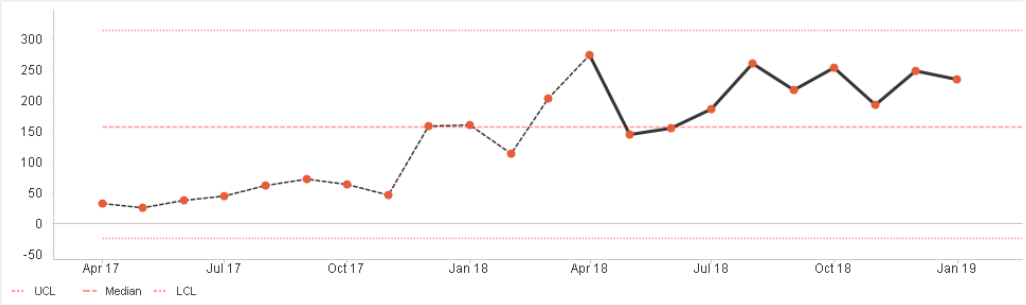
- MSA compliance - remains a challenge although despite a busy month the Trust reported a very slight reduction in breaches.
- Friends and family - overall reduction in response rate although recommended percentage shows a slight increase in month.

See spotlight report for detailed commentary.

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

Caring – Mixed Sex Accommodation Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Admitted Care	Mixed Sex Accommodation Breaches	0.0	#	274	144	154	186	259	216	252	192	248	234



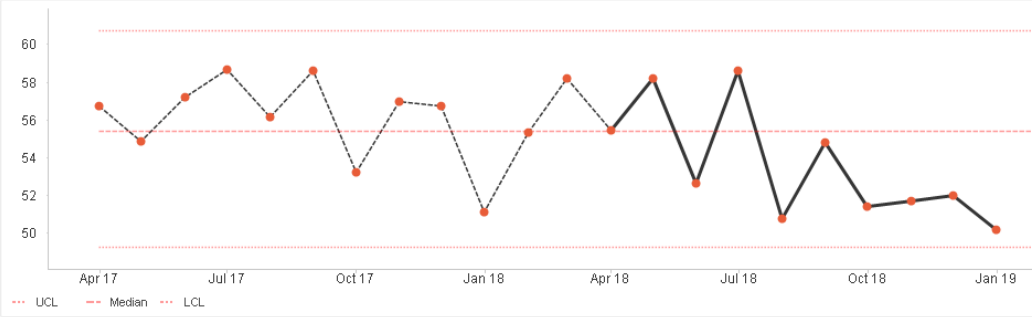
Mixed Sex Accommodation Definition:

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.

Commentary	Risks & Mitigating Actions
Previous IQPR report describes the improvement work undertaken by the Trust to meet its ambition of meeting the Trusts trajectory for 2019/2020. Key drivers for the underperformance in month relates to Level 3 step down patients and the transfer out of patients from MHDU.	• High priority actions identified and implemented as per the improvement action plan • Focus from site team to place patients in the appropriate area out of hours and avoid non-compliance as a priority • All MSA discussed at 3 times daily site meetings. Plans are made to unblock at that meeting within an agreed timeframe • Daily validation of all breaches by senior sisters • Focus on areas with high non-compliance eg critical care and Bronte • Weekly validation review meeting led by DDON • Task and finish group initiated week commencing 4th March

Caring – Electronic Discharge Notification (EDN) Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Admitted Care	% of EDNs Completed Within 24hrs	100.0	%	55.44	58.2	52.64	58.6	50.78	54.83	51.4	51.73	51.98	50.18



Commentary
Risks & Mitigating Actions

EDN performance remains poor and has shown no significant improvement over several months. This issue has been discussed at quality review meetings with the CCG and is recognised as an important clinical risk. The areas with the majority of outstanding EDN's have been identified and these areas will be targeted for specific remedial work to clear the EDN backlog. However, a more robust process going forward is necessary to improve performance and prevent a further backlog accumulating. The Medical Director will therefore lead a specific piece of work to address this with Pharmacy and a focus group of junior medical staff. Actions from this group have yet to be determined but will be documented in next month's IQPR and the group's work will be delivered within two months.

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		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Best Practice	7 Day Readmission Rate	10.0	%	5.19	5.81	4.94	5.46	4.69	4.67	4.38	4.14	4.54	-	-	-	4.87	
	30 Day Readmission Rate	10.0	%	11	11.57	10.78	11.25	9.9	10	9.84	10.47	10.4	-	-	-	10.58	
	Discharges Before Noon	25.0	%	18.78	18.36	17.88	16.56	17.24	17.18	16.29	15.77	17.11	15.4	-	-	17.04	
	Fractured NOF Within 36 Hours	100.0	%	62.5	47.2	39.6	55.3	70.6	57.1	67.7	45.2	46.9	-	-	-	54.68	
	VTE Risk Assessment % Completed	95.0	%	91.56	90.79	86.3	78.3	66.98	59.98	55.6	58.06	54.6	59.37	-	-	70.17	
Maternity	Elective C-Section Rate	13.0	%	11.92	12.04	11.56	11.18	11.9	12.53	13.54	13.32	9.71	13.02	-	-	12.1	
	Emergency C-Section Rate	15.0	%	18	17.94	17.09	17.98	17.32	20.24	18.96	17.06	20.47	20.15	-	-	18.49	
	Total C-Section Rate	28.0	%	29.93	29.98	28.64	29.17	29	33.01	32.51	30.37	30.18	33.17	-	-	30.58	
	Number of Deliveries (Count of Mothers)	-	#	411	406	398	456	462	415	443	428	381	407	-	-	4207	
Stroke	Stroke SSNAP Rating *	B	-	E	E	E	E	E	E	-	-	-	-	-	-		
	% of Pts Seen by Stroke Cons in 24 Hours *	95.0	%	33.33	33.33	33.33	35.87	35.87	35.87	-	-	-	-	-	-	34.78	
	Stroke Pts Scanned Within 1 hour *	90.0	%	49.28	49.28	49.28	35.87	35.87	35.87	-	-	-	-	-	-	41.61	

* Stroke metrics available quarterly from 2018/19

Effective Commentary:

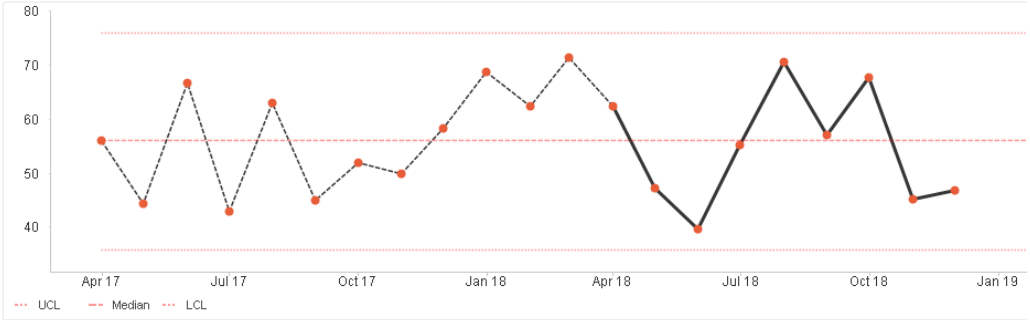
- Discharge before noon - the trust reported the lowest performance for the year to date. The work to improve flow is expected to support improvement against the target of 25%.
- Fractured Neck of Femur - performance against the standard of 36 hours from admission to theatre remains variable. The newly established MEDHIP team have implemented a programme of improvement actions to achieve compliance with this standard. Their work is detailed in the Spotlight report.
- VTE- although the Trust continues to fall below the standard for assessment the improvement work being led by the clinical service is beginning to result in improving performance. There is a trajectory to meet compliance by the end of April.
- Stroke services - the Trust is reviewing the consultant working patterns in light of an impending consultant retirement, and a plan is being worked up to cover the post. The Trust is acutely aware of the challenge of maintaining a stroke service at MFT for the next 18 months in the light of the confirmed final decision from JCCCG. Therapy staffing, including funding, remains a significant risk to SSNAP ratings and to the quality of our service.

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

Effective – Fracture Neck of Femur Spotlight Report

NHS Medway NHS Foundation Trust

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
Best Practice	Fractured NOF Within 36 Hours	100.0	%	62.5	47.2	39.6	55.3	70.6	57.1	67.7	45.2	46.9



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

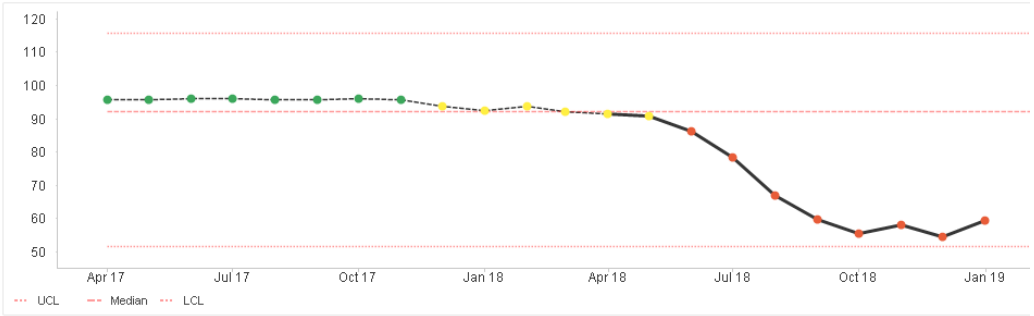
We have seen an improvement in Best Practice Tariff from 48% to 60% over 6 months and the MEDHIP team continue to work on the main stumbling block, which is time to theatre. This was discussed at some length with Prof. Briggs during the GIRFT visit last 18th February 2019.

Mitigating Actions:

1. Real time traffic light colour change signals on the trauma board to alert the clinicians about the 36 hours clock
2. Breach time now printed on the trauma list to ensure theatre team work towards getting patients done within 36 hours of admission
3. Conversion of elective list on alternate Mondays to accommodate extra trauma and hip fractures including patients requiring total hip replacements
4. Appointment of second frailty consultant and one orthogeriatric registrar to ensure patients are optimised for surgery
5. Lead physician associate acts as a ortho-anesthetic liaison
6. Ongoing discussion with the heamatologist to create a pathway for patients on anti-coagulation medications like warfarin, apixaban etc.
7. Modified hip fracture MDT proforma which includes all elements of BPT tariff
8. Priority of hip fracture patients as golden patient on the trauma list
9. Discussion of all BPT breaches in the MEDHIP and clinical governance meetings
10. Initially monthly and now once in two months MDT MEDHIP meetings to create excellence in care to patients with hip fractures and discuss any ongoing issues
11. Ongoing initiatives to avoid hip fracture patients being admitted to non-orthopaedic wards
12. Ongoing initiatives to have red-priority beds on Pembroke ward for hip fracture patients
13. Meeting arranged with Pembroke ward manager and Matron for surgery to comply with BPT

Effective – VTE risk Assessment Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Best Practice	VTE Risk Assessment % Completed	95.0	%	91.56	90.79	86.3	78.3	66.98	59.98	55.6	58.06	54.6	59.37



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
January data demonstrates a slight increase in compliance to 60%. A full time VTE nurse came into post on 7 January 2019. The post holder is working collaboratively with the Consultant VTE clinical lead to deliver sustainable VTE performance. A VTE Task and Finish group in place and is being supported in their work by the Transformation team. Data reports have identified issues with IT reporting system which are detrimentally impacting on reported performance. These are being addressed.	Engaged the ward clerks and supported them to create the correct single way of checking and recording the VTE assessment in their wards • Implemented a standard work document and held 2x engagement and training events with the clerks on the 29th and 30th Jan 2019– the new system went live 31Jan 2019 - VTE nurse is monitoring. • PAS has been updated to reduce the of possible tick boxes for the clerks • The data source has been number changed so the SSRS reports are accurate as to actual – we are engaging with the BI team to explore • Theatres and day case use a different way of recording the VTE risk. Task and finish group exploring how to proceed or delete from data set • BI lead involved and assisting with data set and inclusion/ exclusion criteria

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RESPONSIVE

Best of care
Best of people

Responsive – Non-Elective

NHS Medway NHS Foundation Trust

RESPONSIVE

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Bed Management	Bed Occupancy Rate	92.0	%	91.4	88.38	89.73	88.55	89.66	91.06	92.49	87.96	89.3	91.11	-	-	89.97	
	Average Elective Length of Stay	5.0	#	2	1.94	1.95	2.49	1.96	2.72	2.72	2.02	2.13	1.76	-	-	2.18	
	Average Non-Elective Length of Stay	5.0	#	8.19	8.16	8.02	7.68	8.25	8.43	8.5	8.33	7.97	9.28	-	-	8.27	
	Escalation Beds Open Point Prevalence in Month	0.0	#	0	76	61	123	331	327	334	750	373	775	-	-	3150	
	Delayed Transfer of Care Point Prevalence in Month	0.0	#	86	126	129	121	162	153	164	385	302	228	-	-	1856	
	% of Delayed Transfer of Care Point Prevalence in Month	3.5	%	0.55	0.8	0.83	0.76	1	0.95	0.97	2.43	1.85	1.34	-	-	1.15	
	Medically Fit For Discharge Point Prevalence in Month	0.0	#	2651	2942	3266	3375	3465	3285	3234	3060	2991	3211	-	-	31480	
	% Medically Fit For Discharge Point Prevalence in Month	7.0	%	16.9	18.66	20.98	21.24	21.42	20.38	19.08	19.28	18.28	18.91	-	-	19.51	
ED Access	ED 4 Hour Performance All Types	95.0	%	85.1	86.54	86.94	87.12	85.97	90.32	88.82	89.01	87.39	83.06	-	-	87.02	
	ED 4 Hour Performance Type 1	95.0	%	71.17	74.47	74.4	73.83	71.88	80.52	77.34	77.75	74.52	66.02	-	-	74.15	
	ED 12 hour DTA Breaches	0.0	#	1	0	0	4	10	0	13	0	1	5	-	-	34	
	Median Time to ED Clinician (60mins)	60.0	#	46	52	44	42	35	33	36	36	40	48	-	-		
	Median Time to Ambulance Assessment (15mins)	15.0	#	4	3	3	4	4	3	4	3	3	3	-	-		
	30 Mins Ambulance Handover Delays	0.0	#	511	462	492	620	455	321	332	261	315	364	-	-	4133	
	ED Time to Specialty Review - Median	120.0	#	126	123	133	137	124	121	119	121	135	133	-	-		
	60 Mins Ambulance Handover Delays	0.0	#	53	62	51	80	54	17	18	8	72	192	-	-	607	
	Number of ED arrivals by Ambulance	-	#	3129	3182	3098	3160	3018	2941	3124	3278	3500	3475	-	-	31905	
	ED Conversion Rate	20.0	%	26.46	24.27	25.86	26.74	25.36	25.48	25.71	23.06	24.74	22.15	-	-	24.97	

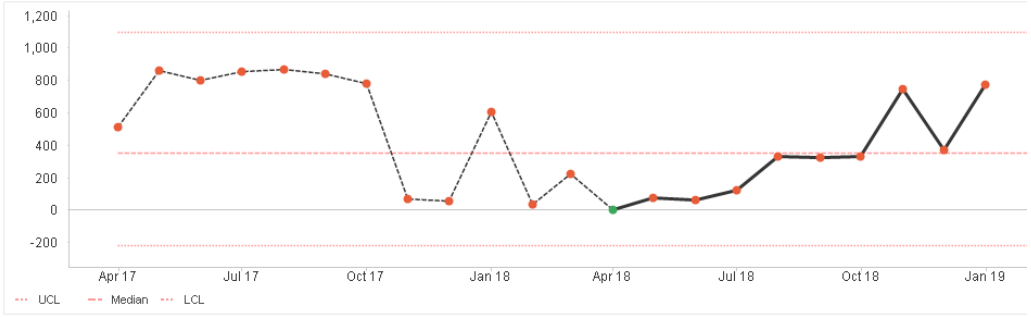
Responsive – Non-Elective Commentary:

- As expected the bed occupancy has risen in January. The Trust has had a number of escalation beds open including, Dickens, Sapphire, Sunderland and ED Escalation. This was expected for this time of year. The teams continue to work with all partners to ensure patients are discharged in a safe manner, as can be seen in the reduction of the average LoS. ED 4 hour performance continues to remain below plan, and unfortunately the Trust has had five 12 hour breaches all of which have had a clinical review.
- Ambulance handover time has increased, we continue to work with SECAmb.

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

Responsive – Escalation Beds Open Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Bed Management	Escalation Beds Open Point Prevalence in Month	0.0	#	0	76	61	123	331	327	334	750	373	775



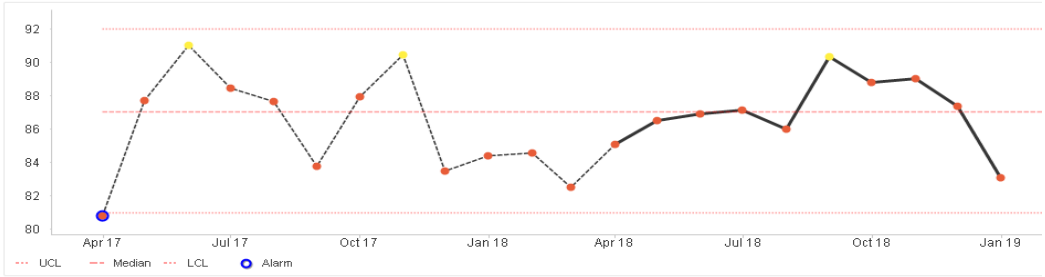
Commentary	Risks & Mitigating Actions
January position has seen an increase in open escalation beds.	Safe staffing of all escalation areas is maintained by flexing staff across the Trust, with decision making on staffing levels supported by the utilisation of Safe Care data (patient acuity & dependency). Dickens is being supported by substantive staff Action plans have been agreed to reduce the number of escalation beds on a weekly from 11th March.

Escalation Beds Definition:

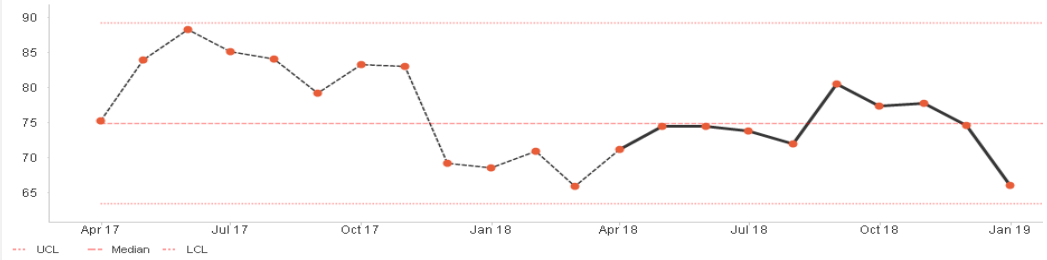
An escalation ward is defined by the NHS as a temporary ward or bed used by a Trust to support capacity in times of high demand to create additional capacity. It is acknowledged that patients "boarded" on an escalation ward are more likely to have poorer experience and high delays in discharge. These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

Responsive – ED 4 Hr Performance All Types and Type 1 Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
ED Access	ED 4 Hour Performance All Types	95.0	%	85.1	86.54	86.94	87.12	85.97	90.32	88.82	89.01	87.39	83.06



Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
ED Access	ED 4 Hour Performance Type 1	95.0	%	71.17	74.47	74.4	73.83	71.88	80.52	77.34	77.75	74.52	66.02



ED 4 Hr Performance Definition:

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

Commentary	Risks & Mitigating Actions
ED performance remains below trajectory largely due to flow on the admitted pathway. Performance in the non admitted pathway dropped off in month to 87%, driven by long waits for access to cubicles. .	Improvement in Operational discipline: Inpatient transformation. Enhancing the effectiveness of operations on the wards and in the AMUs (including delivering SAFER). The interface of Acute Medicine and other specialties with ED: model redesign and operational improvement. The need to introduce 'real time management' of the pathway and improving the effectiveness of the site team and of the daily operational leadership in running the pathway 24x7 Improving management of the patient journey within the ED. Re-design of the medical model Reviewing the bed requirements for each specialty and area of the pathway, and the adequacy of the current footprint to accommodate each specialty's needs Delivering unobstructed patient flow through the hospital Ensuring timely senior medical input necessary for providing the aspired quality and safety Meeting the desired Quality Standards for Emergency and Acute Medicine

Responsive – Elective

NHS Medway NHS Foundation Trust

RESPONSIVE

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Diagnostic Access	DM01 Performance	99.0	%	96.11	92.9	91.86	92.3	98.2	99.24	99.54	98.76	97.4	96.85	-	-	96.19	
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	81.21	82.38	81.68	82.52	82.55	81.77	82.59	82.62	80.97	80.84	-	-	81.91	
	18 Weeks RTT Over 52 Week Breaches	0.0	#	1	1	0	2	12	11	12	9	13	20	-	-	81	
	18 Weeks RTT Total Backlog	2,000.0	#	4080	3773	3807	3645	3693	3915	3803	3791	4111	4236	-	-	38854	
	18 Weeks RTT Completed Admitted Performance	90.0	%	51.96	50.87	54.18	55.94	56.49	55.41	55.12	55.65	62.35	62.79	-	-	55.75	
	18 Weeks RTT Completed Non-Admitted Performance	95.0	%	81.06	82.28	82.32	82.42	81.5	81.27	81.01	79.96	78.57	78.6	-	-	80.96	
	Daycase Rate	85.0	%	65.29	64.07	65.21	66.94	65.7	64.71	66	63.49	63.54	67.49	-	-	65.26	
	DNA Rate	10.0	%	8.41	8.6	8.45	8.55	8.51	8.86	8.7	8.49	8.7	8.54	-	-	8.58	
	First to Follow Up Ratio	-	#	1.18	1.15	1.16	1.12	1.13	1.16	1.16	1.18	1.18	1.18	-	-	1.16	
Theatres & Critical Care	Operations Cancelled By Hospital on Day	0.0	#	21	17	21	19	11	17	29	24	52	48	-	-	259	
	Cancelled Operations Not Rescheduled < 28 days	0.0	#	1	3	3	1	3	2	5	9	29	13	-	-	69	
	Urgent Operations Cancelled for the 2nd Time	0.0	#	1	0	0	0	0	0	1	1	0	0	-	-	3	
	Critical Care Occupancy Rate	92.0	%	96.55	94.33	91.61	92.66	94.44	90.69	96	94.02	94.55	99.56	-	-	94.46	

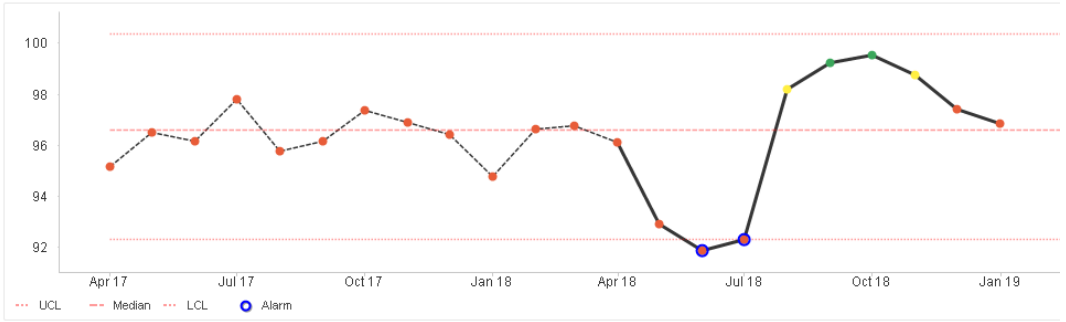
Responsive – Elective Commentary:

- The DM01 performance has dipped in January, this has been due to an increase in MRI demand, endoscopy demand and loss of a third party capacity.
- 18 week performance remains compliant against trajectory. The increase in 52 week breaches has been due to the Dermatology service.
- The number of operations cancelled on the day has still remained high, this has been predominantly due to non elective demand. However all operations are reviewed by the clinical team to ensure no harm.

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

Responsive – DM01 Performance Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Diagnostic Access	DM01 Performance	99.0	%	96.11	92.9	91.86	92.3	98.2	99.24	99.54	98.76	97.4	96.85



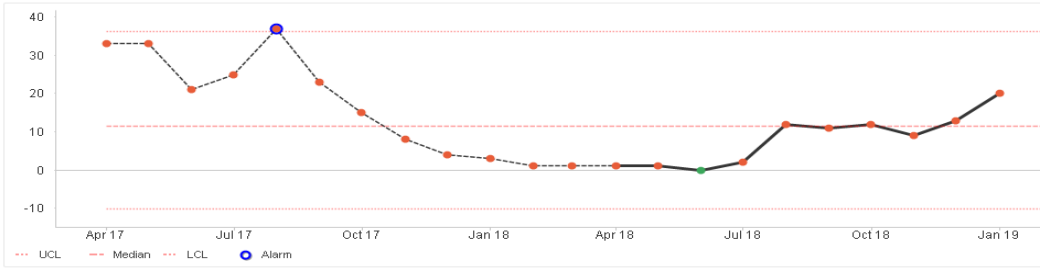
DM01 Performance Definition:

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

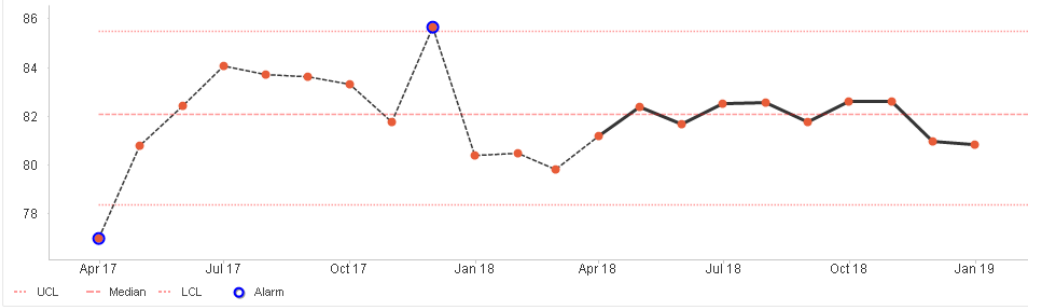
Commentary	Risks & Mitigating Actions
DM01 performance has dipped in the latter half of the 18/19 year, driven predominantly by an increase in: - MRI demand - Gastro scope demand - Loss of third party provider capacity due to long term facilities issue The DM01 & RTT meetings have now joined to ensure pathways are appropriately supported Enhanced processes are being introduced as management of the performance standard of the DM01 matures e.g.: - Weekly DM01 report with patient level information with date of appointment/no appointment date/breech info in order to bring forward breeches - Monthly action report to action breeches with no less than 2 weeks notice of end of month	**Risks:** • Capacity (Routine) ➢ MRI ➢ USS (MSK only) ➢ Gastro ➢ Urodynamics • GA capacity (for Upper GI, Lower GI and MRI) • Consultant vacancy - Gastro --- • Additional MRI capacity purchased (4 weeks), with plan for monitoring breeches & rescheduling as • USS MSK Injector Sonographer in place 2 PA per week to clear backlog • Long term strategy in place to increase MRI and CT scanner by 1 (taking both to 3 scanners) • Urodynamics undertaking a demand capacity exercise • Additional GA & Paed lists running for MRI • Source NHS Locum Gastroenterologist

Responsive – RTT Performance Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Elective Access	18 Weeks RTT Over 52 Week Breaches	0.0	#	1	1	0	2	12	11	12	9	13	20



Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Elective Access	18 Weeks RTT Incomplete Performance	92.0	%	81.21	82.38	81.68	82.52	82.55	81.77	82.59	82.62	80.97	80.84



>52 Weeks Breaches Definition:

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

Commentary	Risks & Mitigating Actions
18 week compliance remains below national standards.	Continue to monitor weekly to ensure compliance to trajectory.

Responsive – Cancer & Complaints

NHS Medway NHS Foundation Trust

RESPONSIVE

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Cancer Access	Cancer 2ww Performance	93.0	%	92.99	92.47	92.76	90.44	72.61	65.19	68.13	73.11	88.35	-	-	-	81.69	
	Cancer 2ww Performance - Breast Symptomatic	93.0	%	77.61	83.33	80	98.46	88.89	90.74	75.76	72	44.3	-	-	-	77.08	
	Cancer 31 Day First Treatment Performance	96.0	%	100	98.78	97.84	98.66	96.6	100	94.77	96.62	95.51	-	-	-	97.6	
	Cancer 31 Day Subsequent Treatments (Surgery)	94.0	%	100	78.95	95	96.15	100	95	92.59	89.66	89.47	-	-	-	93	
	Cancer 31 Day Subsequent Treatments (Drugs)	98.0	%	100	100	100	100	100	100	100	93.94	100	-	-	-	99.07	
	Cancer 62 Day Treatment - GP Refs	85.0	%	86.42	83.78	90.64	85.19	79.17	80.47	83.85	81.7	83.64	-	-	-	84.07	
	Cancer 62 Day Treatment - Screening Refs	90.0	%	88.24	76.92	94.44	86.21	81.13	89.13	83.33	63.41	71.79	-	-	-	80.48	
	Cancer 62 Day Treatment - Cons Upgrades	-	%	81.82	75	91.89	76.67	78.38	79.31	74.19	90.63	81.82	-	-	-	81.27	
	Cancer 62 Day Backlog Performance	0.0	#	22	27	18	20	24	22	24	21	21	-	-	-	199	
	104 Day Cancer Waits	0.0	#	4	4	2	5	7	4	4	3	6	-	-	-	39	
Complaints Management	Number of Complaints	45.0	#	148	165	186	135	121	114	146	95	100	144	-	-	1354	
	Number of Complaints Returners	-	#	2	2	2	5	3	0	6	5	3	3	-	-	31	
	% Complaints Responded to Within 30 Days	85.0	%	41.79	47.22	51.61	64.18	50.88	75.51	87.18	68.89	84.48	94.83	-	-	64.81	

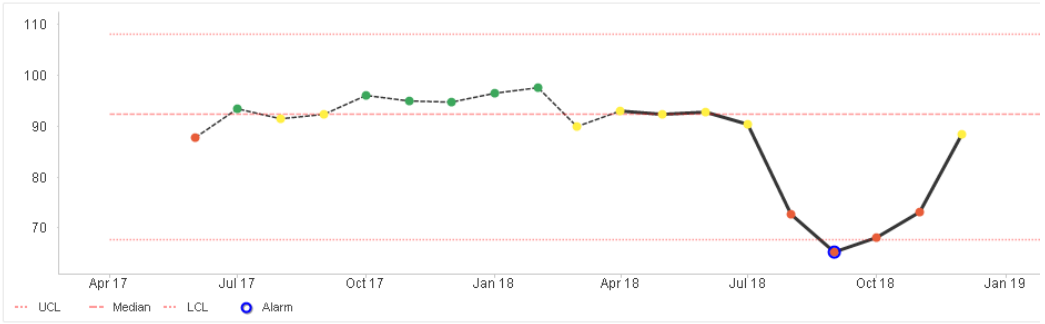
Responsive – Cancer & Complaints Commentary:

- 2WW performance has improved from previous months, however falls below national standards.
- 62 day performance has improved however falls behind national guidance. Shadow reporting puts the Trust at 86.34%. Breaches are detailed as 2.5 Breast, 2 Head & Neck, 2 Lower GI, 1 Skin, 0.5 Upper GI and 5.5 Urology.
- Both clinical directorates have made good progress in managing their backlog of complaints which has enabled them to be more responsive to new complaints, as demonstrated by improving performance against the response standard.

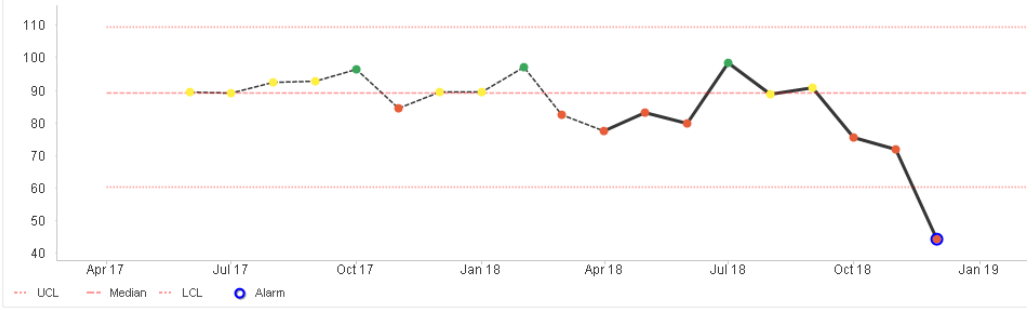
RAG Status – Achieving Target Green, Within 5% Amber, Failing Target more Than 5% Red

Responsive – 2 Week Wait Performance Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
Cancer Access	Cancer 2ww Performance	93.0	%	92.99	92.47	92.76	90.44	72.61	65.19	68.13	73.11	88.35



Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
Cancer Access	Cancer 2ww Performance - Breast Symptomatic	93.0	%	77.61	83.33	80	98.46	88.89	90.74	75.76	72	44.3



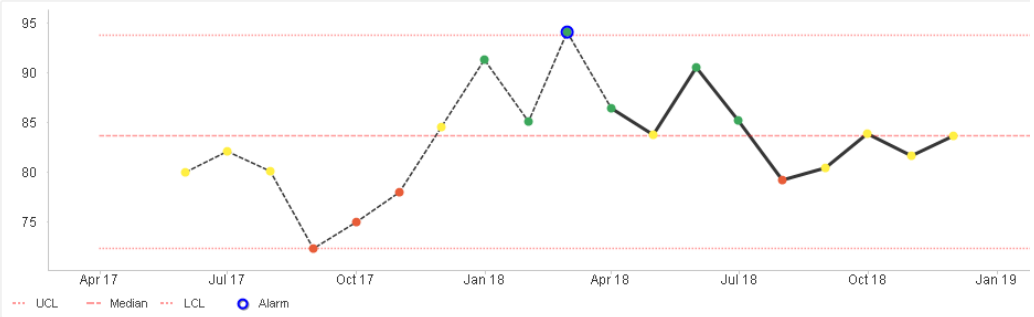
2 Week Wait Definition:

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

Commentary	Risks & Mitigating Actions
Cancer 2ww performance remains below national compliance standards.	Weekly meetings in place and deep dives in specific tumour areas.

Responsive – 62 Day Wait GP Performance Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18
Cancer Access	Cancer 62 Day Treatment - GP Refs	85.0	%	86.42	83.78	90.64	85.19	79.17	80.47	83.85	81.7	83.64



Commentary	Risks & Mitigating Actions
62 day performance remains below national compliance levels.	Weekly meetings and deep dives in place.

62 Day Wait GP Definition:

The percent of patients treated by a specialist within 62 days of an urgent GP referral for first definitive cancer treatment.

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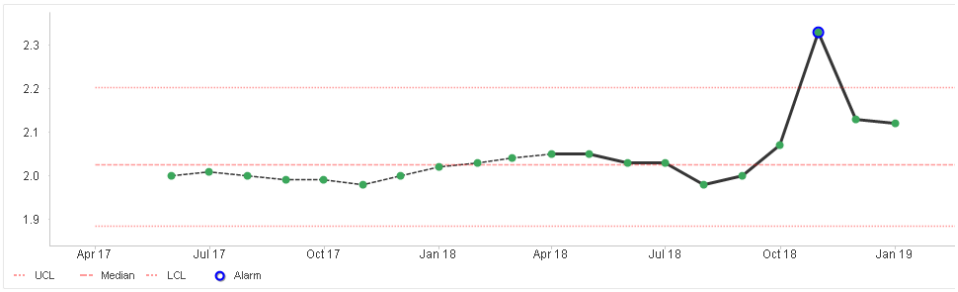
Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19	YTD	Trend
Financial Position	Variance from Plan	0.0	%	-	-	-	-	-	-	-	-	-	-	-	-		
	Liquidity Ratio (In Days)	-	#	-	-	-	-	-	-	-	-	-	-	-	-		
	Cash Actual	1,400,000.0	#	-	-	-	-	-	74000000	44000000	86000000	13700000	-	-	-		
	Overall Underlying Financial Surplus / Deficit	0.0	#	-	-	-	-	-	25.6	30	33	36.2	-	-	-		
	Capital Spend Vs Plan	95.0	%	-	-	-	-	-	-	-	-	-	-	-	-		
	Underlying Performance	0.0	#	-	-	-	-	-	-	-	-	-	-	-	-		
	Cost Improvement Plans (CIPS) - Var to Plan YTD	0.0	#	-	-	-	-	-	-	-	-	-	-	-	-		
Staff Experience	Staff Friends & Family - Recommend Place to Work	62.0	%	51.05	51.05	51.05	43.2	43.2	43.2	-	-	-	-	-	-	47.29	
	Staff Friends & Family - Recommend Care of Treatment	79.0	%	71.14	71.14	71.14	65.22	65.22	65.22	-	-	-	-	-	-	68.3	
Workforce	Appraisal % (Current Reporting Month)	85.0	%	85.11	86.23	82.12	82.19	81.47	80.01	81.01	81.3	81.3	82.8	-	-	82.39	
	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	2.05	2.05	2.03	2.03	1.98	2	2.07	2.33	2.13	2.12	-	-	2.08	
	Short Term Sickness Rate (Current Reporting Month, FTE%)	3.0	%	2.02	1.98	2.03	2.02	1.97	1.98	2	2	1.97	1.96	-	-	1.99	
	Long Term Sickness Rate(Current Reporting Month, FTE%)	1.0	%	2.09	2.11	2.03	2.03	1.99	2.02	2.15	2.74	2.28	2.28	-	-	2.17	
	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	8.0	%	11.61	10.5	11.81	11.98	11.77	10.47	12.05	12.35	12.02	12.34	-	-	11.67	
	Contractual Staff in Post (FTE) (Current Reporting Month)	-	#	3794	3801	3819	3780	3761	3766	3595	3779	3768	3765	-	-		
	StatMan Compliance (Current Reporting Month)	85.0	%	86.69	86.63	87.17	86.65	-	-	-	74.3	76.88	77.75	-	-	82.58	
	Agency Spend as % Paybill (Current Reporting Month)	-	%	5.59	8.43	5.91	5	4.66	5.74	5.11	5.01	5.61	-	-	-	5.67	
	Agency Spend as % Paybill (Financial Year YTD)	-	%	7.28	7.03	6.08	5.05	4.78	4.46	4.52	4.04	4.63	-	-	-	5.32	
	Bank Spend as % Paybill (Current Reporting Month)	-	%	12.06	11.24	11.42	16.26	8.4	13.22	12.44	12.4	11.86	-	-	-	12.14	
	Bank Spend as % Paybill (Financial Year YTD)	-	%	11.87	11.83	11.66	16.43	8.45	13.19	12.57	12.4	12.34	-	-	-	12.3	
	Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	-	%	71.72	76	74	76	73	73	76	79	79	-	-	-	75.3	

Well-led:

- Appraisal completion rate at 82.8% is up by (0.1%) compared to December and is below YTD Average and Trust target.
- Overall Sickness absence rate at 4.26% has gone up by (+0.04) compared to December and is above the tolerance level of 4%. Short term sickness absence at 1.98% is down by (-0.64) compared to December whilst long term sickness absence, at 2.58% is up by (+0.31) compared to December. The ratios of long-term sickness to short-term sickness remain broadly even.
- Voluntary Turnover at 12.90% is up by (+0.60) compared to December and remains above the tolerance level of 8%.
- StatMan compliance in current at 77.75% is up by (+0.98) and remains below Trust target.
- Agency spend (as a percentage of pay bill) at 6% is up by (+2%) compared to the month of November and is below YTD Average. The Trust continues to meet its agency ceiling cap. Ongoing work to reduce use of agency workforce remains in place and focus on converting agency staff into substantive and or bank assignments continues.
- Bank spend (as a percentage of pay bill) at 13% is up by (3%) compared to the month of December and is below YTD Average.
- Temporary staffing fill rate for Nurse and Midwifery at 81% is down by (-9%) compared to the month of December and is above YTD Average 75.3%.

Well Led – Total Sickness Rate Spotlight Report

Domain	KPI Name	Target		Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19
Workforce	Sickness Rate (Current Reporting Month, FTE%)	4.0	%	2.05	2.05	2.03	2.03	1.98	2	2.07	2.33	2.13	2.12



Commentary	Risks & Mitigating Actions
Overall Sickness absence rate at 4.26% has gone up by (+0.04) compared to December and is above the tolerance level of 4%. Short term sickness absence at 1.98% is down by (-0.64) compared to December whilst long term sickness absence, at 2.58% is up by (+0.31) compared to December. The ratios of long-term sickness to short-term sickness remain broadly even.	Risks: Possibility of increased use of temporary staffing to backfill Possibility of impact on patient experience and care due to lack of continuity in care Mitigations: The Employee Relations team continue to focus on supporting the timely management of sickness absence cases across the organisation. Use of the reports from Healthroster platform that identify colleagues who have hit the trigger. Encouraging staff to take up flu vaccine especially at this time

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				Day		Night	
		Registered Staff		Care Staff		Registered Staff		Care Staff					
WARD	Beds	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	Total monthly planned staff hours	Total monthly actual staff hours	*Average fill rate - registered staff (%)*	*Average fill rate - care staff (%)*	Average fill rate - registered staff (%)	Average fill rate - care staff (%)
Bronte Ward	18	1127	1097	742	840	1093	1103	729	810	*97%*	*113%*	*101%*	*111%*
Byron Ward	26	1476	1154	1149	1262	1046	1069	1046	1044	*78%*	*110%*	*102%*	*100%*
CCU	4	930	717	0	139	713	713	0	0	*77%*		*100%*	
Dickens Ward	25	1665	756	1292	1015	1023	892	682	881	*45%*	*79%*	*87%*	*129%*
Harvey Ward	25	1615	1155	1632	1472	1058	1070	1046	1091	*72%*	*90%*	*101%*	*104%*
Keats Ward	26	1573	1072	1173	1410	1023	1111	1023	1133	*68%*	*120%*	*109%*	*111%*
Lawrence Ward	19	1134	991	1143	1174	1046	1001	698	731	*87%*	*103%*	*96%*	*105%*
Lister Assessment Unit	19	2722	1840	1892	1786	1395	1266	698	693	*68%*	*94%*	*91%*	*99%*
Milton Ward	26	1616	1093	1505	1606	1046	1022	1036	1162	*68%*	*107%*	*98%*	*112%*
Nelson Ward	24	1670	1100	1172	1143	1023	1000	675	676	*66%*	*98%*	*98%*	*100%*
Sapphire Ward	23	1588	1124	1161	1246	1034	969	1023	1080	*71%*	*107%*	*94%*	*106%*
Tennyson Ward	27	1613	1132	1204	1316	1023	1005	1012	1100	*70%*	*109%*	*98%*	*109%*
Wakeley Ward	25	1658	1046	1138	1170	1046	1001	1046	1024	*63%*	*103%*	*96%*	*98%*
Will Adams Ward	26	1664	1327	1167	1200	1023	1023	1045	1133	*80%*	*103%*	*100%*	*108%*
Arethusa Ward	27	1560	1175	1632	1469	1012	1047	1023	1045	*75%*	*90%*	*103%*	*102%*
ICU	9	3876	3271	0	0	3480	2984	0	0	*84%*		*86%*	
Kingfisher SAU	18	1915	1619	1161	1111	1705	1624	682	682	*85%*	*96%*	*95%*	*100%*
McCulloch Ward	29	1972	1429	1253	1356	1694	1687	682	848	*72%*	*108%*	*100%*	*124%*
Medical HDU	6	1464	1296	353	346	1426	1323	0	58	*89%*	*98%*	*93%*	
Pembroke Ward	27	1917	1568	1083	1651	1705	1482	682	1414	*82%*	*152%*	*87%*	*207%*
Phoenix Ward	30	2008	1294	1205	1137	1364	1365	1023	946	*64%*	*94%*	*100%*	*92%*
SDCC	26	2510	1552	1314	1035	539	704	286	341	*62%*	*79%*	*131%*	*119%*
Surgical HDU	10	2301	2099	386	338	2031	1978	0	22	*91%*	*88%*	*97%*	
Victory Ward	18	1203	783	799	795	1023	748	682	660	*65%*	*99%*	*73%*	*97%*
Delivery Suite	16	2904	2891	684	665	2832	2820	372	373	*100%*	*97%*	*100%*	*100%*
Dolphin (Paeds)	30	3238	3059	1832	1100	2496	2472	357	357	*94%*	*60%*	*99%*	*100%*
Kent Ward	24	1081	1081	594	559	744	721	696	696	*100%*	*94%*	*97%*	*100%*
NICU	32	4202	3791	385	265	4271	3741	46	0	*90%*	*69%*	*88%*	*0%*
Ocelot Ward	12	917	849	538	550	744	743	372	384	*93%*	*102%*	*100%*	*103%*
Pearl Ward	23	1066	1067	696	695	1032	1037	372	372	*100%*	*100%*	*101%*	*100%*
The Birth Place	9	1101	1101	349	349	1080	1082	288	289	*100%*	*100%*	*100%*	*100%*
Trust total	**659**	**57,282**	**45,525**	**30,630**	**30,194**	**42,769**	**41,800**	**19,321**	**21,044**	***79.5%***	***98.6%***	***95.5%***	***108.9%***

Meeting of the Board of Directors in Public

Thursday, 07 March 2019

Assurance Report from Committees

Title of Committee:	Quality Assurance Committee	**Agenda Item**	**5.2**
Committee Chair:	Jon Billings, Non-Executive Director		
Date of Meeting:	25 January 2019		
Lead Director:	Karen Rule, Director of Nursing		
Report Author:	Karen Rule, Director of Nursing		

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**
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	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. Venous thromboembolism (VTE) Performance Reported VTE performance which has been below target for several months. A deep dive to identify causes for the deterioration in performance has been undertaken, identifying an ineffective reporting process. A new process has been put in place to capture and report VTE data. A VTE Clinical Nurse Specialist has joined the team and is working collaboratively with the Clinical lead to embed the new process and raise staff awareness and compliance with best practice. Improved VTE performance is expected over Q4.	**Amber**
2. Mortality Reviews Both Clinical Directorates reported patchy performance for completion of mortality reviews and frequency or recording of Mortality and Morbidity meetings. The Committee requested an update on Mortality and Morbidity meetings in future directorate reports.	**Red**

3. Staff Friends and Family Test The reasons for the decline in 'would recommend' result from Q1 to Q2 were discussed. The Trust has recently received the high level results of the national staff survey, this matter will be further considered alongside the full national survey results at a future meeting.	**Amber**
4. Integrated Quality and Performance Report/ Directorate reports i. The Integrated Quality and Performance Report (IQPR) was presented with validated performance. ii. Never event in Maternity services – reported in November, investigation complete and recommendations being implemented. iii. Performance against the fracture neck of femur / time to theatre has deteriorated. A Consultant led review of the pathway has been undertaken and a new team (MEDHIP team) established to support a revised clinical pathway. Improved performance has already been noted. iv. Mixed Sex Accommodation (MSA) – MSA performance is discussed at the Board. A deep dive of MSA will be on the agenda for a future Quality Assurance Committee (QAC) development session. v. Encouraging progress was noted within both directorates to deliver improvements in quality of care against a background of operational pressure. Attendees acknowledged an obligation to deliver high quality, safe care to our patients. Changes agreed for future directorate reports/ IQPR 1) Duty of Candour performance data to be included. The directorate reports to the May 2019 QAC will include the outcome of the 2017/2018 Duty of Candour review. 2) Safeguarding alerts - more detail to be provided 3) PALS enquiries in relation to appointments – detailed breakdown of reason for appointment concerns to be provided. 4) An Executive Summary and description of the top 3-5 risks and actions being taken to mitigate or reduce the risk to be included. 5) Trend lines to be included for the constitutional targets reported in the IQPR.	**Amber**
5. KPMG Safeguarding Audit reports The Committee reviewed the KPMG Safeguarding Audit reports and felt assured by the audit outcome, which was 'significant assurance with minor improvement opportunities'.	**Green**
6. Care Quality Commission (CQC) Improvement Plan Update was provided on progress against CQC plan improvement actions. A six month panel review of the plan is scheduled in March 2019 and will be reported at a future Committee meeting.	**Amber**
7. Assurance on other matters 1) The directorates are completing timely incident rapid review investigations, identifying themes and implementing improvement actions thus providing assurance of learning. 2) Quality summits are being held within programmes and jointly to support cross programme & directorate learning. 3) Complaint policy and processes are embedding, evidenced by improved complaints response performance.	**Amber**

Decisions made

Approval of Annual Safeguarding report, subject to two amendments.

Further Risks Identified

High levels of staff turnover and impact on ability to maintain safe staffing levels – nursing retention plan is in place and the Trust is participating in the NHSI intensive retention support programme

NB We await the outcome of a review of directorate quality governance by the internal auditors. The assurance level assessments by the committee may be uprated in some areas once the findings and any recommendations are available.

Escalations to the Board or other Committee

Annual Safeguarding Report to be presented for approval.

Report to the Board of Directors

Board Date: Thursday, 07 March 2019 Agenda Item: 5.4

Title of Report	Safe Working Hours, Doctors and Dentists in Training Annual Report (September 2017 to October 2018)
Prepared By	Miss Delilah Hassanally, Guardian of Safe Working
Lead Director	Dr David Sulch, Medical Director
Committees or Groups who have considered this report	Executive Group
Executive Summary	This is the second annual report by the 'Guardian of Safe Working' (GSW), Miss Delilah Hassanally, to the Medway NHS Foundation Trust Board. This is a requirement of the new junior doctor contract and has been generated with the assistance of the Medical Workforce Team. The New Junior Doctor contract went live on 3rd August 2016, with the gradual transition of all trainees, which was completed by the end of 2017. For the period 1st September 2017 to 31st October 2018, there were a total of 442 exception reports, markedly increased from the previous year. Of these, 436 related to hours and rest, and 6 related to education/training. All of the reports have been dealt with and compensatory payments have been made for excess hours, as agreed by the trainees (as opposed to time off in lieu). There were no penalty fines issued.
Resource Implications	No additional resource
Risk and Assurance	Not applicable
Legal Implications/Regulatory Requirements	Contractual requirement of new Junior Doctors contract that this report is presented on annual basis to the board to provide assurance that appropriate controls and processes are in place to deliver safe working hours for medical staff in training.
Improvement Plan Implication	Not applicable
Quality Impact Assessment	KPMG Audit
Recommendation	The Board is asked to note the report.

Report to the Board of Directors

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

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 The New Junior Doctor Contract has been implemented in all NHS organisations with the collaboration of the Department of Health and the BMA. The contract features two aspects - work schedules (including rotas) and exception reports. The work schedule is expected to be delivered to the trainees at least 6 weeks before commencement of the post, and can be adjusted following discussion between educational supervisors and trainees to accommodate their needs accordingly. The exception report (ER) is submitted by a trainee when their day-to-day work varies significantly from their agreed work schedule. ERs may relate to variations in the hours worked, the pattern of work, missed educational and learning opportunities or due to a lack of support available to the doctor whilst at work. Trainees have been encouraged both by the new contract and the GSW to express their concerns and log an ER. These ERs are notified to the relevant Educational Supervisor (overall trainee supervisor usually for the 1 year attachment) or Clinical Supervisor (trainee supervisor for individual four-monthly attachments during Foundation year – supported by Educational Supervisor) by email via an electronic reporting system (DRS4) and are copied to the Director of Medical Education (Dr Janette Cansick) for training issues, and to the Guardian of Safe Working (Miss Delilah Hassanally) for rest and hours issues. The Educational/Clinical Supervisor is responsible for deciding on the outcome of an ER and informing the trainee of this decision using the DRS4 system.

1.2 At the beginning of the year, the trust workforce evaluated and purchased a new electronic reporting system – 'eRota', which was found to be more comprehensive and versatile, already used in other areas for the appraisal process, and having the ability to perform work schedule reviews. This has been gradually introduced for all trainees and has replaced DRS4.

2 THE EROTA SYSTEM

2.1 <u>Implementation timeline for Medway NHS Foundation Trust (Clinical Council Communications - Appendix 1)</u>

- W/C 04/12/17 - To replicate all 25 live rotas currently in DRS over to eRota
- W/C 11/12/17 - Check eRota compliance and deal with any issues accordingly
- W/C 18/12/17 – Communications sent out to all Education Supervisors and their accounts amended to include access to the Junior Doctor Portal on eRota
- W/C 18/12/17 – Communications sent out to all Junior Doctors and eRota accounts created and login details sent out
- W/C 2/01/2018 – Go live with exception reporting on eRota
  This was in fact completed by the end of January 2018.

2.2 After the first year, it was realised that there was a need to raise awareness of the GSW and the ER system. This required regular input as new trainees joined the hospital. The following structure was developed:

- Trainees are introduced to the GSW at their 'induction' and informed of the reporting system.
- A video is used to demonstrate the process of how to submit an ER.

- A generic email address has been set up for trainees to make contact if required **medwayft.gsw@nhs.net**
- The contact details are available on the trust intranet – Appendix 3
- Trainees are reminded of the details by the GSW at their teaching sessions

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

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

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

3 INFORMATION ON WORKING HOURS FOR DOCTORS IN TRAINING

3.1 High level data

Total number of jobs offers Trust is expected to make under the new contract 2018	227
Number of doctors / dentists in training on 2018 TCS (total)	227
Amount of time available in job plan for guardian for the role	1 PA
Admin support provided to the guardian (if any)	Supported by Medical Workforce team and admin secretary
Amount of job-planned time for educational supervisors	0.25 PAs per trainee

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

For the period 1st September 2017 to 31st October 2018, there were 442 ERs generated.

Total	442
Education	6
Hours and Rest	436

For the early part of the year, these were seen on DRS4 system, and later on the eRotaAllocate system, as shown below:

Report to the Board of Directors

Exception reports (with regard to working hours)
DRS

Exception reports By Grade

Training Level	Total Exception Report Education	Total Exception Report Hours	Total
Foundation Year (F1 and F2)	1	151	152
Junior Trainee (SHO)	1	62	63
Senior Trainee (REG)	0	2	2
TOTAL	**2**	**215**	**217**

Exception reports By Department

Department	Total Exception Report Education	Total Exception Report Hours	Total
Medicine including Haematology	1	80	81
Surgery including Urology	1	98	99
Paediatrics	0	6	6
Obs & Gynaecology	0	0	0
Neonatal	0	0	0
Emergency Department	0	5	5
Orthopaedics	0	26	26
TOTAL	**2**	**215**	**217**

eRota

Exception reports By Grade

Training Level	Total Exception Report Education	Total Exception Report Hours	Total
Foundation Year (F1 and F2)	0	146	146
Junior Trainee (SHO)	4	70	74
Senior Trainee (REG)	0	5	5
TOTAL	**4**	**221**	**225**

Report to the Board of Directors

Exception reports By Department

Department	Total Exception Report Education	Total Exception Report Hours	Total
Medicine including Haematology	4	201	205
Surgery including Urology	0	17	17
Paediatrics	0	0	0
Obs & Gynaecology	0	1	1
Neonatal	0	1	1
Emergency Department	0	1	1
Orthopaedics	0	0	0
TOTAL	**4**	**221**	**225**

Both systems combined

Exception reports By Grade

Training Level	Total Exception Report Education	Total Exception Report Hours	Total
Foundation Year (F1 and F2)	1	297	298
Junior Trainee (SHO)	5	132	137
Senior Trainee (REG)	0	7	7
TOTAL	**6**	**436**	**442**

Exception reports By Department

Department	Total Exception Report Education	Total Exception Report Hours	Total
Medicine including Haematology	5	281	286
Surgery including Urology	1	115	116
Paediatrics	0	6	6
Obs & Gynaecology	0	1	1
Neonatal	0	1	1
Emergency Department	0	6	6
Orthopaedics	0	26	26
TOTAL	**6**	**436**	**442**

In some instances, resolution of reports has not been timely, and for these cases an escalation process is in place.

Escalation process for non-completion of Junior Doctors Exception Reports

For Exception reports that have not been signed off by the Educational / Clinical Supervisor after 7 days, or if no payment is agreed within 14 days, the following action will be taken:

A review is carried out on a weekly basis (Monday) by the GSW admin secretary, to check on the outstanding exception reports (not actioned by the Educational / Clinical Supervisors)

The relevant supervisor is contacted (copying in the GSW), initially by email, followed by telephone to ask them to go onto the system and clear the exception reports of their trainee within 2 days.

If this is still not done, the admin secretary will escalate to the supervisor's Clinical Director, again copying in the GSW, with a deadline for this to be completed within 5 days.

If there is no response from the Clinical Director the final escalation will be to the Medical Director / Guardian of Safe Working asking permission to process the payment.

3.3 Supporting information

Two videos have been made by 'medical staffing' to demonstrate the use of the exception reporting process.
Drs video: https://youtu.be/uKnfWT8FasY

Supervisors video: https://youtu.be/dMM4SNLJ6vc

3.4 Work schedule reviews

Part of the New Junior Doctor contract requires trainees and their supervisors to undergo a work schedule review if there are regular breaches within the personalised work schedule.

Some rotas required amendment following reviews as below.

Work schedule reviews by grade	
FY1	2 (surgery / paeds)
FY2	2 (Surgery, Paeds)
CT1-2 / ST1-2	Combined with FY2
ST3+	8 (gen med, Surgery, 6 x T&O as each trainee works with a named consultant

No particular pattern breaches were seen. However, there remains a problem with rota gaps and difficulty filling these.

There was one instance of a core trainee being given excessive responsibility, and this required discussion with the supervisor to alter expectations.

Report to the Board of Directors

4 LOCUM BOOKINGS

4.1 The following table details the locum bookings required over the 2018 time period to demonstrate total numbers of hours. This is then further broken down to show how many of these hours which were filled by agency, bank or own employees and also those shifts/hours that remained unfilled.

Table 4.1: Total shifts available for bank/agency staff by Division/specialty - 2018 period

Column1	Column2	Column3	Column4
Staff Type	Jan to Dec 2018		
Sum of Hours Booked			
Row Labels	Agency	Bank	Grand Total
A&E Medical Staffing	2,260	7,595	9,855
Anaesthetics	264	115	379
Anaesthetics Main Theatres	405	2,121	2,526
Cardio Med Staff	530	0	530
Cardiology, Cardiac Physiologist	1,600	0	1,600
Community Paediatrics	504	0	504
Derm Med Staff	0	152	152
Elderly Med Staff	75	13	88
Elderly Medicine	1,428	0	1,428
Emergency Department	858	2,727	3,585
ENT	436	326	762
General Medicine	8,397	15,906	24,303
General Surgery	808	3,181	3,689
Gynaecology and Obstetrics	0	736	736
Haematology	232	0	232
interventional radiology, Radiology	438	23	461
Medical HDU	0	186	186
Medical ICU	184	304	488
Neonatology	105	908	1,013
Orthopaedics	5,021	6,126	11,147
Rheum Med Staff	0	154	154
Surgical HDU	78	720	798
Urology	0	56	56
Vascular	0	45	45
Grand Total	**23,623**	**41,394**	**64,717**

5 FINES

5.1 No fines were applied in 2018.

6 QUALITATIVE INFORMATION

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

1. Functioning and quorate group of representative trainees, which meets quarterly at the Junior Doctors Forum (JDF). This group has an agreed TOR based on the ideal model from NHS Employers.
2. Weekly meeting with Medical Workforce / admin team. This meeting reviews exception reports and highlights changes needed.
3. Local agreements on compensatory time off in lieu (TOIL) vs pay to provide clarity on process for trainees and supervisors.
4. Local agreed ER escalation process to support supervisor timely response and ER closure.
5. Representation at National GSW meetings. This has enabled sharing of good practice.
6. Effective links with other local organisations via a GSW network group.

6.2 Following discussion at the Junior doctors' forum with the external BMA representatives, it was agreed that Medway FT would commit to the BMA charter – see link in appendix 2. This showed commitment to maintaining good working practice for the safety of both our doctors and our patients.

6.3 An audit of the GSW role and its function at Medway was completed out by KPMG in August 2018. I am pleased to report that we achieved 'green' status, see Appendix 4 - KPMG executive summary. The recommended actions have been taken and completed.

7 ISSUES ARISING

7.1 The implementation process for the new contract has been successful and has been embraced by most trainees and supervisors. The trainees have been able to engage with the system and have seen positive results. Trainees have been encouraged to submit ERs and this has been discussed and recorded in the minutes of the Junior Doctors Forum (JDF). The JDF has provided the main platform for feedback to the GSW, rota coordinators and workforce team.

7.2 From the GSW perspective there are rotas that clearly have problems, evidenced by the number of ERs logged, especially with respect to rota gaps. This is a nationwide problem and will require substantial recruitment to resolve.

7.3 There is a problem with provision of accommodation for rest periods, particularly after long shifts and night shifts. Although trainees have been able to access accommodation, charges have been applied by the finance department, which is not appropriate. In keeping with the doctors' charter, after a long shift the doctor must be able to rest and

recover in order to travel home safely. This requires a suitable rest room for a period after work and should be available at no cost to the trainee. Human resources have been in discussion with the accommodation team and finance team, and I am hopeful that this issue will be resolved in a timely fashion with a positive outcome.

7.4 The switch from the DRS-4 (rostering and reporting system) to 'Allocate' has been completed and is proving successful. The new system has increased ability and this should be harnessed in the next year. In particular, trainees have requested their work schedules 6 weeks before commencement of their jobs and this should be achievable.

7.5 The 1PA of time for the GSW role was mostly adequate with good administrative and HR support. I have attended the regional meetings (Kent, Surrey, Sussex) which has enabled sharing of practice and networking.

8 ACTIONS TAKEN TO RESOLVE ISSUES

8.1 The trust has actively established the GSW role. I have personally introduced myself, and met with trainees at their induction sessions. I have presented a video to demonstrate the process of how to submit an ER, and set up a generic email address for trainees to make contact if required. Information about the GSW contact details are available on the trust intranet. Trainees are reminded of the details by the GSW at their teaching sessions.

8.2 The electronic system DRS-4 has been replaced by Allocate. With this in place, the work schedules should be published for trainees in good time before they start their jobs so that they can plan their time at Medway.

8.3 I have had weekly meetings with the team as required to maintain the GSW role.

8.4 I am very grateful to have had excellent support from the medical workforce team including Matthew Bradd and Sue Ahmad from the beginning of my appointment and this has been enhanced with the appointment of Rebecca Loates who has very efficiently undertaken administrative duties since September 2017. Also, we have had considerable input from the team of rota co-ordinators who have worked very hard at implementing the new Allocate software, to make this a success.

9 SUMMARY

9.1 This is the second annual report to the Trust Board by myself as Guardian of Safe Working. During this reported period September 2017 to October 2018, there have been 442 exception reports.

9.2 I am satisfied that trainees feel confident and able to submit exception reports on this system, and they also feel supported in doing so – both by me and their supervising consultants. There were concerns that trainees might feel discriminated against if they submitted exception reports but this was discussed in the JDF and trainees were advised this would not be the case. They have been advised and encouraged to log reports promptly. There has been a steady input of exception reports, throughout the year, with numbers increased since last year, suggesting that the system has established itself well.

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

10 QUESTIONS FOR CONSIDERATION

10.1 I can give the board the assurance that trainees on the new contract are engaged with the new Guardian process and as such we have seen positive changes where the hours have been found to be unsafe. As such I feel that we have effective processes in place that are demonstrably working for trainees, supervisors and the GSW team alike. I feel reassured therefore that we are in a good position going forward and with the new electronic system we should be able to provide an environment for safe working for all trainees.

10.2 I require the continued support in my role from the board and the Executive Team to firstly have the time available to engage with trainees and supervising consultants and secondly the reassurance that I have appropriate authority to request changes when they have been identified unsafe for trainees. Clearly a rota that is deemed unsafe in respect of hours and rest will be unsafe for patients being cared for by trainees working such a rota. The authority vested in the GSW must have the ability to be both swift and decisive to immediately diffuse any safety risk once identified.

10.3 Two issues continue to pose significant risk:

1. There remain several gaps in the rotas. These areas will be a focus for the medical workforce team in the next year Rota gaps need to be filled with recruitment of more staff to fulfil the provision of safe working patterns
2. Rest rooms and periods of rest must be made available to trainees after long stressful periods of work, at no extra cost. This is required to ensure their safety of our junior doctors

10.4 Finally, I would like to inform the board that I resigned from the post of GSW, completing my tenure on 31st October 2018. I would like to thank the trust for giving me the opportunity of this role where I learned much about the functioning of the hospital workforce and political influences. I am pleased to have had the opportunity to contribute to setting up a robust infrastructure for the Guardian role and have enjoyed looking after out trainees.

Report to the Board of Directors

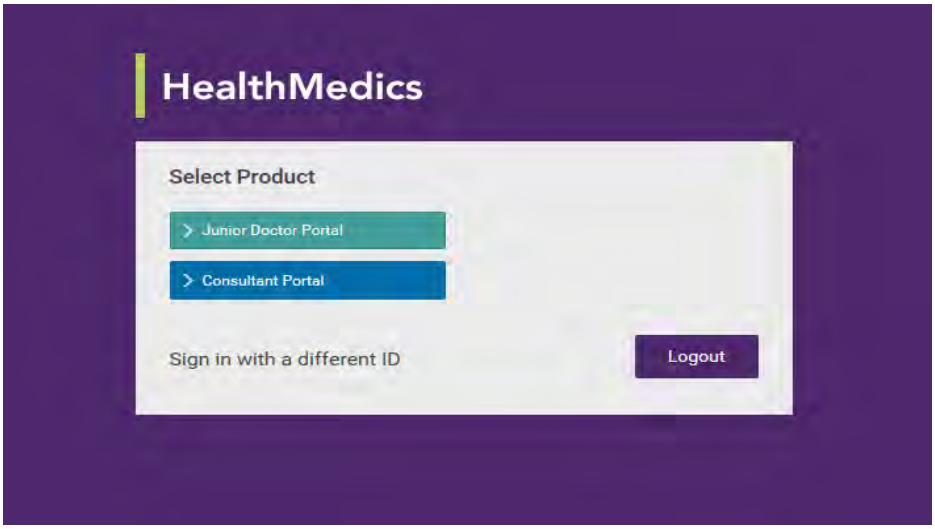
Appendices

Appendix 1. Clinical Council Communications

In preparation for electronic rostering for Junior Doctors in the Trust there are several stages that need to take place.

The first stage is to replace DRS with a tool called eRota. eRota is a rota design tool used by Medical Staffing and is the portal for Junior Doctors to raise exceptions and Education Supervisors to provide resolutions.

- eRota will replace DRS
- **For the Education Supervisors only** the username and password currently used for eJobplan will also now be the same for eRota
- When the Education Supervisors log into HealthMedics they will see two options;



1. Junior Doctor Portal - This will take you to eRota where you will be able to see and deal with any exception reports
2. Consultant Portal - The Consultant portal will take you to eJobplan and this will look exactly the same as you know it (no change has occurred to this)

- All other access to eJobplan will remain the same
- All Junior doctors will be set up with access to eRota only.
- All login details for the Junior Doctors will be emailed to them once the accounts have been created

- Proposed timelines (awaiting agreement from Delilah)
    1. W/C 04/12/17 - To replicate all 25 live rotas currently in DRS over to eRota
    2. W/C 11/12/17 - Check eRota compliance and deal with any issues accordingly
    3. W/C 18/12/17 – Communications sent out to all Education Supervisors and their accounts amended to include access to the Junior Doctor Portal on eRota
    4. W/C 18/12/17 – Communications sent out to all Junior Doctors and eRota accounts created and login details sent out
    5. W/C 2/01/2018 – Go live with exception reporting on eRota

Report to the Board of Directors

Appendix 2 - links to supporting information

1. Drs video: https://youtu.be/uKnfWT8FasY
2. Supervisors video: https://youtu.be/dMM4SNLJ6vc
3. Bma.org.uk/fatigue and facilities charter

Report to the Board of Directors

Appendix 3

Guardians of Safe Working Hours (GSWH) - Intranet Page

The Guardian of Safe Working Hours at Medway NHS Foundation Trust is Miss Delilah Hassanally, Consultant Breast Surgeon. Miss Hassanally can be contacted via her email address – medwayft.gsw@nhs.net

The trust holds quarterly Junior Doctor Forums in which all Junior Doctors are invited to attend, for more details on dates and times please contact Rebecca Loates, Medical Directors System Advisor, on ext 6733 or rebeccajadeloates@nhs.net.

To raise / review an Exception Report please use eRota - www.healthmedics.allocatehealthsuite.com

For Junior Doctors when raising an exception report please be mindful of selecting the correct rota and Supervisor as the trust follow an escalation process to ensure that all exception reports are reviewed in the correct timescale.

If you have not yet received your log in or have any queries in relation to your rota please contact Matt Bradd, Rota Compliance and Medical Contract Advisor on ext 3265.

Report to the Board of Directors

Appendix 4 – KPMG audit

Section One: Executive summary

Conclusion

We reviewed the Trust's implementation of the Guardian of Safe Working Hours requirements in response to the Junior Doctors 2016 contract and have reached an overall assessment of "significant assurance" (green). Overall we have concluded that the controls in place have been effectively designed to meet the NHS Employer guidance in terms of understanding and monitoring the requirements of the contract.

The Guardian of Safe Working Hours (GSWH) job description is commensurate with the NHS Employer sample job description. The nominated GSWH has completed all elements of the NHS Employer Checklist, demonstrating the Trust's commitment to fulfilling the GSWH role. There are appropriate processes in place for receiving and reviewing exception reports created by Junior Doctors. For a sample of exception reports, we followed the process from submission to completion to ensure the processes in place were working as intended. We found these processes to be well designed and operating effectively. We tested controls over the exception reporting process and found that the Trust has established processes to review and monitor these.

However, we also identified that there is scope to improve the timeliness of reviewing exception reports to be in line with the Junior Doctor 2016 contract terms and conditions of service, although an escalation process is in place for this. There is scope to improve the frequency of information reported to the Board regarding the GSWH report. Historically, a safe working hours report, which details important data from exception reports, has been presented to the Board annually. However, as per NHSE guidelines this should be completed on a quarterly basis, and should be presented to a Board sub-committee to improve transparency and awareness.

From March 2018 the Trust is reporting to the Board on a quarterly basis, although due to timing differences between fieldwork and the Board meeting this has not yet happened, so no recommendation has been raised. GSWH reports to the Board currently report the absolute number of exception reports. Junior Doctors can raise up to five incidences on a single exception report. Where Junior Doctors submit exception reports that cover more than one period of work, this should be followed up to prevent the Board from misunderstanding the level of activity reported.

In order to pay overtime payments raised as part of the exception reports, a member of staff periodically reviews completed exception reports from the Allocate eRostering system and manually processes the number of overtime hours requiring compensation for each Junior Doctor. The manual nature of this process increases the risk of payroll being provided with incorrect figures due to human error, and the fact that there is no subsequent check on the information provided.

Report to the Board of Directors

Board Date: Thursday 07 March 2019 Agenda Item: 5.5

Title of Report	Trust Annual Safeguarding Report 2017-18
Prepared By	Bridget Fordham, Head of Safeguarding
Lead Director	Karen Rule, Director of Nursing
Committees or Groups who have considered this report	Safeguarding Assurance Group Trust Executive Group Quality Assurance Committee
Executive Summary	This report is intended to provide assurance to the Trust Executive Group that Safeguarding is embedded and carried out effectively across all areas of the Trust in line with our statutory duties. The CQC describes safeguarding as meaning, "*protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It's fundamental to high-quality health and social care.* *Safeguarding adults includes:* • *Protecting their rights to live in safety, free from abuse and neglect.* • *People and organisations working together to prevent the risk of abuse or neglect, and to stop them from happening.* • *Making sure people's wellbeing is promoted, taking their views, wishes, feelings and beliefs into account.* *Safeguarding children and promoting their welfare includes:* • *Protecting them from maltreatment or things that are bad for their health or development.* • *Making sure they grow up in circumstances that allow safe and effective care*." Referrals to safeguarding adults' team have continued to increase over the last year demonstrating increased awareness of safeguarding adults and the need to report concerns of abuse or neglect as a statutory duty. The number of Safeguarding Alerts received by the Trust has also continued to increase. The Trust takes all alerts seriously and works collaboratively with the Local Authority to investigate all concerns, taking corrective action when concerns are substantiated. The majority of the concerns raised in the alerts are in relation to the discharge or transfer of our most vulnerable patients. Failure to put in place effective discharge plans compromises patient safety and provides a poor patient experience for some of our most at risk patients. This is unacceptable. The Trust is committed to safely discharging patients and improvement

Report to the Board of Directors

	work is ongoing within the clinical directorates to achieve this for all patients. Deprivation of Liberty Safeguards (DoLS) applications have increased by 36.5%% from the previous year through increased staff awareness of the DoLS requirements and case finding by the safeguarding team. Multi-agency working has increased across the adult and children's safeguarding caseloads and as the team become more recognised across both Kent and Medway the inclusion of the Safeguarding team to represent acute health at panels for Serious Case Reviews (SCRs), Domestic Homicide Reviews (DHRs) and Serious Adult Reviews (SARs) has grown. This improves our visibility as a partner agency but also recognises the pieces of the jigsaw that acute health may have to enable a fuller picture to protect the vulnerable in our society. There has been attendance at the external Safeguarding Boards and their subgroups throughout the year ensuring our compliance and active participation with completion of reports and presentations as required to provide assurance externally of our ongoing commitment to our statutory obligations. The ongoing challenge into 2018/2019 is for the clinical Directorates to facilitate staff attendance at safeguarding training and to achieve at least 85% compliance in accordance with Trust training targets.
Resource Implications	Safeguarding workloads are increasing in line with statutory requirements and the increased scrutiny on all providers and care support agencies to protect the most vulnerable in our society. Quarter 4 has seen an increased drive to recognise and respond to Child Sexual Exploitation, Gang activity, Modern Slavery and Domestic Abuse. The time commitment to both participate and be an active partner agency in local responses to these through the local Boards and to fulfil our statutory requirements to respond to Serious Case reviews, Serious Adult reviews and Domestic Homicide reviews has had an impact on the availability of the team to be as visible as they would like. The growing prevalence of domestic abuse also evidences the need to consider how this can be supported in areas such as A&E under the "Think Family" model.
Risk and Assurance	The previous risks within the safeguarding portfolio of work related very much to the training, embedding processes and procedures having governance structures to support the escalation and reporting. These are all now in place and most risks identified through safeguarding are risks owned by the clinical directorates from themes and trends in safeguarding.

Report to the Board of Directors

	The risk to the Trust from those subject to a Deprivation of Liberty Safeguard whose urgent authorisation has expired remains an area of risk for the Trust. Where restrictions and / or restraints are applied to a patient in our care and the local authority is unable to meet the statutory time frames to assess and either grant a standard authorisation or refuse has been an area of concern for some time and does place the Trust at risk of legal challenge. This is regularly escalated within the local authority and to the Adult Safeguarding Board and has been escalated through our own internal governance processes and to the NHSI Integrated Assurance meeting and System Assurance meeting.
Legal Implications/Regulatory Requirements	The Trust has submitted both Self-Assessment Frameworks to the Kent and Medway Safeguarding Adult Board demonstrating that the Trust complies with its statutory duties under The Care Act and Section 11 Audits as required under the Children's Act.
Improvement Plan Implication	Not Applicable
Quality Impact Assessment	Not Applicable
Recommendation	The Board is asked to approve the Annual Safeguarding Report 2017-18 and the assurances it provides in relation to meeting our statutory duties.
Purpose and Actions required by the Board	**Approval** ☒ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

NHS
Medway
NHS Foundation Trust

Safeguarding Adults and Children's Annual Report 2017 - 2018

Bridget Fordham
Head of Safeguarding

Best of care
Best of people

Contents

1 EXECUTIVE SUMMARY

This report is intended to provide assurance to the Trust board that Safeguarding is embedded and carried out effectively across all areas of the Trust in line with our statutory duties.

The Care Quality Commission describes safeguarding as meaning, “protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It's fundamental to high-quality health and social care.

Safeguarding adults includes:

- Protecting their rights to live in safety, free from abuse and neglect
- People and organisations working together to prevent the risk of abuse or neglect, and to stop them from happening
- Making sure people's wellbeing is promoted, taking their views, wishes, feelings and beliefs into account.

Safeguarding children and promoting their welfare includes:

- Protecting them from maltreatment or things that are bad for their health or development
- Making sure they grow up in circumstances that allow safe and effective care

Referrals to the safeguarding adults’ team have continued to rise over the last year demonstrating increased awareness of safeguarding adults and the need to report concerns of abuse or neglect as a statutory duty.

Deprivation of Liberty Safeguards (DoLS) applications have increased by 36.5% from the previous year through increased staff awareness of the DoLS requirements and case finding by the safeguarding team.

Multi-agency working has increased across the adult and children’s safeguarding caseloads and as the team become more recognised across both Kent and Medway the inclusion of the safeguarding team to represent acute health at panels for Serious Case Reviews (SCR’s), Domestic Homicide Reviews (DHR’s) and Serious Adult Reviews (SARs)has grown. This improves our visibility as a partner agency but also recognises the pieces of the jigsaw that acute health may have to enable a fuller picture to protect the vulnerable in our society.

There has been attendance by Trust safeguarding team members at the Kent and Medway Safeguarding Boards and their subgroups throughout the year ensuring our compliance and active participation with completion of reports and presentations as required, to provide assurance externally of our ongoing commitment to our statutory obligations.

2 SAFEGUARDING ADULTS ACTIVITY

Safeguarding Referrals

The numbers of Safeguarding Adults referrals processed by the Trust safeguarding team are shown in the table below giving a comparative of previous years.

SAF's Raised	Before 2015	2015-2016	2016-2017	2017-2018
Raised Against MFT	0	23	60	49
MFT Raised against Self	1	8	26	27
MFT Raised against External	0	3	108	173
External Raised against External	0	5	24	19
Total	**1**	**39**	**218**	**268**

The numbers of referrals continue to rise, which show that staff awareness of when to raise an alert is improving. The recognition of safeguarding continues to improve as training compliance goes up and with increased vigilance and visibility from the safeguarding team who have oversight of Datix incident reporting and collaborative working with specialist teams such as tissue viability nurses and the falls team.

The table below shows which local authority the safeguarding referrals are processed by.

Supervisory Body	Before 2015	2015-2016	2016-2017	2017-2018
Kent	0	13	55	55
Medway	1	26	162	209
Other	0	0	1	4
Total	**1**	**39**	**218**	**268**

Neglect either by another person or organisation continues to dominate the category of abuse cited on referrals. Many referrals give several types of abuse and therefore this table should be reviewed with some caution as one referral can have three abuse categories on it.

Types of Abuse	Before 2015	2015-2016	2016-2017	2017-2018
Discriminatory	0	0	3	4
Domestic	0	0	0	2
Financial	0	3	18	24
Modern Slavery	0	0	0	0
Neglect/Acts of Omission	0	29	150	179
Organisational	0	1	16	15
Physical	0	13	54	66
Psychological	1	2	29	43
Self-Neglect	0	0	11	21
Sexual	1	0	11	8
Total	**2**	**48**	**292**	**362**

Safeguarding Alerts

The purpose of a Safeguarding Alert is to raise a notification of a safeguarding concern**.** An alert is the generic term used to describe the notification of an individual being at risk of or experiencing actual abuse or neglect. An alert can be raised by anyone. Alerts can be raised from a number of different sources including social services, care staff, health colleagues, inspectors or regulators and members of the public.

Since The Care Act 2014 came into force for acute Trusts in 2015 safeguarding activity has changed. The criteria for a person to meet safeguarding support and or investigation is that they;

(a) Have needs for care and support (whether or not the local authority is meeting any of those needs),
(b) Are experiencing, or are at risk of, abuse or neglect, and
(c) As a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

All 3 sections need to be met to make this safeguarding.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case, this is a Section 42 enquiry. It is this instruction from the local authority that leads to the safeguarding investigation.

All alerts are taken seriously. When an alert is raised externally against the Trust the Local Authority Social Services Team will forward the concern to the Adult Safeguarding Team. The Safeguarding team will record an incident on the Trust Datix Incident Reporting system and request a concise review from the clinical team responsible for the care of the patient. The Datix incident raised will be reviewed at the directorate governance meeting with a 72 hour investigation report completed by the Matron. A copy of the investigation report is sent to the Adult Safeguarding Team, as the first step of the section 42 enquiry. This can then be reviewed and further investigation be taken as necessary prior to sharing with the Social Worker assigned. If the alert is raised within the Trust the same process is followed.

In 2017/2018 the Trust received a total of 78 Safeguarding Alerts; 50 Safeguarding Alerts raising concerns against care provided by the Trust and 28 self-raised.

SAF's Raised	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Total
Raised Against MFT	7	5	6	4	2	0	4	4	2	11	2	3	**50**
MFT Raised against Self	1	3	3	3	2	4	1	3	2	3	2	1	**28**
Total	**8**	**8**	**9**	**7**	**4**	**4**	**5**	**7**	**4**	**14**	**4**	**4**	**78**

The Alerts are then screened by adult social care and a discussion may be had with the safeguarding team to determine whether the concern meets the safeguarding threshold or

indeed may need to be dealt with through a different route such as a complaints or SI process.

Some of the 78 alerts raised concerns about more than one type of abuse. Neglect by others was the highest category of alleged abuse reported over the last year. This category includes incidents such as acquisition and /or deterioration of pressure ulcers, delayed diagnosis or treatment, omissions of care by formal and informal carers and failed or poor discharge. The table below provides the numbers of concerns related to abuse split by category.

Types of Abuse on Safeguarding Alerts raised against the Trust	Before 2015	2015-2016	2016-2017	2017-2018
Tissue Viability	0	13	21	28
Staff Conduct	1	3	13	6
Nutrition	0	2	0	1
Transfer of Care/Poor Discharge	0	6	27	30
Total	**1**	**24**	**61**	**65**

It is the responsibility of the Local Authority to undertake an unbiased investigation of all concerns raised and to determine if the concerns are substantiated or not. During the investigation the investigating officer may decide that the concerns raised do not meet the Safeguarding threshold, in these cases the Safeguarding Alert is closed without further action.

The Local Authority informs the Trust of the outcome of the investigation. The outcome and status of the 64 investigations commenced in response to 2017/2018 Safeguarding Alerts is provided in the table below. The 14 other alerts were for “other” concerns such as medication not given, delay in treatment and diagnosis. These concerns were considered outside of the Safeguarding process, for example as a formal complaint or serious incident investigation.

	Type of Abuse		
Investigation Outcome	**Tissue Viability**	**Staff Conduct**	**Transfer of Care / Poor Discharge**
Substantiated	14	0	8
Unsubstantiated	6	5	10
No Case	0	0	5
Unknown*	5	1	5
Outstanding	3	0	2
Total	**28**	**6**	**30**

*The Trust has not been informed of the outcome of **11** investigations. This has been escalated to the Local Authority.

The majority of the concerns raised are in relation to the discharge or transfer of our older patients who often have vulnerabilities such as dementia or frailty due to long term conditions. Failure to put in place effective discharge plans compromises patient safety and provides a poor patient experience for some of our most at risk patients. This is

unacceptable and the Trust is committed to delivering improvements which will keep our patients safe on discharge.

In 2017/2018 the Deputy Director of Nursing, Unplanned Care implemented a monthly 'Transfer of Care Concerns' Group meeting. At the meeting all concerns are discussed by directorate and programme staff and colleagues from partner organisations. This provides an opportunity for sector partners to identify joint improvement actions which are then monitored at the meetings. Thematic analysis of all concerns is undertaken and actions agreed which link to the directorate safeguarding action plans which are monitored at the programme governance meetings. Regular staff communications are used to raise awareness of the importance of effective discharge planning and Matrons support effective discharge planning when they are in the clinical areas. Further work will be undertaken to review the effectiveness of these arrangements.

In relation to pressure ulcers, the Trust has an established Tissue Viability quality improvement plan which is delivering improvements in care but there is still more to do. Progress against the plan is monitored at the Trust Patient Safety group. All Safeguarding Alerts about tissue viability are discussed at a weekly meeting held with representatives from the clinical directorates, the Safeguarding team, the Tissue Viability team and Patient Safety team. All pressure ulcer acquisitions are subject to investigation via a RCA 'toolkit' which is validated by the Tissue Viability team. A monthly cross directorate meeting is led by the Tissue viability team to validate the toolkits, to identify themes and to share learning.

Self-neglect is a growing concern that falls within adult safeguarding, the team scrutinises such referrals and liaises with social care to ensure that there are no safeguarding reasons for the self-neglect such as financial abuse or neglect by others. As part of our investigations into pressure sore acquisition it has been found that patient's refusal of care that is essential for their health and wellbeing is a contributing factor.

The safeguarding team work with the clinical teams on a daily basis advising the use of the Mental Capacity Act to ascertain capacity for the patient to refuse care together with other strategies of engagement. However, respecting the wishes of patients with capacity to refuse care when they have the capacity to do so is an important consideration.
The challenge organisationally is how to deliver the care required when someone lacks capacity to consent to this treatment and actively resists care. This makes staff feel very challenged and uncomfortable and is a frequent concern that the team are asked to advise and support with.

Advice requested by staff has gone up and is captured on advice recording sheets which are often required further into the patient journey either where complaints, incidents, DoLS or Safeguarding concerns are progressed. Staff are more confident in asking for advice from the team and escalating concerns early and appropriately.

In many cases referrals are complex and often require a multi-agency approach to resolving some of the issues. To support staff with advice and early escalation with complex cases staff can ring or email the generic safeguarding email inbox. The safeguarding team cover

an 8am-6pm Monday to Friday time period. Empowering and educating the workforce to be confident in raising concerns and escalating concerns early has been a key focus throughout the year.

The population we serve has much vulnerability identified within safeguarding and it is widely recognised there cannot be a one size fits all solution to keeping someone safe. The growing problems of domestic abuse, drug and alcohol misuse and homelessness require multi-agency responses.

Multi-agency meetings occur across the Kent and Medway locality to work on individual cases and manage risk collaboratively. The safeguarding team continue to have a presence at these wherever possible.

Mental capacity Act 2005 (MHA) and Deprivation of Liberty Safeguards (DoLS)

The Mental Capacity Act 2005 is a legal framework to support people who cannot make decisions about themselves. In hospital this applies to how all care and treatment is provided to patients who lack capacity and supporting them to make decisions about their discharge destination. The safeguarding team have been working continuously towards embedding the principles of the MCA throughout the Trust through teaching, ward visits and ward rounds and spot checks on the wards.

A case note audit was commenced early in 2018 however due to capacity in the team and demands on the safeguarding practitioner time this is not due for completion until August 2018.

Deprivation of Liberty Safeguards (DoLS)

The Deprivation of Liberty Safeguards (DoLS) were added to Mental Capacity Act 2005 by the Mental Health Act 2007 with Safeguards coming into effect in April 2009.

The aim is to prevent breaches of Article 5 of the European Convention on Human Rights 1998 'everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law'.

The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

The Cheshire West Supreme Court Judgement in March 2014 made reference to the 'acid test' to see whether a person is being deprived of their liberty, which consisted of three points to consideration:

- Does the person lack capacity to make decisions for themselves regarding care, treatment and /or accommodation?

- Is the person subject to continuous supervision and control?

- Is the person free to leave? – with the focus being not on whether a person seems to be wanting to leave, but on how those who support them would react if they did want to leave.

There were 548 applications for an Urgent Authorisation for a DoLS over the last year.

Of these, 244 patients were not assessed by the local authority within the 14 day period and subsequently breached their 7 days urgent authorisation and 7 day extension (14 days in total) which results in an unlawful detention of a person lacking capacity – a risk shared by the local authorities as this remains a national problem. This risk has been escalated by the Trust to NHSI via the Integrated Assurance meeting and System Assurance meeting.

The tables below demonstrate how the Trust has continued to comply with its statutory obligations and the increase in applications shows that there is a better understanding and compliance across the Trust of mental capacity and deprivation of liberty. This also demonstrates the complexities and vulnerabilities of the patients that are admitted to our hospital.

Number of DoLS Applications	2015-2016	2016-2017	2017-2018
DoLS referrals made	15	348	548
Standard Authorisations received	4	39	17
Breached 14 days urgent and extension	9	201	244
Number rejected by local authority	2	11	2
Number withdrawn due to discharge or regain of capacity	1	14	15

DoLS applied for by Local Authority	2015-2016	2016-2017	2017-2018
Medway Council	1	174	354
Kent County Council	3	110	188
Other Local Authority	0	4	6

The Policing and Crime Act 2017 came into force on Monday 3 April 2017, the Coroners and Justice Act 2009 was amended so that people subject to authorisations under DoLS will no longer be considered to be ‘otherwise in state detention’ for the purposes of Section 1 of the Coroners and Justice Act 2009. This meant that coroners will no longer be under a duty to investigate a death purely because a patient was subject of a DoLS. Such deaths are only reported to the coroner if the cause of death is unknown, or where there are concerns that the death may have been affected by the restrictions and restraints used during the DoLS period.

Number of patients that died whilst subject to a DoLS	2015-2016	2016-2017	2017-2018
Total	6	60	80

Deprivation of liberty and the application of Deprivation of Liberty Safeguards (DoLS) has been a huge challenge for the health and care sector, especially since the Cheshire West Supreme Court judgment in 2014 (after which DoLS referrals increased nationally from 13,000 to 200,000+ pa, with no increase in resources to support local authority assessment).

There has been widespread criticism about the current legal framework being both ineffective to protect people's rights and hugely onerous to implement - and consensus that it needs urgent replacement.

The House of Lords commissioned a review of the Mental Capacity Act and Deprivation of Liberty Safeguards which has been conducted and recommendations made for a change in the law. A proposal is made to move from Deprivation of Liberty Safeguards to Liberty Protection Safeguards (LPS). Under this change it is anticipated that the local authority will no longer be the responsible body for authorising the LPS and this will fall to specialist practitioners within the managing authority, i.e. the Trust.

There is expected to be progress towards these changes late in 2019 /2020.

In addition to managing the safeguarding workload described above the Safeguarding team have commenced regular liaison with the prison teams due to safeguarding issues raised by the Trust in regards to prisoners admitted with pressure ulcers, prisoners disclosing concerns, the safeguarding of prisoners whilst in the Trust and prisoners not being brought for their appointments and investigations therefore possible delay in diagnosis and treatments.

There have been six allegations against staff that have been raised through safeguarding and /or the LADO, all but one referral were made regarding their conduct or concerns outside of the workplace.

3 Safeguarding Children's' Activity

Safeguarding children activities are governed by the children Acts 1989 and 2004. Under the 2004 Act the following are key areas:

- Section 10 – we must cooperate with partners working with children in the community to improve the well-being of all children and young people in our care
- Section 11 - creates a duty for the key agencies who work with children to put in place arrangements to make sure they take account of the need to safeguard and promote the welfare of children when doing their jobs

The safeguarding team continues to work with the Local Safeguarding Children Boards (LSCB) in Kent and Medway to fulfil our duties to safeguard the children and young people we see on a daily basis.

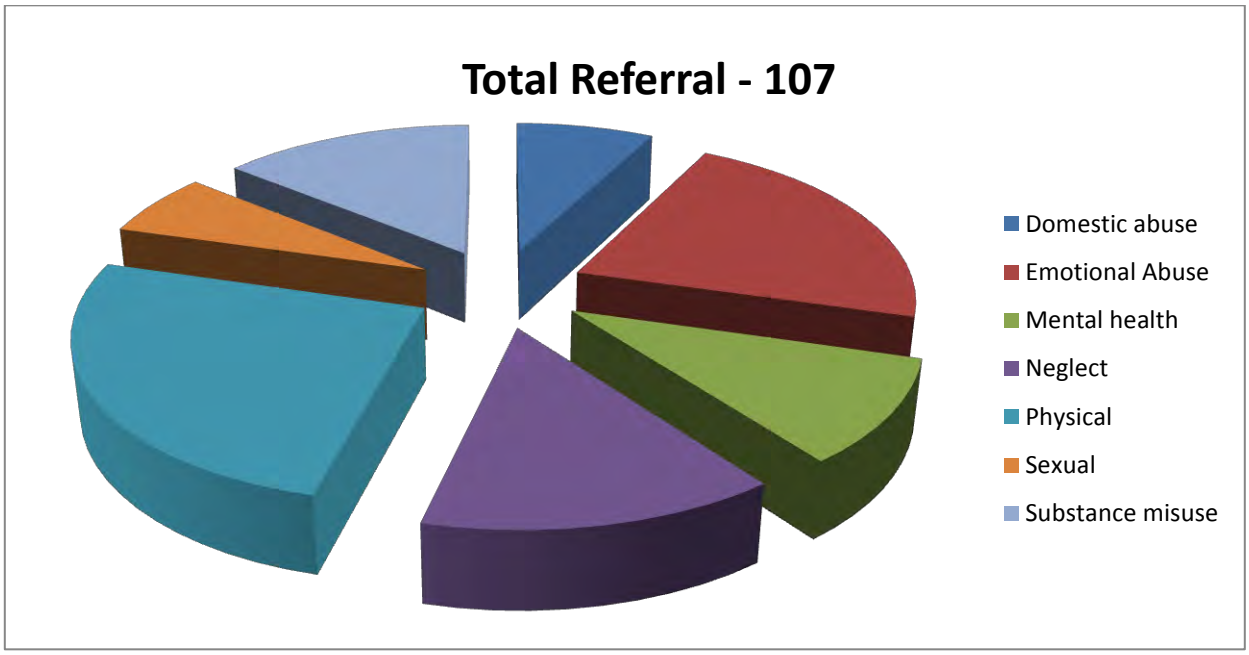
By amalgamating the safeguarding teams in the Trust, the pooling of resources and sharing of expertise has allowed the safeguarding and "Think Family" message to be reinforced throughout the Trust. It will also allow for transition of children and young people known to the safeguarding children team to be handed over to the adult team in a safe and timely manner.

In the past year we have been able to implement the Child Protection Information Sharing System (CP – IS) in both the children's assessment ward and the emergency department. This has allowed frontline staff to be alerted to those children who are either on a CP Plan or Looked after Children (LAC). The CP-IS system provides clinician with essential data surrounding the child, such responsible local authority and contact details for allocated worker. This allows clinician to focus on delivery of care and commencement of safeguarding activity. The system also ensures alerts on the attendance of these children and young people are sent to the respective Local authorities.

As a result of this the Liaison Nurse does not have to notify the local authority of the attendance of children on a plan or Looked After, allowing for a more a more supportive and reflective approach to the liaison role. However should concerns be raised around the attendance, then the social worker for the child will be contacted as soon as possible and information shared accordingly.

The safeguarding team continues to work very closely with our multi-agency partners, including Independent reviewing officer team and Medway Safeguarding Children's Board (MSCB).

We continue to provide key performance indicator data to aid in local service development. From this data the number of safeguarding referrals initiated by the trust is shown in the table below.



Within the last year, one of our changes has been within the children's emergency department where we have reviewed the assessment of the children and young people seen in the department. The rational for this change was to incorporate safeguarding children assessments within the triage pathway, to ensure safeguarding was embedded within practice and not a silo assessment. The tool is designed to aid frontline staff in their assessments and decision making process; as well as offering triggers for consideration when seeing children and young people.

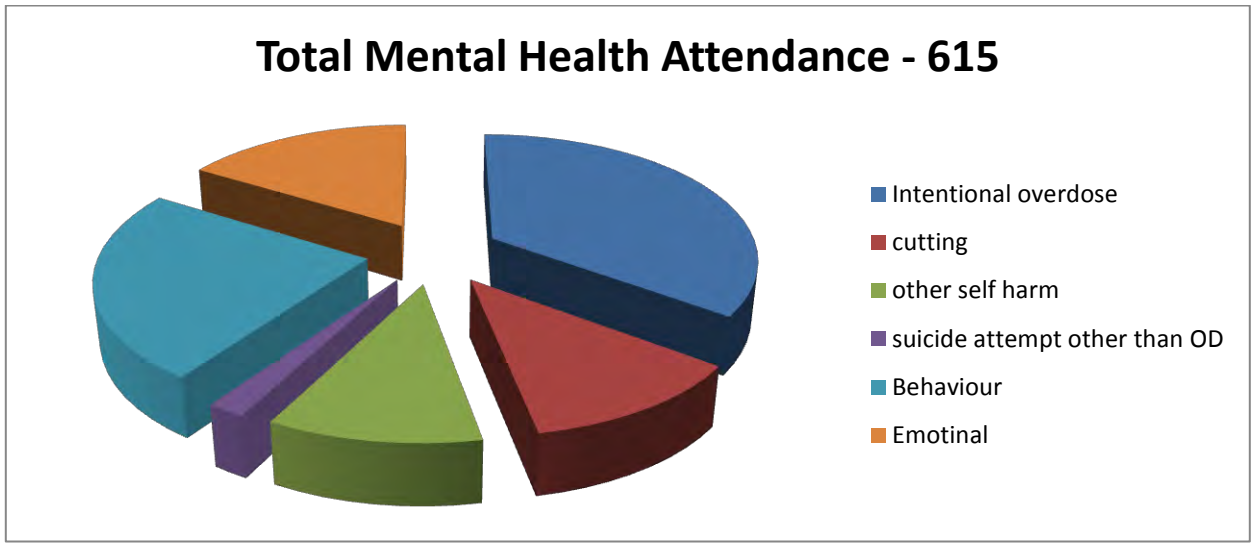
The safeguarding care plans have also been updated to help staff document their concerns. This has benefitted our work as it ensures children have a more detailed social assessment and appropriate referral for support or protection. This project is currently on a second cycle of audit to assess the impact of clinicians understanding of local safeguarding thresholds.

The use of the assessment tool has aided in collecting more in depth data regarding the types of attendances we are seeing and treating within the children's emergency department on a daily basis.

One major area of concern is children / young people presenting with mental health issues including self-harming and suicidal thoughts and ideation. This continues to be a challenge to both the Children's Emergency Department and paediatric wards. It has been acknowledged that this isn't a problem related to Medway alone but an issue nationally. In order to overcome some of the barriers encountered over the years the matron and senior sister on the paediatric wards and children's emergency department have been having regular monthly meetings with the manager from CAMHS. This has facilitated a shared understanding of roles and services in both Trusts which means there is a more

collaborative approach to managing these young people who present with some very challenging behaviours.

We have established close working relationships with the public health nurse for adolescent mental health, who we liaise with on a daily basis to ensure all children and young people are identified and receiving the right support at the right time. The table below highlights the scale of the concern



Of the 615 attendances for mental health concerns; 464 of these young people were referred to CAMHS services for assessment.

The safeguarding team is now working in partnership with external agencies to establish a working party to address the mental and emotional needs of our young people population. This work is still in its infancy and ongoing.

Physical abuse is another area highlighted within the data set. Paediatric consultants continue to engage with social care, providing non accidental medical examinations and reports as necessary.

Child Deaths

The safeguarding team continues to play a key role in the management of the child death process within the trust. Over the past year we experienced a total of 45 child deaths across Medway.

During 2017/2018 we were notified of 20 unexpected deaths. Ten of these deaths were out of hospital cardiac arrests, brought in to children Emergency Department, however unable to revive. All of these cases were referred to the coroner for examination, post mortem results are sent to consultant on call at the time of death.

One of these deaths occurred directly after discharge from Penguin ward, an investigation was completed with no direct link to attendance at the Trust identified.

A further death occurred as the result of Bronchiolitis.

One death was the result of a road traffic accident and was investigated by police.
Four deaths were the result of extreme prematurity complications and a further two deaths the result of complications during labour, which are reported and investigated by Maternity services.

Lastly two children died as the result of non-accidental injury and have been escalated to serious case reviews / lessons learnt panels.

Maternity

Within Maternity safeguarding continues to play a major role. The Concerns and Vulnerability forms continue to be used to highlight both safeguarding concerns and any other vulnerabilities of women and families in our care. Generally raised for 16 weeks gestation, these forms are a way of communicating concerns or vulnerability within our own trust but with consent are also shared with the health visiting team and named GP'S via secure email. Maternity store these forms electronically and are linked to the woman's Euro king episode so that staff are signposted to concerns with the women and families that they are providing care for in both the hospital and community setting. Concerns and Vulnerability forms raised for mental health concerns are consistently the main concern highlighted within maternity statistics.

A separate maternity report has been produced and reported within the Women's & Children's programme as required.

4 LEARNING DISABILITIES

Activity around supporting patients with a learning disability continues to grow throughout this year. The table below captures the comparison of the numbers of patients seen compared to the previous quarter and the time spent on liaison for these patients.

	2016-2017	2017-2018
Number of Patients LDL Nurse made aware of per month	210	404
Number of Patient Visited by LDL Nurse	294	751
Number of Patients Seen for the First Time by LDL Nurse	147	211
Number of Repeat Attendees	47	135
Number of Patients seen without a Learning Disability	15	40
Time spent liaising	455:45:00	1195:25:00
Gender of patients seen for the first time	**2016-2017**	**2017-2018**
Male	82	109
Female	65	102
Total	**147**	**211**

At the beginning of 2018 the Trust signed up to the new “Treat me well” campaign by Mencap - the national charity supporting people with learning disabilities. The new health campaign aims to transform how the NHS treats people with a learning disability in hospital.

Examples of the top 10 reasonable adjustments that the trust is encouraged to make which relate to the Treat me well campaign

1. Speak clearly and use simple words, without being patronising. It is important not to make assumptions that someone has understood information they have been given.
2. Allow extra time. People with a learning disability (PwLD) may need a bit longer to be able to understand information they are given. Just an additional ten minutes can make a big difference.
3. Work with supporters. This could be a support worker or family member. Supporters are really important, particularly for people with profound and multiple learning disabilities, but remember to talk to the person directly and support them to make decisions - supporters are there to help you do this!
4. Be flexible with appointment times or consultations. Many people with a learning disability will find it easier coming to hospital when it is quieter, so an appointment at the very beginning or very end of the day might make their appointment go more smoothly. They may also need an appointment at a time when their supporter is able to accompany them.

5. Make sure people can get into and around the hospital. This includes ensuring there are no physical barriers for people using wheelchairs or with mobility issues, but also making sure signs in the hospital are as easy to understand as possible.
6. Provide a quiet place to talk. Hospitals are often busy, noisy places and this can be overwhelming for many people with a learning disability. Having a quiet place to wait can prevent people getting anxious and having to leave the hospital. Many people also find waiting a long time very difficult.
7. Talk to our learning disability liaison nurse if you know you will be seeing a patient with a learning disability whom you may have concern for their care and treatment.
8. Read our patients' hospital passports. These are a patient-held, personalised record of what people with a learning disability have. Reading them will make your job a lot easier.
9. Provide written information in an easy read format. Many easy read documents can be found on the Trust intranet on the Safeguarding page.
10. Always ask the person what they need. Reasonable adjustments are about what the person in front of you needs and they know that better than anyone, as well as any family or carers with them.

Over the past year the Learning Disability Liaison Nurse (LDLN) has been asked to deliver a number of bespoke training sessions in the trust on LD awareness, including the Emergency Department governance day which involved simulation training with a service user who has a learning disability. This was followed by a questions and answers session.

The LDLN has continued to support medical staff to follow the principles of MCA 2005 for assessing capacity to make decisions on care and treatment & application of DoLS.

The LDLN has been raising awareness of the use of the "yellow smiley face" symbol that was initiated by the outpatient's team to act as a flagging system to other staff that the patient has a learning disability. The symbol is now being used Trust-wide on Extramed bed management system and stickers on patient's notes.

The LDLN enlisted Clinical Support Workers, Staff Nurses and therapists as Learning Disability Champions within the Trust. The trust currently has 70 LD champions and the LDLN ensures they have adequate knowledge and are supporting PwLD to make reasonable adjustments.

There has been an increase in mental health cases that have been referred to the LDLN and classed as patient having learning difficulties, the LDLN has investigated to clarify if patient is previously known to LD services and has a social worker. The LDLN works closely with the Psychiatry liaison team based in the hospital.

The table below demonstrates the types of learning disability our patients are diagnosed with.

Learning Disability - Made Aware of for First Time	2016-2017	2017-2018
Aspergers	1	5
Autism	21	20
Borderline	0	0
Down Syndrome	10	9
Mild	52	78
Moderate	12	24
Profound	18	15
Severe	21	30
Total	**135**	**181**

The Learning Disability Strategy has been ratified at the Safeguarding Assurance group and is now on the Trust Intranet.

LD policies are currently being reviewed & updated to include up to date national policies. Including the national drive to make improvements in the healthcare for people with learning disabilities led to the establishment of the Learning Disabilities Mortality Review (LeDeR) Programme which reviews the deaths of people with learning disabilities and provides expert panel scrutiny. This process has been implemented within the trust and the adult safeguarding team maintains a database of all PwLD who have been referred to the LeDeR programme. The LDLN has completed the training provided by LeDeR to be a reviewer however further reviewers will be required as this is a time consuming and challenging addition to the current workload.

Deaths in hospital for those with a learning disability for the past year do not differ much from the previous year. No LeDeR reviews have yet been undertaken to identify if there is any learning to be identified. There is concern at the overlap of processes such as Serious Adult Reviews in line with LeDeR and this has been raised with the Kent and Medway Safeguarding Adults Board.

Died	2016-2017	2017-2018
Death in Hospital	13	13
Was the death expected	10	9
Death Elsewhere	2	5

5 SAFEGUARDING TRAINING

Safeguarding Adults training comprises of two levels of training, Basic Awareness at Level 1 for non- clinical staff and Level 2 for all clinical and non-clinical staff with patient contact. Level 3 applies to all staff that may investigate and /or report on safeguarding matters or carry out a section 42 enquiry. This data is not currently captured by L&D.

The Trust is required to maintain a training compliance level of 85% at all times. The table below shows training compliance at the end of March 2018 which was below the 85% required.

Course	Trust Wide	
	Compliant	Non-compliant
MCA / DoLS	70.18%	29.56%
Prevent Level 1	81.59%	18.41%
Prevent Level 2 (WRAP3)	72.25%	27.75%
Safeguarding Adults Level 1	84.62%	15.26%
Safeguarding Adults Level 2	78.62%	21.30%
Safeguarding Children Level 1	79.08%	20.76%
Safeguarding Children Level 2	76.78%	22.52%
Safeguarding Children Level 3	64.67%	34.32%

There are some anomalies in the % data. Staff within 3 months of expiring their 3 year competency are removed from 'compliant' and are not recorded as 'non-compliant'.

Staff turnover has been a factor for not reaching the level of compliance required however all sessions have high Did Not Attend (DNA) rates – often due to work and staffing pressures.

Number of staff Cancelled or DNA	**2016-2017**	**2017-2018**
Domestic Violence Level 2 Training	20	0
Workshop to Raise Awareness of Prevent (WRAP3) - Prevent Level 2	217	525
Learning Disabilities Awareness	59	498
MCA & DoLs	47	454
Safeguarding Adults Level 1	16	32
Safeguarding Adults Level 2	59	522
Total	**418**	**2031**

Safeguarding Children training is set at 3 levels and whilst a concerted effort has gone into delivering the training by increasing bespoke sessions in theatres, paediatrics and A&E the reported figures are far lower than expected.

There have been a number of issues with reporting and data capturing on MOLLIE that have increased the safeguarding teams concerns that staff remain profiled incorrectly and data does not pull across into statistics despite the attendance and completion showing as confirmed on an individual's records. This has been escalated for investigation. A remedial plan to review the training profiles is scheduled again to ensure the correct staff are having training at the required levels.

Having said that the table below does evidence a growing compliance of other levels of training by quarter where data was available to us.

Course Name	Q1 2017/18	Q2 2017/18	Q3 2017/18	Q4 2017/18
Safeguarding Children - Level 1		79%	74%	79%
Safeguarding Children - Level 2		60%	63%	77%
Safeguarding Children - Level 3			72%	65%
Safeguarding Adults - Level 1	69%	75%	76%	85%
Safeguarding Adults - Level 2	55%	68%	73%	80%
MCA and DoLS	-	-	-	70%
Prevent - Level 1		73%	72%	82%
Prevent - Level 2		57%	66%	72%

This table below demonstrates the number of courses put on by the safeguarding team for adults. Domestic Abuse / Violence is included briefly in all safeguarding training. However the prevalence in Medway is very high and we plan to review this to improve recognition and reporting next year.

Number of Courses	2016-2017	2017-2018
Domestic Violence Level 2 Training	7	0
Evaluation for Prevent Workshop to Raise Awareness of Prevent (WRAP) - Prevent Level 2	61	39
Learning Disabilities Awareness	14	50
MCA & DoLs	63	38
Safeguarding Adults Level 1	20	8
Safeguarding Adults Level 2	62	49
Total	**227**	**184**

The table below demonstrates the number of staff attending training sessions.

Numbers Attending Course	2016-2017	2017-2018
Domestic Violence Level 2 Training	87	0
Workshop to Raise Awareness of Prevent (WRAP3) - Prevent Level 2	1558	1328
Learning Disabilities Awareness	325	1400
MCA & DoLs	694	1104
Safeguarding Adults Level 1	171	102
Safeguarding Adults Level 2	725	1417
Total	**3560**	**5351**

An e-learning package for WRAP 3 has just been made available to all provider trusts by the Home Office and will soon be available on the Trust L&D eLearning along with a safeguarding adult's level 2 e-Learning.

Safeguarding children training continues to be offered for all levels according to the intercollegiate document. Level 1 is now incorporated within the induction program. Level 2 is now available either face to face or via the on line link. Level 3 is delivered on a face to face basis, either through the trust training program or via MSCB multi-agency training courses.

Bespoke training is delivered on Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM) on a quarterly basis, however this now available on line.

Training around gang activity has been offered and attended by a significant number of staff across the Trust including our security team and staff in both the adult and children's Emergency Departments. This training was well received particularly in the adult emergency department as they have reported there are several knife incidents seen each week. This has therefore raised that awareness when assessing these young people presenting in addition to triggering more professional curiosity.

-End of report-

Report to the Board of Directors

Board Date: Thursday 07 March 2019 Agenda Item: 6.1

Title of Report	Finance Report January 2019
Prepared By	Ian O'Connor, Director of Finance (Interim)
Lead Director	Ian O'Connor, Director of Finance (Interim)
Committees or Groups who have considered this report	Executive Group 20th February 2019 Finance Committee 28th February 2019
Executive Summary	Summary report attached.
Resource Implications	None
Risk and Assurance	The Board Assurance Framework (BAF) compliance and Risk assessments undertaken.
Legal Implications/Regulatory Requirements	The year to date (YTD) adverse to plan by £1.8 million and forecast outturn (FOT) adverse to plan by £5.1 million. Regulators have been informed and are working closely with the Trust on plans to limit any deficit and deliver the best possible position.
Improvement Plan Implication	Additional cost improvements will be required and a continuation of the grip and control processes already in place.
Quality Impact Assessment	Resources are not being starved to front line provision. Confirm and challenge sessions and additional cost improvement opportunities continue to be developed and managed through the established Quality Impact Assessment Framework.
Recommendation	The Board is asked to note the financial position as at 31st January 2019 is adverse to plan by £1.8 million in line with expectations and the revised forecast adverse to plan by £5.2 million excluding Provider Sustainability Fund. The Board is asked to consider any further delegated action it might want to delegate through the finance committee.
Purpose and Actions required by the Board	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

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

1.2 The flash report detailing key performance indicators is attached at Appendix 1 and was circulated on 18th February. It sets out a series of individual metrics designed to show progress over time and assess the risks associated with operational performance and the impact on the Trust's financial position.

2 INCOME AND EXPENDITURE

2.1 To the end of January the Trust is reporting a year to date deficit of £42.2 million (excluding Provider Sustainability Funds (PSF). This is adverse to the planned deficit by £1.8 million as expected and is in line with the expectation that delivers a £52.1 million deficit before PSF by the end of the financial year. January's in month performance is a deficit of £6.0 million adverse to plan by £1.8 million. The flash report detailing key performance indicators is attached at Appendix 1 to this report and was circulated on 18th February.

2.2 The forecast year end position at Month 10 reported to NHSI excluding PSF is a deficit of £52.1 million. This is adverse to plan by £5.2 million. Table 1 shows a summary of the reported position.

2.3 PSF income in January is adverse to plan by £1.5 million due to the Trust not meeting the A&E performance target and the planned deficit. The year to date and forecast year end income for PSF is £5.8 million adverse to plan by £6.9 million due to the A&E performance target and the adverse forecast year end position for the last quarter of the year.

Table 1

	Month 10			Year to Date			Annual		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Clinical Income	19,480	19,188	(292)	206,037	208,543	2,505	246,617	250,449	3,831
Other Income	1,918	2,160	241	19,369	22,414	3,045	23,243	26,838	3,595
Pay	(15,871)	(17,385)	(1,514)	(166,410)	(171,275)	(4,865)	(197,966)	(206,312)	(8,346)
Non -pay	(8,527)	(8,917)	(390)	(87,834)	(90,275)	(2,441)	(104,801)	(108,683)	(3,882)
EBITDA	**(3,000)**	**(4,955)**	**(1,955)**	**(28,838)**	**(30,593)**	**(1,755)**	**(32,907)**	**(37,708)**	**(4,801)**
Non Operating Expenses	(1,235)	(1,055)	180	(11,572)	(11,571)	1	(14,036)	(14,371)	(336)
Surplus/(Deficit) before STF	**(4,234)**	**(6,009)**	**(1,775)**	**(40,410)**	**(42,165)**	**(1,754)**	**(46,943)**	**(52,080)**	**(5,137)**
PSF	1,477	0	(1,477)	9,708	5,760	(3,948)	12,663	5,760	(6,903)
Total Surplus/(Deficit)	**(2,757)**	**(6,009)**	**(3,252)**	**(30,702)**	**(36,405)**	**(5,702)**	**(34,280)**	**(46,320)**	**(12,040)**

3 COST IMPROVEMENT PROGRAMME

3.1 The targeted cost improvement programme overall is reported ahead of plan at the end of January by £0.7 million. This has been offset by number of pressures across divisions, although of most significance in unplanned care.

4 CAPITAL

4.1 The capital plan for 2018/19 was ambitious with expenditure of £31.8 million anticipated. Capital expenditure as at 31st January 2019 is £0.5 million, which represents a £17.7 million year to date underspend against plan. This is mainly due to slippage in long term projects. These are now phased over the 2019/21 planning round.

Table 8

	Current Month			Year To Date			Annual		
	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Actual £'000	Variance £'000	Plan £'000	Forecast £'000	Variance £'000
Backlog Maint-Land,Build,Dwell	572	181	(391)	3,902	1,315	2,587	5,200	1,887	(3,313)
Routine Maint (non-backlog)	55	(76)	(131)	380	75	305	500	178	(322)
Plant/Equip/Trans/Fits/Other	264	130	(134)	1,824	212	1,612	2,400	487	(1,913)
Fire Safety	1,562	274	(1,288)	10,792	1,837	8,955	14,200	4,671	(9,529)
IT	242	(93)	(335)	1,672	3,186	(1,514)	2,804	3,279	475
New Build - Land, Build, Dwell	883	122	(761)	5,645	(60)	5,705	6,581	(89)	(6,670)
Original Plan Total	**3,578**	**538**	**(3,040)**	**24,215**	**6,565**	**17,650**	**31,685**	**10,413**	**(21,272)**
WIFI Enhancements	0	(20)	(20)	127	102	25	127	127	0
Total	**3,578**	**518**	**(3,060)**	**24,342**	**6,667**	**17,675**	**31,812**	**10,540**	**(21,272)**

5 WORKING CAPITAL

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

6 FINANCE AND USE OF RESOURCES METRICS

6.1 The rating at Month 10 is a 3. With the adverse to plan position reported, the Trust has now moved away from a score of 2, to a score of 4 for distance from financial plan. However, the overall use of resources rating remains at 3 due to the excellent agency rating of 1.

Key Metrics	Current Month	Trend
Capital service cover rating	4	
Liquidity rating	4	
I&E margin rating	4	
Distance from financial plan	4	
Agency rating	1	
Overall Use of Resources Rating	3	

7 RECOMMENDATION

7.1 The Board is asked to note the financial position as at 31st January 2019 is adverse to plan by £1.8 million in line with expectations and the revised forecast adverse to plan by £5.2 million excluding PSF. The Board is asked to consider any further delegated action it might want to delegate through the finance committee.

Ian O'Connor
Interim Director of Finance
February 2019

Report to the Board of Directors

NHS Medway NHS Foundation Trust

NHS Medway NHS Foundation Trust

Appendix 1 – Flash Report

I&E Deficit Excluding PSF YTD (£m)

	Oct	Nov	Dec	Jan	RATING
Plan	(30.0)	(33.0)	(36.2)	(40.4)	
Actual	(30.0)	(33.0)	(36.2)	(42.2)	
Variance	0.0	0.0	0.0	(1.8)	

The Trust is reporting a year to date deficit of £42.2m excluding PSF adverse to plan by £1.8m.

Capital Expenditure YTD (£m)

	Oct	Nov	Dec	Jan	RATING
Plan	(15.5)	(18.1)	(21.1)	(24.1)	
Actual	(5.5)	(5.8)	(6.1)	(6.7)	
Variance	10.0	12.3	15.0	17.5	

Capital Expenditure continues below plan due to underspends on ED and Fire projects. These are now phased over the 2019/21 planning round.

CIP Delivery YTD (£m)

	Oct	Nov	Dec	Jan	RATING
Plan	8.1	10.6	13.1	15.7	
Actual	10.5	11.9	14.1	16.4	
Variance	2.4	1.4	1.0	0.7	

YTD CIP is £0.7m favourable to plan.

Cash Actual £m

	Oct	Nov	Dec	Jan	RATING
Plan	6.0	6.0	6.0	6.0	
Actual	4.4	8.6	13.7	7.5	
Variance	(1.6)	2.6	7.7	1.5	

The Trust plans to retain approx £6m each month in order to manage weekly payroll and supplier payments until contract invoices and loan monies are received around the 15th of each month.

Normalised Monthly Pay

	Oct	Nov	Dec	Jan	RATING
Plan	(16.5)	(15.5)	(15.9)	(15.9)	
Actual	(17.2)	(17.0)	(17.1)	(17.4)	
Variance	(0.8)	(1.2)	(0.4)	(1.4)	

Pay expenditure in month is £17.4m increased due to winter pressures premium costs

Normalised Monthly Agency Expenditure (£m)

	Oct	Nov	Dec	Jan	RATING
Plan	0.0	0.0	0.0	0.0	
Actual	(0.9)	(0.8)	(0.9)	(1.1)	
Variance	(0.9)	(0.3)	(0.7)	(1.1)	

An increase due to winter presssures.

Better Payment Practice Code (BPPC by Volume (%)

	Oct	Nov	Dec	Jan	RATING
Plan	95.0	95.0	95.0	95.0	
Actual	44.00	44.00	45.00	43.00	
Variance	(51.0)	(51.0)	(50.0)	(52.0)	

BPPC percentages are low mainly due slow invoice approval and a backlog of aged creditors- as these invoices are paid they bring the %'s down. Currently all approved invoices are paid as soon as they become due, aged creditors are paid immediately when approval is given.

All Aged Creditors 60+ Days (£m)

	Oct	Nov	Dec	Jan	RATING
Actual	7.2	7.3	6.9	3.5	

Aged Creditors have improved due to approval of invoices for NHS Supply Chain,which would normally be paid within terms.

All Aged Debtors 60+ Days (£m)

	Oct	Nov	Dec	Jan	RATING
Actual	21.0	25.9	21.4	19.4	

Aged Debtors have reduced due to payments from Dartford NHS Trust for some long standing debts. This is expected to improve further in the coming months as CCG debts are settled.

Key:

	Adverse to Plan
	Favourable to Plan

Going in the right direction

Going in the wrong direction

Glossary of Terms:

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

Thursday, 07 March 2019

Assurance Report from Committees

Title of Committee:	Finance Committee	**Agenda Item**	**6.2**
Committee Chair:	Tony Moore, Non-Executive Director		
Date of Meeting:	08 January and 12 February 2019		
Lead Director:	Ian O'Connor, Director of Finance (Interim)		
Report Author:	Ian O'Connor, Director of Finance (Interim)		

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**
Not assured	Red - there are significant gaps in assurance and we are not assured as to the adequacy of current action plans
Partially assured	Amber - there are gaps in assurance but we are assured appropriate action plans are in place to address these
Assured	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. Finance Month 8 Report The Committee discussed the month 8 figures (Month 10 is on the Board agenda).	**Green**
2. Cost Improvement Programme (CIP) The Committee received assurance of the Month 8 CIP position (Month 10 position is on the Board agenda). The transformation and finance teams are working closely, and the ability to deliver on CIPs has improved. Known cost pressures are fully funded via an agreed means.	**Green**
3. Change to Forecast The Committee discussed the need for the forecast to be revised. The range is between £49.6m and £54.8m deficit with a most likely outturn of £52.1m (excluding circa £4m outstanding CCG debt). This would be £5.1m adverse to	**Amber**

control total before Provider Sustainability Fund (PSF) income. Any change to the forecast delivery of that control total needs to be formally notified to NHS Improvement, following the published protocol. The forecast outturn represents a positive step change in the underlying financial position of the Trust, which was £66.4m deficit in 2017/18.	
4. Joint Planning Guidance Draft plans were required for submission by 12 February 2019.	**Green**
5. Governance changes to North Kent Pathology Service The Committee discussed a paper which sets out proposed changes to the governance arrangements of the contractual joint venture between Medway Foundation Trust (MFT) and Dartford and Gravesham NHS Trust. The key change is moving from a single Consortium Management Board to an Assurance Board and an Operational Board. The Committee was assured that due to the increased oversight, there had been no recent issues.	**Green**
6. Business Planning Numbers have been agreed with the Clinical Commissioning Group (CCG) and the expectation is that activity would likely increase by more than 1%. The Committee received assurance that the numbers are realistic.	**Green**
7. Draft Financial Plan 2019/20 The Committee was assured that good progress has been made this year, which puts the Trust in a really good position for the next financial year. The plan would be submitted to NHS Improvement and would be reviewed in more detail at the 21 March Committee meeting.	**Green**

Decisions made

1) The Committee approved the recommendation to present a revised forecast of £52.1m to the Trust Board for approval. This £52.1m ignores a £4m debt from the CCG which could have an adverse effect on the control total.
2) The Committee, having satisfied itself that due process has been followed and that the necessary remedial action has to be taken, recommended to the Trust Board for approval, the formal change to the forecast outturn position from £47m to £52.1m, recognising a £4m outstanding debt from the CCG, which could increase the control total to circa £56.1m.
3) The Committee approved the new governance arrangement for the North Kent Pathology Service.
4) The Committee endorsed the submission of the 2019/20 draft financial plan indicating adherence to the proposed control total.

Further Risks Identified

£4m outstanding debt from the CCG (this has been resolved).

Escalations to the Board or other Committee

1) Revised forecast of £52.1m to the Trust Board for approval.
2) Draft Plan for discussion at the Board development session in February.

Report to the Board of Directors

Board Date: Thursday, 07 March 2019 Agenda Item: 6.3

Title of Report	Communications and Engagement report
Prepared By	Glynis Alexander, Director of Communications and Engagement
Lead Director	Glynis Alexander, Director of Communications and Engagement
Committees or Groups who have considered this report	Not Applicable
Executive Summary	We are using all our communications channels to promote the transformation of services taking place under our Better, Best, Brilliant banner. This is linked to messages about the efficiency of the Trust and working to ensure future sustainability. Improving the culture within the hospital is key to our success, and we continue to promote our You Are The Difference programme, which has been well received by staff. Externally we are engaging with stakeholders, patients and public to ensure they are aware of all that is happening to improve the hospital and can have an input into the development of services.
Resource Implications	Not Applicable
Risk and Assurance	Not Applicable
Legal Implications/Regulatory Requirements	Not Applicable
Improvement Plan Implication	Communications and engagement activity is aligned with the Better, Best, Brilliant transformation plan.
Quality Impact Assessment	Not Applicable
Recommendation	The Board is asked to note the report.
Purpose and Actions required by the Board	**Approval** ☐ **Assurance** ☐ **Discussion** ☐ **Noting** ☒

Report to the Board of Directors

1 EXECUTIVE OVERVIEW

1.1 We are using all our communications channels to promote the transformation of services taking place under our Better, Best, Brilliant banner.

1.2 This is linked to messages about the efficiency of the Trust and working to ensure future sustainability.

1.3 Improving the culture within the hospital is key to our success, and we continue to promote our You Are The Difference programme, which has been well received by staff.

1.4 Externally we are engaging with stakeholders, patients and public to ensure they are aware of all that is happening to improve the hospital and can have an input into the development of services.

2 ENGAGING COLLEAGUES

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

2.2 Part of this is the 'I'm making Medway brilliant' poster campaign, which features examples of how staff have led improvement projects.

2.3 We have recently briefed staff about the Trust's financial position and communicated work taking place to improve patient care and achieve financial sustainability as part of Better, Best, Brilliant.

2.4 The monthly team briefings with James Devine have continued with very good attendance and engagement from staff. Discussion topics have included parking and the Trust's financial plan.

2.5 'Back to the floor sessions' (also known as Gemba) have been held to help the Executive Team understand what it's like to walk in our staff members' shoes, observing, listening and seeing how they can support staff in their efforts to provide brilliant care for our patients.

2.6 A very successful senior manager session was held which included a workshop to discuss what the Trust needs to do in order to attain a rating of 'good' from the CQC.

2.7 Communications to promote awareness of the 'You are the Difference' culture programme have continued. A video was produced in collaboration with the Transformation Team to highlight the programme and benefits to staff.

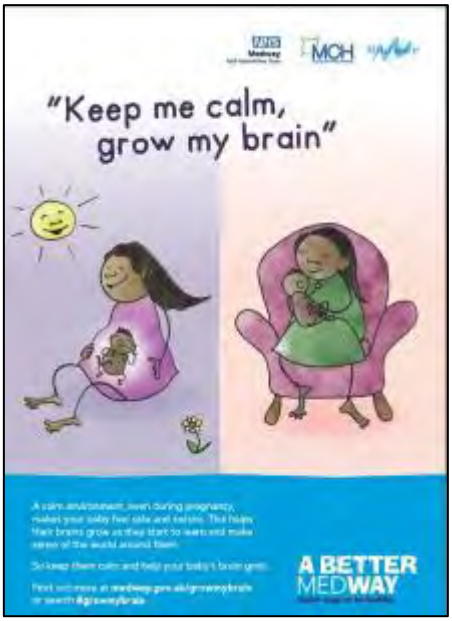
2.8 We have continued to support the flu vaccination campaign, encouraging staff to have their jab to help protect patients.

2.9 We have worked with teams to promote the eDRMS project which will enable clinicians to see more patient information electronically and reduce paperwork. Attendance from clinicians at the drop-in sessions has been good.

3 MEDIA

3.1 Since the beginning of January the communications team has dealt with 24 enquiries from local, regional and national media.

3.2 During a particularly challenging few weeks at the Trust, there were several negative stories in the local press about patients' experiences at the hospital. Following this coverage, a reporter from the paper accepted our invitation to interview the chief executive and speak to staff about recent improvements to support patient flow. This led to a double page interview with James Devine, covering the Trust's overall improvement in recent years, and some thoughtful coverage about the challenges of a busy hospital.



3.3 Other positive stories have included news about our midwives' shortlisting for Midwifery Service of the year, excellent results in the CQC Maternity Survey 2018 and the donation of a state-of-the-art scanner to our breast screening unit.

3.4 ITV Meridian spent the morning covering the launch of Grow my Brain, a collaboration between the Trust, Medway Council and Medway Community Healthcare. The campaign was the brainchild of two midwives at the Trust and was featured on TV and in the local press.

3.5 The Medway Messenger has also covered news about the provision of dermatology services, and the outcome of the stroke review which will see hyper acute stroke units in Dartford, Maidstone and Ashford.

Report to the Board of Directors

4 SOCIAL MEDIA

4.1 This winter, for the first time, we have used targeted Facebook advertising to promote messages about keeping well in winter and where to go for treatment, including the appropriate use of our Emergency Department.

4.2 Since the last update Medway has continued to grow its following across all social media channels and has retained its position as Kent's most-followed acute Trust on both Twitter and Instagram.

4.3 A range of key messages were shared widely across social media in this period – particularly our frailty unit knitting appeal – which resulted in a significantly increased number of people viewing our posts throughout January and February (286,931 on Facebook and 67,100 on Twitter, up from a total of approximately 100,000 as reported in the last update).

4.4 Medway's social media account followers now total 4,560 on Twitter (up from 4,435 at the last update), 6,677 on Facebook (up from 6,220) and 1,262 on Instagram (up from 1,151).

4.5 Elsewhere, our social media channels also raised awareness of two major award nominations for the Trust (Midwifery Unit – Royal College of Midwives 'Service of the Year' and Dr Manisha Shah/ Simulation Team for their Medical Training Initiative for Overseas Physicians – BMJ Awards); positive responses to the Care Quality Commission's 2018 Maternity Survey; the continuation of the Trust's 'You are the Difference' culture programme; the launch of our Charity and Fundraising Team's Easter knitting campaign; our regular members' and Governor events; and other more appropriate treatment options, such as NHS 111 and pharmacies, for those considering visiting our Emergency Department.

5 COMMUNITY ENGAGEMENT

5.1 Governors

5.1.1 Since the last board meeting our governors have engaged with Medway residents at Hoo Leisure Centre.

5.1.2 This was a very successful morning recruiting to our membership.

5.1.3 Our governors heard a number of historical negative experiences highlighting the need to do further outreach work in this area to explain how we have improved services.

Report to the Board of Directors

5.2 Members

5.2.1 We invited our membership to give feedback on our member events and how we can make these sessions as useful as possible.

5.2.2 Feedback suggested we need to do more to let people know more about the subject matter of the presentations, to encourage their interest.

5.2.3 The timing of events, parking and insufficient notice prevented some people from attending.

5.2.4 In response we have already increased the promotion of events, for example distributing flyers through GP surgeries.

5.2.5 The most recent member event in early February attracted more than twice the usual number of people.

5.2.6 To encourage participation we will also hold events in the community and vary the start times.

5.3 Reaching out to less engaged audiences

5.3.1 We have been invited by Medway Pensioners Forum to present to their members.

5.3.2 In collaboration with Macmillan and supported by our Community Engagement Officer, the Trust held it first Cancer Information and Wellbeing session.

5.3.3 These sessions were well received by people who have just been diagnosed with cancer.

5.3.4 The Trust will be delivering further sessions at different locations in Medway and Swale.

5.4 Other engagement

5.4.1 As part of the transformation of outpatients services, we will be holding a focus group with Rheumatology patients on 6 March 2019. We will be seeking their input into the redesign of this service.

5.4.2 We have actively increased our outreach to Swale through local community networks.

5.4.3 We are exploring a collaborative approach to community engagement with the Kent and Medway Fire and Rescue Service.

Report to the Board of Directors

Board Date: Thursday, 07 March 2019 Agenda item: 7.1

Title of Report	Workforce Report
Prepared By	Elizabeth Nyawade, Deputy Director of HR and OD
Lead Director	Leon Hinton, Executive Director of HR and OD
Committees or Groups who have considered this report	Senior HR Team
Executive Summary	This workforce report to the Trust Board focusses on the core workforce risks, and looks to provide assurance that robust plans are in place to mitigate and remedy these risks. In addition, the report provides an update on the broader workforce agenda across the Trust. The Trust's recruitment campaigns, including national, local and international have delivered 290 candidates to date – 14 candidates supplied to us by Cpl Healthcare and 80 candidates provided by HCL. Trust turnover has increased at 12.90% (+0.60%) from 12.30%, sickness absence at 4.24% (-0.02% from 4.26%) is above the Trust's tolerance level of 4%, and appraisal compliance has increased to 82.8% (+0.1% from 82.7%) and is below Trust target of 85%. Statutory and Mandatory training is at 80.13% (+3.36 % from 76.77%) and is below Trust target of 85%. The percentage of pay bill spent on substantive staff in January at (81%) decreased (-6% from 87%) compared to the month of December. The percentage of agency usage at 6% (+2% from 4%) is up compared to the month of December. The percentage of pay bill spent on bank staff at 13% in January has increased (+4%) compared to December.
Resource Implications	None
Risk and Assurance	• Nurse Recruitment • Temporary Staffing Spend The following activities are in place to mitigate this through: 1. Targeted campaign to attract local and national nurses; 2. Update on overseas campaign; 3. Ensuring a robust temporary staffing service; 4. Review of temporary staffing usage, particularly agency usage, currently in use at Medway Foundation Trust (MFT); 5. Agency/Temporary Staffing Work stream as part of the 2018/19 cost improvement programme.
Legal Implications/ Regulatory Requirements	Staffing levels and use of temporary/agency workers have been identified as areas that need improvement by the Trust and our regulators.

Report to the Board of Directors

Improvement Plan Implication	Workforce is a priority programme as part of the Recovery plan and is a key enabler for organisational delivery as part of the plan. Supports Better, Best, Brilliant programme 8 (building a sustainable workforce).			
Quality Impact Assessment	Not applicable			
Recommendation	Not applicable			
Purpose and Actions required by the Board	**Approval** ☐	**Assurance** ☒	**Discussion** ☐	**Noting** ☒

Report to the Board of Directors

1 INTRODUCTION

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

2 RECRUITMENT

2.1 The Trust continues to build a recruitment pipeline in order to deliver the recruitment trajectory in the workforce plan. During January 2019, 23 full time equivalent (FTE) registered nurses and midwives joined the Trust on a substantive basis, alongside 2 FTE substantive clinical support worker.

2.2 A total of 75 international nurses have undertaken the Objective Structured Clinical Examination (OSCE) since April 2018; 74 out of the 75 nurses have passed. Eight international nurses successfully undertook the OSCE exam in January 2019 and are now working in their allocated ward areas. Sixteen international nurses who joined the Trust in January 2019 are on the OSCE training programme and will be taking the exam in the month of April 2019.

2.3 Further to the collaborative regional procurement approach to international nurse recruitment the Trust selected two partner providers: Cpl Healthcare (Cpl) and HCL. Four Cpl international nurses have commenced in post, with 13 in the pipeline. Thirty one HCL nurses have also commenced in post, with a further 80 candidates with offers being processed.

2.4 The Trust is also working with 8 additional permanent recruitment agency providers: We Solutions, Ascend, Cromwell Medical Recruitment, Medline, Kate Cowhig, HealthPerm, Xander Hendrix and International English Language Testing System (IELTS) Medical. The agency partners are working with the Trust on developing a pipeline of nurses for the calendar year 2019.

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

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

Agency Provider	Commenced	Pipeline	Agency total	Anticipated new starters over the next 12 months from pipeline	
Harvey Nash	6	1	80	(100%)	1
Cpl Healthcare	5	14	19	(52%)	10
HCL	38	80	118	(50%)	40
Person Anderson	28	0	28	(100%)	0
Cromwell Medical Recruitment	23	68	91	(55%)	50
MSI Group	3	5	8	(0%)	0
Xander Hendrix	4	13	17	(61%)	8
We Solutions	8	56	64	(66%)	40
Blue Thistle	0	8	8	(0%)	0
Medline	0	38	42	(53%)	20
HealthPerm	0	7	7	(71%)	5
IELTS Medical	0	0	0	(0%)	0
EPSN	1	0	1	(-%)	0
Total	87	444	531		174

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

2.6 To increase reach the Trust commissioned the services of Medical Careers Global, a careers advertising platform for 12 months on a fixed fee. All clinical posts are advertised on this platform with a view to attracting more applicants. A total of 59,601 individuals have recently reviewed MFT vacancies and 23 applications have been received. The applications received through this platform from candidates who are yet to undertake the required IELTS/ OET (Occupational English Test) examinations will be stored to create a local talent pool.

Table 2 below summarises offers made, starters and leavers for January 2019.

Role	Offers made in month	Actual starters	Actual leavers
Registered nurses & midwives	55 (36 NHS Jobs/open days & 22 international nurses via skype)	23	12
Clinical support workers	21	2	10

(Table 2: Nursing starters and leavers January 2019)

2.7 During January 14 medical staff joined the Trust; these included 11 junior doctors in training and 3 consultant radiologists.

3 DIRECTORATE METRICS

3.1 The table below (table 3) shows performance across five core indicators by the directorate. Turnover, at 12.90% (+0.60% from 12.30%), remains above the tolerance level of 8%. HR Business Partners will work with all existing information sources (exit interview data and

face to face interviews), system-wide knowledge (let's work together commissioned by Health Education England) and staff survey results to implement service specific retention plans. Sickness absence at 4.24% (-0.02% from December) is above the tolerance level of 4%. Employee Relations are proactively carrying out analysis to support managers to manage sickness and reviewing trends for interventional support.

3.2 The Trust appraisal rate stands at 82.8% (+0.1% from 82.7%) and is below the Trust target of 85%, one directorate (Corporate) is meeting the appraisal target. A revised appraisal system was implemented across the Trust from 1 April 2018 which builds on what works in the current mechanism and adds value to the process for both the appraisee and corporate intelligence. Two new ratings have been included – performance and values/behaviour (scores 1-5) to identify and promote talent in the organisation in addition to leadership metrics. Statutory and Mandatory training stands at 80.13% (+3.36% from 76.77%) and is below Trust target of 85%.

		Trust			Corporate			Estates & Facilities			Planned Care			Unplanned & Integrated Care		
	Trust Target	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend	Rate	1-month trend	12-month trend
Turnover rate (Voluntary, 12-month rolling)	8.0%	12.9%	▲		15.5%	▲		5.7%	▲		12.3%	▲		14.8%	▲	
Vacancy rate	12.0%	18.0%	▼		14.5%	▼		16.0%	▼		17.0%	▼		18.8%	▲	
Sickness rate (12-month rolling)	4.0%	4.2%	▼		2.7%	▼		6.4%	▲		4.4%	▼		3.9%	▼	
Statutory & Mandatory Training	85.0%	80.1%	▲		89.5%	▲		74.7%	▲		81.1%	▼		78.6%	▼	
Medway Appraisal	85.0%	82.8%	▲		86.7%	▼		81.7%	▼		84.2%	▲		80.7%	▼	
Agency costs (as % of total paybill)		3.8%	▼		3.1%	▼		1.6%	▼		3.6%	▼		4.5%	▼	
Bank costs (as % of total paybill)		11.1%	▼		0.7%	▼		8.4%	▼		8.5%	▼		16.6%	▼	
Substantive costs (as % of total paybill)		85.1%	▲		96.3%	▲		90.1%	▲		88.0%	▲		78.9%	▲	

(Table 3: Key workforce metrics)

3.3 The Trust migrated from a bespoke learning management system (MOLLIE) to the national NHS learning management system myESR (Electronic Staff Record) system in quarter 2, 2018/19. The migration provided the opportunity to move from broad training needs analysis to position-based training needs, allowing for greater granularity when determining needs. The review enabled the Trust's subject matter experts (SME) to re-examine our alignment to the Core Skills Training Framework (CSTF) for position requirements. This review and subsequent implementation resulted in a decrease to the overall StatMan compliance with the addition of reporting conflict resolution and mental capacity act (deprivation of liberty safeguards) alongside some changes to position-based requirements. Manual data migrations were required for 6,200 records.

3.4 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. The Trust's StatMan target across areas is 85% and is being met for conflict resolution; equality and diversity; health and safety, infection prevention and control, safeguarding children (level 1), safeguarding adults and prevent. However, the minimum is not met for moving and handling; resuscitation; safeguarding children (level 2, 3) and fire training.

3.5 The table below shows the compliance with StatMan on a directorate and programme basis:

Directorate >> Programme	Compliance %
Corporate	90.97%
>> Communications	97.37%
>> Governance & Legal	93.85%
>> Finance	86.86%
>> Human Resources & Organisational Development	97.42%
>> IT	90.47%
>> Medical Directorate	90.21%
>> Nursing Directorate	87.40%
>> Strategy & Planning	98.34%
>> Transformation	89.09%
Estates & Facilities	82.49%
>> Estates & Facilities Management	82.83%
>> Hard Facilities Management	91.23%
>> Soft Facilities Management	81.18%
Planned Care	81.40%
>> Perioperative & Critical Care	84.05%
>> Planned Care Management	78.72%
>> Surgical Services	74.74%
>> Women's & Children's Health	83.04%
Unplanned & Integrated Care	78.88%
>> Acute Medicine	74.58%
>> Cancer, Diagnostics & Clinical Support Services	82.12%
>> Specialist Medicine	82.08%
>> Unplanned Care & Integrated Care Management	82.25%

4 TEMPORARY STAFFING

Table 4 below demonstrates that temporary staffing expenditure increased in January 2019 compared to December 2018.

Report to the Board of Directors

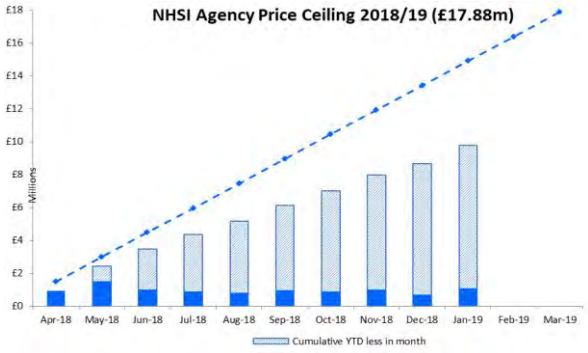
		Mar-17	Mar 18	Apr 18	Aug 18	Sep 18	Oct 18	Nov 18	**Dec 18**	**Jan 19**
Spend	Agency	3,890,198	2,597,697	943,419	799,288	968,606	881,163	988,934	689,179	1,095,639
	Bank	920,473	2,329,768	2,307,191	1,441,538	2,231,622	2,145,475	2,068,000	1,544,845	2,227,879
	Substantive	13,611,458	13,542,990	13,904,703	14,916,485	13,681,072	14,213,731	14,283,166	14,092,671	14,061,431
% Pay bill	Agency	21%	14%	5.5%	5%	6%	5%	6%	4%	6%
	Bank	5%	12%	13.5%	8%	13%	12%	12%	9%	13%
	Substantive	74%	74%	81%	87%	81%	82%	82%	87%	81%

(Table 4: Workforce profile based on contractual arrangement)

4.1 The agency cap breaches across all staff groups continues to decrease as illustrated in chart 1 below. During the month of January 2019 the Trust reported an average of 9 breaches per week.

(Chart 1: NHSI cap breaches)

4.2 The Trust's NHSi annual agency spend celing has decreased from £21.6m in 2017/18 to £17.88m (corrected ceiling based on Model hospital figures) in 2018/19. Based on cumulative agency spend YTD, the Trust is £5.1m below the NHSi agency ceiling cap target as illustrated in the chart and table below.



(Chart 2: NHSI agency ceiling)

Table 5 below shows NHSI agency ceiling performance

Column1	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-18
Cumulative NHSI ceiling target	£5,960,000	£7,450,000	£8,940,000	£10,430,000	£11,920,000	£13,410,000	£14,900,000
Agency in month actual spend	£895,452	£799,288	£986,606	£881,163	£988,934	£689,179	£1,095,639
Cumulative below ceiling	£1,620,833	£2,311,544	£2,832,938	£3,441,775	£3,942,842	£5,662,914	£9,761,977

(Table 5: NHSI agency ceiling performance)

4.3 Temporary nursing demand in January 2019 increased compared to December 2018 (7,945 shift requests in December 2018 compared to 8,570 shift requests in January 2019). The fill rate reduced to 72% (-5%). Medical locum demand increased in January 2019 compared December 2018 (1,634 shift requests in December 2018 compared to 1,837 shift requests in January 2019). The fill rate decreased to 81%.

5 REPORTING HEALTHCARE WORKER FLU VACCINATION INFORMATION

5.1 NHS Foundation Trusts and NHS Trusts are required to publicly report information on frontline healthcare worker flu vaccination via public board meetings on the four areas listed below:

1. Total flu vaccination uptake and opt-out numbers and rates;
2. A list of areas designated higher-risk and the uptake and opt-out rates for each;
3. Details of actions taken to deliver the 100% uptake ambition;
4. A breakdown of the reasons that staff have given for opting-out.

5.2 Total flu vaccination uptake and opt-out numbers and rates: as at 21 February 2019, there has been an uptake amongst frontline workers of 73.5%. A total of 97 frontline workers have chosen to opt-out of vaccination following being made aware of the benefits, making the opt-out rate 3.5% of frontline workers.

5.3 Areas designated higher-risk and the uptake and opt-out rates for each: the table below shows the areas designated higher-risk and the uptake and opt-out rates for each.

	Vaccinated	Opt-Out	No Response	Uptake%
NICU Nursing	65	7	25	67%
Lawrence Ward	19	3	1	83%
Neonatal Medical Staff	12	0	4	75%
NICU Administration	5	0	1	83%
Galton Day Unit	19	1	2	86%
Haematology Staff	8	1	2	73%

Report to the Board of Directors

5.4 Details of actions taken to deliver the 100% uptake ambition: the Trust set out to achieve 100% uptake and below are some of the supportive actions that were put in place:

- A board level champion for flu campaign was appointed;
- Board level members and senior managers received flu vaccination and this was publicised;
- Wide publication of drop in clinics and mobile vaccination schedule electronically, on social media and on posters;
- Peer vaccinators, one in each clinical area was identified, trained and released to vaccinate;
- Publishing weekly feedback on percentage uptake for directorates, teams and professional groups and celebrating progress and success.

5.5 A breakdown of the reasons that staff have given for opting-out: the table below shows a breakdown of the reasons given by staff for opting-out.

Reasons provided for opting-out	Number of Staff
I don't like needles	6
I don't think I will get flu	11
I don't believe the evidence that being vaccinated is beneficial	21
I am concerned about possible side effects	18
I don't know how or where to get vaccinated	0
It was too inconvenient to get to a place where I could get vaccinated	0
The times when the vaccination is available are not convenient	0
Other reasons – examples below:	
• Allergy to eggs / allergies	0
• Chemotherapy	0
• Unwell / bad reaction previously (including medical advice to abstain)	0
• Link to autism	0
• Personal Choice / Reasons	0
• Opts for homeopathic remedies instead	0
• Doesn't want to be vaccinated	0
• No guarantee it covers this years' strains	0
• Previously caused migraine	0
• Not specified	41

5.6 Next Steps: the Executive Director of Nursing who is also the board level champion for flu campaign will send the above information to NHSI and NHS England in line with the letter received by the Trust on 14 February 2019. Meanwhile, the flu vaccination campaign continues with a plan to reach 75% uptake amongst frontline workers by end of the month of February.

- End

Report to the Board of Directors

Board Date: Thursday, 07 March 2019 Agenda item: 7.2

Title of Report	Equality Delivery System (EDS2)
Prepared By	Alister McClure, Head of Equality and Inclusion
Lead Director	Leon Hinton, Director of HR and OD
Committees or Groups who have considered this report	Executive Team Senior HR Team
Executive Summary	EDS2 is a generic tool designed for both NHS commissioners and NHS providers. At the heart of EDS2 are 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four Goals: Better health outcomes; Improved patient access and experience; A representative and supported workforce; and Inclusive leadership. There are four possible grades for each outcome and goal. These are: **Undeveloped**; **Developing**; **Achieving**; **Excelling**. The Trust undertook its first assessment against the EDS2 in September 2017, and set objectives against the EDS2 Goals. These objectives were incorporated into the Trust's Equality Strategy in July 2018, along with the implementation plans for the Workforce Race Standard and Gender Pay Gap. A subsequent review, in January 2019, shows that performance against the EDS2 grades has improved with 13 of the EDS2 outcomes being assessed at Developing, and 5 at Achieving. None are now at Undeveloped. The report also sets out the results of self-assessments and external assessment surveys. The Trust is required to publish its EDS2 review on its website. The report recommends that the Equality and Inclusion Steering Group oversee the development of an action plan to take the Trust to achieving in 2020.
Resource Implications	None identified at this stage
Risk and Assurance	Reputation and Contract Compliance. Publication of the EDS2 assessment will remove the risk of non-compliance.
Legal Implications/Regulatory Requirements	EDS2 is part of our contractual obligations under the NHS Standard Contract.
Improvement Plan Implication	EDS2 is a key component of delivering equitable outcomes and experience for patients and staff.

Report to the Board of Directors

Quality Impact Assessment	Not applicable			
Recommendation	To approve the publication of the EDS2 assessment and task the Equality and Inclusion Steering Group to oversee an action plan to take the Trust to 'Achieving' in 2020.			
Purpose and Actions required by the Board	**Approval**	**Assurance**	**Discussion**	**Noting**
	☒	☐	☐	☐

Report to the Board of Directors

1 EXECUTIVE SUMMARY

1.1 EDS2 is a generic tool designed for both NHS commissioners and NHS providers. As different NHS organisations apply EDS2 outcomes to their performance, they should do so with regard to their specific roles and responsibilities.

1.2 At the heart of EDS2 are 18 outcomes, against which NHS organisations assess and grade themselves. They are grouped under four Goals:

- Goal 1 Better health outcomes;
- Goal 2 Improved patient access and experience;
- Goal 3 A representative and supported workforce;
- Goal 4 Inclusive leadership.

1.3 Among other things they support the themes of, and deliver on, the NHS Outcomes Framework, the NHS Constitution, and the Care Quality Commission's key inspection questions.

1.4 There are four possible grades for each outcome and goal. These are:

- **Undeveloped** if either, there is no evidence one way or another for any protected group of how people fare, *or* if evidence shows that the majority of people in only two or fewer protected groups fare well;
- **Developing** if evidence shows that the majority of people in three to five protected groups fare well;
- **Achieving** if evidence shows that the majority of people in six to eight protected groups fare well;
- **Excelling** if evidence shows that the majority of people in all nine protected groups fare well.

1.5 The Trust undertook its first assessment against the EDS2 in September 2017, and set objectives against the EDS2 Goals. These objectives were incorporated into the Trust's Equality Strategy in July 2018, along with the implementation plans for the Workforce Race Standard and Gender Pay Gap.

1.6 A subsequent review, in January 2019, shows that performance against the EDS2 Grades has improved as follows:

EDS2 Grade across all four Goals	2017	2018	Direction of Travel
Undeveloped	6	0	Improvement
Developing	12	13	Improvement
Achieving	0	5	Improvement
Excelling	0	0	No change

2 METHODOLOGY

2.1 This assessment of the Trust's progress on EDS2 builds on the initial assessment conducted in 2017, which included information from stakeholders, such as commissioners, partner organisations and Healthwatch. For the assessments conducted both in 2017 and at the end of 2018, a survey was sent to commissioners and partners, and in January 2019, an internal self-assessment survey was sent to clinical managers across the Trust.

2.2 In both 2017 and 2018, the Head of Equality and Inclusion has examined a range information and data sources, including:

- Inpatient surveys, end equivalent surveys such as the national cancer patient experience survey (NCPES);
- Patient experience feedback;
- Staff Survey;
- Workforce data, including demographics, recruitment, training and progression;
- Trust policies and standard operating procedures;
- Initiatives, such as the Dandelion scheme (for patients in end of life care), the Butterfly scheme (for patients with dementia), access to interpretation and translation services, access to chaplaincy, counselling and support, for both staff and patients, and apprenticeships;
- Formal reports, such as the Trust Improvement Plan and Quality Assurance Reports;
- Contextual evidence, such as external awards (e.g. the UNICEF 'Baby-friendly Initiative), Trust-wide and external communications, such as weekly bulletins, 'theme of the week' and social media.
- The Trust's plans to address issues identified in formal reports such as the Gender Pay Gap Report, Workforce Race Equality Standard.

2.3 Having assembled evidence, the evidence was matched wherever possible to the 18 EDS2 objectives, and examined for relevance to the protected characteristics of the Equality Act 2010. The grading system from the EDS2 guidance has been applied, as set out in section 1.4 above.

2.4 In addition the survey of our commissioners/partners in 2018 and the internal survey in 2019 asked what the Trust did well and needed to improve in relation to equality and inclusion.

Report to the Board of Directors

3 KEY FINDINGS

3.1 The key findings of the assessment are set out in the EDS2 Summary Report (appendix 2), appended to this report. In all cases it was possible to identify at least three protected characteristics that fare well, meaning that all EDS2 objectives were identified as at least 'developing'; and five of the outcomes are now judged as achieving. This compares to the assessment in 2017, where only 12 of the 18 EDS2 outcomes met the criteria for being judged 'developing'. In other words, there was evidence of good or developing practice that was delivering either equitable (or near equitable) outcomes, and/or was actively and intentionally addressing inequalities.

3.2 The EDS2 scoring measures whether there is evidence of equitable outcomes for each protected characteristic, but not necessarily the quality of the outcome.

3.3 All four of the EDS2 Goals have sufficient evidence to be scored as developing. Performance against the EDS2 grades has improved as follows:

EDS2 Grade across all four Goals	2017	2018	Direction of Travel
Undeveloped	6	0	Improvement
Developing	12	13	Improvement
Achieving	0	5	Improvement
Excelling	0	0	No change

EDS2 Improvements for each goal	2017	2018	Direction of Travel
Goal 1 Better health outcomes	4x developing 1x undeveloped	5x developing	Improvement
Goal 2 Improved patient access and experience	3x developing 1x undeveloped	4x developing	Improvement
Goal 3 A representative and supported workforce	3x developing 3x undeveloped	4x achieving 2x developing	Improvement
Goal 4 Inclusive leadership	2x developing 1x undeveloped	1x achieving 2x developing	Improvement

3.4 The key learning from the survey with commissioners (only one was returned in 2018) was generally positive, with the responses to most questions about health outcomes and patient experience being graded as mainly or fully met. In terms of protected characteristics, the feedback was the Trust performs well on pregnancy and paternity, and adequately on age, disability and marriage and relationships. [The other protected characteristics were not graded]. The Trust was commended for its 'Meet Your Governors' events, and recommended to do more outreach into the community. Areas identified for further work were improving the transitions from one service to another, and keeping patients informed about their treatment.

3.5 The key learning from the self-assessment surveys broadly mirrored the feedback from the commissioners' survey in relation to health outcomes and patient experience. In terms of protected characteristics, at least two thirds of respondents considered that the Trust performs well or adequately on all nine protected characteristics, none considered that the Trust performs poorly. A third of respondents could not say how the Trust performs in relation to the protected characteristics. Respondents were asked to identify what the Trust does well and could do better in relation to equality and inclusion. The results were.

Does Well	Could be improved
1) Training 2) Follows guidelines to deliver equity and fairness 3) Supports patients through complex pathways	1) Information made accessible and in different languages 2) Greater awareness of cultural backgrounds, in order to tailor healthcare better 3) Empowering staff, patients and relatives to be part of the patient journey

3.6 One of the key challenges of the Trust is that the use of patient demographic data to inform service design and delivery has been very limited, and more work is needed to ensure consistent use of patient demographic data to inform equality analysis.

4 CONCLUSION

4.1 Taking together the EDS2 review (set out in the appendix) and the feedback from the surveys, the Trust has improved its performance since September 2017, but remains at 'Developing'. The greatest improvements have been seen in Goal 3 (a representative and supported workforce), where some practice has moved from 'Undeveloped' to 'Achieving'.

4.2 The report illustrates that further work is needed to elevate the assessment from 'Developing' to 'Achieving'. This includes:

- Improving the use of demographic data to improve patient experience and outcomes
- Following through on Trust guidelines and policies designed to improve equality and inclusion outcomes (for example, ensuring that equality analysis informs all relevant decisions)
- Improving the confidence of staff in relation to patient and community diversity
- Continue and accelerate work to understand and address concerns raised through feedback (e.g. patient experience/complaints and staff survey)

5 PUBLICATION

5.1 Subject to approval by the Trust Board at its meeting on 7th March 2019, the EDS2 Report, including the attached assessment, will be published on the Trust website before 31 March 2019.

5.2 It is recommended that the report be referred to the Equality and Inclusion Steering Group to develop an action plan to take the Trust from Developing to Achieving, and beyond, in 2020.

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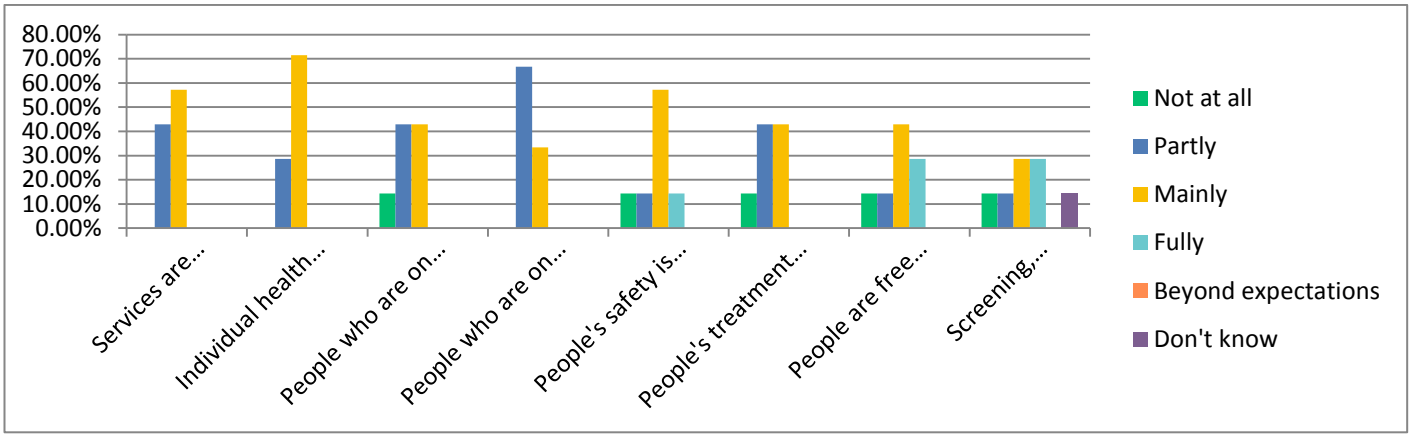
-End

Report to the Board of Directors

Appendix 1 Self-Assessment Responses From Clinical Teams

Q1 How well does the hospital improve patient experience, when judged against the following?

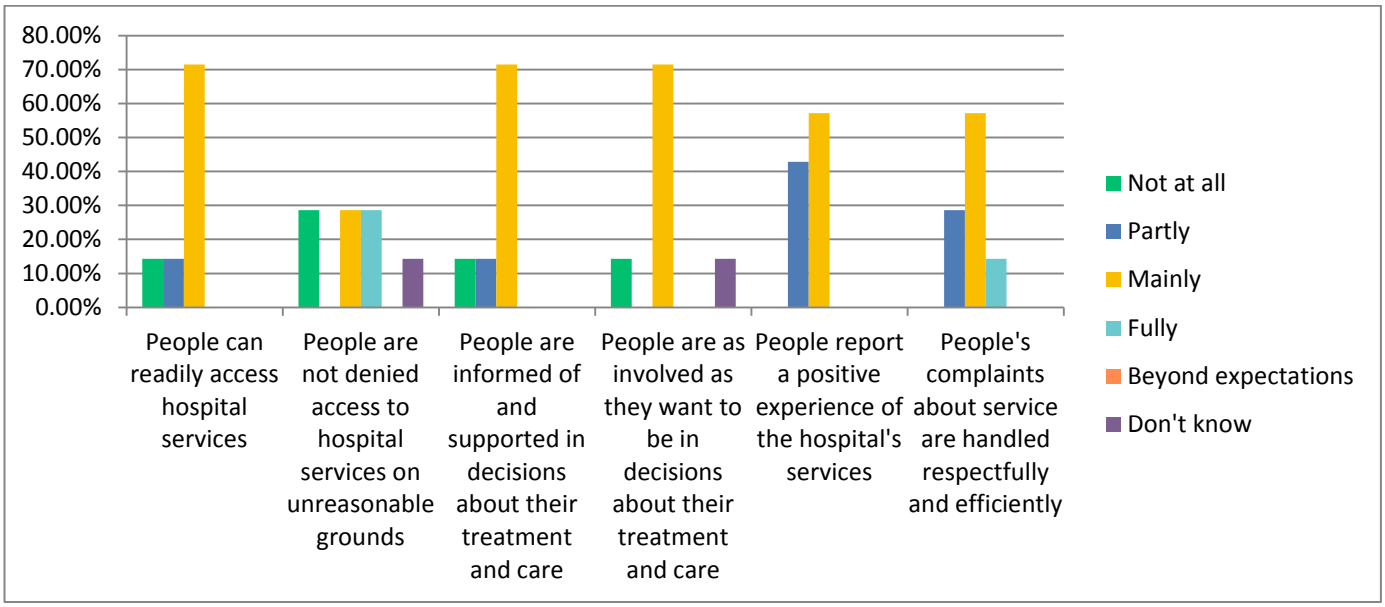
1) Services are designed to meet the health needs of our local communities
2) Individual health needs are assessed and met in appropriate and effective ways
3) People who are on care pathways experience a smooth transition from one service to another
4) People who are on care pathways are well informed about their treatment
5) People's safety is prioritised
6) People's treatment is free from mistakes
7) People are free from mistreatment and abuse
8) Screening, vaccination and other health promotion services reach and benefit all local communities



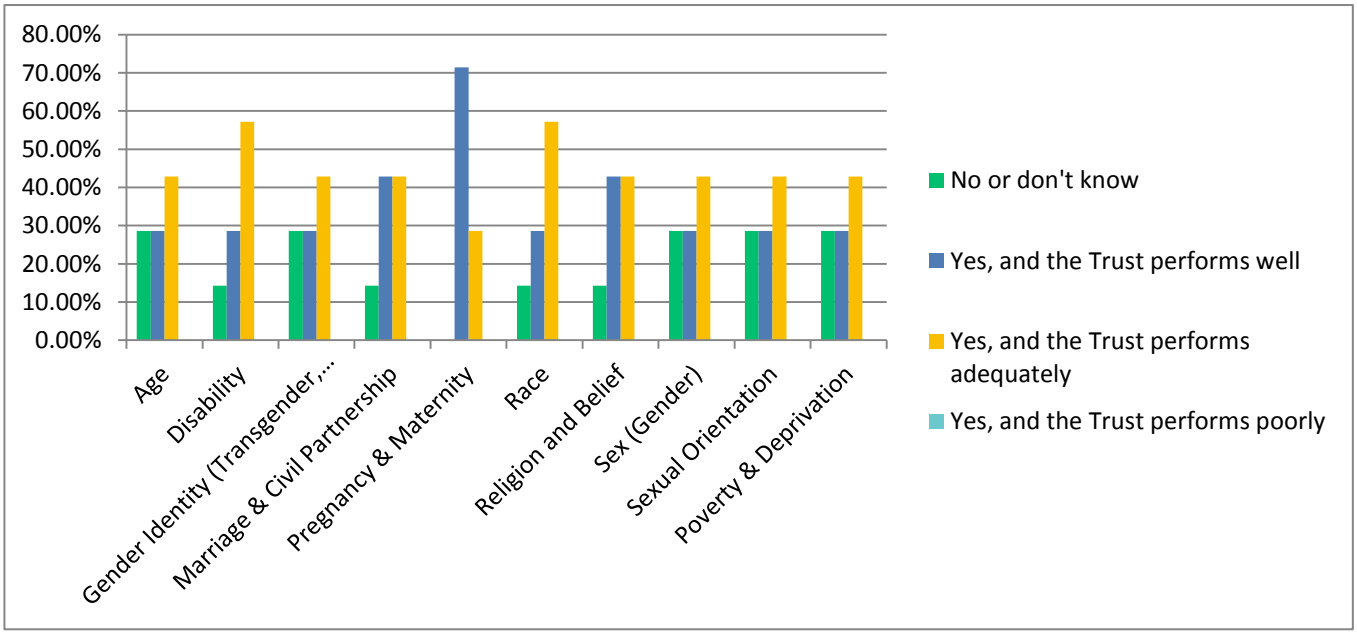
Q2 How well does the hospital improve patient experience, when judged against the following?

1) People can readily access hospital services
2) People are not denied access to hospital services on unreasonable grounds
3) People are informed of and supported in decisions about their treatment and care
4) People are as involved as they want to be in decisions about their treatment and care
5) People report a positive experience of the hospital's services
6) People's complaints about service are handled respectfully and efficiently.

Report to the Board of Directors



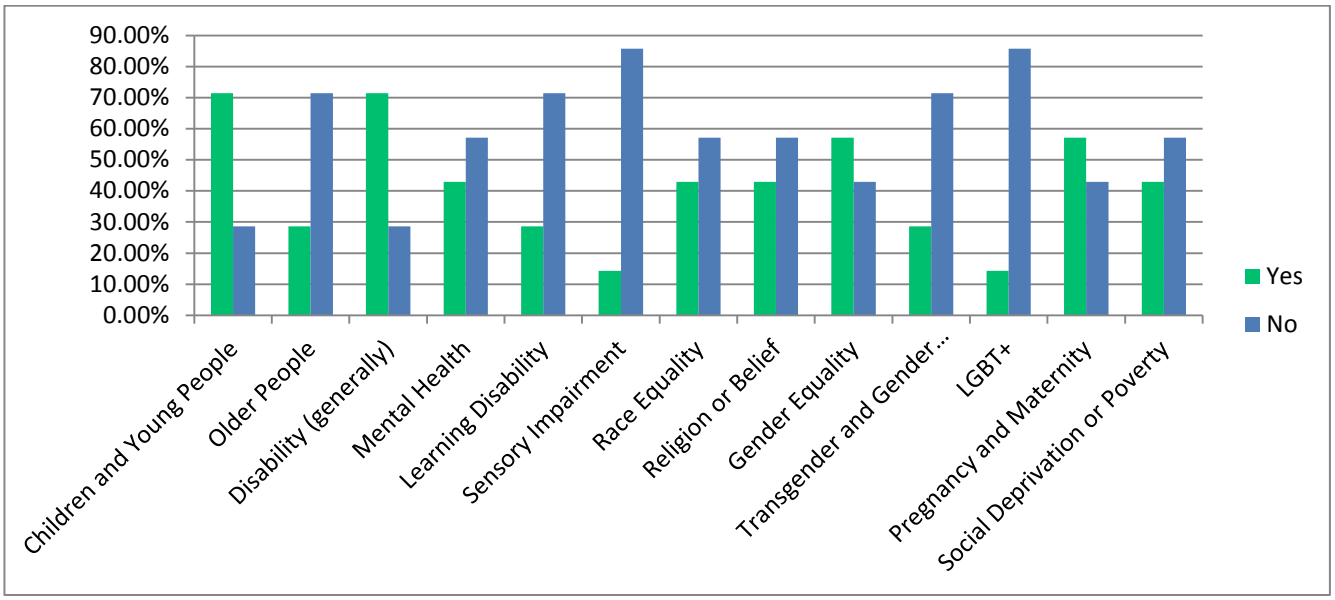
Q3 Do you have knowledge or experience of how well the hospital provides equality of access to our services across each of the following? (The 9 Protected Characteristics plus Poverty and Deprivation)



Q4 What does your team(s), or the hospital generally, do well around equality, diversity and inclusion?

Q5 What could the hospital do better, with regard to equality and inclusion, to help improve patients' experience?

Q6 Do you (as in individual) or your Team have specialist knowledge and experience in any of the following areas?



Q7 Can you please state your directorate?

Equality Delivery System for the NHS

EDS2 Summary Report

Implementation of the Equality Delivery System – EDS2 is a requirement on both NHS commissioners and NHS providers. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. The document can be found at: **http://www.england.nhs.uk/wp-content/uploads/2013/11/eds-nov131.pdf**

This *EDS2 Summary Report* is designed to give an overview of the organisation's most recent EDS2 implementation. It is recommended that once completed, this Summary Report is published on the organisation's website.

NHS organisation name:

Medway NHS Foundation Trust

Organisation's Board lead for EDS2:

Leon Hinton, Executive Director of HR&OD

Organisation's EDS2 lead (name/email):

Alister McClure, Head of Equality and Inclusion alister.mcclure@nhs.net

Organisation's Equality Objectives (including duration period):

1 Improving equitable health outcomes and patient experience by developing a culturally competent workforce
2 Improving patient experience and access by achieving a better understanding of the diversity of experience, through more effective use community feedback and reviewing how we capture and analyse demographics on patient experience and complaints.
3 Achieving workforce stability, enabling the Trust to be an employer of choice, ensuring we have a representative and valued workforce, through equitable

Level of stakeholder involvement in EDS2 grading and subsequent actions:

Commissioners and delivery partners were invited to score the Trust via a questionnaire. The assessment is based on stakeholder evidence, including patient experience reports, inpatient surveys and staff
surveys. There was also an internal self assessment completed by clinical teams across the Trust.

Headline good practice examples of EDS2 outcomes (for patients/community/workforce):

Continued improvement in 2016/17 and 2017/18 on narrowing the differentials between the recruitment of White and BME Staff
Reduction in Gender Pay Gap from 2017 to 2018, and projected reduction (based on December 2018 data) for 2019.
Increased workforce stability impacting on improved patient care

Publication Gateway Reference Number: 03247

Date of EDS2 grading February 2019 **Date of next EDS2 grading** January 2020

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes	1.1	**Services are commissioned, procured, designed and delivered to meet the health needs of local communities** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; Gender reassignment; Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; Religion or belief; ✓ Sex; Sexual orientation Evidence drawn upon for rating: Trust strategies and plans Quality Assurance Reports 2017 to date Families and Clinical Support Services (womens & childrens) achievement of UNICEF Baby-friendly award Trust policies and standard operation procedures for clinical practice	✓
	1.2	**Individual people's health needs are assessed and met in appropriate and effective ways** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; Gender reassignment; Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ✓ Sex; Sexual orientation Evidence drawn upon for rating: Quality Assurance Reports 2017 to date Dandelion and Butterfly schemes Adaptation of meals to cultural needs Availability of same gender examination and treatment Review of dignity and respect Advice on Fasting in Ramadan Use of RCN Advice on the treatment of Transgender patients	✓
	1.3	**Transitions from one service to another, for people on care pathways, are made smoothly with everyone well-informed** Grade: Undeveloped / Developing / Achieving / Excelling Which protected characteristics fare well: ✓ Age; ✓ Disability; Gender reassignment; Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; Religion or belief; ✓ Sex; Sexual orientation Evidence drawn upon for rating: Dandelion and Butterfly schemes Use of NCPES to identify performance gaps and set improvement Improvements to Flow Trust policies and SOPS eg on consent, mental capacity Introduction of the Red Bag Scheme Exploration of hybrid mail and adaptable communications	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Better health outcomes, continued	1.4	**When people use NHS services their safety is prioritised and they are free from mistakes, mistreatment and abuse** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Mandatory training on safeguarding, prevent, and equality Theme of the Week bulletins with case studies to improve clinical practice Trust policies and SOPs - e.g. emergency access for adults with Learning Disabilities Use of translation services where needed	✓
	1.5	**Screening, vaccination and other health promotion services reach and benefit all local communities** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Flu vaccination programme for staff Participation in research programmes	✓
Improved patient access and experience	2.1	**People, carers and communities can readily access hospital, community health or primary care services and should not be denied access on unreasonable grounds** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Dandelion and Butterfly schemes Interpretation and Translation Services Development of hybrid mail and automated translation for correspondence Use of RCN Guideline on the treatment of Transgender Patients Introduction of schemes such as Rainbow NHS Badge	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Improved patient access and experience	2.2	**People are informed and supported to be as involved as they wish to be in decisions about their care** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ✓ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Chaplaincy Trust Policies and SOPs including consent, end of life care, access to health records etc Patient experience feedback Interpretation and translation facility, including BSL	✓
	2.3	**People report positive experiences of the NHS** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Patient experience feedback, including Healthwatch reports Feedback from commissioners (via survey)	✓
	2.4	**People's complaints about services are handled respectfully and efficiently** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Currently complaints are not monitored for demographics - although some information on disability, age and gender is known.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.1	**Fair NHS recruitment and selection processes lead to a more representative workforce at all levels** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☐ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Nurse recruitment from UK, EU and International WRES improvements on recruitment Apprenticeships and work experience Further work required on progression and development for BME staff and women Pay Gap Analysis and WRES informing workforce planning	✓
	3.2	**The NHS is committed to equal pay for work of equal value and expects employers to use equal pay audits to help fulfil their legal obligations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** Gender Pay Audits on 2017 and 2018 Participation in national research programme Trust HR policies and SOPs WRES highlighting some progression issues, but improving Pay audits completed in autumn 2018 on 6 out of 8 protected characteristics (confidential information at this stage)	✓
	3.3	**Training and development opportunities are taken up and positively evaluated by all staff** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** Access to non-mandatory training (via WRES, but measurable across 6 protected characteristics vis ESR) Stat/Man Training (via MOLLIE) Access to CPD (via WRES) Apprenticeships available to all ages Accessibility to training considered	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
A representative and supported workforce	3.4	**When at work, staff are free from abuse, harassment, bullying and violence from any source** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ☑ Race; ☐ Religion or belief; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** Trust policies and SOPS Quality Assurance Reports Health and Wellbeing service, FTSUG, workplace listeners Appointment of specialist staff (including Head of Equality & Inclusion, Community Engagement Officer) You Are The Difference and the Culture programme more generally	✓
	3.5	**Flexible working options are available to all staff consistent with the needs of the service and the way people lead their lives** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☑ Age; ☑ Disability; ☑ Gender reassignment; ☑ Marriage and civil partnership; ☑ Pregnancy and maternity; ☑ Race; ☑ Religion or belief; ☑ Sex; ☑ Sexual orientation **Evidence drawn upon for rating:** Workforce reports to Board Trust Policies and SOPs on flexible working, family/carer leave (including Trans-friendly 'maternity' language) Use of Reasonable Adjustment Use of Trust policies to adjust for carers needs or requirements for religious observance Engagement with Unions via JCC	✓
	3.6	**Staff report positive experiences of their membership of the workforce** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ☑ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☑ Pregnancy and maternity; ☐ Race; ☐ Religion or belief; ☑ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Evidence from the staff survey shows further work is required in relation to race when asked about opportunities for promotion, and the Trust being an equitable employer. However, the incidence of grievances and formal complaints from staff is low.	✓

Goal	Outcome	Grade and reasons for rating	Outcome links to an Equality Objective
Inclusive leadership	4.1	**Boards and senior leaders routinely demonstrate their commitment to promoting equality within and beyond their organisations** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ✓ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Trust policies and SOPS Quality Assurance Reports Communications from senior managers, including weekly bulletins, social media Appointment of specialist staff (including Head of Equality & Inclusion, and Community Engagement Officer)	✓
	4.2	**Papers that come before the Board and other major Committees identify equality-related impacts including risks, and say how these risks are to be managed** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ✓ Disability; ☐ Gender reassignment; ☐ Marriage and civil partnership; ☐ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ☐ Sexual orientation **Evidence drawn upon for rating:** Regular Workforce reports to Board 2016 onwards (Including EDS2) WRES 2016 2017 2018 Gender Pay Gap Report 2017 and 2018 More work need to bring equality assessment as a mainstream habit into Board reports, policies etc.	✓
	4.3	**Middle managers and other line managers support their staff to work in culturally competent ways within a work environment free from discrimination** **Grade:** Undeveloped / Developing / Achieving / Excelling **Which protected characteristics fare well:** ☐ Age; ✓ Disability; ✓ Gender reassignment; ☐ Marriage and civil partnership; ✓ Pregnancy and maternity; ✓ Race; ☐ Religion or belief; ✓ Sex; ✓ Sexual orientation **Evidence drawn upon for rating:** Introduction of Trust Leadership Programme, Culture Programme and a range of equality and inclusion training taken up by managers Use of policies, role of key adviser (HR Business Partners, HR Advisors, Head of E&I - including ability to respond to complex cases)	✓

Report to the Board of Directors

Board Date: Thursday, 07 March 2019 Agenda item: 7.3

Title of Report	Workforce Report: Gender Pay Gap
Prepared By	Alister McClure, Head of Equality and Inclusion
Lead Director	Leon Hinton, Director of HR and OD
Committees or Groups who have considered this report	Executive Team
Executive Summary	This report sets out the gender pay gap calculations and supporting statement for 2018. It is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017. The Trust's mean gender pay gap is 32.09% (compared to 33.27% in 2017) and the median gender pay gap of 21.84% (compared to 23.60% in 2017). The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles.
Resource Implications	None identified at this stage
Risk and Assurance	Reputation and Contract Compliance. Publication of the gender pay gap along with the supporting statement will remove the risk of non-compliance. Development of an implementation plan will enable the Trust to mitigate the reputational risks associated with a gender pay gap.
Legal Implications/Regulatory Requirements	The Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 requires the Trust to publish its gender pay gap.
Improvement Plan Implication	Workforce equality, including being an employer of choice, is a priority for the Trust's improvement.
Quality Impact Assessment	Not applicable
Recommendation	To approve the publication of the Trust's Gender Pay Gap and supporting statement (as set out is section 5)

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

Report to the Board of Directors

1 EXECUTIVE SUMMARY

1.1 This report sets out the gender pay gap calculations for 2018, together with a supporting statement. The report is required under the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017

1.2 The Trust's mean gender pay gap is 32.09% (compared to 33.27% in 2017) and the median gender pay gap of 21.84% (compared to 23.60% in 2017). The gender pay gap relates to gender differentials in the progression to senior roles, particularly in medical roles. There is some evidence that this pattern is repeated in many other Trusts across the NHS, and relates to professional career paths.

2 BACKGROUND

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

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

2.3 The difference between the gender pay gap and equal pay

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

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

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

3 REPORTING REQUIREMENTS

3.1 Employers with 250 employees and over need to publish the following information annually for all employees who are employed under a contract of employment, a contract of apprenticeship or a contract personally to do work. This includes those under Agenda for Change terms and conditions, medical staff and very senior

managers. All calculations must be made relating to the pay period in which the snapshot day falls. For this first year, this will be the pay period including 31 March 2018.

3.2 Employers must:

- calculate the hourly rate of ordinary pay relating to the pay period in which the snapshot day falls;
- calculate the differences between both the median and mean hourly rate of ordinary pay of male and female employees;
- calculate the difference between the median (and mean) bonus pay paid to male and female employees. For the NHS, bonus payments are defined as: clinical excellence awards; long service awards (monetary vouchers); workplace vouchers in addition to salary; recruitment bonuses; and relocation costs in excess of expenses. [The following are not to be considered as either pay or bonuses: salary sacrifice schemes, benefits in kind (e.g. NHS discounts); and the reimbursement of expenses.]
- calculate the proportions of male and female employees who were paid bonus pay;
- calculate the proportions of male and female employees in the lower, lower middle, upper middle and upper quartile pay bands by number of employees rather than rate of pay.

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

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

4 GENDER PAY GAP CALCULATIONS

4.1 Mean and Median Hourly Rates (All staff groups)

Gender	Average (mean) Hourly Rate		Median Hourly Rate	
Year	2018	2017	2018	2017
Male	21.82	21.81	16.42	16.44
Female	14.82	14.55	12.83	12.56
Difference	7.00	7.26	3.59	3.88
Pay Gap % (2018)	32.09%	33.27%	21.84%	23.60%
Direction of travel	Improvement		Improvement	

4.2 Number of employees per quartile

Quartile	Female		Male		Female %		Male %	
Year	2018	2017	2018	2017	2018	2017	2018	2017
1 (lower)	882	866	156	156	84.97	84.74	15.03	15.26
2 (lower middle)	899	932	157	160	85.13	85.35	14.87	14.65
3 (upper middle)	887	908	157	151	84.96	85.74	15.04	14.26
4 (upper)	691	688	360	372	65.75	64.91	34.25	35.09

4.3 Bonus Payments

4.3.1 There is no comparator for 2017, as bonus payments (CEAs, i.e. clinical excellence awards) in that year were incorporated into pay. As there was comparatively small number of CEAs, the impact on the mean and median pay rates was statistically negligible.

4.3.2 Mean and Median Bonus Rates (2018 only)

Gender	Average (mean) Hourly Rate	Median Hourly Rate
Male	6.11	4.34
Female	4.99	3.62
Difference	1.12	0.72
Pay Gap %	18.37	16.67

4.3.3 Number of Employees paid bonuses per quartile

Quartile	Female	Male	Female %	Male %
1	6	13	31.58	68.42
2	4	15	21.05	78.95
3	6	12	33.33	66.67
4	4	17	19.05	80.95

4.3.4 Percentage of Employees paid bonuses

	Female	Male	Total
Number of employees	2559	830	3389
Number paid bonuses	20	57	77
Percentage	0.78%	6.87%	2.27%

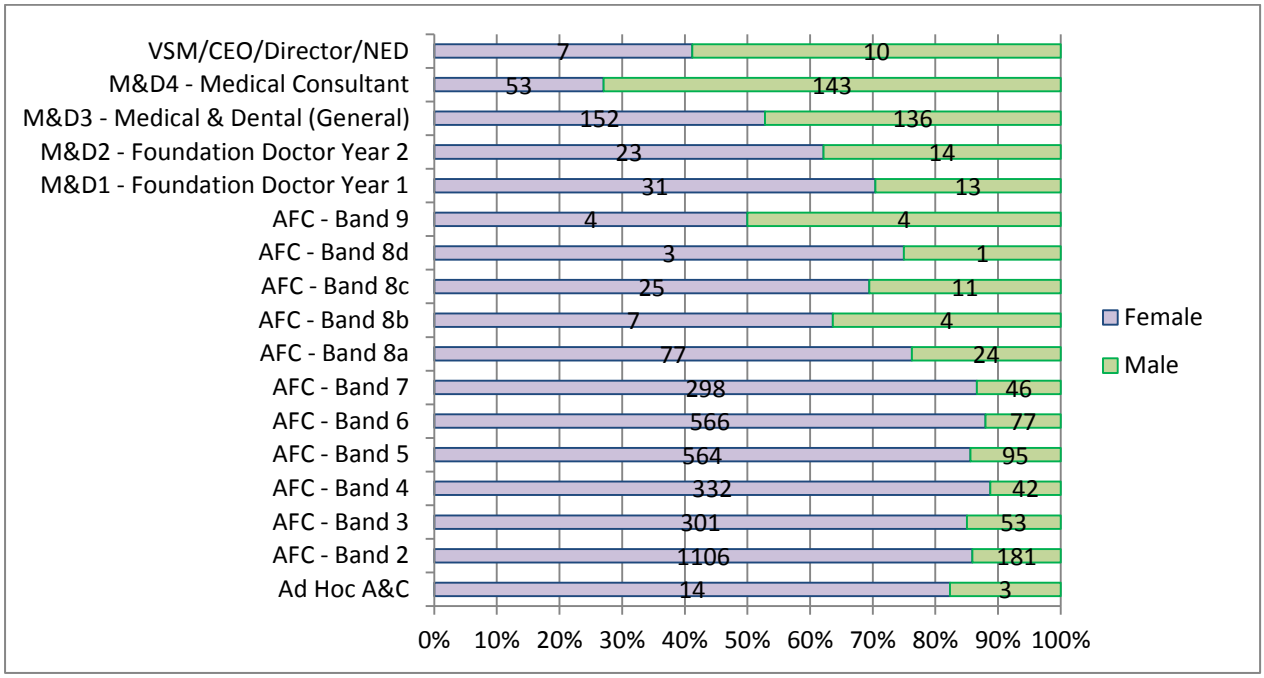
5 SUPPORTING STATEMENT

5.1 The headline calculations for this Trust are a Mean gender pay gap of 32.09 (compared to 33.27% in 2017) and a Median gender pay gap of 21.84% (compared to 23.60% in 2017). It is evident that the proportion of men in the workforce increases in the upper quartile, compared to quartiles 1 to 3

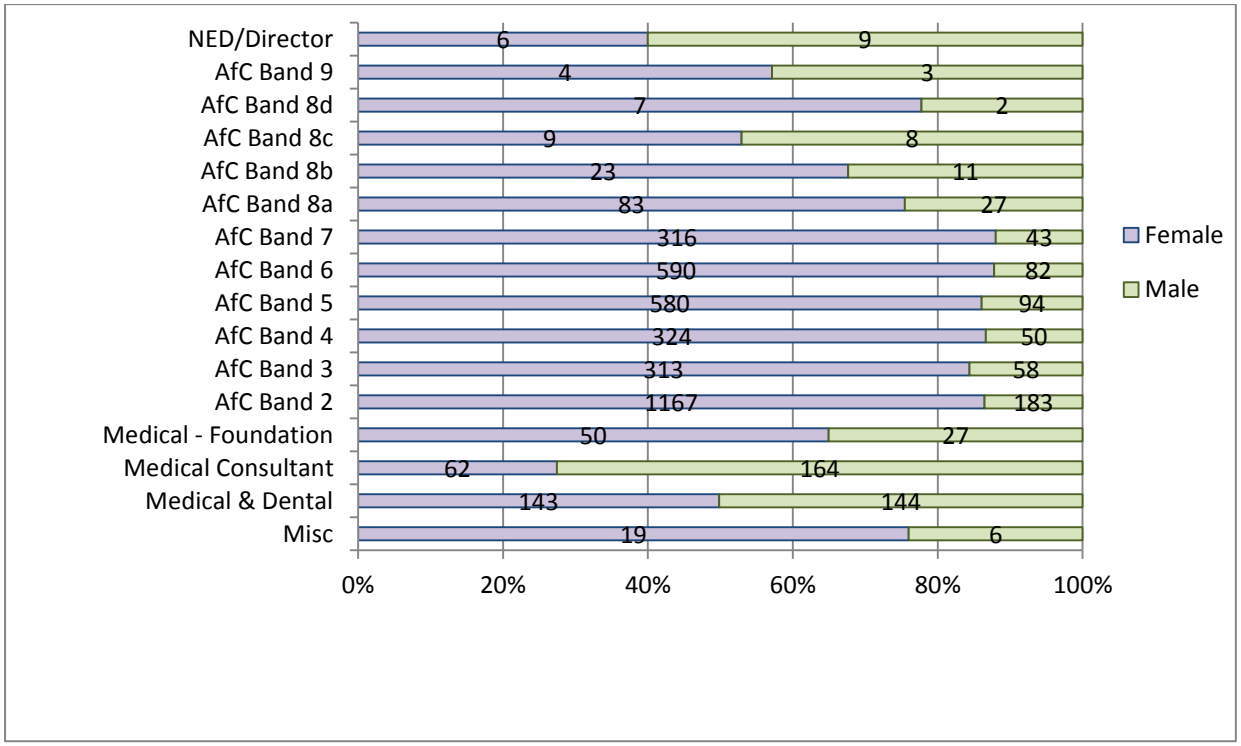
5.2 When calculating the pay gap separately for medical and dental, and non-medical staff, the mean reduces for both groups, and the median reduces for non-medical staff. Indeed, the mean pay gap for non-medical staff (chiefly AfC pay bands) there is very little variation in the mean, at 5.36%, and the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

5.3 The gender pay gap issue for the Trust comes when we combine medical and non-medical grades, as the number of men in the medical workforce, particularly consultants, is significantly higher than the number of women. The graph below illustrates, from the Trust's workforce demographics report 2017, that amongst medical consultants, men comprise over 75% of the workforce. In Agenda for Change (AfC) pay bands, women form over 80% of the workforce. This means that, compared to women, a greater proportion of men are in higher paid roles. Another potential matter to consider is the fact that the Trust has not outsourced some services, such as catering and housekeeping, which have a higher proportion of women in lower pay bands. A current externally managed study of organisational culture and gender pay may help the trust identify the reasons for apparent glass ceilings of women, and what practical actions can be taken to address these.

Graph 1: Gender by payband, 2018



Graph 2: Gender by payband, 2017 (as presented in last year's report)



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

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

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

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

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

6 PUBLICATION

6.1 Subject to approval by the Trust Board at its meeting in March 2019, the gender pay gap and supporting statement will be published on the Trust website and the Government portal before 31 March 2019. The next steps (set out in 5 above) will be developed into an implementation plan.

6.2 It is recommended:

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

6.2.2 that the Trust continues to work with partners across the NHS to develop the next steps (5 above) into a detailed implementation plan.

-End

Report to the Board of Directors

Board Date: Thursday, 07 March 2019 Agenda Item: 9.1

Title of Report	Consent Policy
Prepared By	Paul Mullane, Head of Integrated Governance and Legal
Lead Director	Leon Hinton, Director of HR and OD
Committees or Groups who have considered this report	Brachers Solicitors
Executive Summary	Annual review of corporate policy, no major changes were required in this review, only an additional reference to a court judgement in 2015 at the UK Supreme Court – section 2.14.
Resource Implications	Not Applicable
Risk and Assurance	Not Applicable
Legal Implications/ Regulatory Requirements	No change to existing policy and procedures.
Improvement Plan Implication	Not Applicable
Quality Impact Assessment	Not Applicable
Recommendation	Not Applicable
Purpose and Actions required by the Board	**Approval** ☒ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

CORPORATE POLICY - Consent Policy

Author:	Head of Integrated Governance & Legal Trust Data Protection Officer (DPO) – Paul Mullane in conjunction with Brachers LLP
Document Owner:	Executive Director of HR and OD – Leon Hinton
Revision No:	8
Document ID Number	POLCGR034
Approved By:	Trust Board
Implementation Date:	2019
Date of Next Review:	2020

Consent Policy

Document Control / History	
Revision No	**Reason for change**
Updated	Alteration to reflect changes to legislation – Mental Capacity Act (2005) and Human Tissue Act (2004) and Department of Health: Reference guide to consent for examination or treatment 2nd Edition 2009
1	Amendment – change of contact details for IMCA – see 1.3.8.
2	Changes to Case Law and Legislation; inclusion of Monitoring Table and Equality Impact Assessment
3	Inclusion of consent for post mortems
4	To accommodate revisions to NHSLA risk management standards
5	Scheduled update – no changes to guidance
6	Policy updated and split into individual SOPs
7	Reviewed – remove Form 8 no longer required
8	Reviewed with no major changes – added reference to 2.14

Consultation
Brachers Solicitors

Consent Policy

Table of Contents

Consent Policy

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

1 Introduction

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

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

2 Purpose / Aim and Objective

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

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

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

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

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

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

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

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

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

  See Montgomery v Lanarkshire Health Board (2015) UK Supreme Court.

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

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

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

3 Definitions

3.1 Capacity

3.1.1 The ability to carry out the processes involved to make and communicate a specific decision at a specific time (as set out in the Mental Capacity Act)

3.1.2 "Consent" is a patient's agreement for a health professional to provide care. Patients may indicate consent non-verbally (for example by presenting their arm for their pulse to be taken), orally, or in writing. For the consent to be valid, the patient must:

3.1.3 have capacity to take the particular decision;

3.1.4 have received sufficient information to take it; and

3.1.5 not be acting under duress.

3.2 A signature on a form is not consent; it is part of the consent process. It can be evidence of understanding and acceptance of information given during the consent process. Patients with capacity may withdraw consent at any time before or during an investigation or treatment taking place.

3.3 **Independent Medical Capacity Advocate (IMCA)**

3.3.1 This service helps the Trust to make decisions in the best interests of people who lack the capacity and who have no family or friends that it would be appropriate to consult about these decisions.

3.4 **Risk**

3.4.1 Any adverse outcome, including those which some health professionals would describe as 'side-effects' or 'complications'

4 (Duties) Roles and Responsibilities

4.1 The health professional actually carrying out any procedure is ultimately responsible for ensuring that the patient is genuinely consenting to what is being done: it is this health professional that will be held responsible in law if there is a challenge later.

4.2 Where oral or non-verbal consent is being sought at the point the procedure will be carried out, this will naturally be done by the health professional that is to carry out the procedure. However, team work is a crucial part of the way the NHS operates, and where written consent is being sought it may be appropriate for other members of the team to participate in the process of seeking consent.

4.3 Completing consent forms

4.3.1 The standard consent form provides space for a health professional to specify key information provided to patients and to sign confirming that they have done so. The health professional providing the information must be competent to do so: either because they themselves carry out the procedure, or because they have received specialist training in advising patients about this procedure, have been assessed, are aware of their own knowledge limitations and are subject to audit.

4.3.2 The consent form will normally also be signed by the patient. However, if a patient is unable to do so (e.g. because of blindness, amputation, locked in syndrome), verbal consent can be witnessed and documented by a second member of staff after the whole form has been read out to the patient. If a patient completes the form in advance of a procedure (e.g. in out-patients or

at a pre-assessment clinic), a health professional involved in their care on the day of the procedure should sign the form to confirm that the patient still wishes to go ahead and has had any further questions answered. It will be appropriate for any member of the healthcare team (for example a nurse admitting the patient for an elective procedure) to provide the second signature, as long as they have access to appropriate colleagues to answer any questions they cannot handle themselves.

4.4 Delegation of Consent

4.4.1 Any specialty that wishes to develop training for health professionals to enable them to seek informed consent for one or more specified procedures (which they are not able to perform themselves) must produce documentation specifying the knowledge and practical skills required before this is undertaken. They must also produce details of the competency assessment that will be undertaken before such a practitioner seeks consent for the procedure, specifying how often this will be reviewed or the person will be reassessed. This training and documentation must be approved by the specialty lead consultant (who must confirm in writing that it meets the requirements of the consent policy), and by the Clinical Management Board, before it is implemented.

4.4.2 Each specialty is responsible for keeping a list of those staff approved to obtain delegated consent, together with the date of this approval, and a note of each procedure for which the member of staff is now competent to obtain delegated consent.

4.4.3 The annual consent audit will include a process for checking that consent is being sought by staff who are competent to perform the procedure concerned, or who are documented as having successfully completed the relevant training showing they are competent to undertake this process.

4.4.4 Any member of staff who is asked a supplementary question by a patient, which is outside their immediate professional expertise to be able to answer, should not countersign the form unless or until they are satisfied that

- an appropriate professional has addressed any outstanding concerns of the patient; and
- the patient has received full information to enable him/her to make a decision on whether or not they wish the proposed procedure to go ahead.

4.5 Responsibility of health professionals

4.5.1 It is a health professional's own responsibility:

- to ensure that if a colleague seeks consent on their behalf they are confident that the colleague is competent to do so; and
- to work within their own competence and not to agree to perform tasks which exceed that competence.

4.5.2 If a health professional feels that they are being pressurised to seek consent when they do not feel competent to do so, they should contact one of the following for advice and support:

- a member of the Directorate management team,
- the specialty lead or principal lead consultant,
- the Medical Director

4.5.3 If the Trust has reason to believe (e.g. following an audit / investigation) that any trainee doctor has inappropriately sought consent for a medical procedure, or obtained consent without the authorisation to do so, this should be reported to the Medical Director, who will take it up if appropriate with the General Medical Council (GMC)

5 Monitoring and Review

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	First review in one year and then every three years	Author	Clinical Effectiveness and Research Group	Policy will be updated and made available to staff.
Elective Surgical Consent process to include: Process for obtaining consent Process for recording consent Process for identifying staff authorised to take consent Process for delivery of procedure specific training on consent for those staff to whom consent training is delegated Generic training on consent	Annual audit of patient records, delegated consent directories, procedure specific and generic training records as required.	Medical Directors' Assistant	Medical Director	Where gaps are recognised action plans will be put into place

What will be monitored	How/Method/ Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Trust – wide Consent Forms	Annual audit	Medical Directors' Assistant	Medical Director	Where gaps are recognised action plans will be put into place

6 Training and Implementation

6.1 Training on generic consent issues is available for all staff via the Trust e-learning programme. In addition, ad hoc training services are available at Directorate/departmental levels as required. Staff requiring general training on the Consent policy, procedure or best practice in obtaining consent in specific clinical settings should contact the Head of Legal Services, Corporate Compliance and Resilience on ext 3881.

6.2 Training and assessment for nurses or junior doctors obtaining consent, who do not themselves undertake the procedure(s) being consented for, should be developed locally by the senior clinicians. The Trust requires that each Directorate should identify which individual nurses or junior doctors are deemed competent to obtain consent for specific procedures (which are serious enough to usually warrant written consent) either by virtue of their existing skill base, or by virtue of having undertaken specific training in obtaining consent for that procedure. This procedure specific training should be provided by a person trained to perform the procedure or by a person with the required medico-legal skills. Training should relate to a specific procedure or groups of procedures and cover the knowledge and skills required to enable the nurse to advise the patients and respond to specific questions, especially in relation to the risks and benefits of the procedure in question and the risks and benefits of the alternatives to that procedure. Competence to perform the consent process for nurses or junior doctors not undertaking the clinical procedure must be documented on the individuals' training record and a note should be added to the procedure Directory held by the relevant Directorate. Directorates must also ensure that where nurses and junior doctors are involved in assessing continuance of consent, that ready access is available to appropriate colleagues where they are unable to answer personally any questions raised by the patient.

6.3 Any incident about the process of gaining consent or giving patients sufficient information on which to make a decision will be reported via the incident reporting system. In the event that a patient's consent is obtained by Trust personnel not considered appropriate to obtain such consent, the matter will be reported using the Trust's incident reporting system.

6.4 The effectiveness of the implementation of this policy will be subject to annual audit which will be led by the Medical Director's Assistant and the results of which will be considered at Directorate governance group meetings.

7 References

Document	Ref No
References:	
Care Quality Commission Fundamental Standard	Regulation 11
Human Tissue Act 2004	
Mental Capacity Act 2005	
Consent: Supported Decision Making – a good practice guide (Royal College of Surgeons November 2016)	
Good practice in consent implementation guide (Department of Health 2002)	
Trust Associated Documents:	
Consent Procedure	SOP0131
Consent - Tissue	SOP0134
Consent - Clinical photography and conventional or digital video recordings	SOP0135
Consent - Medway Elective Surgical Consent Pathway	OTCGR161
Consent - Consent Flow Chart for Children Under 16 Years of Age	OTCGR162
Consent - ICU Photographs Guideline	GULGR003
Consent - Form 1 - Patient agreement to investigation or treatment	OTCGR165
Consent - Form 2 - Parental agreement to investigation or treatment	OTCGR166
Consent - Form 3 - Patient-parental agreement to investigation or treatment -procedures where consciousness not impaired	OTCGR167
Consent - Form 4 - Form for adults who are unable to consent to investigation or treatment	OTCGR168
Consent - Form 6 - Supplementary Consent for Gifting of Tissue	OTCGR158
Consent - Form 7 - Consent to photography and conventional or digital video recordings	OTCGR159
Consent - Form 9 - Post Mortem Consent Form - Baby	OTCGR163
Consent - Patient Diary Acceptance Form	OTLGR0023
Management and Publication of Written Patient Information Policy and Procedure	POLCGR019
Interpreter/Translator Policy	POLCGR023
Use of Unlicensed Products	POLCPCM034

END OF DOCUMENT

Report to the Board of Directors

Board Date: Thursday, 07 March 2019 Agenda Item: 9.2

Title of Report	Corporate Safeguarding Policy
Prepared By	Bridget Fordham, Head of Safeguarding
Lead Director	Karen Rule, Director of Nursing
Committees or Groups who have considered this report	Safeguarding Operational Group Safeguarding Assurance Group
Executive Summary	The Corporate Safeguarding Policy is reviewed annually to ensure it reflects current legislative requirements. Minor changes were required in this review. Additional references have been included to Team connects, a new safeguarding team structure within Maternity and to the legislative framework, The Care Act and Working Together – section 3.
Resource Implications	Not Applicable
Risk and Assurance	This policy supports the Trust and its staff to work within the legislative framework for Safeguarding.
Legal Implications/ Regulatory Requirements	No change to existing policy and procedures.
Improvement Plan Implication	Not Applicable
Quality Impact Assessment	Not Applicable
Recommendation	Not Applicable
Purpose and Actions required by the Board	**Approval** ☒ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

CORPORATE POLICY: Safeguarding

Author:	Safeguarding Team
Document Owner	Head of Safeguarding
Revision No:	2
Document ID Number	POLCPCM082 (replaces GUCPCM001)
Approved By:	Trust Board
Implementation Date:	February 2019
Date of Next Review:	February 2020

Medway NHS Foundation Trust
Safeguarding Policy

Document Control / History	
Revision No	**Reason for change**
1	New high level document combining adults and children
2	Review and changes to include legislation and new document links

Consultation
Executive Group
Trust Board

Medway NHS Foundation Trust
Safeguarding Policy

Table of Contents

Medway NHS Foundation Trust
Safeguarding Policy

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

1 Introduction

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

2 Purpose / Aim and Objective

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

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

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

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

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

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

3 Policy Framework

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

Adult The Care Act http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf
GUCPCM001 - Safeguarding Vulnerable Adults This document then has been developed to meet and work within the safeguarding adult lawful requirements set out within the Care Act 2014; it's supporting Statutory Guidance and the associated Schedules and Regulations.
https://www.kent.gov.uk/__data/assets/pdf_file/0018/11574/Multi-Agency-Safeguarding-Adults-Policy,-Protocols-and-Guidance-for-Kent-and-Medway.pdf
SOP0194 - Safeguarding Adults - Making Safeguarding Referrals Explains how to make a safeguarding referral.
SOP0195 - Safeguarding Adults - Process for Applying for a Deprivation of Liberty Safeguards - DoLS Explains how to apply for a Deprivation of Liberty Safeguards – DoLS.
STRCPCM001 - Safeguarding and Protecting Children Training Strategy (1 attachment) Training required to ensure all staff in the Trust understand their role in safeguarding children and can recognise when a child is at risk and know what to do if they are concerned about a child.
Children https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
POLCPCM055 - Kent & Medway Safeguarding Procedures Joint procedures that reflect the level of cross boundary work undertaken by many of the agencies and organisations who use the procedures. They reflect those local procedures that relate only to Kent or Medway.
POLCPCM027 - Safeguarding and Protecting Children Policy Local policy document used in conjunction with Kent and Medway procedures.
SOP0053 - Safeguarding Children - Raising Concerns Provides guidance on how to raise a concern about children.
SOP0051 - Safeguarding Children - Child Abuse Neglect Sexual Exploitation and trafficking This guidance is to support staff in the management of children who are at risk of abuse or where abuse has been identified.
SOP0050 - Safeguarding Children - Community This document is produced to assist staff working in the community to fulfil their

safeguarding responsibilities.
SOP0054 - Safeguarding Children - Interagency Working This document ensures all staff know what is expected in their role particularly when working with partner agencies.
SOP0052 - Safeguarding Children - Female Genital Mutilation - FGM Local guidance for clinicians who have direct contact with patients where this practice may be identified or where a disclosure may be made.
GUDNM228 - Safeguarding Children - Kent and Medway Female Genital Mutilation Kent and Medway guidance for clinicians who have direct contact with patients where this practice may be identified or where a disclosure may be made.
SOP0055 - Safeguarding Children - Looked After Children - Consent Explains how to obtain consent for Looked After Children.
SOP0117 - Safeguarding Children - In the Emergency Department including gangs Principles of safeguarding children in ED and information on gangs.
SOP0060 - Safeguarding Children - Useful Contacts Supplies staff with contact details of safeguarding teams both in and out of the Trust to support their work in safeguarding children.
PROCPCM001 - Safeguarding Children - Responding to Child Death Procedure Describes the mandatory process that must be followed when a child dies.
GULPCM202 - Safeguarding Children - Safeguarding Children who may have been trafficked - HM Government Home office guidance for trafficked children
GUDNM231 - Safeguarding Children on the Neonatal Unit - Neonatal Nursing Local guidance for the Neonatal Unit.
SOP0483 - Identifying and Supporting Vulnerable Families within the Maternity Setting New Team Connect for Safeguarding in Maternity.

4 Roles and Responsibilities

4.1 Trust Board

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

4.2 Chief Executive

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

4.3 Board Leads for Safeguarding

4.3.1 The Executive Board Lead is the Director of Nursing whose role it is to provide executive level leadership for safeguarding, ensuring the Trust is represented at the Safeguarding Boards across Kent and Medway..

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

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

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

4.4 Head of Safeguarding

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

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

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

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

4.5 MFT Safeguarding Assurance Group

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

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

4.6 The Safeguarding Group

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

4.7 Lead Nurse Safeguarding Children

4.7.1 The Lead Nurse will undertake the duties of the Named Nurse under the leadership of the Named Professional, (Head of Safeguarding) and will provide leadership at an operational level to all staff within the Trust.

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

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

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

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

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

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

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

4.8 Named Midwife for Safeguarding

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

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

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

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

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

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

4.9 Line Managers

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

4.10 All Staff

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

5 Monitoring and Review

What will be monitored	How/Method / Frequency	Lead	Reporting to	Deficiencies/ gaps Recommendations and actions
Policy review	Annually	Head of Safeguarding	Director of Nursing	Where gaps are recognised action plans will be put into place
Mental Capacity and Deprivation of Liberty (DoLS)	Annually Audited	Adult Safeguarding Lead	Head of Safeguarding / Director of Nursing	Compliance monitoring and effectiveness of education and support required.
Kent and Medway Self-Assessment Framework for the KMSAB	Annually Audited	Adult Safeguarding Lead	Head of Safeguarding / Director of Nursing/ KMSAB	Where gaps are recognised the Assurance Group to decide remedial actions required
S11 Self-assessment document of compliance to the Children Act.	Bi annually for Kent LSCB and Medway LSCB. These are completed alternately annually	Named Nurse for Children	Head of Safeguarding / Director of Nursing	Ensure that in discharging their functions staff have regard to the need to safeguard and promote the welfare of children.
KMSAB Self-assessment framework	Annually	Head of Safeguarding	Director of Nursing / KMSAB	Where gaps recognised the Assurance Group to decide remedial actions required

6 Training and Implementation

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

6.1.1 Mandatory training to all staff;

6.1.2 Bespoke training for dedicated cohorts and staff groups.

7 Equality Impact Assessment Statement & Tool

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

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

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

9 References

Document	Ref No
References:	
Trust Associated Documents:	
See framework	

END OF DOCUMENT

Report to the Board of Directors

Board Date: Thursday 07 March 2019 Agenda Item: 9.3

Title of Report	Freedom to Speak Up Strategy
Prepared By	Benn Best, Deputy Chief Operating Officer and Acting Freedom to Speak Up Lead
Lead Director	James Devine, Chief Executive
Committees or Groups who have considered this report	Executive Group
Executive Summary	Freedom to Speak up (FTSU) promotes the raising of concerns for NHS staff and volunteers to ensure patient safety is maintained at all times and to make the health service a better place to work. The Trust is committed to supporting the national requirements for the FTSU and has appointed a new Freedom to Speak Up Guardian & Ambassadors along with a new strategy. The strategy and the roles are both proactive and reactive and sets out the following purpose: ▪ **Protect patient safety and the quality of care** ▪ **Improve the experience of workers** ▪ **Promote learning and improvement.** By ensuring that: ▪ **Workers are supported in speaking up** ▪ **Barriers to speaking up are addressed** ▪ **A positive culture of speaking up is fostered** ▪ **Issues raised are used as opportunities for learning and improvement.** Medway is committed to embedding an open and transparent culture; one in which staff members and volunteers feel empowered to speak up and raise any concerns, with the confidence that these will be acted upon and without fear of detriment for speaking up. This includes having the appropriate structure and processes to supports speaking up and ensuring that all staff members demonstrate the values and behaviours required to deliver this in practice. This strategy sets out our new vision for speaking up) and demonstrates our commitment to making it safe for our staff to raise any concerns. It will also ensure that we always keep our patients at the centre of everything. With a refreshed approach and a new Lead Guardian we will be able to deliver on our aims. Monthly meetings with the Trust CEO take place with the Lead Guardian reporting directly. Quarterly data returns to the National

Report to the Board of Directors

	guardian offices is mandated and completed.
Resource Implications	None
Risk and Assurance	Not applicable
Legal Implications/Regulatory Requirements	The quarterly data return to the National guardian offices is a national requirement.
Improvement Plan Implication	Freedom to Speak Up has positive implications across all improvement plans and strategic objectives.
Quality Impact Assessment	Not applicable
Recommendation	The Board is asked to approve the strategy.
Purpose and Actions required by the Board	**Approval** ☒ **Assurance** ☐ **Discussion** ☐ **Noting** ☐

Speaking up Strategy

Author:	Benn Best and Rita Lawrence
Document Owner	Lead Guardian\Head of Culture & Engagement
Revision No:	1
Document ID Number	
Approved By:	Executive Committee
Implementation Date:	January 2019
Date of Next Review:	January 2020

Strategy

Document Control / History: New Document	
Revision No	**Reason for change**
1	New document

Consultation

Table of Contents

Strategy

1 Introduction

Freedom to Speak up (FTSU) promotes the raising of concerns for NHS staff and volunteers to ensure patient safety is maintained at all times and to make the health service a better place to work.

In 2013 the Francis report identified a fundamental shift that was required across the whole of the NHS system. The emphasis in the Francis report was on the need to develop the right culture of care within the NHS, through better leadership, training, information and transparency. The fundamental shift in culture can only be achieved if patient care is put at the top of the agenda for Boards and this mindset, belief and way of working is the first responsibility of professionals working in the NHS.

Positive leadership and a culture that places less emphasis on blame when things go wrong and more importance on transparency and learning from mistakes is required across the NHS in order to achieve this.

Medway is committed to embedding an open and transparent speaking up culture; one in which staff members and volunteers feel empowered to raise concerns, with the confidence that these concerns will be acted upon and without fear of detriment for speaking up. This includes the appropriate structure and process that supports speaking up and ensuring that all staff members demonstrate the values and behaviors required to deliver this in practice.

This strategy sets out our new vision for Speaking Up and demonstrates our commitment to making it safe for our staff to raise any concerns. It will also ensure that we always keep our patients at the centre of everything and that safe, effective and high quality patient care is top of our agenda.

2 Medway's Vision

2.1 The Trust's vision is to provide the best of care through the best of people.

2.2 Our values are at the core of everything we do at Medway as we put our patients first and they inspire us to be the best we can be every day.

2.3 Our values enable us to strive to consistently deliver the high standard of care that our patients expect of us.

2.4 Our values

Bold - We are inspiring and ambitious

We have high aspirations and want to be the best we can be every day.

We make the right decisions with our patients using evidence and best practice and we share a common vision.

We can be BOLD by through our actions and always demonstrating a “can do” attitude, as well as welcoming and learning from new opportunities.

Every Person Counts - We are respectful and supportive

We treat everybody with respect and we value the contribution of all staff. We also support and encourage each other to be our best.

We can make sure we live these values by looking for ways to create a positive experience for others, treating others with kindness and challenging behaviour that is not in line with our values

Sharing and Open - We are open and speak up and encourage everyone to create the environment for this to happen.

We strive to be open and transparent in all that we do.

This value is critical, as we can only be sharing and open when we all can work in an environment that when we see we see issues that affect the safety, quality and well-being of others and have the right processes and people that we can talk to or raise with.

We can all start to create this type of environment by asking questions and challenging behaviors and practices that do not support the way we want to work.

Together - We are inclusive and responsible

We deliver the best care for our patients together every day.

We work in partnership with our patients, families and our community.

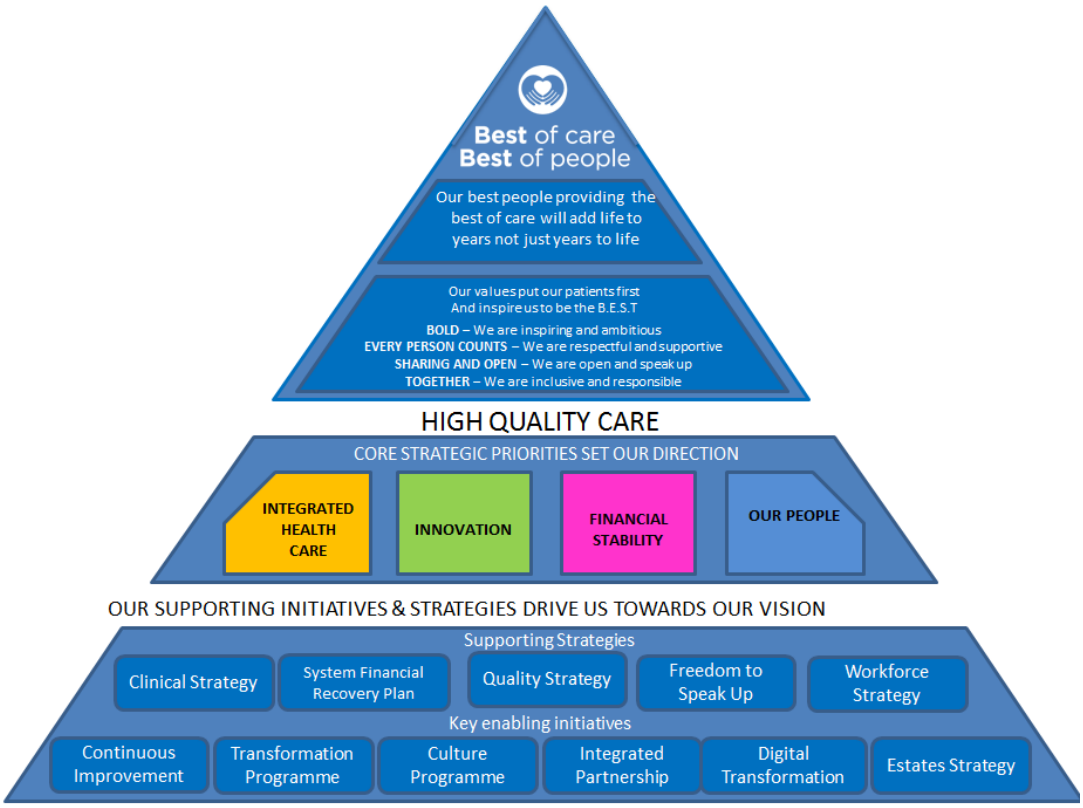
We encourage team working to deliver the best outcomes and we will do what we say we will do.

We can live these values by ensuring that we are accountable and responsible for everything we do and make a positive contribution to the success of the Trust.

We will strive to make sure that everyone of us can, and will, make a positive difference to providing brilliant care every day.

2.5 To support the implementation of the Speaking up strategy, leaders and managers within the Trust will need to model and develop these behaviors and promote them within the teams that they work in. We aim to ensure that openness, transparency and embedding a positive culture is visible to everyone and how that impacts the quality of the care we provide is referenced in the Trust’s new quality strategy.

2.6 The Speaking up strategy is one of the five enabling strategies developed by the Trust and it is recognised that this will have some interface with other strategies which are detailed in the diagram below. We must ensure that these are joined up and linked and must deliver the Trust's strategic priorities.



3 Speaking Up strategic aims:

3.1 We want to work with our staff, our patients and our volunteers to:

- Create a culture where all staff feel safe and supported to raise any concerns.
- The Public Interest Disclosure Act states a worker can make a disclosure to a prescribed person/body depending on the nature of the issue the want to raise. A worker who makes a protected disclosure within the meaning of the relevant legislation to their employer, a prescribed body or a wider public disclosure is protected by the law and should not be treated unfairly or lose their job for so doing.
- Enable our leaders/managers to be responsive to concerns and act on them promptly;
- Learn from any concerns and share the learning across the Trust to improve patient quality and safety.
- To complete the Freedom to Speak Up Guardian Competency Framework and Self-Assessment Toolkit on a 6-12 month Frequency. The tool is

designed to help Freedom To Speak Up Guardians assess their competence to carry out the role to the best of their ability. It is designed to help Guardians identity their learning and training needs, to aid conversations with line managers about training and development, and to measure how their capability grows with experience. It is not intended as a means of assessing performance but should help inform discussions on wider training priorities and also help identify local- and national- subject matter experts who will be able to help support wider development across the Freedom to Speak Up Guardian network, and health and care system more widely. A copy of the toolkit and instructions on how to use it can be found here. https://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf

4 National Drivers

4.1 The NHS staff survey should be noted and the results used as an indicator and measure of staff engagement.

4.2 The Francis report identified five key themes that were pivotal for the whole of the NHS to develop to ensure that they were able to create an open and honest reporting culture.

The five themes showed a need for:

- Culture change;
- Improved handling of cases;
- Measures to support good practice;
- Particular measures for vulnerable groups;
- Extending the legal protection.

These were all mandated alongside the need to appoint a Freedom to Speak up Guardian and to have a clear policy in place.

More recent guidance prescribes the requirement to develop a Freedom to Speak up vision and strategy to strengthen and support delivery.

4.3 The NHS Improvement well-led framework for governance reviews acknowledged that any provider who must continue to operate in a challenging environment, which is characterised by the increasingly complex needs of an ageing population, a growing emphasis on working with local system partners to create more innovative solutions to long standing sustainability problems, workforce shortages and the slowing growth in the NHS budget.

4.4 The CQC assesses a Trust speaking up culture during any inspections which aims to assess that the leadership, management and governance of the Trust assures the

delivery of high quality and person centred care, supports learning and innovation and promotes an open and fair culture

4.5 Assurance is provided through reporting achievements and key issues will be presented to the Executive Board.

5 Work undertaken to date at Medway:

5.1 The role of the Freedom to Speak up Guardians have been created as a result of recommendations from Sir Robert Francis' Freedom to Speak up review.

At Medway, Freedom to Speak up Guardians were appointed in 2016. At the time, there were six, and since then there have been a number of actions completed:

- Appointed Guardians within the workplace to raise concerns and a process to support staff was developed.
- Appointed Lead Guardian.
- Datix system is available to log concerns.
- Role of Guardians is covered in Trust induction process when new staff join.
- Guardians to date have been involved in the handling of less than 20 cases across the Trust.
- Regular diarised meeting with the Chief Executive and updates to Board now in place.
- Self- assessment tool of FTSU was undertaken in September 2018.
- Awareness raising campaigns were developed and rolled out initially but over recent months and with the nature of the changing cohort of current Guardians, this now needs an overhaul.
- Freedom to Speak up Week was promoted during October 2018 but was low key across the Trust. In October, a new interim Lead Guardian was appointed, with an external recruitment campaign to find a new Lead. This post has now been offered and the new Lead started with the Trust on the 7th January 2019.
- Expressions of interest for new advocates to support the Lead Guardian were publicised and to date 2 people have been appointed.
- Promoting Professionalism Programme (PPP) launched.
- As part of the strategy it will be imperative to ensure the Guardians advocates have the right attitude, training and support to fulfil their roles as advocates. Any new advocates will be asked to attend appropriate training upon appointment.

6 Create a culture where all staff feel safe to raise concerns

6.1 The Trust wants to continue to build an open speaking up culture that supports our staff to raise any concerns. With the appointment of a dedicated lead Freedom to Speak up Guardian and the opportunity to recruit more advocates across the Trust,

there is more work to be done to embed this further and these will be focused by our strategic aims.

The principle behind developing a culture that embraces speaking up is to empower staff to raise concerns where they believe there is a patient or staff safety risk, or it is a matter of public interest to do so.

We want our staff to speak up when they have a genuine concern about the following:

- Abuse of patients/service users;
- Clinical malpractice including ill treatment of patients;
- Criminal offences which have been committed or likely to have been committed;
- Financial malpractice including fraud or suspected fraud;
- Disregard for legislation particularly to health and safety at work;
- Damage or risk of damage to the environment or Trust property;
- Failure to comply with a legal duty;
- A deliberate attempt to cover up any of the above.

(This list is not exclusive or exhaustive.)

6.2 The Trust must develop its staff to feel comfortable and confident in raising these concerns with their leadership/management teams who would be responsive to the concern raised and take the appropriate action. However, we recognise that this may not always be the case and it is important that alternative routes exist, including Freedom to Speak Up.

6.3 To support the change in culture that this may require, all staff and leaders need to have an awareness of speaking up and recognise the importance of it. The new Guardian and the new advocates need to promote this in all interactions with their team and we want raising concerns to be part of our “business as usual” at Medway.

We will:

- Ensure that all of our staff, contractors and volunteers are aware of FTSU;
- We will encourage speaking up and thank and support those who do so;
- We will challenge poor behaviour when these do not align with our vision and values;
- Actively encourage an open and transparent culture in all that we do;
- Continue to self-assess as a Board to reflect on our commitment to speaking up and identify any improvement required;

- Continue to commit to the regular contact with Freedom to Speak up Guardians and deal quickly and effectively with any concerns using the appropriate channels;
- Enable our leaders to be responsive to concerns and act on these promptly.

6.4 The Trust recognises that when a concern is raised with managers it is important that they know how to handle the concern and have the correct escalation processes to ensure action is taken to resolve these concerns. This will involve a more collaborative approach to working across departments and trust and confidence in colleagues' commitment to respond appropriately.

6.5 We need to ensure that any leadership development at the Trust includes any behavioural expectations in this area, including how to respond to any concerns as well as developing clear leadership skills, such as listening to and acting on staff feedback.

6.6 We want our Medway leaders to welcome concerns that are raised and view these as opportunities for growth. We must ensure that we keep patients and our staff at the forefront of our minds to make Medway a place we are all proud to live and work and provide brilliant patient care.

We will:

- Review existing leadership development offers to ensure that the vision, values and behavioural expectations are clearly defined and embedded in any development interventions. This includes both work that is delivered internally and with external training provider partners;
- Work collaboratively with all colleagues in the trust to resolve concerns;
- Ensure that the appropriate structure and policies for concerns to be managed and escalated are embedded in 2019 and continue to hold the quarterly meetings between the Guardian and the CEO connecting the Board to the front line;
- Ensure that all staff knows how to access Freedom to speak up through lead guardian and the new guardian advocates;
- Provide clarity on how staff can access speaking up if they need, to using a variety of different communications options;
- Continue to roll out and promote the PPP work across the Trust and connect up more actively to identify themes and trends across the Trust;
- Refresh the existing Freedom to Speak up policies and processes to ensure that they are up to date and accessible;
- Ensure that Guardians and advocates have the right support and time to undertake their duties.
- Work with Communications team colleagues to launch a large and new campaign across the Trust about speaking up by end of February 2019;

- Monitor concerns raised at a senior level and the progress made on these to ensure that they are addressed promptly;
- Share learning from these concerns to demonstrate our responsiveness and the actions that have been taken;
- Share learning to improve patient safety with appropriate Executives and associated governance processes.

6.7 To help deliver a fundamental change in culture we know that our staff need confidence in raising concerns, know that they will be taken seriously, and that the concern will be acted upon and above all, without fear of repercussions as a result of speaking up.

In order for us to do this we must start to share learning and feedback and put in place the following suggested areas:

- Actively share and celebrate areas that have changed or developed as a result of speaking up, by March 2019 and on-going.
- Continue to report our data using the national office reporting mechanisms.
- Share results from those that have accessed the FTSU process – what did they value, how did they access etc. by March 2019
- Support all of those involved in raising concerns by March 2019 and beyond.
- Measure our success using feedback mechanisms such as NHS survey to assess our progress, by the next staff survey and use benchmarking data to assess our progress.
- Introduce quarterly pulse checks to test the mood of the organisation and respond quickly, by June 2019
- Engage with the new FTSU Guardian and new advocates to help us further shape this strategy and empower them to suggest improvements, by end February 2019.

7 Delivering the strategy

7.1 Ultimately the Chief Executive Officer (CEO) has overall accountability and responsibility for ensuring the Trust meets its statutory and legal requirements and adherence to guidance issued by the Department of Health and Social Care and other NHS bodies. The Trust Board is responsible for ensuring that the Trust creates an open and transparent learning culture that is designed to keep patients and staff safe and well cared for.

7.2 The Non-executive lead for FTSU is responsible for

- Ensuring they are aware of latest guidance from National Guardian's Office

- Holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement
- Role-modelling high standards of conduct around FTSU
- Acting as an alternative source of advice and support for the FTSU Guardian
- Overseeing speaking up concerns regarding board members

7.3 The FTSU lead is responsible for

- Ensuring they are aware of latest guidance from National Guardian's Office
- Overseeing the creation of the speaking up vision and strategy
- Ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- Ensuring that the FTSU Guardian and advocates have a suitable amount of ring-fenced time and other resources and that there is cover for planned and unplanned absence.
- Ensuring that a sample of speaking up cases have been quality assured
- Conducting an annual review of the strategy, policy and process
- Operationalising the learning derived from speaking up issues
- Ensuring allegations of detriment are promptly and fairly investigated and acted on
- Providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.
- Work closely with the communications team to ensure that momentum in promoting speaking up is not dropped.
- Ensure that contact is made with vulnerable staff groups to encourage speaking up.

7.4 Medical Director and Director of Nursing are responsible for:

- Ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues
- Ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- Ensuring learning is operationalised within the teams and departments they oversee.

7.5 Speaking up sits within the office of the Chief Executive and therefore is led by the Executive Director responsible and supported by the Lead Guardian. As mandated nationally the Guardian will have a direct line to the CEO.

7.6 The governance of FTSU reports solely to the Board of Executives

7.7 FTSU Guardian reports –

- Reports are submitted frequently enough to enable the board to maintain a good oversight of FTSU matters and issues, and no less than every six months. Reports are presented by the FTSU Guardian or a member of the trust's local Guardian network in person.
- Reports include both quantitative and qualitative information and case studies or other information that will enable the board to fully engage with FTSU in their organisation and to understand the issues being identified, areas for improvement, and take informed decisions about action.
- Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.
- Themes and Treads will be presented to the board in order for the board to make recommendations and will include:
- **Assessment of issues**
- **Potential patient safety or workers experience issues**
- **Action taken to improve FTSU culture**
- **Learning and improvement**
- **Recommendations**

8 References

Document	Ref No
References: **Care Quality Commission** https://www.cqc.org.uk/national-guardians-office/content/national-guardians-office **NHS Employers** https://www.nhsemployers.org/blog/2016/12/now-that-you-are-a-freedom-to-speak-up-guardian **e-Learning for Health** https://www.e-lfh.org.uk/programmes/freedom-to-speak-up/ **Freedom to speak up .org** http://freedomtospeakup.org.uk/the-report/ **East London NHS Trust** https://www.elft.nhs.uk/About-Us/Freedom-To-Speak-Up **NHS England** https://www.england.nhs.uk/wp-content/uploads/2016/11/whistleblowing-guidance.pdf **NHS Improvement (Whistleblowing Policy)** https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/ Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts	

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Trust Associated Documents:

http://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_Executive-summary.pdf Executive Summery

END OF DOCUMENT