Agenda

NHS Medway NHS Foundation Trust

Public Trust Board Meeting

Thursday, 15 December 2022 at 12:30 – 15:30 in the Trust Boardroom and via MS TEAMS

Item	Subject	Presenter	Page	Time	Action
Opening Matters					
1.	Chair's Welcome and Apologies	Chair	Verbal	12:30	Note
2.	Quorum		Verbal		Note
3.	Declarations of Interest		Verbal		Note
4.	Minutes of the last meeting held on 05 October 2022, and matters arising/actions		3		Approve
5.	Chair's introduction and update		Verbal		Note
6.	Chief executive update	CEO	17	12:40	Assurance
Patient and Staff Experience					
7.	Patient Story – Call for Concern	Acute Response Team	21	12:45	Note
8.	Council of Governors Update	Chair of the Council	Verbal	12:50	Note
9.	Questions from the public	Chair	Verbal	13:00	
Assurance Items					
10.	Board Assurance Framework	Director of Integrated Governance, Quality & Patient Safety	33	13:10	Assurance
11.	Trust Risk Register		41		Assurance
12.	Committee updates: • Audit and Risk • People • Quality and Assurance • Finance, Planning and Performance	Chairs of each Committee	55	13:20	Assurance
13.	Finance Report	CFO	79	13:45	Assurance
14.	Annual Business Plan (23/24) development update	CFO/COO	95	13:50	Assurance
15.	Edenfield update	CNO	101	14:05	Assurance
16.	Maternity Safety Update	Director of Midwifery	107	14:10	Assurance
17.	Infection, Prevention and Control update	CNO	169	14:20	Assurance
Quality, Performance and Items for Escalation or Decision					

18.	Integrated Quality performance Report	COO, CNO, CMO	181	14:25	Approve
19.	Winter Plan • Nursing & Midwifery Safer Staffing	COO	223	14:40	Approve
20.	Business Case Sheppey Ward	CFO	267	14:50	Approve
Closing Matters					
21.	Any other business	Chair	Verbal	15:00	Note
22.	Board review of meeting				
23.	Date of next meeting: 01 February 2022				

Additional documents circulated for information and note:

- Medical Education Annual Report – Page 297
- Organ and Tissue Annual Report – Page 309

Board of Directors in Public
Action Log

Actions are RAG Rated as follows:

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

Meeting Date	Minute Ref / Action No	Action	Action Due Date	Owner	Current position	Status
05.10.22	PU/TB/005/22	Full IQPR to be published to the Trust website for transparency	06.10.22	Matt Capper - Co.Sec	**Propose to close** - Published to website 06.10.22	Green
05.10.22	PU/TB/006/22	Succession Planning structures to be reviewed at People Committee	24.11.22	Matt Capper - Co.Sec	**Propose to close** - Noted for next People Committee meeting - added to the agenda	Green
05.10.22	PU/TB/007/22	Nutrition and Hyrdration presentation to to the next Public Board	15.12.22	Alison Davis - CMO	CoSec to add to the Board agenda	White
05.10.22	PU/TB/008/22	Narrative from Datix to be aligned to risk registrer for maternity	15.12.22	Alison Herron		White
05.10.22	PU/TB/009/22	Trust Board Template to incorporate target points	15.12.22	Matt Capper - Co.Sec	Template updated 13.10.22 - awaiting approval	White

NHS Medway NHS Foundation Trust

Minutes of the Trust Board PUBLIC Meeting

Wednesday, 05 October 2022 at 12:30 – 15:30

Hybrid Meeting

Members	Name	Job Title
Voting:	Jo Palmer	Chair
	Adrian Ward	Non-Executive Director
	Alison Davis	Chief Medical Officer
	Annyes Laheurte	Non-Executive Director
	Jayne Black	Chief Executive
	Leon Hinton	Chief People Officer
	Mandy Woodley	Chief Operating Officer (Interim)
	Mark Spragg	Non-Executive Director
	Sue Mackenzie	Non-Executive Director
	Evonne Hunt	Chief Nursing Officer
	Paula Tinniswood	Chief Strategy and Transformation Officer
Non-Voting:	Glynis Alexander	Director of Communications and Engagement
	Jenny Chong	Associate Non-Executive Director
Attendees:	Adebayo Da-Costa	Governor
	Alison Herron	Director of Midwifery
	Anan Shetty	Governor
	David Brake	Lead Governor
	Emma Tench	Assistant Company Secretary (Minutes)
	Jignesh Patel	Governor
	Matt Capper	Company Secretary (Interim)
	Nicola Lewis	Associate Director of Patient Experience
	Nitesh Mathai	Governor
	Paul Kimber	Deputy Chief Financial Officer
	Sarah Garman	Head of EPRR
	Sarah Levitt	Professional Development Nurse
Apologies:	Alan Davies	Chief Financial Officer
	Rama Thirunamachandran	Academic Non-Executive Director

1 Preliminary Matters

1.1 Chair's Welcome and Apologies

The Chair welcomed all present and apologies were given as listed above. Chair continued with the following update:

a) *Welcome and introduction from Matt Capper, the interim Trust Company Secretary.*
b) *Thanks and best wishes to Paula Tinniswood who leaves the organisation the end of October 2022.*
c) *Firstly, thank you for joining us for this virtual Trust Board meeting today.*
d) *I would like to take this opportunity to thank colleagues who are working incredibly hard to care for increasing numbers of patients while also planning to ensure that the Trust is prepared for winter – we know it is going to be a challenging one.*
e) *As we approach winter it is more important than ever that we have the full support of our community. You can help us by using our services appropriately – remember A&E is not always the best place to receive care – and by ensuring that you have your Covid booster and flu vaccination if you are eligible.*
f) *We know that this winter the double threat of Covid and flu will be significant, so anything you can do to avoid this would not only help the healthcare system, but most importantly be beneficial to your health.*
g) *Like everyone else across the nation, I was saddened by the death of Her Majesty the Queen.*
h) *I was proud to have the opportunity to speak about what she meant to me in an event to commemorate her life that took place in the hospital last month. She was an inspiration to many of us, and a constant figure in our lives. There is no doubt that she has left a legacy that will never die, even though she has now left us.*
i) *We are incredibly grateful for the kind donations we receive from our former patients and their families. Last month, I had the pleasure of being at the opening of a state-of-the-art simulator for trainee surgeons to practise the skills needed to carry out orthopaedic arthroscopic joint surgery. The new facility was possible thanks to a £1million legacy from Ralph Barrett, a retired BBC engineer, who had a serious motorbike accident during the Second World War and underwent 14 operations to save his leg.* He was so thankful for the outstanding care he received that he left the Trust this incredible gift in his will. We were delighted to welcome Ralph's family to our hospital to showcase the impact of his legacy.

1.2 Quorum

The meeting was confirmed to be quorate with at least one-third of the whole number of the Directors (including at least one Executive Director and one Non-Executive Director) being present.

1.3 Conflicts of Interest

There were no conflicts of interest raised.

1.4 Chief Executive Update

Jayne Black, Chief Executive gave the following update to the Board:

a) *Like everyone else in the country, I was saddened to hear of the death of Her Majesty Queen Elizabeth last month.*
b) *For most of us the Queen has been a constant presence in changing times, and many have found her to be an inspiration through her devotion to duty; may she rest in peace.*
c) *As winter approaches we are expecting to see a rise in cases of COVID-19 and seasonal flu in our community. We are offering the Covid booster vaccination and seasonal flu vaccination to our staff and encouraging them to take up this opportunity to protect their patients, themselves, and their loved ones. We would also urge members of our community to have their vaccinations when invited; this will not only help to protect their own health, but also help to protect our services during what is likely to be a very busy period.*
d) *The Trust is working in partnership with Gillingham Street Angels to offer a 'donate and take' scheme for our community.*
e) *Located in the lobby area of the Chapel/Prayer Room at Medway Maritime Hospital (level 2, blue zone), the donation and collection point is open to patients, visitors and staff, to take and*

donate non-perishable every day essential items, especially items which can be used to make healthy meals.

f) *Times are difficult at the moment and we know from the national media coverage that people across the country are struggling to afford to buy food and every day essentials. We wanted to do something to help those who may be struggling financially, and the 'donate and take' scheme is one way of us showing our support. We hope it will bring comfort to those who need to use it and that patients, visitors and staff will support it by donating items too*

g) *Hundreds of patients are benefitting from vital scans every month thanks to a new Magnetic Resonance Imaging (MRI) scanner that has been installed at Medway Maritime Hospital.*

h) *The new mobile scanner is helping patients to get their diagnostic appointments quicker and reducing the number of people waiting for scans, which has increased since the COVID-19 pandemic.*

i) *The Annual Members' Meeting due to take place last month was postponed as a mark of respect during the national mourning period. The new date for the event will be Tuesday 18 October 2022.*

j) *Last month, I was delighted to present our Learning Disability Liaison Nurse Eloise Brett with a prestigious Cavell Star Award. Eloise won the prize for promoting equality in healthcare and ensuring a positive experience for our patients with learning disabilities and autism. This is fantastic recognition for all the incredible work Eloise has done since joining the Trust six years ago.*

k) *I am incredibly proud of the fantastic new 'one stop shop' initiative the Trust has launched for patients with learning disabilities and autism who require a medical procedure under a general anaesthetic.*

l) *The initiative, which aims to improve healthcare outcomes, allows patients to have a combination of important treatments such as dental and podiatry work, and endoscopies or colonoscopies, while they are sedated and following a best interest decision.*

m) *I am incredibly proud of all colleagues who came together, including the Learning Disability Nursing Team, theatre staff and partners from Medway Community Healthcare, to launch this project for our patients with learning disabilities and autism. By having more access to these important treatments, it will ensure that patients have a better quality of life and improved outcomes.*

2 Minutes of the previous meeting and matters arising

2.1 The minutes of the last meeting, held on 03 August 2022 were reviewed by the Board. The minutes were **APPROVED** as a true and accurate record.

2.2 Matters arising and actions from the last meeting.
See Action Log for current position on actions.

3 Board Assurance Framework

3.1 BAF Report

The Trust has redesigned BAF in alignment to the revised Risk Management Framework.
The current BAF contains the following Risks:

- **Integrated healthcare**: 1a Failure of System Integration
- **Innovation**: 2a Future IT Strategy, 2b Capacity and Capability, 2c Funding for Investment
- **Finance**: 3a Delivery of Financial Control total, 3b Capital Investment, 3c Failure to achieve long term financial sustainability, 3d Going concern
- **Workforce**: 4a Sufficient staffing of clinical areas, 4b Staff engagement, 4c Best staff to deliver the best care
- **Quality**: 5a CQC Progress, 5b Failure to meet requirement of Health and Social Care, 5c Patient flow capacity and demand

The paper presented the current position for the Finance, Workforce and Quality Risks in the new format and acknowledged the further work to be completed to set KPIs for Workforce.

In line with Patient First, the Transformation team have also undertaken a piece of work to identify the top risks to the Trust True North Domains, which now need to be approved by the Executive and added into the BAF format for approval at a future committee.

Work is also required to review all risk on the Trust Risk Register scoring less than 15 which may impact on the True North Domains.

a) Jayne Black and Annyes Laheurte thanked all involved with the new alignment to Patient First.

The Board **APPROVED** the new BAF format.

4 Quality

4.1 Integrated Quality Performance Report

ACTION: TB/005/2022 Full IQPR to be published the Trust web site; full IQPR unavailable prior to the meeting. (Post meeting note: the full IQPR was published to the Trust website on 06.10.22)

Mandy Woodley reported on the slides, providing a Performance Update for Medway Foundation NHS Trust (MFT) across the key business performance metrics of Emergency Demand, Patient Flow, RTT, Cancer and Diagnostics Performance.
The purpose of the report was to provide assurance around performance, explain any key variances and also detail any key actions being taken to enhance performance where required.

a) Jenny Chong asked regarding the RTT over 50 week breaches, what has the review uncovered in terms of trends. Evonne Hunt advised in terms of the real time harm review, historically 12 hour breaches would have been reported as a Datix and then a review to determine risk; the ED have implemented 12 hour real time for as soon as the patient comes into ED, the team will continuously review them, a proactive rather than reactive approach; with no report of harm to date.

b) Mandy Woodley confirmed the same approach is used for RTT, reviewed on first or virtual appointment, referrals have gone up, however cancer numbers have not increased. Suggests no harm.

c) Jayne Black commented on the large amount of work to reduce the wait times, the learning from ENT has been essential to drive down long waits. A recovery fund is being used proactively to add additional sessions as required. Around emergency care, across the county, all are extremely challenged. Medway Foundation Trust (MFT) numbers around those patient who are medically fit is important to note. Important for Medway and Swale to work together with regional colleagues.

Alison Davis updated the Board providing a Performance Update for Medway Foundation Trust (MFT) across the key business performance metrics of Quality Assurance including: harm free care, incident reporting, infection control and mortality

Evonne Hunt updated the Board providing a Performance Update for Medway Foundation (MFT) across the key business performance metrics of Quality Assurance including: Admitted patients, ED, Maternity and Outpatients care.

4.2 Quality Assurance Committee Assurance Reports

Jo Palmer presented the report from the Committee. The report noted received assurance and escalation report from the Quality and Patient Safety Sub-committee that took place on Thursday 18 August 2022.

The Committee were assured by the excellent report which provided a really good summary of the discussions and provided a real essence of the things QPSSC are assured about and those that QPSSC are not assured of.

The Committee noted the items where QPSSC have requested further assurance from; review of 2 child deaths and safeguarding Children's annual report, will be re-presented at QPSSC and then to this Committee.

The Committee noted that a number of papers on the agenda for the quality assurance committee had been discussed at QPSSC.

a) Mark Spragg asked with alignment of reports on maternity from QAC to the Trust Risk Register; the Risk Register has staffing and induction of labour as two high risk categories, whereas the QAC reports are stated as managing with new staff. It is important reports come to board and align with capital spending.
Evonne Hunt advised the paper gives summary and highlights of discussions, the risk register is very clear in terms of insufficient midwifery staff. Alison Herron will be giving at update (at this meeting) regarding the new staff in post from September 2022. The emphasis on the new staff is induction and retention. Work will be undertaken to align the reports.

b) Mark Spragg commented the reports from Alison Herron will not emphasis the major risk. The reports are read as the risk being under control.
Evonne Hunt advised there are controls in place, we are still short staffed but do have a number of new staff coming in September and October. Controls with bank staff in place.

c) Mark Spragg commented on the induction of labour being a very high risk on the Risk Register due to the lack of staff; with maternity department being the Trusts biggest risk area of a claim against the hospital effecting the CNST. Concerns the Trust are not asking for help that might be available, and not asking the board to address as an urgent problem. There needs to be a deep dive into this to determine the level of the risk.

d) Jayne Black commented there is a timeline around this issue, we need to ensure the new staff coming in can reduce the risk. The plans in place are appropriate and will address the risk, this will be reviewed and brought down to reflect the new staffing arrangements mitigating the risks. The risk is not about asking for help, the plans in place are right and proper.

e) Jo Palmer asked the board to note the new Patient Record system has gone live. A presentation on Nutrition and hydration has been recommend for the next formal Public Board meeting. Brought forward the progress report of actions regarding self-harm brought to the private board today. Three Escalation reports are being presented today from Maternity. Two events relating to femoral implants and nasal gastric tube that was not correctly sited and identified quickly; noted to committee controls had identified issue before any harm had been caused. Reviewed proposed new reporting to replace the IQPR, Quality Performance Report to include Patient First. Review of Safeguarding reports, including an update on the EPRR safeguarding flags that have not been migrated across.

The Board **APPROVED** the Quality Assurance Reports.

4.3 Emergency Planning, Resilience and Response

Sarah Garman presented the Annual Assurance Report and Business Continuity Policy and Framework.

Annual Assurance Report

This report provides the Trust Board with:

- Update on EPRR work streams and issues related to its progress throughout 2022
- Overview and understanding of Trust compliance with the NHS EPRR Core Standards Assurance for 2022
- Improvements plan, detailing actions required to enhance compliance for the EPRR Core Standards Assurance in 2023.

Business Continuity Policy and Framework

The Policy document is a requirement for the Trust as a Category 1 responder organisation in England, under the Civil Contingencies Act 2004.

Such requirements for the Trust are detailed within the NHS England EPRR Core Standards 2022), referenced within the updated NHS England EPRR Framework 2022.

The Policy is a revision of the current version (EPRR and Business Continuity Policy 2020 v08.01) published to the public facing website and acts as a statement of commitment and intent from the Trust Board, on its delivery of Emergency Preparedness, Resilience and Response activities.

This document is revised to align with reference to the updated NHS England EPRR Framework (2022), the new Health and Care Act 2022 *in place of the Health and Social Care Act 2012* and content alignment with the new Reporting and Accountability structures for EPRR and its establishment within the Trust.

a) Jayne Black thanked the team for their hard work with the reports. CBRN states non-compliant, but in table 3.2 it states is partially compliant. Sarah Garman confirmed the table should show non-compliance.

b) Jenny Chong recognised the hard work from EPRR. Raised the question, in regards to succession planning, across key functions in the organisation, if there was a serious incident. Jayne Black confirmed this is a piece of work as part of Executive is looking at work across the divisions, reviewing structures. Know where there is vacancies with plans in place to ensure people are coming in. Reviewing succession planning within operations, as a team looking to facilitate and grow our own.

ACTION TB/006/2022: Succession planning structures to be reviewed at the People Committee.

Approved at Audit and Risk Committee – **ENDORSED** at the Public Trust Board.

4.4 Risk Register Review

Medway NHS Foundation Trust (MFT) is committed to establishing and implementing a revised Risk Management Framework and Policy which minimises risk to its stakeholders' through a comprehensive system of internal controls. The Risk Management Framework encompasses strategic, financial, quality, reputational, compliance and health and safety risks.

A new style Trust Risk Register (TRR) report has been introduced, this provides a direction of travel and comparison summary of all the extreme risks on a quarterly basis.
Following a detailed review of the Trust Risk Register, there are now 17 (initially 43) extreme risks on the TRR. These are risks scored at 15 and above, escalated from other risk registers into the TRR.

a) Jenny Chong enquired, with the risk numbers, how are they ordered. Evonne Hunt confirmed these will be ordered in priority moving forward.

b) Annyes Laheurte commented if a control is identified as inadequate should this trigger an action, with more urgent scrutiny needed. Evonne Hunt advised this has been put into the revised risk framework and given timescales for individuals, there is power in the conversations with the teams ensuring correct actions are put into place. The board committees will start to see risk actions coming through ensuring they can be challenge the details.

c) Jo Palmer asked with 'three ambers and one red' on page 87 does this need to be discussed to mitigate a risk. Evonne Hunt stated the teams are reviewing their mitigations, a number of actions are being put into place, challenging individuals, these will be captured and reviewed at the next meeting.

d) Jo Palmer asked if Evonne was happy that all mitigation actions are in place. Evonne Hunt definitely for the Trust Risk Register these are all in place.

e) The Non-Executive Directors all commented on a fantastic piece of work, credit to Evonne and Dan Rennie-Hale, will be a really helpful tool.

4.5 Patient Experience Update

Nicola Lewis highlighted the purpose of the report; is to give an update summary of the work undertaken within patient experience.

This report provides a quarterly update on patient experience. A report is routinely presented at the Patient Experience Group. The report focus on:

- Patient First True North Domain Patient: FFT 95% of patients completing the friends and family test would recommend us as a place to receive care
- Complaints, PALS and Compliment
- Enhanced Care
- Falls
- Tissue Viability
- Privacy and Dignity
- Nutrition and Hydration
- Mixed Sex Accommodation
- End of Life Care
- Voluntary services provision update
- Chaplaincy

- An update against the patient experience strategy delivery action plan

Nicola Lewis, the new Associate Director of Patient Experience will be tasked to support the teams to build upon the work in progress and to drive the patient experience work plan going forward.

a) Mark Spragg enquired what the escalation process from PALs is. Nicola Lewis advised there is a delay nationally with PALs contacts and complaints. The escalation process should feed back to the patient. Evonne confirmed Dan is working with the team and going through a consultation process. There is a revised PALS Policy that will be going to QAC for review.

b) Sue Mackenzie enquired about the Patient Experience Academy, and if this was a MFT initiative. Nicola Lewis confirmed a MFT initiative, celebrating the patient experience, learning from patient stories and experiences. The team would like all staff take part in the academy.

c) Jo Palmer confirmed a recommendation for a presentation on Nutrition and Hydration to the come to the next Public Trust Board. ACTION TB/007/2022: Nutrition and Hydration to be added to the next Public Trust Board Agenda.

4.6 Medical Appraisal and Revalidation Board Report

In view of Covid-19 pandemic, appraisals and revalidation process for the doctors was put on hold completely by NHS England from Mid-March 2020. From June 2020, the appraisal and revalidation process was restarted as per choice of the individual organisations and MFT restarted the process in a phased manner taking into account the individual doctor's personal ability and circumstances to complete the appraisal.

NHS England has stopped the requirement of sending the Annual Organisational Audit (AoA) report for this reporting year. As a result, no AoA has been submitted to NHSE for 2021-22 reporting year. We are still required to submit a statement of compliance to NHSE.

Medway NHS Foundation Trust has **454** doctors connected as on 31 March 2022.

- **398(87.6%)** doctors completed an appraisal for the reporting year.
- **54** doctors had an approved missed or incomplete appraisal out of which –
    1. **39** doctors were working for less than 6 months and were new to UK and were not required to complete an appraisal before March 2022.
    2. **2** doctors were on maternity leave.
    3. **5** appraisals were closed due to sickness of the individual doctors.
    4. **1** doctor held temporary covid-19 registration and retired very soon after this period ended.
    5. **2** doctors had a career break during the appraisal window
    6. **3** appraisals were late due to lack of time of the appraiser.
    7. **2** doctors were late due to lack of time of the doctor

- **Two** doctors had unapproved or missed appraisals. Both Doctors met with Jeremy Davis, Deputy Chief Medical Officer and Deputy Responsible Officer, clear guidelines were given with dates in which the appraisal will need to be completed. Both Doctors followed the deadline dates given and submitted the appraisal late.

For the year ending 31 March 2022, a total of 116 revalidation recommendations were sent to the GMC during the reporting year. 24 deferral recommendations were sent with 5 doctors having a positive recommendation sent during the report period.

- Following the retirements of David Sulch (Responsible Officer) and Kirtida Mukjerjee (Deputy Responsible Officer), Jeremy Davis took up the position of Responsible Officer in an interim role from 01 December 2021.
- For clarity and information, although outside the period covered in this report, Alison Davis, CMO, took up the permanent position of Responsible Officer from 15 August 2022

The Medical Appraisal and Revalidation Board Report **APPROVED** by the Public Trust Board.

4.7 Ockenden Assurance Report

Alison Heron updated on the report which provides an update made to the Quality and Patient Safety Sub-Committee and Quality Assurance Group on the Maternity Service's progress against compliance with the initial 7 Immediate and Essential Actions (IEAs) from the first Ockenden report (2020) along with the 15 IEAs from the second Ockenden report (2022).

The report also provides a summary of the NHS England Insight Assurance Visit on 16 August 2022 to review MFT's compliance with the first Ockenden report 7 IEA's

4.8 CNST Assurance Report

Alison Heron updated on the report which provides an update made to the Quality and Patient Safety Sub-Committee and Quality Assurance Group on the Maternity Service's progress against compliance the 10 Safety Actions for CNST Year 4

4.9 Maternity Workforce

Alison Herron updated on the report which provided a Maternity Workforce Oversight report to the Quality and Patient Safety Sub-Committee and Quality Assurance Group in line with the requirements for Safety Action 5 for CNST Year 4.

a) Mark Spragg raised concerns regarding the issues being assured at QAC, but being reported as a major issue on the risk register today at Board; regarding staffing and induction of labour. When the board is faced with analysis and then told there are no staffing issues the question needs to be asked if the information is correct.

b) Alison Herron commented there are reasons behind disconnect of the data. There has been a deep dive on the risk register to ensure clarity of information; the ratings on the risk register could have been deescalated however felt they should remain until the new staff were in place and being properly supported to ensure retention. The report shows the mitigation and background. A review will be taking place in early November 2022. In terms of Labour Induction a huge amount of work is taking place, reviewing induction on a daily basis, with a number of immediate actions in place. This will be reviewed and changed on the risk register once initiatives are sustained.

c) Mark Spragg commented the board do not always get sight of a detailed report alongside the risk register; raising concerns on how the data is presented to the NEDs, with the NEDs having the same responsibilities as the Execs.

d) Alison Herron advised will look back to ensure the narrative in Datix and the risk register aligns. ACTION TB/008/2022

e) Mark Spragg commented on risk 4 going from major to catastrophic. Evonne Hunt stated this was initially a 12 (and not reviewed since July 2021), then went through a review with Alison Heron and given a more realistic score. In the next quarter will see a reflection of mitigations, and de-escalation on the risk register.

f) Jo Palmer advised there is a comparison of actions recorded as green and on track and consistent with risk evaluation treatment control, but overall risk not crystalised if controls are not yet effective.

g) Mark Spragg commented the data is the best assessment from management regarding the likelihood of a risk occurring. As an example of the new documents, exploring maternity, it's interaction between reality and theory, with risk register the theory; this is maybe too slow moving to be concerned as risk register will only change every quarter.

h) Jo Palmer commented whilst the formal reporting is quarterly, the controls and mitigations are live. Evonne Hunt advised the risk register will go to the Audit and Risk group monthly and will be presented back to Board Committees for assurance. The revised approach will become embedded and familiar.

i) Alison Herron commented there is a focus to get a live risk register on a daily basis, with staff now being familiar with the process. Colleagues are utilising the risk register and familiarising themselves with the data, escalating and alerting if something catastrophic is coming up, knowing the pinch points.

j) Jenny Chong agreed with Mark Spraggs concerns, highlighting the different perceptions when reading actions against risks. Jo Palmer advised training and watching mitigating actions does need to be completed to address.

k) Matt Capper advised a refresh of the Trust Board template to incorporate target points. ACTION TB/009/2022

5 Sustainability

5.1 Finance Report

Paul Kimber reported on the Finance report for the period ending 31 August 2022.
The Trust reports a £1,191k deficit position for August; reducing to £1,182k after making the technical adjustments for donated assets, this being £985k adverse to the submitted plan. The reported position includes Elective Services Recovery Funding (ESRF) income of £4.1m year to date; ESRF activity plans continue to not fully achieve however there is not be a requirement to repay ESRF income in H1. An assessment of goods received not invoiced (GRNI) accruals relating to previous years has released £1.5m into the position as an estimate of those accruals no longer needed. The non-recurrent benefit from general accruals released into the position year to date totals £7.0m. A further report on the financial risks is being presented to the September committee; this will address in more detail the root causes of overspending and implementing additional controls as one of the corporate objectives.

The delivered efficiency programme position of £2.6m includes £1.8m of the approved cross cutting themes and £0.2m full year effect of schemes continuing from 2021/22. The remaining efficiencies continue to be predominantly from the Corporate functions £0.2m as well as Facilities and Estates £0.3m.

A detailed and prioritised capital plan for the £10,970k was agreed at the start of September along with approval for the PDC funding streams. The request from the operational and clinical teams was approx. £5m in excess of the funding available; this value of schemes of lower priority designation has therefore been deferred to future years or until further funding becomes available.

The Trust Capital Resource Limit (CRL) and plan has been set at £11,550k, to be funded from system capital, depreciation (£10,970k) and PDC (£580k). Since M4 a further £13,007k of PDC funding is in the pipeline mainly for diagnostic equipment, endoscopy expansion and EPR. This funding is highly likely but MOU's are yet to be issued as final confirmation.

The Trust cash balance is £8,175k higher than plan due to the implementation of cash maximisation strategy, which mainly involves reverting to paying HMRC, NHS Pensions and suppliers on contractual terms. During periods of excess cash and then mandated throughout COVID, these were paid as soon as invoices were approved and/or the cash was available

a) Jo Palmer with outpatient follow up being capped at 85% how is MFT addressing this. Paul Kimber advised a very specific piece of work taking place for elective work moving forward, there have been some coding issues. Looking at making sure that additional clinics are seeing patients for their first appointment. Making medically informed decision about follow up appointments.
Alison Davis commented different specialist will have different needs, need to ensure having the right clinical conversations.

b) Jayne Black commented on the piece of work through Patient First and discussed at the weekly huddle and fortnightly ERF meetings to drive. MFT are in a better position than a few months ago, with the Minster development on board will be able to drive this. Changes being supported through EFR funding.

c) Paul Kimber stated relating to ERF income for first half of year this will not be clawed back, awaiting confirmation regarding the second half of the year.

5.2 Finance, Planning and Performance Committee Assurance Report

Annyes Laheurte presented the report:

- Escalation to the Board: Current financial performance is £1.0m adverse to plan. Additional controls have been established and implemented on the financial position with Executive leads agreed for each of the key overspending and risk areas.

a) Jayne Black commented with drivers around escalation the board needs to recognise the difficulties with discharge which has stopped MFT from doing what had been planned; despite this other plans are still going ahead within our gift, with continuous work to improve discharge.

b) Jo Palmer advised tying in financial plan with the risk register, ensuring best practice opportunities and best outcomes for patients.

6 People

6.1 People Committee Assurance Report

Sue Mackenzie presented the report:

- No changes to BAF
- Reviewed HEE, first time against national, submitted as compliant.
- IQPR areas contributing to turnover.
- WRES and WDES completing a Bullying and Harassment deep dive.

- HR Resourcing report, nothing off plan
- Vaccinations for Flu and Covid in progress, meeting guidelines from NHS England, consistent with best practice.
- Escalation – short term sickness deep dive to be escalated.

Any Other Business

7.1 Council of Governors Update

David Brake gave the following update to the board:

- Governors, and the therapy dogs, took part in a Summer Fun Day in August 2022 raising £500, also brought awareness of other charities who support the Trust.
- Last week Governors attended two 'drop in' sessions at local libraries in Lupton and Lordswood, sharing the benefits of becoming a Governor for MFT.
- The Annual Member Meeting will be taking place on 18 October 2022, 18:00 in the Below Deck staff restaurant, with an option to join virtually.
- Governors have been invited to participate in the upcoming place assessments on ward accreditation visits.

7.2 Questions from the Public

No questions form public

7.3 Any Other Business

Jo Palmer asked for Board Papers to use full names with acronyms in brackets.

Evonne Hunt gave a brief verbal report on Covid numbers:

- 38 currently in the hospital, fluctuates daily, between 25-38.
- Guidance has changed for screening, when patients leave they are screened whereas before was on admission at day 3 and day 6.
- Workforce levels have remained steady.
- IPC have robust approach.
- The immunisation programme has started for staff.

Date and time of next meeting

The next meeting will be held on Wednesday, 02 November 2022 Patient First Board Review

The meeting closed at 15:50

These minutes are agreed to be a correct record of the Trust Board of Medway NHS Foundation Trust held on Wednesday, 05 October 2022

Signed …….. Date ……

Chair

NHS
Medway
NHS Foundation Trust

Chief Executive's Report – December 2022

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.

COVID-19 and seasonal flu

With winter now upon us we are likely to see a rise in cases of COVID-19 and seasonal flu in our community, although currently we are pleased to note that we have not seen a significant increase in admissions.

We would encourage members of our community to have their vaccinations when invited; this will not only help to protect their own health, but also help to protect NHS services in Medway and Swale.

Acute medical model

Last month we were delighted to launch our new acute medical model at the Trust. The initiative is supported by NHS England and brings a new model to the Trust for patients with an acute medical need. We hope it will play a major part in tackling winter pressures and reducing ambulance handover times, as it brings a far more comprehensive approach to managing patients on a same day basis.

The model sees our existing Same Day Emergency Care (SDEC) service upgraded to an Acute Ambulatory Medical Centre, containing three dedicated pathways:

1. Early Discharge Review Clinic
2. GP Assessment Unit
3. SDEC pathway.

Each of these pathways will help to reduce length of stay and enhance flow throughout the hospital.

Since its launch we have seen considerable improvements for our patients who need urgent and emergency care, and as a result Medway is not only the busiest but also one of the best performing sites in the region for ambulance handovers. As well as improving the way we care for our patients, the new model is also helping our partner organisations such as South East Coast Ambulance Service (SECAmb) to improve their performance, as it frees up ambulances to provide faster care to people who need emergency help.

Celebrating five years of robotic surgery

I had the pleasure of speaking at a special event to mark the fifth anniversary of robotic surgery at the Trust in November.

It was great to see so much support from internal and external guests, including the Leader of Medway Council Cllr Alan Jarrett, our lead governor Cllr David Brake, and two sixth form students, who are both studying A-level biology at The University of Kent Academies Trust.

We were ahead of the robotic curve when we introduced the programme in 2017 and we were one of the early adopters of the da Vinci Xi technology. Since its arrival, the minimally invasive surgery tool has revolutionised the care we provide to patients undergoing urology and colorectal surgical procedures as it is able to perform complex and incredibly precise procedures not possible by human hands.

Robotic surgery is a ‘team sport’ and requires buy-in at all levels to work effectively, something our surgical and operational teams have certainly fully embraced, and as a result they have implemented a safe and effective programme which has seen patient outcomes improve and the programme develop year-on-year.

I’m proud to say that the da Vinci robotic training pathway has recently been accredited by the Royal College of Surgeons as one of the safest and most effective robotic training pathways. The team here at Medway has completed this training pathway and is now helping to teach teams at other Trusts along with Intuitive.

In addition, the Trust has also been recognised by NHS England for offering gold standard treatment to urology patients by using the robotic system – so there really is lots for us to be proud of here at Medway.

Providing care closer to home for frail patients in Sheppey

Last month we shared the good news that we are creating capacity to care for frail Swale patients closer to home. We have been working with partners to find ways of providing this much-needed service, and to create more beds within our own hospital for planned operations and treatment.

With funding from NHS England, we will use vacant space in Sheppey Community Hospital, creating a frailty ward, primarily for patients living in Swale. The ward will be staffed by a clinical and support team employed by the Trust. The majority of

patients who live in Medway and require care within a specialised frailty setting will continue to be looked after at Medway Maritime Hospital.

Creating beds in Sheppey will free capacity within Medway and enable us to allocate further beds for planned operations and treatment, referred to as elective services. We anticipate this will result in waiting times for surgery being reduced. The aim is to open the ward before the end of the year to maximise the benefit over the winter.

Marking World Prematurity Day

Last month we were proud to mark World Prematurity Day, a chance to raise awareness of premature births and the impact on families.

ITV Meridian News came into speak to parents Laura Jewiss and Paul Burr about the care provided by the Oliver Fisher Baby Care Unit not once but twice, following the birth of two sets of twins.

Their story is extremely moving and highlights the great care our neonatal team provides, not just to babies who are born prematurely, but the whole family. You can read their story in full on the Trust's website.

The hospital's clock tower was also illuminated in purple to mark the end of the awareness day.

Recognising our staff

Thank you to members of our community who have taken the time to nominate our colleagues for a Hospital Hero award, which is a part of our annual staff awards.

The awards are a lovely way for the Trust to recognise and reward staff who have gone that extra mile or have shown great passion and commitment to improving the working environment for their colleagues and patients. We've all been through difficult and challenging times over the last 12 months so saying thank you and well done is important.

Award winners will be announced at a special event in the new year.

Communicating with colleagues and the community

The graphic below gives a flavour of some of the work we have done to communicate with our staff and community over the last month.

Photo gallery






NHS Medway NHS Foundation Trust

Communications update

December 2022

21,400
total social media impressions

330
media mentions

Best of care
Best of people

CALL FOR CONCERN
C4C

Amanda Cameron - Senior Acute Response Team Sister
Emma Coutts - Lead Nurse Acute Response Team

NHS Medway NHS Foundation Trust

Patient FIRST

DEFINING THE ACUTE RESPONSE TEAM

NHS Medway NHS Foundation Trust

"can be defined as a multidisciplinary organisational approach to ensure safe, equitable and quality care for all acutely unwell, critically ill and recovering patients irrespective of location or pathway" (NOrF 2012)

Critical Care Outreach Service One of the key recommendations of the Comprehensive Critical Care Review Report is the formation of 'Outreach Services' to enable earlier detection and management of patients at risk of developing critical illness in a hospital ward environment.

HEALTH CARE MODEL FOR RECOGNITION

- SOURCE OF Referral
- All health care professionals
- NEWS2 trigger
- Standard Operating Procedure, protocols
- NICE Guidelines
- Calling due to concerns
- Knowledge
- Skills
- Right person, right place, right time

MISSED EPISODES OF DETERIORATION

- Delay to escalate
- Delay to respond
- Delay to treat
- Failure to act
- Patient Stories
- Informal calls of concern
- Serious incidents
- Coroners reports

MIND THE GAP - VALUES

“Relatives see themselves as collaborative partners with nurses and as a valuable resource of knowledge”. (Wilson, 2005; Lindhardt et al)

“identified as a vital source of information, and can often pick up subtle cues that lead to clinical deterioration, long before it is detected by monitoring, observation or healthcare worker”. (O’dell at el, 2009)

NATIONALLY RECOGNISED

NHS Medway NHS Foundation Trust

NICE
National Institute for Health and Care Excellence

intensive care society
care when it matters

THE UK SEPSIS TRUST

RIGHT TIME • RIGHT PEOPLE • RIGHT PLACE •
NOrF
The National Outreach Forum

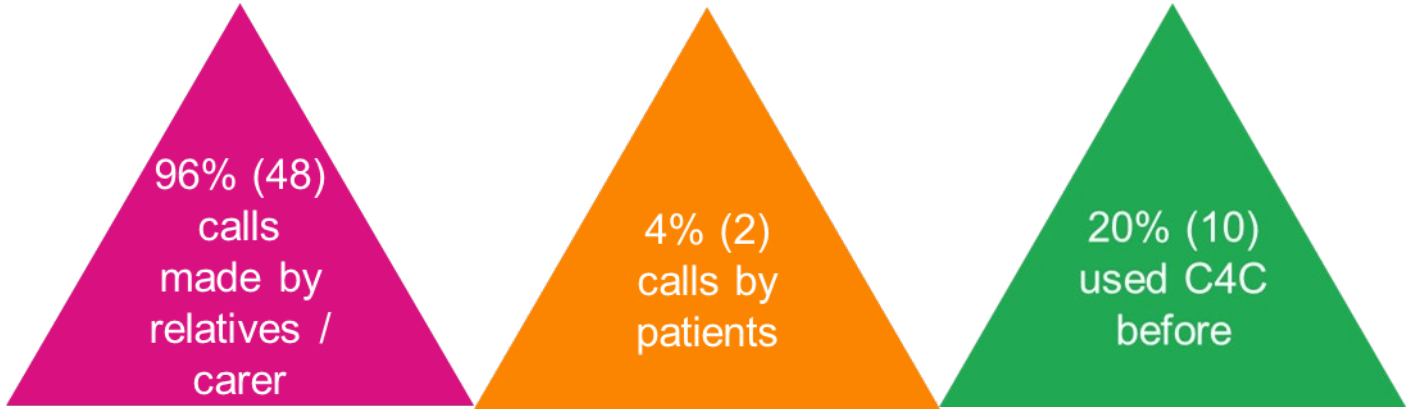
WHAT IS THE RESPONSE

- The Call 4 Concern initiative (C4C) initially launched by the Royal Berkshire NHS Trust 2009 followed by University Hospital Sussex, Kingston Hospital, East Suffolk and Essex NHS Foundation Trust.
- Enabling patients and families to contact the Acute Response Team Directly
- Safety net for patients that supports the challenges and the business of the ward & hospital.
- Adding the Patient Voice to the Health Care Model for recognition allows relatives or loved ones to contribute to the culture for empowering patients and gives them a voice.
- Cares strategy- ensuring cares are universally recognised and valued as being a fundamental in patient care
- MDT has to focus on multiple things with the relatives and visitors focus on 1 important thing..

DATA - SUSTAINABILTY

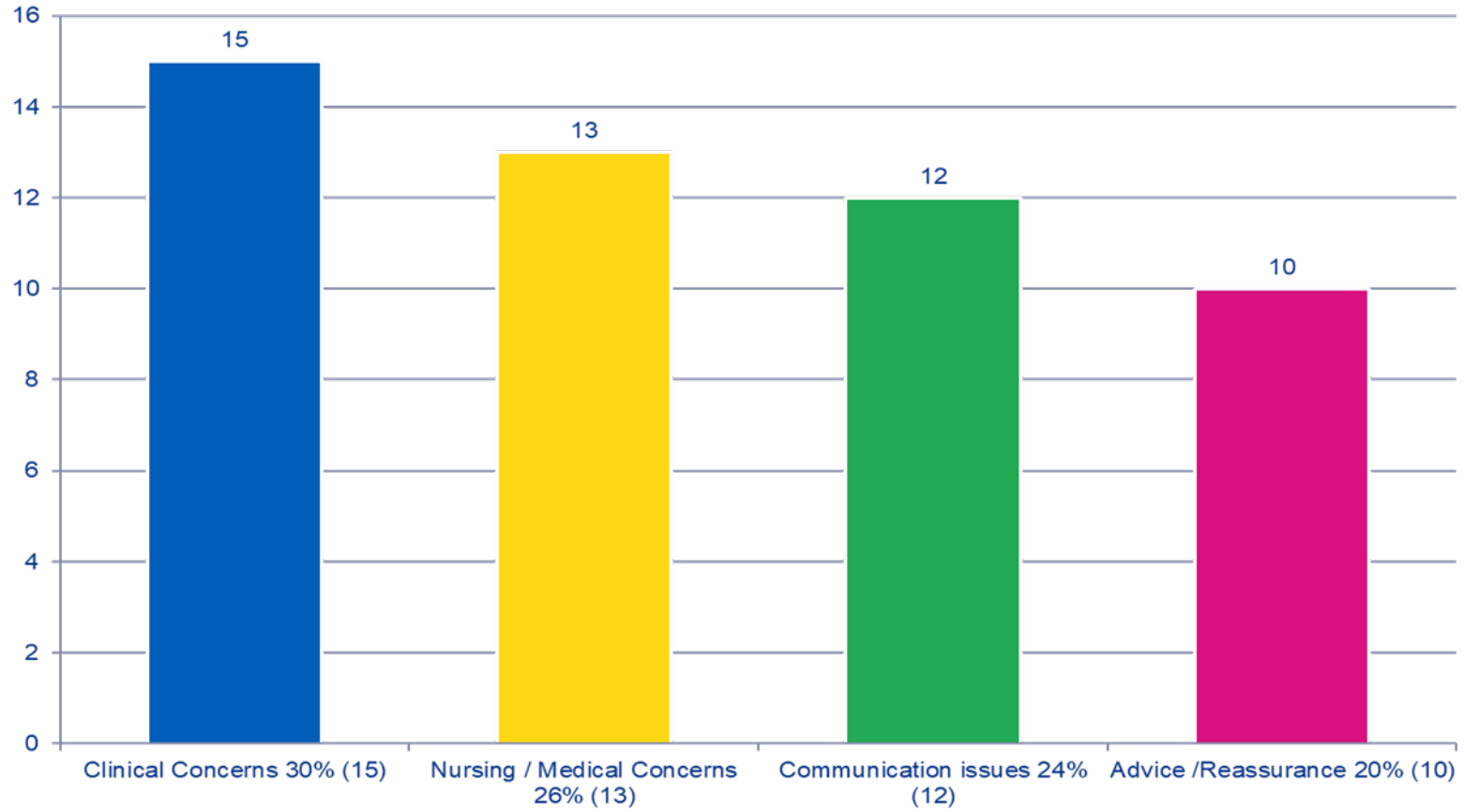
Medway NHS Foundation Trust

2019-2022 University Hospital Sussex received 50 calls since launch

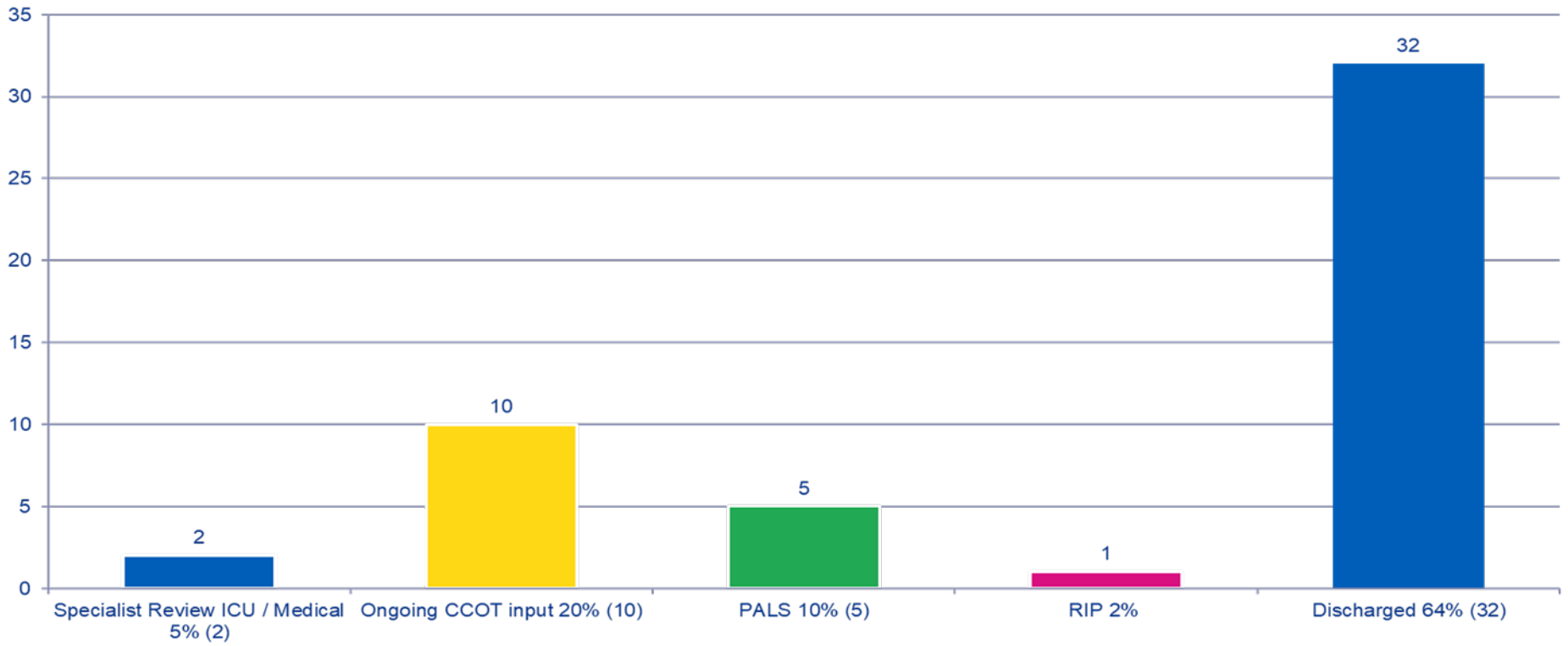


0.8% increase in to the Critical Care Outreach Referrals over the year
51 referrals out of 5840
Data closely matches Royal Berkshire NHS trust

REASON FOR REFERAL - QUALITY



OUTCOME OF CALLS – PEOPLE & PATIENTS



WHAT SUCCESS CAN LOOK LIKE - QUALITY

- Vulnerable patient groups highlighted
- Facilitation of prompt end of life care
- Extra Safety net for patients stepping down from ICU
- Patient / Relative experience
- Reduced number of formal complaints raised

TAKING THE NEXT STEP – SYSTEMS & PARTNERSHIP

NHS Medway NHS Foundation Trust

- Utilising Audit to Shape our service and help others
- Co-production – Expert Patient & Experience
- Working as a trust and not in silo

Meeting of the Trust Board (Public)
Thursday, 15 December 2022

Title of Report	Board Assurance Framework (BAF)			**Agenda Item**	10
Author	Dan Rennie-Hale, Director of Quality & Patient Safety				
Lead Executive Director	Evonne Hunt, Chief Nursing Officer				
Executive Summary	The Trust has redesigned the BAF in alignment to the revised Risk Management Framework. The previous risks have been reviewed and updated to reflect the Patient First True North Domains and Break Through Objectives. This paper provides an outcome of the review of the previous BAF and provides the current proposed risks. Once approved the BAF will be monitored via the relevant Board Committee. In addition work is also required to review all risks on the Trust Risk Register scoring less than 15 which may impact on the True North Domains.				
Proposal and/or key recommendation:	The Board is recommended to approve the outcome of the previous BAF and development of new risks to be adopted from Q4, further work can then be undertaken to identify the KPIs that need to be monitored and full completion of the BAF Templates.				
Purpose of the report (tick box to indicate)	Assurance		Approval	√	
	Noting		Discussion	√	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:	
Committee/Group at which the paper has been submitted:	Domains have been reviewed by Executive Leads. Updated Sustainability risks were presented to the Finance Committee.				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) √	Priority 2: (People) √	Priority 3: (Patients) √	Priority 4: (Quality) √	Priority 5: (Systems) √

Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led:
Identified Risks, issues and mitigations:	A review has taken place of the existing BAF, along with the identification of new risks aligned to the Patient First Domains and break through objectives to support the development of a new BAF for adoption in Q4.				
Resource implications:	NIL				
Sustainability and /or Public and patient engagement considerations:	NIL				
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☐ Not applicable (*please indicate why an equality assessment was not required)*				
Legal and Regulatory implications:	Failure to implement an effective system of risk management will impact the Trust compliance to the Health and Social Care Act, as regulated by the Care Quality Commission.				
Appendices:	Board Assurance Framework				
Freedom of Information (FOI) status:	State either: This paper is disclosable under the FOI Act, or This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.				
For further information or any enquires relating to this paper please contact:	Dan Rennie-Hale, Director of Quality & Patient Safety				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			

	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Board Assurance Framework

1.0 Introduction

A revised template for the Board Assurance Framework (BAF) aligned to the newly developed Risk Management Framework was approved by the Audit and Risk Committee in September 2022.

A review has taken place of the existing BAF, along with the identification of new risks aligned to the Patient First Domains and break through objectives to support the development of a new BAF for adoption in Q4.

The BAF will be monitored by the Board Committees responsible for the Patient First Domain, with regular update provided to the Board.

In addition work is required to review all risks on the Trust Risk Register scoring less than 15 which may impact on the True North Domains. Work has been completed within the Risk Management Records System (Datix) to enable risks to be assigned to True North Domains to better enable this work moving forward.

2.0 BAF Review

A review of the previous BAF has been completed with Executive Leads. Previously there were 12 BAF risks;

Area	Risk Description	Outcome	Rationale
Integrated Healthcare	1a. Failure of System Integration	Closed	Incorporated into new risk 4d.
Innovation	2a. Future IT strategy	Closed	Captured on Trust Risk Register as required
	2b. Capacity and Capability	Closed	Closed December 2021
	2c. Funding for investment	Closed	Closed December 2021
Finance	3a. Delivery of financial control total	Carried over	Revised 5g
	3b. Capital Investment	Closed	Current risk score 12 against a target of 12
	3c. Failure to achieve long term financial sustainability	Carried over	Revised 5g
	3d. Going concern	Closed	Closed December 2021
Workforce	4a. Sufficient staffing of clinical areas	Carried over	Revised as 3a
	4b. Staff engagement	Carried over	Revised as 3b
	4c. Best staff to deliver the best care	Carried over	Revised as 3c
Quality	5a. CQC Progress	Closed	Current risk score of 8 against a target of 12
	5b. Failure to meet requirements of Health and Social Care Act	Carried over	Revised as 4c
	5c. Patient flow - Capacity and demand	Carried over	Revised as 4e

3.0 Proposed BAF

Domain	Patient First Objective	Risk Description	Initial Score	Current Score	Target Score
Patient	Providing outstanding, compassionate care for our patients and their families, every time	1a. Low FFT uptake as a result of patient feedback fatigue due to patients not being able to see the improvement being made from completing a survey makes	12	12	6
		1b. Potential lack of patient feedback standardisation approach could result in development of multiple approach to feedback questions and data collection which could lead to data variation which cannot be used for benchmarking across the Trust	12	9	6
		1c. Potential lack of delivery across other True North Domains could leads to patients not recommending our services as a place to receive care	12	9	4
		1d. Another Covid surge could lead to staff losing momentum in the delivery of the FFT breakthrough objective	12	9	4
		1e. As other wards (aside from the initial 4 implementation wards) gain interest in Patient First roll out, there is a risk that they commence development of their own patient feedback approach, outside of the Patient First frontline implementation programme. This could lead to data variation and identification of areas for improvement which are not linked back to the Patient First programme	16	12	6
Quality	Excellent outcomes ensuring no patient comes to harm and no patient dies who should not have	2a. Lack of timely escalation and treatment of deteriorating patients	25	20	10
People	To be the employer of choice and have the most highly engaged staff within the NHS	3a. There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function	16	16	8
		3b. Should there be a deterioration of staff engagement with the Trust due to lack of confidence, this may lead to worsening morale and subsequent increase in turnover	12	12	6
		3c. Should the Trust lack the right skills and the right values, this may lead to poor performance, poor care, worsening morale and subsequent increase in turnover with an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice	12	6	6
System & Partnerships	Delivering timely, appropriate access to acute	4a. Not meeting the 104% target for the Elective Recovery Fund will provide further financial challenge. (Financial Value)	9	9	4

	care as part of a wider integrated care system	4b. Not meeting the RTT standards brings a risk to the quality of care we are providing our patients as well as their overall experience	12	12	4
		4c. Risk around lack of operational performance for example not meeting constitutional measures (new quality indicators)	12	12	4
		4d. Shared quality of care and performance across the heath and Care Partnership may impact on the Trusts quality and safety through increased ambulance handovers, patient acuity, mortality and admissions	16	8	4
		4e. There is a risk of financial impact if we are unable to increase flow and close escalation areas in unplanned care	16	16	4
Sustainability	Living within our means providing high quality services through optimising the use of our resources	5a. The cost of our escalation capacity raises a risk against our current overspend. If the Length of Stay (Trust wide) efficiency cannot mitigate this there will be a financial impact	25	25	6
		5b. Not delivering the Efficiencies Programme will impact Trust overspend and increase cost pressures Trust wide	20	20	4
		5c. Current spend on drugs Trust wide is a risk to reducing overspend due to overall overspend on drugs – there needs to be a focus on changes in prescribing habits	25	25	6
		5d. Mitigating against medical staffing (agency/locum/additional sessions) is a risk to overspend	25	25	6
		5e. Financial governance to be strengthened	16	16	4
		5f. Covid-19 income and expenditure	10	10	4
		5g. Delivery of the control total and FRP	25	25	9

4.0 Recommendation

The Board is recommended to approve the outcome of the previous BAF and development of new risks to be adopted from Q4, further work can then be undertaken to identify the KPIs that need to be monitored and full completion of the BAF Templates.

Board Assurance Framework

Objective:	Living within our means providing high quality services through optimising the use of our resources	**Executive Owner**	Alan Davies, Chief Financial Officer	**Operational Owner**	Paul Kimber, Deputy Chief Financial Officer
Risk ID: 5e	**Principal Risk Name & Description:** Financial governance to be strengthened	**Primary Risk Grouping:** (Quality - QUL, Patient - PT, People - PPLE, Systems & Partnership - SP, Sustainability - SUS)	Sustainability - SUS	**CQC Domain:**	Well-led

Risk Rating & Analysis: (▲, —, ▼, N)	Likelihood	Consequence	Risk Score	Direction of Risk Score (since previous)
Initial Risk Score:	4	4	16	—
Current Risk Score: (from last assessment)	4	4	16	—
Target Risk Score:	2	2	4	—
Assurance Strength	Medium			
Adequacy of Controls	Adequate			

Relevant Key Performance Metrics:
(taken from the Patient First dashboard)

Indicator:	Tar	May	Jun	Jul	Aug	Sep	Oct	YTD	Comments
Number of lapsed budget holder training (no.)	0	TBC	TBC	TBC	TBC	TBC	TBC		The number of budget holders trained vs not trained will be kept under review to ensure staff have had appropriate training to meet their fiduciary duties.
Number of lapsed budget holder training (%)	0%	TBC	TBC	TBC	TBC	TBC	TBC		

Context Summary
(Patient First problem statement, current situation)

The financial awareness and relative importance across the Trust is considered to be low, e.g. engagement/ownership of financial performance, time given to this as performance reviews, etc.
This manifests in poor budget management and financial performance.
Failure to address this as an issue could impact the Trust's exit from SOF4.

Rationale for current score

Consequence: staffing and competence - moderate error(s) due to levels of competency (individual or team). Finance including claims: currently the Trust overall is adverse by >1% of budget in clinical divisions. Statutory duty: low performance rating.

Key Existing Controls: (What are we currently doing about the risk?)	**Assurances on Control:** (What's the arrangement for obtaining assurance that the key controls in place are working effectively and having an impact?)
Budget holder training Finance Training Policy Mandatory objective in appraisal form Efficiencies as a corporate project Control of overspending implementation as a breakthrough objective Communication via senior managers meetings and Trust Management Board	Previously performance review meetings - now Strategic Deployment Reviews. Care group and divisional board meetings. Budget holder meetings Efficiency Delivery Group Finance, Planning and Performance Committee Trust Board Oversight meetings Internal audit

Gaps in controls and assurances: (What additional controls and assurances should we seek?)	**Mitigating actions to address gaps:** (What more should we do to address gaps?)		
	Action	**Action Lead**	**Action Due Date**
The controls themselves should be sufficient if implemented wholly and fully. Non-adherence to the controls (and SFIs) to be considered.	-		

Current performance / Progress: (With these actions taken, what's going well inc future opportunities, how serious is the problem?)			**Additional Comments:** (Any blockages/challenges to progress, how are these challenges being managed, additional cost not met through existing budget)		
Governance arrangements have been in a state of flux as Patient First continues to be implemented; the Trust is identifying the means by which financial matters are kept under review using this methodology.			-		
Date of last review:	15/11/2022	**Date of next review**	Dec-22	**Relevant Committee/Group**	Finance, Planning and Performance Committee

NHS Medway NHS Foundation Trust

Meeting of the Board of Directors in Public
Thursday, 15 December 2022

Title of Report	Risk Register Report – November 2022		**Agenda Item**	11
Author	Dan Rennie-Hale – Director of Integrated Governance, Quality & Patient Safety			
Lead Executive Director	Evonne Hunt – Chief Nursing Officer			
Executive Summary	Attached is a Risk Register report for November 2022. The report details new risks added and the movement of existing ones.			
Proposal and/or key recommendation:	Note			
Purpose of the report (tick box to indicate)	Assurance		Approval	
	Noting	✓	Discussion	✓
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Risk and Compliance Assurance Group			
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:			
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality) ✓ / Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:			
	Safe:	Effective:	Caring:	Responsive: / Well-Led: ✓
Identified Risks, issues and mitigations:	Risks not fully completed on DATIX due to system update.			
Resource implications:				
Sustainability and /or Public and patient engagement considerations:				

Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☐ Not applicable (*please indicate why an equality assessment was not required)*	
Legal and Regulatory implications:	The Board is responsible for ensuring that the organisation has appropriate risk management processes in place to deliver its strategic and operational plans and comply with the registration requirements of the quality regulator. This includes systematically assessing and managing its risks. These include financial, corporate and clinical risks. For Foundation Trusts, this also includes risks to compliance with the terms of authorisation. The Trust Board is accountable for ensuring a system of internal control and stewardship is in place which supports the achievement of the organisation's objectives.	
Appendices:	Appendix 1 - Risk Register Report November 2022	
Freedom of Information (FOI) status:	State either: This paper is disclosable under the FOI Act, or This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Maritime Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.	
For further information or any enquires relating to this paper please contact:	Dan Rennie-Hall, Director of Integrated Governance, Quality & Patient Safety d.rennie-hale@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

NHS
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NHS Foundation Trust

Trust Risk Register Report

November 2022

Patient
FIRST

Executive Summary

The Trust Risk Register, now has 35 risks. 2 risks have been closed down and one scored reduced to 12 from the previous month.
2 new risks are now scoring 15 and above and a decision to approve is to be made at RCAG before adding to the Trust risk register.

These are risks scored at 15 and above have been escalated from other risk registers into the TRR.

New risks are show below:

By Division/Register
Estates and Facilities
- *The general condition of the laundry roof is leading to water ingress into the building in multiple areas.*

Human Resources Risk Register
- *Trust's inability to enable extremely high numbers of new nurses, care support workers and midwifery to commence in their role within the Trust in a timely fashion. This is due to lack of capacity of OH nurses within the team (unable to recruit substantively)*

Grand Total 2

Further detailed work is still required to ensure the remaining 224 risks (less 35 TRR risks), across other risk registers in the Trust are updated with the new fields.

Trust Risk Profile – 'Extreme' Risks Q2 2022/23 (Risks scored 15 and above) Month Profile (Valid at 28/11/22)

NHS Medway NHS Foundation Trust

The table below shows the Trust's extreme risks for October with the changes in risk rating from month to month.

Key: **20 = Risk score** **NEW = New risk added from last month**

4 x 5= Risk rating shown as Likelihood x Consequence

— ▲▼= Arrow indicates previous monthly change

Risk ID	Risk No	New	Risk Title	Risk Description	November			
1323	1		ENT Workforce: ageing workforce, inability to recruit an have a sustainable workforce	Stability of the workforce for this specialty is fragile particularly at Consultant level which is below national standards . This is resulting in the increased of locums, bank and agency and Delays in patients not being seen in a timely manner	5	4	20	—
1285	2		Lack of adequate critical care consultant to manage the critical care unit	There is a risk that lack of adequate critical care consultant could lead to patients safety and experience concerns, including the closure of some critical care beds	5	4	20	—
1137	3		Not achieving CIP target	Failure to meet Divisional CIP target for 2021/22	5	4	20	▲
1337	4		Lack of capacity for Endoscopy to reduce backlog and address cancer targets	Due to contractual issues with Practice Plus Group (PPG) requiring negotiations before the end of the current financial year to prevent inappropriate penalties, there will be a period where there will be substantially reduced capacity for endoscopy provision for MFT.	5	4	20	▲
1386	5		Internal Fire Compartmentation Site Wide including 2000 Building.	Risk of spread of fire and smoke between fire zones due to poor integrity of internal fire separation. (Fire compartmentation is incomplete and missing in some areas - the true extent is unknown at this time. In addition compartments have been breached in some areas through wiring and pipework installations over the years. Fire compartmentation does not align with fire alarm zones in some areas).	4	5	20	▲
1388	6		Protected means of escape (2000 New Build)	Due to the inadequate Fire Compartmentation, in the event of fire spread there is a risk that patients and staff will be evacuated into unsafe areas. Risk is compounded by E&F-2017-004 through the ingress of smoke from the ventilation system.	4	5	20	—
1433	7		Delayed Recording of Observations on Electronic Patient Record (EPR)	Delayed Recording of Observations on EPR due to insufficient access to computers or devices. Results in a delayed NEWS score calculation and alert for staff, leading to in a delay in staff recognising deterioration and calling for help this results in delayed responses to deteriorating patients due to staff inability to remember NEWS scores without the adequate tools.	5	4	20	—
1434	8		Partially blocked fire exits	Due to the lack of space and storage in theatres the corridors have been used to store equipment and stores.	5	4	20	—
1402	9		CCTV Infrastructure	CCTV Infrastructure. The CCTV installation is varied, with parts of the system circa 12 years old. There is no routine maintenance or replacement programme to ensure the system functions reliably and effectively. CCTV System was designed to be used retrospectively with no CCTV monitoring area for exclusive CCTV use. No scheduled replacement program for the system and no maintenance budget. CCTV User group is a ICO and Home Office requirement and has not taken place for some years.	5	4	20	—
1459	10	NEW	Trust's inability to enable extremely high numbers of new nurses, care support workers and midwifery to commence in their role	Trust's inability to enable extremely high numbers of new nurses, care support workers and midwifery to commence in their role within the Trust in a timely fashion. This is due to lack of capacity of OH nurses within the team (unable to recruit substantively)	4	5	20	—

N.B. Full details of all risks are available on the Trust Risk Register.

Trust Risk Profile – 'Extreme' Risks Q2 2022/23 (Risks scored →15)
Quarter on Quarter Profile (Valid at 28/11/22)

NHS Medway NHS Foundation Trust

The table below shows the Trust's extreme risks for October with the changes in risk rating from month to month.

Key: **16 = Risk score** **NEW = New risk added from last month**

4 x 5= Risk rating shown as Likelihood x Consequence

— ▲▼= Arrow indicates previous monthly change

Risk ID	id	New	Risk Title	Risk Description	November			
1450	11	NEW	General condition of laundry roof	The general condition of the laundry roof is leading to water ingress into the building in multiple areas.	4	4	16	
1394	12		Security Capacity	Insufficient capacity within the established security team.	4	4	16	—
1417	13		Nuclear Medicine License Non-Renewal Due to Aging Equipment	The licensing body for nuclear medicine has told us that our relicensing depends on our equipment being up to date. This means replacing our 28 year old gamma camera before our license requires renewal in 18 months time. Given the lead times required this is urgent	4	4	16	—
1377	14		ED- Staff Security	Due to the environment and patient groups there is a threat of verbal and physical Attacks on staff members in the ED and assessment area/wards, leading to absence from work and increased staff turnover.	4	4	16	
1346	15		Lack of Specialist Physiotherapist (Band 7) for Paediatrics and Neonates	Due to the specialist nature of the post there is only one identified Specialist Physiotherapist (Band 7) for Paediatrics and Neonates. This means there is no adequate cover, this impacts on the ability to deliver physiotherapy to Paediatrics and Neonates	4	4	16	—
1329	16		Gastroenterology backlog	"There is currently a huge backlog of patients waiting for a first outpatient appointment for the speciality. Currently patients are being offered their first appointment between 46 to 52 weeks, which is off the target of 18 weeks. A large number of patients (more than 20 pts per week) are breaching the 52 week target, due to increased demand and the numbers are expected to increase for 52 week breaches	4	4	16	▼
1133	17		Insufficient Midwifery Staffing	Insufficient midwifery workforce to meet demand.	4	4	16	—
1189	18		PHARMACY- risk of service disruption due to failure of the dispensing robot	There is a chance that the robot could break down and was unrepairable as the robot is no longer produced	4	4	16	▲
1292	19		Sustainable One Stop Clinic Capacity to meet increasing 2ww Breast Cancer referrals	The increased levels of demand for 2ww Breast referrals has been increasing steadily over the past 2 years, with a particular upturn in September this year (set out in the table below). Therefore, the demand for One Stop Breast clinic capacity has been increasing. Core clinic capacity should be 304 slots per month, reduced to 248 by taking into account slots taken by non-one stop demand. Through additional sessions the capacity can be supplemented with an additional 36 slots over 2 evenings and alternate Saturdays. The capacity of 284, with the additional sessions is clearly inadequate and puts patients on the 2ww pathway for Breast cancer at risk. As a consequence of higher than usual referral rates, the need for additional capacity is becoming increasingly difficult for the Breast Unit Team to meet. The diagnostic element of the One Stop Breast Clinic, despite every effort, are no longer able to flex their capacity sufficiently to be able to meet these extraordinary levels of demand. Essentially, we have a Surgeon to see and assess the patients without the resource to support them with the necessary Radiologist and Radiographer. The primary risk to providing the required capacity levels is: • The numbers of appropriately skilled and trained staff to be able to flex capacity to meet surges in demand. In addition to the staffing challenge, sustained delivery of the required level of capacity is compromised by the following factors: - Availability and reliability of the appropriate equipment specifically including mammography and Ultra-sound. - The Physical capacity within the unit to be able to accommodate any additional equipment or clinic capacity - Late escalation form the Cancer Referrals Office of the need for additional capacity making it far more difficult to respond.	4	4	16	▲
1305	20		Financial loss to organisation: 2022/23 efficiency target	The Trust is yet to identify the full value of efficiencies required as part of it's 2022/23 budget. Delivery aganst identified schemes is behind plan so far in 22/23.	4	4	16	—

N.B. Full details of all risks are available on the Trust Risk Register.

Trust Risk Profile – 'Extreme' Risks Q2 2022/23 (Risks scored →15)
Quarter on Quarter Profile (Valid at 28/11/22)

NHS Medway NHS Foundation Trust

The table below shows the Trust's extreme risks for October with the changes in risk rating from month to month.

Key: **15 = Risk score** **NEW = New risk added from last month**

4 x 5= Risk rating shown as Likelihood x Consequence

— ▲▼= Arrow indicates previous monthly change

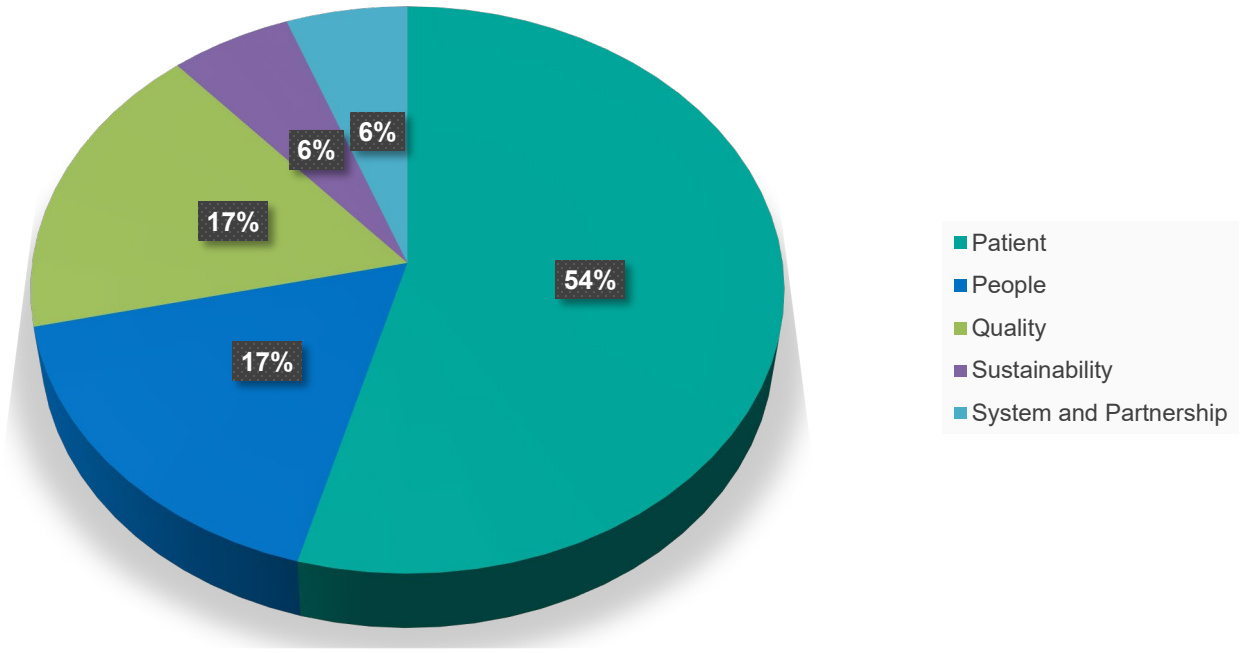
Risk ID	id	New	Risk Title	Risk Description	November			
1053	21		Risk of inability to provide adequate plain film service due to ageing equipment and increased downtime. Loss/interruption of h	Due to their age, the CR readers used in General Imaging to process x-rays are unreliable and very prone to breaking down. The age of the equipment also means sourcing parts for the machines is becoming increasingly difficult. There is a risk that these concerns could lead to potential delays in care delivery, damage to Trust reputation and patient safety concerns through potential wrong information being given to patients or test result being wrong	3	5	15	—
1131	22		Delays in Induction of Labour	The unit is currently unable to meet induction of labour demand due to capacity and staffing on a daily basis due to significant staff absence relating to C19.	3	5	15	—
1324	23		Delays in responding to SARS requests due to staff shortages within the department	Not responding to SARS request within statutory timeframe could lead to non-compliance of our data processing statutory obligations	5	3	15	—
1343	24		Escalation Beds on Emerald Short Stay and Emerald Assessment Unit	There is a potential risk to patient safety and patient experience due to: - Gaps in staffing as a result of the additional beds- Lack of adequate privacy and dignity due to limited number of curtain rails - Limited access to buzzers- limited space for manoeuvring patient equipment	5	3	15	—
1345	25		Care of inpatient in an unsuitable area	ADL is being used as a bedded area for inpatient due to patient flow challenges which may result in patient harm and negative impact on discharges before noon breakthrough objective	5	3	15	—
1383	26		Fire Alarm System (Age and Obsolescence)	Fire alarm system requires upgrading as the existing system has become obsolete and spare parts are not readily available, leading to a risk of failure of the fire alarm system. The level of fire safety will be reduced dramatically if the fire alarm system fails to detect a fire and raise an alarm. The failure of the fire alarms system constitutes a risk to life of all building occupants and users.	3	5	15	▲
1384	27		Management of Contractors and Sub Contractors	Failure to manage Contractors and their Sub Contractors leading to breaches in Health and safety compliance on Construction and Engineering Projects.	3	5	15	—
1385	28		Fire dampers non compliance	The majority of fire dampers across site are non compliant fusible link type. They should be actuator types which protect against fire and smoke. Furthermore, many of the fusible link dampers are inaccessible for testing due to other services being installed in the way of access to the dampers.	3	5	15	—
1356	29		Failure of fire alarm sounders in McCulloch and Trafalgar wards	The fire alarm system on McCulloch and Trafalgar Wards has a sounder fault. The system will detect an activation normally - but the local sounders will not ring.	3	5	15	▲
1376	30		Falls from height - car park	Potential for patients to accidently or intentionally fall from the top deck of the car park.	3	5	15	▲
1387	31		Emergency Lighting system - non compliance	Risk of failure of the emergency lighting system which will compromise the safety of building occupants and users in the event of a local power failure and subsequent loss of general lighting.	3	5	15	▲
1404	32		HSE Improvement notice issued to the Trust	Following a planned inspection by the HSE in October 2021, the Trust has received an improvement notice in relation to the management of Violence and Aggression and Moving and Handling.	5	3	15	—
1408	33		Emergency Bleep/Pager system reliability	Emergency pager/Bleep system is unreliable and has failed on multiple occasions in the last six months	3	5	15	—
1441	34		Water Tower Block 7	Water tower 100 + years old susceptible to high winds and weather erosion. Possible falling of building debris causing potential injury within related/surrounding areas area. Staff/visitors and static buildings/cars	3	5	15	▲
1442	35		Clock Tower	Water tower 100 + years old susceptible to high winds and weather erosion. Possible falling of building debris causing potential injury within related/surrounding areas area. Staff/visitors and static buildings/cars Aircraft warning lights have to be checked.	3	5	15	—

N.B. Full details of all risks are available on the Trust Risk Register.

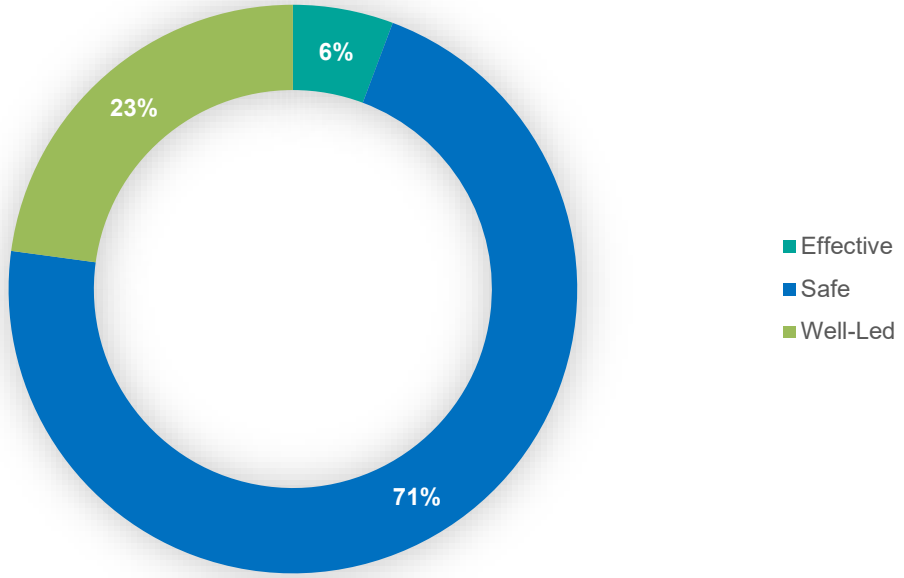
True North Domains and CQC Domains

The charts below shows the Trust's percentage of risks relating to the True North Domain and CQC Domains.

True North Domain



CQC Domain



N.B. Full details of all risks are available on the Trust Risk Register.

Trust Risk Profile – 'Extreme' Risks October 2022 (Risks scored 15 and above) Action Status Profile (Valid at 28/11/22)

Medway NHS Foundation Trust

Risk No	Risk Title	Direction of risk score	Action RAG
1053	Risk of inability to provide adequate plain film service due to ageing equipment and increased downtime.	—	On Track
1131	Delays in Induction of Labour	—	On Track
1324	Delays in responding to SARS requests due to staff shortages within the department	—	On Track
1343	Escalation Beds on Emerald Short Stay and Emerald Assessment Unit	—	On Track
1345	Care of inpatient in an unsuitable area	—	On Track
1383	Fire Alarm System (Age and Obsolescence)	▲	On Track
1384	Management of Contractors and Sub Contractors	—	On Track
1385	Fire dampers non compliance	—	On Track
1356	Failure of fire alarm sounders in McCulloch and Trafalgar wards	▲	On Track
1376	Falls from height - car park	▲	On Track
1387	Emergency Lighting system - non compliance	▲	On Track
1404	HSE Improvement notice issued to the Trust	—	On Track
1408	Emergency Bleep/Pager system reliability	—	On Track
1441	Water Tower Block 7	▲	On Track
1442	Clock Tower	—	On Track
1450	General condition of laundry roof		Not scored
1394	Security Capacity	—	On Track
1417	Nuclear Medicine License Non-Renewal Due to Aging Equipment	—	On Track
1377	ED- Staff Security		On Track
1346	Lack of Specialist Physiotherapist (Band 7) for Paediatrics and Neonates	—	On Track
1329	Gastroenterology backlog	▼	Overdue

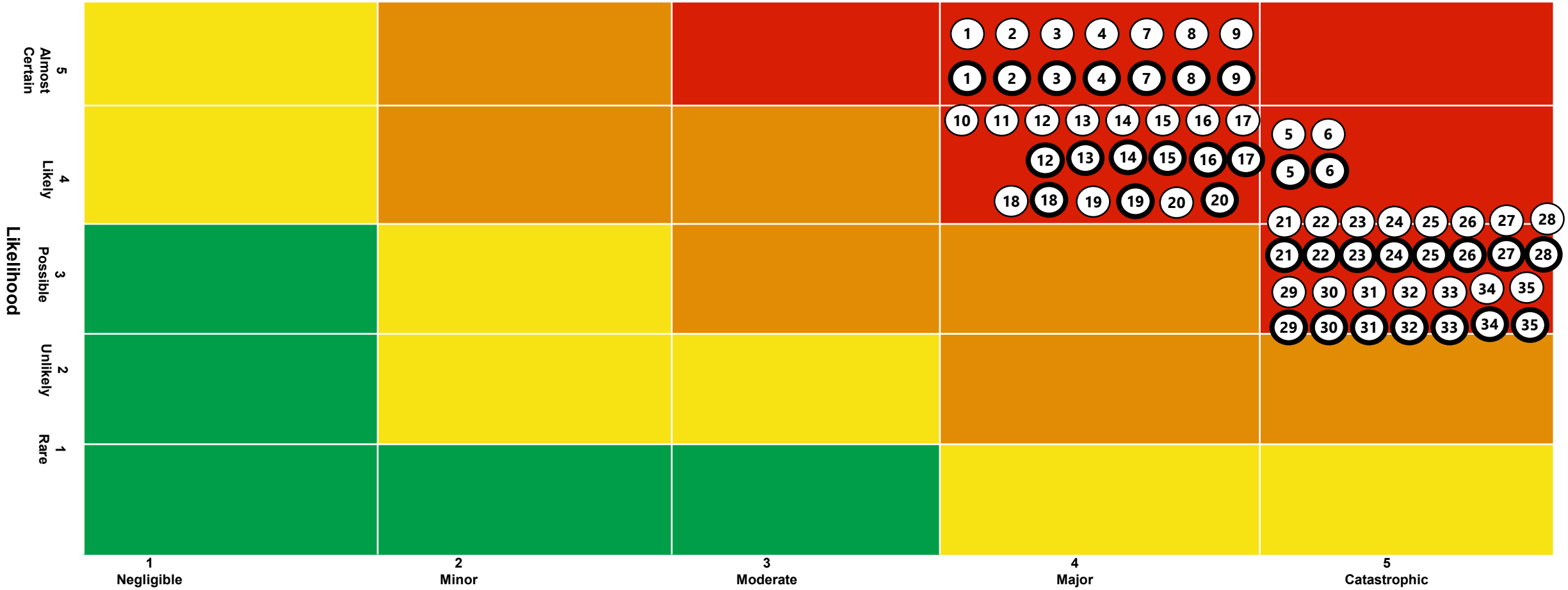
Risk No	Risk Title	Direction of risk score	Action RAG
1133	Insufficient Midwifery Staffing	—	On Track
1189	PHARMACY- risk of service disruption due to failure of the dispensing robot	▲	On Track
1292	Sustainable One Stop Clinic Capacity to meet increasing 2ww Breast Cancer referrals	▲	On Track
1305	Financial loss to organisation: 2022/23 efficiency target	—	At Risk
1323	ENT Workforce: ageing workforce, inability to recruit an have a sustainable workforce	—	On Track
1285	Lack of adequate critical care consultant to manage the critical care unit	—	On Track
1137	Not achieving CIP target	▲	On Track
1337	Lack of capacity for Endoscopy to reduce backlog and address cancer targets	▲	At Risk
1386	Internal Fire Compartmentation Site Wide including 2000 Building.	▲	On Track
1388	Protected means of escape (2000 New Build)	—	On Track
1433	Delayed Recording of Observations on Electronic Patient Record (EPR)	—	On Track
1434	Partially blocked fire exits	—	On Track
1402	CCTV Infrastructure	—	On Track
1459	Trust's inability to enable extremely high numbers of new nurses, care support workers and midwifery to commence in their role	—	Not scored

On track	G/Green = All actions within timescale at point of last review	At risk	A/Amber = Some actions overdue at the point of last review	Overdue	R/Red = All actions identified overdue at the point of last review

Trust Risk Profile – ‘Extreme’ Risks October 2022 (Risks scored 15 and above) Heat Map (Valid at 28/11/22)

Medway NHS Foundation Trust

This chart makes a comparison between the current risks score currently and previous months’ score



= Current risk score

= Risk score in previous month

Consequence

The white dots represent the organisations’ highest priority risks, scored as >15.
The black dots show their status in the previous quarter of the previous year.

N.B. Full details of all risks are available on the Trust Risk Register.

Action Status Profile (Valid at 28/11/22)

NHS Medway NHS Foundation Trust

The risk rating summary across the TRR:

Risk Group	TOTAL		Adequacy of Controls				Current Risk Score			
			Ad	Pa	IN	Un	1-3	4-6	8-12	15-25
Clinical Performance and Medical Devices	7		2	2	1	1			2	4
Emergency Preparedness / Business Continuity (EPRR/BC)	6							1	3	2
Estates, facilities and non-medical equipment	12		3					4	6	2
Finance	19		1		1			4	12	3
Governance, Compliance and Regulation	27		2	1	1			1	14	12
Health, Safety, Security and Fire	88		13				1	20	58	8
Information Governance	23		1				1	3	14	4
IT Infrastructure	19		1		1	1	16	1	2	
Quality and Patient Safety	14		10	2		1		3	11	
Reputation and Media	6								6	
Workforce	3		3		3				3	
Grand Total	224		36	5	7	3	18	32	107	34

The risk group area with the largest number of risks (88 of 224) is quality and patient safety.
Divisions with more than 10 risks include:

Unplanned and Integrated Care Division Register	50
EPRR and Business Continuity Risk Register	19
Planned Care Division Risk Register	16
Estates and Facilities Risk Issue Log	16
	10

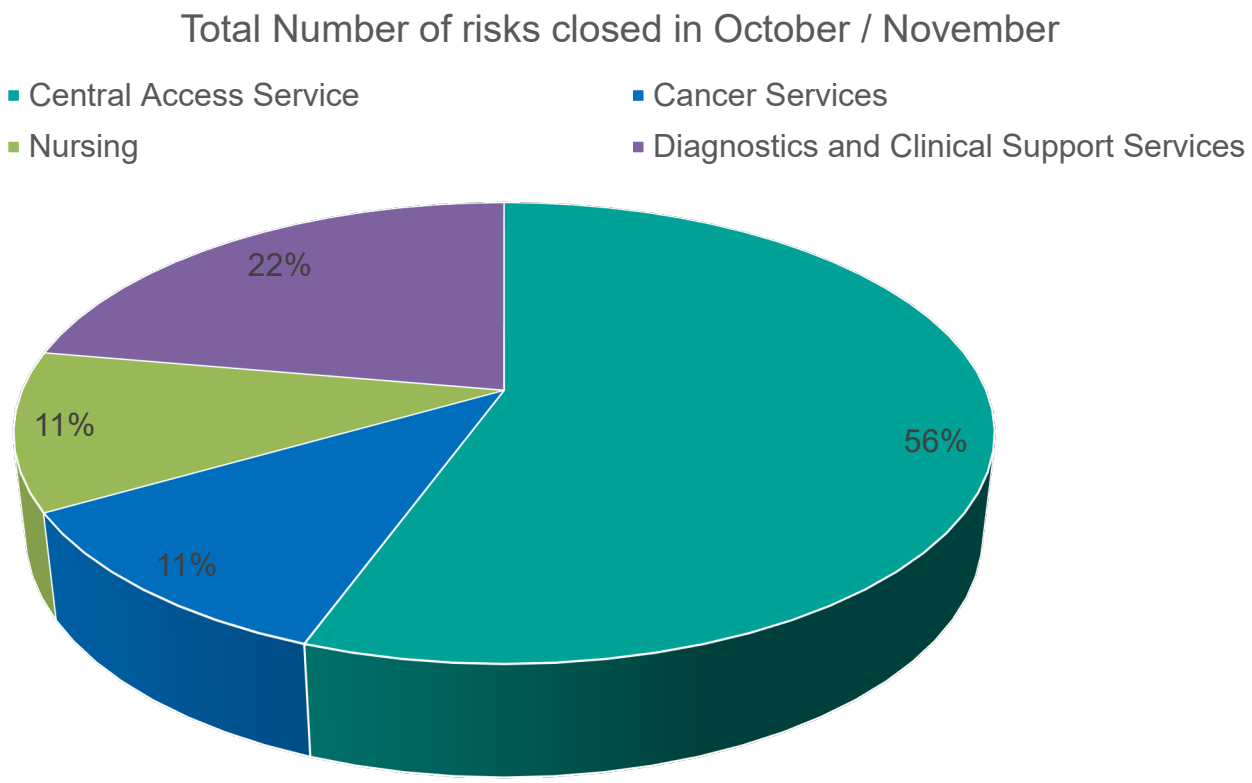
21 new risks were escalated to the TRR. The risk title and description can be found in slides 3, 4 & 5.

*Adequacy of controls will be completed when the DATIX update goes live and all risks will be reviewed and updated with the new information required.

Adequacy of Control 173 risks not scored, Risk Score 33 risks not scored

TRR Overview continues: closed risks (Valid at 28/11/22)

22 risks were closed in October 2022.
5 risks closed so far during November 2022 overall.



2 risks scoring 15+ were closed

1296 - Neurology back log of new referrals due to lack of consultant cover now amalgamated with Risk 1328.

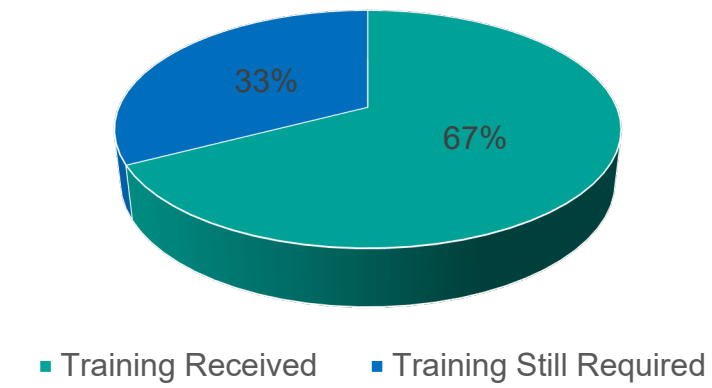
1430 - GDU Patients - PCR Guidelines – We are using LFT and patients are registering their own results. This will only become as risk if the current policy reverts back to PCR.

Reduced Risks 15+
1398 - risk reduced to 12
Security Competency - Security guards do not have sufficient training to perform their duties.

Risk Management Training Stats

Current Position to Date
95 people have been identified as requiring training.
64 have received their training and have been given access to the system.
31 staff members still require training

Further training required
Due to the recent changes with the additional fields added to DATIX all staff will require some re-training. This training will commence in January 2023. A full review of access and security levels will also take place as part of the update.



Meeting of the Trust Board (Public)
Thursday, 15 December 2022

Title of Report	Audit and Risk Committee – Assurance Report		**Agenda Item**	12
Author	Matthew Capper, Interim Company Secretary			
Lead Executive Director	Jayne Black, Chief Executive, Mark Spragg, Independent Member			
Executive Summary	Assurance report to the Trust Board from the Audit and Risk Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee.			
Proposal and/or key recommendation:	N/A			
Purpose of the report (tick box to indicate)	Assurance	✓	Approval	
	Noting		Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Minutes from the Audit and Risk Committee approved at the Committee.			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) ✓	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems) ✓
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓

Identified Risks, issues and mitigations:	NIL
Resource implications:	NIL
Sustainability and /or Public and patient engagement considerations:	NIL

Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☐ Not applicable (*please indicate why an equality assessment was not required)*	
Legal and Regulatory implications:	NIL	
Appendices:	Key headlines and assurance level listed below.	
Freedom of Information (FOI) status:	State either: This paper is disclosable under the FOI Act.	
For further information or any enquires relating to this paper please contact:	Matthew Capper, Interim Company Secretary	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Key headlines	Assurance Level (use appropriate colour code as above)
1. Internal audit progress report The Committee received a routine audit report from the Trusts auditors. There have been 6 audit reviews undertaken to date and no significant issues or failures detected. There were several outstanding audit actions brought to the Committees attention, however, these have now been followed up by the new in post Trust Company Secretary and responses provided. The Committee discussed the scope of the audit plan for 2023/24; the plan will include a review of the core finance systems, the adequacy of the safer staffing policy and data collection as well as those items on this year's reserve audit list.	Green
2. Local counter fraud progress report The Committee received the report and discussed the following items: • Adequacy of reporting from Estates and Facilities team while the Trust recruits to the currently vacant post, • IT asset security, • Health and Safety and physical security of the hospital site, and • Spot checking accounts of split invoices The Committee agreed that losses, single tender waivers and financial instruction breaches would be standing items for every committee agenda.	Amber
3. Policy approval The Committee reviewed and ratified the following policies and procedures on behalf of the Trust Board: • Anti-Fraud and Bribery Procedure • Anti-Fraud, Bribery and Corruption Policy	Green
4. External audit report An update on the work completed since the last Audit and Risk Committee meeting was provided as well as an outline plan for the remaining year. A timetable for auditing the Trusts final accounts and producing the external audit opinion was provided The Committee was assured by the contents of the report.	Green
5. Board Assurance Framework (Health and Safety/ Improvement Plan) The Committee received an update on the work being undertaken to consolidate health and safety reporting and recovery/improvement action reporting (excluding HSE reporting).	Green

The Committee also discussed the procedures and practices for dealing with aggressive or higher security risk patients and visitors. A series of approaches will be looked at and brought back to the Committee. The Committee endorsed the Improvement Plan.	
6. Trust risk register The Committee were introduced to the revised Trust Risk Register and the Risk Management Framework (and policy) and a description of both was provided. A review process of all risks held on the "old" risk register has been carried out and duplicates have been removed and the remaining risks have been matched to the revised risk scoring criteria (described by the risk management framework). The Committee discussed several of the highest rated risks and their mitigations and treatments. The Committee approved the revised Trust risk register and Risk Management Framework to be taken to the next Trust Board for ratification as per the Scheme of Reservation and Delegation.	Green
7. Risk and Compliance Assurance Group Terms of Reference An updated work plan and complimentary Terms of Reference for the Risk and Compliance Assurance Group were presented to the Committee. It was noted by the auditor members of the committee that the approach described had been successfully deployed in other Trusts. It was also noted that the core attendees of the Group would be reviewed as the Group matured. The Committee approved the Terms of Reference and work plan for the Group.	Green
8. Standing Financial Instruction – amendment An issue with the Assistant Procurement Officers level of financial delegate limited had been identified by the Chief Finance Officer and a request was made to the Audit and Risk Committee to recommend to the Trust Board that this is adjusted. The recommendation is for the limit to be increased from £250,000 to £300,000. This would bring the delegated financial limits in line with the recently revised procurement governance changes. The Committee agreed to recommend the amendment to the Trust Board.	Green

9. EPRR and Business Continuity Policy The Committee received the annual EPRR and Business Continuity plan and policy for review and approval. An outline of the annual review process was also described, including any actions identified through the review process that require some improvement. The Trust had received an overall assured position from the national process. The Committee endorsed the report and policy and recommended it to go to the Trust Board for ratification.	Green

Meeting of the Board of Directors in Public
Thursday, 15 December 2022

Title of Report	Assurance report – People Committee 24 November 2022	**Agenda Item**	12
Author	Leon Hinton, Chief People Officer		
Committee Chair	Sue Mackenzie, Chair of Committee/NED		

Key headline and assurance level

Key headline	Assurance Level
1. Board Assurance Framework – People The Workforce risks were reviewed and assurances have been updated in order to provide further assurance for the mitigations and controls identified for each risk. No changes were made to the current risk score for the BAF items. Updates have been made to the current appraisal rate, a slightly improving turnover rate which does not mirror the deteriorating national turnover rate. The Committee **APPROVED** the BAF	Assurance
2. IQPR The Committee reviewed the refreshed version of the IQPR in using Statistical Process Control charts to display the data. It reported on the HR performance across all key performance indicators for October 2022. The Committee was asked to note the worsening of fire safety training compliance, resuscitation and MCA/DoLs which is being reviewed at the StatMan group with actions to mitigate. The Committee noted the quantity of appraisals being completed as positive and the Trust must ensure quality of appraisals continues. The Committee noted the improving turnover and vacancy rates across the Trust. The Committee **APPROVED** the Deep Dives regarding harassment and bullying trends	Partial Assurance
3. HR Resourcing Report Key highlights was information on; Nursing/Midwifery recruitment and Medical/Dental recruitment.	Partial Assurance

Recruitment to band 5 positions had improved; and a significant number of band 6s are under offer. The planned band 5 to 6 development programme is designed to address this through nurse education. Nursing turnover has decreased overall opposed to a national pattern of elevated leavers through to April 2022. A significant number of AHP starters are also under offer including a higher number of international hires than previously achieved. The Committee **NOTED** the report.	
4. Plan for reducing nursing and AHP vacancies The Committee reviewed the Patient First A3 approach to reducing nursing, clinical support worker and allied health professional (AHP) vacancies, including the underlying root cause, proposed actions and the progress made to date. The Committee **NOTED** the report.	Assurance
5. Modern slavery and human trafficking statement 2022/23 The Committee reviewed the proposed modern slavery and human trafficking statement for 2022/23. No reports were received from our staff, the public, or law enforcement agencies to indicate that modern slavery or human trafficking practices have been identified. The People Committee **APPROVED** the 2022/23 statement for publication.	Significant Assurance
6. Guardian of safe working report The Committee received a report from the Guardian of safe working hours which detailed engagement levels, the improvement of the Doctors' Mess and training in relation to exception reporting. For the year August 2021 to July 2022, a total of 452 exception reports were raised highlighting particular pressures through the pandemic including loss of educational time – a formal rota has been put in place to resolve this. The Committee **NOTED** the report.	Assurance
7. Wellbeing Guardian assurance report Q2 2022/23 The Committee received a report updating the progress made against the national health and wellbeing framework. This included TRiM practitioner training (50% progress) and mental health first aiders (79% progress) and improved access to the employee assistance programme. The Committee **NOTED** the report.	Assurance
8. Organisational Development and culture update The Committee received a report updating the Trust's organisation development (OD) offerings and uptake. The update included	Assurance

apprenticeship progress, work experiences and management essentials. The Committee **NOTED** the report.	
9. Medical Education report The Committee received a reporting providing an update on the current Health Education England quality visits, GMC survey, postgraduate doctor establishments and the medical school student plans. The Committee **NOTED** the report.	Assurance
10. Trust's preparedness for potential industrial action The Committee received an update in relation to key actions the Trust is taking in preparedness for possible industrial action including management through EPRR (emergency preparedness) including trade union engagement, exemptions and derogations, tactical command group structure, redeployment, national EPRR exercises and communicating with staff. The Committee **NOTED** the report.	Partial Assurance
11. Freedom to speak up lead guardian's report Q1-Q2 2022/23 The Committee received the Q1 and Q2 report from the lead guardian including a comparative review of the Kirkup review's emphasis on the speaking up culture and the Trust's own speaking up routes. Over the two quarters, the number of cases rose whilst the number of anonymous decreased. The report detailed themes, lessons learnt from cases and triangulation with other indicators. The Committee **NOTED** the report.	Assurance
12. Nursing and midwifery retention self-assessment 2022 The Committee received the retention self-assessment for nursing and midwifery. The report highlight areas of good practice and areas of development across a number of domains. The self-assessment highlighted strong progress with health and wellbeing and excellence in care and work in progress for the other domains which will determine the actions through the retention group. The Committee **APPROVED** the self-assessment.	Partial Assurance
Decisions made: 1) Chair asked for a deep dive on the Bullying and Harassment allegations at the next meeting to gain a better understanding.	

	Further Risks Identified: None to report **Escalations to the Board or other Committee:** None
Proposal and/or key recommendation:	Not applicable

Purpose of the report (tick box to indicate)	Assurance	✓	Approval	
	Noting		Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:

Committee/Group at which the paper has been submitted:	People Committee, 24 November 2022				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People) ✓	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: ✓
Identified Risks, issues and mitigations:	All risk, issues and mitigations are reference in the Board Assurance Framework item.				
Resource implications:	Individual resource considerations are provided at the People Committee.				
Sustainability and /or Public and patient engagement considerations:	Individual considerations are provided at the People Committee.				

Integrated Impact assessment:	Where applicable, Individual considerations are provided at the People Committee.	
Legal and Regulatory implications:	Individual legal and regulatory implications are provided at the People Committee.	
Appendices:	None	
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act	
For further information or any enquires relating to this paper please contact:	Leon Hinton, leon.hinton@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Meeting of the Trust Board (Public)
Thursday, 15 December 2022

Title of Report	Quality Assurance Committee – Assurance Report		**Agenda Item**	12
Author	Joanne Adams, Business Support Manager			
Lead Executive Director	Evonne Hunt, Chief Nursing Officer			
Executive Summary	Assurance report to the Trust Board from the Quality Assurance Committee, ensuring all nominated authorities have been reviewed and approved. The report includes key headlines from the Committee, and papers to be escalated to the Board.			
Proposal and/or key recommendation:	The Committee approved the following papers for onward sharing with Trust Board:- • IPC update • Edenfield update • CNST • Ockenden update • Perinatal quality surveillance • Call for Concern initiative • Nutrition and hydration – A3 The Committee inform the Board on the following points:- Mattress incident			
Purpose of the report (tick box to indicate)	Assurance	√	Approval	
	Noting		Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	QPSCC and QAC			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients) √	Priority 4: (Quality) √	Priority 5: (Systems)

Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led:
Identified Risks, issues and mitigations:	NIL				
Resource implications:	NIL				
Sustainability and /or Public and patient engagement considerations:	NIL				
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☐ Not applicable (*please indicate why an equality assessment was not required)*				
Legal and Regulatory implications:	NIL				
Appendices:	Key headlines and assurance level listed below.				
Freedom of Information (FOI) status:	State either: This paper is disclosable under the FOI Act, or This paper is exempt from publication under the FOI Act which allows for the application of various exemptions to information where the public authority has applied a valid public interest test. Medway Foundation Trust confirms that either of the following exemptions: s22 (information intended for future publication), s36 (prejudice to effective conduct of public affairs) and s43 (commercial interests) apply to this paper.				
For further information or any enquires relating to this paper please contact:	Evonne Hunt, Chief Nursing Officer				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			
	Significant Assurance	There are no gaps in assurance			

	Not Applicable	No assurance required.

Key headlines	Assurance Level (use appropriate colour code as above)
1. Organ and Tissue Donation Annual Report The Committee received the organ and tissue donation annual report which was presented by Dr Gill Fargher, Chair of the Organ and Tissue Donation Committee and Dr Paul Hayden, Clinical Lead for Organ Donation. Dr Fargher and Dr Hayden were invited to present at the January Council of Governor's meeting.	Green
2. Quality and Patient Safety Sub-Committee (QPSSC) assurance and escalation report The Committee received the assurance and escalation report from the Quality and Patient Safety Sub-committee that took place on Monday 21st November 2022. The Committee were assured by the report which provided a summary of the discussions and provided a real essence of the things QPSSC are assured about and those where further work is required. The Committee noted that a number of papers on the agenda for the quality assurance committee had been discussed at QPSSC.	Green
3. Quality performance report The Committee received the quality performance report which provided progress updates detailing performance against the hospital's key quality metrics, including: • Patient Safety • Quality Assurance and Compliance • Clinical Effectiveness • Mortality and Morbidity • Risk & Policy Management • Legal and Information Governance The Committee were assured by the content of the quality performance report.	Green
4. IQPR The Committee made an independent decision to retire the old style IQPR. This decision was made following conversations that have been taking place	Green

over the last few months on the development of the new style IQPR and watch metrics. The Committee were assured the new report provides more assurance and level of scrutiny on the Trusts performance against key performance indicators and contractual metrics.	
5. Infection Prevention and Control Update The Committee received and noted the infection prevention control update report and were pleased by the progress the infection control team have made over the last year to improve infection control standards at the Trust. This report is presented to Board.	Green
6. Edenfield Update Following an undercover Panorama TV documentary filmed at a secure mental health facility showing patients being subject to abuse, the Committee requested the Head of Safeguarding carry out a gap analysis on the outcomes to ensure such abuse would not be possible at the Trust. The Committee appreciated such a thorough review had been undertaken and expressed their thanks to the safeguarding team. This report is presented to Board.	Green
7. CNST Update The Committee were informed that 9 out of the10 standards are compliant with a trajectory in place to bring safety action 8: multidisciplinary training up to compliance before submission to Trust Board for sign off. The Committee were advised that Director of Midwifery for LMNS has reviewed all CNST evidence and will submit a letter of confirmation that they are happy with the Trust's compliance against CNST. The Committee approved the report for onward sharing with Trust Board.	Green
8. Ockenden Update The Committee received the Ockenden update report which provided an update on the actions from the Ockenden one and two reports. The Committee were informed that no actions are off track, there has been success in recruitment to 26 whole time equivalent (wte) vacancies being reducing down to 7 wte and a Thrive midwife has also been appointed. The Committee approved the report for onward sharing with Trust Board.	Green

9. Perinatal Quality Surveillance The Committee received the perinatal quality surveillance report which provided and update on all quality aspects of maternity services. The Committee were informed about an internal CQC style inspection that has been undertaken in maternity. The internal inspection rated the service as 'requires improvement' and subsequent actions that the service is working on to make improvements. The internal team will carry out a second inspection early in the new year. The Committee approved the report for onward sharing with Trust Board.	Green
10. Call for Concern Initiative The Committee received a presentation from the Lead Nurse Acute Response Team on the Call for Concern Initiative which is about introducing a system where relatives will be able to contact the ART out-reach team directly to escalate deterioration concerns about their relatives. The initiative will be trailed for 3 months from the 1st December 2022. The report is presented to Board.	Green
11. Nutrition and Hydration – A3 The Committee were informed about the A3 patient first methodology being used to review nutrition and hydration provision at the trust. Dieticians and the lead nurse for nutrition have been reviewing the trusts compliance against the 10 aspects of nutrition and hydration set out by NHS England, such as MUST scores, how we observe protected mealtimes and the number of incidents relating to nutrition and hydration. The Committee were pleased to hear about the improvements being made and the further work required. The Committee thanked the team for their hard work. The report is presented to Board.	Green
12. Briefing Paper – Mattress incident The Committee were informed of some incidences relating to mattresses and mattress that piping that sits between the mattress and pressure box. The piping on 63 mattresses disintegrated and deteriorated within the devices. An audit of all mattresses has taken place with the damaged mattresses removed from service. The Trust has raised this as an immediate concern with the supplier who we are liaising with assistance from the Trusts legal team. Regular audits are being undertaken by the tissue viability team. The Committee will escalate this matter to the Board.	Amber / Green

13. Research and Innovation Annual Report This paper was deferred to the December meeting.	

NHS Medway NHS Foundation Trust

Meeting of the Trust Board
Thursday, 15 December 2022

Title of Report	Finance, Planning and Performance Committee Assurance Report		**Agenda Item**	12
Author	Paul Kimber, Deputy Chief Financial Officer			
Lead Executive Director	Alan Davies, Chief Financial Officer Annyes Laheurte, Non-Executive Director			
Executive Summary	The enclosed report sets out the key discussions held at the Finance, Planning and Performance Report. These included a review of the financial performance, capital expenditure, delivery of efficiencies, the key risks and Board Assurance Framework extracts and the operational performance report.			
Proposal and/or key recommendation:	The Trust Board is asked to note this report.			
Purpose of the report (tick box to indicate)	Assurance		Approval	
	Noting	X	Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	The report summarises the Finance, Planning and Performance Committee meeting on 24 November.			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) X	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: X

Identified Risks, issues and mitigations:	The Committee noted the key risk that the Trust may not meet its control total. The meeting also noted the risk of delay to the endoscopy capital project and the availability of funding if this were to slip into 2023/24.
Resource implications:	The report sets out the use of financial resources.

Sustainability and /or Public and patient engagement considerations:	The report sets out the financial performance and hence the sustainability.	
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes ☑ Not applicable	
Legal and Regulatory implications:	The Trust has a statutory duty to breakeven – the discussions held indicated that the Trust has a high risk of this not being achieved in 222/23.	
Appendices:	See enclosed report	
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act	
For further information or any enquires relating to this paper please contact:	Alan Davies, Chief Financial Officer alan.davies13@nhs.net Paul Kimber, Deputy Chief Financial Officer paul.kimber1@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Meeting of the Board of Directors in Public

Thursday, 15 December 2022

Assurance Report from Committees

Title of Committee:	**Finance, Planning and Performance Committee**	**Agenda Item**	**12**
Committee Chair:	Annyes Laheurte		
Date of Meeting:	Thursday 24 November 2022		
Lead Director:	Alan Davies, Chief Financial Officer		
Report Author:	Paul Kimber, Deputy Chief Financial Officer		

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

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
1. BAF strategic risks The legacy BAF entries remain unchanged in scoring, namely: • 3a "Delivery of Financial Control Total" at 20. • 3b "Capital Investment" at 12. • 3c "Financial Recovery Plan" at 20. The new BAF entries were presented to the committee; it was noted that these are aligned to the Patient First programme and the Trust's True North domain of sustainability. The scoring of these was discussed further as a number were included at the extreme risk score of 25, including those which correlated to the existing entries noted above. The	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
Committee referred to the BAF sections which sets out the rationale, noting that the 'Risk Management Framework and Policy' scoring matrix had been followed. The new BAF entries were **APPROVED**.	
2. Corporate risk register Due to the continued under delivery of the efficiency programme, it was agreed to maintain the risk rating to 20.	**Amber/Red**
3. Finance report, including capital – month 7 The Chief Financial Officer presented the report with the key highlights being: • The Trust is reporting a £3.0m deficit position in month and £7.5m year to date (YTD), this being £6.5m adverse to the final plan submitted to NHSE/I in June. • To date, £8.8m of non-recurrent mitigations have been released into the position. • As with the previous month, the main drivers of the adverse position remain, these include escalation capacity remaining open, medical staff pay pressures including additional locums in the emergency department, premium cost of temporary staffing, drugs & clinical supplies price and volume increases, unidentified and undelivered efficiencies. • Capital expenditure is reporting £1.1m under plan YTD due to the timing of schemes becoming live. A risk was flagged in respect of the endoscopy project; this had been approved for £4.6m of PDC funding in 22/23, with approximately half of this sum being for construction/estates work. The current environment is such that this estates work is unlikely to be able to begin this year; consequently, the Trust is to discuss with NHSE the possibility of rolling over the funding into 23/24. If this is not possible the project could be at risk. It was **AGREED** that an update on this project would be reported at the December meeting. • Delivery of efficiencies is £1.2m behind plan YTD, with achievement YTD of £3.9m. • Cash sums remain in a stable position.	**Amber/Red**
4. Finance Risk 2022/23 A paper was submitted to the committee detailing the current drivers of the adverse position and risks to delivering the financial plan. The forecast position for 22/23 is a deficit and adverse position of £15m; this is not without risk as there is an assumption around run-rate improvement from interventions that is yet to crystallise.	**Amber/Red**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
Work is ongoing with the system to ensure robustness of the forecast. Following a recent meeting, the Trust may be expected to deliver an outturn position better than £15m. The executive actions continue in order to mitigate any further overspending and diagnose the key drivers.	
5. Efficiency programme update The Chief Financial Officer provided an overview of the efficiencies position. He noted the realignment of staffing that had been made based on recommendations from the Financial Improvement Director to provide dedicated support to the efficiency programme. The Head of Strategy outlined how the classification of theatres productivity, outpatients productivity and flow and discharge (length of stay) as corporate projects would provide a more focused approach to those schemes. The Financial Improvement Director set out his assessment of the cross-cutting themes, the work being undertaken to develop these and the planning that has begun for 23/24.	**Amber/Red**
6. Acute productivity report The Deputy Chief Financial Officer presented the results of national NHSE benchmarking of providers, looking at their real terms cost growth and implied productivity in 22/23 compared to both 19/20 and 21/22. In both regards the Trust was performing better than the national average. The paper also set out the detailed work being undertaken using Model Health Systems and how this is feeding into the business planning process. The above, coupled with a lower than median cost per weighted activity unit (Model Health System) and a lower than average reference cost (as indicated by the national cost collection paper) pointed towards the Trust needing to "work harder" to identify and realise new efficiency schemes.	**Green**
7. Medicines efficiency programme The Deputy Chief Pharmacist presented this report, which followed up on one made earlier in the year. It was noted that medicines management is now being established as a cross-cutting efficiency theme and will focus on four areas: data management, financial mapping, governance and medicines efficiencies. It was **AGREED** that this would be reported back to the Committee on a quarterly basis.	**Amber/Green**
8. Performance report month 7 The performance report was presented to the committee, this included a comprehensive slide pack detailing performance across key business performance metrics of emergency demand, patient flow, RTT, cancer and diagnostics.	**Amber/Green**

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
9. ESRF operational delivery plan The elective services recovery plan was discussed at the committee. The proposal is to seek to achieve the 104% target, with a risk of a financial impact of 75% clawback of income for under delivery. This risk has been covered by the ICB and NHSE/I for H1, arrangements are uncertain for H2 although it is believed that the clawback mechanism will not be enacted.	**Amber/Green**
10. National Cost Collection The paper was acknowledged, noting that this was compliant with the guidance and submitted on time. The indicative findings are that the Trust's reference cost has reduced, meaning that the organisation is more efficient/lower cost than the national average.	**Green**
11. Digital clinical capacity bed management business case The business case was presented; it set out the proposal to invest in the titled system to support patient capacity management within the Trust. It was noted that the case was supported by the executive team but that there were a number of outstanding matters that had been raised by the Trust Investment Group that still required resolution. The Committee therefore requested that those matters be resolved and be presented back to the Committee at its next meeting.	**Amber/Red**
12. Committee work plan The Committee work plan – running to the end of the 2023/24 financial year was noted and **APPROVED**. However, it was recommended that the balance between finance and performance (and there interconnectedness) be considered at all future meetings. It was also advised that the membership and attendance be reviewed (noting that the terms of reference are due for review in March 2023) and to take care with the papers, which were considered lengthy. A meeting to discuss papers content was noted as being diarised for early December on this topic.	**Amber/Green**
Decisions made The revised BAF extracts that correlate back to the Trust's true north sustainability domain were **APPROVED**. It was **AGREED** that an update on the endoscopy capital project would be reported at the December meeting. It was **AGREED** that a detailed medicines management update would be provided to the Committee on a quarterly basis. The digital clinical capacity be management business case was **NOT APPROVED** but agreed to be brought back to the December meeting following further work. The Committee work plan was **APPROVED**.	

Key headlines and assurance level	
Key headline	**Assurance Level** **(use appropriate colour code as above)**
It was **AGREED** to consider the membership and attendance at the Committee together with the length of the papers.	
Further Risks Identified As outlined above, the solution and funding risk to the endoscopy capital project in 22/23 could jeopardise the project or other projects in 23/24.	
Escalations to the Board or other Committee Current financial performance is £6.5m adverse to plan YTD. Additional controls have been implemented and work to determine a realistic, robust forecast is underway.	

NHS Medway NHS Foundation Trust

Meeting of the Trust Board
Thursday, 15 December 2022

Title of Report	**Financial report – month 7**		**Agenda Item**	**13**
Author	Matthew Chapman, Head of Financial Management Cleo Chella, Associate Director Income and Contracts Isla Fraser, Financial Controller			
Lead Executive Director	Alan Davies, Chief Finance Officer			
Executive Summary	The Trust reports a deficit for the year to date (YTD) at the end of October of £7.5m. The planned deficit at this date was £1m. The £6.5m adverse position is largely as a result of unbudgeted escalation capacity remaining open to meet activity demands, however other factors include overspends against medical staffing, clinical supplies and drugs (associated with activity and demand) together with underperformance against the efficiency programme. The Trust is working with its system partners on a robust forecasting exercise to set out whether we believe we can achieve our control total for the year. This is particularly risky given the YTD performance and ongoing pressures faced.			
Proposal and/or key recommendation:	The Trust Board is asked to note the financial performance for the year to date (YTD).			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	

(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:

Committee/Group at which the paper has been submitted:	The report was presented at the Finance, Planning and Performance Committee meeting on 24 November. A Summary of the Committee is included on the Trust Board agenda.				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) X	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)

Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe:	Effective:	Caring:	Responsive:	Well-Led: X
Identified Risks, issues and mitigations:	There is a risk that the Trust does not meet its control total in 2022/23.				
Resource implications:	The report sets out the use of financial resources.				
Sustainability and /or Public and patient engagement considerations:	The report sets out the financial performance and hence the sustainability.				
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes ☒ Not applicable – this reports the financial performance of the Trust and not the service provision.				
Legal and Regulatory implications:	The Trust has a statutory duty to breakeven – the report indicates that the Trust has a high risk of this not being achieved in 222/23.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information or any enquires relating to this paper please contact:	Alan Davies, Chief Financial Officer alan.davies13@nhs.net Paul Kimber, Deputy Chief Financial Officer paul.kimber1@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			
	Significant Assurance	There are no gaps in assurance			
	Not Applicable	No assurance required.			

Finance report

For the period ending 31 October 2022

Contents

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(106)	(3,042)	(2,936)	The Trust reports a £3,042k deficit position for October; increasing to £3,125k after making the technical adjustments for donated assets, this being £6,482k adverse to the submitted plan year to date. The reported position includes Elective Services Recovery Funding (ESRF) income of £5.8m year to date. A further assessment of the provision for outstanding debts relating to previous years has released £0.5m into the position, and a reduction to the benefit from GRNI accruals of £0.4m. The non-recurrent mitigations benefit year to date total £8.4m. Across the divisions there was an increase to the run rate of £0.5m mainly driven by medical staffing.
Donated Asset Depreciation	13	(83)	(96)	
In-month total	**(93)**	**(3,125)**	**(3,032)**	
YTD total	**(1,053)**	**(7,535)**	**(6,482)**	
Efficiencies Programme				
In-month	904	590	(315)	The delivered efficiency programme position of £3.9m includes £2.5m of the approved cross cutting themes and £0.2m full year effect of schemes continuing from 2021/22. The remaining efficiencies continue to be predominantly from the Corporate functions (£0.3m) as well as Facilities and Estates (£0.4m).
YTD	5,080	3,873	(1,207)	
Capital				
In-month	1,078	704	(374)	The original Trust Capital Resource Limit (CRL) and plan has been set at £11,550k, to be funded from depreciation (£10,970k) and PDC (£580k). Since M5 the £13,673k of additional PDC funding in the pipeline has decreased by £2,855k to £10,818k: - £2,805k CDC brokerage deal has been entirely withdrawn by NHSE, (planned to fund the Cristina Rosettie upgrades [£1,275k] and a mobile MRI [£1,530k]) - EPR Digital diagnostics PDC funding confirmed at £1,800k, £850k short of the bid. The Trust has submitted a bid to the system to cover £800k of the shortfall from their contingency pot. - The Trust has also submitted a bid to fund replacement of 28-year old Gamma camera, but this has not been included in the pipeline funding as there remains uncertainty.
YTD	5,125	4,019	(1,106)	
System Annual	10,970	10,970	0	
Total Annual	22,288	22,288	0	
Cash				
Month end	25,453	28,149	3,909	The Trust cash balance is £3,909k higher than plan due to the implementation of a cash maximisation strategy as detailed in month 5. This is a reduction on the prior month due to increased employer costs associated with the pay award in month 6 and quarterly HEE income not yet paid. We will monitor the cash position and forecasts in light of the deterioration in financial performance.

2. Income and expenditure (reporting against NHSE/I plan)

£'000	In-month			Year-to-date*		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	27,878	28,319	441	195,149	198,875	3,726
High cost drugs	1,888	1,727	(161)	13,215	14,081	866
Other income	2,460	2,593	133	17,220	17,128	(92)
PSF/MRET/FRP	-	-	-	-	-	-
Donated Asset Adjustment	-	1	1	-	5	5
Total income	**32,226**	**32,640**	**415**	**225,584**	**230,089**	**4,505**
Nursing	(8,835)	(8,825)	10	(61,635)	(62,277)	(642)
Medical	(6,732)	(7,605)	(874)	(47,432)	(49,373)	(1,940)
Other	(4,893)	(6,312)	(1,419)	(36,585)	(38,804)	(2,219)
Total pay	**(20,460)**	**(22,743)**	**(2,283)**	**(145,652)**	**(150,453)**	**(4,801)**
Clinical supplies	(3,992)	(4,161)	(169)	(25,886)	(27,796)	(1,910)
Drugs	(632)	(999)	(367)	(4,424)	(6,993)	(2,569)
High cost drugs	(1,888)	(2,045)	(157)	(13,215)	(14,147)	(932)
Other	(3,487)	(3,990)	(503)	(24,430)	(25,209)	(779)
Total non-pay	**(9,999)**	**(11,195)**	**(1,196)**	**(67,955)**	**(74,145)**	**(6,191)**
EBITDA	**1,767**	**(1,297)**	**(3,064)**	**11,977**	**5,490**	**(6,487)**
Depreciation	(1,253)	(1,290)	(38)	(8,771)	(9,056)	(286)
Donated asset adjustment	(13)	83	96	(93)	8	102
Net finance income/(cost)	-	69	69	(4)	286	290
PDC dividend	(607)	(607)	-	(4,255)	(4,255)	-
Non-operating exp.	**(1,873)**	**(1,745)**	**128**	**(13,123)**	**(13,017)**	**106**
Reported surplus/(deficit)	**(106)**	**(3,042)**	**(2,936)**	**(1,146)**	**(7,527)**	**(6,381)**
Adj. to control total	**13**	**(83)**	**(96)**	**93**	**(8)**	**(102)**
Control total	**(93)**	**(3,125)**	**(3,032)**	**(1,053)**	**(7,535)**	**(6,482)**

1. Block funding arrangements for the full year 2022/23 were agreed with the Kent & Medway CCG and included in the June plan submission.
2. Clinical income favourable variance includes the extra £3.3m pay award funding not in the submitted plan.
3. Other income includes recharges for pass through clinical supplies costs and drugs, these costs are recorded in the relevant non-pay category. Also included are the NHS provider to provider contracts, car parking income, F&E retail income and medical education contribution to overheads.
4. The ESRF income year to date included is £5.8m with aassociated cost to independent sector healthcare providers and additional consultant sessions of £2.2m. The risk of the 75% clawback due to under performance against the ESRF plan was covered by NHSE/I in H1; formal notification of arrangements for H2 is awaited, although it is likely this will also be covered.
5. Pay budgets are reporting a £4.8m adverse position YTD, this position includes £4.5m benefit from the non-recurrent release of accruals, and the impact of the pay award £3.3m offset by the clinical income favourable variance.
6. The overall reported deficit position continues to be driven by unbudgeted escalation capacity, premium costs for junior doctors to cover vacancies within the medical rota, staff sickness, and temporary theatres staff.
7. Nurse enhanced care costs have reduced again this month, with a total unfunded cost pressure year to date of £0.5m.
8. Escalation capacity in PAHU, ADL and SDEC overnight stays, additional beds on McCulloch & Emerald wards as well as Will Adams ward previously known as Jade remain open. The length of stay efficiency scheme to close Nelson Ward has fully delivered. The escalation capacity cost pressure is c£3.5m YTD.
9. Covid costs have remained constant at £0.1m in month following executive action to control spend.

3. SLA Activity and Income

	Planned care				Unplanned & Integrated Care				Totals			
POD Group	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s	Annual Plan £'000s	YTD Plan £'000s	YTD Actual £'000s	YTD Variance £'000s
A&E	-	-	-	-	16,842	10,092	10,941	849	16,842	10,092	10,941	849
Adult Critical Care	10,203	5,952	5,923	(29)	-	-	-	-	10,203	5,952	5,923	(29)
Block Contracts	1,704	998	998	-	1,365	800	800	-	3,069	1,797	1,797	-
Chemotherapy	2,069	1,212	1,329	117	1	0	73	72	2,070	1,212	1,402	189
Day Cases	15,211	9,103	8,572	(531)	7,993	4,809	3,959	(850)	23,204	13,912	12,531	(1,381)
Direct Access	1,327	841	440	(401)	8,590	5,094	6,613	1,519	9,917	5,935	7,053	1,118
Elective Inpatient	20,594	12,712	10,421	(2,290)	908	575	379	(196)	21,502	13,286	10,800	(2,486)
Excess Bed Days	1,756	984	1,285	301	2,232	1,052	2,703	1,651	3,988	2,036	3,988	1,952
Excluded Devices	428	251	83	(168)	1,742	1,032	985	(47)	2,170	1,282	1,068	(215)
HCD	6,571	3,677	3,820	143	16,082	9,327	10,327	1,001	22,653	13,003	14,147	1,144
Maternity Pathway	11,388	6,599	6,966	367	-	-	-	-	11,388	6,599	6,966	367
Neonatal Critical Care	10,445	5,896	6,797	901	-	-	-	-	10,445	5,896	6,797	901
Non Elective Inpatient	56,347	33,198	32,962	(236)	62,306	35,628	30,164	(5,464)	118,655	68,828	63,126	(5,702)
Other cost per case	2,793	1,694	1,482	(211)	1,388	830	863	33	4,180	2,523	2,345	(178)
Outpatients	27,595	16,105	16,683	578	23,556	13,909	11,363	(2,546)	51,151	30,014	28,046	(1,969)
Paediatric Critical Care	675	313	133	(181)	-	-	-	-	675	313	133	(181)
	169,105	99,533	97,893	(1,640)	143,005	83,146	79,168	(3,978)	312,114	182,682	177,061	(5,620)
Cancer Drug Fund									(1,675)	(977)	(904)	73
Block Adjustment K&M ICB									47,830	27,207	34,844	7,637
Block Adjustment SEL ICB									(24)	(38)	(400)	(362)
Block Adjustment Spec Comm									(184)	92	512	421
Block Adjustment NHSE Other									931	585	144	(441)
Block Adjustment LVA									(893)	(660)	(2,368)	(1,708)
Total Block Adjustments	-	-	-	-	-	-	-	-	45,983	26,208	31,829	5,620
Total Block Income	169,105	99,533	97,893	(1,640)	143,005	83,146	79,168	(3,978)	358,097	208,890	208,890	-

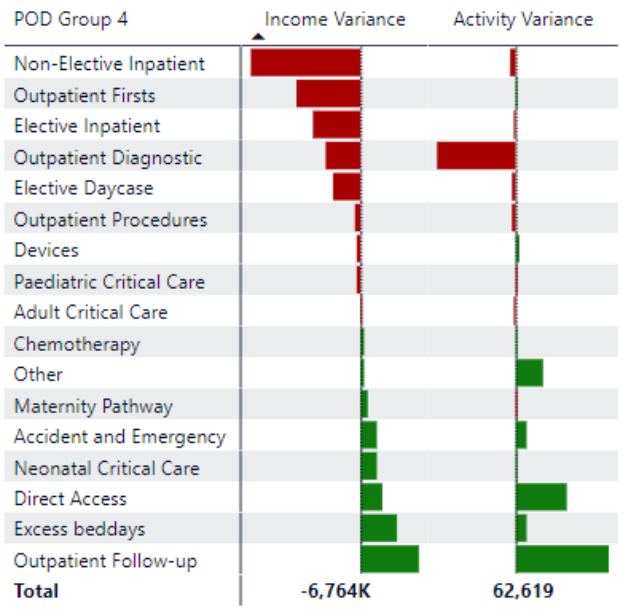
Providers continue to be funded on block contracts for 22/23 for most services except for elective patient care, which is funded using the national tariff as part of the Elective Services Recovery Fund (ESRF).

The table sets out the income and activity performance for the Trust at point of delivery (POD) as at month 7.

- In 22/23 all clinical income has been devolved to divisions based on activity plans priced at national tariff (or local prices in the absence of a national tariff).
- The table shows that MFT receives a benefit of £46m in its annual budget compared to funding activity on national tariff.
- Planned Care division is £1.6m below plan driven by underperformance in elective inpatients of £2.3m and £0.5m in day cases. This is largely offset by over performance in Neonatal critical care of £0.9m and Outpatients of £0.6m.
- Unplanned care is £4.0m below plan, driven by non-elective underperformance £5.7m and outpatients of £2.6m. This is offset by over performance in excess bed days of £1.6m and direct access of £1.5m.

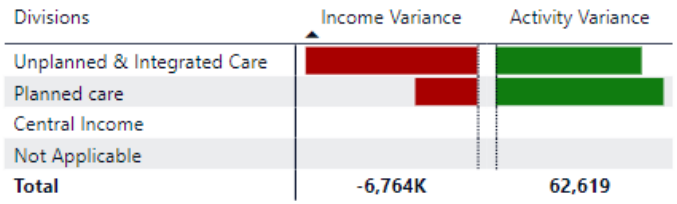
M7 Income and activity by POD (excl. HCD)

The estimated value of the underperformance in M7 for the SLA income based on national tariff is £6.8m YTD (excluding high cost drugs).



POD Group 4	Income Variance	Activity Variance
Non-Elective Inpatient		
Outpatient Firsts		
Elective Inpatient		
Outpatient Diagnostic		
Elective Daycase		
Outpatient Procedures		
Devices		
Paediatric Critical Care		
Adult Critical Care		
Chemotherapy		
Other		
Maternity Pathway		
Accident and Emergency		
Neonatal Critical Care		
Direct Access		
Excess beddays		
Outpatient Follow-up		
Total	**-6,764K**	**62,619**

POD Group 4	Income Plan	Income Actual	Income Variance	Activity Plan	Activity Actual	Activity Variance
Non-Elective Inpatient	£68,828K	£63,126K	-5,702K	29927	27271	-2,656
Outpatient Firsts	£12,615K	£9,273K	-3,342K	59721	59825	104
Elective Inpatient	£13,286K	£10,800K	-2,486K	3202	2789	-413
Outpatient Diagnostic	£4,820K	£3,010K	-1,810K	74616	29433	-45,183
Elective Daycase	£13,912K	£12,531K	-1,381K	16025	14115	-1,910
Outpatient Procedures	£4,941K	£4,668K	-272K	25016	22665	-2,351
Devices	£1,282K	£1,068K	-215K	40555	43132	2,577
Paediatric Critical Care	£313K	£133K	-181K	424	180	-244
Adult Critical Care	£5,952K	£5,923K	-29K	5447	4880	-567
Chemotherapy	£1,212K	£1,402K	189K	7969	8298	329
Other	£5,343K	£5,564K	222K	45155	61452	16,297
Maternity Pathway	£5,699K	£6,040K	341K	3110	3004	-106
Accident and Emergency	£10,092K	£10,941K	849K	51821	57981	6,160
Neonatal Critical Care	£5,896K	£6,797K	901K	6137	6616	479
Direct Access	£5,935K	£7,053K	1,118K	1441273	1471151	29,879
Excess beddays	£2,036K	£3,988K	1,952K	6208	12302	6,094
Outpatient Follow-up	£7,517K	£10,599K	3,082K	71266	125395	54,129
Total	**£169,679K**	**£162,915K**	**-6,764K**	**1887870**	**1950489**	**62,619**



Divisions	Income Variance	Activity Variance
Unplanned & Integrated Care		
Planned care		
Central Income		
Not Applicable		
Total	**-6,764K**	**62,619**

Divisions	Income Plan	Income Actual	Income Variance	Activity Plan	Activity Actual	Activity Variance
Unplanned & Integrated Care	£73,819K	£68,841K	-4,978K	1693593	1722731	29,137
Planned care	£95,857K	£94,073K	-1,783K	194272	227757	33,486
Central Income	£2K	£0K	-2K	5	0	-5
Not Applicable	£0K	£0K	0K	0	1	1
Total	**£169,679K**	**£162,915K**	**-6,764K**	**1887870**	**1950489**	**62,619**

M7 Income and activity by POD (excl. HCD)

Inpatient activity is driving the underperformance because services have not recovered to pre-pandemic activity levels of 19/20.

- The main underperformance is within elective, day cases, non-elective inpatients and outpatient first attendances.
- Non-elective is driven in part by Stroke inpatient activity (£1.2m). Stroke services have moved to MTW and DVH but the activity and income remains within the budgets for MFT. The funding is covering costs in other areas, work will be done with commissioners to reallocate this funding to other services. Other underperformance is mainly in General Medicine £1.4m, Geriatric Medicine £0.9m and Respiratory Medicine £1m. Performance by division shows that UIC is above plan in activity terms but below plan on income. This is driven by a lower casemix in the above mentioned specialties driven by underperformance in respiratory conditions such as complex Pneumonia and COPD. Further investigation is underway to understand the activity drop in these conditions compared to 19-20. There is offsetting over performance in A&E short stay admissions of £1.2m on other conditions.
- Elective inpatients and day cases are £3.6m below plan and was mainly driven reduced surgical activity due to the lack of anaesthetists.
- Outpatient's income for first attendances is below plan of £2.8m YTD mainly driven by low activity in General Medicine and ENT.
- Outpatient's income for follow up attendances is significantly above plan of £2.8m YTD mainly driven by high virtual activity in General Medicine. Coding for some of the FUP activity is being investigated and will be coded as Firsts for future months.
- Adult critical care bed days are above plan and creating a gain of £63k YTD.
- Chemotherapy treatments are above the activity and financial plan of £78k YTD.
- Direct access activity is above plan especially for MRIs £400k and x-rays £341k.
- Neonatal cot days are above plan and resulting in a favourable income of £1m YTD.
- The underperformance is mainly offset by the over performance in outpatient follow-up. Unfortunately outpatient follow-up income is capped at 85% of the 2019/20 activity levels under the ESRF.

Elective Services Recovery Fund (ESRF)

For 22/23 ESRF achievement will based on delivering 104% in value of 19/20 activity. Over performance above this threshold will be paid at 75%, underperformance will be deducted at 75%, although the rules have been suspended in H1 and expected to be suspended H2 as well. All elective activity has been valued at 22/23 tariff (except OP Follow up which is fixed at 85% of the 19/20 baseline) as per the ESRF rules. Outpatient follow up activity is expected to reduce by 25% of 19/20 levels in 22/23

The table below shows the ESRF baseline provided by NHSE/I by month and POD and the actual performance for months 1 to 7.

Elective Services Recovery Fund (ESRF)- Income

ESRF Finanacial Threshold at 104%

Month £'000	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	1,748	1,837	1,772	1,778	1,805	1,828	1,735	2,004	1,696	1,785	1,879	2,153	**22,020**
Elective Inpatient	1,725	1,862	1,874	1,748	1,724	1,733	1,506	1,887	1,489	1,492	1,858	2,229	**21,125**
OPFA	1,303	1,418	1,415	1,491	1,349	1,491	1,363	1,412	1,270	1,355	1,494	1,707	**17,067**
OPPROC	699	747	702	704	703	787	713	815	716	763	743	850	**8,942**
OPFU	1,269	1,364	1,295	1,298	1,267	1,391	1,324	1,442	1,153	1,382	1,266	1,447	**15,898**
Total	**6,744**	**7,228**	**7,058**	**7,018**	**6,849**	**7,230**	**6,640**	**7,559**	**6,325**	**6,777**	**7,240**	**8,385**	**85,052**

Actual income delivered

Month £'000	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	1,538	1,792	1,801	1,878	1,815	1,914	1,679	2,062	2,046	2,159	2,017	2,141	**22,841**
Elective Inpatient	1,538	1,682	1,590	1,592	1,519	1,664	1,445	1,498	1,477	1,561	1,380	1,561	**18,508**
OPFA	1,154	1,421	1,317	1,289	1,380	1,365	1,346	1,551	1,532	1,660	1,460	1,660	**17,136**
OPPROC	557	700	713	707	732	680	516	690	713	697	732	610	**8,048**
OPFU (fixed block)	1,037	1,115	1,059	1,061	1,036	1,137	1,082	1,178	943	1,130	1,034	1,182	**12,994**
OPFU actuals	1,533	1,825	1,629	1,435	1,496	1,463	1,220	1,300	1,300	1,300	1,300	1,300	**17,101**
Total	**6,320**	**7,420**	**7,050**	**6,901**	**6,942**	**7,086**	**6,206**	**7,100**	**7,068**	**7,378**	**6,890**	**7,273**	**83,634**
FUP activity not paid	(495)	(710)	(570)	(374)	(460)	(326)	(138)	(122)	(358)	(170)	(266)	(118)	(4,108)
Over/Underperfomance	(918)	(518)	(578)	(492)	(367)	(470)	(572)	(581)	385	430	(616)	(1,230)	(5,526)
RISK/ERF	**(689)**	**(388)**	**(433)**	**(369)**	**(275)**	**(352)**	**(429)**	**(436)**	**289**	**323**	**(462)**	**(923)**	**(4,145)**
Percentage achievement against Plan	**86%**	**93%**	**92%**	**93%**	**95%**	**94%**	**91%**	**92%**	**106%**	**106%**	**91%**	**85%**	**94%**

At Month 7 the trust underperformed against the ESRF target by £3.9m. The financial risk of this is to the Trust is £2.9m, this being 75% of the underperformance. This has not been reflected in the financial position at M7 because it is been covered by NHSE/I and the ICB for the first half of the year

The table includes forecast ESRF income for months 8 to month 12. Full year expected underperformance is £5.5m which would result in clawback risk of £4.1m, this being 94% of the target. This position includes income from ESRF PIDs approved to date.

The table below provides the performance in terms of activity achieved in M1 to M7 compared to the activity that plan the trust has set to achieve ESRF.

Elective Services Recovery Fund (ESRF) - Activity

19-20 activity actuals

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	2,203	2,236	2,139	2,283	2,031	2,015	2,200	2,225	2,050	2,234	2,132	1,744	**25,492**
Elective Inpatient	442	458	482	496	423	415	429	433	402	390	434	284	**5,088**
OPFA	5,744	5,880	5,846	6,730	5,277	5,956	6,291	5,678	5,330	5,882	5,922	4,930	**69,466**
OPPROC	3,784	3,895	3,646	4,068	3,387	3,844	3,962	4,006	3,634	4,165	3,849	2,973	**45,213**
OPFU	11,305	11,570	11,043	12,186	10,213	11,316	12,245	11,657	9,894	12,214	10,588	9,003	**133,234**
Totals	**23,478**	**24,039**	**23,156**	**25,763**	**21,331**	**23,546**	**25,127**	**23,999**	**21,310**	**24,885**	**22,925**	**18,934**	**278,493**

22-23 activity plan

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	2,286	2,319	2,220	2,368	2,104	2,090	2,282	2,306	2,128	2,320	2,215	1,811	**26,449**
Elective Inpatient	450	467	487	498	433	425	435	443	407	400	443	287	**5,175**
OPFA	8,151	8,425	8,350	9,382	7,559	8,613	9,240	8,281	8,029	8,927	8,985	8,185	**102,127**
OPPROC	3,541	3,476	3,483	3,651	3,469	3,721	3,674	3,694	3,467	3,559	3,427	3,550	**42,713**
OPFU	9,798	10,135	9,968	11,498	8,924	9,957	10,986	9,891	9,402	10,455	10,862	9,921	**121,795**
Totals	**24,226**	**24,823**	**24,509**	**27,396**	**22,489**	**24,806**	**26,617**	**24,615**	**23,432**	**25,660**	**25,933**	**23,753**	**298,261**

22-23 activity actuals

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	1,793	2,051	1,967	2,088	2,046	2,071	1,898	-	-	-	-	-	**13,914**
Elective Inpatient	380	415	397	392	393	408	394	-	-	-	-	-	**2,779**
OPFA	5,542	6,661	6,224	6,253	6,831	6,408	6,156	-	-	-	-	-	**44,075**
OPPROC	2,764	3,356	3,490	3,429	3,540	3,325	2,553	-	-	-	-	-	**22,457**
OPFU actuals	14,699	17,268	15,521	13,847	14,743	14,447	12,137	-	-	-	-	-	**102,662**
Totals	**25,178**	**29,751**	**27,599**	**26,009**	**27,553**	**26,659**	**23,138**	**-**	**-**	**-**	**-**	**-**	**185,887**

75% of 19-20 FUP	8,479	8,678	8,282	9,140	7,660	8,487	9,184	8,743	7,421	9,161	7,941	6,752	99,926
Excess OP FUP	(6,220)	(8,591)	(7,239)	(4,708)	(7,083)	(5,960)	(2,953)						(42,754)

Performance % against the Trust plan

Month	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Day Cases	78%	88%	89%	88%	97%	99%	83%	-	-	-	-	-	**89%**
Elective Inpatient	85%	89%	81%	79%	91%	96%	91%	-	-	-	-	-	**87%**
OPFA	68%	79%	75%	67%	90%	74%	67%	-	-	-	-	-	**74%**
OPPROC	78%	97%	100%	94%	102%	89%	69%	-	-	-	-	-	**90%**
OPFU actuals	150%	170%	141%	114%	144%	128%	99%	-	-	-	-	-	**135%**

Inpatients- The average activity for M7 YTD for Day cases is 89% and 87% for elective inpatients of the trust plan set to achieve ESRF. This is below the average achieved last year partly because Sunderland ward is yet to be converted to a day case suite, required to increase day case activity. This is currently being worked on as part of the ERF recovery plan.

Outpatients- Outpatient first attendances and Outpatient procedures are below plan having achieved 74% and 90% of the activity plan. This is because divisions are seeing a lot more follow up appointments because they make the majority of the waiting list the moment. This is because priority was given to first attendances during the Covid pandemic. Outpatient follow up attendances are significantly above plan at 135% of the plan at Month 7. Payment for this activity is fixed at 85% of 19/20 values and the excess activity will not be paid for and does not count towards the ESRF target.

Actions- Weekly monitoring of activity and bi-weekly performance review meetings now in place. Actions form the ESRF meeting to improve numbers include correcting the coding for some Follow up activity within General medicines to Firsts. Attendances following an emergency spell have been coded as follow-up instead of first attendances. The second is to review missing procedure codes for some procedures defaulting to Follow ups instead of OP Procures.

4. Efficiency programme (status and summary)

Status £'000	Blue	Green	Amber	Red	Cross Cutting Schemes	Sub-total Identified	Over Identified / (Unidentified)	Plan Target	YTD Plan	YTD Delivery	Variance
Planned care	10	735	84	0	1,593	2,422	(1,203)	3,625	1,092	385	**(708)**
UIC	144	658	0	321	3,000	4,124	893	3,231	2,315	1,551	**(763)**
E&F	89	598	0	0	0	687	1	686	454	461	**7**
Corporate	42	540	0	0	156	738	115	623	402	337	**(65)**
Central	0	47	0	0	1,419	1,466	0	1,466	817	1,139	**322**
Sub Total	**284**	**2,579**	**84**	**321**	**6,168**	**9,435**	**(196)**	**9,631**	**5,080**	**3,873**	**(1,207)**
Stretch target 0.5%						**0**	**(851)**	**851**			
Total for 22/23	**284**	**2,579**	**84**	**321**	**6,168**	**9,435**	**(1,047)**	**10,482**	**5,080**	**3,873**	**(1,207)**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	**904**	**590**	**(315)**	**5,080**	**3,873**	**(1,207)**	**10,482**	**10,482**	**-**

Process

1. Efficiency schemes are the responsibility of the budget holders.
2. The Improvement team supports the budget holders to deliver both quality and cost improvements.
3. The S&T team oversees these programmes, supporting with PID writing/management and works to fill the programme.
4. The finance department counts the extent to which the financial improvements have been made.
5. The Chief Finance Officer monitors and works with budget-holders to achieve targets.

The delivered efficiency programme position of £3.9m includes £2.4m from 8 of the cross cutting schemes; in addition, corporate functions have delivered a total of £0.3m and F&E £0.4m. The main schemes contributing to the £1.2m undelivered position include Jade Ward length of stay cross cutting efficiency £0.5m, outpatients including virtual clinics £0.2m, and theatres redesign following the review with independent consultants £0.3m.

The efficiency programme continues to be prioritised across all of the services with regular progress meetings and position reporting at the efficiency review group and efficiency delivery group meetings. Further detail is provided within the Efficiencies Report.

5. Balance sheet summary

Prior year end	£'000	Month end actual	Var on PY.
240,295	**Non-current assets**	**236,998**	**(3,297)**
5,996	Inventory	6,384	388
13,889	Trade and other receivables	23,053	9,164
33,455	Cash	32,058	(1,397)
53,340	**Current assets**	**61,495**	**8,155**
(136)	Borrowings	(427)	(291)
(28,147))	Trade and other payables	(34,959)	(6,812)
(2,116)	Other liabilities	(6,520)	(4,404)
(30,399)	**Current liabilities**	**(41,906)**	**(11,507)**
(2,025)	Borrowings	(2,899)	(874)
(1,248)	Other liabilities	(1,248)	0
(3,273)	**Non-current liabilities**	**(4,147)**	**(874)**
259,963	**Net assets employed**	**252,440**	**(7,523)**
461,656	Public dividend capital	461,656	0
(245,218)	Retained earnings	(249,699)	(7,523)
43,525	Revaluation reserve	43,525	0
259,963	**Total taxpayers' equity**	**255,440**	**(7,523)**

Key messages:

1. Receivables have increased by £9.2m.
   The current balance represents approximately 71% of one month's average turnover (£32.2m).

2. Payables have increased by £6.8m from the prior year which is linked to the cash maximisation strategy.
   Current payables balance represents 108% of one month's average turnover.

3. Total Trust borrowings (current and non-current) are £3.3m, £1.2m higher than the prior year. This is due to the implementation of IFRS16 which is being re-assessed up until M9 as new information is provided.

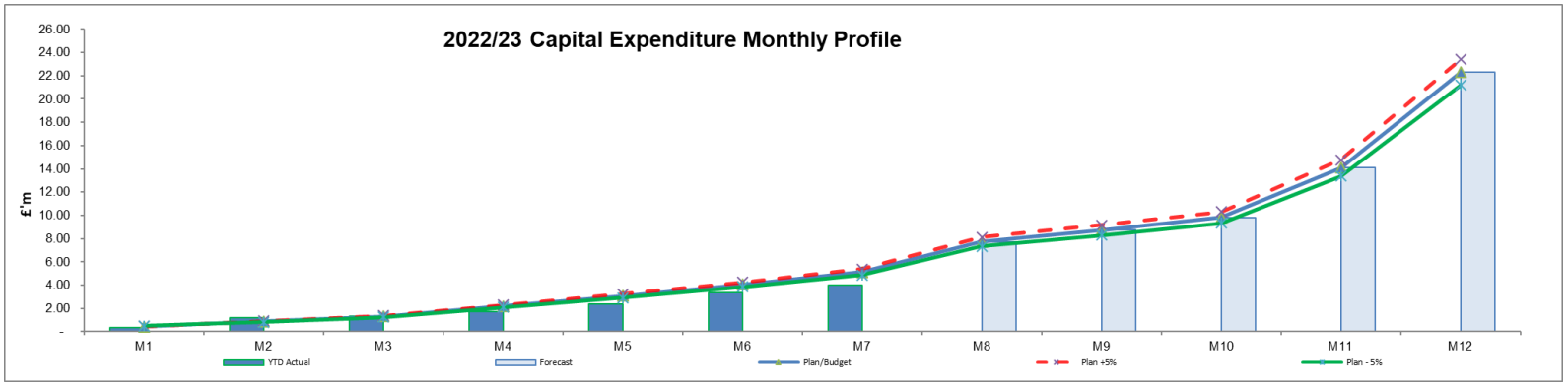
4. Other Liabilities are deferred income and have increased by £4.4m from the prior year. This is due to the nature of the transactions. In year we receive income in advance but only minimal income is paid in advance of a financial year.

6. Capital

2022/23 Capital Expenditure

£'000	In-month			Year To Date			Annual					Funding		
	Plan	Actual	Var.	Plan	Actual	Var.	NHSI Plan	Revised Trust Plan	Forecast	Var on revised Trust plan	Real Forecast	Internal (system capital)	PDC	OTHER
Backlog Maintenance	391	(71)	(462)	573	684	111	2,954	2,675	2,675	0	2,804	2,675	0	0
Emergency Department	15	(57)	(72)	15	(503)	(518)	0	74	74	0	(321)	74	0	0
Fire Urgency Works	327	(23)	(350)	367	192	(175)	0	2,100	2,100	0	2,100	2,100	0	0
Information Technology	213	(2)	(215)	622	331	(291)	2,619	1,220	1,285	65	1,285	1,220	0	0
Medical and Surgical Equipment Programme	43	114	71	313	106	(207)	1,086	1,394	1,394	0	1,352	1,394	0	0
Routine Maintenance	0	7	7	0	7	7	500	435	435	0	435	435	0	0
Service Developments	197	200	4	414	417	3	3,811	3,072	3,065	(7)	2,943	3,072	0	0
Unfunded projects	0	(33)	(33)	0	(58)	(58)	0	0	(58)	(58)	(58)	0	0	0
Phasing Adjustment to align to NHSI Plan*	(299)	0	299	2,629	0	(2,629)								
Total System Capital	**886**	**135**	**(751)**	**4,933**	**1,176**	**(3,757)**	**10,970**	**10,970**	**10,970**	**0**	**10,540**	**10,970**	**0**	**0**
UTC	0	0	0	0	181	181	500	500	500	0	500		500	0
Unspecified PDC Schemes	0	0	0	0	0	0	80	0	0	0	0		0	0
Total Planned Additional Capital	**0**	**0**	**0**	**0**	**181**	**181**	**580**	**500**	**500**	**0**	**500**	**0**	**500**	**0**
Total Planned Capital	**886**	**135**	**(751)**	**4,933**	**1,357**	**(3,576)**	**11,550**	**11,470**	**11,470**	**0**	**11,040**	**10,970**	**500**	**0**
EPR	0	569	569	0	2,662	2,662	0	1,800	1,800	0	1,800		1,800	0
EPR system bid	0	0	0	0	0	0		800	800	0	800	800		
Ultrasound	90	0	(90)	90	0	(90)	0	90	90	0	90		90	0
PACS/RIS (Image sharing)	0	0	0	0	0	0	0	272	272	0	272		272	0
Endoscopy	0	0	0	0	0	0	0	4,560	4,560	0	2,300		4,560	0
CDC brokerage CR Uprades withdrawn by NHSI	0	0	0	0	0	0	0	0	0	0	0		0	0
CDC brokerage - Mobile MRI withdrawn by NHSI	0	0	0	0	0	0	0	0	0	0	0		0	0
Injector pumps ICB NOT AGREED - Bid sent to NHSE/I	0	0	0	0	0	0	0	0	0	0	0		0	0
Gamma Camera ICB NOT AGREED- Bid sent to NHSE/I	0	0	0	0	0	0	0	0	0	0	0		0	0
IR Suite - ICB NOT AGREED - Bid sent to NHSE/I	0	0	0	0	0	0	0	0	0	0	0		0	0
Defibrillators	102	0	(102)	102	0	(102)	0	102	102	0	102		0	102
Irefer	0	0	0	0	0	0	0	29	29	0	29		29	0
CDC Business Case	0	0	0	0	0	0	0	3,165	3,165	0	3,165		3,165	0
Total Additional Capex	**192**	**569**	**377**	**192**	**2,662**	**2,470**		**10,818**	**10,818**	**0**	**8,558**	**800**	**9,916**	**102**
Total Capex	**1,078**	**704**	**(374)**	**5,125**	**4,019**	**(1,106)**	**11,550**	**22,288**	**22,288**	**0**	**19,598**	**11,770**	**10,416**	**102**

* Since plan has been approved project phasing has been reset, this line is to align with the original phasing as set out in the NHSI plan which cannot be changed



6.1 **System Capital**

System capital is funded from internal depreciation of £15,033k. In the past the Trust would have been able to re-invest all depreciation but due to the national regime the Trust is now only able to re-invest the CRL as set by NHSI and then distributed by the ICS. For 2022/23 this is £4,063k less, which means the Trust does not have sufficient funding to replace assets let alone invest in developments, which is a huge challenge to capital planning and potentially of great risk to the Trust.

Year to date system capital expenditure is £3,757k behind plan, this is mainly due to late approval of the plan. These projects are expected to catch up in the remaining months with an overall underspend of £430k currently being forecast. This should not be utilised until funding for the EPR shortfall has been confirmed

6.2 **Planned Additional Capital, approved in the prior year**

Annual Budget £500k, Forecast £500k on Plan

This relates to the final stages of the UTC project started in 2021/22. The project is currently ahead of plan by £181k but this is only due to the phasing of the plan which expected costs to be incurred in month 12 only.

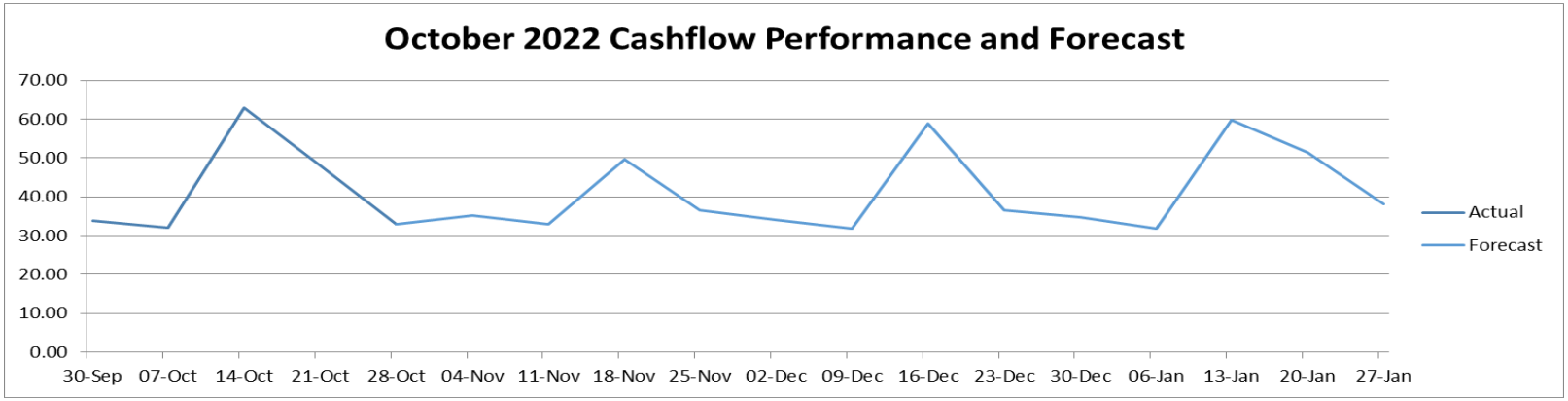
6.3 **Additional Capital, as agreed in year** £10,818k additional capital funding is in the pipeline.

- **Donations £102k**, this funding has been agreed and equipment ordered. Delivery was expected in October but was delayed until November.
- **Approved PDC £8,116k** this funding must be spent on the specific projects unless otherwise permitted by NHSE.
    - Ultrasound £90k, PACS/RIS £272k, Irefer £29k and CDC £3,165k have all been approved and expected to deliver on plan.
    - Endoscopy funded at £4,560k to purchase £2,000k of equipment and £2,660k of building works. Project Managers have advised that only a minimal £100k buildings work design can happen in year which would create an underspend of £2,260k with the funding being lost to the Trust and the project. Discussions are underway to evaluate options before a discussion with NHSI takes place.
- **Pending PDC £1,800k**, The Trust bid for £2,650k to fund 2022/23 EPR looks to have been agreed at £1,800k, a shortfall of £850k which was an identified risk to The Board when the annual plan was approved. As a consequence the Trust has bid for £800k of system contingency. If this is agreed only a minimal balance will need to be funded internally. If it is not agreed all of the slippage currently forecast plus an additional £450k will be required for EPR.

7. Cash

13 Week Forecast w/e

£m	Actual 30/09/22	07/10/22	14/10/22	21/10/22	28/10/22	Forecast 04/11/22	11/11/22	18/11/22	25/11/22	02/12/22	09/12/22	16/12/22	23/12/22	30/12/22	06/01/23	13/01/23	20/01/23	27/01/23
BANK BALANCE B/FWD	**36.98**	**33.89**	**32.11**	**62.93**	**48.16**	**33.00**	**35.11**	**32.92**	**49.75**	**36.44**	**33.96**	**31.90**	**58.91**	**36.50**	**34.74**	**31.76**	**59.89**	**51.38**
Receipts																		
NHS Contract Income	0.00	0.28	33.06	0.02	0.00	0.09	0.00	30.06	0.00	0.00	0.00	30.06	0.00	0.00	0.00	30.06	0.00	0.00
Other	0.30	0.34	0.46	0.54	0.12	5.13	0.65	0.38	0.38	0.38	0.78	0.51	0.38	0.15	0.33	0.91	0.38	0.38
Total receipts	**0.30**	**0.62**	**33.51**	**0.56**	**0.12**	**5.22**	**0.65**	**30.44**	**0.38**	**0.38**	**0.78**	**30.57**	**0.38**	**0.15**	**0.33**	**30.97**	**0.38**	**0.38**
Payments																		
Pay Expenditure (excl. Agency)	(0.46)	(0.42)	(0.40)	(12.54)	(11.03)	(0.40)	(0.41)	(9.51)	(11.26)	(0.44)	(0.41)	(0.41)	(20.36)	(0.41)	(0.41)	(0.41)	(9.51)	(11.26)
Non Pay Expenditure	(2.75)	(1.94)	(2.29)	(2.66)	(3.87)	(2.49)	(2.21)	(3.81)	(2.21)	(2.21)	(2.21)	(3.81)	(1.71)	(1.28)	(2.68)	(2.21)	(3.81)	(2.21)
Capital Expenditure	(0.17)	(0.04)	(0.00)	(0.12)	(0.39)	(0.22)	(0.22)	(0.22)	(0.22)	(0.22)	(0.22)	(0.22)	(0.72)	(0.22)	(0.22)	(0.22)	(0.22)	(0.22)
Total payments	**(3.38)**	**(2.40)**	**(2.69)**	**(15.33)**	**(15.29)**	**(3.11)**	**(2.84)**	**(13.54)**	**(13.69)**	**(2.86)**	**(2.84)**	**(4.44)**	**(22.79)**	**(1.91)**	**(3.31)**	**(2.84)**	**(13.54)**	**(13.69)**
Net Receipts/ (Payments)	**(3.08)**	**(1.78)**	**30.82**	**(14.77)**	**(15.17)**	**2.11**	**(2.19)**	**16.90**	**(13.31)**	**(2.48)**	**(2.06)**	**26.13**	**(22.41)**	**(1.76)**	**(2.98)**	**28.13**	**(13.16)**	**(13.31)**
Funding Flows																		
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.88	0.00	0.00	0.00	0.00	4.65	0.00
Loan Repayment/Interest payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**(0.08)**	**0.00**	**0.00**	**0.00**	**0.88**	**0.00**	**0.00**	**0.00**	**0.00**	**4.65**	**0.00**
BANK BALANCE C/FWD	**33.89**	**32.11**	**62.93**	**48.16**	**33.00**	**35.11**	**32.92**	**49.75**	**36.44**	**33.96**	**31.90**	**58.91**	**36.50**	**34.74**	**31.76**	**59.89**	**51.38**	**38.08**



Prior year end	£'000	Month end actual	Var.
33,455	Cash	32,058	(1,397)

The overall cash balance has decreased by £1.9m in October, mainly due to the on-costs associated with the backdated annual pay award in September.

£34.8m of cash was received in month

£33.3m NHS contract income for the month and £1.5m cash receipts in relation to trading activities and settlement of prior period sales invoices.

£36.7m of cash was paid out by the Trust in month

£12.2m (33%) in direct salary costs to substantive and bank employees.

£12.2m (33%) employer costs to HMRC and NHSP - now paid as due rather than prepaid.

£12.3m (34%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

8. Conclusions

The Finance Committee is asked to note the report and financial performance, which is £3,125k deficit in-month, £7,535k year to date; this is £6,482k adverse to the YTD plan submitted to NHSE and the Kent & Medway ICS in June 2022. The overall plan for the year is a breakeven position; there is a high degree of risk in delivering this control total in 2022/23 and work is taking place both internally and with system partners in respect of mitigating actions, intervention requirements and deliverability. The Trust continues to work with the Kent & Medway ICB to produce a revised system position, this will be agreed across all providers prior to being reported to NHSE/I.

The current efficiency programme is £1.2m adverse to plan, with a delivery of £3.9m year to date. ESRF income of £5.8m has been included at a cost of £2.2m for activity delivered by the independent sector and additional consultant sessions; the risk of repaying the ESRF income has been mitigated by NHSE and the ICB for the first half of the year, there is a risk this will not continue for H2 however confirmation has not been received.

The Executive Leads and their actions continue to make progress to address each of the key financial risks, including divisional overspendings and efficiencies.

Alan Davies
Chief Financial Officer
November 2022

Meeting of the Trust Board (Public)
Thursday, 15 December 2022

Title of Report	Annual Business Plan 2023/24 – update		**Agenda Item**	14
Author	Paul Kimber, Deputy Chief Financial Officer			
Lead Executive Director	Mandy Woodley, Chief Operating Officer Alan Davies, Chief Financial Officer			
Executive Summary	The Trust has issued its internal business planning guidance, with first draft plans due in mid-December 2022. These plans – covering activity, workforce, budgets and strategic priorities – must cover 2023/24 in detail and the following two years in summary. There has been no national, regional or system-level guidance issued at the time of writing. Upon its release the Trust will review and update its own guidance as applicable. Progress reports are due to the Finance, Planning and Performance Committee from January 2023.			
Proposal and/or key recommendation:	This report is made to the Trust Board for assurance.			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting		Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	The Finance, Planning and Performance Committee agreed the Trust's business planning guidance. Progress reporting will be made to that Committee from January 2023 in line with its work plan.			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) X	Priority 2: (People) X	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems) X
	Tick CQC domain the report aims to support:				

Relevant CQC Domain:	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	Operational pressures could disrupt delivery of the business plans to the timetable. There is sufficient time between the draft and final submissions to ensure robust work and some slippage.				
Resource implications:	The business plans will require multi-disciplinary work across interdependent services.				
Sustainability and /or Public and patient engagement considerations:	The business plans will set the direction of travel against the Trust's sustainability domain.				
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes ☑ Not applicable				
Legal and Regulatory implications:	No issues to note at this time. The plans will set out proposed performance against its constitutional standards.				
Appendices:	None				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information or any enquires relating to this paper please contact:	Mandy Woodley, Chief Operating Officer m.woodley2@nhs.net Paul Kimber, Deputy Chief Financial Officer paul.kimber1@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			
	Significant Assurance	There are no gaps in assurance			
	Not Applicable	No assurance required.			

1 Executive Overview

1.1 The Trust has issued its internal business planning guidance, with first draft plans due in mid-December 2022. These plans – covering activity, workforce, budgets and strategic priorities – must cover 2023/24 in detail and the following two years in summary.

1.2 There has been no national, regional or system-level guidance issued at the time of writing. Upon its release the Trust will review and update its own guidance as applicable.

1.3 Progress reports are due to the Finance, Planning and Performance Committee from January 2023.

2 Background

White

2.1 The Trust issued its internal business planning guidance for 2023/24 to clinical divisions and corporate directorates in September 2022. Business planning incorporates demand and capacity modelling, activity agreement, budget setting and workforce planning. This is triangulated and encompassed within an overall strategic narrative which reflects the Trust's Patient First priorities.

2.2 This guidance requires our services to plan for 2023/24 in detail, with summary/outline plans for the following two financial years.

3 Regional and National Guidance

White

3.1 At the time of writing, there has been no national, regional or system-level business planning guidance issued.

3.2 The Trust's internal guidance gives full consideration to the national guidance and priorities issued for 2022/23; to the extent that the national/system guidance diverges from that which has gone before the Trust will update its own internal guidance to ensure compliance.

3.3 The operating plan guidance issued in previous years has been very prescriptive in respect of budget setting as a result of the uncertainty arising from the pandemic. Whilst no formal announcement has been made, there are signs that there could be a national return to Payment by Results (PbR). This would mean a move away from block contracts for income (or 'aligned incentive contracts', which comprise a block amount and incentive to earn more income through meeting certain activity targets, such as with the elective services recovery fund) and a move back to income generated being dependent on the volume of activity undertaken. Even if this were prescribed nationally, the system and its partners could agree an alternative payment system.

4 Timetable

Amber / Green

4.1 The high level timetable for draft business plans is set out below. Draft plans are required by 16 December, with final plans due in March 2023. The December deadline was set in consultation with clinical divisions.

Date	Event	Expected outcome/milestone	Progress
By 16-Sep	TMB / Trust Executive	Approve business planning guidance	The guidance was approved in September and agreed at the Finance, Planning and Performance Committee that month.
19-Sep	Business planning guidance released	Issued business planning guidance	The guidance was issued on 27 September.
From 19-Sep	Roadshows	Run c4-6 weeks of events to explain the business planning guidance and take questions from divisional, care group and directorate teams	The roadshow presentation was made at both clinical divisional boards. Due to issue of going into business continuity, this was only completed in late October and mid-November.
19-Sep to 28-Oct	Demand and capacity planning	Build the D&C models on a service-by-service basis	Demand and capacity templates were released in September, however due to operational pressures these are still awaiting finalisation.
25-Nov	Rollover budgets issued	Issue standing budgets for 23/24 on a rollover basis, incorporating the full year effect of approved investments, etc.	These have been released on time.
28-Nov to 9-Dec	Proposed budget changes identified	Building on the rollover budgets issued, identify further proposed and requested changes to budgets for 23/24 and beyond	Not yet due.
3-Oct to 16-Dec	Capital pipeline	5-year capital programme and master list to be reviewed for completeness and content	Not yet due.
w/c 12-Dec	Triangulation	Exercise to ensure alignment between D&C, activity, workforce and budgets	Not yet due.

16-Dec	Draft business plans	Completion of 1st draft plans by Clinical Divisions	Not yet due.

4.2 As noted above, operational pressures (including business continuity) during October have delayed some of the work to date. However, this is expected to recover and the draft submission deadline met.

5 Conclusion and Next Steps

5.1 Work is ongoing in respect of the Trust's business planning for 2023/24 (and subsequent years).

5.2 Detailed updates are scheduled into the reporting timetable to the Finance, Planning and Performance Committee from January 2023.

NHS
Medway
NHS Foundation Trust

BBC Panorama Programme: Edenfield Secure Mental Health Hospital Review

Patient FIRST

Background

- On 28th September 2022 BBC Panorama programme aired a documentary showing vulnerable patients being abused while in the care of an NHS Trust
- The abuse took place within Edenfield Centre, a secure mental health facility in Greater Manchester.
- Edenfield provides secure treatment and care for adult patients (men and women), many of whom have been to prison or sentenced to hospital orders for criminal offences, helping them to adjust back into the community.
- Secret footage filmed over three months showed staff taunting patients in vulnerable situations, using inappropriate restraint and faking paperwork intended to ensure patient safety.
- Staff were filmed swearing at patients, mocking them, pinching and slapping them and depriving patients of their liberty and human rights.
- There were examples of poor processes around medicines management and near miss medication incidents.
- Letter received from Claire Murdoch, National Director, Mental Health to all provider organisations. Setting out vital questions the Board should be asking:
  - Could this happen here?
  - How would we know?
  - How robust is the assessment of services and the culture of services?
  - Are we visible enough and do we hear from patients, their families and all staff on a ward e.g. the porter, cleaners, HCAs
- MFT is committed to ensuring that our patients receive safe and dignified care at all times.
- The purpose of this report is to review the safeguarding of care in the Trust against the findings outlined within the programme to explore and ensure such abuse is not occurring to our patients.

Immediate Issues

NHS Medway NHS Foundation Trust

Immediate Issues Identified	MFT Evidence and Assurance	Further Mitigating Actions Required
Psychological and emotional abuse of patients: - Staff swearing, taunting and mocking patients in vulnerable situations including joking about their self-harm.	• Visible leadership from Ward to Board: day and night time • Freedom to Speak Up Guardian (FSUG) • Robust safeguarding processes • Patient First approach • New patient experience approach • Complaints and PALS • Patient feedback through survey introduced • Medway Council commission advocacy services for the locality • Fortnightly meeting with Legal, Patient Safety, Safeguarding, Complaints and Mortality to triangulate themes / concerns	• Safeguarding to work with FSUG to triangulate themes and concerns. • Promote new advocacy provider through a communications approach.
Unsafe and abusive care of patients: - Inappropriately restrained, slapped or pinched by staff. Some female staff acting in a sexualised way towards male patients	• Allegations against staff policy, systems and processes has been revised to ensure safeguarding oversight. • Gemba walkrounds • Incident reporting and management systems • Local Security Management Officer liaises with safeguarding regarding security incidents.	• Placing the voice of the patient and families at the heart of governance, service design and delivery: through the roll out of national patient safety strategy • Senior Nursing night walkabout to be commenced • Director of Estates leading on the introduction of Maybo training for front line staff on de-escalating workplace violence
Deprivation of liberty (DoLS): - Long term segregation and seclusion of patients in small seclusion rooms, designed for short-term isolation to prevent immediate harm - for days, weeks or even months, with only brief breaks	• MFT does not have seclusion rooms as not a registered provider of mental health or secure forensic health care. • MCA lead and safeguarding team review incidents reported on Datix to pick up concerns of safeguarding. restraint or Mental Capacity Act / DoLS issues for escalation.	
Paperwork intended to ensure patient safety was frequently falsified: - Showing staff had completed patient observations when they had not. - - Near miss drug errors not reported.	• EPR system: provides documentation audit trail, supports prevention of false record keeping. • Medication charts are on EPR system, eliminating risk from paper medication charts. • Documentation audits completed • Matrons undertake spot checks at weekends • Ward managers undertake NEWS2 audits, Matrons review results and action improvements if required	• Matrons to work with ward managers to ensure that any further assurances are in place.

Immediate Issues

Immediate Issues Identified	MFT Evidence and Assurance	Further Mitigating Actions Required
Staffing shortages	• Use of temporary staffing to mitigate any shortages • Daily safe staffing reviews carried out • Safe staffing policy, systems and process • Multi-disciplinary safe staffing establishment review commenced	• Safe staffing policy being updated at present
Poor leadership and toxic culture	• Listening forums with Heads of Nursing, Matrons, Ward Managers, Band 6s, Care Support Workers, Specialist Nurses • Confidential listening reviews carried out by the Organisational Development Team • Leadership Compact to provide clear support and guidance of being an effective leader • Health and Wellbeing support - reflective practice and debrief sessions • - Listening ear and psychological support • Staff compact developed -clearly displays what behaviours and attitudes are expected from all staff in all roles and levels.	• Manchester Patient Safety Framework culture barometer to be carried out • Consistent listening forums to be developed for porters, cleaners,
Patient dignity and compassion	• Patient experience academy in development • Staff training programme • Dignity and Privacy audit • Namaste practitioner recruited	• Launch of Academy in the new year

Next Steps

- NHS England will be launching the inpatient quality programme which aims to tackle the root causes of unsafe poor quality care, looking at the best evidence for preventing and uncovering abuse

- The work will capture the views of professionals about what support, education and information will best help prevent and fight abusive and poor care.

- MFT Safeguarding team will review the output of the inpatient quality programme to ensure any learning as relevant is learnt.

- Further mitigating actions required outlined in this report are actions that were already underway and being monitored through various governance routes.

Meeting of the Trust Board (Public/Private)/ Committee
Thursday, 15 December 2022

Title of Report	Kirkup Report Executive briefing for QAC and Trust Board		**Agenda Item**	
Author	Alison Herron, Director of Midwifery			
Lead Executive Director	Evonne Hunt, Chief Nursing and Quality Officer			
	This report provides a brief to the Trust Executive Team and Board on the recent publication (October 19th 2022) of the Dr Bill Kirkup Independent Investigation report of maternity and neonatal services in East Kent Foundation Trust, titled "Reading the Signals" This briefing includes the key recommendations within the Kirkup report for maternity services to review in relation to maternity care at Medway NHS Foundation Trust. An update on the Medway maternity leadership initial review of the Kirkup report and their preliminary priority areas for further deep dive and potential areas of improvement within our services. Awaiting future guidance from NHSE/CMO team on next steps, including any benchmarking tool/template and data/evidence reporting schedule anticipated in Spring/Summer 2023.			
Proposal and/or key recommendation:	The Board is requested to note the briefing report.			
Purpose of the report (tick box to indicate)	Assurance		Approval	
	Noting	X	Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Planned Care Group meeting Planned Care Divisional Governance Board Quality Assurance Committee October 2022			
	Tick the priorities the report aims to support:			

Patient First Domain/True North priorities (tick box to indicate):	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients) X	Priority 4: (Quality) X	Priority 5: (Systems)
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	Not applicable				
Resource implications:	No additional resource implications				
Sustainability and /or Public and patient engagement considerations:	Not applicable				
Integrated Impact assessment:	Not applicable				
Legal and Regulatory implications:	Not applicable				
Appendices:	**Appendix 1:** Kirkup Report Executive briefing for QAC and Trust Board				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information or any enquires relating to this paper please contact:	Alison Herron, Director of Midwifery Alison.herron2@nhs.net				

Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Meeting of the Trust Board (Public/Private)/ Committee
Thursday, 15 December 2022

Title of Report	CNST Assurance Report		**Agenda Item**	
Author	Alison Herron, Director of Midwifery			
Lead Executive Director	Evonne Hunt, Chief Nursing and Quality Officer			
Executive Summary	This report provides an update to the Trust Board on the Maternity Service's progress against compliance with the 10 Safety Actions for CNST Year 4.			
Proposal and/or key recommendation:	The committee is requested to note the assurance and give approval for the Trust to submit a declaration of full compliance to all 10 CNST standards, to NHSR, by the 2nd February 2023.			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	X
	Noting	X	Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Planned Care Group meeting Planned Care Divisional Governance Board Quality and Patient Safety Sub-Committee 21/11/22 Quality Assurance Committee 29/11/22			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
			X	X	
	Tick CQC domain the report aims to support:				

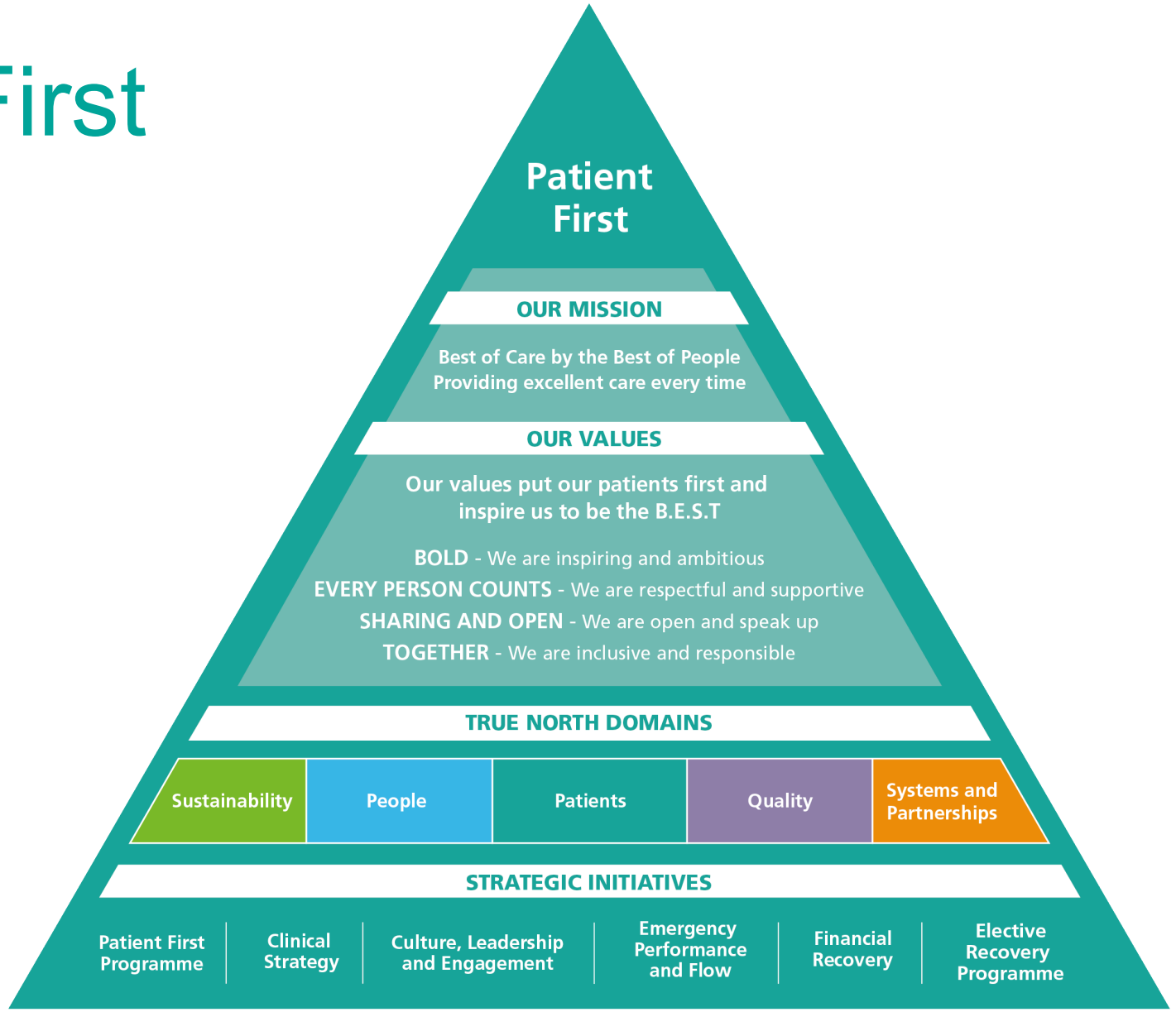
Relevant CQC Domain:	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	Not applicable				
Resource implications:	No additional resource implications				
Sustainability and /or Public and patient engagement considerations:	Not applicable				
Integrated Impact assessment:	Not applicable				
Legal and Regulatory implications:	Compliance with CNST				
Appendices:	Appendix 1: CNST Assurance Report				
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act				
For further information or any enquires relating to this paper please contact:	Alison Herron, Director of Midwifery Alison.herron2@nhs.net				
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions			
	Partial Assurance	There are gaps in assurance			
	Assurance	Assurance with minor improvements needed.			
	Significant Assurance	There are no gaps in assurance			
	Not Applicable	No assurance required.			

Quality Assurance Committee Meeting –

CNST

Ali Herron – Director of Midwifery
December 2022

Patient First



SIOR- CNST

Successful Deliverables

- Reporting compliance to all 10 CNST standards with MDT training compliance achieved for PROMPT and NBLS
- Trajectory of Fetal Monitoring training 100% by end of Jan '23.
- Obstetric staffing aligns with RCOG requirements and audit demonstrates 100% compliance with consultant attendance at required events.
- Compliance with PMRT reporting requirements.
- Maternity Digital Strategy written – requires approval through internal governance processes in January 23

Identified Challenges

- Maintaining training schedule and MDT attendance in face of staffing challenges was challenging to reach the required compliance.
- Reporting requirements changed for Safety Action 8 – MDT training – which was reduced from 18months to 12 months – 90% compliance achieved by 5th December 2022
- Changes to requirements for Safety Action 5 regarding Coordinator Supernumerary status

Opportunities

- Opportunities to strengthen staff and service user feedback through staff engagement events and collaborative working with Maternity Voice Partnership.
- Reviewing of adding Bedstate onto Gthr to increase ease of data collection

Risks

- Maternity Digital Strategy needs to be discussed and approved in principle in January 2023 MNSCAB and TMB, prior to full CNST submission to NHSR on 2nd February.
- ESR needs updating in relation to MDT doctor training and staff leavers removed from the database to ensure robust evidence available if NHSR request this.

Summary

Safety Action	Description	RAG – June 2022	RAG – September 2022	RAG – November 2022
Safety Action 1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard	On Track	On Track	Complete
Safety Action 2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	Off Track with actions to deliver	Off Track with actions to deliver	Complete
Safety Action 3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	On Track	On Track	Complete
Safety Action 4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	On Track	On Track	Complete
Safety Action 5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Off Track with actions to deliver	On Track	Complete
Safety Action 6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle version two?	On Track	On Track	Complete
Safety Action 7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership (MVP) to coproduce local maternity services?	Off track with actions to deliver	On Track	Complete
Safety Action 8	Can you evidence that the maternity unit staff groups have attended an 'in-house' multi-professional maternity emergencies training session since the launch of MIS year three in December 2019?	Off track with actions to deliver	Off track with actions to deliver	**Complete**
Safety Action 9	Can you demonstrate that the Trust safety champions (obstetric, midwifery and neonatal) are meeting bi-monthly with Board level champions to escalate locally identified issues?	On track	On track	Complete
Safety Action 10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?	On Track	On Track	Complete

Medway NHS Foundation Trust

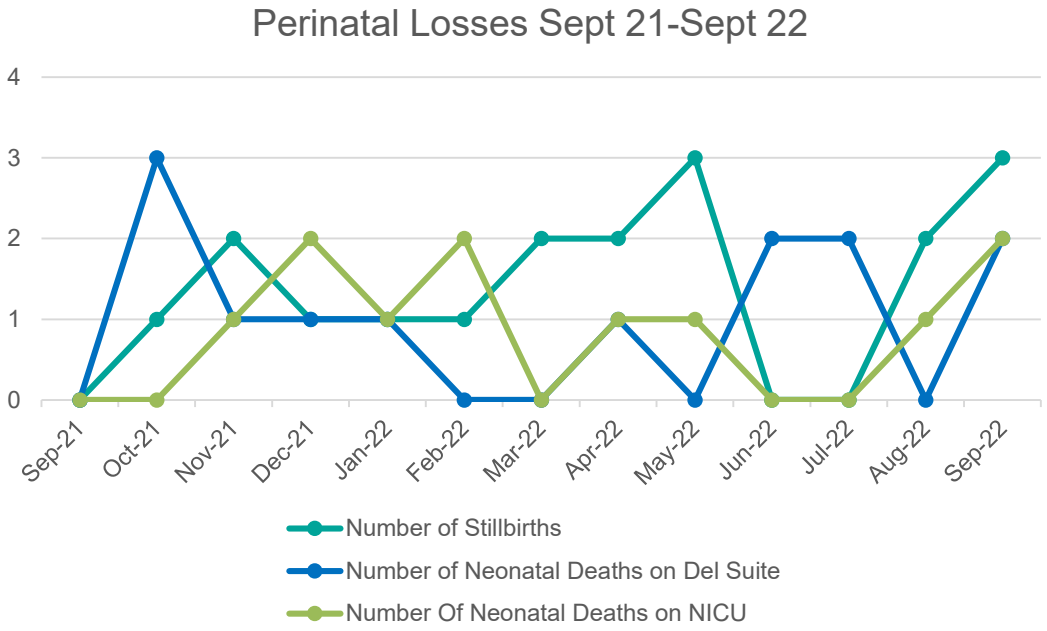
Completed	Action has been completed and there is robust evidence to support that the action has been completed and where relevant embedded in practice
Overdue	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address.
Off Track with actions to deliver	Action is off track and plans are being put in place to mitigate any delay
On Track	Action is on track with progress noted and on trajectory

True North: Quality

Safety Action 1: PMRT Complete

Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.

Goal: To ensure all eligible perinatal losses are reported to the required standard.



Key Messages:

- Continued compliance with reporting to MBRRACE and publishing reports within required timescales.
- Q2 – 0 Stillbirths in July. 2 stillbirth cases reviewed in August
  - 1 x ?placental abruption – acute event. Patient had missed 35-37 wk USS due to being out of the country. Baby delivered was small – impression of late onset growth restriction, which would have been identified on missed USS
  - 1 x unexplained stillbirth, with normal USS at 37+3, 2 days prior to diagnosis of loss.
- 3 stillbirth cases reviewed in September
  - 1 x unexplained – no themes emerged from PMRT meeting
  - 1 x loss of triplet – diagnosed anomalies
  - 1 x baby with multiple abnormalities – parents chose expectant management
- No immediate care concerns or learning identified with above cases.

- 7 Neonatal deaths in Q2
  - On Delivery Suite - 21+6 – sepsis and extreme prematurity wt 440g, 20+3 – spontaneous delivery – extreme prematurity, 20/40 – extreme prematurity, 21/40 – extreme prematurity
    - No learning identified with above cases
  - On NICU – 24/40 – extreme prematurity, 23/40 extreme prematurity.
    - No learning identified with above cases
  - PMRT reviews continue for 1 x term Neonatal Death. Awaiting coronial post mortem and HSIB reports.

Issues, Concerns & Gaps:

- The need to provide enhanced care in the post natal period
- Unannounced HTA inspection – requested evidence of post mortem SOPs and consent forms

Actions & Improvements:

- MDT CRIG meetings commenced for shared learning, including review of ‘born in poor condition babies’
- NICU Nursing QIS has been reported to Trust Board

True North: System & Partnership

NHS Medway NHS Foundation Trust

Safety Action 2: MSDS Complete

Ambition: Ensuring data submitted as part of Maternity System Data Set is robust and accurate and there is maternity digital strategy in place.

Goal: To ensure accurate data input and correct data mapping to achieve compliance with Safety Action 2.

Key Messages:

- Maternity Digital Strategy presented at Care Group and at ICT Trust committee. To be discussed at January MNSCAB and TMB for approval in principle.
- Safety Action 2 been presented at Trust Board in October in line with CNST requirements
- PIF for July 2022 data confirms achieving 11/11 for CQIMs – showing compliance for Safety Action 2

Issues, Concerns & Gaps:

- To continue monitoring reporting process to ensure all CQIMs remain reporting correctly

Actions & Improvements:

- Continue to work closely with EuroKing provider to identify and correct data mapping errors
- Euroking provider now corrected data mapping errors – 11/11 CQIMs now reporting
- Medway Trust Management Board to approve Maternity Digital strategy and confirm approval from LMNS/ICB
- Regular meetings with Euroking provider continue to address data mapping issue continues

True North: Quality

Safety Action 3 - ATAIN – Avoiding Term Admissions into Neonatal Units

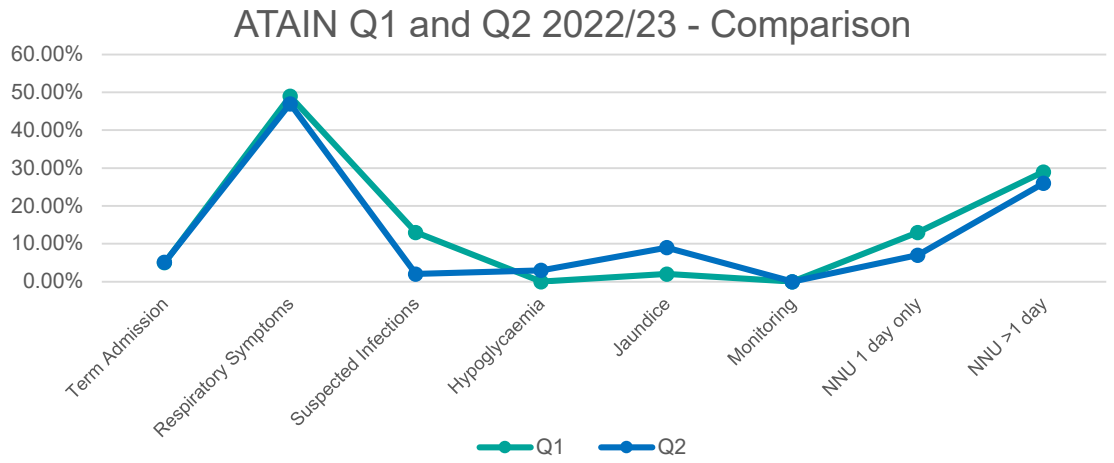
Ambition: To identify harm leading to term admissions

Goal: To reduce harm avoiding unnecessary separation of mother and baby

Complete

NHS Medway NHS Foundation Trust

Medway Maritime	Live births	Term Admissions		Respiratory Symptoms			Suspected Infection			Hypoglycaemia			Jaundice			Monitoring			HRG 3-5 Only			
																			NNU 1 day only		NNU >1 day	
		N	% live births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	per 1000 births	n	% term ads	n	% term ads
Q1 - Apr-June '22	1103	55	5.0%	27	49%	24.5	7	13%	6.3	0	0%	0.0	1	2%	0.9	0	0%	0.0	7	13%	16	29%
Q2 - July-Sept '22	1145	58	5.1%	27	47%	23.6	1	2%	0.9	2	3%	1.7	5	9%	4.4	0	0%	0.0	4	7%	15	26%



Key Messages:

- Number of Term admission from Q1 to Q2 increased by N=42 but percentage remained consistent at 5%-5.1%.
- Respiratory symptoms remained the same at n=27
- Suspected infection rates reduced by 11% to 2%
- Hypoglycaemic cases increased by n=2
- Jaundice increased by 4 cases
- Length of stay in NICU for 1 day reduced by 6% and more than 1 day length of stay reduced by 3%

Issues, Concerns & Gaps:

- Data input issue identified regarding babies incorrectly being allocated to NNU rather than TC for part of admission, therefore increasing number of Term Admissions recorded.

Actions & Improvements:

- ATAIN action plan ongoing and collating evidence continues
- ATAIN report sent to LMNS QAC in November 2022
- Learning shared with staff regarding thermoregulation and hypoglycaemic pathways
- Electronic database for ward attenders to NICU now in place to support compliance with CNST and to provide improved monitoring of workload on NNU.

True North: Patients

Safety Action 3 - ATAIN – Avoiding Term Admissions into Neonatal Units Complete

Ambition: To identify harm leading to term admissions

Goal: To reduce harm avoiding unnecessary separation of mother and baby

CNST Year 4 ATAIN Action Plan

Accountable Lead: Felicity Brokke **Action Plan Completion Date: 23/11/2022**

Objectives List of actions	Tasks What you need to do to achieve the action	Success Criteria How will you identify success	Target Date	Owner	Current position	Actual Date	Progress	Evidence Source
100% compliance with daily, documented, neonatal medical ward round on Transitional Care (TC) and Maternity Additional Care (MAC).	Communicate expectation of daily documented consultant ward round with all staff.	Improved compliance with guideline on subsequent audit.	January 2022	Ghada Ramadan, Clinical Director, Women's	Complete			Minutes of band 7/consultant meeting RE ATAIN audit reports.msg 02.12.2021 - B7CONS MINUTES
	Monthly audit of 20 cases to demonstrate compliance with	Completed audit demonstrating improved compliance.	1 June 2022	Helen Gbinigie, Neonatal ATAIN Lead	Complete			2022.11 Q1 22-23 and MAC audit rep

Key Messages:

- ATAIN action plan – completed
- ATAIN admission will be reviewed on a weekly basis to identify case to be discussed at CRIG
- FWB team review cases to be discussed at CRIG in preparation collating of details of case during CRIG
- FWB team will complete ATAIN form during weekly CRIG meetings – then send to Risk midwives attached to DATIX, providing summary of learning
- FWB team will maintain spreadsheet of all ATAIN babies to monitor any trends and number of babies admitted

Actions & Improvements:

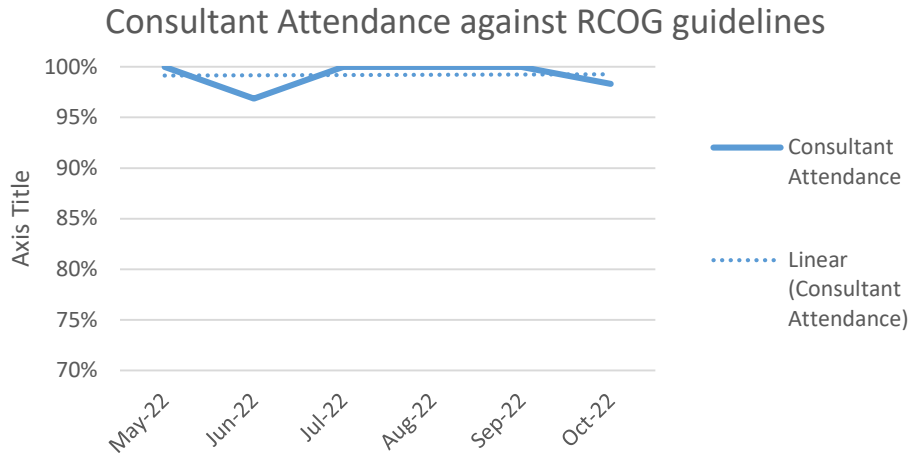
- Deep dive exercise to understand any thematic trends if seeing a rise in HIE cases
- ATAIN spreadsheet created for ease of data collection

True North: People

Safety Action 4: Clinical Workforce Complete

Ambition: Ensure clinical workforce meets the needs of the service and can provide the best patient care

Goal: Ensure Obstetric, Neonatal Medical, Neonatal Nursing and Anaesthetic workforce meet the required standard



Key Messages:

- Obstetric rota enhanced and SOP in place to support compliance with RCOG guidance for Obstetric Consultant roles and responsibilities.
- Audit of consultant attendance commenced ahead of 29 July 2022 deadline. 100% compliance for July, August, September 2022.
- NICU junior medical staffing compliant with BAPM requirements
- NICU Nursing staff currently 68.4% Qualified in Speciality (QIS) due to increase in QIS establishment by 16 WTE – rolling recruitment continues
- NICU nursing staffing now exceeding anticipated 64.52% Qualified in Speciality (QIS). New cohort of nurses commenced NICU nursing course

Issues, Concerns & Gaps:

- Revised bed state to improve consultant attendance audit data recording. Also collecting data on consultant ward rounds.
- 2 occasions where consultant ward round did not occur on night shifts due to (1) consultant decision and (1) consultant went home due to high work load in theatre all day
- Current audit does not capture patient level detail or allow outcomes or themes to be easily monitored.
- NICU nursing workforce currently below 70% QIS requirement, however rolling recruitment continues
- One isolated occasion where the Consultant was not contactable in October – Senior Gynae Register attended in absence

Actions & Improvements:

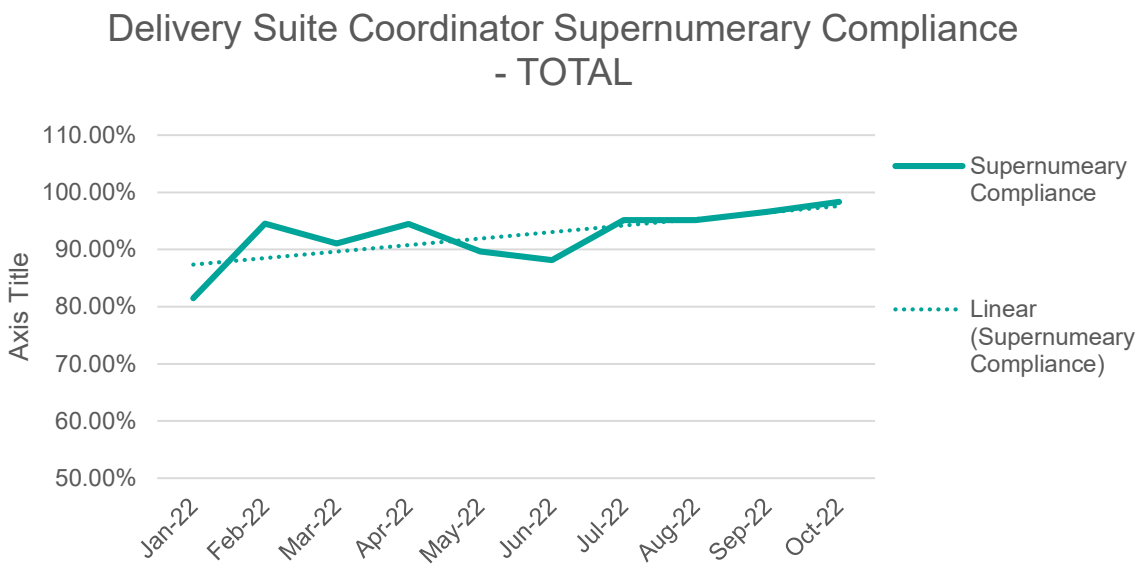
- Work continues with LMNS colleagues to consider adding workflow to Maternity Information System to allow patient level audit directly from EuroKing which will support enhanced audit, improved data and allow outcomes and learning to be monitored.
- Ongoing audit and monitoring at local level as well as presenting to Trust Board as per CNST requirements.
- Action plan in place to address shortfall of NICU Nursing QIS requirement. 5 staff commenced course in September 2022.

True North: People

Safety Action 5: Midwifery Workforce Complete

Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care

Goal: Ensure Midwifery workforce meets the required standard



Key Messages:

- 100% compliance with 1:1 Care in Labour maintained.
- Improved compliance with Supernumerary status of Delivery Suite Coordinator – 96% for September 2022, 98% for October, currently 100% for November 2022.
- Fully recruited to Birthrate Plus 2020 recommendations including recruitment of Consultant Midwife.
- Huge improvement in filling vacancy - currently down from 24WTE to 7WTE vacancy.
- Local Birth-rate plus review completed.
- DOM has provided full workforce paper to Trust Board in October 2022 in line with CNST reporting requirements.
- Ongoing work to improve recruitment and retention, including successful recruitment into Education Lead B8 role

Issues, Concerns & Gaps:

- Large intake of newly qualified midwives will require additional support and preceptorship package.
- External Birth-rate plus to be undertaken in 2023 – LMNS have agreed to fund across K&M.

Actions & Improvements:

- Refreshed preceptorship package in place for newly qualified midwives.
- Recruitment and retention plan in place, including international recruitment and active engagement with students and open days.
- Full external workforce review to be undertaken in 2023.

True North: People

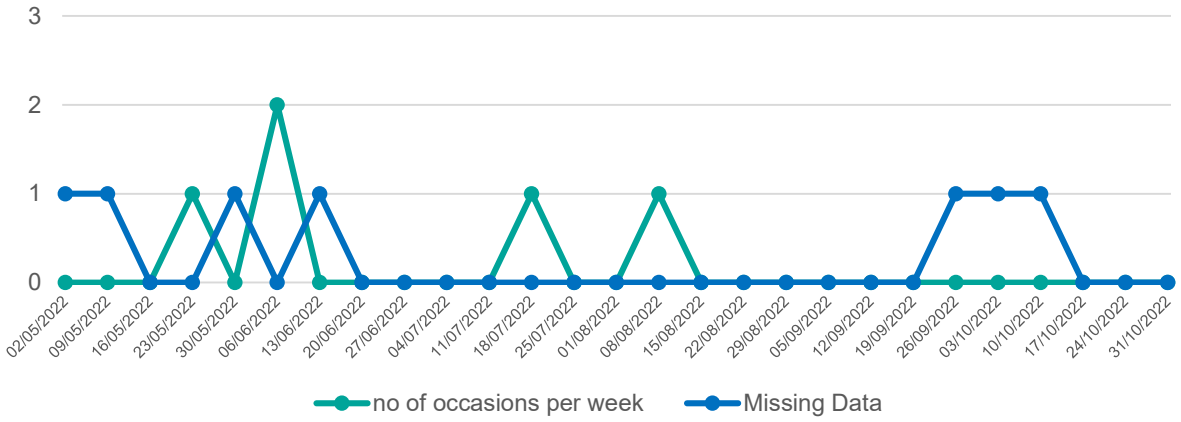
Safety Action 5: Midwifery Workforce Complete

Ambition: Ensure midwifery workforce meets the needs of the service and can provide the best patient care

Goal: Ensure Midwifery workforce meets the required standard

Medway NHS Foundation Trust

Coordinator Non-Supernumerary Compliance per week - **LABOUR**



Actions & Improvements:

- Rolling recruitment continues with aim for full establishing, which will assist in reducing the need for coordinators to lose their supernumerary status

Issues, Concerns & Gaps:

- There are currently 7 missing Bedstates (out of 414 as of 25th Nov) that we are unable to report on.
- Missing data is due to IT issues where Bedstates were not able to be saved.

Key Messages:

- Technical guidance for SA 5 saw a change in October –
- *'Supernumerary status will be lost if the labour ward coordinator is required to be solely responsible for any 1:1 care for a labouring woman or relieve for break, (or any short period of time) a midwife who is providing 1:1 care for a high risk woman requiring constant observation. This includes supervising a student midwife providing 1:1 care. The Trust can report compliance with this standard if this is a **one off event** and the coordinator is **not required to provide 1:1 care for a woman in established labour** during this time.*

If this is a recurrent event (i.e. occurs on a regular basis and more than once a week), the Trust should declare non-compliance with the standard and include actions to address this specific requirement going forward in their action plan mentioned in the section above'

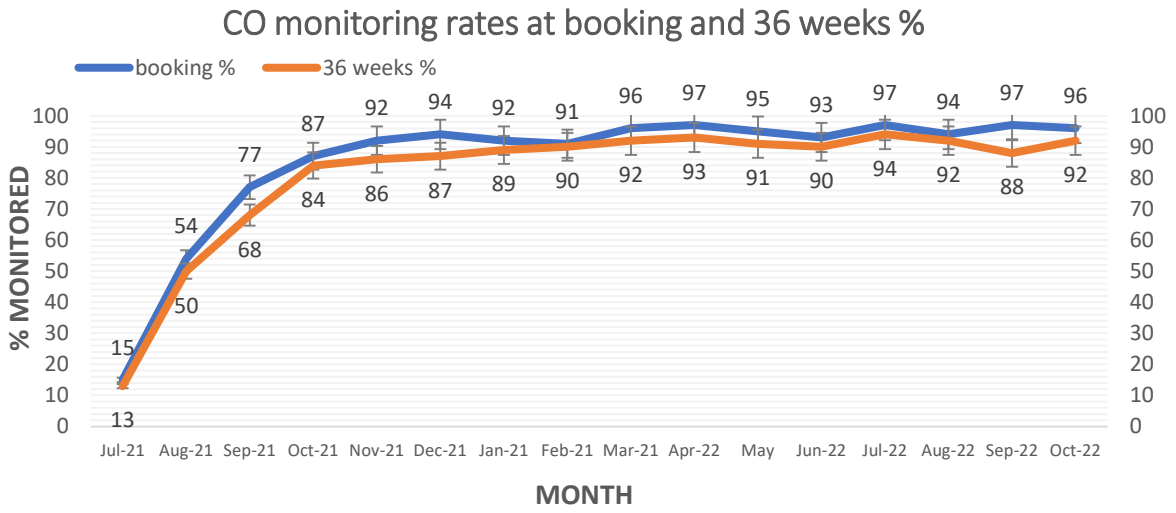
- When benchmarking against the new guidance the coordinator has been unable to maintain supernumerary status whilst caring for a women in labour a total of 5 times since May 2022
  - 3 occasions where this has occurred once during a weekly period
  - 1 occasion where this has occurred twice during a weekly period (June 22)
- Deep Dive against non-supernumerary we can evidence we are compliant in the new revised guidelines
- The coordinator has been able to maintain supernumerary status since 13th August

True North: Quality

Safety Action 6: Saving Babies Lives Care Bundle v2 (SBLCB) Complete

Ambition: Support positive clinical outcomes through compliance with SBLCBv2 requirements.

Goal: Ensure compliance with all 5 Elements of SBLCB v2



Key Messages:

- CNST >80% requirements for element 1 achieved – action plan in place to achieve >95%. Currently achieving 96% compliance for booking CO
- Audit completed for additional scanning pathway for women and birthing people with BMI >35 – will present through governance
- 100% compliance with computerised CTG for Reduced Fetal Movements by 28 weeks and women and birthing people presenting with RFM in labour
- Obstetric lead and fetal wellbeing midwives in post.
- New training programme for Physiological Fetal Monitoring launched in October 2022 and new guideline to be launched in January 2023.
- Compliant with Birth in Appropriate Location due to level 3 neonatal unit.
- Compliant with administration of magnesium sulphate <30 weeks (>90%) excluding imminent deliveries

Actions & Improvements:

- Action plan and revised guideline to support improvements in steroid administration compliance.
- Additional scanning at 40 weeks for increased BMI pathway in line with FGR guidance to commence 2023, which will help increase compliance for BMI screening pathway
- Continue working with Maternity Information System to improve reporting and data mapping for Smoking/CO monitoring as per SA 2.
- Prem 7 launched which should assist with compliance with steroid administration
- Smoking and CO monitoring now reporting via MSDS.

Issues, Concerns & Gaps:

- Action plan required to improve compliance with steroid administration – Preterm birth guideline will support this
- Slight reduction seen in 36 week CO compliance in September – some 36 week appointments carried out via phone calls – to monitor this as 36 week appointment should be f2f. Matrons aware. However compliance back to >90% in October 2022
- Continue to monitor compliance of Smoking and CO monitoring manually and cross reference with MSDS, until confident historical mapping errors from Maternity Information System are fixed

True North: Patients

Safety Action 7: Maternity Voices Partnership (MVP) Complete

Ambition: Ensuring that the voices of women, birthing people and their families are heard within the service and that service users are involved in coproducing maternity services.

Goal: Mechanisms in place for gathering service user feedback, and work with service users, through the MVP to coproduce local maternity services.

Key Messages:

- MVP Chair provides regular feedback to the service and supports the co-production of services, including action plans, reviewing guidelines and attending governance meetings.
- Service user feedback is gathered through maternity specific friends and family tests, area and service specific service user feedback surveys and via the MVP.
- Formal 15 Steps challenge completed in September 2022, receiving excellent feedback.
- Regional co-production SOP to be approved at MVP level along with co-production templates to support evidencing co-production.
- Non-Executive Director joins MVP meeting.
- Listening Events for patient feedback – including specific BAME listening event held in October ’22
- Formal MVP meetings have recommenced

Issues, Concerns & Gaps:

- Limited capacity of MVP chair to meet demands of CNST and Ockenden.
- Limited engagement from service users for 1st listening event

Actions & Improvements:

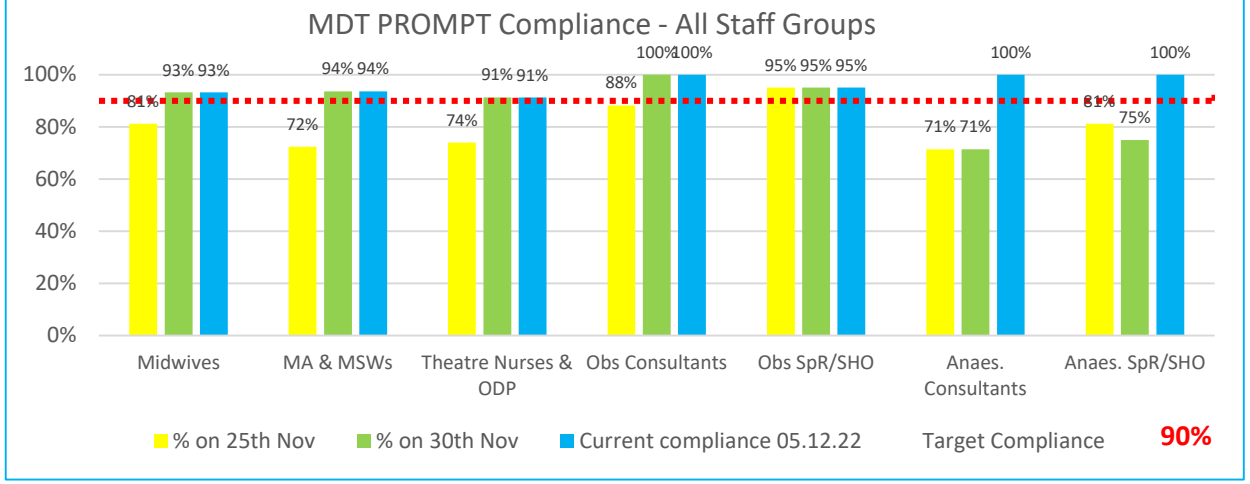
- Recommenced regular formal MVP meetings to ensure a minimum of 4 per year (paused due to Covid-19)
- Work with LMNS to consider additional regional MVP support and explore opportunities to increase local MVP involvement.
- Work with local churches/communities to increase engagement from BAME community for listening events.
- Develop QR codes will all dates for listening events for 2023 to give to women and birthing people during booking appointment and postnatal visits to increase engagement for listening events

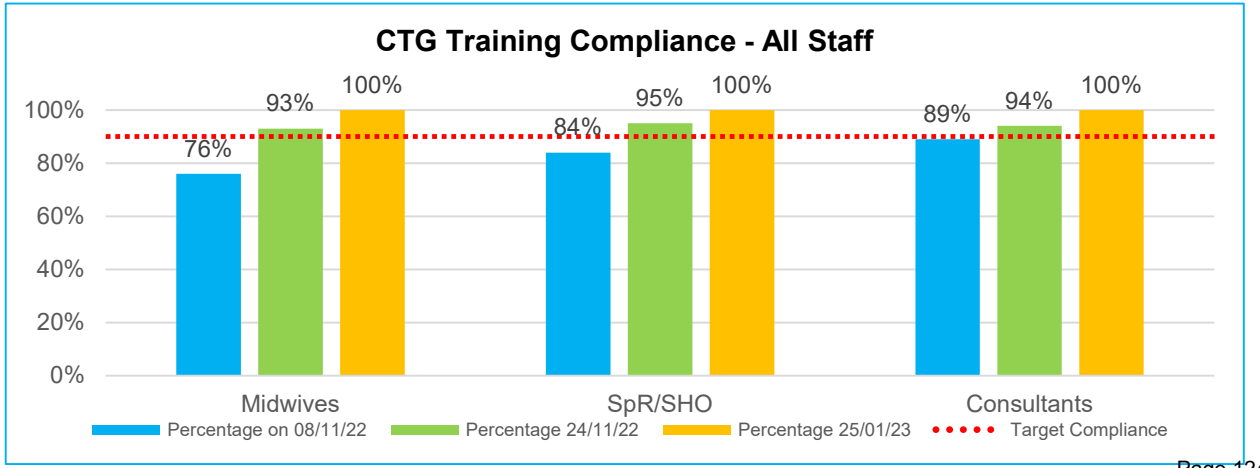
True North: People

Safety Action 8: Multidisciplinary Training Complete

Ambition: All staff to attend annual multidisciplinary training, including obstetric emergency training, in line with the core competency framework.

Goal: >90% of all staff groups to have attended the relevant training within the CNST reporting period (Aug 2021-5th Dec 2022)





Key Messages:

- Education Lead now in post
- Current compliance >90% for PROMPT for all staff groups. Midwives and Midwifery management and all nursing staff compliance >90% for NBLS – Statman not pulling correct data for NBLS compliance for obstetric
- Education team have been proactive in ensuring daily training sessions available for staff for NBLS
- Reporting period moved to include data up until 5th January 2023

Issues, Concerns & Gaps:

- Face to face MDT training risk to compliance due to clinical pressures and short staffing.
- Statman pulling incorrect data for Obstetric Doctors – working with Workforce to rectify this prior to new reporting period of 5th January 2023

Actions & Improvements:

- Training prioritised where clinically possible and concerns escalated to Clinical Director and Director/Head of Midwifery.
- Regular meetings established with all training leads to support compliance.
- Trajectory of CTG training is 100% by Jan 2023 - movement of allocation completed to ensure meet >90% compliance for required reporting period

True North: Quality

Safety Action 9: Safety Champion **Complete**

Ambition: To provide assurance to the Board on maternity and neonatal safety and quality issues.

Goal: Ensure there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues.

Key Messages:

- Board Level Safety Champion and Non-Executive Director undertake regular walk-arounds across the maternity and neonatal unit.
- Process for reporting maternity and neonatal safety and quality issues to Board is established and supported by Director of Midwifery and Chief Nursing Officer.
- Continuity of Carer national target now retracted – continue with action plan to introduce Continuity of Carer when staffing allows
- Maternity and Neonatal Teams actively involved in MatNeoSIP programme and attending required events. Culture surveys being used to inform local quality improvement plans – due to be sent November 2022 by Trust well-being team.
- Results will be analysed via the Gather system and will support identification of cultural strengths and weaknesses

Issues, Concerns & Gaps:

- Ensuring Trust Board has appropriate oversight of all relevant maternity and neonatal quality and safety issues as required by CNST, Ockenden and the Perinatal Surveillance Model.
- Process for capturing staff feedback and resulting actions from walk-arounds/engagement sessions to be strengthened.
- Walk-around cancelled in September and October due to site pressures

Actions & Improvements:

- Hold staff engagement events with Board Level Safety Champions to support more robust ward to Board feedback.
- Work with Director of Midwifery and Chief Nursing officer to ensure all required quality and safety issues are presented to Trust Board.
- Walk-around booked for 30th November
- Results for survey will be analysed via the Gather system and will support identification of cultural strengths and weaknesses

True North: Quality

Safety Action 10: HSIB and NHSR EN reporting **Complete**

Ambition: Ensure all eligible cases are investigated to the highest standard and receive appropriate external review.

Goal: Ensure all eligible cases are reported to Health Care Safety Investigation Branch (HSIB) and NHSR's Early notification scheme.

Top recommendations

HSIB

HEALTHCARE SAFETY INVESTIGATION BRANCH

'The Trust to ensure placentas are sent for pathological examination including histology in line with national guidance (RCPath, 2019)'

[MI-004517, MI-006956]

BMI - 3 recommendations

'The Trust to ensure that there is a protocol-based approach to care planning for mothers who have a raised BMI.'

[MI-005724]

Growth USS - 2 recommendations

'The Trust to ensure staff have a clear pathway to assist them in recognising those mothers who require additional growth USS.'

[MI-005724, MI-006956]

CTG- 2 recommendations

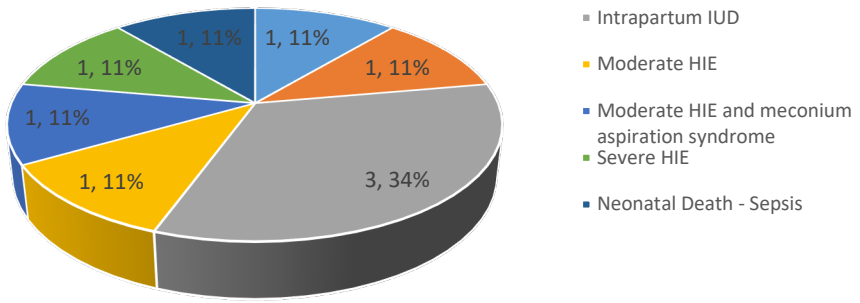
'The Trust to ensure that staff are supported to escalate CTG concerns in line with local guidance.'

[MI-006956]

WWW.HSIB.ORG.UK

HSIB Referrals MFT
Aug 2021-Sept 2022

Total = 9



Key Messages:

- 100% of eligible cases reported to HSIB and NHSR EN as required.
- 0 HIE cases grade 2&3 for August and September
- Quarterly HSIB meeting October - 4 reports completed in Q1 22/23
  - 1 report with no recommendations, 3 reports with 11 recommendations (8 related to guidance, 1 escalation, 1 fetal monitoring, 1 clinical oversite)
- Physiological Fetal Monitoring Training has commenced, including a new revised guideline, ready for full launch of new physiological fetal monitoring in clinical setting in January 2023 when all staff are trained.

Issues, Concerns & Gaps:

- Increased numbers of HIE in past 12 months – prompted revision of Fetal Monitoring Training and move to Physiological Fetal Monitoring.

Actions & Improvements:

- Widening shared learning opportunities to support sharing the findings and recommendations from any incidents.
- Launch of new Physiological Fetal Monitoring guideline in January 2023 once all staff trained.

Meeting of the Trust Board (Public/Private)/ Committee
Thursday, 15 December 2022

Title of Report	Ockenden Assurance Report for Trust Board December 2022		**Agenda Item**	
Author	Alison Herron, Director of Midwifery			
Lead Executive Director	Evonne Hunt, Chief Nursing and Quality Officer			
Executive Summary	This report provides an update to the Trust Board on the Maternity Service's progress against compliance with the initial 7 Immediate and Essential Actions (IEAs) from the preliminary findings Ockenden report (2020) along with the 15 IEAs from the final Ockenden report (2022).			
Proposal and/or key recommendation:	The committee is requested to note the report and progress against the recommendations and actions.			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Planned Care Group meeting Planned Care Divisional Governance Board Quality and Patient Safety Sub-Committee 21/11/22 Quality Assurance Committee 29/11/22			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
			X	X	
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	Not applicable				

Resource implications:	No additional resource implications	
Sustainability and /or Public and patient engagement considerations:	Not applicable	
Integrated Impact assessment:	Not applicable	
Legal and Regulatory implications:	Compliance with the Ockenden recommendations and actions and CNST.	
Appendices:	Appendix 1: Ockenden Assurance Report for Trust Board Dec 22	
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act	
For further information or any enquires relating to this paper please contact:	Alison Herron, Director of Midwifery Alison.herron2@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Ockenden Assurance update report

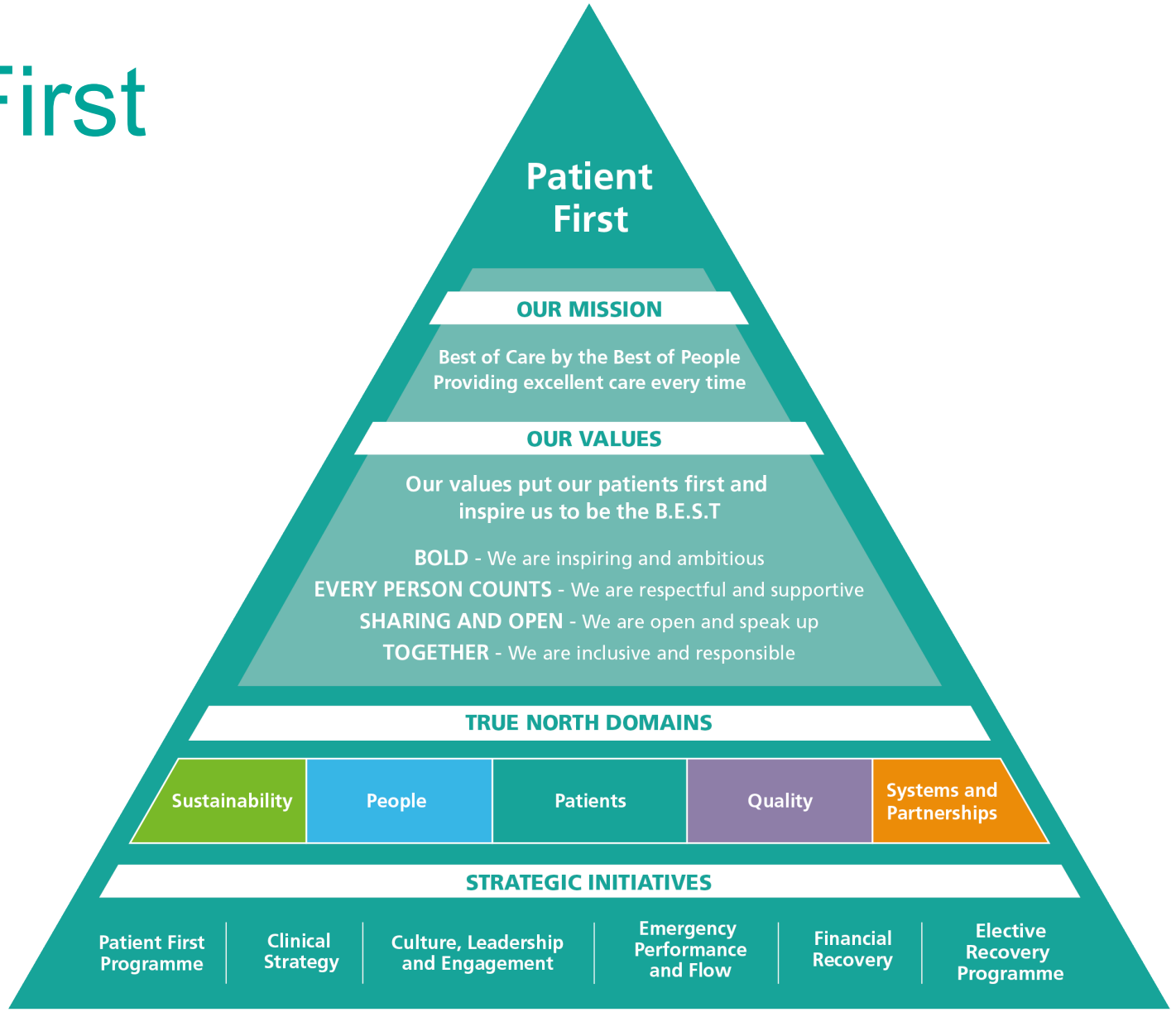
NHS Medway NHS Foundation Trust

Alison Herron, Director of Midwifery

December 2022

Patient FIRST

Patient First



SIOR- Ockenden

Successful Deliverables

- Ockenden reporting established to assure and monitor compliance across all Ockenden IEA's.
- Position improved for Ockenden 1 since Sept 22, with 4 completed IEAs, 5 IEAs on track and 0 off track or overdue.
- IEA 6 positive trajectory to be above required 80% for PROMPT training
- Risk assessment at every contact audit completed – action plan based on recommendations created
- Maternal death guideline completed – for LWF sign off (Ockenden 2)
- All recommendations of Birthrate plus review 2020 recruited to including Consultant Midwife
- Listening Events held end of October 22 – including specific BAME listening event.

Identified Challenges

- Maintaining training schedule and MDT attendance in face of staffing challenges.
- Launch of LMNS wide Personalised Care and Support plans (PSCP) delayed from October 2022 to January 2023
- MDT attendance for LMNS Training Assurance Board meeting challenging due to clinical commitments
- Increasing engagement for listening events, including BAME listening events

Opportunities

- Opportunities to strengthen staff and service user feedback through staff engagement events and collaborative working with MVP.
- Huge improvement in filling vacancy - currently down from 24WTE to 7WTE vacancy.
- Received draft report from Ockenden Insight visit – for factual accuracy checking

Risks

- If staffing challenges continue longer term will pose a risk to education training schedule

Ockenden 1 Self-Assessment October 2022

NHS Medway

True North	Immediate and Essential Action	RAG June 22	RAG Sept 22	RAG Nov 22	Comments	Target Date
Quality	IEA 1: Safety in maternity units across England must be strengthened by increasing partnerships between Trusts and within local networks. Neighbouring Trusts must work collaboratively to ensure that local investigations into Serious Incidents (SIs) have regional and Local Maternity System (LMNS) oversight				All requirements of Ockenden met. To work with DOM to improve Board Reporting in line with Patient First methodology.	Nov 21
Patients	IEA 2: Listening to Women and their Families: Maternity services must ensure that women and their families are listened to with their voices heard.				NED now member of MVP meeting and additional quarterly meetings arranged with MVP/NED and HOM/DOM.. Continue to monitor MVP co-production/engagement via CNST Year 4 Safety Action 7	Oct 22
People	IEA3: Staff Training and Working Together: Staff who work together must train together				Monitoring of CNST 4 training requirements continue. Trajectory of >80% in line with new reporting schedule requirements for PROMPT. Consultant AM and PM ward rounds continue. Audit ongoing LMNS review process commenced June 2022 with review of Training Needs Analysis and training figures. Action plan in place to support.	Dec 22
Quality	IEA4: Managing Complex Pregnancy: There must be robust pathways in place for managing women with complex pregnancies				Local maternal medicine SOP now in place. Working with LMNS to develop regional maternal medicine centre. Consultant Midwife recruited Externally funded lead midwife for maternal medicine (8a) advertised September 2022.	Dec 22
Quality	IEA5: Risk Assessment Throughout Pregnancy: Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway				Risk assessment guideline now live on QPulse and compliant for Ockenden PCSP eLearning to be added to PROMPT pre-course training, to capture MDT compliance Risk assessment at every contact audit completed – action plan developed with recommendations Draft version of LMNS-wide, Personalised Care and Support plans (PSCP) now out for review – awaiting full comments before going Live	Dec 22

Ockenden 1 -Self-Assessment October 2022

Medway NHS Foundation Trust

True North	Immediate and Essential Action	RAG June 22	RAG Sept 22	RAG Nov 22	Comments	Target Date	Revised Target date
Quality	IEA6: Monitoring Fetal Wellbeing: All maternity services must appoint a dedicated Lead Midwife and Lead Obstetrician both with demonstrated expertise to focus on and champion best practice in fetal monitoring.				Appropriate fetal wellbeing leads in post (1.4 WTE midwives and obstetric lead). Trajectory of 100% compliance in new Physiological Fetal Monitoring by end of January 2023	Jan 23	N/A
Patients	IEA7: Informed Consent: All Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery				Action plan in place following MVP website review. LMNS PSCP will also support closing this action when implemented in January 2023. Maternal request audit commenced looking at documentation in intrapartum period when women choosing caesarean section	Dec 22	N/A
People	Workforce				All recommendations of Birthrate Plus review 2020 recruited to, including Consultant Midwife post (start date Jan 2023) Director of Midwifery now in post.	Oct 22	N/A
Quality	NICE Guidance in Maternity				Process in place to monitor and review new NICE guidelines and ensure local guidance is appropriate and in date. Conditional formatting added to spreadsheet to ease alert of when guidelines are due for renewal or out of date.	Oct 22	Jan 23

Complete	Action has been completed and there is robust evidence to support that the action has been completed and where relevant, embedded practice
Overdue	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address
Off track with actions to deliver	Action is off track and plan are being put in place to mitigate any delay
On track	Action is on track with progress noted and on trajectory

Ockenden 2 – Self-Assessment Sept 22

True North	Immediate and Essential Action	RAG Jun 22	RAG Sept 22	RAG Nov 22	Comments	Target date	Revised Target
Systems and Partnership	IEA 1: Workforce Planning and Sustainability : Financing a Safe Maternity Workforce				Workforce report for 2022 completed presented to Trust Board in Oct '22. Funding for full external workforce review to be requested for 2023.	Aug 2022	April 2023
Sustainability	IEA1: Workforce Planning and Sustainability: Training				Induction and preceptorship package strengthened. Community Induction pack approved and development of similar packs for all areas completed – including role/band specific information. Develop progression packages for staff to support advanced decision-making.	Dec 2022	N/A
People	IEA2: Safe Staffing				Enhanced Maternity Escalation plan now in place (June 2022). Develop formal mentorship programme for senior midwives.	Dec 2022	N/A
Quality	IEA3: Escalation and Accountability				Develop conflict of clinical opinion policy and ensure psychological safety amongst the workforce. Elements have been incorporated into new fetal monitoring training package which was launched in October '22. Trajectory of 100% staff trained end of January '23	Nov 2022	N/A
Quality	IEA4: Clinical Governance Leadership				NHSEI self-assessment refreshed and reported to Board Aug 2022. Kirkup EKHUFT report published – awaiting update from national team. Formalise clinical responsibility for guidelines.	Dec 2022	N/A
Quality	IEA5: Clinical Governance – Incident investigations and complaints				Meetings established between governance and education teams to improve shared learning. Weekly MDT incident review group was relaunched in October 2022 with in depth review. Continue to strengthen triangulation from clinical incidents and shared learning.	Dec 2022	N/A

Ockenden 2 – Self-Assessment Sept 22

True North	Immediate and Essential Action	RAG Jun 22	RAG Sept 22	RAG Nov 22	Comments	Target date	Revised Target	2nd Revised Target Date
Quality	IEA6: Learning from Maternal Deaths				Maternal death guideline completed including relevant checklists updated – to be sent for sign off at LWF. Awaiting national guidance on the allocation of maternal cases to expert pathologist in maternal physiology.	Aug 2022	October 2022	December 2022
People	IEA7: Multidisciplinary Training				Updated TNA approved in line with core competency framework – now live on QPulse. Education Lead Band 8a post recruited to. LMNS training review process established. Implementation plan being developed to reinstate simulation sessions across the unit and closely monitor training compliance.	Jan 2023	N/A	
Systems and Partnerships	IEA8: Complex Antenatal Care				Diabetes in pregnancy guidelines updated inline with current guidance. Review pre-conception care with Primary Care. Case note audit to confirm compliance with guidance for diabetes and hypertension.	Dec 2022	N/A	
Quality	IEA9: Preterm Birth				Preterm birth guidelines completed and awaiting sign off. “Prem7” antenatal optimisation bundle Quality Improvement project launched in October 2022 with ongoing audit throughout the project.	Dec 2022	N/A	
Quality	IEA10: Labour and Birth				Development of Midwifery Led Unit operational risk assessment tool delayed due to clinical and staffing pressures, as well as awaiting start date of new recruit into TBP Senior Sister post. Approved at Labour Ward Forum October 2022. Governance process continues Education Lead post recruited – working on commencing regular in-situ simulation programme – with Sims already commenced. New physiological fetal monitoring training commenced Oct ’22	Aug 2022	December 2022	

Ockenden 2 – Self-Assessment Sept 22

True North	Immediate and Essential Action	RAG June 22	RAG Sept 22	RAG Nov 22	Comments	Target date	Revised Target
Patients	IEA11: Obstetric Anaesthesia				Formalise postnatal anaesthetic follow-up for women and birthing people and review need for local guidelines for anaesthetic roles.	Dec 2022	N/A
Quality	IEA12: Postnatal Care				Audit required to confirm compliance with consultant ward rounds and review of postnatal readmissions (commenced)	Oct 2022	N/A
Patients	IEA13: Bereavement Care				Submitted EOI for national funding bid for workforce to move to 7 day service. Current workforce covering 7 days where possible. Bereavement champions being identified who will attend additional training to support them in their role	Nov 2022	N/A
Quality	IEA14: Neonatal Care				Ongoing Audit to confirm compliance with ODN requirements including born in appropriate location, outcomes of in-utero transfers.	Dec 2022	N/A
Patients	IEA15: Supporting Families				THRIVE midwife to support women with perinatal trauma commences in Nov. Audit to confirm compliance with mental health pathways deferred until revised guidelines ratified and implemented. Anticipated October 2022.	Aug 2022	December 2022

Complete	Action has been completed and there is robust evidence to support that the action has been completed and where relevant, embedded practice
Overdue	Action is off track and assessed as unrecoverable within the current timescales and requires urgent action to address
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Meeting of the Trust Board (Public/Private)/ Committee
Thursday, 15 December 2022

Title of Report	Perinatal Surveillance Tool Assurance Report December 22		**Agenda Item**	
Author	Alison Herron, Director of Midwifery			
Lead Executive Director	Evonne Hunt, Chief Nursing and Quality Officer			
Executive Summary	This report provides an update and assurance to the Trust Board on the quarterly Perinatal Surveillance Data			
Proposal and/or key recommendation:	The committee is requested to note the assurance and report.			
Purpose of the report (tick box to indicate)	Assurance	X	Approval	
	Noting	X	Discussion	
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:
Committee/Group at which the paper has been submitted:	Planned Care Group meeting Planned Care Divisional Governance Board Quality and Patient Safety Sub-Committee 21/11/22 Quality Assurance Committee 29/11/22			

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability)	Priority 2: (People)	Priority 3: (Patients)	Priority 4: (Quality)	Priority 5: (Systems)
			X	X	
Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: X	Effective: X	Caring: X	Responsive: X	Well-Led: X
Identified Risks, issues and mitigations:	Not applicable				

Resource implications:	No additional resource implications	
Sustainability and /or Public and patient engagement considerations:	Not applicable	
Integrated Impact assessment:	Not applicable	
Legal and Regulatory implications:	Compliance with Ockenden and CNST	
Appendices:	Appendix 1: Perinatal Surveillance Tool Assurance Report	
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act	
For further information or any enquires relating to this paper please contact:	Alison Herron, Director of Midwifery Alison.herron2@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

NHS
Medway
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Perinatal Quality Surveillance Tool – quarterly update report

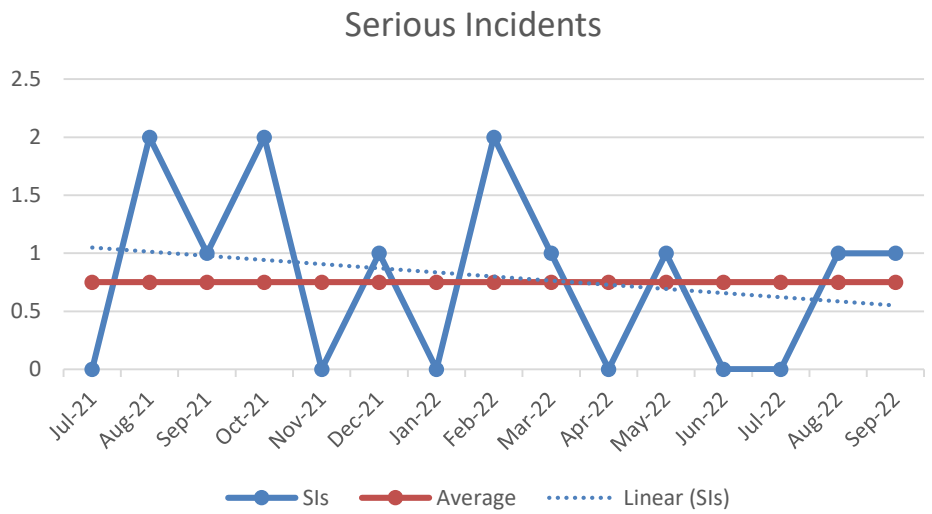
Ali Herron – Director of Midwifery

December 2022

Patient FIRST

True North: Quality

Perinatal Surveillance Tool Data Quarter 2 – Serious Incidents (SIs)
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.



Key Messages:

- SIs – Quarter 2 2022/23
  - 2 SIs in Q2
  - 1 x HSIB Neonatal Death – MFT involved with HSIB for investigation - ongoing
  - 1 x PPH following missed miscarriage. Whilst in theatre it was detected the patient had significant raised White Cell Count and lymphocytes in Oct 2021 and not referred to haematologist

Issues, Concerns & Gaps:

- No haematologist involvement after blood results showed abnormal results
- Lack of obstetric review
- CTG interpretation
- LSCS classification

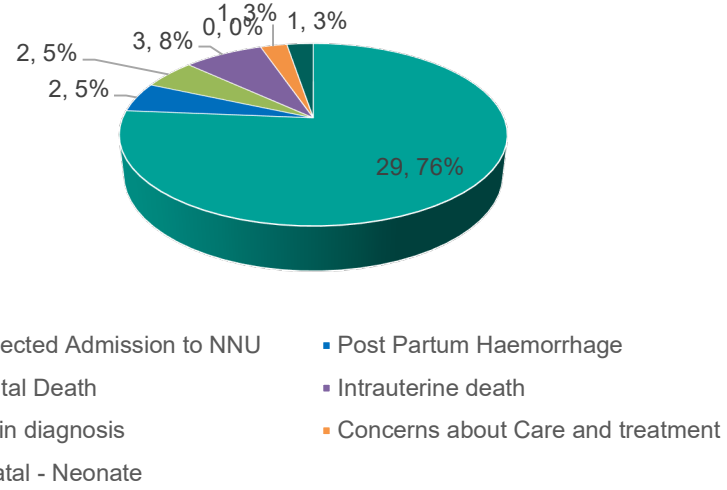
Actions & Improvements:

- Recommendations – The trust to ensure that staff are supported to escalate CTG concerns
- Actions – New Physiological Fetal Monitoring training commenced (launch guideline in Jan 23 once all staff trained).
- Recommendations – Review of Personalised Support and Care Plans
- Actions – Working with LMNS to produce regional wide Personalised Support and Care Plan forms

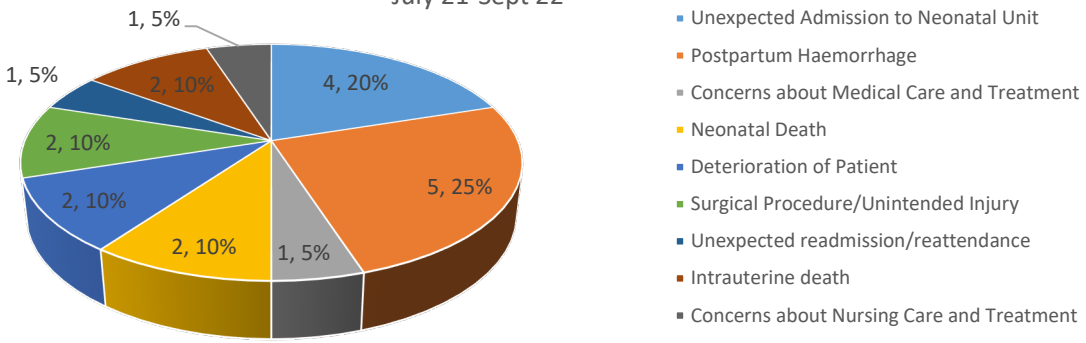
True North: Quality

Perinatal Surveillance Tool Data Quarter 2 – Rapid Reviews (RR) and High Level Investigations (HLI)
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

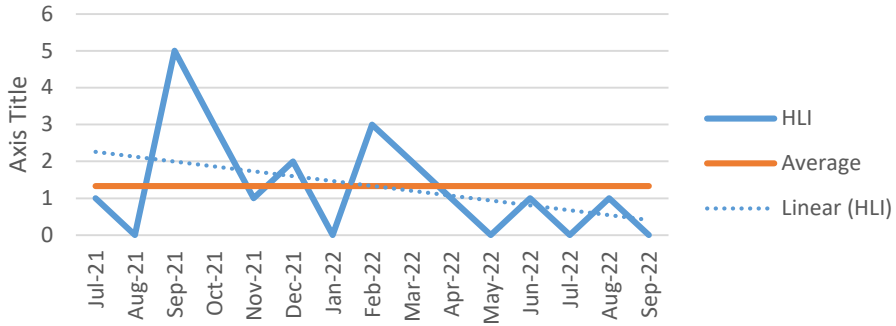
Maternity and Neonatal Rapid Reviews - Q2 22/23



Maternity and Neonatal High-Level Investigations
July 21-Sept 22



Maternity and Neonatal HLI - July 21- Sept 22



Key Messages:

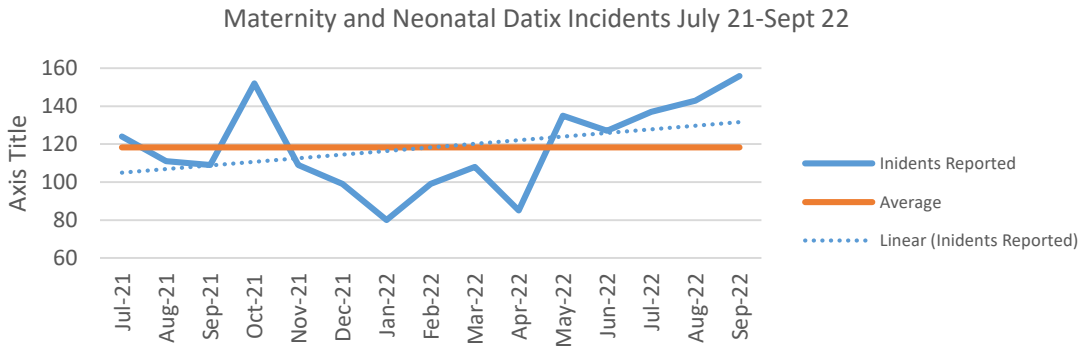
- 38 Rapid reviews (RR) completed in Q2 2022/23 (reduction from 41 in Q1)
  - Main theme = unexpected admission to NNU
- 1 High-Level Investigations (HLI) for Q2 2022/23.
  - Fractured humerus in neonate following delivery – diagnosed on PN day 1. **Learning** – detailed documentation of procedures in labour is essential. No departure of care noted

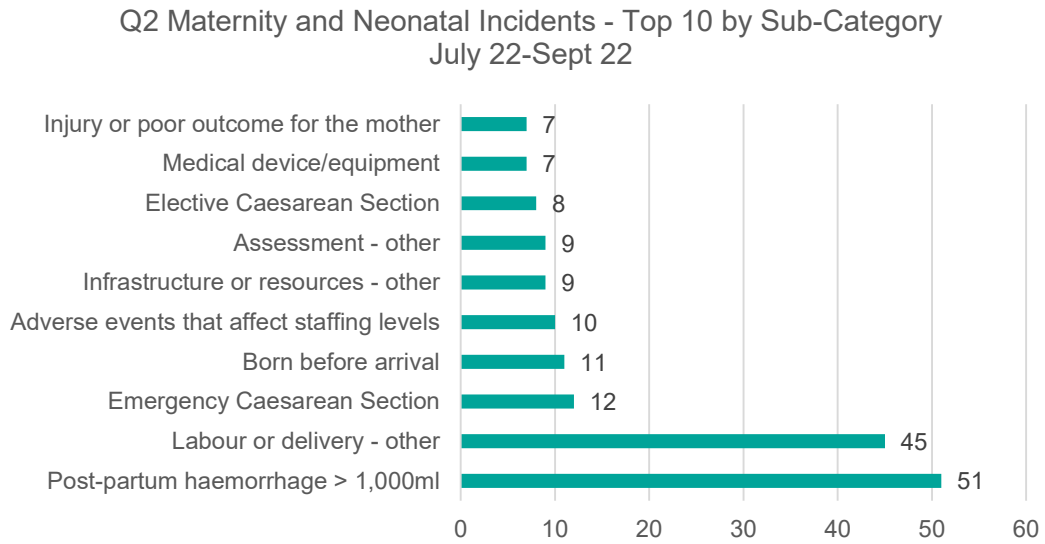
Actions & Improvements:

- Rapid Review required for all unexpected admissions to neonatal unit
- All Rapid Review data now being reviewed during weekly MDT CRIG meetings for timely review – ongoing work with new template
- Audit of birth injuries at MFT commenced to benchmark against existing data

True North: Quality

Perinatal Surveillance Tool Data Quarter 2 – Datixes
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.





Key Messages: top 3 themes

- **PPH (number = 51)** - Following the CRIG meeting the learning from the cases were shared with staff via the TOP 5 and the Governance Snap Shot to use the PPH proforma in real time.
- **Labour and Delivery (number = 45)** - Top 2 themes – unexpected admission to NNU (common cause = respiratory distress) & readmission of mother
- **Emergency Caesarean Section (number = 12)** – Top 3 themes – unexpected admission to NNU, Delay, & Wound or surgical site infection

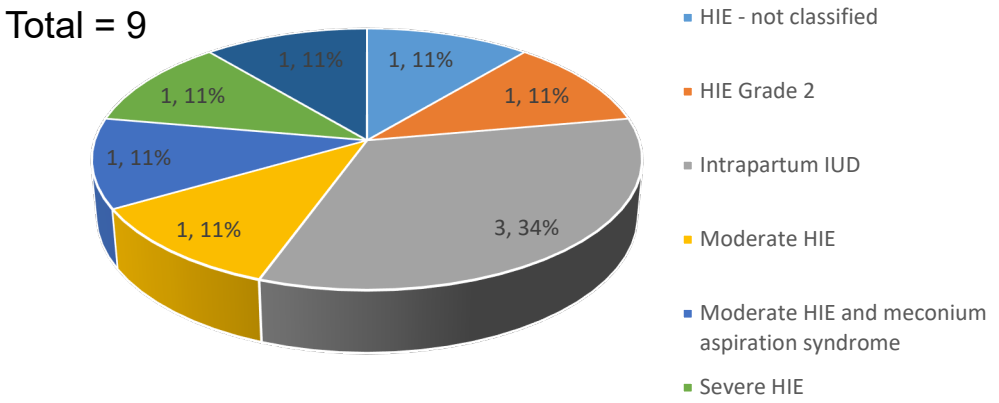
Actions & Improvements:

- **PPH** - PPH proformas are readily available in every Delivery Room.
- Audit of PPH ongoing and to include use of Proforma going forward
- Encouraged staff to continue to Datix all PPH >1L
- HDU SS informed of step down protocol from HDU to MECU following datix.
- **Term/Unexpected admission to Neonatal Unit** - A weekly MDT review meeting implemented to review cases in a timely manner (previously the meeting was monthly) to review all term unexpected admissions to NNU, capture immediate learning, implement actions in real time and share the learning.
- **Maternal Readmission** - Further deep dive of cases being undertaken to identify any common factors. Pending outcome quality improvement measures will be implemented and monitored for sustained improvements

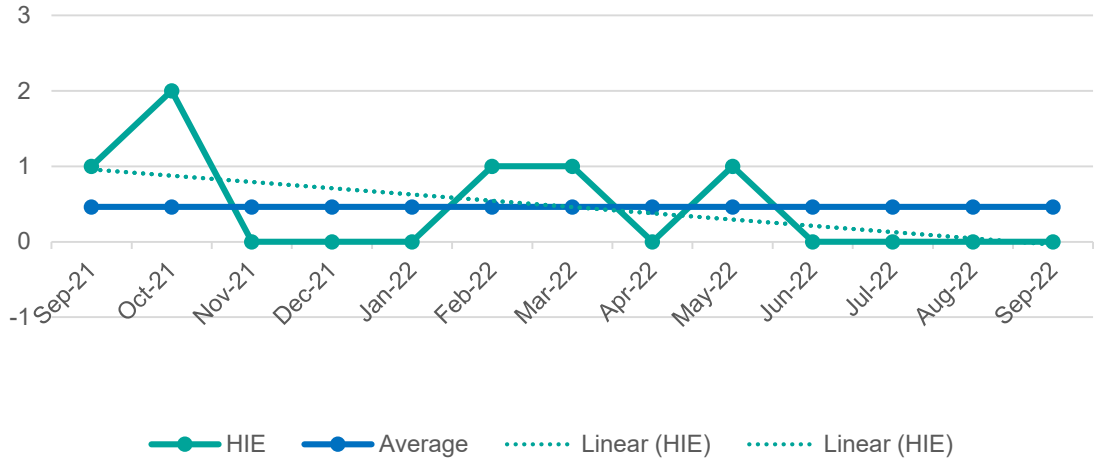
True North: Quality

Perinatal Surveillance Tool Data Quarter 2 – Healthcare Safety Investigation Branch (HSIB)
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.

HSIB Referrals MFT Aug 2021-Sept 2022



Number of cases of hypoxic encephalopathy (HIE) grades 2&3



Key Messages:

- 1 x HSIB case for Q2 2022/23 – Neonatal Death. MFT received an early information letter regarding this case
- 0 HIE in Q2
- 9 cases have been referred to HSIB since August 2021
- Top 5 recommendations – Guidance (21), Fetal Monitoring (9), Risk Assessment (6), Escalation (6), Communication (5)

Issues, Concerns & Gaps:

- MFT received an early information letter from HSIB

Actions & Improvements:

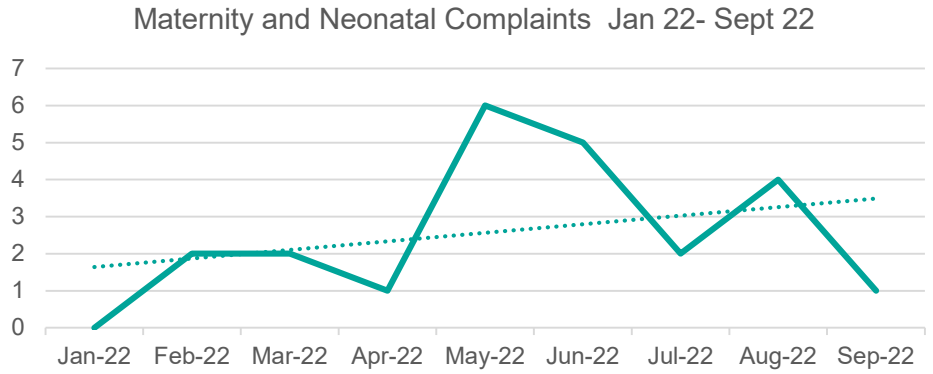
- New Physiological Fetal Monitoring training commenced (launch guideline in Jan 23 once all staff trained). (Fetal monitoring & Escalation)
- Conflict of clinical opinion guideline underdevelopment in line with Ockenden 2 recommendations (Dec 2022) (escalation)
- Attending registrar/consultant indicates and documents timeframe for delivery for all cases including instrumentals to ensure timely delivery as required (communication)

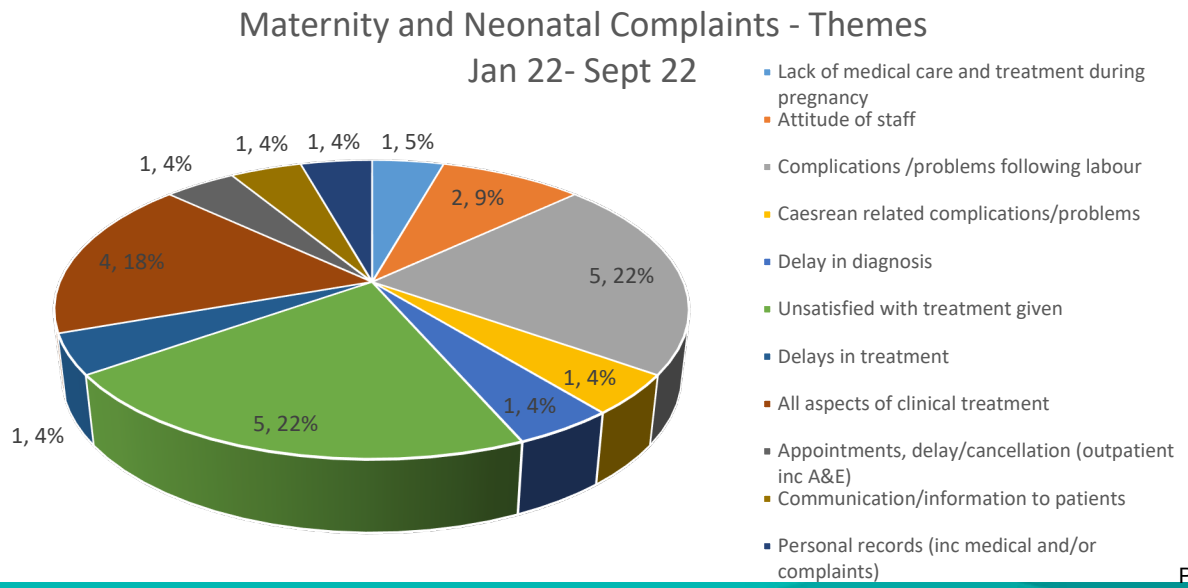
True North: Quality

Perinatal Surveillance Tool Data Quarter 2 – Complaints

Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.

Goal: To ensure all eligible perinatal losses are reported to the required standard.





Key Messages:

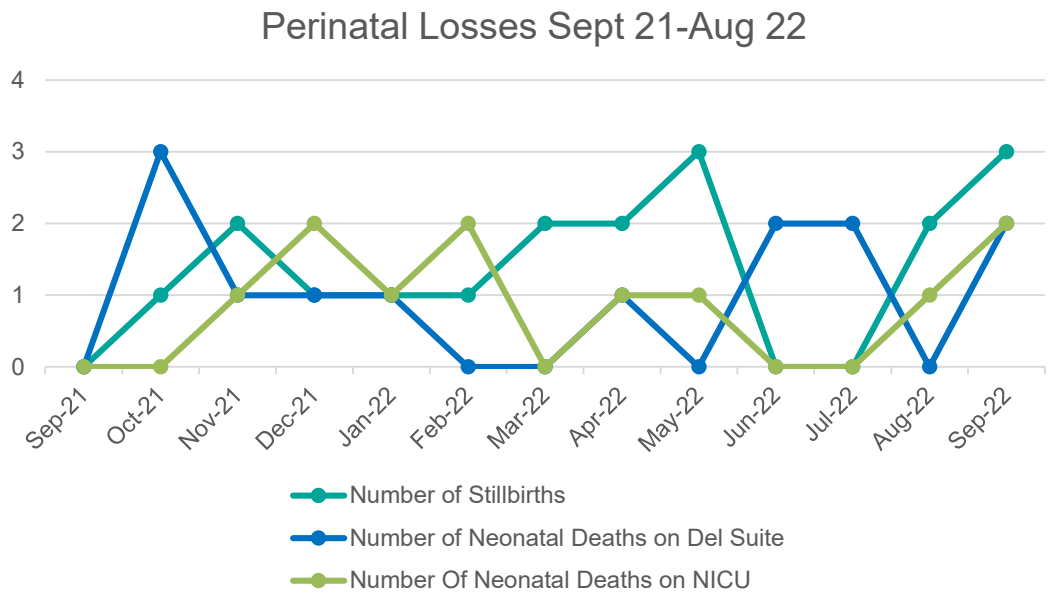
- Closed Complaints for Maternity Q2 –
  - All aspects of clinical care x 3
  - Appointments delayed/cancelled x 1
  - Communication/information to patients x 1
  - Personal records (inc medical and/or complaints) x 1
  - Unsatisfied with treatment given x 1

Actions & Improvements:

- Unsatisfied with treatment given – Fractured humerus in neonate following delivery – diagnosed on PN day 1. **Learning** – detailed documentation of procedures in labour is essential. No departure of care noted
- All aspects of clinical care – staff reminded to:
  - Remain professional in their attitude at all times
- Appointments, delay/cancellation – review of correct referral process for staff involved
- Communication/information to patients – staff reminded to:
  - Listen to women (PCSPs)
  - Ensure information given during labour and birth is accurate and clear
  - Debriefs to occur in a timely manner post delivery
- Personal records (inc medical and/or complaints) – staff reminded of importance of patient confidentiality. Communications regarding ‘no photography in clinical areas’ on all wards

True North: Quality

Perinatal Surveillance Tool Data Quarter 2 – Perinatal Mortality Review Tool (PMRT)
Ambition: To ensure robust, transparent, multidisciplinary and patient-centred review of all perinatal losses with external oversight.
Goal: To ensure all eligible perinatal losses are reported to the required standard.



Key Messages:

- Continued compliance with reporting to MBRRACE and publishing reports within required timescales.
- Q2 – 0 Stillbirths in July. 2 stillbirth cases reviewed in August
  - 1 x ?placental abruption – acute event. Patient had missed 35-37 wk USS due to being out of the country. Baby delivered was small – impression of late onset growth restriction, which would have been identified on missed USS
  - 1 x unexplained stillbirth, with normal USS at 37+3, 2 days prior to diagnosis of loss.
- 3 stillbirth cases reviewed in September
  - 1 x unexplained – no themes emerged from PMRT meeting
  - 1 x loss of triplet – diagnosed anomalies
  - 1 x baby with multiple abnormalities – parents chose expectant management
- No immediate care concerns or learning identified with above cases.

- 7 Neonatal deaths in Q2
  - On Delivery Suite - 21+6 – sepsis and extreme prematurity wt 440g, 20+3 – spontaneous delivery – extreme prematurity, 20/40 – extreme prematurity, 21/40 – extreme prematurity
    - No learning identified with above cases
  - On NICU – 24/40 – extreme prematurity, 23/40 extreme prematurity.
    - No learning identified with above cases
  - PMRT reviews continue for 1 x term Neonatal Death. Awaiting coronial post mortem and HSIB reports.

Issues, Concerns & Gaps:

- The need to provide enhanced care in the post natal period
- Unannounced HTA inspection – requested evidence of post mortem SOPs and consent forms

Actions & Improvements:

- MDT CRIG meetings commenced for shared learning, including review of 'born in poor condition babies'
- NICU Nursing QIS has been reported to Trust Board

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CQC update – Internal Assurance Visit

October 2022 Report

Patient FIRST

True North: People

IAV Findings
Ambition: Ensure that all women and birthing people have access to safe, effective and personalised care
Goal: That the maternity service is safe, effective, responsive, well-led and caring

- An Internal Assurance Visit (IAV) was undertaken across Maternity Services at Medway Maritime Hospital in preparation for the expected Care Quality Commission (CQC) National reviews of all maternity services, between September 22 and March 23.
- The unannounced IAV was carried out on 23 August 2022
- The IAV included those services delivered from the Medway Maritime Hospital Site only, and did not include community midwifery services.
- The unannounced IAV was carried out using the CQC Key Lines of Enquiry by a team consisting of;
    - Alison Herron, Director of Midwifery Services
    - Sarajane Poole, Deputy Chief Nursing Officer
    - Dan Rennie-Hale, Director Quality & Patient Safety
    - Stephanie Gorman, Associate Director Infection, Prevention & Control
    - Sumiah Al-Azeib, Principle Clinical Pharmacist Neonatology, Paediatrics & Women
    - Bridget Fordham, Head of Safeguarding
- Draft IAV report sent to the Care Group and Divisional Leadership team for factual accuracy on 1st September 22 and to develop a Quality Improvement action plan against any gaps in compliance.

True North: People

IAV Findings
Ambition: Ensure that all women and birthing people have access to safe, effective and personalised care
Goal: That the maternity service is safe, effective, responsive, well-led and caring

The assurance visit focused on the following areas:

- Awareness of Managing a Regulatory Visit / Access Control
- Incident Reporting & Learning from Incidents and Complaints
- Safeguarding
- Patient Risk
- Emergency Preparedness & Business Continuity
- Staffing Levels (Midwifery)
- Staffing Levels (Medical)
- Staff Training, Appraisal & Support
- Medication
- Records
- Infection, Prevention & Control
- Environment & Equipment
- Compassionate Care
- Evidence Based Care & Treatment & Patient Outcomes

True North: People

IAV Findings
Ambition: Ensure that all women and birthing people have access to safe, effective and personalised care
Goal: That the maternity service is safe, effective, responsive, well-led and caring

Internal Review Rating of Services

Overall Rating Maternity Services	Requires Improvement	
Are services safe?	Requires Improvement	
Are services effective?	Requires Improvement	
Are services caring	Good	
Are services responsive?	Requires Improvement	
Are services well-led?	Requires Improvement	

SIOR- Maternity Internal Assurance Visit

NHS Medway ndation Trust

Successful Deliverables

- Additional avenues for reviewing current staff information created
- All immediate actions (excluding Obstetric Theatre) closed
- Additional MDT reviewing of SI's/incidences
- Role and Band specific Induction packs updated
- BAME network already available at the Trust communicated to staff

Identified Challenges

- Develop Trust wide SOP for management of Regulatory Visits
- Business Continuity Plan (BCP) training
- Obstetric Theatre Action Plan
- Obstetric Theatre Immediate actions required from IAV
- Trajectory of PAT testing – delays ongoing due to COVID

Opportunities

- Opportunities to ensure readiness for formal CQC visit
- ERPP lead to join Band 7 meeting so senior clinical staff are trained until additional recruitment successful

Risks

- Obstetric Theatre Lead on long term sick – identifying cover and interim lead for Obstetric Theatre Action plan actions to be carried out
- BCP training due to short staffing
- Dedicated maternity pharmacist

True North: People

IVA Findings

Ambition: Ensure that all women and birthing people have access to safe, effective and personalised care

Goal: That the maternity service is safe, effective, responsive, well-led and caring

	Safe	Effective	Caring	Responsive	Well led
Outstanding					
Good					
Requires Improvement					
Inadequate					

Issues, Concerns & Gaps:

- Obstetric Theatre Action Plan - ongoing
- Business Continuity Plan training due to inadequate staffing to accommodate training sessions
- Dedicated maternity Pharmacist

Actions & Improvements:

- 40 out of 49 actions are complete, 7 are on track, 1 with ongoing trajectory on action plan, 1 with issues
- Continue with Obstetric Theatre Action Plan – actions either completed or on track
- Spot checks will be undertaken by the senior team to ensure learning is embedded in practice
- Team will commenced collation of maternity CQC requested documents
- Audits will be allocated to appropriate staff

Key Messages:

- All maternity services will have a well-led and safe inspection by March 2023
- The IAV utilised CQC methodology to review whether services in maternity are delivering safe, effective, compassionate, high-quality care
- An action plan was developed in response to the key findings from the report.
- Top 5 good seen -
  - Staff described the processes for clinical emergencies such as PPH, resuscitation and shoulder dystocia and described appropriate escalation pathways
  - Staff spoken to described that they escalate to the MIC if concerned re staffing/acuity and it was reported that there are 22 new band 5 midwives due to start in September
  - PROMPT training is taking place monthly, and UNICEF level 3 for feeding was observed to be in place
  - Staff described having had their appraisal and that process had improved in last year or 2 – feels more supportive
  - Staff reported that senior teams support junior members of staff with complex patients
- Issues raised
  - Obstetric Theatre Action Plan
  - Appropriate use of 2222
  - Induction process for agency staff
  - BCP requiring update
  - PAT testing trajectory

Maternity Internal Assurance Visit – Action plan progress

Areas of Focus	Position prior to Action Plan	Position post Action Plan (indicating no. of actions in revised position)
Awareness of Managing a Regulatory Visit / Access Control		1 | 1
Incident Reporting & Learning from Incidents and Complaints		6
Safeguarding		4
Patient Risk		1
Emergency Preparedness & Business Continuity		1 | 1
Staffing Levels (Midwifery)		2 | 1
Staffing Levels (Medical)		1
Staff Training, Appraisal & Support		1 | 3
Medication		1 | 6
Records		3
Infection, Prevention & Control		1
Environment & Equipment		1 | 8
Compassionate Care		1 | 2
Evidence Based Care & Treatment & Patient Outcomes		3

Actions & Improvements:

- 1 x off track – no provisions for dedicated maternity Pharmacist
- 1 x issues
  - Trust wide SOP for management of regulatory visits
- 7 x on track with on going trajectory within action plan, including audit follow ups to ensure compliance

15 Steps

NHS
Medway
NHS Foundation Trust

Patient
FIRST

True North: Patients

Service User Feedback – 15 steps
Ambition: To ensure quality from the patients' perspective
Goal: To explore maternity through the eyes of patients and relatives

Key Messages:

- Formal 15 Steps feedback carried out on Kent Ward (postnatal), Antenatal Unit including Fetal Medicine (antenatal) and The Birth Place (intrapartum)
- **Kent Ward positive feedback –**
  - Staff were very welcoming and friendly, they seemed busy but were happy to stop and show us round the ward. Staff were calm and considerate.
  - There were lots of display boards some with interesting information on them pertaining to BESTT for staff particularly, including evidence-based information on safe baby care, including skin to skin, feeding and sleeping easily accessible to all.
  - Corridors were clean, tidy and clutter free. Feeding support was available with the infant feeding lead being based on the ward.
  - The ward felt extremely organised, adding to the general feeling of calmness
- **Antenatal Unit positive feedback –**
  - Staff extremely welcoming and friendly, beautifully decorated. Very clean, organised and overall had a relaxed and calm feeling. 15 steps team very impressed on how quiet the area was.
  - Notice boards and leaflets were in all areas offering information, some in other languages. Each area had a sign that had the word "Welcome" in a variety of languages at the entrance.
  - There were notices in all the toilets regarding domestic violence and how to seek help. Information was also available about Professional Midwifery Advocates with a QR code to access support from them.
  - Speaking with a number of service users they were very impressed with the care they had received. They said they felt welcomed and cared for and that the staff were very attentive.
  - The areas are staffed by friendly, compassionate people who were keen to talk to us and show us around. They had a clear sense of pride about the areas in which they work and this truly showed.
- **The Birth Place positive feedback –**
  - The birth place was easy to find and well sign posted Immediately upon entering the area it's noticeable how clean and tidy it is, it's decorated beautifully and feels calm and generally just a lovely place to be.
  - The Birth Place is well monitored with a buzzer to be let in and a key card needed to let someone out.
  - The rooms were all well set up for active labour with access to various types of birthing equipment such as balls, birthing stools and couches. All the rooms have birth pools, calm decor and soft lighting.

True North: Patients

Service User Feedback – 15 steps
Ambition: To ensure quality from the patients' perspective
Goal: To explore maternity through the eyes of patients and relatives

Issues, Concerns & Gaps:

- **Kent ward –**
  - Paint work needed freshening up and communal areas brightening
  - Relook at storing of equipment off of corridors
  - The needs of those with hearing or sight impairment have not been considered
- **Antenatal Unit –**
  - Some of the notice boards in the waiting room were hard to see due to chair placement and some equipment blocking them.
  - There was no information about the MVP on the notice boards
  - There were no adaptions for those with a sight impairment, no signs in braille for example
  - Birth reflections information could be more obvious, perhaps with QR code taking you to the email address/contact details.
  - Feedback from a service user that when pregnant previously and this unfortunately ended in an miscarriage, she felt like this was not taken very seriously as it was fairly early on. She also felt like she wasn't given an appropriate place to be whilst going through this.
- **The Birth Place –**
  - Unfortunately on the day of our visit the birthplace was not open due to staffing levels
  - Information on birth reflections not found and information about the MVP was not available
  - Some red cords in bathrooms had been hooked up so were not able to be used in an emergency
  - When The Birth Place is closed are there signs up in the delivery suite that say birthing equipment is available on request?

Actions & Improvements:

- Action plan to be created for all areas following from recommendations made from 15 Steps

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PICKER SURVEY

Patient
FIRST

True North: People

Perinatal Surveillance Tool Data Quarter 1 – Service User feedback – Picker Survey
Ambition: To continuingly improve upon MFT's Picker Survey results
Goal: To provide a safe and caring environment for all patients within the maternity services

Medway NHS Foundation Trust

Key Messages:

- MFT saw a slightly reduced response rate in 2022 (41%) when compared to 2021 (45%) – however respondents (number = 147) in 2022 is only 2 less than respondents in 2021 (number = 149)
- 359 surveys were eligible at the end of the survey
- A total of 87 questions were asked in the 2022 survey, of these 53 can be positively scored, with 48 (of these 53) which can be historically compared. Your results include every question where your organisation received at least 30 responses (the minimum required).
- 3 questions showed significantly worse results from historical comparison (intrapartum questions as previously explained) and 4 questions showed significantly worse results from national average comparison (GP 6 weeks postnatal check for physical and mental health discussion and partners able to stay with them as long as they wanted I hospital after birth (explained by Covid-19 visiting restrictions)
- All results showing a reduced score (historically for MFT or nationally) have been added to Picker Survey Action Plan
- 1 question showed significant improvement from previous 2021 survey (offered a choice of where to have baby) – increase of 12% and 2 questions showed significant improvement from national average (provided with relevant information about feeding their baby and discharged without delay) – increase of 10% and 7% respectively

Issues, Concerns & Gaps:

- A theme emerged when analysing the data of 3 questions – showing a 17, 18 and 19% reduction (respectively) from 2021 regarding intrapartum care questions 'given appropriate advice and support at the start of labour', 'not left alone when worried during labour/birth' and 'felt concerns were taken seriously during labour/birth' – this could be due to the impact of reduced workforce
- Consistently scoring low for 'felt GP talked enough about physical/mental health during 6 week postnatal check up' question – to share results to enable GPs to action

Actions & Improvements:

- Action Plan created to assist in implementing improvements to results shown as a reduced score from previous Picker Survey, and when receiving a lower score from the national average
- Established workforce due to increase to full capacity in the coming months

362	359	41%	48%	45%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (147)	Average response rate for similar organisations	Your previous response rate

97%	C21. Treated with respect and dignity (during labour and birth)
92%	C22. Had confidence and trust in staff (during labour and birth)
90%	C20. Involved enough in decisions about their care (during labour and birth)

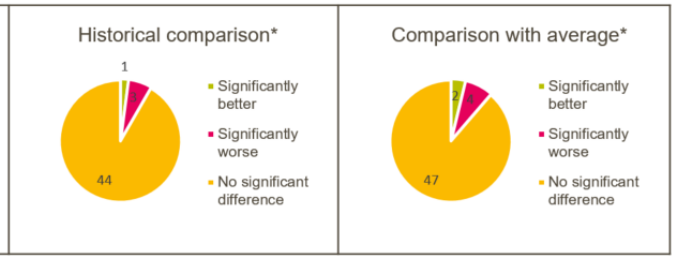

*Chart shows the number of questions that are better, worse, or show no significant difference

Picker

SCORE/Culture Survey

True North: People

NHS Medway NHS Foundation Trust

Score/Culture Survey

Ambition: To gauge an understanding of how employees perceive the culture to be and what can be improved to enhance a positive working culture

Goal: Comply with CNST Safety action 9

Key Messages:

- Survey questions developed with support of Trust Quality Team and Trust well-being team
- Survey sent to all clinical and non-clinical maternity and neonatal staff November 2022 by the Trust well-being team.
- Results will be analysed via the Gather system and will support identification of cultural strengths and weaknesses.

Actions & Improvements:

- An action plan will be developed once the data has been analysed in order to improve working relations within maternity and neonatology.

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Midwifery Workforce/Safe Staffing

Patient FIRST

SIOR- Midwifery Workforce

NHS Medway NHS Foundation Trust

Successful Deliverables

- Significant recruitment to Band 5/6 vacancies. Vacancy reduced to 7wte qualified staff
- Increased recruitment into Band 2/3 MSWs
- Ongoing recruitment program.
- Ongoing focus on retention.
- Band 8a successfully recruited into lead for education role
- Consultant Midwife post appointed to – start date Jan 2023.

Identified Challenges

- Retention and wellbeing support for all staff
- Skill mix – new starters Q3 of 22wte band5 midwives

Opportunities

- Band 8a Education Lead to take strategic responsibility for recruitment and retention.
- Support newly qualified staff with revised preceptorship package.
- Maternity workforce NHSE funding received for Maternity service support worker lead – in post now

Risks

- CCCU – 1st year students not commenced Sep 22 due to NMC non-approval – risk to workforce in 3 years and Trust reputation

True North: People

Midwifery Workforce: (full report included)
Ambition: To provide a fully staffed maternity service to ensure the best care for women, birthing people and families.
Goal: Recruit to all midwifery staffing vacancies and maintain a high level of staff retention.

Midwifery Vacancy	Over or under establishment	Posts offered but not yet commenced employment
Band 7 Midwives	1.55 WTE vacancy	1 WTE Senior Sister for TBP awaiting start date Advertising for Band 7 DS Coordinators
Band 5&6 Midwives	7.51 WTE vacancy	15.37 WTE posts starting between now and January
Specialist Midwives	0.57 WTE vacancy	

MSW Vacancy	Over or Under establishment	Posts offered but not yet commenced employment
Band 3 MSW's	0.54 WTE	2.64 WTE awaiting start dates
Band 2 MSW's	1.96 WTE	4.92 WTE awaiting start dates

Issues, Concerns & Gaps:

- Challenge to maintain fully established workforce in light of national midwifery shortage.
- High intake of newly qualified midwives will impact on skill mix and require additional preceptorship and support.

Key Messages:

- Rolling recruitment in place to ensure ongoing management of vacancy.
- Huge improvement in workforce recruiting to band 5/6 vacancy 24.52 WTE. Rota starting to show gradual increase in number of staff on per shift. Currently 7.51 WTE vacancies
- Recruitment to Band 2/3 MSW ongoing with work in progress to align with the MSW competency framework to provide development opportunities and improve retention.
- Local and regional international recruitment continues, along with successful engagement with students at secondary schools and university open days
- Retention Midwife in post to support newly qualified midwives.
- Exit interviews to be held by retention midwife to support thematic analysis of leavers.
- Band 8a Education Lead successfully recruited to and will have responsibility for strategic overview of recruitment and retention.

Actions & Improvements:

- Action plans for recruitment and retention in place.
- Refreshed preceptorship programme in place to support newly qualified midwives.
- Retention midwife supporting newly qualified midwives and focus on improving staff retention.
- Band 8a Education lead will now take strategic responsibility for recruitment and retention

Safeguarding

NHS Medway NHS Foundation Trust

Patient FIRST

SIOR- Safeguarding

Successful Deliverables

- Team Connect – effective antenatal and postnatal continuity for families with complex social needs
- Safeguarding Swale and Medway Hub – ongoing effective multi-agency working
- Training – Safeguarding Training compliance remains above 93%
- Maternity Safeguarding Supervision Drop-in sessions now live. Mandatory 2 sessions per year for staff from 2023
- 100% compliance maintained for safeguarding supervision for case holders

Identified Challenges

- Increased number of families open to social care in Swale
- Lack of dedicated leadership for Team Connect – currently recruiting to Band 7 Senior Sister
- Lack of succession planning and support for Named Midwife
- Ongoing increase in Child Practice Reviews, which are in depth and time consuming
- The current role of the Named Midwife is increasingly strategic focused
- Recent knowledge of site within Kent & Medway of potential trafficking, exploitation and lack of service engagement – expected increase of bookings with Medway Hospital

Opportunities

- Implementation of antenatal toxicology testing ongoing
- Recruitment of Band 7 Senior Sister for Team Connect
- Maternity Safeguarding Supervision Drop-in sessions to be uploaded on ESR from 2023 to ease data collection and monitoring of compliance
- To explore into developing teenage specific parenting classes

Risks

- No current cover for periods of leave for the Named Midwife (added to risk register)
- Due to increased demands, workload needs to be prioritised, resulting in deadlines not being met
- Strategic aspects of the Named Midwife role are taking priority over the operational aspects

True North: Patients Incidents – Safeguarding

NHS Medway NHS Foundation Trust

Ambition: Excellent outcomes, ensuring no patient comes to harm with no adverse outcome
Goal: Protect others from abuse harm and neglect.

Key Messages: - Significant head trauma of child - 8 months old (Independent Management Review)

- Good Practice from investigation -
  - Continuity of care under Team Connect even following movement between Medway and Swale
  - Safe enquiry of domestic abuse in challenging situations from Team Connect
  - Liaison with multi professional teams during antenatal and postnatal period for the mother

Issues, Concerns & Gaps: - Missed Opportunities (Independent Management Review)

- Lack of exploration into father's history – missed opportunity to directly contact fathers' allocated social worker
- Overall lack of professional curiosity
- Parents declined Early Help support – missed opportunity to follow up with specific teenage pregnancy parent education

Actions & Improvements:

- Band 7 post PID agreed – awaiting final approval then to advertise
- DNA policy reviews continue to ensure an improved monitoring process
- Safeguarding management now added to risk register
- Once Band 7 in post they will have the oversight of safeguarding cases in the absence of the Named Lead Safeguarding Midwife
- Action plan to be created for above Independent Management Review

CNST Ockenden

See separate report

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Saving Babies Lives Care Bundle

See CNST separate report

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IPC Update Report

Steph Gorman
Associate Director of IPC

Patient FIRST

SIOR

NHS Medway NHS Foundation Trust

Successful Deliverables

- Learning from Post Infection Review's (PIR) being discussed at IPC Operational Group
- Remaining below threshold for Pseudomonas and now Klebsiella
- IPC Week as celebrated with a display in Trust's main entrance
- Trial of single product for ward cleaning commenced 3rd October
- Review and demonstration to clinical areas of 3 commodes with a voting mechanism
- Reduction in COVID infections and outbreaks in line with national figures leading to the de-escalation of a specific COVID ward ad utilisation of side rooms.

Identified Challenges

- Continued acquisition of hospital acquired infections (HAIs) particularly C.Difficiles, and E.Coli which are now above trajectory – this is in line with a national and regional increase.
- Care agencies continuing to ask for PCR testing for patients returning to their own home with a package of care even though this is against Government guidance
- Staff compliance with mask wearing in clinical areas along with Personal Protective Equipment (PPE) use
- Early isolation of any suspected infection
- Symptom checker not yet on Electronic Patient Records (EPR)
- Clinical waste management
- Wrong bags being used for Laundry as well as not just linen in bags

Opportunities

- Therapies and Older Persons (TOP) care group have identified HAI's as a driver metric for their areas
- Gap analysis for decontamination identifying issues and problems
- Implementation of IPC screening on EPR may allow for real time assessment for compliance
- First month of Trust compliance for commode observations at 91%
- Potential to use Hydrogen Peroxide Vapour (HPV) cleaning in areas with frequent infections particularly in side rooms and sluices
- Explore potential for easing mask wearing in low risk areas such as Outpatients

Risks

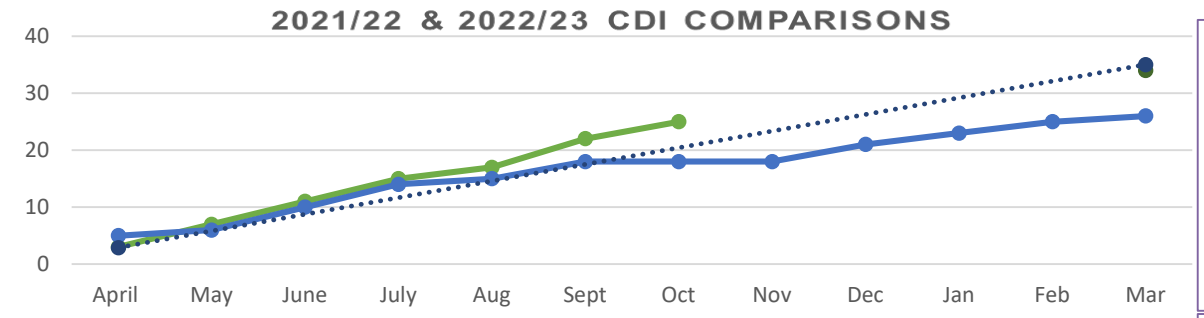
- Continued high use of terminal cleans and enhanced cleans when not needed reducing turn around times for bed spaces and impacting on patient flow within the hospital
- Delay in implementation of national cleaning standards
- Risk of the Trust not meeting the 22/23 threshold for C.Difficiles by January: only 1 PIR shows the infection to be avoidable. Work on the learning would not have prevented the infection as the antibiotics were appropriate and needed.
- Lack of Occupational Health attendance at IPCG to discuss inoculation injuries
- Limited movement on antimicrobial stewardship actions within the improvement plan runs the risk of the Trust not being compliant with antimicrobial stewardship standards

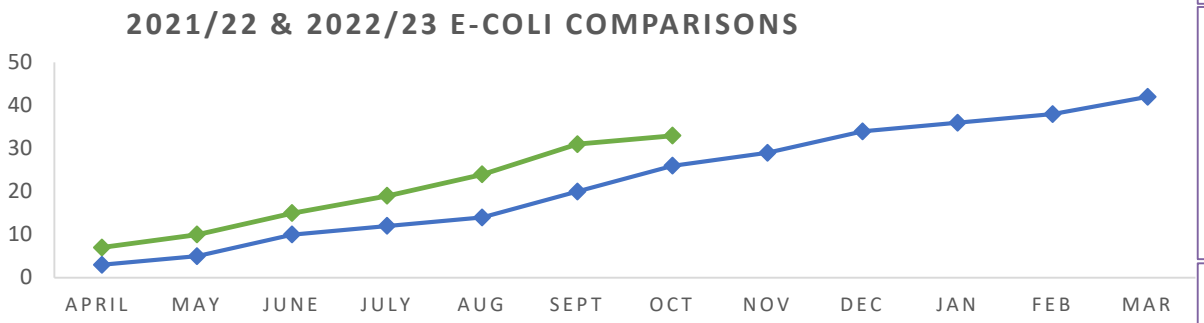
Remedial actions against identified challenges, opportunities and risks have been reflected within the IPC improvement plan and risk register.

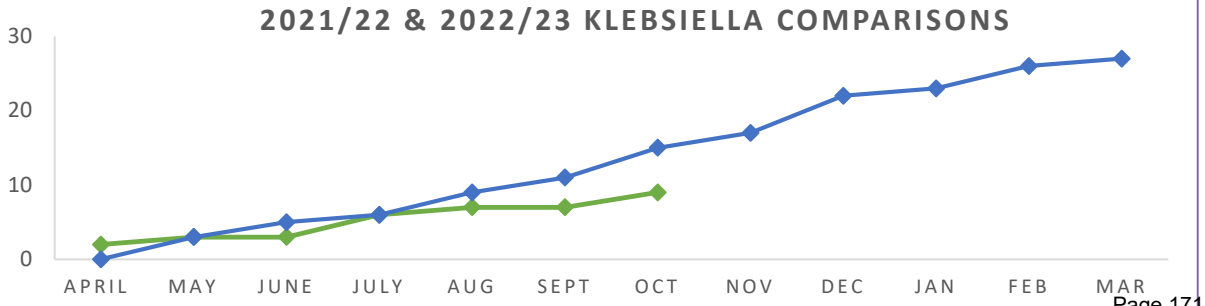
True North: Quality

NHS Medway NHS Foundation Trust

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have
Goal: To ensure the Trust's rates of hospital acquired infections remains below the thresholds set by NHSE/I for 2022-23







Key Messages:

- MRSA bacteraemia threshold breached in April but remains at 1 case this year.
- C.Difficiles had 3 cases this month and E.coli had 2 cases this month this is down on previous months
- Within the region DVH have breached their threshold for C.Difficiles. MTW and EKUFT are the same as MFT, close but not yet breached

Issues, Concerns & Gaps:

- C.Difficiles and E.Coli are both above the same point last year and above trajectory
- Risk of breaching C.Difficiles threshold by January 2023
- Key themes from PIR's remain delay in isolation, sampling, poor documentation of stool chart, HAPPINESS stool assessment tool

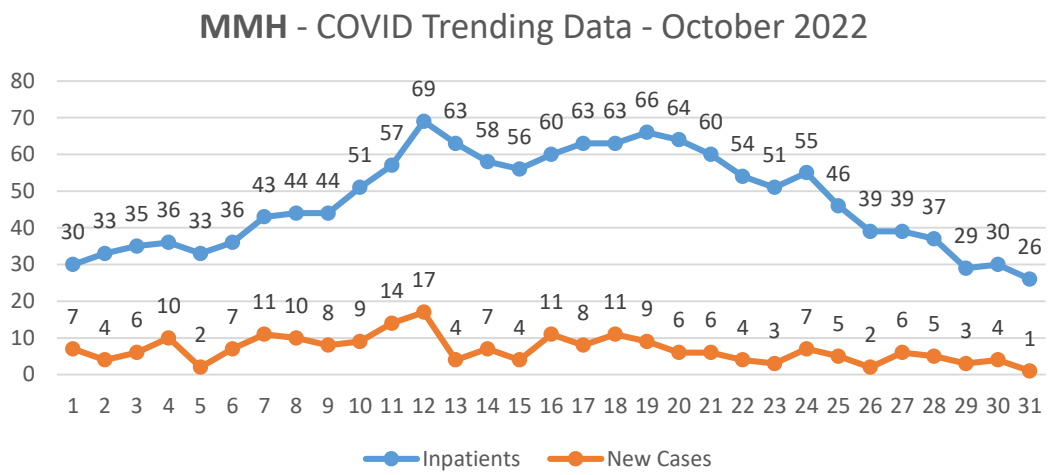
Actions & Improvements:

- Commode competencies have been rolled out.
- Trial of cleaning agent for commodes and mattresses completed at end of October proposal to be presented at IPCG in December
- 3 commodes trialled in the hospital also in October and PID for replacements being written
- A new Diarrhoea assessment tool developed and presented to IPCG in November
- To start to implement Period of Increased Incidence for 2 or more Hospital acquired GDH (precursor to C.Difficiles) as a preventative measure

True North: Quality

Medway NHS Foundation Trust

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have
Goal: To monitor the levels of COVID-19 in the hospital and ensure correct testing and placement to reduce the risk of nosocomial infections and outbreaks



Staff/Patient	Ward	First Case	Total # of cases	Close Date	Status
Patient	**Will Adams**	14/09/2022	8	06/11/2022	OPEN
Patient	**Milton**	29/09/2022	7	29/10/2022	CLOSED

Key Messages:

- Numbers of COVID patients peaked 2nd week of October and then has reduced
- 0 Outbreaks were declared in October, and 1 outbreak from September was closed leaving 1 outbreak open closed early November.
- 1 ward is COVID remaining patients are managed in side rooms and D bay on Respiratory ward in October. The remaining ward was de-escalated from COVID in November

Issues, Concerns & Gaps:

- Symptom checker is being more widely used to support decision making re swabbing however staff are still waiting results before isolating
- Discharge swabbing for care homes/hospices and rehab identifying “new” cases which have not been identified earlier due to asymptomatic testing pause
- Issues with discharging to care homes of known positive patients who have completed their isolation as homes require a negative swab which can be positive at 90 days.

Actions & Improvements:

- Symptom checker audit on Gthr.
- To finalise the guideline to support reducing isolation period to 7 days
- Reminder for visitors to not attend if experiencing symptoms
- To work on process for lateral flow testing for known positive patients being discharged to care homes
- To add symptom checker and COVID screening to EPR

True North: Quality

Ambition: Excellent outcomes, ensuring no patient comes to harm and no patient dies who should not have

Goal: Improve performance on Gthr for IPC audits to above 90% for both Divisions

Metric	Apr 22	May 22	Jun 22	Jul 22	Aug 22	Sep 22	Oct 22
Infection Control	Amber	Amber	Green	Green	Amber	Amber	Green
IPC Hand Hygiene v2	93 (408)	90 (806)	90 (813)	91 (780)	93 (815)	92 (723)	94 (759)
IPC - Hand Hygiene Facilities	87 (11)	89 (25)	93 (24)	96 (25)	98 (42)	99 (26)	96 (39)
Are staff bare below the elbows?	98.8 (407)	99 (793)	98.3 (802)	98.4 (763)	98.3 (651)	99.6 (568)	98.3 (602)
IPC - Symptom Checker	No data (0)	No data (0)	N/A	N/A	46 (211)	74 (209)	82 (259)
IPC - Commode & Sluice Facilities	83 (23)	87 (61)	98 (45)	97 (48)	94 (72)	95 (73)	94 (62)
IPC - Commode Observation	88 (54)	74 (183)	66 (29)	86 (136)	78 (94)	83 (155)	91 (136)
IPC - Environmental	81 (7)	85 (16)	91 (15)	90 (20)	92 (21)	91 (24)	93 (24)
IPC - MRSA Screening Audit -	82 (37)	77 (30)	86 (37)	88 (102)	83 (80)	85 (105)	82 (153)
IPC - Saving Lives: Peripheral Cannula	83 (216)	91 (219)	92 (254)	91 (306)	91 (253)	90 (300)	89 (306)
IPC - Urinary Catheter	92 (83)	94 (112)	95 (149)	91 (149)	93 (147)	93 (190)	97 (170)

Metric	April 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22
IPC Hand Hygiene V2	91% (288)	91% (482)	90% (486)	92% (453)	93% (471)	93% (419)	94% (417)
Bare below the elbows	98.3 % 287)	98.7% (469)	97.7% (481)	98.2% (447)	98.1% (377)	99.4% (341)	97.4% (344)
IPC – Commode and sluice facilities	82% (19)	87% (56)	98% (43)	97% (36)	94% (58)	97% (55)	94% (49)
IPC – Commode Obs	88% (51)	76% (152)	62% (21)	85% (102)	78% (77)	85% (124)	90% (95)
IPC Environmental	75% (4)	80% (13)	90% (14)	90% (12)	91% (11)	89% (15)	92% (11)
IPC HH Facilities	85% (7)	88% (20)	90% (12)	94% (11)	98% (29)	98% (14)	98% (17)
IPC – MRSA screening	81% (32)	77% (30)	86% (37)	88% (100)	84% (70)	85% (88)	85% (109)
IPC – PPE facilities	77% (2)	78% (10)	84% (3)	72% (8)	87% (30)	90% (26)	93% (33)
IPC – Saving lives: Peripheral Cannula	85% (188)	92% (195)	94% (214)	93% (263)	92% (211)	93% (209)	91% (201)
IPC – Urinary Catheter	92% (78)	95% (103)	95% (134)	91% (136)	93% (130)	93% (155)	96% (138)
IPC – Symptom Checker	No Data	No Data	No Data	No Data	49% (157)	78% (141)	91% (160)

Unplanned Care

Metric	April 22	May 22	June 22	July 22	Aug 22	Sept 22	Oct 22
IPC Hand Hygiene V2	93% (102)	91% (324)	93% (305)	92% (297)	94% (340)	91% (299)	93% (342)
Bare below the elbows	100% (120)	99.4% (324)	99% (303)	98.6% (293)	98.5% (271)	100%(11)	99.6% (258)
IPC – Commode and sluice facilities	86% (4)	81% (5)	100% (2)	97% (12)	94% (14)	90% (18)	95% (13)
IPC – Commode Obs	89% (3)	65% (29)	80% (8)	87% (34)	77% (17)	77% (29)	91% (41)
IPC Environmental	84% (3)	94% (3)	88% (2)	90% (8)	93% (10)	94% (9)	94% (13)
IPC HH Facilities	89% (4)	93% (5)	96% (13)	97% (12)	98% (13)	100 (11)	95% (22)
IPC – MRSA screening	88% (5)	No data	No data	83% (2)	74% (10)	86% (17)	73% (44)
IPC – PPE facilities	94% (1)	62% (3)	82% (4)	79% (7)	87% (14)	88% (11)	89% (23)
IPC – Saving lives: Peripheral Cannula	70% (28)	77% (24)	85% (40)	80% (43)	85% (42)	88% (91)	86% (105)
IPC – Urinary Catheter	93% (5)	78% (9)	97% (15)	82% (13)	94% (17)	93% (35)	98% (32)
IPC – Symptom Checker	No data	No data	No data	No data	37% (54)	64% (68)	69% (99)

Planned Care

Key Messages:

- Overall IPC has achieved green rating for 3 month since April.
- 5 areas are in Period of Increased Incidence (PII) with weekly audits by IPC team during October. This is now 3 in November
- Significant improvement with symptom checker this month
- Further work needed for cannula's and MRSA screening
- Commode observation achieved compliance this month for the first time
- Continued improvement in IPC audits with compliance now being achieved in all areas except MRSA screening within Unplanned Care
- Improvement noted in the majority of audits for Planned Care
- Maternity and Children's care group working with the head of housekeeping to have consistent housekeeping staff on the wards/units
- Disposable head/Hijab covers implemented across Peri-Op departments for Planned Care

Issues, Concerns & Gaps:

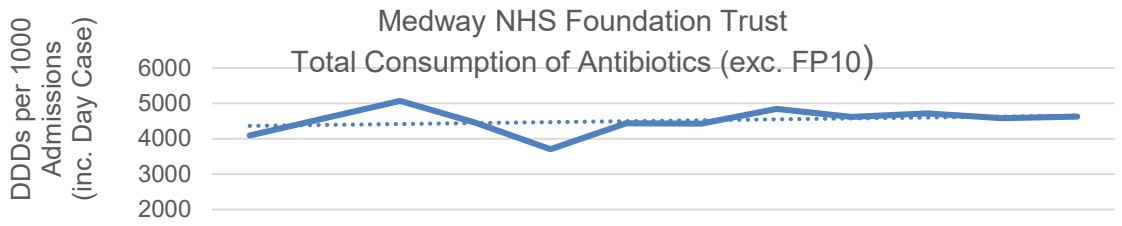
- Wounds and indwelling devices not been screened is affecting compliance for MRSA screening
- Guidance changes for management of MRSA not reflected in Policy and practice affecting MRSA screening compliance
- MRSA screening continues to be a concern with little improvement within Unplanned Care. It should be noted that a review of the MRSA screening standards is being undertaken to bring the Trust in line with current guidelines which may positively affect this standard

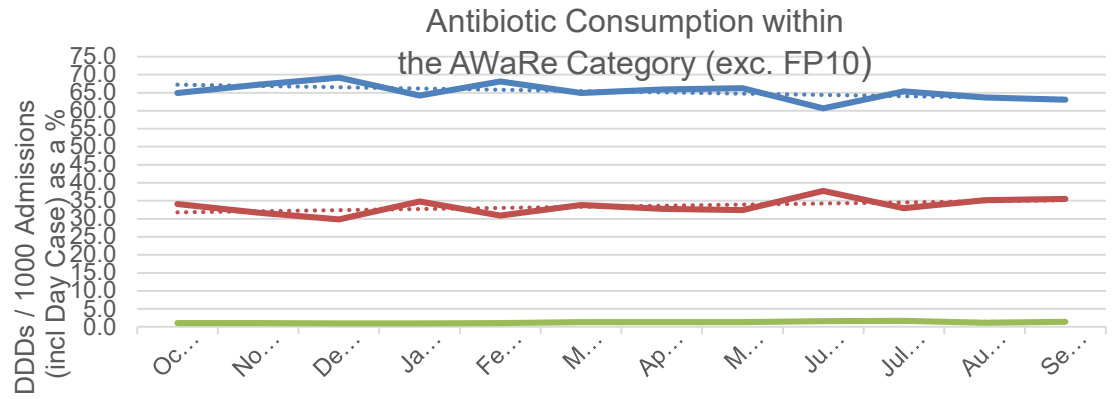
Actions & Improvements: .

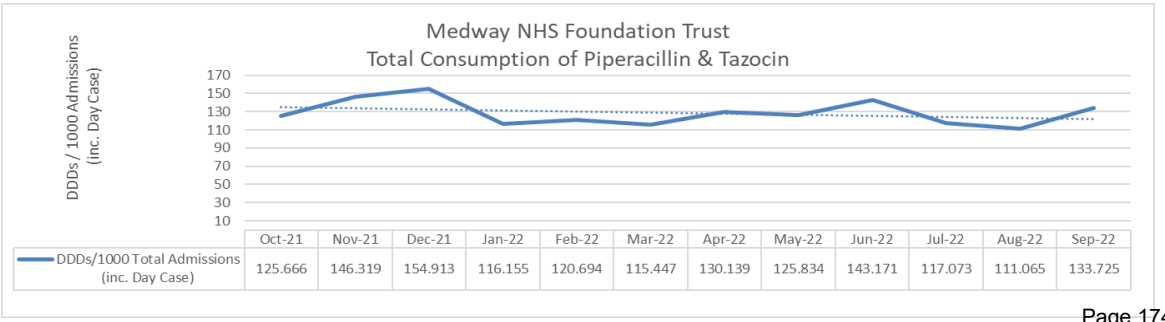
- MRSA Policy to be presented to IPCG in December with guidance changed for best practice
- Infection control screening now on EPR so ADIPC to work with BI on how to pull compliance data for a true reflection
- Work with IPC teams on wards to monitor insertion dates of cannula/s and phlebitis infection scores
- Ensure staff are questioning continued need for cannula to be in
- Work continues to complete commode cleaning competencies which is likely linked to this improvement

True North: Quality

Antimicrobial Stewardship report from IPCG focusing on antibiotic consumption







	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
DDDs/1000 Total Admissions (inc. Day Case)	125.666	146.319	154.913	116.155	120.694	115.447	130.139	125.834	143.171	117.073	111.065	133.725

Key Messages:

- Positive trend on consumption of antibiotics within the AWaRe categories.
- Antimicrobial consumption in September 2022 has increased slightly by 0.98%,

Issues, Concerns & Gaps:

- In September 2022, there was an increase in consumption of piperacillin-tazobactam compared to usage in August 2022, an increase of 20.3%. The increased consumption are linked to Cancer services, Care of the Elderly/Frailty, general surgery, ICU, Trafalgar and urology.

Actions & Improvements:

- Antimicrobial point prevalence completed on Gather in September before EPMA go live.
- Daily catch ups with Microbiologists, IPC team and Antimicrobial Pharmacist to flag concerns and discuss management of infections
- Antimicrobial ward round to commence following implementation of C.Difficiles ward round – BAF outstanding action
- EPMA now live and facilitating easier review of patient medication history.
- Antimicrobial consumption oversight by the board which is an action in the BAF IPC Improvement plan

Further updates from IPC Group

NHS Medway NHS Foundation Trust

- Link practitioners: 2 sessions ran in July and October with over 30 people attending across the both sessions. The focus was on hand hygiene, commode cleaning, sharps safety, swabbing for infections, infection admission assessment, C Diff infections, trends from post infection reviews and the stool assessment on EPR.
- IPC Operational Group (IPCOG) continues to be well attended with discussions around areas achieving good audit scores and sharing best practice to ensure improvement in all areas.
- Cleaning group continues with good attendance demonstrating 85% compliance for ward participation scores. Assurance provided that there were 117 audits completed in October with 25 not achieving the required score. All areas rated red now have an action plan for improvement in place. Discussion on new process to reduce number of deep clean requests to enable priority to areas that need it and to reduce impact on patient flow.
- Waste and Laundry is being reported to both cleaning group and Decontamination Group and have shown an increase in dangerous items being received in dirty laundry. The IPC team are working with the Laundry team to identify concern and develop and improvement plan.
- Decontamination Group has focused on completing a gap analysis of all areas which will support an action plan, work plan and audit plan which will form the ongoing agenda.

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IPC Board Assurance Framework (BAF) Update

Patient FIRST

Summary Update

- NHSE introduced the BAF to support IPC improvements and changes during the pandemic. The version that the Trust developed as an IPC Improvement plan was published 24th December 2021.
- Subsequently NHSE released a revised guidance following the “Living with COVID” measures to continue and support service recovery: Issued 28th September 2022 published 15th October 2022.
- The next few slides details the gap analysis of the most recent proposed changes. The changes identified would be consolidated with the existing improvement plan.
- There were 216 actions identified within the Trust’s 2021 IPC improvement plan. To date, 159 actions have been fully implemented, 57 remain overdue awaiting full implementation.
- Following the consolidation of the 2021 improvement plan with the September 2022 publication, the Trust now has a total of 145 actions, 38 remain overdue awaiting full implementation. These have been broken down against the Trust’s Patient First True North Domain:
  - 10 actions against **People**
  - 4 actions against **Patients**
  - 15 actions against **Quality**
  - 9 actions against for **Sustainability.**
- The update has been agreed at IPCG and Quality and Patient Safety Subcommittee.
- Work has already started on completing the overdue actions as for the actions to be completed in November and December

Gap Analysis

NHS Medway NHS Foundation Trust

IPC Area	Proposed Change	MFT Position	Gaps and Risks	Proposed Actions
1. Respiratory Plan	All respiratory seasonal viruses should not just focus on COVID. Consideration is required for those vulnerable to infection. Must include a surge/escalation plan for an increase in both patient and staff infections. Risk assessments for the organisation are reassessed where there is a change i.e. changes to local prevalence in infection rates	• Point of care testing (POCT) in place to support diagnosis of respiratory seasonal viruses with funding secured until March 2023 • Currently only monitoring and managing COVID patients • Use of symptom checker to assess for respiratory symptoms • IPC cell continues a minimum weekly • Escalation trigger levels amended and agreed at executive huddle • Side room list circulated daily by IPC team • IPC team attend morning and afternoon site meetings	• Visitors not questioned on arrival regarding symptoms • No posters on current symptoms displayed at hospital entrance or ward entrances • Staff and visitors nor always complying with mask wearing in clinical areas	• Respiratory pathway and COVID policy to be approved through Divisions and executives by mid November • Ongoing plan to be confirmed for rapid POCT testing team • Second area to be identified for cohorting respiratory viruses outside of respiratory ward
2. Clean and Appropriate Environment	Use of the national IPC manual (NIPCM) to support frequency of cleaning and staff training. This includes introduction of National Standards of Healthcare Cleanliness with clearly defined responsibilities for staff groups. Ventilation systems should comply with HBN 03.01 and meet national recommendations for minimal air changes. There should be plans in place to mitigate/improve inadequate ventilation systems. Decontamination processes removed and to be managed according to NIPCM and National Standards for Healthcare Cleanliness	• Use of NIPCM approved and uploaded on q-pulse • Study of all areas ventilation and air changes completed in 2021/2022. • Trial in place for cleaning products in October 2022 • Cleaning group initiated to provide assurance on cleaning standards • Currently use 2 products for decontamination of environment • Use Chlorine based solution for terminal cleans	• National standards of Healthcare Cleanliness not implemented and no plan in place • Areas with less than minimal numbers of air changes within the Trust • Use of chlorine solution for mattresses has caused damage and need for replacements with an increased cost	• Task and Finish group to be commenced to implement the National Standards of Healthcare Cleanliness • Executive Lead to be confirmed for this implementation. • Revisit mitigations for ventilation in areas with zero air changes • Move to a single product for equipment cleaning and terminal cleans
3. Antimicrobial Stewardship (AMS)	Naming of a formal lead for AMS to ensure maintenance of AMS. Implementation of NICE Guideline NG15. For prescription of antimicrobials to optimise patient outcomes and to ensure the principles of Start Smart, Then Focus. The board to maintain oversight of total antimicrobial prescribing, broad-spectrum prescribing and IV route prescribing. Adherence to AMS audit standards set by NICE NG15. Resources in place to support and measure adherence to good practice and quality improvement	• CMO is formal lead for AMS • AM Pharmacist in place • AMSG in place with TOR's • EPMA now in place for electronic prescribing	• Vacancies in pharmacy limit time AM Pharmacist can support audit and quality improvement due to clinical requirements • Need new chair for AMSG to oversee adherence to standards • Numbers of antimicrobial prescribing not currently shared with the board • AMSG meetings mot consistent with cancellations	• NICE guideline to be implemented by end of year • Plan for completing audits on antimicrobial use and for quality improvements • Start to pull data for number of total antimicrobial prescribing, broad-spectrum prescribing and IV route prescribing to be presented to IPCG

Gap Analysis

NHS Medway NHS Foundation Trust

IPC Area	Proposed Change	MFT Position	Gaps and Risks	Proposed Actions
4. Infection Information	IPC advice/resources/information is available to support visitors with good practices. National principles on hospital visiting will remain in place as an absolute minimum standard. Patients being accompanied in urgent and emergency care or outpatients should not be alone unless this is their choice. The use of face masks should be determined following a local risk assessment. Visitors who feel unwell or have symptoms of an infectious illness should not visit. If required for compassionate reasons mitigations should be put in place	• National principles for hospital visiting are in place • Posters regarding hand hygiene, respiratory etiquette and PPE are throughout the hospital and relevant to the area • Facemask use has been assessed and amended relevant to the area	• Respiratory pathway is in draft awaiting agreement • Funding for Rapid swabbing team only until March so recruitment and retention is an issue with resignations • COVID Policy in draft awaiting agreement to support the changes • Limited number of side rooms to support isolation and limited number of respiratory beds	• "Do not visit if" posters to be at entrances to hospital and clinical areas • Staff to challenge visitors on arrival regarding symptoms • To consider purchase of wall mounted mask dispensers
5. Risk Transmission	COVID specific changed to infectious illnesses and infections. Risk assessment of all patients on admission to ensure appropriate placement. Facemasks to be used dependent on local risk assessment. 2 or more infection cases linked in time, place and person trigger an incident/outbreak investigation	• Currently risk assess symptomatic patients to ensure correct patients • Facemasks within clinical areas due to surge in positive results. • Currently declare 2 patients linked to time and place as an outbreak • PCR tests for patients for COVID if symptomatic or for discharge to care homes/ hospices	• Multiple outbreaks declared due to link between time and place • Only doing COVID testing and not all respiratory viruses on admission or if develop symptoms so Flu may be reason for symptoms • Asymptomatic patients test positive on discharge swab which delays discharge and patient potentially move to cohort ward increasing risk of reinfection	• Investigate as incident unless clear outbreak with clear forward transmission • Do not report to UKHSA unless outbreak • Start testing all symptomatic patients for COVID and Flu • Use lateral flow tests for patients being discharged to care home/hospice • Isolate any positive PCR for discharge in a side room rather than cohort if possible
6. Preventing and Controlling Infections	IPC education is provided in line with national guidance / recommendations for all staff in relation to their role. To include hand hygiene technique training as per NIPCM. Aprons to be worn in addition to gloves when exposure to blood and/or other bodily fluids is anticipated. To focus on WHO 5 moments of hand hygiene	• IPC level 2 training has been updated for face to face training and reflects current guidance • Hand hygiene competencies has been re assessed by Matrons, ward managers and link practitioners • Staff currently wear gloves and aprons for patient contact	• Face to face training and electronic training do not match and local guidance is not reflected on ESR • Staff unaware of standard based precautions and transmission based precautions and when each should be used • Staff do not always change gloves between each task or each patient which loses opportunity for hand washing.	• To review electronic training by end of November to ensure correct information being provided. • To provide increased dates for face to face training • Link practitioners to continue assessing hand hygiene competencies • Immediately adding questions to Gthr hand hygiene audit to capture correct information

Gap Analysis

NHS Medway NHS Foundation Trust

IPC Area	Proposed Change	MFT Position	Gaps and Risks	Proposed Actions
7. Isolation Facilities	To monitor the compliance of face mask wearing by patients with symptoms of respiratory viruses. Standard infection control precautions (SICP) to be used for all patients, at all times in all settings including if not tested as asymptomatic. Transmission based precautions (TBP) when caring for known/ suspected infection/ colonisation	• Currently using SICP plus masks in all clinical areas • Staff wear masks in all clinical areas and no masks required by staff or visitors/patients in on clinical areas. • TBP in all high risk areas, known COVID patient areas and rooms • Patients encouraged to wear masks if have symptoms or are moving around the hospital	• Staff not always wearing masks correctly in any area • Not all areas caring for COVID patients understand TBP • No challenge or encouragement to patients with symptoms • Symptom checker not always used so not always clear which patients should be encouraged to wear a mask.	• Consider removing need to wear masks in all clinical areas by staff and patients but continue to wear in critical care, McCulloch, ED RAU, Resus and Majors and Lawrence/Galton • To focus on difference between SCIP and TBP in future training and with Link Practitioners • Continue to monitor symptom checker audit results and ensure added to EPR
8. Laboratory Support	Change in wording for viruses to infectious illnesses. Adds in changes to testing prior to discharge to a care home and that they are tested 48 hours prior to discharge. Includes pausing to testing for asymptomatic patients during periods of low prevalence	• Patients being discharged to care home/hospice are tested with PCR 48 hours prior to discharge. • Patients testing positive prior to discharge to a care home then wait 10 days isolation period prior to discharge. • Pause for asymptomatic testing in place since 5th September	• PCR results can stay positive for 90 days so new result might not be active virus as not testing on admission • Lateral flow tests on site but not yet being used for early step down or for known positives to be discharged to care homes as not quite in place on EPR • Positive asymptomatic patients on discharge may have been positive at any time in previous 90 days and by moving to cohort area may become re-infected. • Symptom checker not always used so patients may be symptomatic.	• Get symptom checker and lateral flow results on EPR • Lateral flows for day 7 step down agreed at IPC cell needs to get executive approval • To look to use lateral flow tests for discharges to care homes for known positive within 90 day patients • For asymptomatic positive patients tested for discharge to isolate in side room and not cohort area • MFT IPC to work with community IPC teams to use lateral flow tests for discharge to care homes rather than PCR • To secure funding for COVID swabbing team to support the roll out of lateral flow testing across the wards
9. Policies to Prevent Infections	The addition of ensuring adherence to good AMS practice alongside IPC practice. Change of PPE to available to all staff when required in line with NIPCM	• AMS pharmacist in place • AMS audit on Gthr • PPE stock monitored by procurement.	• Identified risk of lack of time for AMS pharmacist to complete her role due to vacancies within pharmacy • AMS pharmacist unable to complete regular audits on AMS compliance on Gthr • Some PPE coming to end of life as not as much in use.	• To ensure time for AMS pharmacist to work with microbiologist • AMS reviews to become part of board round • EPR to support management of AMS best practice • Procurement to continue to rotate stock
10. Occupational Health needs of staff	Pause in asymptomatic testing of staff. Staff to be adequately trained in safe systems of work in line with their duties	• Pause of asymptomatic testing in place since 5th September 2022 • Fit testing continues to be provided by external company until March 2023. • Records of FIT testing of staff held on individuals personal ESR records as well as on statman report weekly	• Only 2 members of staff within IPC are FIT testers • Staff currently only required to pass 1 mask on ESR • Need further portocath machines for testing to improve pass rate once external company leaves	• Further team members to be trained as FIT testers although this will have a cost. • Consider using COVID swabbing team member as a future FIT tester to enable access to wards for testing • Business case for portocath machine for testing • Once in house to test staff on 2 masks and add to ESR and only certified once passed 2 masks.

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Integrated Quality and Performance Report

Reporting Period: October 2022

NHS Medway NHS Foundation Trust

What is Statistical Process Control (SPC)?

Statistical process control (SPC) is an analytical technique that plots data over time. It helps us understand variation and in so doing guides us to take the most appropriate action.

The IQPR incorporates the use of SPC charts to identify **Common Cause** and **Special Cause** variation and NHS Improvement SPC Icons, which replaces the traditional RAG rating format in favour of Icons to show SPC **variation (trend)** and **assurance (target)** to provide an aggregated view of how each KPI is performing with statistical rigor.

The main aims of using Statistical Process Control (SPC) charts is to understand what is **different** and what is **normal** to be able to determine where work needs to be concentrated to make a change. The charts also allow us to monitor whether KPIs are improving.

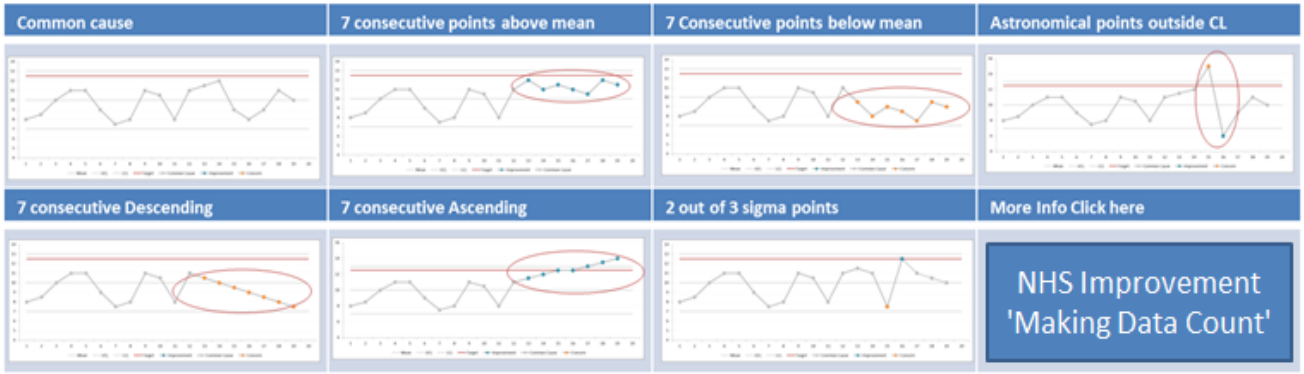
Key Facts about a SPC Chart:

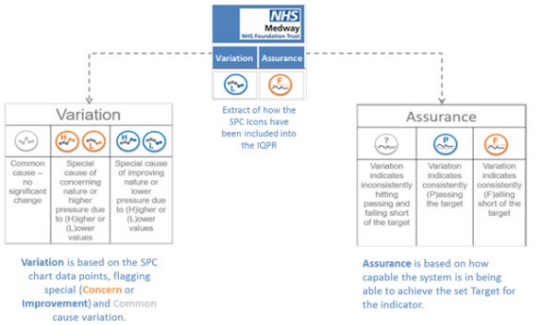
Minimum of 15 - 20 + data points are needed for a statistical process control (SPC) chart to have meaningful insight. Less than 15 data points will generate a run chart containing a mean line until enough data points have been recorded to produce a SPC Chart.

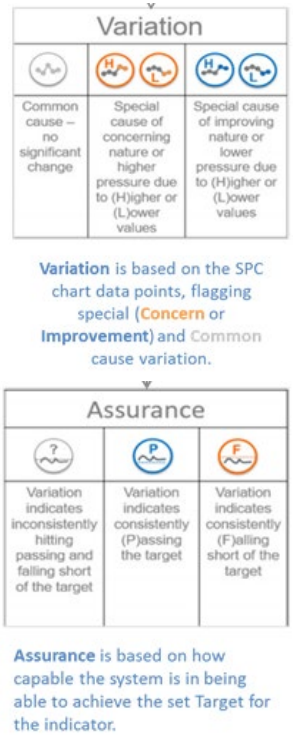
Contains a mean (the average), **lower and upper confidence levels**. 99% of all data will fall between the lower and upper confidence levels. If a data point falls outside these levels, an investigation would be triggered.

Contains two types of trend variation: Special Cause (Concern or Improvement) and Common Cause.

Below are examples of SPC trends that define common or special variation which will support understanding the variation Icons:







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Executive Summary

NHS Medway NHS Foundation Trust

	Success	Challenge
Trust	• Safety Standards & Patient Flow improvement	• RTT & Emergency Pathways
Caring	• Both Maternity & Outpatients FFT % Recommended is over target • The number of Complaints received is consistently achieving under plan and being responded to within target	• High number of breaches in Mixed Sex Accommodation continues • Inpatient & ED FFT scores are showing sign of decline • EDN % Completion is declining
Effective	• 7 & 30 Day Readmission Rates showing improved statistical variation	• High statistical variance in C-Section rates evidenced • Fractured NOF significantly below target • VTE Risk Assessment % has dropped below lower confidence limit
Safe	• PU Incidence continuously passes (achieves under) the target set & Falls per 1,000 Bed Days under target • 0 Never Events reported • % SIs Responded to has met target	• All HSMR metrics are showing signs of decline
Responsive	• Cancelled Ops Not Rescheduled has hit target • DToC/MFFD levels & Elective LoS show continued signs of improvement	• ED % Target has declined together with number of 12hr breaches increasing & Bed Occupancy showing high statistical variance • RTT Incomplete Performance decreased
Well Led	• Appraisal Compliance has increased • Agency staff spend is below plan	• Turnover Rate shows an increase in statistical variance • Whilst met Trust target for StatMan Compliance, variation in month has dropped

Summary | Caring | Effective | Safe | Responsive | Well Led

Best of care Best of people

NHS Medway NHS Foundation Trust

Executive Summary

CQC Domain	CQC Sub Domain	TRUST Variation					TRUST Assurance			
			L	H	L	H	P	F	?	
Caring	Admitted Care	4	1	0	0	0	0	1	4	0
	ED Care	0	2	0	0	0	0	1	1	0
	Maternity Care	1	1	0	0	0	1	0	1	0
	Outpatients Care	1	1	0	0	0	1	1	0	0
Effective	Best Practice	2	1	0	2	0	0	1	4	0
	Maternity	1	0	3	0	0	0	2	2	0
Responsive	Bed Management	1	0	1	2	0	2	2	0	0
	Cancer Access	3	0	1	0	1	0	0	5	0
	Diagnostic Access	0	1	0	0	0	0	1	0	0
	ED Access	1	2	1	0	0	0	2	2	0
	Elective Access	0	1	2	0	0	0	3	0	0
	Theatres & Critical Care	1	0	0	1	0	0	0	2	0
Safe	Infection Control	1	0	0	0	0	1	0	0	0
	Mortality	2	0	3	0	0	0	1	1	3
Well Led	Workforce	0	1	0	0	0	1	0	0	0

Variation

Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

Variation is based on the SPC chart data points, flagging special (**Concern** or **Improvement**) and Common cause variation.

Assurance

Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Assurance is based on how capable the system is in being able to achieve the set Target for the indicator.

Executive Summary

NHS Medway NHS Foundation Trust

Safe		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
S1	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	3	3	43	75		
S9	HSMR (All)	100	109.49	100	1.60		
S10	HSMR (Weekday)	100	106.49	100	0.98		
S11	HSMR (Weekend)	100	121.23	100	1.10		
S12	SHMI	1	1.07	-	27.42		

Caring		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
C1	Mixed Sex Accommodation Breaches	0	211	0	3,422		
C4	% of EDNs Completed Within 24hrs	100.0%	27.2%	100.0%	66.7%		
C5	Inpatients Friends & Family Response Rate	22.0%	18.8%	22.0%	19.8%		
C6	Inpatients Friends & Family % Recommended	85.0%	75.1%	85.0%	80.2%		
C7	ED Friends & Family Response Rate	22.0%	12.7%	22.0%	14.4%		
C8	ED Friends & Family % Recommended	85.0%	61.3%	85.0%	76.8%		
C9	Maternity Friends & Family Response Rate	22.0%	10.0%	22.0%	25.1%		
C10	Maternity Friends & Family % Recommended	85.0%	95.0%	85.0%	99.8%		
C11	Outpatients Friends & Family Response Rate	22.0%	8.5%	22.0%	9.2%		
C12	Outpatients Friends & Family % Recommended	85.0%	89.7%	85.0%	89.0%		

Responsive - Non-Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R2	Average Non-Elective Length of Stay	5	11.08	5	8.85		
R3	Average Elective Length of Stay	5	3	5	2.37		
R4	% of Delayed Transfer of Care Point Prevalence in Month	4.0%	0.0%	4.0%	0.5%		
R5	% Medically Fit For Discharge Point Prevalence in Month	7.0%	0.1%	7.0%	11.7%		
R6	ED 4 Hour Performance All Types	95.0%	62.0%	95.0%	76.4%		
R7	ED 4 Hour Performance Type 1	95.0%	45.5%	95.0%	66.3%		
R8	ED 12 hour DTA Breaches	0	419	0	1,756		
R9	Number of ED arrivals by Ambulance	-	3,109	-	98,772		
R10	60 Mins Ambulance Handover Delays	0	300	0	6,256		

Effective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
E1	7 Day Readmission Rate	5.0%	5.3%	5.0%	6.2%		
E2	30 Day Readmission Rate	10.0%	10.4%	10.0%	12.1%		
E3	Discharges Before Noon	25.0%	16.1%	25.0%	16.7%		
E4	Fractured NOF Within 36 Hours	100.0%	79.3%	100.0%	68.4%		
E5	VTE Risk Assessment % Completed	95.0%	71.2%	95.0%	93.9%		
E6	Elective C-Section Rate	13.0%	16.8%	13.0%	15.1%		
E7	Total C-Section Rate	28.0%	49.3%	28.0%	39.4%		
E8	Emergency C-Section Rate	15.0%	32.5%	15.0%	24.3%		
E9	12+6 Risk Assessment	90.0%	80.3%	90.0%	84.5%		

Responsive - Elective		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
R11	DM01 Performance	99.0%	79.0%	99.0%	78.0%		
R12	18 Weeks RTT Incomplete Performance	92.0%	61.5%	92.0%	64.0%		
R13	18 Weeks RTT Over 52 Week Breaches	0	504	0	7,368		
R14	Operations Cancelled By Hospital on Day	0	6	0	339		
R15	Cancelled Operations Not Rescheduled < 28 days	0	0	0	51		
R16	Cancer 2ww Performance	93.0%	95.4%	93.0%	95.6%		
R17	Cancer 2ww Performance - Breast Symptomatic	93.0%	85.7%	93.0%	90.8%		
R18	Cancer 31 Day First Treatment Performance	96.0%	98.2%	96.0%	97.5%		
R19	Cancer 62 Day Treatment - GP Refs	85.0%	83.5%	85.0%	78.4%		
R20	104 Day Cancer Waits	0	7	-	82		

Well led		Monthly		YTD		Icons	
ID	KPI	Plan	Actual	Plan	Actual	V	A
W3	Appraisal % (Current Reporting Month)	-	88.6%	-	83.9%		
W4	Sickness Rate (Current Reporting Month, FTE%)	4.0%	0.0%	4.0%	4.5%		
W5	Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	12.0%	13.2%	12.0%	13.5%		
W6	StatMan Compliance (Current Reporting Month)	85.0%	86.1%	85.0%	88.2%		
W7	Contractual Staff in Post (FTE) (Current Reporting Month)	-	4,516.78	-	122,478.16		
W8	Agency Spend as % Paybill (Current Reporting Month)	4.0%	3.1%	4.0%	2.9%		
W9	Bank Spend as % Paybill (Current Reporting Month)	9.0%	11.9%	9.0%	13.0%		

Domain: Caring Dashboard

Executive Lead: Evonne Hunt–Chief Nursing Officer
Operational Lead: N/A
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

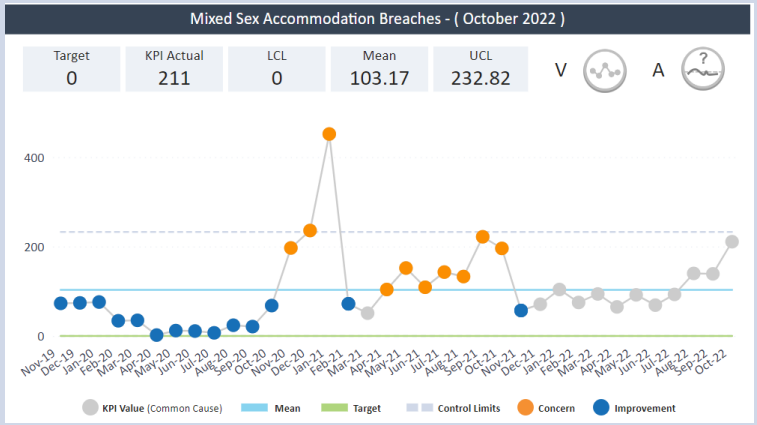
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Caring	Admitted Care	% of EDNs Completed Within 24hrs	Oct-22	100.0%	27.2%	58.8%	67.5%	76.1%		
		Inpatients Friends & Family % Recommended	Oct-22	85.0%	75.1%	69.3%	81.0%	92.7%		
		Inpatients Friends & Family Response Rate	Oct-22	22.0%	18.8%	15.4%	19.7%	24.0%		
		Mixed Sex Accommodation Breaches	Oct-22	0	211	0	103.17	232.82		
		MSA %	Oct-22	0.0%	0.0%	0.0%	0.6%	1.7%		
	ED Care	ED Friends & Family % Recommended	Oct-22	85.0%	61.3%	66.1%	77.4%	88.8%		
		ED Friends & Family Response Rate	Oct-22	22.0%	12.7%	12.4%	14.6%	16.8%		
	Maternity Care	Maternity Friends & Family % Recommended	Oct-22	85.0%	95.0%	98.8%	99.7%	100.6%		
		Maternity Friends & Family Response Rate	Oct-22	22.0%	10.0%	9.2%	24.0%	38.8%		
	Outpatients Care	Outpatients Friends & Family % Recommended	Oct-22	85.0%	89.7%	87.1%	89.4%	91.7%		
		Outpatients Friends & Family Response Rate	Oct-22	22.0%	8.5%	8.3%	10.2%	12.1%		

Safe: Mixed Sex Accommodation (MSA)
Aim: Reduction in mixed sex accommodation
Latest Period: October 2022

Executive Lead: Evonne Hunt
Operational Lead: Nicola Lewis
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Mixed Sex Accommodation Breaches



Outcome Measure: Mixed Sex Accommodation Breaches By Ward

Ward	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22
Arethusa/SAU							18				1			
Bronte	14				4		6							
Byron										6				
Critical Care Unit														
Dolphin Ward			1									11		
Emerald Assessment Unit							19							
Emerald Short Stay Ward							2							
Intensive Care Unit	1	5	2	2	8	12	1	7	2	15	17	20	8	27
McCulloch Ward	3	15			1								3	2
Milton Ward													6	22
Harvey Ward														
Jade Ward		4	4		12			8						
Keats Ward	14						3							
Lawrence Ward	7													
Lister Assessment Unit	34	22					40					32	23	22
Nelson Ward	5	10												
Ocelot	29	32	1		5									
Pembroke Ward												1	14	64
Phoenix Ward											1			
Pre Op Care Unit														
Sapphire Ward	25	24									5			
SDEC														
Sunderland Day Case Centre	5	19							6					
Surgical Assessment Unit	20					3								
Theatre Intensive Care Unit														
Trafalgar Ward SHDU	86	65	46	69	74	60	73	50	84	48	69	70	78	70
Tennyson Ward														
Wakeley														
Victory														
Will Adams	8		4									6	7	4
Totals	251	196	58	71	104	75	162	65	92	69	93	140	139	211

What do the outcome measures show?

Breaches have risen month on month but remain within common cause variation
Breaches identified are attributed to;

- A rise in Covid cases and cohorting
- Business continuity / OPEL 4 measures / delays in patient flow
- Delay in ICU discharges to HDU
- Delay in HDU discharges to the wards, in the region of 7-9 days

Delays in ICU / HDU discharges remains a risk on the register

What changes have been implemented and improvements made?

- 'Medical model' has been implemented, starting in ED which has improved patient flow from ED through the ward areas

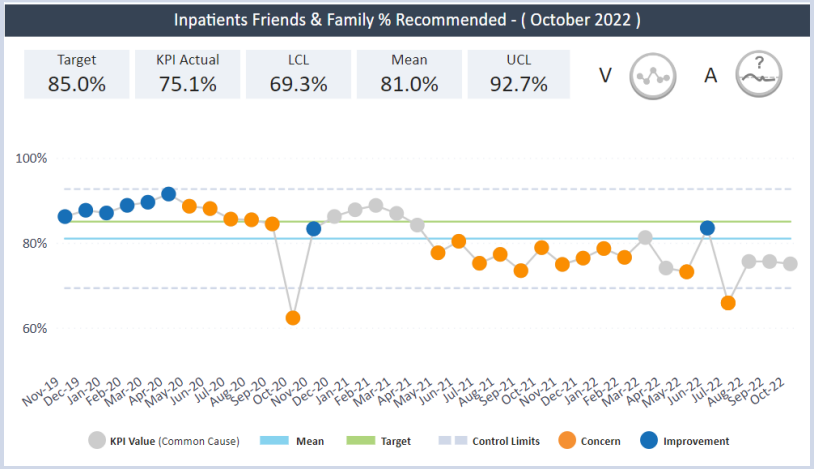
- A3 methodology work ongoing to improve reporting, validation and the escalation of breaches. AD for PE leading on this with the teams

Patient Centred: IP Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: October 2022

Executive Lead: Evonne Hunt
Operational Lead: Nicola Lewis
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

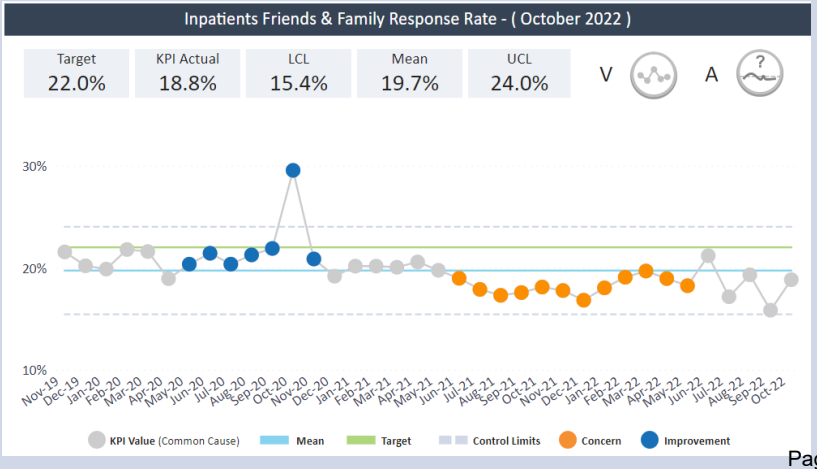
Outcome Measure: Inpatient Friends & Family % Recommended



What changes have been implemented and improvements made?

- Triangulation piece to be generated between Complaints / PALS / FFT / Live feedback / Social Media
- Patient Experience Academy is supporting the wider agenda in regards the top contributors from themes and trends within complaints / PALS contacts. These are similar themes within FFT feedback
- Focus wards as part of patient first roll out focusing on the qualitative element of feedback

Outcome Measure: Inpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

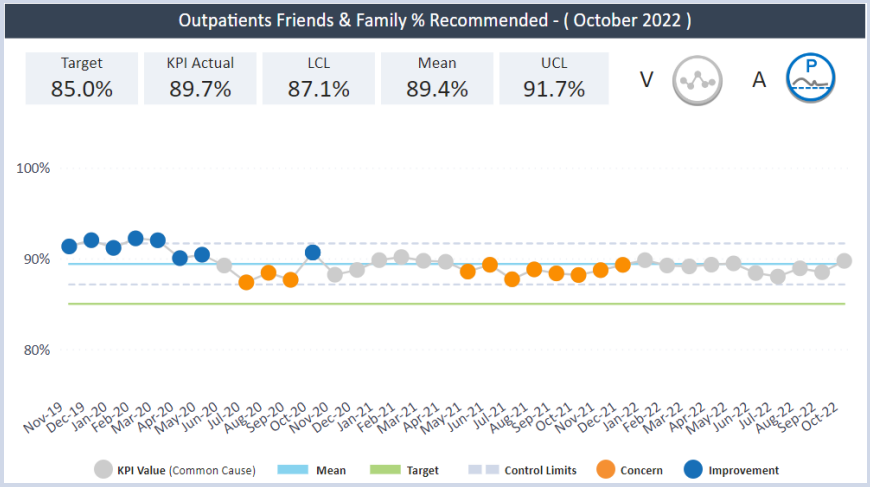
- Transition period from Envoy to gather with SMS text messaging
- QR code posters generated and circulated
- Good engagement from clinical teams / divisional leads to support the FFT agenda
- Comms engagement with ‘feedback Friday’ and ward of the week
- Patient experience lead to support the agenda with teaching sessions in huddles
- Configuration of electronic devices for use in the trial areas
- Consistent approach to FFT capture across services

Patient Centred: OP Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: October 2022

Executive Lead: Evonne Hunt
Operational Lead: Nicola Lewis
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Outpatient Friends & Family % Recommended



What changes have been implemented and improvements made?

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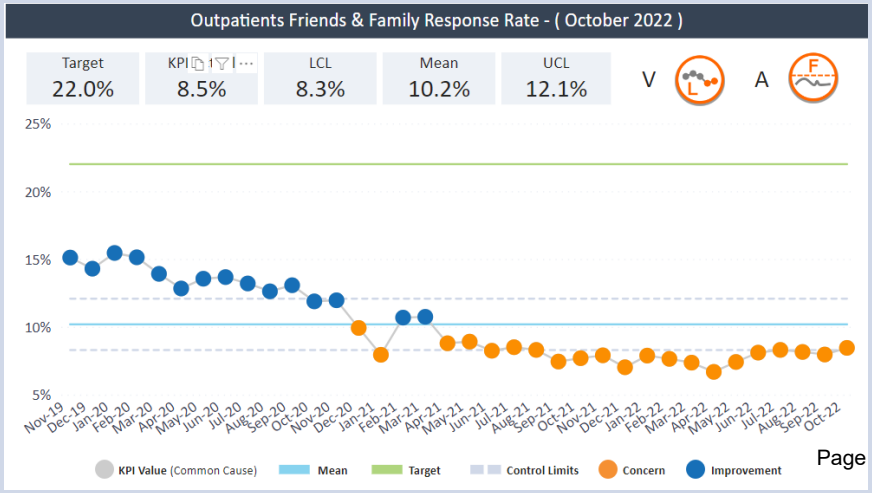
- Focus wards as part of patient first roll out focusing on the qualitative element of feedback

Outcome Measure: Outpatient Friends & Family % Response Rate



What changes have been implemented and improvements made?

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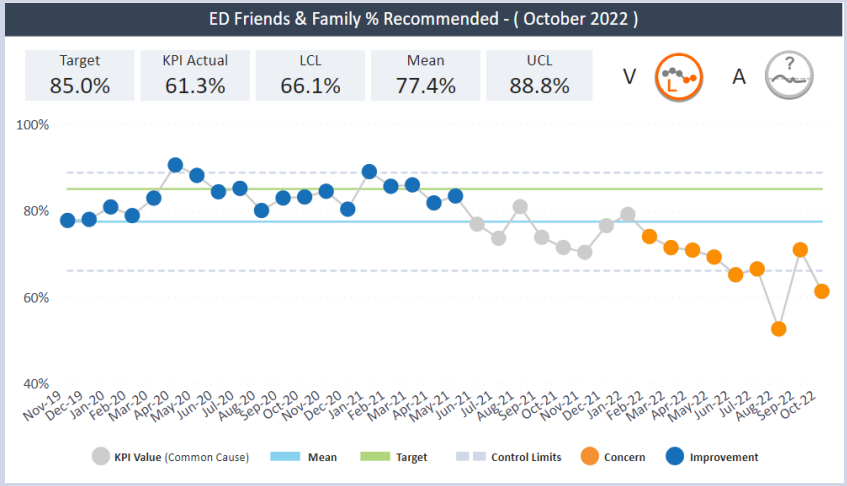
- Comms engagement with ‘feedback Friday’ and ward of the week
- Patient experience lead to support the agenda with teaching sessions in huddles
- Configuration of electronic devices for use in the trial areas
- Consistent approach to FFT capture across services

Patient Centred: ED Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: October 2022

Executive Lead: Evonne Hunt
Operational Lead: Nicola Lewis
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

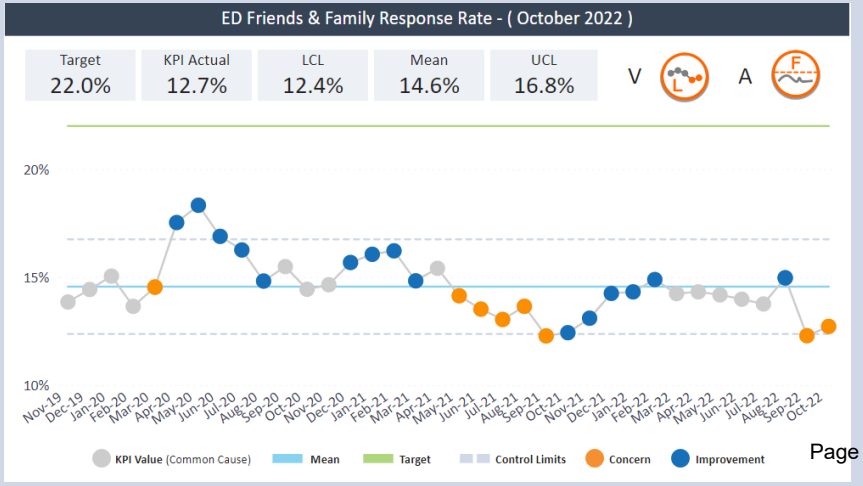
Outcome Measure: ED Friends & Family % Recommended



What changes have been implemented and improvements made?

- Reduction in recommend rate due to increased pressures in ED based on OPEL / BC status
- Leaflets generated and approved by the team to generate conversations with patients waiting for long periods in ED
- Volunteers recruited to assist with the general well-being of patients. To assist with refreshments, understanding and dealing with issues early
- Patient Experience Academy is supporting the wider agenda in regards the top contributors from themes and trends within complaints / PALS contacts. These are similar themes within FFT feedback

Outcome Measure: ED Friends & Family % Response Rate



What changes have been implemented and improvements made?

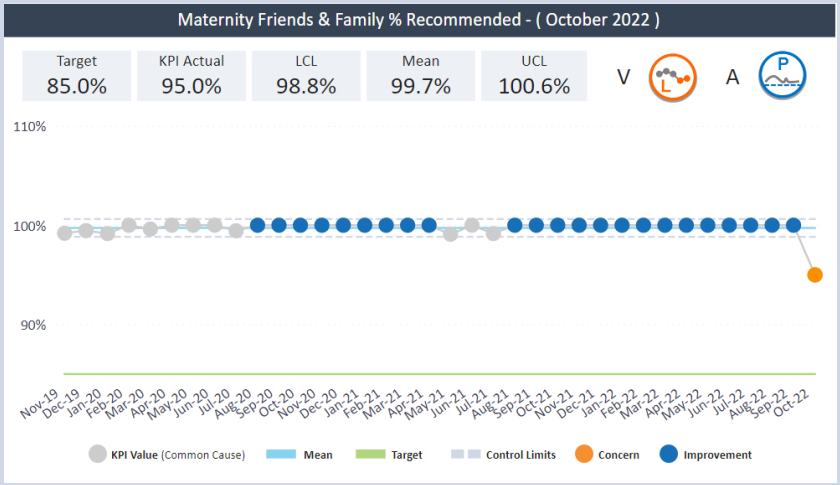
- Transition period from Envoy to gather with SMS text messaging
- QR code posters generated and circulated
- Good engagement from clinical teams / divisional leads to support the FFT agenda
- Comms engagement with ‘feedback Friday’ and ward of the week
- Patient experience lead to support the agenda with teaching sessions in huddles
- Configuration of electronic devices for use in the trial areas
- Consistent approach to FFT capture across services

Patient Centred: Mat Friends & Family Test
Aim: TBC – Currently Under Development
Latest Period: October 2022

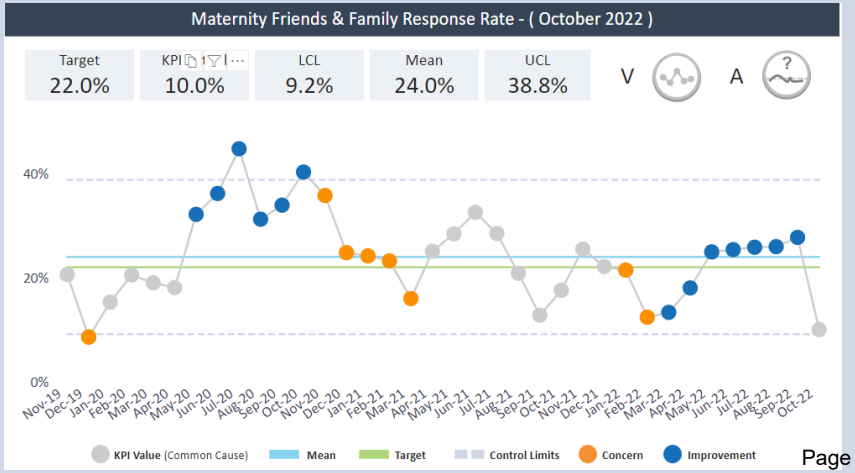
Executive Lead: Evonne Hunt
Operational Lead: Nicola Lewis
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Maternity Friends & Family % Recommended



Outcome Measure: Maternity Friends & Family % Response Rate



What changes have been implemented and improvements made?

A decrease seen in October

Total responses – 86
Question 'how was your experience of our service?'. Answers -

- 69 rated very good, 13 rated good (95%)
- 1 rated poor, 3 rated very poor (5%) (2 antenatal FFTs and 1 postnatal FFT)

Question 'would you recommend you services to friends and family members?' Answers –

- Yes – 92%
- No – 6%
- Don't know – 2%

FFT now available via QR code on posters throughout Maternity Services (hospital and community) as well as iPads across the units. Data collected via Gthr system

What changes have been implemented and improvements made?

October is the first month of using Gthr for FFT. Moving forward a comparison and deep dive into FFTs can commence.

Information on use of QR code and new iPads disseminated to staff through huddles, Friday news, handover and walkabout. Posters have been repositioned to ensure best visibility by parents.

Postcards and a stickers with QR code. Disseminated to every bedside and patient and stickers used on hand held records and discharge papers.

Domain: Effective Dashboard

Executive Lead: Evonne Hunt–Chief Nursing Officer
Alison Davis – Chief Medical Officer
Sub Groups : Quality Assurance Committee

NHS Medway NHS Foundation Trust

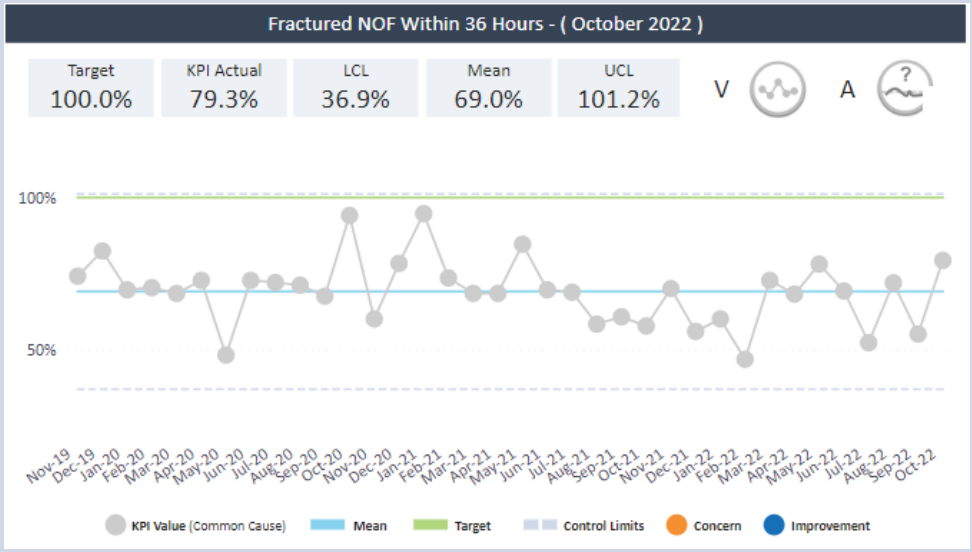
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Effective	Best Practice	30 Day Readmission Rate	Sep-22	10.0%	10.4%	9.7%	12.3%	14.9%		
		7 Day Readmission Rate	Sep-22	5.0%	5.3%	4.5%	6.4%	8.2%		
		Discharges Before Noon	Oct-22	40.0%	16.1%	13.0%	16.3%	19.5%		
		Fractured NOF Within 36 Hours	Oct-22	100.0%	79.3%	36.9%	69.0%	101.2%		
		VTE Risk Assessment % Completed	Oct-22	95.0%	71.2%	88.5%	94.1%	99.6%		
	Maternity	12+6 Risk Assessment	Jul-22	90.0%	80.3%	78.3%	84.2%	90.1%		
		Elective C-Section Rate	Oct-22	13.0%	16.8%	11.0%	14.9%	18.9%		
		Emergency C-Section Rate	Oct-22	15.0%	32.5%	17.5%	23.7%	29.9%		
		Total C-Section Rate	Oct-22	28.0%	49.3%	32.5%	38.6%	44.7%		

Effective: Fracture NOF Within 36 Hours
Aim: TBC
Latest Period: October 2022

Executive Lead: Alison Davis, Chief Medical Officer
Operational Lead: Howard Cottam
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Process Measure: Fractured NOF Within 36 Hours



What do the outcome measures show?

Validated activity shows 29 hip fracture patients managed in October, with 6 breaches, of which 3 (~10%) were due to nonmedical delay

What changes have been implemented and improvements made?

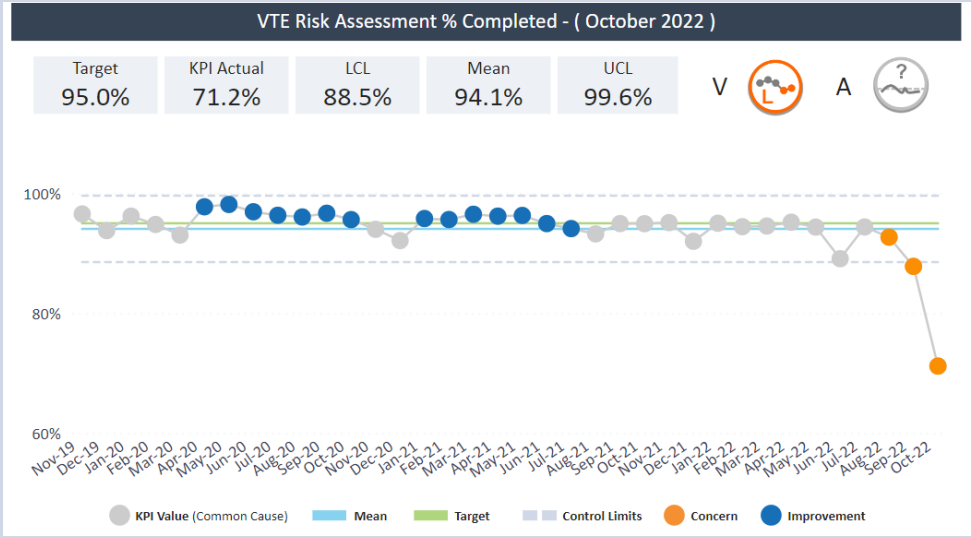
Relatively good performance this month appears to relate to an even distribution of daily admissions across the month.

Effective: VTE Risk Assessments
Aim: TBC
Latest Period: October 2022

Executive Lead: Alison Davis, Chief Medical Officer
Operational Lead: Kerry O'Neil, Nicola Lewis
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: VTE Risk Assessments Completed



What does the measure show?

The venous thromboembolism (VTE) risk assessment data collection is used to inform a national quality requirement in the NHS Standard Contract, which sets an operational standard of 95% of inpatients (aged 16 and over at the time of admission) undergoing risk assessments each month. The graph demonstrates special cause variation and is assignable to process instability Current process for data collection relies on ward clerks ensuring the VTE risk assessment completed by doctors on EPMA is recorded on PAS. Ward clerks were unclear that this role would continue in terms of VTE risk assessment now being recorded on EPMA and, assumption this would be used as the data collection source.

What changes have been implemented and improvements made?

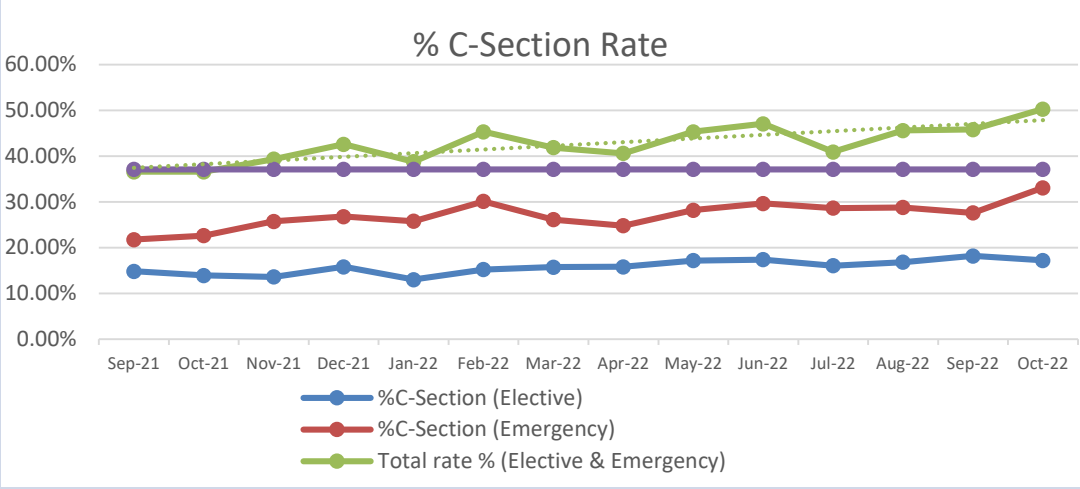
• Bank VTE administration support secured and will commence in November 2022 to improve recorded VTE risk assessment compliance • With support from the Transformation Team and led by the Executive Lead, an improvement approach using Patient First A3 problem solving methodology is being utilised to understand the reduction in compliance. • EPR does not currently support direct reporting to Business Intelligence and ward clerks should continue uploading risk assessment compliance onto PAS. EPR Team are investigating appropriate reporting EPR Platform

Safe: Maternity
Aim: Ensure maternity services are fit for purpose, safe and offer a high quality of care
Latest Period: October 2022

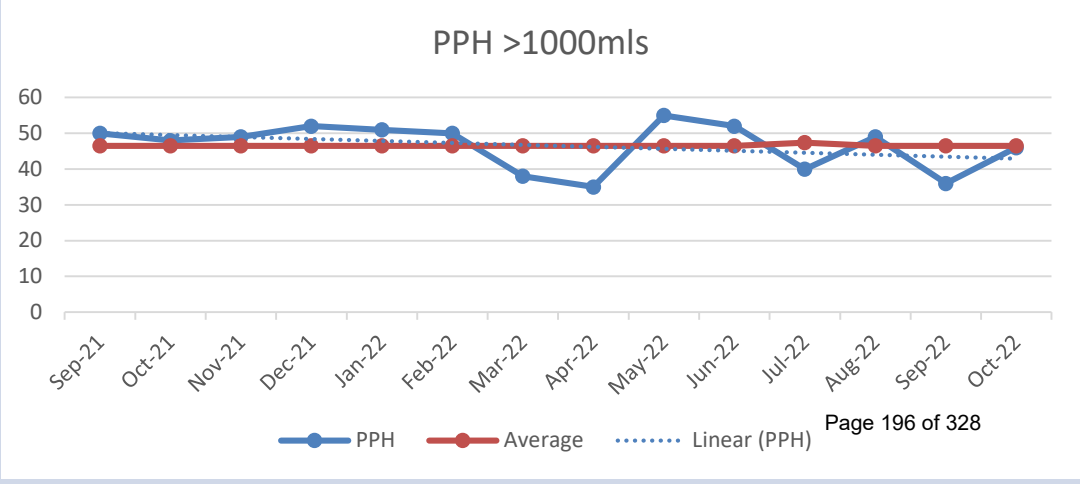
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Alison Herron/Kate Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: % C-Sections



Outcome Measure: Elective and Emergency C-Section Rate



What do the measures show?

CS targets have been removed from reporting, in line with Health Social Care Select Committee (HSCSC) guidance 2022.

Total rates has seen an increase of 17% for October due to the increase of emergency caesarean sections, but an reduction of 1% seen for elective caesarean sections

Quality improvement work through the Patient first methodology continues to identify if delays in induction of labour are a contributing factor to emergency caesarean section rates. The increasing high risk patients we are seeing may be a contributing factor to the increase in emergency caesarean section rates.

We have seen a 10% increase in the number of PPHs for October, however we are still seeing an overall reduction in the linear line. This is possibly in correlation to the increase in number of emergency caesarean section rates this month.

What changes have been implemented and improvements made?

Consultant presence on Delivery Suite continues to be audited. There was one isolated incident in October where the Consultant was uncontactable, however the senior Gynae registrar did attend in their absence. There has been 100% attendance for Consultant presence for 3 consecutive months prior to October

Awaiting Maternity Bedstates to be added to Gthr to aid data collection. Manual audit continues and ongoing collaboration with gthr team to create this electronically as presenting challenges to add all information required for bedstates onto Gthr

The Induction of labour QI project is progressing utilising A3 thinking. An immediate key change was implemented to perform ARM where appropriate on the ward with the intention of reducing the length of time women waiting to move to delivery suite for ARM.

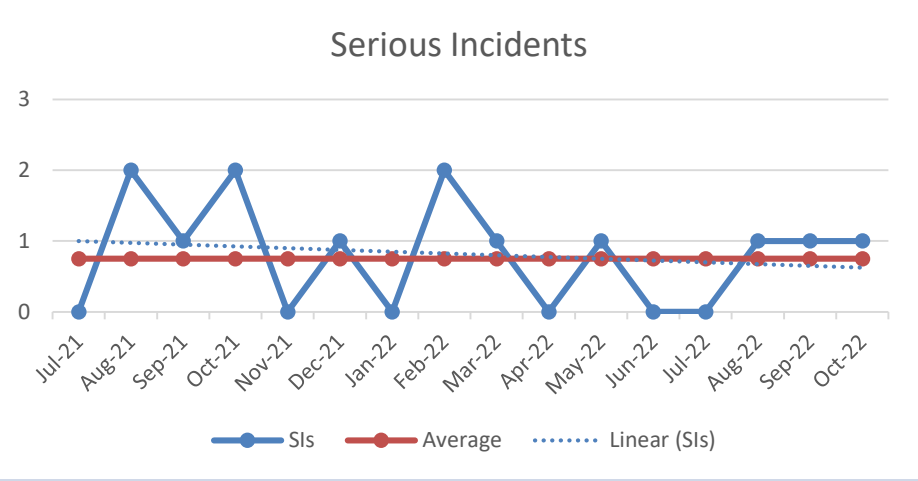
Audit of PPH including a retrospective review of antenatal and labour care continues to ascertain whether PPH could have been avoided.

Safe: Maternity serious Incidents
Aim: Learning from adverse incidents
Latest Period: October 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Alison Herron/Kate Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Serious Incidents



What do these measures show?

There was 1 Serious Incident in the month of October -

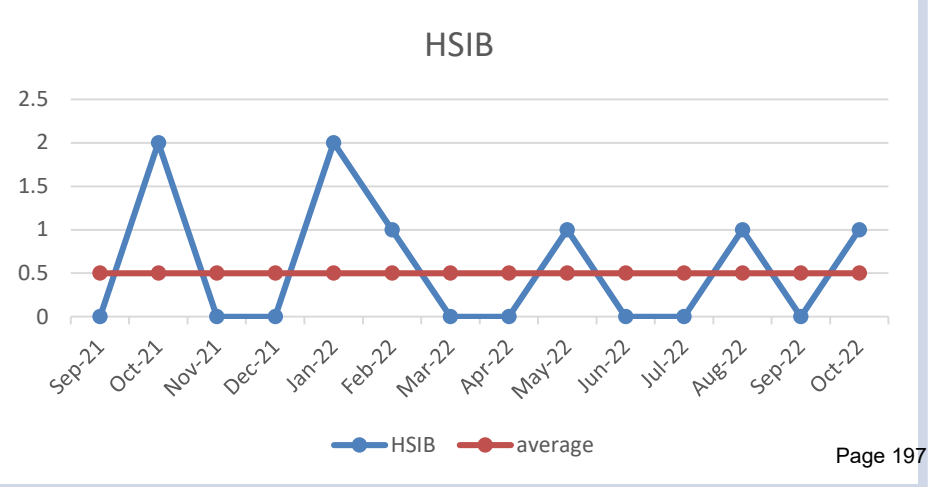
- 37+1 - BBA breech delivery at home
- Subsequent normal MRI

Learning –

- Staff not to discourage women from calling an ambulance

The 'linear' continues to show a decline, with the average remaining less than 1 Serious Incident per month.

Outcome Measure: HSIB



What changes have been implemented and improvements made?

100% of eligible cases reported to HSIB and NHSR EN as required.

There was 1 eligible HSIB case for October

- 37+1 – BBA breech delivery at home (same case as above)

Weekly MDT case review meetings continue and working well with robust challenges and discussions (commenced in October)

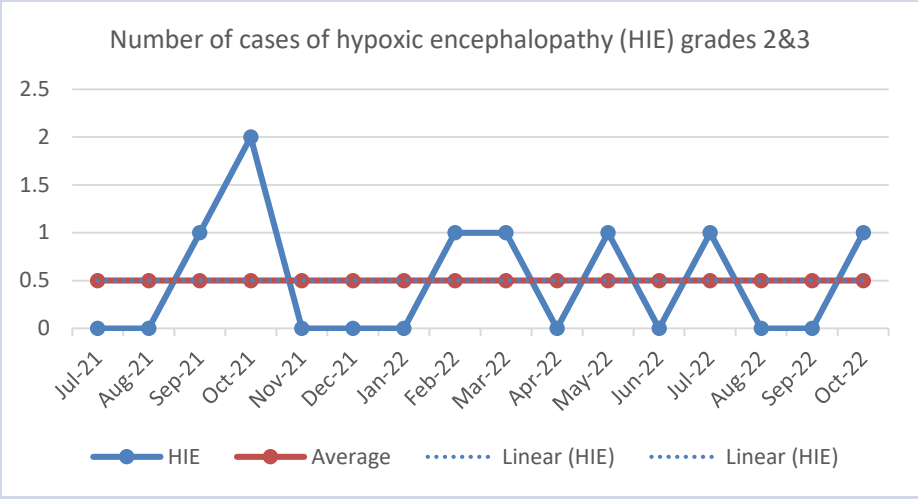
Learning also shared through Friday News and on Governance Padlet. Recommendations from the recent IAV have increased the platforms staff are able to obtain Friday's News information to increase shared learning.

Safe: Maternity
Aim: To reduce the number of HIE, stillbirths and neonatal deaths and improve outcomes for all babies
Latest Period: October 2022

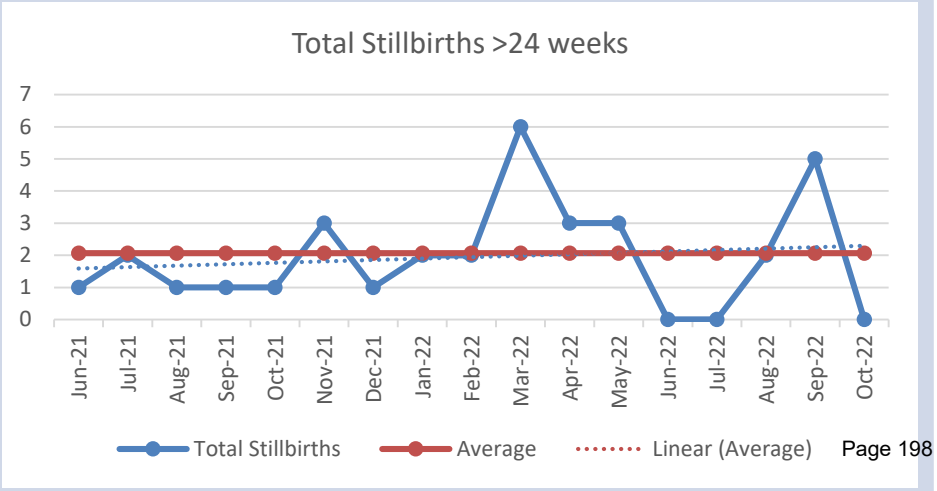
Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Alison Herron/Kate Harris
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

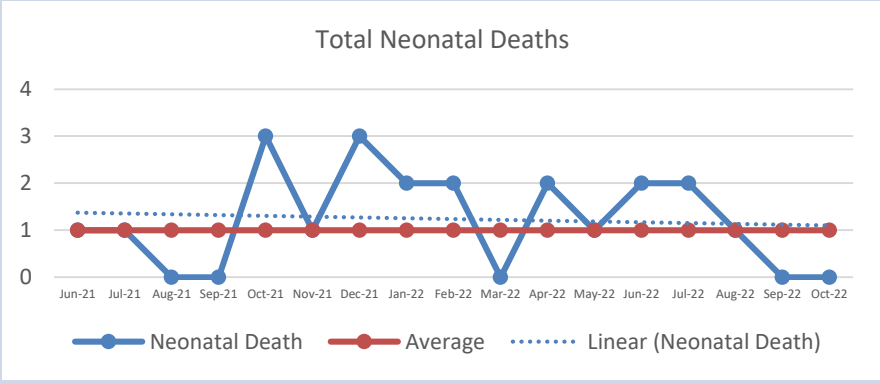
Outcome Measure: Number of cases of hypoxic encephalopathy (HIE) grades 2&3



Outcome Measure: Total Stillbirths >24 Weeks



Outcome measure: Neonatal deaths



What do these measures show?

There were 0 antenatal stillbirths >24 weeks in October

There was 1 HIE case in October –

- 37+1 BBA breech delivery at home (same as previous case)

There were 0 neonatal deaths in October

What changes have been implemented and improvements made?

Noted a slight increase in the linear line – however stillbirths noted in Q1+2 2022 were due to extreme prematurity. No learning identified from cases

Actions and recommendations from investigations incorporated in to training plans and MDT weekly case review meeting.

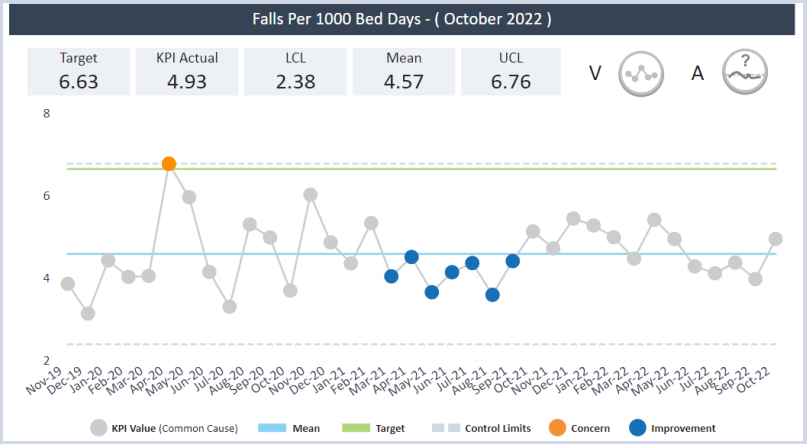
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Safe	Harm Free Care	Falls Per 1000 Bed Days	Oct-22	6.63	4.93	2.38	4.57	6.76		
		Pressure Ulcer Incidence Per 1000 days (High Harm)	Oct-22	1.04	0	0	0	0.03		
	Incident Reporting	% of SIs Responded To In 60 Days	Oct-22		100.0%	0.0%	52.9%	124.0%		
		Never Events	Oct-22	0	0	0	0.17	0.93		
		No of SIs on STEIS	Oct-22	90	6	0	14	31.48		
	Infection Control	C-Diff Acquisitions (Trust Attributable, Post 48 Hours)	Oct-22	43 [43]	3	0	2.25	7.72		
		C-Diff: Hospital Onset Hospital Acquired (HOHA)	Oct-22		2	0	2.44	6.33		
		E-coli (Trust Acquired) Infections	Oct-22	0	2	0	3.09	6.84		
		MRSA Bacteraemia (Trust Attributable)	Oct-22	0	0	0	0.06	0.36		
	Mortality	Crude Mortality Rate	Oct-22	2.5%	1.8%	0.3%	1.9%	3.4%		
		HSMR (All)	Jun-22	100	109.49		69.72			
		HSMR (Weekday)	Jun-22	100	106.49		97.58			
		HSMR (Weekend)	Jun-22	100	121.23		110.37			
		SHMI	May-22	1	1.07	1.04	1.06	1.09		

Safe: Falls management and reduction
Aim: 12% reduction in number of falls with harm
Latest Period: October 2022

Executive Lead: Evonne Hunt, Chief Nursing Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Outcome Measure: Falls Per 1000 bed days

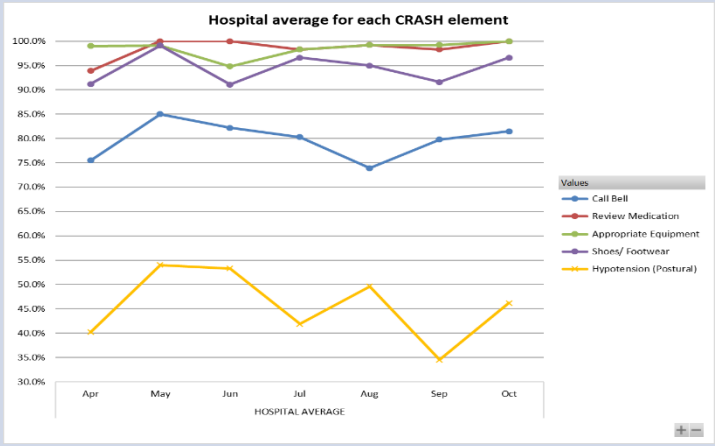


What do the outcome measures show?

Month	Total Falls	No and low harm	Moderate harm	Severe harm/ Death
October-22	101	99	1	1
October **21**	85	81	1	3
Sept-22	76	72	2	2
Aug-22	84	84	0	0

- 73% of falls occurred in Unplanned care (size of division and specialties and additional escalation beds),
- 82% of falls were unwitnessed
- 36% of falls were from level ground (often whilst patient mobilising)
- 12% of falls occurred between 6-7 pm
- 20% of falls across the Trust occurred on a Wednesday
- The number of patients who have fallen previously on this admission increased from 16-18 this month

Process measure: 95% Crash Bundle Reliability (Pilot wards)



What do the process measures show?

- The key consistent themes continue to be, call bell out of reach and lying and standing blood pressure recording.
- Lying and standing blood pressure recording has increased by 6% this month.
- Trust wide falls CRASH Bundle overall performance (% average) currently demonstrating common cause variation.

- **What changes have been implemented and improvements made?**

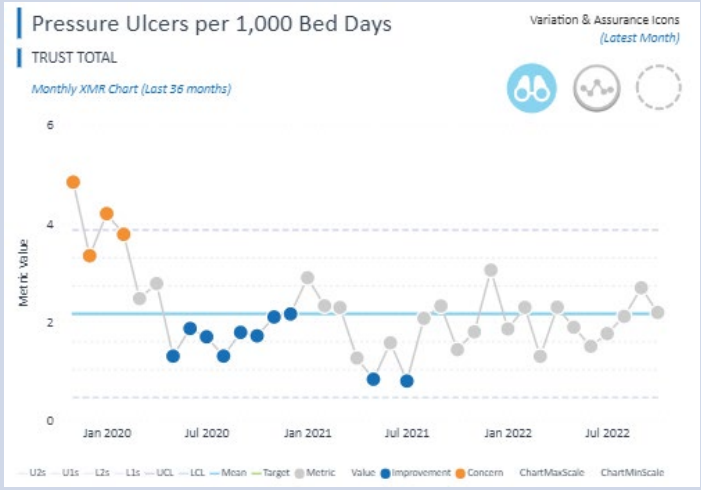
- To date, 14 wards have undergone data examination with A3 problem solving methodology to fully discover root causes in order to identify appropriate solutions.
- Currently 10 wards have quality improvement plans at the “do” stage of the PDSA cycle (Plan, Do Study, Act).

Safe: Pressure Damage Reduction
Aim: 10% Reduction in Hospital Acquired Pressure Ulcers
Latest Period: October 2022

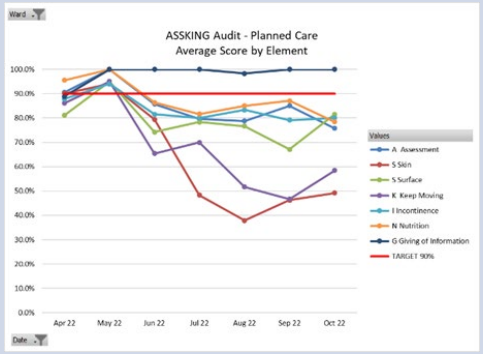
Executive Lead: Evonne Hunt
Operational Lead: Hayley Jones
Sub Groups: Quality Assurance Committee

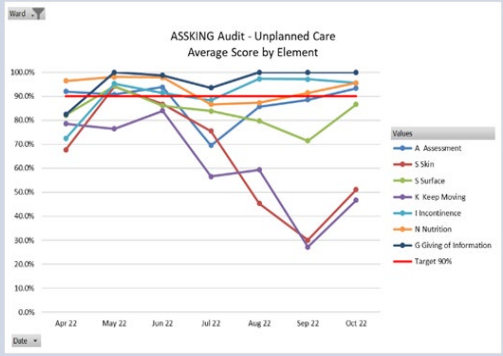
NHS Medway NHS Foundation Trust

Outcome Measure: Pressure Ulcer Incidence Per 1000 days (All Harm)



Process Measures: ASSKING Bundle Reliability (Pilot Wards)





What do the outcome measures show?

- 68% of hospital acquired pressure ulcers were within Unplanned care while 32% of hospital acquired pressure ulcers were within Planned care
- Milton, Pembroke, Byron, Sapphire, Kingfisher, Harvey and Jade had 2 or more HAPU's.

Month	Total HAPU	low harm	Moderate harm	Severe harm/ Death
October 2022	25	22	2	1
October 2021	11	10	0	1
September 2022	23	23	0	0
August 2022	18	16	1	1
July 2022	15	15	0	0
June 2022	15	15	0	0
May 2022	26	26	0	0
April 2022	23	22	1	

Hospital Acquired pressure ulcers HAPU for Month of report by category

Category 2	Category 3	Category 4	DTI	Unstagable	Total
5	0	2	6	12	25

Pressure Ulcer's on admission (POA)

Category 1	Category 2	Category 3	Category 4	DTI	Unstagable	Total
4	118	9	3	22	22	178

What do the process measures show?

The Trust scored 77% in the ASSKING audit in October 2022, with 109 audits completed. This is up from 72% in September.

	August 2022	September 2022	October2022
Assessment	83%	87%	84%
Skin	42%	36%	50%
Surface	78%	69%	84%
Keep Moving	55%	34%	53%
Incontinence	91%	89%	86%
Nutrition	86%	90%	85%
Giving Information	99%	100%	100%

What changes have been implemented and improvements made?

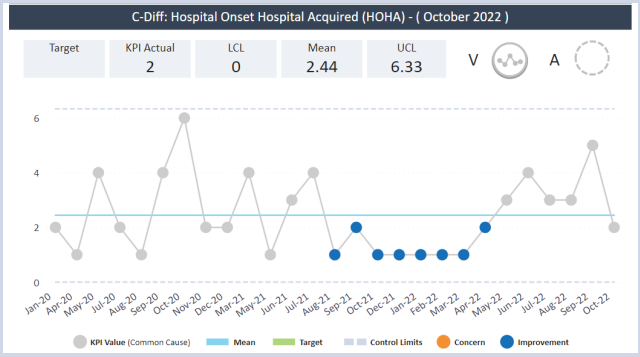
- An improvement approach using an A3 problem solving methodology is being utilized across the Trust. Interrogation of data for each ward who acquire more than two pressure ulcer a month underway and will form a deep dive report for each area which will be presented at QAC.
- Re-configuration of the documents on EPR has taken place. The tissue viability team are currently working on providing education to all ward staff to ensure there is a consistent approach with all tissue viability documents on EPR.

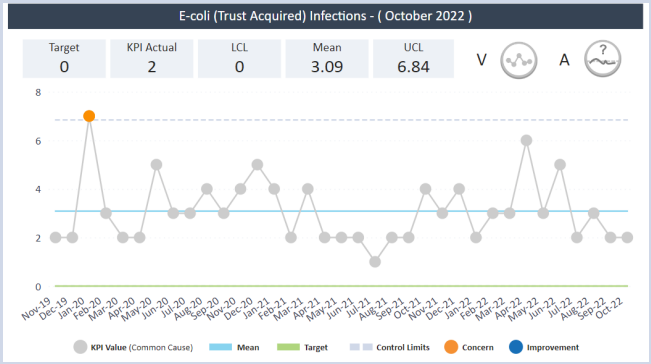
Safe: Improving Infection Control
Aim: Reduction in healthcare acquired infections.
Latest Period: October 2022

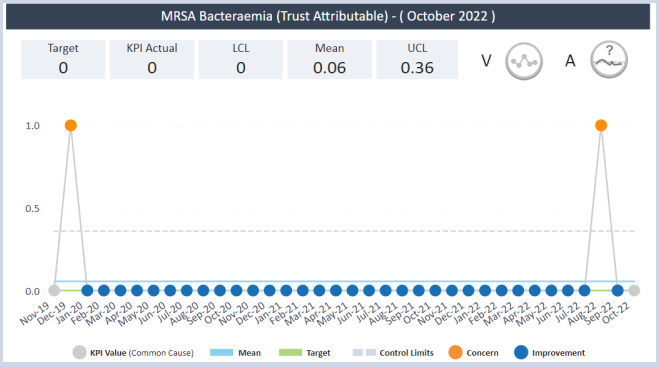
Executive Lead: Evonne Hunt
Operational Lead: Steph Gorman
Sub Groups: Quality Assurance Committee

NHS Medway NHS Foundation Trust

Infection Prevention Control measures







What do the outcome measures show?

MFT continue to work to achieve their thresholds in 22/23. With the 1 MRSA Bacteremia MFT has breached that threshold. The below numbers are cumulative for the year.
MRSA Bacteremia 1 HOHA with 0 new cases
C.Difficile rates since 1st April 2022 is 25 HOHA's against a threshold of 34 which is an increase of 3 in October.
E.Coli : 33 against a threshold of 77 which is an increase of 2 in October..
Klebsiella : 9 against a threshold of 37 with 2 cases in October which is below this time last year
Pseudomonas : 34 against a threshold of 17 with 1 case in October which is below this time last year

What do the process measures show?

C.Difficile is above this point 21/22 by 7 cases but within trajectory.
.E.coli is 7 above this point last year but Klebsiella and Pseudomonas are below.

What changes have been implemented and improvements made?

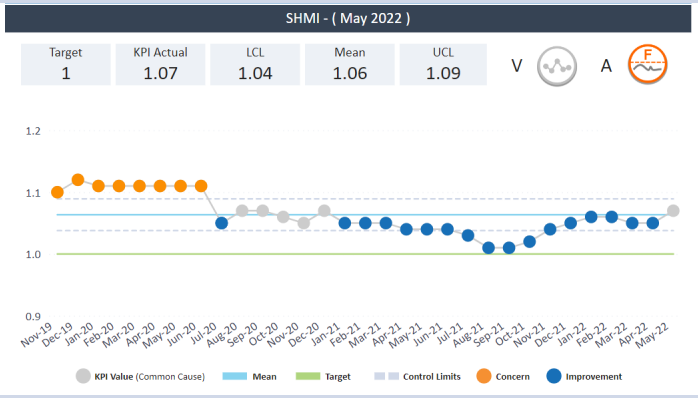
- The ongoing execution of the IPC improvement plan, & IPC BAF ensuring evidence and assurance.
- Cleaning product trial commenced 3rd October and has completed. A proposal for change is now to be written in November
- Different styles of commodes have been demonstrated and costings now being considered
- Link practitioner focus on stool charts, stool assessment and isolation in October
- IPC week in October also focused on those as well as hand hygiene and demonstrating potential new commodes

Effective: Mortality
Aim: TBC
Latest Period: SHMI Reporting Period: May-22
HSMR Reporting Period: Jun-22

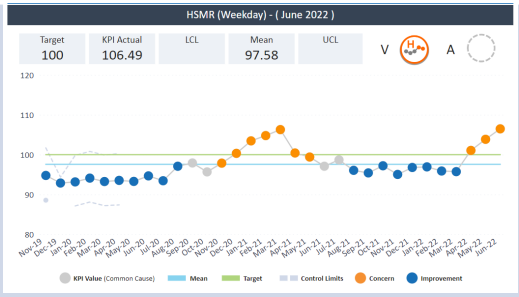
Executive Lead: Alison Davis, Chief Medical Officer
Operational Lead: Not applicable
Sub Groups: Quality Assurance Committee

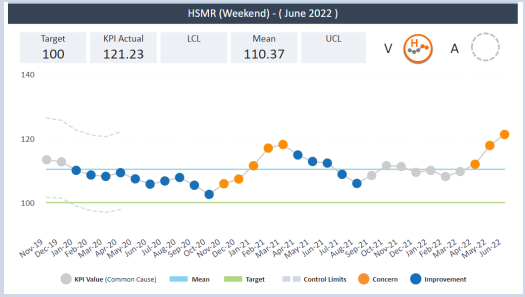
NHS Medway NHS Foundation Trust

Outcome Measure: SHMI Mortality



Outcome Measure: HSMR Weekend and Weekday Mortality





What do the measures show?

HSMR for Jul 21- Jun 22 is 109.0 and 'higher than expected'
Weekend HSMR- 119.7 'higher than expected'
Weekday HSMR is 105.8 'as expected.

Outlier alerts

- Acute cerebrovascular disease- deep dive completed with no significant findings
- Cancer of the liver and intrahepatic bile duct- deep dive completed with no significant findings
- Genitourinary congenital anomalies- cases already reviewed using PMRT tool
- Intestinal obstruction without Hernia- deep dive completed with no significant findings.
- Meningitis- no new deaths; diagnosis group being monitored.
- Other infection, including parasitic- undergoing deep dive
- Other perinatal conditions
- Short gestation, low birth weight and fetal growth retardation

SHMI for Jun 21- May 22 is 1.07 and ' as expected'.
The Trust is 'as expected' for 9 out of the 10 diagnosis groups with the most patient activity and 'lower than expected; for Urinary Tract Infection.

What changes have been implemented and improvements made?

- For this data set, and when looking at the month on month trend, June 2022 is showing as 'as expected'. If this trend continues, the Trust's overall HSMR will return to the 'as expected' banding.
- For the last data set, the Trust expected deaths dropped (as opposed to the observed deaths). A drop in expected deaths could be due to either there being a genuine decrease in the severity of patients being treated at the Trust, or the case mix adjustment is underestimating the risk of admissions.
- A number of deep dives and possible root causes for our rise in HSMR are underway. Coding are completing a review of patients who fall into three categories: Saturday non-elective low risk, Saturday non-elective low risk and low comorbidity and Other Infections including parasitic where the primary diagnosis changes during a spell. So far, all comorbidities for these cases have been coded correctly but for a number of cases, a definitive diagnosis is often made on the last FCE. This will be further explored at the MSSG in November.
- Anecdotal evidence raised by the MEO office around patients being discharged before they are ready on the days that the hospital is in business continuity is being explored. BI have conducted some analysis around this and are presenting findings to the MMSG in November.

Domain: Responsive – Non Elective Dashboard

Executive Lead: Mandy Woodley–Chief Operating Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Bed Management	Average Elective Length of Stay	Oct-22	5	3	1.51	2.38	3.25		
		Average Non-Elective Length of Stay	Oct-22	5	11.08	7.48	8.91	10.34		
		Bed Occupancy Rate	Oct-22	85.0%	92.7%	79.3%	85.5%	91.8%		
		Delayed Transfer of Care Point Prevalence in Month	Oct-22		0	0	118.64	262.35		
		Escalation Beds Open Point Prevalence in Month	Oct-22	0	0	0	0	0		
	Complaints Management	% Complaints Responded to Within 30 Days	Oct-22	85.0%	100.0%	14.6%	52.9%	91.3%		
		Number of Complaints	Oct-22	41	48	14.16	44.33	74.51		
	ED Access	30 Mins Ambulance Handover Delays	Oct-22	0	984	339.75	747.72	1,155.69		
		60 Mins Ambulance Handover Delays	Oct-22	0	300	0	188.22	415.01		
		ED 12 hour DTA Breaches	Oct-22	0	419	0	55.64	154.06		
		ED 4 Hour Performance All Types	Oct-22	95.0%	62.0%	70.1%	77.5%	84.9%		
		ED 4 Hour Performance Type 1	Oct-22	95.0%	45.5%	56.3%	67.4%	78.6%		
		Median Time to Ambulance Assessment (15mins)	Oct-22	15	18.50	10.68	20.90	31.12		
		Median Time to ED Clinician (60mins)	Sep-22	60	65	30.78	44.94	59.10		
		Number of ED arrivals by Ambulance	Oct-22		3,109	2,554.95	3,234.69	3,914.44		

Domain: Responsive – Elective Dashboard

Executive Lead: Mandy Woodley–Chief Operating Officer
Operational Lead: Benn Best – DDO Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

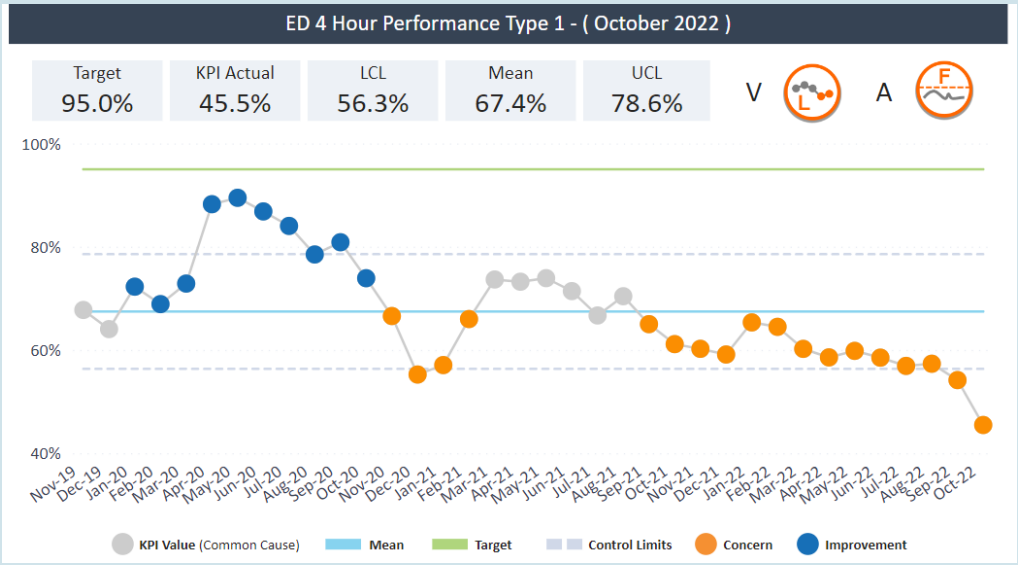
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Responsive	Cancer Access	104 Day Cancer Waits	Sep-22	0	7	0	2.34	5.55		
		Cancer 28 Faster Diagnosis	Sep-22	75.0%	74.5%	52.0%	68.6%	85.1%		
		Cancer 28 Faster Diagnosis - Breast Symptomatic	Sep-22	75.0%	100.0%	36.5%	88.1%	139.8%		
		Cancer 28 Faster Diagnosis Screening	Sep-22	75.0%	24.2%	0.0%	44.6%	112.4%		
		Cancer 2ww Performance	Sep-22	93.0%	95.4%	92.3%	95.8%	99.3%		
		Cancer 2ww Performance - Breast Symptomatic	Sep-22	93.0%	85.7%	73.4%	90.9%	108.5%		
		Cancer 31 Day First Treatment Performance	Sep-22	96.0%	98.2%	92.4%	97.3%	102.1%		
		Cancer 31 Day Subsequent Treatments (Drugs)	Sep-22	98.0%	93.3%	88.7%	96.6%	104.6%		
		Cancer 31 Day Subsequent Treatments (Surgery)	Sep-22	94.0%	90.9%	70.3%	93.2%	116.1%		
		Cancer 62 Day Treatment - Cons Upgrades	Sep-22		72.7%	38.6%	70.7%	102.8%		
		Cancer 62 Day Treatment - GP Refs	Sep-22	85.0%	83.5%	59.6%	76.5%	93.3%		
		Cancer 62 Day Treatment - Screening Refs	Sep-22	90.0%	92.1%	22.6%	72.4%	122.2%		
	Diagnostic Access	DM01 Performance	Oct-22	99.0%	79.0%	66.6%	81.4%	96.3%		
	Elective Access	18 Weeks RTT Incomplete Performance	Oct-22	92.0%	61.5%	60.1%	66.7%	73.2%		
		18 Weeks RTT Over 52 Week Breaches	Oct-22	0	504	60.29	204.69	349.09		
		Daycase Rate	Oct-22	85.0%	66.8%	60.3%	67.1%	73.9%		
		DNA Rate	Oct-22	10.0%	8.7%	6.7%	7.9%	9.1%		
		First to Follow Up Ratio	Oct-22		2.21	2.17	2.64	3.12		
		PTL Size	Oct-22	22,477	34,347	23,880.12	25,329.97	26,779.82		
	Theatres & Critical Care	Cancelled Operations Not Rescheduled < 28 days	Sep-22	0	0	0	1.80	7.28		
		Operations Cancelled By Hospital on Day	Sep-22	0	6	0	13.37	33.56		
		Urgent Operations Cancelled for the 2nd Time	Sep-22	0	0	0	0.03	0.19		

Responsive: – Non Elective Insights
4hr Performance

Executive Lead: Mandy Woodley – Chief Operating Officer
Operational Lead: TBC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 4 Hour Performance Type 1



Indicator Background:

The total number of Accident & Emergency (A&E) Type 1 attendances show the number of patients who were not moved within 4 hours of arrival into the Emergency Department (ED).

What the Chart is Telling Us:

The SPC is showing a gradual decline in performance in recent months, with this Trend continuing through to October.

Actions:

1. Project to relocate mental health patients away from CDU
2. Review of divisional systems and processes
3. Implementation of Acute Medical Model 1st November
4. Increased front-door streaming to UTC, MEDOCC, EAU, SAU
5. Opening of frailty Capacity at Sheppey
6. Breaking the cycle event planned for w/c 28th November with system partners, KPMG & ECIST
7. Successful appointment of Divisional Director of Operations for Unplanned Care

Outcomes:

1. Release CDU capacity for ambulatory patients
2. Improved communication and escalation and adherence to processes
3. Results in first two weeks show reduction in aggregated patient delays of approximately 2 hours, and reduction in average LOS in department of 5 hours
4. Right care, right place, improved patient pathways
5. Limit frailty admissions via ED
6. Improved flow, increased discharges, reduced MFFD

Underlying issues and risks:

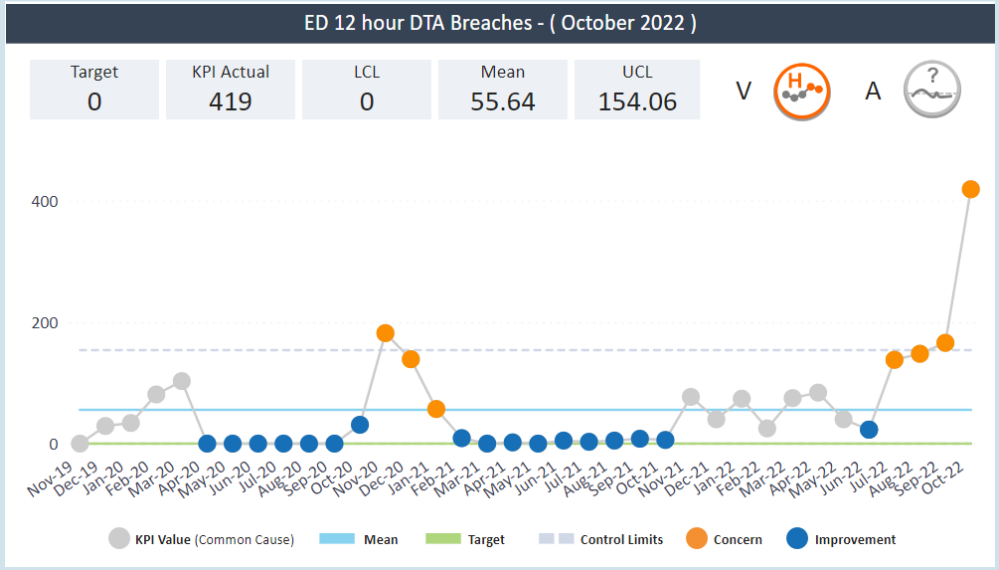
1. Physical capacity on site, delays to works required, competing demands for space
2. High MFFD number has a direct impact on ED performance due to lack of flow (DTA's awaiting beds).
3. Staff consultation underway which may impact the role out of Sheppey beds
4. Sustaining of improvements beyond intervention

Responsive: – Non Elective Insights

Executive Lead: Mandy Woodley–Chief Operating Officer
Operational Lead: TBC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: ED 12 hour DTA Breaches



Indicator Background:

The proportion of Accident & Emergency (A&E) attendances that are admitted, transferred or discharged within 12 hours of arrival.

What the Chart is Telling Us:

There has been an increase in 12 hour DTA breaches during the reporting period, with the position significantly worsening from September 22 to October 22. Since the implementation of the Acute Medical Model the trend has started to reverse, with a decrease in patients exceeding 12 hours LOS

Actions:

1. Go-live of Acute Medical Model (completed on 1st November 2022)
2. Opening of capacity at Sheppey (planned for December 2022)
3. Flow co-ordinators role, improved processes
4. Break the cycle event planned w/c 28th November
5. Improved board round processes, faster decision-making, improved access to senior decision makers
6. Escalate through Site Operations teams patients with an extended length of stay in ED (every hour).
7. Ensure EPR processes are embedded within the clinical teams.

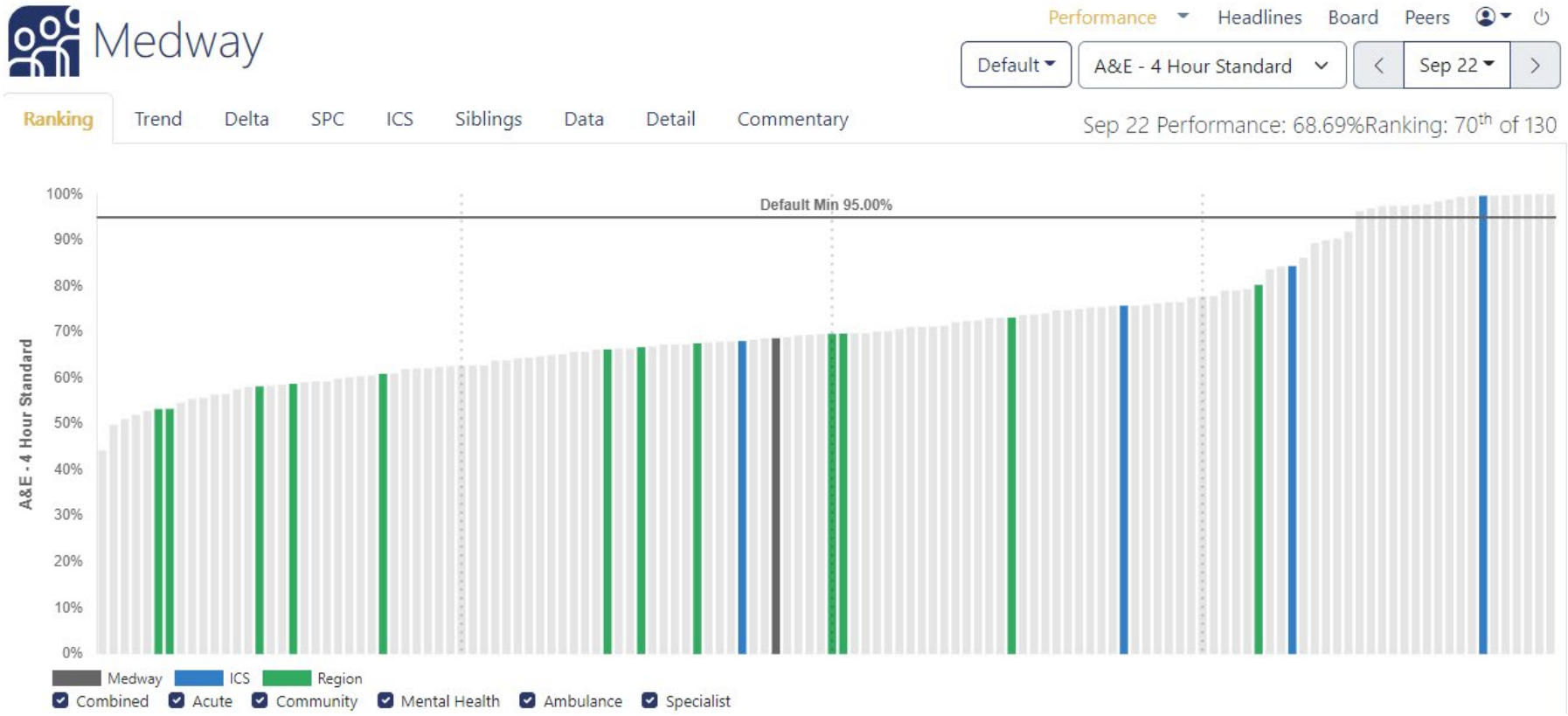
Outcomes:

1. Reduction in average number of patients exceeding 12 hours LOS.
2. Providing care closer to home for frailty patients, offering timely transfer to reduce waits in ED.
3. Inpatient Wards to use a Pull model (next patient) to reduce overcrowding in the emergency department.
4. Improved flow, increased discharges, reduced MFFD
5. De-escalation from additional capacity
6. To embed a renewed focus on 4-hour performance.
7. To remove data quality errors

Underlying issues and risks:

1. Sustaining improvement throughout Winter
2. Recruitment to vacancies
3. Embedding of change through wider workforce, resilience
4. To maintain a continued organisational response to ED performance.

EC 4 Hour Benchmarking

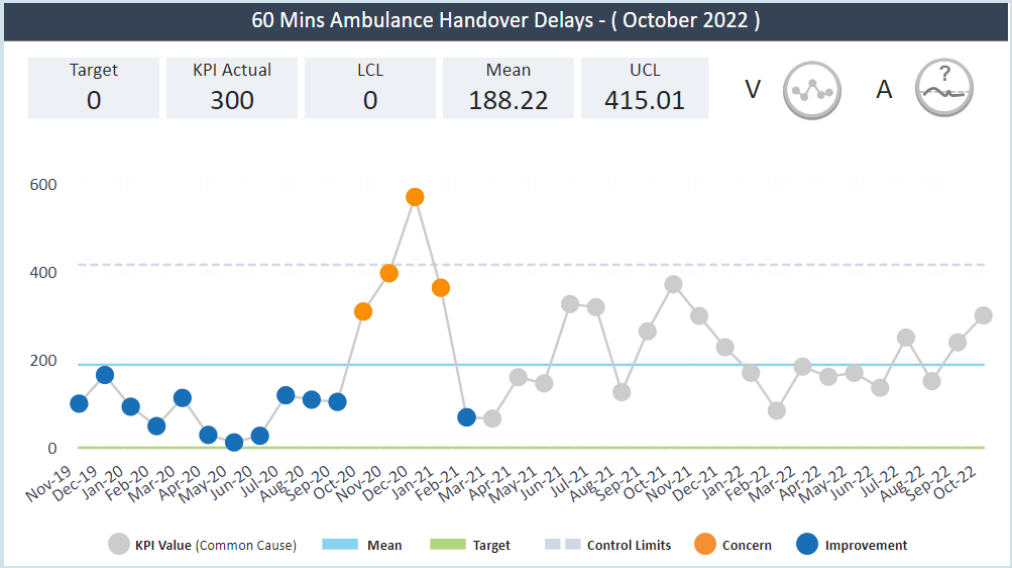


Responsive: – Non Elective Insights

Executive Lead: Mandy Woodley–Chief Operating Officer
Operational Lead: TBC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: 60mins Ambulance Handover Delays



Indicator Background:

The total number of Accident & Emergency (A&E) attendances where the patient is not offloaded within 60 minutes of arrival

What the Chart is Telling Us:

The SPC data chart is showing a decline in performance, with increasing handover delays for September and October.

Actions:

1. Implementation of Acute Medical Model (1st November) in conjunction with implementation of Delayed Handover Policy from SECAmb
2. Improvement actions to 4 and 12 hours performance and ED Crowding
3. Re-establishment of bi-weekly meetings with MFT & SECAmb
4. Project to relocate mental health patients away from CDU
5. System-wide project (HARIS) to address inappropriate attendances

Outcomes:

1. Elimination of 60 minute handover delays (existing data for November shows a significant improvement in 30-60 minute handover delays)
2. Reduced crowding and delay in Acute and Emergency areas, capacity for ambulance offload
3. Maintain improved working relationships and communication channels
4. Release CDU capacity for ambulatory patients
5. Reduced bed occupancy, reduced ED attendances, improved capacity within acute and emergency areas

Underlying issues and risks:

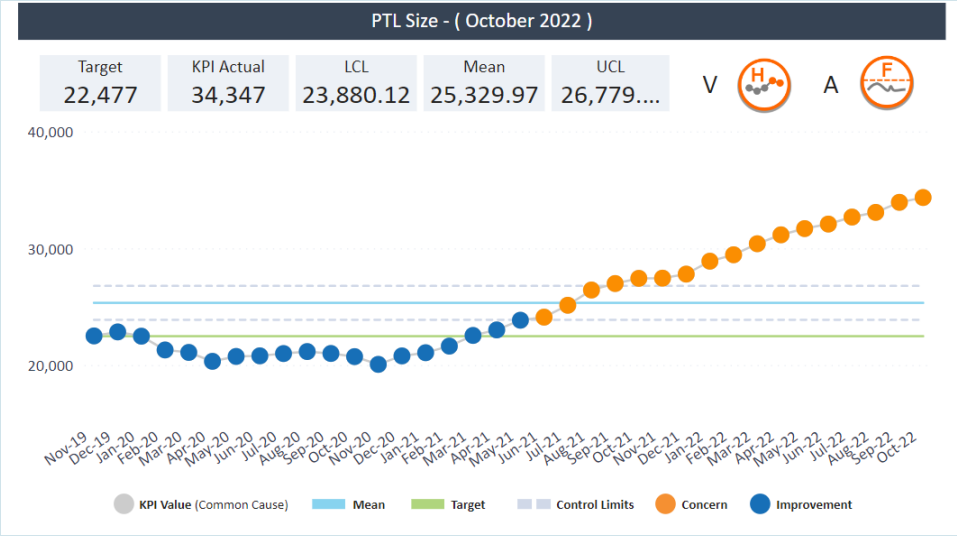
1. Sustaining improvement beyond winter pressures.
2. Failure to reduce MFFD position will lose capacity.
3. Limited capacity due to estate.
4. Slow descalation of escalation areas
5. Increase in Frailty and MFFD over winter due to increase in Flu, Covid, RSV etc

Responsive: Elective Insights

Executive Lead: Mandy Woodley–Chief Operating Officer
Operational Lead: Benn Best – Director of Operations Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: PTL Size



Indicator Background:

The total number of patients on a Referral to Treatment (RTT) pathway that are currently listed on the Trusts waiting list (Patient Tracking List or PTL)

What the Chart is Telling Us:

The SPC data point is showing an increase in the overall PTL size.

Actions:

- Agree system-wide interventions for challenged specialities in ENT
- Joint Commissioner/Trust groups have been started to support pathway reviews for challenged specialities
- Theatre and Outpatient efficiency groups have been established to drive improved productivity and remove waste.
- Improve utilisation using the independent sector.
- To maintain PTL validation
- Improve one-stop clinics
- Relaunch PIFU throughout all specialities

Outcomes:

- Reductions in inappropriate referrals
- To support a reduction in referrals
- Trust Outpatients and Theatre Efficiency plans will improve the utilisation and productivity of Outpatient and Theatre activity
- Value for money and ensure all external capacity is used.
- Sustain data quality improvements
- Delivery timely discharge
- Release capacity and improve discharge.

Underlying issues and risks:

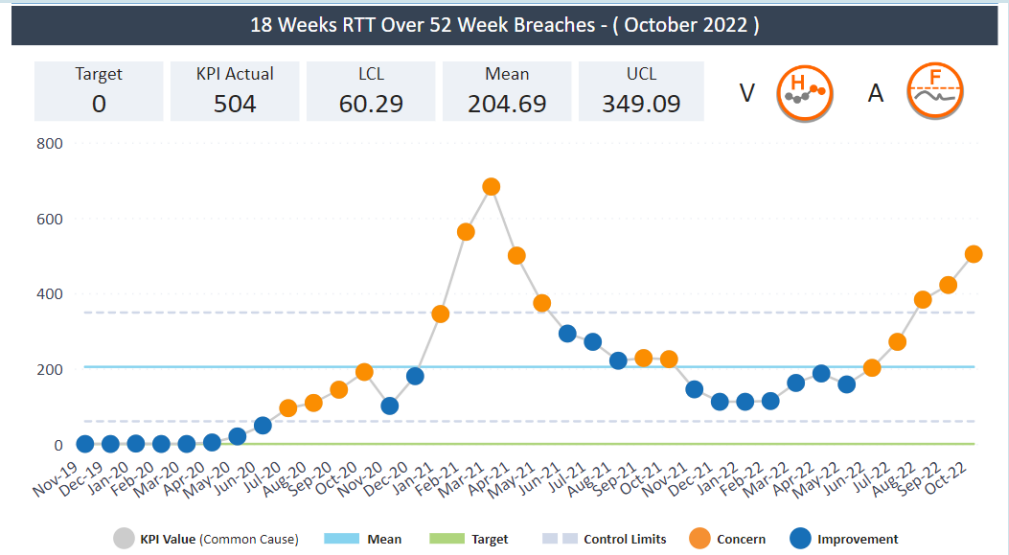
- Inability to sustain PIFU pathway
- Outpatient capacity
- Anaesthetic workforce gaps delay IP RTT performance.
- Demand and capacity mismatch
- Equipment failure
- Diagnostic capacity

Responsive: Elective Insights

Executive Lead: Mandy Woodley–Chief Operating Officer
Operational Lead: Benn Best – Director of Operations Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: 18 Weeks RTT Over 52 Week Breaches



Indicator Background:

The proportion of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for more than 52 weeks from referral.

What the Chart is Telling Us:

The proportion of patients on a Referral to Treatment (RTT) pathway that are currently waiting for treatment for more than 52 weeks from referral.

Actions:

- Continuous validation of patients with long waiting times and harm review process has been established
- Independent Sector capacity (insourcing and outsourcing) used where available to manage waiting times and increase volumes of activity
- Currently developing a new BI dashboard
- Maintain weekly breakthrough Huddles
- Work with primary care/CAS services to support with timely referrals into secondary care.
- Deescalate surgical capacity
- Continued elective capacity and activity monitored through weekly PTLs
- Revised scheduling meetings for Theatres and Outpatients

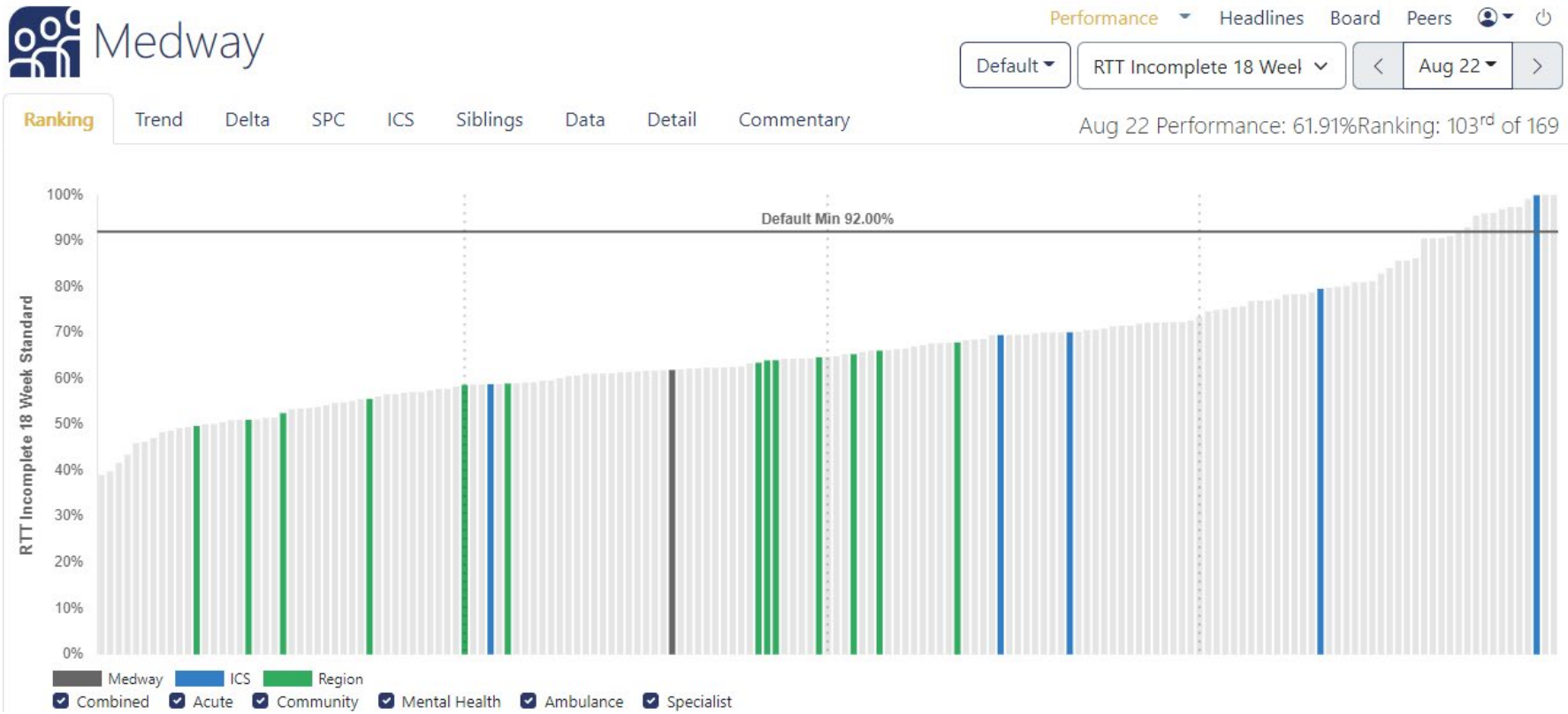
Outcomes:

- Improved data quality and patient experience
- Ensuring that all internal and external capacity is utilised
- Dashboard will allow us clear visibility on patient pathways (by daily timeline
- This will provide a refocus at speciality level through all care groups.
- Reducing future 52 week breaches.
- Improve inpatient RTT waits. Elective capacity and activity monitored with weekly PTL and revised scheduling meetings for Theatres and Outpatients
- Improved ownership and oversight
- Improved utilisation.

Underlying issues and risks:

- Lack of diagnostic capacity may delay diagnosis in high referral.
- Potential impact of Trust Business Continuity on Elective activity.
- Equipment failures.

RTT Benchmarking

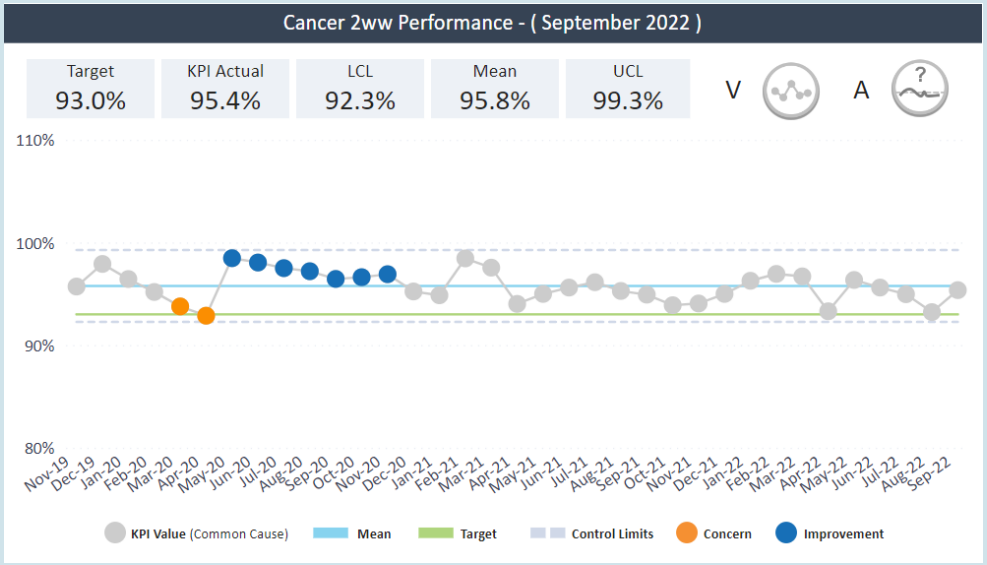


Responsive: Cancer Insights

Executive Lead: Mandy Woodley–Chief Operating Officer
Operational Lead: TBC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 2ww Performance



Indicator Background:

The proportion of patients urgently referred by GPs/GDPs for suspected cancer and who should be seen within 14 days from referral.

What the Chart is Telling Us:

- Few concerns at present - continues to be compliant.
- MFT were ranked 11th in the country for 2 week wait on Public View.

Actions:

- Straight to Test Nurses have been recruited and implemented within UGI.
- Straight To Test referrals are currently under review.
- Undertake diagnostic review to allow a refreshed capacity trajectory.
- The Cancer Service Team are currently recruiting to all posts funded by the Cancer Alliance.
- We are working with BI to provide weekly reports on diagnostic turnaround times.

Outcomes:

- Faster access to diagnosis.
- Patients will have their tests as their first appointments and be reviewed by a clinician with their results.
- Understand demand and capacity gaps in diagnostics.
- New posts will support the time to pathways for non symptomatic patients.
- Ensure booking are within 7 days

Underlying issues and risks:

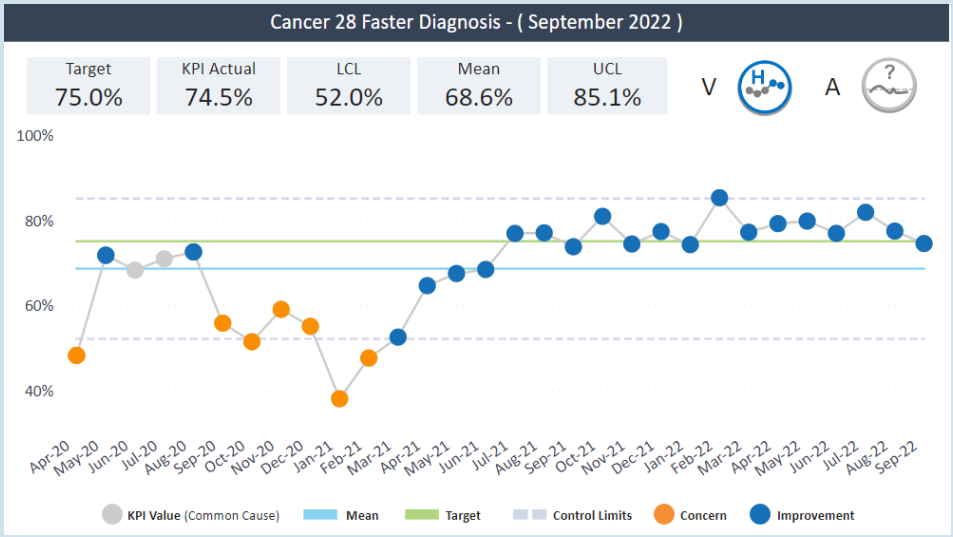
- Demand versus capacity challenges
- Patient choice (patients sometimes choose to delay their appointments)
- Diagnostic capacity is having an impact on booking patients within our internal target of 7 days.
- MRI equipment failures
- Breast unit capacity remains challenged.

Responsive: Cancer Insights

Executive Lead: Mandy Woodley–Chief Operating Officer
Operational Lead: TBC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 28 Faster Diagnosis



Indicator Background:

28 Day Faster Diagnosis Standard The new Faster Diagnosis Standard will ensure that all patients who are referred for the investigation of suspected cancer find out, within 28 days

What the Chart is Telling Us:

- MFT improved in ranking this month to 11th in the country for 28 day for faster diagnosis on Public View.
- The 28 day is now part of the daily validations and PTL's.

Actions:

- The introduction of Cancer Navigators has meant faster tracking of patients. Their roles are to help support Clinicians in ensuring patients are aware of their Cancer diagnosis within 28 days.
- Sustaining improvements with new staff.
- Operational issues monitored through individual Task and Finish Groups and the Cancer Improvement Plan Meeting.
- Breach reports are completed and fully analysed to identify themes and trends.
- Provide full handover to new cancer operational lead
- Daily diagnostic huddles to support faster treatment for cancer referrals is now in place.

Outcomes:

- Improved oversight monitoring
- Improved systems and processes.
- Improved visibility of issues/delays allowing timely mitigation.
- Improved focus on initiatives required.
- Embedding new senior staff.
- Improve diagnostic delays.

Underlying issues and risks:

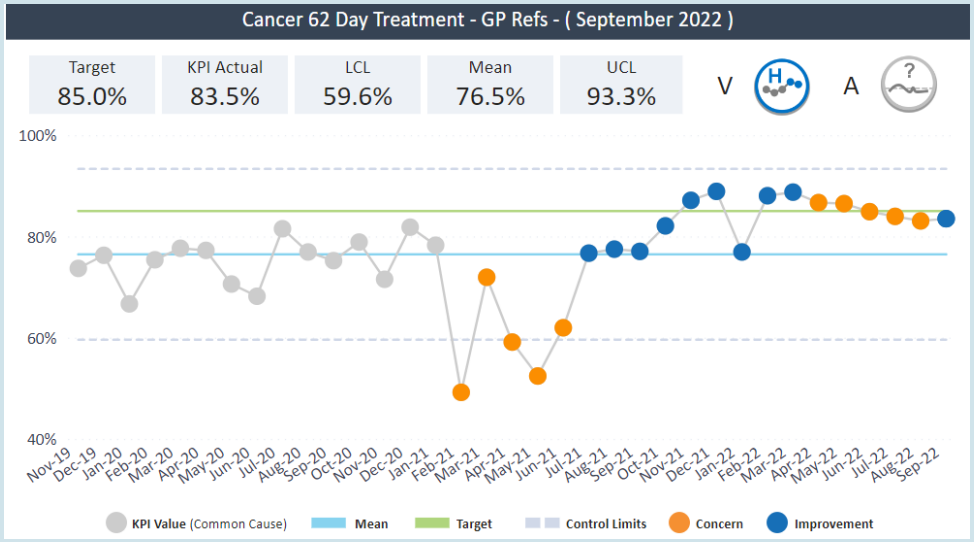
- Diagnostics capacity and reporting turnaround
- Equipment failure
- Impact of vacancy factor
- Retention of fixed term staff funded externally

Responsive: Cancer Insights

Executive Lead: Mandy Woodley–Chief Operating Officer
Operational Lead: TBC
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Cancer 62 Days Treatment – GP Ref



Indicator Background:

MFT achieved compliance against the 62D standard.

What the Chart is Telling Us:

MFT were ranked 11th in the country for 62 day treatment August performance on Public View.

Actions:

- Operational issues monitored through individual Task and Finish Groups and the Cancer Improvement Plan Meeting.
- Tumour Site Specific Improvements being taken through Cancer Board led by the Cancer Specialty Leads.
- Breach reports are completed and fully analysed to identify themes and trends.
- All validation and analysis is overseen by the clinical leads inline with the SOP
- Provide full handover to new cancer operational lead
- Daily diagnostic huddles to support faster treatment for cancer referrals is now in place.

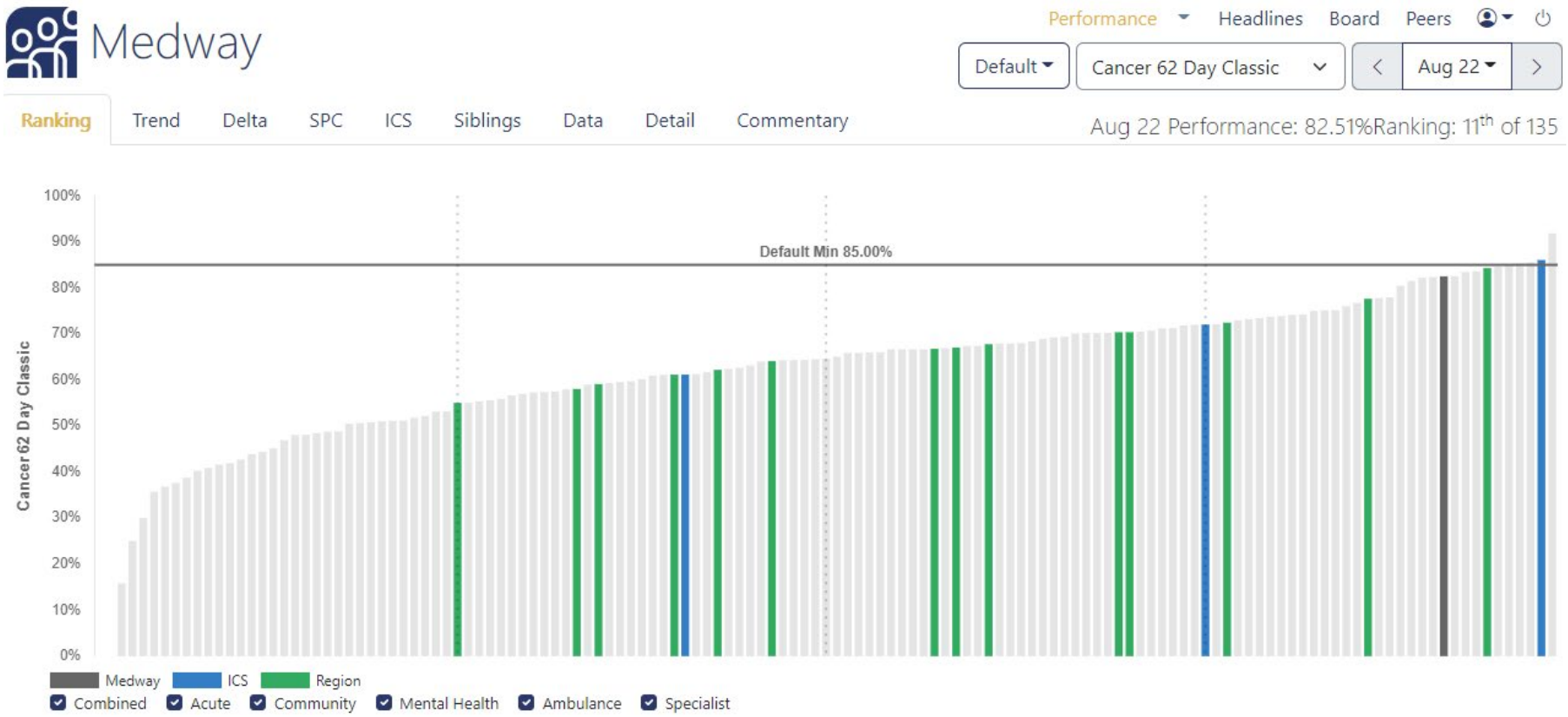
Outcomes:

- Cancer patients at Medway NHS Foundation Trust are receiving some of the fastest access to cancer treatment in the UK.
- The Trust achieved the national standard in three out of four key areas for cancer care.
- Improved diagnostic access for cancer patients

Underlying issues and risks:

- Securing fixed term contracts through the business planning process.
- Unpredictable referral rates
- Risk of equipment failure

Cancer 62day Benchmarking

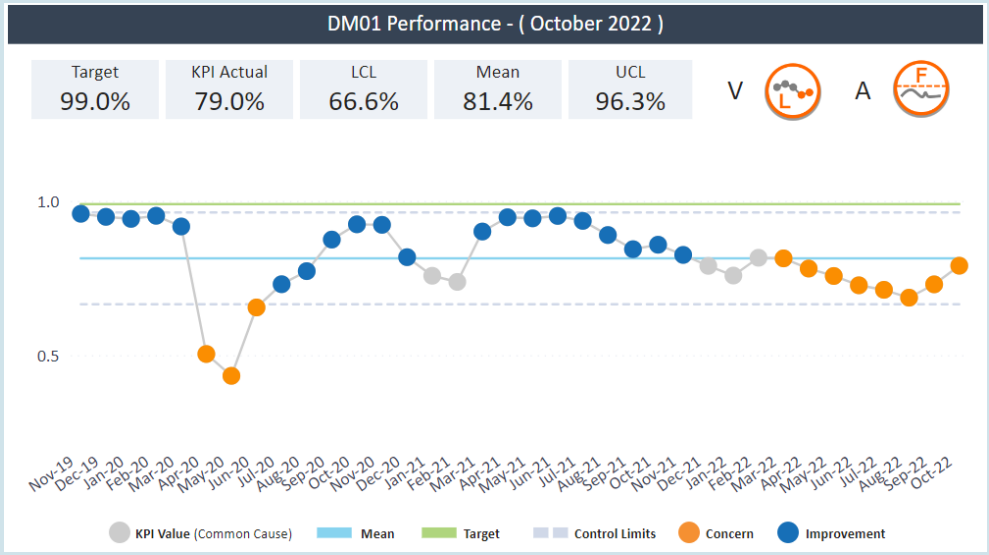


Responsive: Elective Insights

Executive Lead: Mandy Woodley – Chief Operating Officer
Operational Lead: Benn Best – Director of Operations Planned Care
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: DM01 Performance



Indicator Background:

The proportion of patients that are currently waiting for a diagnostic test for less than 6 weeks from referral.

What the Chart is Telling Us:

The SPC data point is showing special cause variation of a low concerning nature. Assurance indicates that the KPI is inconsistently achieving target

Actions:

- Triaging of patients on diagnostic waiting lists (D-code) by clinical team in line with national standard
- Use of Independent Sector for Endoscopy Insourcing (18WS) and Outsourcing (PPG) continues with good utilisation of lists
- Second mobile MRI now onsite and operational
- Insourcing capacity is in place for Sleep Studies
- Echocardiography insourcing operational
- Refreshed trajectory of diagnostic capacity is required.

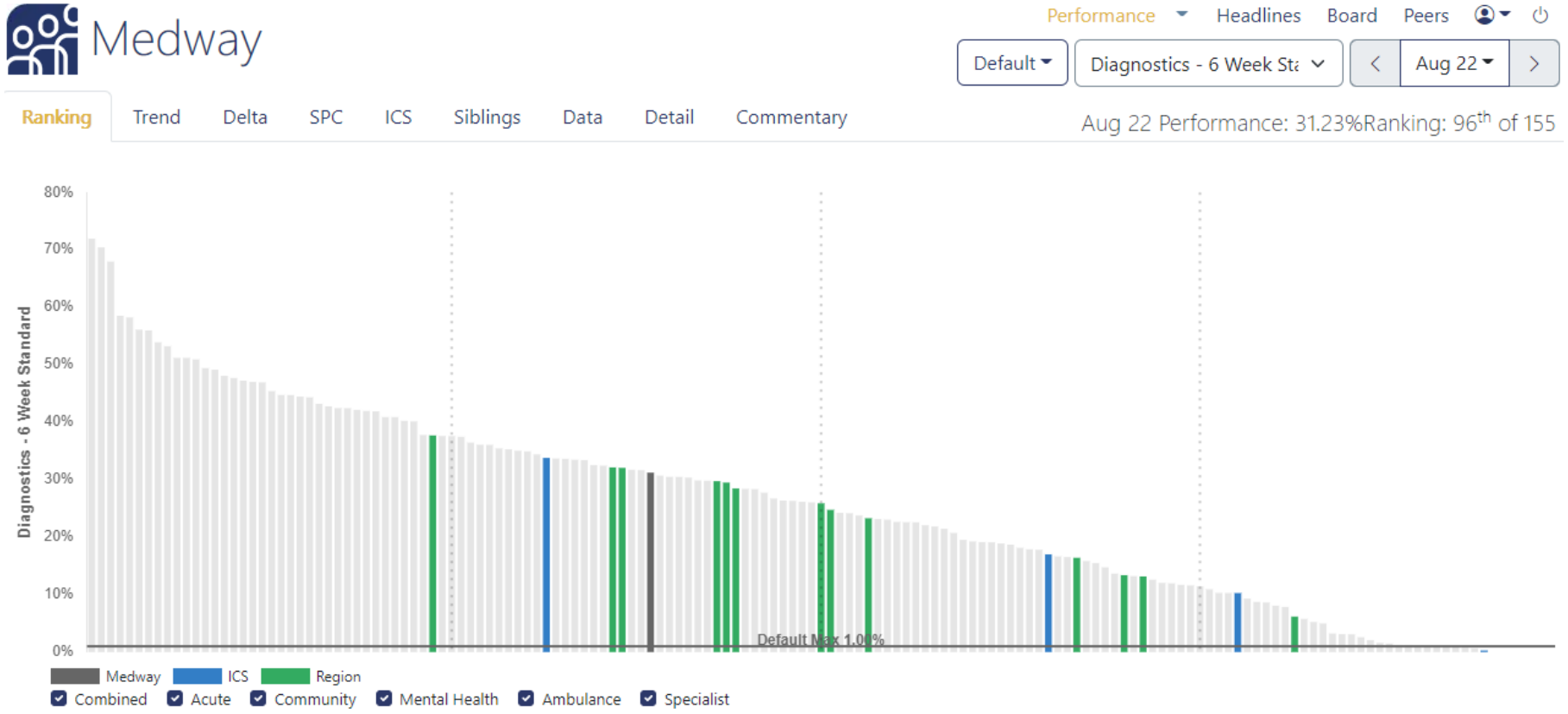
Outcomes:

- Improved triage should improve waits.
- Additional MRI capacity will support the backlog reduction for all specialities
- Insourcing and outsourcing of Endoscopy has now increased capacity.

Underlying issues and risks:

- Equipment failure for diagnostics
- Impact of further COVID wave.
- Winter pressures resulting in increased diagnostics
- Insufficient internal Endoscopy capacity means that outsourcing continues to be required
- Further inpatient MRI capacity required
- National shortage of imaging staff may result lost capacity.

DM01 Benchmarking



Domain: Well Led – Dashboard

Executive Lead: Leon Hinton – Chief People Officer
Operational Lead: N/A
Sub Groups : N/A

NHS Medway NHS Foundation Trust

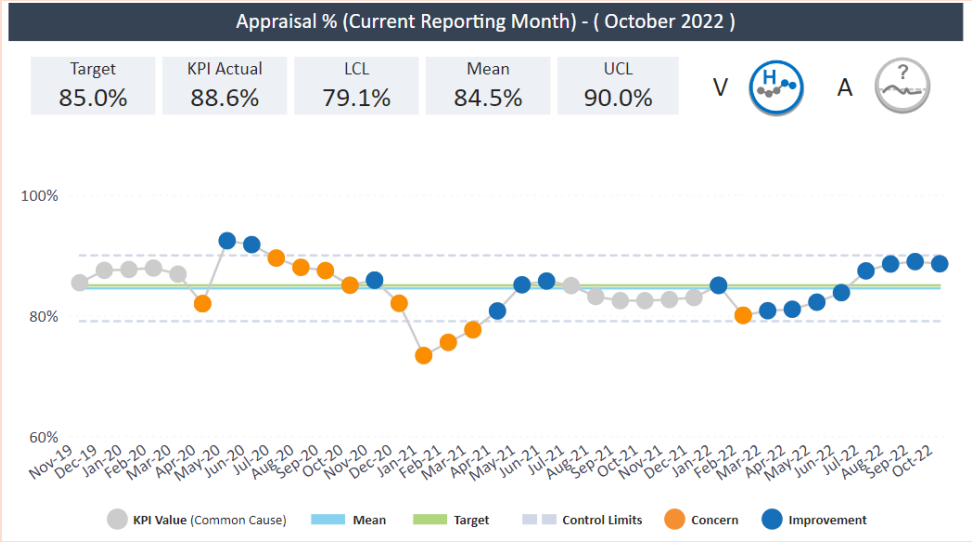
CQC Domain	CQC Sub Domain	Key Performance Indicator	Period	Target	Actual	LCL	Mean	UCL	V	A
Well Led	Workforce	Agency Spend as % Paybill (Current Reporting Month)	Oct-22	4.0%	3.1%	1.2%	3.1%	5.1%		
		Agency Spend as % Paybill (Financial Year YTD)	Oct-22	4.0%	3.3%	2.8%	3.2%	3.6%		
		Appraisal % (Current Reporting Month)	Oct-22	85.0%	88.6%	79.1%	84.5%	90.0%		
		Bank Spend as % Paybill (Current Reporting Month)	Oct-22	9.0%	11.9%	8.0%	13.0%	18.0%		
		Bank Spend as % Paybill (Financial Year YTD)	Oct-22	9.0%	12.7%	11.7%	13.2%	14.7%		
		Contractual Staff in Post (FTE) (Current Reporting Month)	Oct-22		4,516.78	4,078.85	4,204.92	4,330.98		
		Long Term Sickness Rate(Current Reporting Month, FTE%)	Oct-22	2.5%	0.0%	1.3%	2.1%	3.0%		
		Short Term Sickness Rate (Current Reporting Month, FTE%)	Oct-22	1.5%	0.0%	1.3%	2.2%	3.2%		
		Sickness Rate (Current Reporting Month, FTE%)	Oct-22	4.0%	0.0%	2.9%	4.3%	5.8%		
		StatMan Compliance (Current Reporting Month)	Oct-22	85.0%	86.1%	86.5%	88.8%	91.2%		
		Temp Staffing Fill Rate – Nurse & Midwifery (Current Reporting Month)	Oct-22	75.0%	56.5%	50.4%	62.0%	73.7%		
		Voluntary Turnover Rate – (Current Reporting Month) (FTE Not Headcount) (exc. Junior Drs)	Oct-22	12.0%	13.2%	11.5%	13.3%	15.1%		

Well Led: Workforce - Insights

Executive Lead: Leon Hinton – Chief People Officer
Operational Lead: James Kendall
Sub Groups : N/A

NHS Medway NHS Foundation Trust

Indicator: Appraisal % (Current Reporting Month)



Indicator Background:

The percentage of staff who have had an appraisal in the last 12-months compared to the total number of staff.

What the Chart is Telling Us:

Special cause of improving nature or lower pressure due to (H)igher or (L)ower Values

Variation indicates inconsistently hitting passing and falling short of the target

Actions:

- Identified as a breakthrough objective under Patient First.
- Weekly reporting in place with automated reminders in place;
- Weekly and monthly progress to form actions with
- care group leaders in place;
- Matrons, senior sisters and line managers required to build appraisal trajectory to correct current position (recovery plans);
- Appraisal workshops provided with good uptake;
- Pay progression policy linked to appraisal completion in place
- HR Business Partners continue to work with their respective Divisions to produce improvement plans

Outcomes:

3859 members of staff have an in-date appraisal
with objectives and personal development plan
outlined (from a total of 4357).

Underlying issues and risks:

- Continued COVID-19 disruption is likely to continue to negatively affect appraisal completion for clinical areas.
- Recent increase in sickness levels across the Trust has had a negative impact on compliance
- Failure to appraise staff timely reduces the opportunity to identify skills requirement for development, succession planning and talent management. Low appraisal rate are linked to high turnover of staff, low staff engagement and low team-working. Appraisal is also an indicator to ensure health and wellbeing conversations are occurring between staff and their line manager, low compliance gives little assurance that such conversations are occurring regularly.

Domain: Well Led - Financial Position

Executive Lead: Alan Davies – Chief Financial Officer
Operational Lead: Paul Kimber – Deputy Chief Financial Officer
Sub Groups : Finance Committee

NHS Medway NHS Foundation Trust

Indicator: Financial Position

Income & Expenditure £k	In-month Baseline budget	In-month Actual	In-month Variance	YTD Baseline budget	YTD Actual	YTD Variance
Income	32,226	32,640	415	225,584	230,089	4,505
Pay	(20,460)	(22,743)	(2,283)	(145,652)	(150,453)	(4,801)
Total non-pay	(9,999)	(11,195)	(1,196)	(67,955)	(74,145)	(6,191)
Non-operating expense	(1,873)	(1,745)	128	(13,123)	(13,017)	106
Reported surplus/(deficit)	**(106)**	**(3,042)**	**(2,936)**	**(1,146)**	**(7,527)**	**(6,381)**
Donated Asset / DHSC Stock Adj.	13	(83)	(96)	93	(8)	(102)
Control total	**(93)**	**(3,125)**	**(3,032)**	**(1,053)**	**(7,535)**	**(6,481)**

Other financial stability work streams £k	In-month Plan	In-month Actual	In-month Variance	YTD Plan	YTD Actual	YTD Variance	Annual Plan
Cost Improvement Programme	904	590	(315)	5,080	3,873	(1,207)	10,484
Capital	(1,078)	(704)	374	(5,125)	(4,019)	1,106	(11,550)

Indicator Background:

The Trust reports a £3,042k deficit position for October; after removing adjustments for donated assets this increases to £3,125k, which is £3,032 adverse to plan.

What the Chart is Telling Us:

The Trust has delivered a £7.5m deficit year to date (YTD), this is £6.5m adverse to the submitted plan. The efficiency programme delivered £590k in month, this being £315k adverse to the £904k plan and £1,207k adverse to the £5,080k plan YTD. The capital programme is reporting £1,106k behind plan due to timing of the schemes.

Actions:

Financial performance is measured against the resubmitted plan to NHSE/I in June for 22/23, which is a planned breakeven position for the year. The plan contains a high level of risk including a £10.5m efficiency programme as well as £8m of non-recurrent mitigations. The Executive Team has agreed Executive Leads and actions which are addressing each of the key financial risks, including divisional overspendings and efficiencies.

Outcomes:

The Trust is reporting a £3.0m adverse position to plan in month and £6.5m YTD.

- This reported position would have been worse had it not been for the non-recurrent benefit of £8.5m from accruals reversals YTD, this being an increase of £0.5m from month 6.
- Across the divisions there was an adverse movement in run rate of £0.5m, mainly due to escalation capacity, use of temp medical staff, clinical supplies & drugs.

Underlying issues and risks:

The current plan is a breakeven position for the year and includes the risk of delivering £8m of mitigations and the £9.6m efficiency programme, there is a further stretch target of £0.9m to add in the 2nd half of the financial year, to date £9.4m of schemes have been identified, £0.2m below the original target and £1.2m behind the stretch target. In month a further £0.5m of non-recurrent mitigations have been released into the position. The Trust is working with the ICB to agree a forecast outturn position for the whole K&M system.

Medway Foundation Trust

Winter Plan and Approach

Medway and Swale
Health and Care Partnership

Version 0.1

MFT Summary

Approach to planning for 2022/2023

- This year we have looked at the approach to the system planning and have decided not to repeat the process of addressing winter planning as we have done in previous years.
- In the first instance we have viewed this exercise as a review of all year-round planning, rather than specifically for winter alone.
- We have determined not to write documents that are aspirational and in the main confirm that previously we have neither worked to the plan, or looked at the plan
- We have approached the exercise in the art of the possible, with focus on system partners working closer together and both partners and individuals understanding their actions, triggers and escalation points
- There are multiple programmes that are ongoing across the system that are going to deliver change to the system, the key to this success is the delivery of the change and the exploitation of the wins that these changes will bring.
- Many of these changes will be driven through either the **HARIS** programme or work that will feed into the 4 **UEC** workstreams that feed into **LAEDB**

MFT Summary continued…

- Demand & Capacity modelling for the winter months 2022/2023 has been supplied and constantly reviewed. Although a plan for all seasons, this information is included in this document, along with supporting, anecdotal system data, that has been supplied by system partners where possible and available.
- This inclusion will give a better understanding and view for the system pressures and will lead to a system wide D&C exercise taking place in the following years
- Acute bed modelling assumes MFFD remains at current levels, however this opportunity is variable and is subject to the ability to enable discharges due to the workforce/care market capacity.
- Bed modelling has been based on maintaining 92% bed occupancy within the MFT
- The actions within this plan have been structured into main sections providing the overview of the system partner actions from within the Medway and Swale Place system.
- The triggers and actions in this document have been:
    - Reviewed
    - Updated/amended/deleted – where appropriate
    - Cross referenced to ensure that specific actions by partners correlate with actions other partners are taking
    - Sanitised, where appropriate
    - OPERL 4 actions moved to the left (into OPEL 3 actions) where appropriate

Medway and Swale
Health and Care Partnership

MFT Summary continued…

Schemes, plans and programmes of work

- We are currently delivering, or plan to deliver the following programmes of work across the system to unlock the demands that we are facing. Some of these are in progress, whilst others have been delivered and are in an embedding phase:
  - **HARIS*** (Hospital Ambulance Reception Improvement System)
    - Frailty — Minster Ward to open the in December 2022
    - Virtual Ward — To start delivering December 2022
    - Acute Medical Model — Phase 1 went live on the 2nd November
    - **LAEDB** Workstreams
      - Front Door — Workstreams updated end of November
      - Out of Hospital — Strategic workshops underway
      - Local (Primary) Care — Programme/project plans being developed
      - Discharge — 10 point discharge process being implemented
  - D2A funding proposals — Pathway mapping underway
  - Demand and capacity funding — £1.2M secured for Minster Ward
  - **Mental Heath** — Solutions being worked up

* **HARIS** will expand to multiple workstreams in light of the At_ED report following the National Team audit that concluded at the end of October. The National team completed an extensive audit at the end of Apil that has shaped the **HARIS** programme of work and deliverables

Medway and Swale
Health and Care Partnership

Risks and Mitigations

Workforce

- all system partners have reported current workforce challenges and there is a risk that this will continue and/or be exacerbated all year round.
- Recruitment of staff needs to be made across the system and 'over recruitment' needs to be considered.

Care providers

- Currently there are significant capacity issues with community agencies to provide new packages of care due to their workforce issues.
- Hand backs of care packages are increasing.
- Lack of bed vacancies in Nursing/Residential Care Homes in Medway which is causing a significant challenge in place people from the both the community and hospital discharge aspect.

Ambulance Handovers

- Increased pressures in ED some of which are due to poor flow through the hospital is resulting in no space to accept ambulance cases. 30 minute and 60-minute handover breaches are increasing in number

Hospital discharge and flow

- New D2A challenges
- New pathways
- Increased scope and responsibility of the IDT and in continued and improved use of the Inpatient PTL across the Acute and the implementation of the Community PTL

Elective programme delivery

- in the event of significant pressure there is a risk that elective delivery will be compromised although there are plans to increase the elective bed base and suspending elective surgery is a decision made in extremis

Mental Health

- demand and capacity for both Adults and Children's and Adolescent Mental Health (CAMHs) services remains high

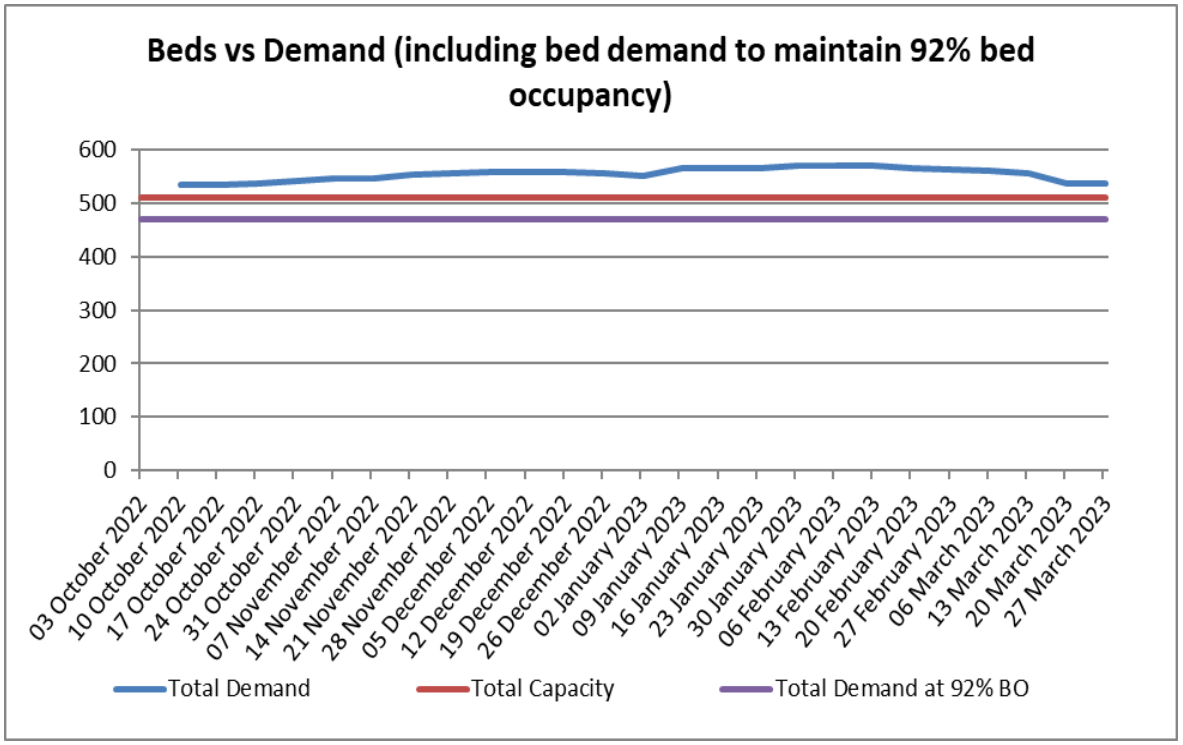
All mitigations will be identified by respective system partners and will be monitored by system leaders at scheduled system calls and the SORG meetings.

Objectives and KPIs

Key Performance Indicators

- The resilience of the system throughout the year will be monitored against key indicators of pressure, flow and performance in line with NHSE/I directed metrics.
- A comprehensive interactive performance Dashboard has been developed which includes the metrics agreed by system partners to measure both pressures and improvements across the system.
- The performance KPIs included focus on:
  - Standard ED measures
  - Ambulance standards and handover timings
  - UTC – type 3 measures
  - Mental Health Urgent Care measures – including crisis
  - Admission avoidance interventions
  - Readmission and Length of Stay
- Reporting on exceptions to recover performance will be required 7/7 and will be monitored accordingly
- The OPEL framework remains in place and has been refreshed to align with the updated national OPEL framework.
- The OPEL actions, trigger points and escalations have been thoroughly reviewed and crossed reference for all system partners this year
- System data has been collected for the first time in this planning exercise and reflects the approach to be taken and widens the understanding of the performance of the system as a whole for the first time
- The framework will be used to manage system response to surge in pressure via established place-based system calls and through monitoring SHREWD.
- **SHREWD Action** will be implemented and used to manage escalation and actions across the system

Acute Demand and Capacity Model – Overview (1)



- Surgery require 16 additional beds to deliver protected elective program to plan whilst maintaining no outliers and protected SAU otherwise gap is up to 30
- Medicine bed modelling suggests 356 beds required plus 25 assessment trolleys and at least 40 of the 356 being dedicated short stay split across frailty and acute medicine/ specialist medicine
- Increasing the assessment capacity in medicine could reduce the demand by at least 16 day and up to 23 a day and with a functional short stay of 48hrs demand could further be reduced by 4 a day
- Same day emergency care pathways and hot clinics could also support the reduction in demand and modelling against other trusts suggests at least 8 beds a day.
- Overall demand could be reduced by 31 beds a day

Medway and Swale
Health and Care Partnership

Winter demand vs capacity

Medway Foundation Trust Bed Capacity current

Bed Modelling	2022/2023																										
	03 October 2022	10 October 2022	17 October 2022	24 October 2022	31 October 2022	07 November 2022	14 November 2022	21 November 2022	28 November 2022	05 December 2022	12 December 2022	19 December 2022	26 December 2022	02 January 2023	09 January 2023	16 January 2023	23 January 2023	30 January 2023	06 February 2023	13 February 2023	20 February 2023	27 February 2023	06 March 2023	13 March 2023	20 March 2023	27 March 2023
Total Capacity																											
Planned Care (inc T&O and Paeds)	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125	125
Urgent Care	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283	283
Cancer & Haem	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19
Critical Care (inc CCU/ HDU)	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24	24
Escalation	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59
Total	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510	510
Assessment Capacity Surgery	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
Assessment Capacity Medicine (EAU)	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12

Medway and Swale
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Winter demand vs capacity

Bed Demand - NEL

	03 October 2022	10 October 2022	17 October 2022	24 October 2022	31 October 2022	07 November 2022	14 November 2022	21 November 2022	28 November 2022	05 December 2022	12 December 2022	19 December 2022	26 December 2022	02 January 2023	09 January 2023	16 January 2023	23 January 2023	30 January 2023	06 February 2023	13 February 2023	20 February 2023	27 February 2023	06 March 2023	13 March 2023	20 March 2023	27 March 2023
NEL DEMAND																										
Planned Care (inc T&O) demand	119	119	119	119	121	121	121	124	124	126	126	128	128	126	126	123	123	121	121	119	119	122	125	129	131	119
Urgent Care demand	339	339	342	347	347	347	355	355	355	351	351	347	342	351	352	352	354	355	355	355	351	351	347	329	329	329
Cancer & Haem	15	15	15	15	15	15	15	15	17	17	17	17	17	17	17	17	17	17	17	17	17	15	15	15	15	15
Critical Care (inc CCU/ HDU)	19	19	19	19	21	21	21	21	21	23	23	23	23	24	24	24	24	24	24	24	24	23	23	23	23	23
Total	492	492	495	500	504	504	512	515	517	517	517	515	510	518	519	516	518	517	517	515	511	511	510	496	498	486

Bed Demand EL

Bed Modelling	2022/2023																									
	03 October 2022	10 October 2022	17 October 2022	24 October 2022	31 October 2022	07 November 2022	14 November 2022	21 November 2022	28 November 2022	05 December 2022	12 December 2022	19 December 2022	26 December 2022	02 January 2023	09 January 2023	16 January 2023	23 January 2023	30 January 2023	06 February 2023	13 February 2023	20 February 2023	27 February 2023	06 March 2023	13 March 2023	20 March 2023	27 March 2023
EL DEMAND OVERNIGHT																										
Planned Care (inc T&O) in order to deliver plan	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26	26
Urgent Care	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
Cancer & Haem	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Critical Care (inc CCU/ HDU)	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
Total	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32	32

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Activity forecast

Activity modelling	2022/2023																										
	03 October 2022	10 October 2022	17 October 2022	24 October 2022	31 October 2022	07 November 2022	14 November 2022	21 November 2022	28 November 2022	05 December 2022	12 December 2022	19 December 2022	26 December 2022	02 January 2023	09 January 2023	16 January 2023	23 January 2023	30 January 2023	06 February 2023	13 February 2023	20 February 2023	27 February 2023	06 March 2023	13 March 2023	20 March 2023	27 March 2023
FLOW																											
Attendances	216	218	219	218	224	231	240	272	281	238	252	204	233	235	223	258	272	266	264	242	255	257	292	299	290	271
Ambulance Attendances	116	117	119	114	107	113	114	111	107	100	103	112	110	99	108	104	106	109	104	103	102	112	106	97	101	102
Admissions	75	76	71	66	72	71	68	64	59	66	59	62	72	68	64	69	70	66	67	71	75	74	75	72	75	70
Discharges	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85	85

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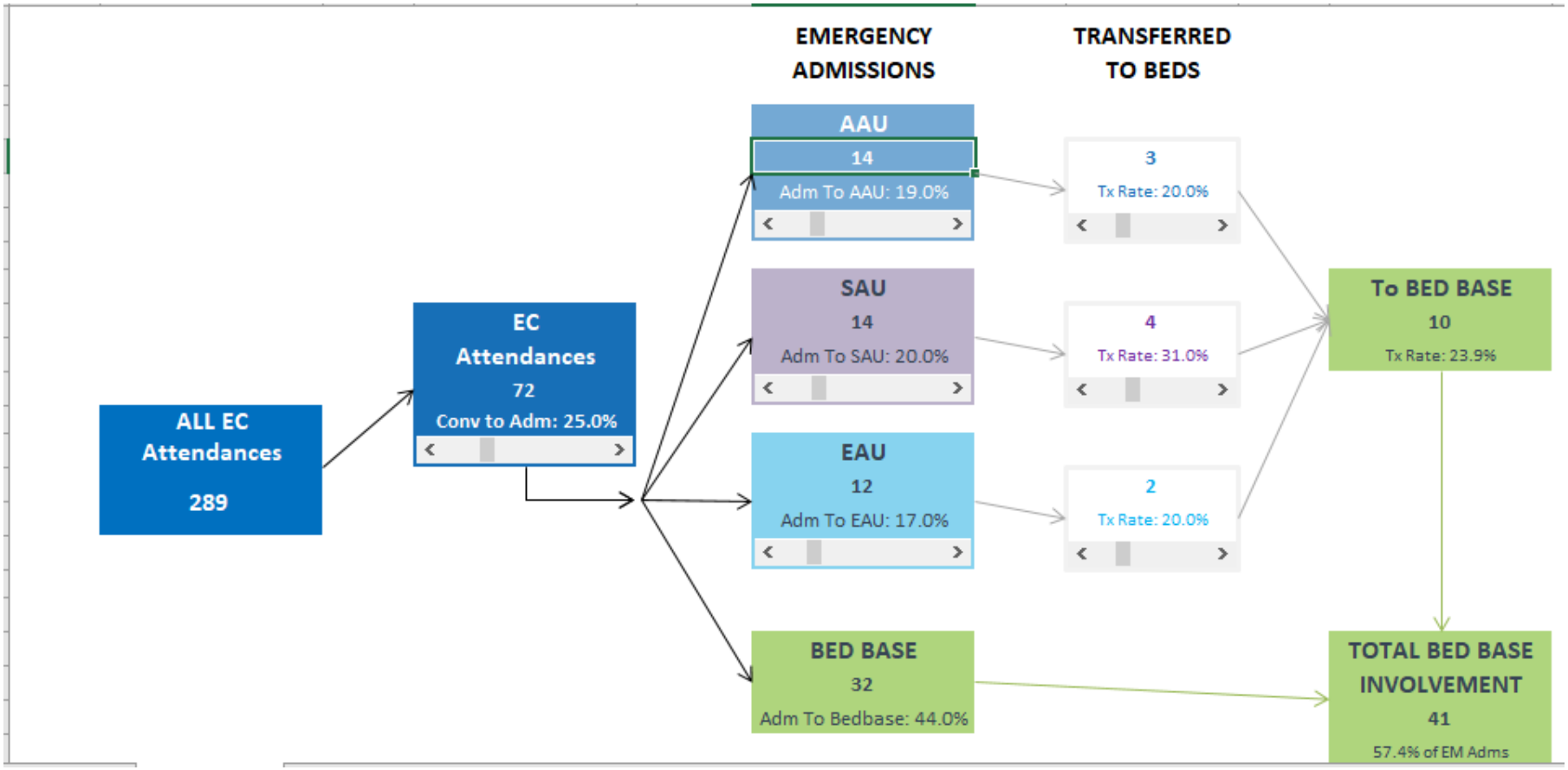
Assessment modelling



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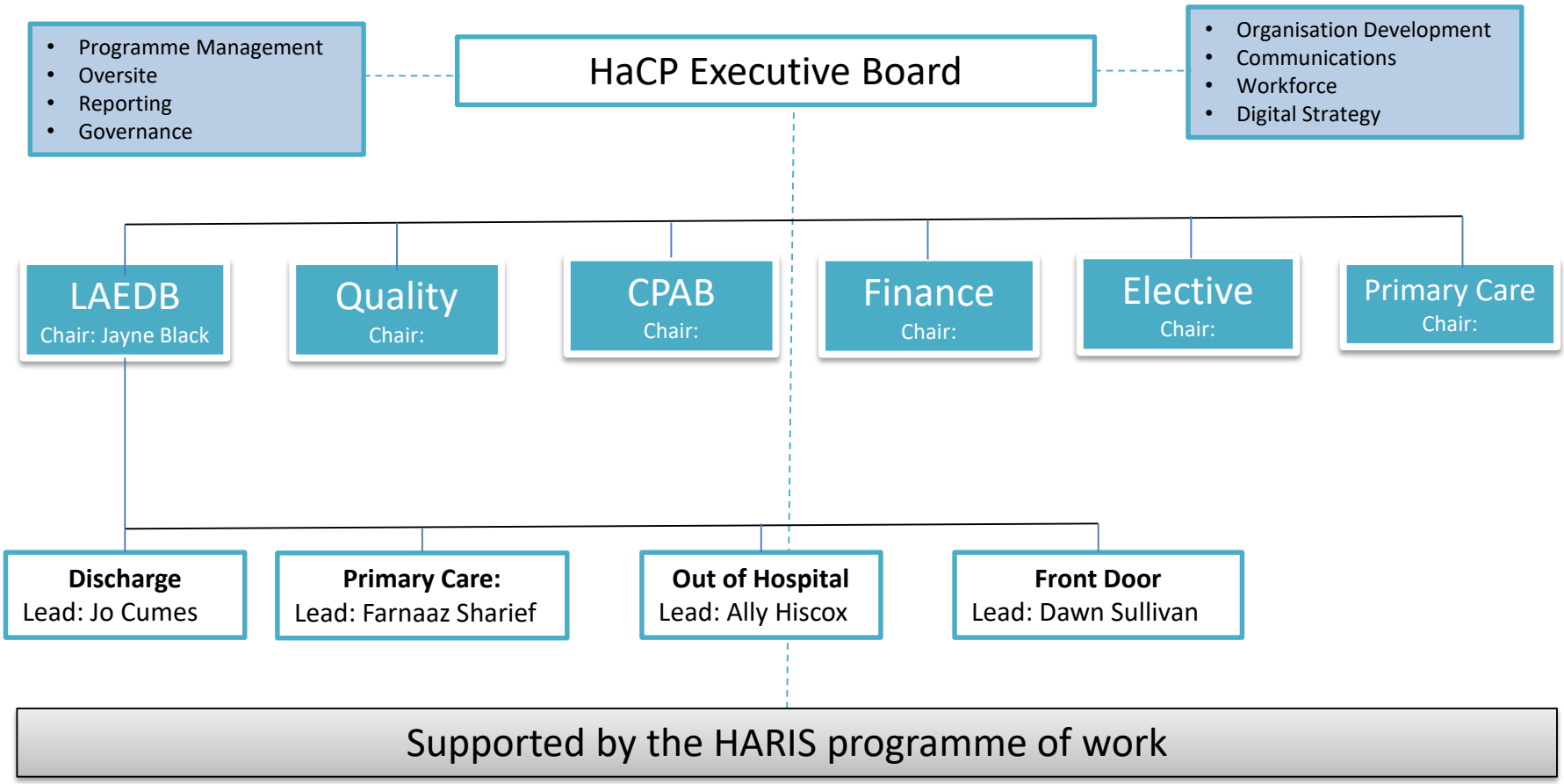
Governance Flow



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LAEDB Workstream Structure

Workstreams Programme of work

1 - Front Door: Dawn Sullivan

- Admissions Avoidance
- High Intensity User Service (use of MedOcc)
- Acute Pathway – Senior decision making at front door
- Streaming to Acute Assessment Areas/SDEC/UTC
- Ambulance Handovers – HARIS
- Acute Frailty Pathway
- HARIS Programme

2 - Discharge: Jo Cumes

- Improving Discharge programme
  - Increase capacity of the discharge lounge to free up beds earlier in the day
  - Maximise discharge – using and refining Trust and community SOP's
  - Implement the new IDT Hub Model Phases I/II/III (Wider Hub model agreement)
  - Use of Inpatient PTL
  - MFFD SOP

3 - Out of Hospital: Ally Hiscox

- Community Urgent Hub
- Mental Heath Service – Increased capacity
- Crisis Response Teams
- Prison Health conveyances
- Establish additional community capacity to support earlier discharge

4 - Primary Care: Farnaaz Sharief

- UTC
- MedOCC
- Improved Access

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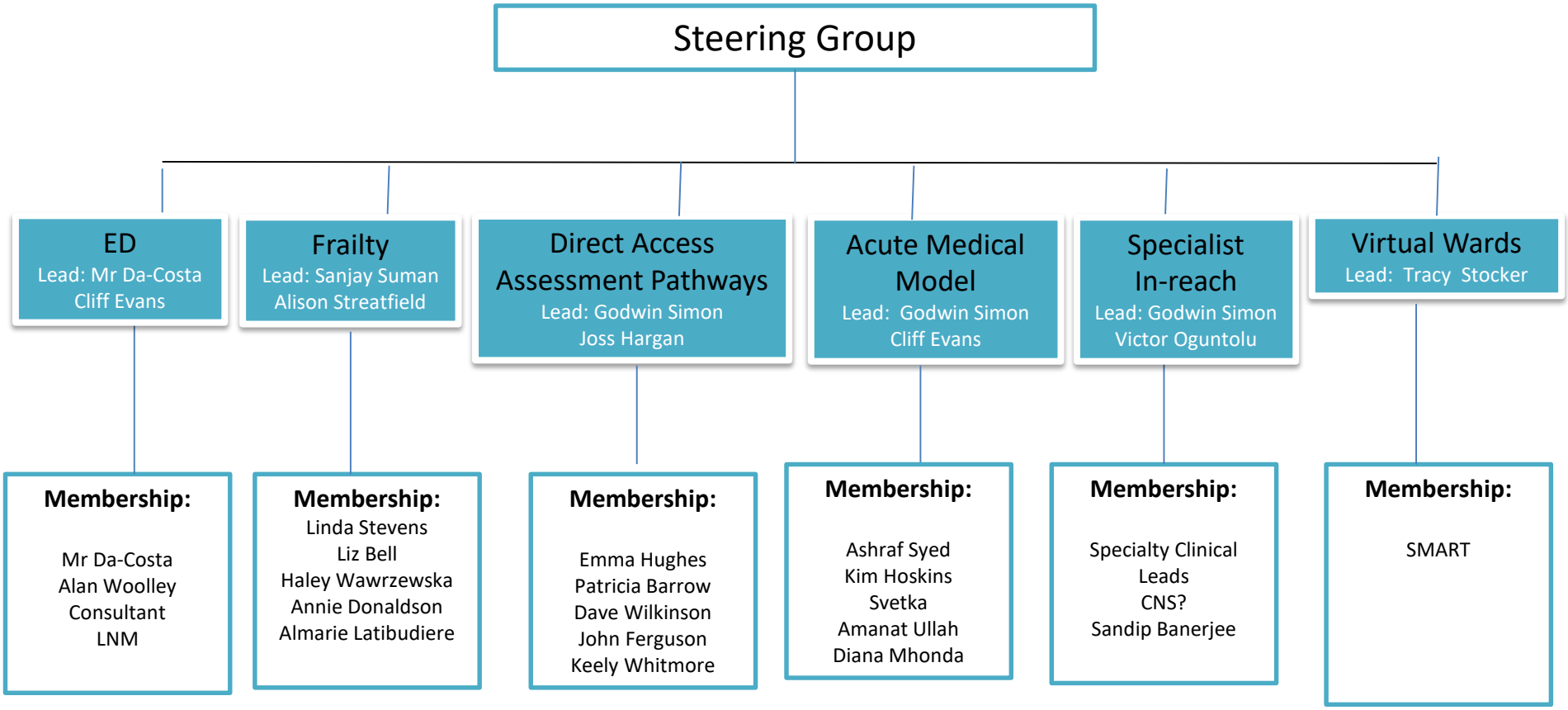
HARIS Governance



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HARIS Workstream Structure

Workstream 1: ED

- Senior clinical decision making at the front door – medical and nursing – e.g. ED new model, RAT
- Front door streaming to alternative services (internally and externally)
- Streaming from SeCamb straight to assessment areas – reduction in ED first
- Streaming to community hub
- Direct access for advice for ambulance and community staff
- Patient communication campaign
- Live view of current and expected demand
- Clinical validation of ED dispositions

Workstream 2: Frailty

- Direct access
- Admissions
- Virtual model for Frailty, Respiratory, cardiology, Gastro
- Development of 'diagnostic' model – utilising internal and external diagnostic capacity and safety net of hot clinics/video consultations
- Frailty – Hospital at home

Workstream 3: Assessment and Pathways

- Assessment Units
- Alternative pathways direct access model
- SDEC – AAU
- MedOCC
- Video consultation and prehospital/conveyancing conversation
- Direct access to alternative pathways (SAU/GAU/EPAC/PAU/ENT/Urology)

Workstream 4: Virtual Ward

- Diagnostics
  - Respiratory
  - Cardiology
  - Virtual model for Frailty, Respiratory, cardiology, Gastro
- Expansion of 'virtual wards'
  - Frailty – Hospital at home
  - General Medicine (COPD, heart failure)
  - End of life care

Workstream 5&6: Acute Medical Model

- Hyperacute Assessment Area
- Lister Assessment Unit
- Acute Medical Ambulatory Centre
- Enhanced Care Facility
- Specialist in-reach services become intrinsic component of Acute Medical Model

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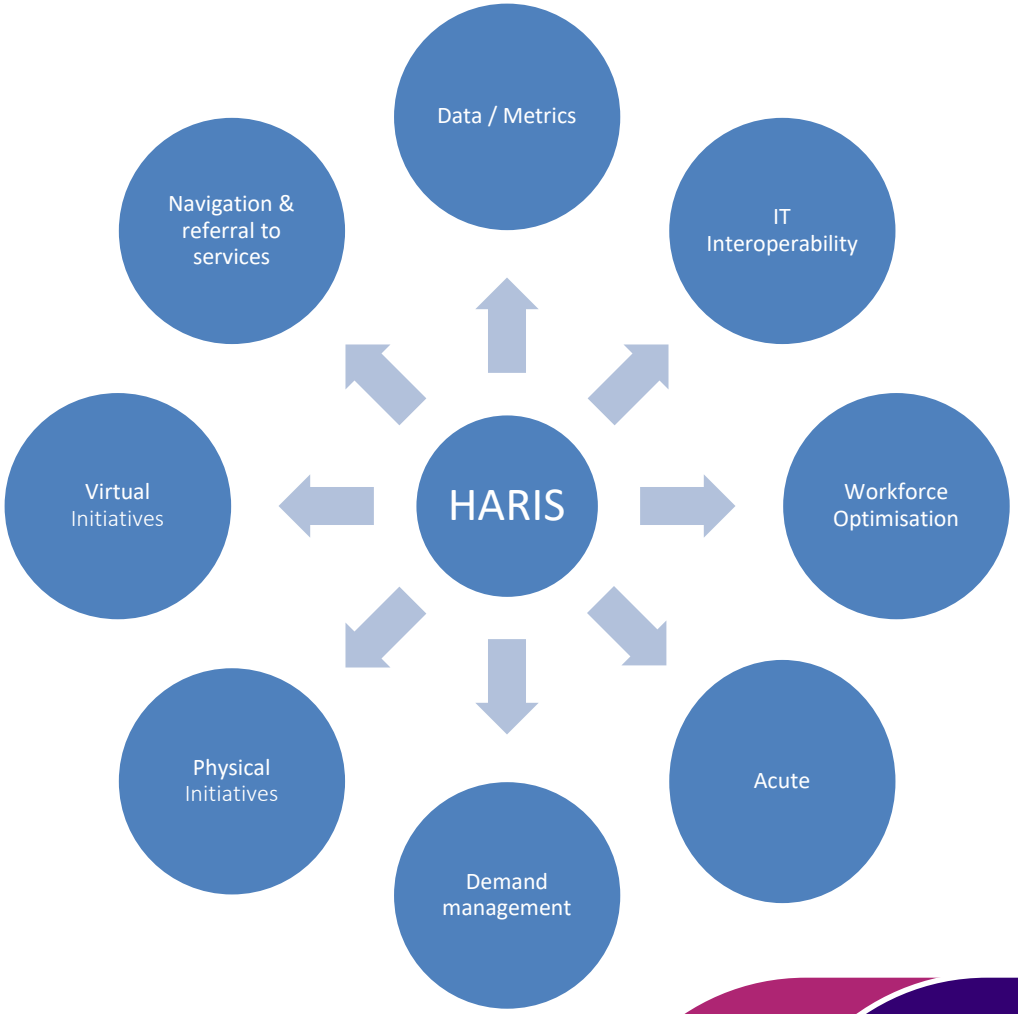
HARIS Initiatives



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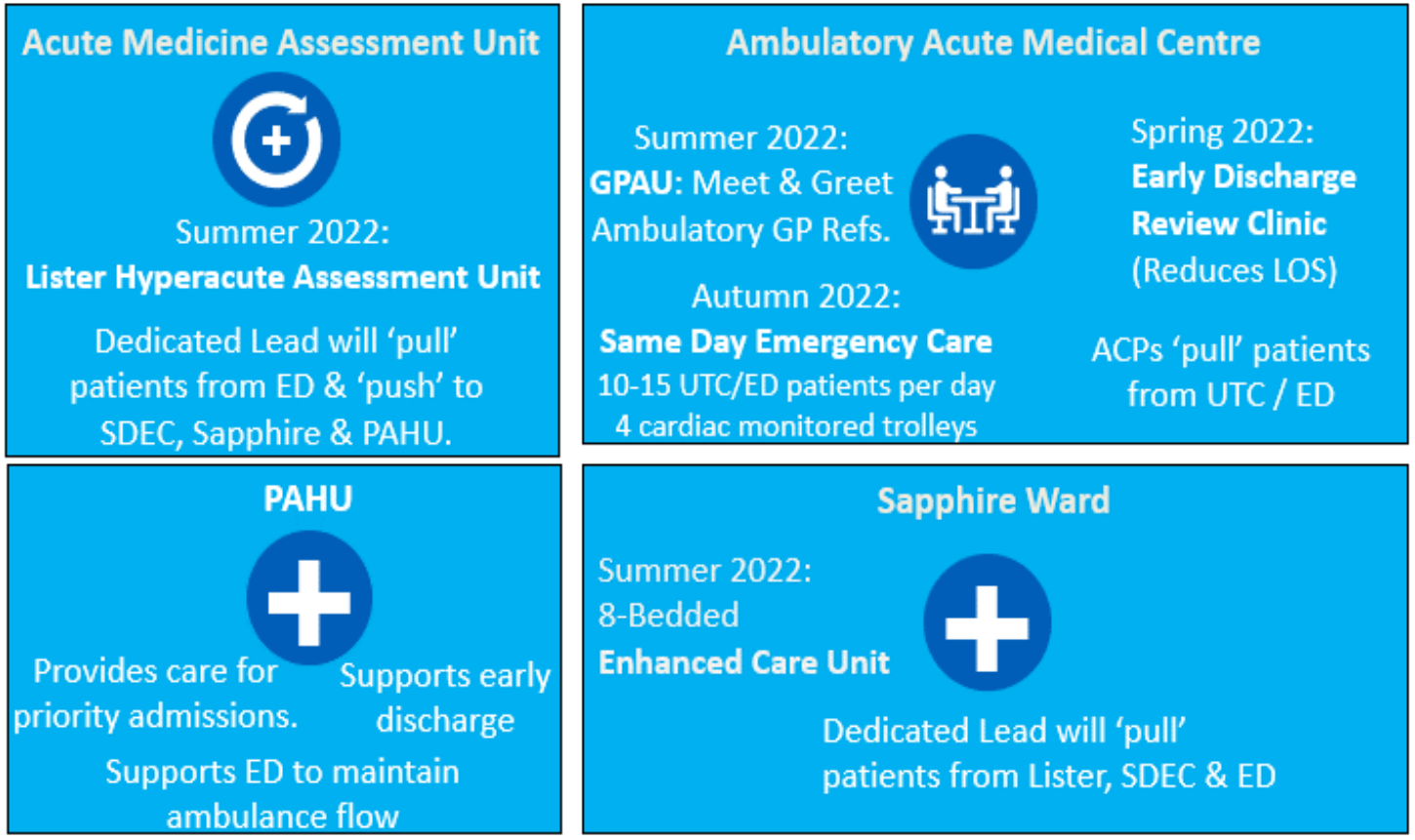
HARIS – Acute Medical Model

Acute Medical Model Schematic



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HARIS – Acute Medical Model continued…1

Enhanced Level Care Unit (ECU)

- The primary purpose of the ECU is to provide high quality medical and nursing care to acutely unwell patients who require enhanced level of observation and monitoring that cannot be provided on a general ward (Faculty of Intensive Care Medicine 2020)
- The Aims of the Unit are as follows:
    - To enable closer monitoring and management of acutely unwell patients admitted via A&E and the Acute Assessment Unit (AAU).
    - To improve the outcomes of patients who experience acute, reversible, physiological deterioration while in hospital on any medical ward
    - The ECU is not to be used as a general bed pool for non-acutely unwell inpatients.
    - The ECU is only to be used for patients under the management of the acute medical teams.
    - Staffing levels are to be maintained so as to allow unplanned admissions and transfers 24 hours a day/7 days a week, at a level consistent with the hospital's level of emergency activity.
- **PAHU & SDEC**
    - Enhancements being introduced as part of the delivery of the new acute medical model

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HARIS – Acute Medical Model continued…2

Hot Clinics

Referrals in EPR

- The electronic hot clinic referral form has been developed, trialled and demo'ed in EPR. Tweaks have taken/are taking place and bearing no major changes in requirement the form will go live in the third quarter of the year.

In Reach Referrals

- Symphony is end of life (August), so electronic in reach referral form will not be developed on this platform. It will be developed in EPR (EPR and ED EPR retrospectively). In the meantime, the tactical solution is to build in reach options into the hot clinic referral form. This will be scoped next week, commencing 13th June, with focus on the process that will sit behind this proposed solution.

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HARIS – Frailty Programme - Minster

To put more capacity in the system Harvey Ward (Harvey ward is a 25 bedded Frailty ward with an admission criteria in line with the Frailty bed base of CFS score of >6) in Medway community hospital will be lifted and moved to Sheppey Community Hospital, becoming Minster Ward.

- Minster Ward, on Sheppey (Community hospital) be a 22 bedded ward.
- The current plan is for Harvey Ward to be handed over to planned care operating 18 elective beds.

- This a sub-acute frailty model that has been taken and developed from the Brentwood Community Hospital 'Programme 70' clinical model
- Minster Frailty unit will offer a valuable service for the local frail population to be managed closer to home if they need a hospital-based treatment.
    - As the service matures, in time, we would also offer a Rapid Access Clinic for Elderly (RACE), this would provide a consultant led assessment in a timely manner with a view to hospital admission avoidance.
- Other benefits of establishing these services include:
    - Residents of Sheppey priority but would extend to Medway residents if there were not enough Swale patients
    - Better integration with community services
    - Offering opportunities for training
    - Education
    - Career progression for staff working in this unit.

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HARIS – Frailty Programme - Minster

- The plan will include Harvey being handed to surgical for an elective ward
- This would allow for the removal of overnight electives in the day surgery unit (Sunderland) meaning the 8 ring fenced beds could be used by the day surgery theatres, resulting in an additional 14 patients a day if the beds were used twice a day with LOS of at 6hrs and allowing for at least 2 slightly longer stay
- This would increase the monthly day cases completed by a minimum of 224 and from around 75% to 87% in terms of 2019 activity (this could be slightly increased with additional anaesthetic and theatre support resourcing)
- This could also provide bed space for an additional 20 elective inpatients a month

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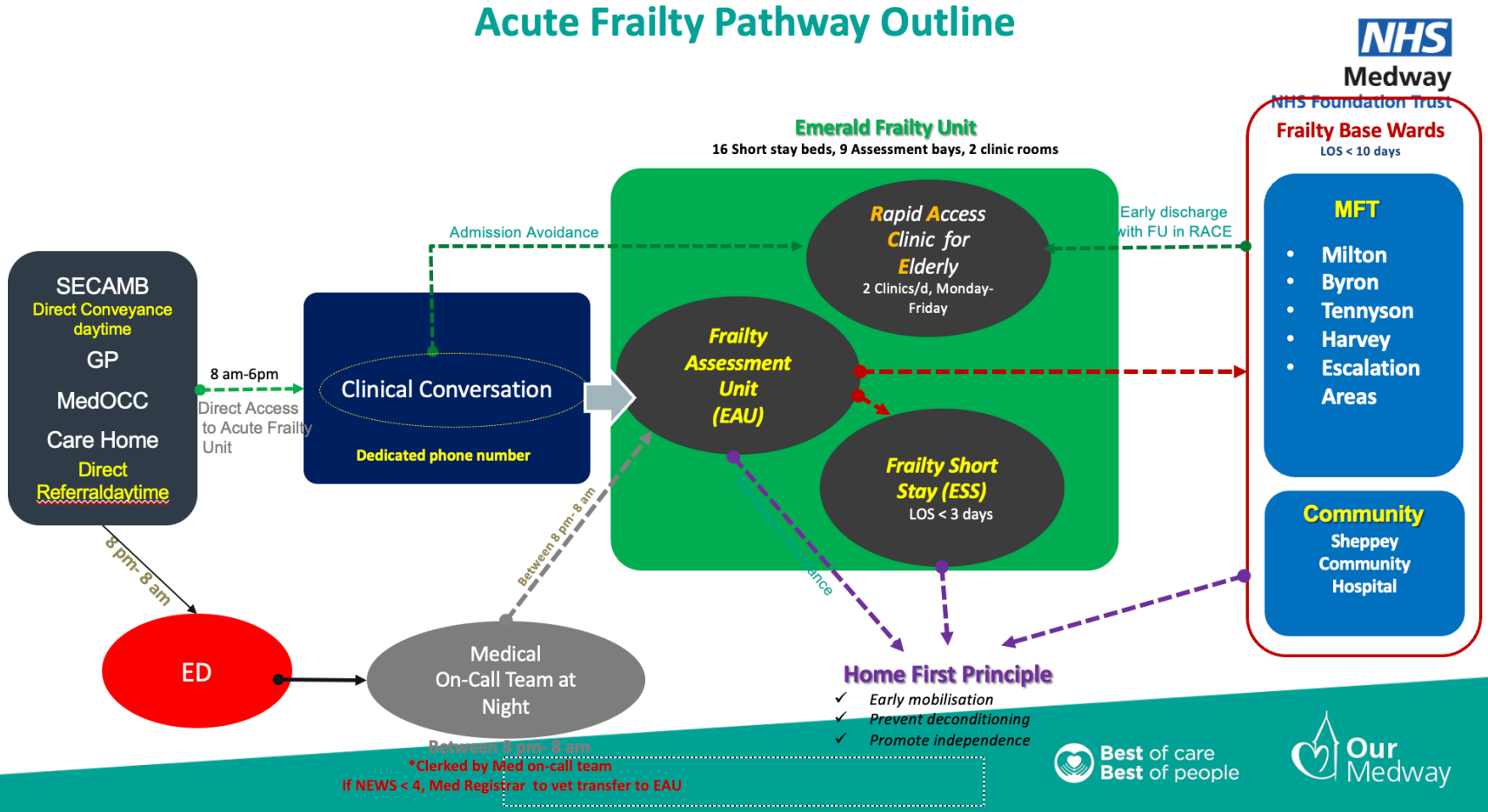
HARIS – Minster Ward Model



HARIS – Frailty EAU

- There has been the Relaunch of EAU on the 17th May 2022
- Requires closure of current escalation beds (4) prior to launch
- Triumvirate to discuss and seek agreement from COO
- Senior Team to discuss relaunch with teams across the trust, including Senior Managers re: protection of Frailty Assessment Beds
- Proposed to start with 1-2 direct Ambulance admissions per day 8th June 2022
- EAU needs to be closed for escalation long term (4 beds and then another 4 beds would require)
- Comms to PCNs/SECAmb to make them aware direct access pathway is being relaunched
- Frailty Specialist Nurse to continue scoping SMART current pathways and processes

Medway and Swale
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HARIS – Virtual Ward

- Kent and Medway ICB have set up a programme to ensure the ICB can design a Virtual Ward model which is in line with national requirements and within scope for the funding which has been set for 22/23 and 23/24.
- Medway and Swale HaCP are working collaboratively as system partners to meet the requirements within the prescripted time scales and in line with the scope.
- Within the publication of the Planning and Operational guidance it set out expectations for all systems to introduce virtual wards.
- The expectation is each system will delivery 45 beds per 100,000 population which for Medway and Swale is equivalent to 193 virtual beds by December 2023. Funding has been made available to support systems with the introduction of virtual wards with an expectation that systems will also do match funding.
- In order to progress the change programme as a system, an M&S HaCP Steering Group has been established with partners from MFT, MCH, Primary Care, HCRG Care Group, MPA and Social Care which is chaired jointly chaired by the Director of Transformation HaCP and the Director of Operations for Flow and Integration.

Reports will be made available to the HARIS Steering group which are reported to LAEDB as well as progress updates are captured in the HaCP Delivery Plan

Medway and Swale
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Key actions

Winter 2022 preparedness: Nursing and midwifery safer staffing

November 2022, Version 2, Updates to version 1 are highlighted.

Trust board members are collectively responsible for workforce planning, practice, and safeguards. The following actions focus on preparedness, decision making and escalation processes to support safer nursing and midwifery staffing as the winter period approaches. They build on the previous guidance issued in relation to staffing in extremis workforce models and the fundamental principles for the nursing and midwifery workforce as set out in the National Quality Board (NQB) Safe Sustainable and Productive staffing guidance. The document summarises and signposts to existing resources, tools, and templates in support of nursing and midwifery workforce planning, preparation, and board assurance.

Planning

- When planning the nursing and midwifery workforce, boards should ensure that system wide and local learning from previous staffing deployments, including from the COVID-19 pandemic, continue to be incorporated into staffing escalation plans.

- Work with providers of temporary workforce to be clear about anticipated requirements during activity peaks and consider steps such as block booking for hard to fill areas.

- Executive directors of nursing should ensure that all forecast staffing plans are reviewed weekly or more frequently as required by the operating context and changing circumstances. Executive directors of nursing are expected to work with the Board and with ICBs/ICSs to align system approaches to workforce planning.

- Changes in estate function or staffing configuration should be subject to a quality impact assessment with final sign-off by the executive director of nursing and countersigned by the medical director as joint quality lead.

- Redeployment should be voluntary where possible and individual risk assessments must be undertaken with staff prior to any redeployment.
- Now that ICBs/ICSs are operational, Trusts must consider whether system level solutions are appropriate

Decision making and escalation

- Even during challenging times, executive directors of nursing should be mindful of the fundamental principles set out in the NQB Safe Sustainable and Productive staffing guidance and Developing Workforce Safeguards guidance.

- When implementing escalation plans, decisions regarding skill mix and staffing numbers should be taken in conjunction with an assessment of patient acuity and dependency, professional judgement and the environment of care.

- In preparation for periods of increased demand, organisations should ensure that staffing plans are reviewed and signed off by the executive director of nursing, with staffing decisions including redeployment and daily deployment of staff led by the senior clinical leadership teams.

- Staffing risk assessments should be undertaken on a shift by shift basis and concerns and issues escalated in a timely manner via clearly established routes. Unresolved issues should be escalated in line with provider governance processes. A system wide discussion and focus should be taken to reach solutions wherever appropriate.

- Escalation mechanisms and governance processes should be clear to all staff and the board should seek assurance that effective escalation occurs and that issues are addressed and recorded.

- Staff should be supported to discuss and raise concerns regarding staffing and their ability to safely care for patients. The board must seek assurance that there are clear mechanisms in place for staff to raise concerns and that these are acknowledged and mitigated where possible.

- Clinical leaders should take a multi-professional and skills-based approach to staffing and ensure each clinical area is supervised by a senior clinical leader.

Staff training and wellbeing

- Supporting the workforce is paramount; boards should seek assurance that there are well-publicised and accessible resources in place for staff.

- Staff wellbeing should be embedded at every level. For example, team -based check-ins, wellbeing support hubs and wobble rooms.

- Professional nurse/midwife Advocates (PNA/PMAs) who are trained to provide confidential restorative clinical supervision and support nurses in clinical practice, should be readily available.

- Boards should ensure that local leaders are supporting staff wellbeing, which in turn will support the delivery of high standards of patient care.

Indemnity and regulation

- It is recognised that at times staff might need to act outside their normal role or places of work/scope of practice. A risk-based approach should be used to mitigate emerging risks using available resources effectively and responsibly.

- The UK's Chief Nursing Officers, the CQC and the NMC have published a joint letter on how staff will be supported over the winter period.

- Working in partnership with people receiving care and their fellow professionals remains of utmost importance; and of using professional judgement to assess risk, informed by the values and principles set out in NMC professional standards. Trust boards must be assured that wherever possible these standards are met.

Governance and assurance

- There must be a clear and effective line of sight from point of care delivery to board, in relation to nursing and midwifery staffing decisions and challenges.

- To help boards understand the quality impact of decisions that have been taken around staffing, boards should be provided with triangulated information linking staffing with wider intelligence, through regular reporting. For example incidents, complaints and NICE red flags.

- Boards should have reviewed their risk appetite in relation to quality and workforce risks and be clear on the tolerances the board is willing to accept, understanding that not all risks can be fully mitigated. This should be clearly communicated to the organisation.

- Boards should seek assurance that plans are in place to ensure safe nursing and midwifery staffing over the winter period and that these plans are connected to the wider system staffing planning, resourcing and mutual aid.

- The Care Quality Commission (CQC) recognises that services are facing tremendous challenges which are expected to increase over the winter period – and that the nursing and midwifery workforce is experiencing these pressures particularly acutely. This includes decisions around nursing, midwifery and care staffing capacity and capability. CQC expects boards to make staffing decisions with a focus on mitigating emerging risks and trends using available resources effectively and responsibly, in line with national guidance – and that where staffing shortages are identified, use of temporary solutions including a multidisciplinary approach to manage immediate risks should be implemented.

- Where necessary, ICBs/ICSs, the CQC and regional NHS England teams should be made aware of any fundamental concerns arising from significant and sustained staffing challenges.

- PEOPLE FIRST is an online resource available on CQC's website for system leaders and service providers. It presents suggested actions for individual services and the wider system to help manage the challenges in urgent and emergency care and includes a section on staffing and staff training.

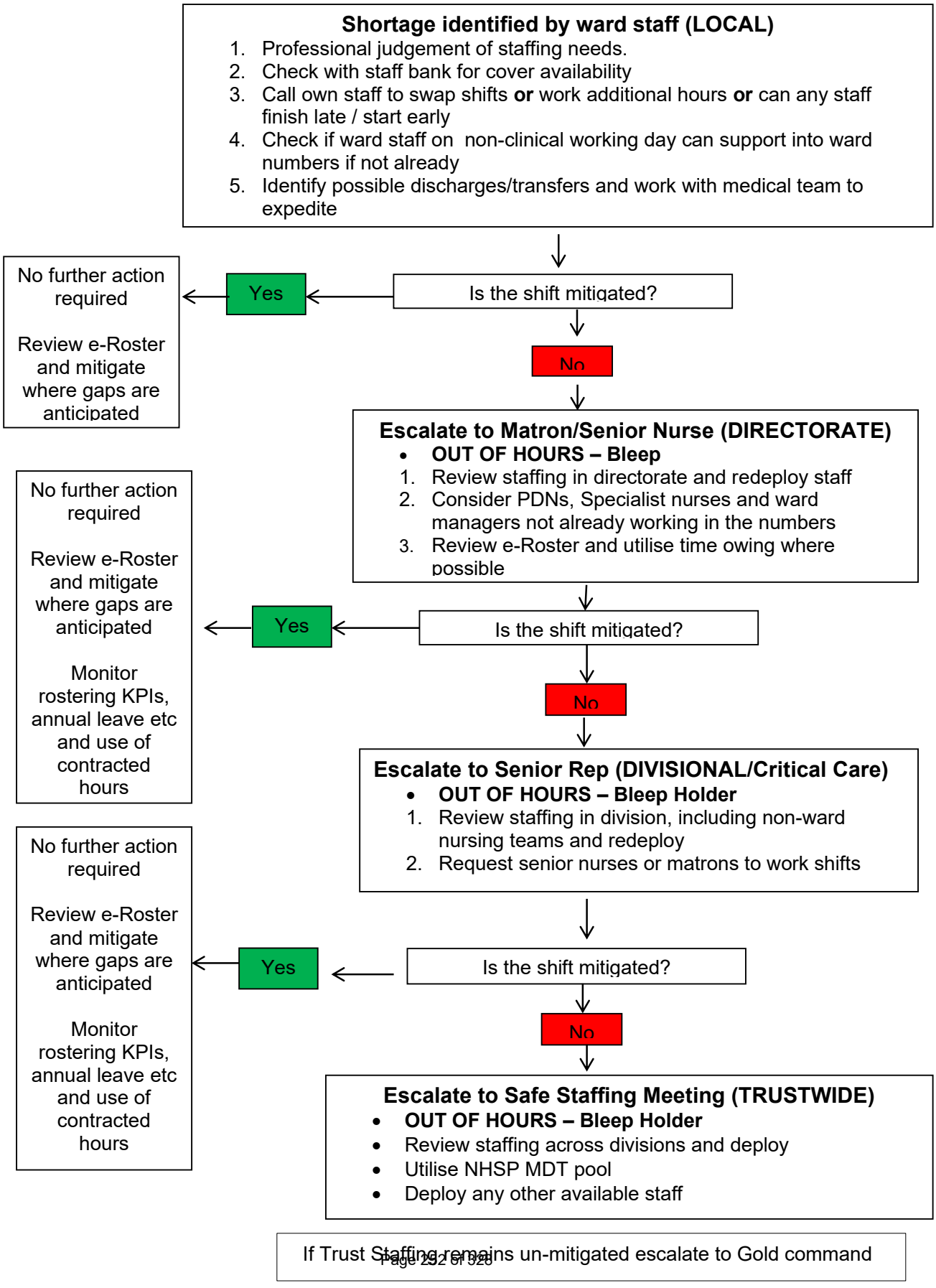
Useful links:

Alongside the formal guidance that has previously been issued in this area, a collection of additional resources has been collated for use by providers. These resources are attached as appendices and/or via the following links:

Planning • NHS England – Respiratory syncytial virus preparedness: Children' safer nurse staffing framework for inpatient care in acute hospitals • Safe staffing in maternity settings • NHS England e-Rostering and e-Job Planning • Preparedness for potential industrial action in the NHS	**Staff training and wellbeing** • NHSX: Digital staff passport • NHS People: Support and wellbeing resources • NHS Horizons: Caring for NHS people • NHS Employers: Risk assessment for all staff
Decision making and escalation • Appendix 1: decision and escalation framework tool • Appendix 2: Quality Impact Assessment • Appendix 3: Staffing escalation (SBAR) • Appendix 7: EPRR escalation and alerting	**Governance, assurance and reporting** • Appendix 4: Risk appetite statement • Appendix 5: Assurance Framework • Appendix 6: Safe staffing Governance framework • NQB Safe Sustainable and Productive staffing guidance • Developing Workforce Safeguards • Care Quality Commission

Appendix 1: Decision tool and escalation framework

Flow chart for resolution of staff shortages, to support nurse(s) in charge and matrons on a shift-by-shift basis. (Courtesy of Oxford University Hospitals)



LEVEL 1 Required staffing levels achieved across most wards Required CHPPD met Activity can continue as planned	Local redeployment of staff within and across Divisions has mitigated staffing requirements Activity unaffected “Business as usual can continue”
LEVEL 2 Staffing levels remain below planned across most wards CHPPD across organisation are not met Staff are able to deliver a basic level of care May affect or delay patient flow Patient experience at risk of being affected Activity continues as planned but further staffing reductions may impact planned activity. Monitoring must continue.	Follow Level 2 protocol Non – ward based nursing teams across divisions are supporting patient care All available temporary staffing solutions explored, authorised and booked. Study leave reviewed and stood down where possible. Rosters reviewed for shift swaps and overtime etc. Any staff working non-clinical days reviewed Identify possible patient discharges and transfers in collaboration with medical teams. Consider bed closures. Escalate, and utilise flexible temporary staffing pool.
LEVEL 3 Staffing levels remain considerably lower than planned despite mitigation **Nurse to Patient ratios 1:8 on adult wards, 1:6 on Childrens wards, and nurse 1&2 model in critical care and respiratory high care** Significant deficiency in required CHPPD across organisation Activity cannot continue as normal. Ability to deliver all aspects of patient care affected Patient flow will be significantly delayed Staff likely to miss breaks	All other protocol exhausted-. **Step down of all non-urgent meetings** **Study leave cancellation mandated** **Urgent meeting of Divisional Directors of Nursing with Head Nurse for Workforce to discuss any further possible mitigation.(If declared at the weekend Duty Manager to meet with ops and senior representative from each division)** **Review all planned elective and emergency activity to prioritise care and deployment of staff, consider regional support** **Trust wide deployment of indirect patient care staff considered to support delivery of direct care.** **As with OPEL 4, all effort will be focussed until step down to level 1 or 2 has been achieved.**

Appendix 2: Example quality impact assessment

Follow this link to view (FutureNHS account required):
https://future.nhs.uk/BeneficialChangesCOVID19/view?objectId=93995109

Appendix 3: Example staffing SBAR Tool

Staffing communication tool using situation, background, assessment, recommendation (SBAR) principles to ensure critical staffing issues are received and actioned.

Staffing Escalation SBAR

SITUATION:

Ward:

Date, Shift and Band that require covering:

Number of beds:

Acuity and dependency score:

Describe your concern, include Safety/Quality concern:

BACKGROUND:

Current problem:

Reason for problem on shift:

How long has the shift been out to the Hospital Nurse Bank:

How long has the shift been out to Framework Agency:

ASSESSMENT:

My assessment of the situation is:

Current concern:

Describe actions have been taken to solve the current problem:

RECOMMENDATION:

Based on my assessment I request that you approve:

Things to consider:

Explain what you need:

Appendix 4: Example risk appetite statement

For boards and senior leaders outlining the pressures on the service and any potential changes in the level of accepted risk.

Category (highest impact of the risk)	Proposed Risk appetite statement	Risk appetite	Risk score
Clinical innovation	We have a HIGH risk appetite for clinical innovation that does not compromise quality of care	HIGH	8-12
Commercial	We have a HIGH risk appetite aimed at increasing the impact of services. The high risk appetite allows the Trust to explore opportunities to deliver existing and new services into new markets	HIGH	8-12
Compliance / regulatory	We have a LOW risk appetite for risks which may compromise compliance with statutory duties and regulatory requirements	LOW	1-3
Environment	We are committed to providing patient care in a safe environment; however we have a MEDIUM risk appetite for risks related to the Trust estate and infrastructure except where they adversely impact on patient safety and regulatory compliance.	MEDIUM	4-6
Financial / value for money	We have a HIGH risk appetite for financial / value for money risks which may grow the size of the organisation whilst ensuring we minimise the possibility of financial loss and comply with statutory requirements Our appetite for risk in this area recognises the financial environment in which NHS trusts are operating, and the requirement to maintain regulatory and constitutional standards	HIGH	8-12
Systems and Partnerships	We have a HIGH risk appetite for system working and partnerships which will benefit our local population	HIGH	8-12
Reputation	We have a HIGH risk appetite for actions and decisions taken in the interest of ensuring quality and sustainability which may affect the reputation of the Trust	HIGH	8-12
Quality – effectiveness	We have a LOW risk appetite for risks that may compromise the delivery of outcomes for our patients	LOW	1-3
Quality - experience	We have a MEDIUM risk appetite for risks to patient experience if this is required to achieve patient safety and quality improvements	MEDIUM	4-6
Quality - safety	Patient safety is paramount to the Trust and as such it we have a LOW appetite for risks which may compromise patient safety	LOW	1-3
Technology	We have a HIGH risk appetite for the adoption and spread of new technologies whilst ensuring quality for our service users	HIGH	8-12
Workforce	We have a MEDIUM appetite for risks to workforce. This medium appetite allows scope to implement initiatives that support transformational change whilst ensuring it remains a safe place to work	MEDIUM	4-6

Appendix 5: Assurance framework – nursing and midwifery staffing

For quality (or other board level) committees and board members to support discussion and challenge surrounding the active staffing challenges faced and the potential impact this may have on patients.

Ref	Details	Controls	Assurance (positive and Negative)	Residual Risk Score / Risk register reference	Further action needed	Issues currently escalated to Local Resilience Forum / Regional Cell / National Cell	Ongoing Monitoring / Review
	Guidance notes	*Outline the current controls (controls are actions that mitigate risk include policies, practice, process and technologies)*	*Detail both the current positive and negative assurance position to give a balanced view of the current position* *Assurance is evidence that the control is effective – or conversely is evidence that a control is ineffective / there are still gaps* *Recurrent forms of assurance are audit results, key performance indicators, written reports, intelligence and insight.* *Effective Assurance should be a triangulated picture of the evidence (staff shortages, sickness absence,pt outcomes, complaints, harm reviews)*	*What is the remaining risk score (using the trusts existing risk systems and matrix)* *Are these risks recorded on the risk register?*	*Where there are identified gaps in either control or assurance, outline the additional action to be undertaken to mitigate the risk. Where the organisation is unable to mitigate fully, this should be escalated to the LRF/region/ national teams and outlined in the following column*	*Provide oversight to the board what the current significant gaps are* *Outline those risks that are currently not fully mitigated /needing external oversight and support*	*Due to the likely prevailing nature of these risks, outlines through what operational channels and how are these active risk being monitored (e.g daily silver meetings via safe staffing heatmap)*
1.	**Staffing Escalation / Surge and Super Surge Plans**						

1.1	Staffing Escalation plans have been defined to support surge and super surge plans which includes triggers for escalation through the surge levels and the corresponding deployment approaches for staff. Plans are detailed enough to evidence delivery of additional training and competency assessment, and expectations where staffing levels are contrary to required ratios (i.e intensive care) or as per the NQB safe staffing guidance						
1.2	Staffing escalation plans have been reviewed and refreshed with learning incorporated into revised version in preparation for winter.						
1.3	Staffing escalation plans have been widely consulted and agreed with trust' staff side committee						
1.4	Quality impact assessments are undertaken where there are changes in estate or ward function or staff roles (including base staffing levels) and this is signed off by the CN/MD						
2.0 Operational delivery							
2.1	There are clear processes for review and escalation of an immediate						

	shortfall on a shift basis including a documented risk assessment which includes a potential quality impact. Local leadership is engaged and where possible mitigates the risk. Staffing challenges are reported at least twice daily via Bronze.						
2.2	Daily and weekly forecast position is risk assessed and mitigated where possible via silver / gold discussions. Activation of staffing deployment plans are clearly documented in the incident logs and assurance is gained that this is successful and that safe care is sustained.						
2.3	The Nurse in charge who is handing over patients are clear in their responsibilities to check that the member of staff receiving the patient is capable of meeting their individual care needs.						
2.4	Staff receiving the patient (s) are clear in their responsibilities to raise concerns they do not have the skills to adequately care for the patients being handed over.						

2.5	There is a clear induction policy for agency staff There is documented evidence that agency staff have received a suitable and sufficient local induction to the area and patients that they will be supporting.						
2.6	The trust has clear and effective mechanisms for reporting staffing concerns or where the patient needs are outside of an individuals scope of practice.						
2.7	The trust can evidence that the mechanisms for raising concerns about staffing levels or scope of practice is used by staff and leaders have taken action to address these risks to minimise the impact on patient care.						
2.8	The trust can evidence that there are robust mechanisms in place to support staff physical and mental wellbeing. The trust is assured that these mechanisms meet staff needs and are having a positive impact on the workforce and therefore on patient care.						
2.9	The trust has robust mechanisms for understanding the current staffing						

	levels and its potential impact on patient care. These mechanisms take into account both those staff who are absent from clinical duties due to required self Isolation, shielding, and those that are off sick. Leaders and board members therefore have a holistic understanding of those staff not able to work clinically not just pure sickness absence.						
2.10	Staff are encouraged to report incidents in line with the normal trust processes. Due to staffing pressures, the trust considers novel mechanisms outside of incident reporting for capturing potential physical or psychological harm caused by staffing pressures (e.g use of arrest or peri arrest debriefs, use of outreach team feedback etc) and learns from this intelligence.						
3.0 Daily Governance via EPRR route (when/if required)							
3.1	Where necessary the trust has convened a multidisciplinary clinical and or workforce /wellbeing advisory group that informs the tactical and strategic staffing decisions via Silver						

	and Bronze to provider the safest and sustained care to patients and its decision making is clearly documented in incident logs or notes of meetings.						
3.2	Immediate, and forecast staffing challenges are discussed and documented at least daily via the internal incident structures (bronze, silver, gold).						
3.3	The trust ensures system workforce leads and executive leads within the system are sighted on workforce issues and risks as necessary. The trust utilises local/ system reliance forums and regional EPRR escalation routes to raise and resolve staffing challenges to ensure safe care provided to patients.						
3.4	The trust has sufficiently granular, timely and reliable staffing data to identify and where possibly mitigate staffing risks to prevent harm to patients.						
4.0 Board oversight and Assurance (BAU structures)							
4.1	The quality committee (or other relevant designated board committee) receives regular staffing report that evidences the current staffing hotspots, the potential impact on patient care and the short and						

	medium term solutions to mitigate the risks.						
4.2	Information from the staffing report is considered and triangulated alongside the trusts' SI reports, patient outcomes, patient feedback and clinical harms process.						
4.3	The trusts integrated Performance dashboard has been updated to include COVID/winter focused metrics. COVID/winter related staffing challenges are assessed and reported for their impact on the quality of care alongside staff wellbeing and operational challenges.						
4.4	The Board (via reports to the quality committee) is sighted on the key staffing issues that are being discussed and actively managed via the incident management structures and are assured that high quality care is at the centre of decision making.						
4.5	The quality committee is assured that the decision making via the Incident management structures (bronze, silver, gold) minimises any potential exposure of patients to harm than may occur delivering care through staffing in extremis.						

4.6	The quality committee receives regular information on the system wide solutions in place to mitigate risks to patients due to staffing challenges.						
4.7	The Board is fully sighted on the workforce challenges and any potential impact on patient care via the reports from the quality committee. The Board is further assured that active operational risks are recorded and managed via the trusts risk register process.						
4.8	The trust has considered and where necessary, revised its appetite to both workforce and quality risks given the sustained pressures and novel risks caused by the pandemic The risk appetite is embedded and is lived by local leaders and the Board (i.e risks outside of the desired appetite are not tolerated without clear discussion and rationale and are challenged if longstanding)						
4.9	The trust considers the impact of any significant and sustained staffing challenges on their ability to deliver on the strategic objectives and these risks are adequately documented on the Board Assurance Framework						

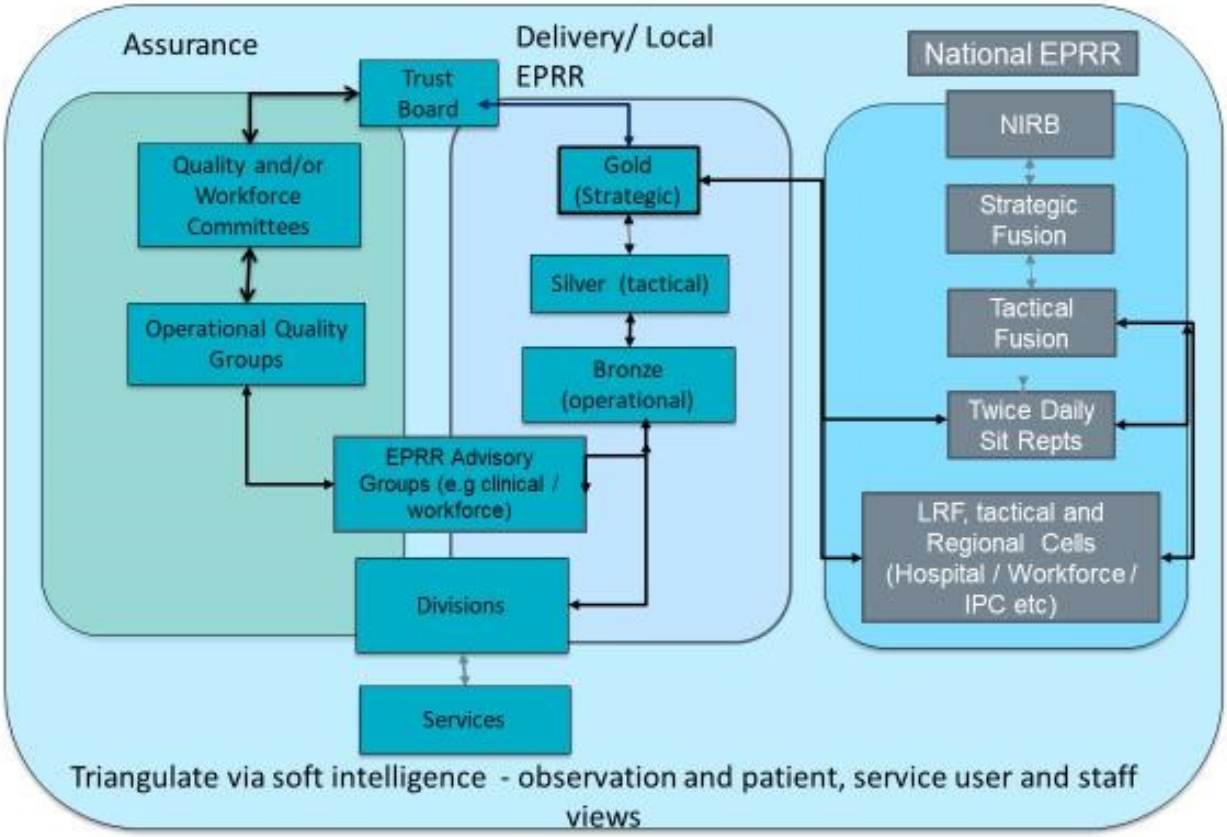
4.10	Any active significant workforce risks on the Board Assurance Framework inform the board agenda and focus						
4.11	The Board is assured that where necessary CQC and Regional NHSE/I team are made aware of any fundamental concerns arising from significant and sustained staffing challenges						

Appendix 6: Example safe staffing governance framework

The flowchart below is a general illustrative example. It outlines the two arms of a provider governance framework (assurance and delivery) and further indicates the relationships with the national emergency preparedness, resilience and response (EPRR) structures.

Providers must ensure that non-executive members of the board have clear sight of the significant or sustained operational issues and challenges that are being discussed in the day-to-day delivery of care during these challenging times.

This should be through their existing board assurance routes (ie quality committee, strategic workforce and organisational development committee to the board), to allow the non-executive directors to adequately fulfil their duties of holding the executive director members to account so that quality care is maintained.



Appendix 7: EPRR escalation and alerting

Extracted from NHS England EPRR Framework

Level 1 – Organisation level response
Coordinating organisation: NHS-funded organisation

If the following applies the incident may need to be escalated to Level 2:

- Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by the provider
- A Business Continuity Incident that threatens the delivery of patient services (in line with ISO 22301)
- Responding to a declared Major Incident or Major Incident standby
- A media or public confidence issue that may result in local, regional or national interest
- A significant operational issue that may have implications wider than the organisation e.g. public health outbreak, suspected high consequence infectious disease (HCID), security incident, Hazmat incident

Level 2 – Local level response
Coordinating organisation: ICB with NHS England (Region)

If the following applies the incident may need to be escalated to Level 3:

- Capacity and demand reaches, or threatens to surpass, a level that requires wider resources that cannot be accessed by the ICB
- A Critical Incident that threatens the delivery of **critical** services or presents a risk of harm to patients and/or staff
- Responding to a declared Major Incident or Major Incident standby
- A media or public confidence issue that may result in local, regional or national interest
- A significant operational issue that may have implications wider than the local ICS e.g. public health outbreak, suspected HCID, security incident, Hazmat/CBRN incident

Level 3 – Regional level response
Coordinating organisation: NHS England (Region)

If the following applies the incident may need to be escalated to Level 4:

- Capacity and demand reaches, or threatens to surpass, a level that requires national coordination or NHS mutual aid e.g. need for ECMO, HCID, burns treatment or other specialist functions
- A Business Continuity Incident that threatens the delivery of an **essential** NHS England function or a protracted incident effecting one or more NHS England site
- A Critical Incident with the potential to impact on more than one ICB
- A declared Major Incident which may have a significant NHS impact and/or the establishment of an NHS England Incident Coordination Centre
- A media or public confidence issue that may result in regional, national or international interest
- A significant operational issue that may have implications wider than the remit of one NHS England region e.g. flooding, security incident, Hazmat/CBRN incident, Critical National Infrastructure, collapse of a commissioned supplier that provides services to more than one region
- An incident that may require the request and activation of Military Aid to the Civil Authorities (**MACA**)

Level 4 – National level response
Coordinating organisation: NHS England National Team (with DHSC where appropriate)

If any of the following apply or are required, DHSC should be informed:

- Capacity and demand reaches, or threatens to surpass, a level that requires international coordination e.g. need for ECMO, HCID, burns treatment or other specialist function
- Invocation of central government emergency response arrangements
- Issues that may require **invocation of** 'Emergency Powers' to be invoked under the CCA 2004 or measures under sections 252A or 253 of the NHS Act 2006
- A Business Continuity Incident with the potential to impact on significant aspects of the NHS e.g. NHS Supply Chain, NHS Blood and Transplant
- A declared Major Incident which may have national and/or international implications e.g. CBRN, MTA
- A media or public confidence issue that may result in national or international interest
- A significant operational issue that may have implications wider than the remit of the NHS e.g. Critical National Infrastructure
- An incident that may require the request and activation of MACA

NHS Medway NHS Foundation Trust

Meeting of the Trust Board (Public)
Thursday, 15 December 2022

Title of Report	**Minster Ward - Business Case**			**Agenda Item**	**20**
Author	Steve Reipond, Director of Winter Planning				
Lead Executive Director	Mandy Woodley, Interim Chief Operating Officer				
Executive Summary	Owing to a challenging project timeline this paper was presented and approved at an extraordinary formal Board meeting on 9 November 2022, and is brought to this meeting as the first opportunity to present the paper and decision in public. This paper sets out the business case and strategic plan for the relocation of the Harvey ward on the Medway Maritime Hospital site to Sheppey Community Hospital (Minster Ward). This would involve a "lift and shift" of a current Harvey ward with staff and support services providing care at Minster, with a view to eventually taking direct from the Emergency Department to avoid admission into the acute trust. An illustration of finance and activity are presented through this Business Case and the project plan will be updated and included (including NHSPS plans).				
Proposal and/or key recommendation:	To note the paper and the decision taken by the extraordinary board meeting on the 9 November 2022.				
Purpose of the report (tick box to indicate)	Assurance		Approval		
	Noting	✓	Discussion		
(If appropriate) state reason for submission to Private section of Board:	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:	
Committee/Group at which the paper has been submitted:	• Estates and Facilities Group • Finance Performance and Planning Committee • Formal Trust Board (Extraordinary)				
Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) ✓	Priority 2: (People) ✓	Priority 3: (Patients) ✓	Priority 4: (Quality) ✓	Priority 5: (Systems)

Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: ✓	Effective: ✓	Caring: ✓	Responsive: ✓	Well-Led:
Identified Risks, issues and mitigations:	A Risk, Assumptions, Issues and Dependencies (RAID) has been undertaken and is summarised in the business case. The risk identified are: • Staffing – Transfer of Medway NHS Foundation Trust staff to Minster (whether this is welcomed by the current staff working on Harvey Ward). Consultation due to commence upon sign off. • Recruitment does not lend itself to the timescale based on HR processes. • Consultation process may not lend itself to the projected timescale. • Access to the site should there be issues with transport. • That the 22 beds at Minster are used correctly and in line with the pathway and processes in place –the model needs to be upheld and the processes strong and understood by all staff. • Transfer of patients to the ward. • Stocking of equipment and medicines. • As an acute ward, a requirement for DNAR and treatment escalation forms to be filled out (ward-based care only) • Staff transport				
Resource implications:	The resource and financial assumptions are divided into scoping and planning and operationalisation of the project. The business case described the both. The resource implications and contributions have been reviewed and approved by the Trust Chief of Finance and the Finance, Performance and Planning Committee.				
Sustainability and /or Public and patient engagement considerations:	The outlined business case aligns with the Trust's green plan and financial sustainability strategy. Engagement has been carried out with stakeholders in Swale and with the Medway Health and Adult Social Care Health Overview and Scrutiny Committee, and engagement with Healthwatch is planned. A full programme of communications with patients and public has been developed.				
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☒ Yes (*please attach the action plan to this paper*)* ☐ Not applicable (*please indicate why an equality assessment was not required)* *Impact assessments will be appended to the operationalisation plans.				
Legal and Regulatory implications:	Nil.				
Appendices:	• The Business Case				

Freedom of Information (FOI) status:	State either: This paper is disclosable under the FOI Act	
For further information or any enquires relating to this paper please contact:	Mandy Woodley, Interim Chief Operating Officer m.woodley2@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

Medway and Swale
Health and Care Partnership

Transforming
health and social care
in Kent and Medway

Harvey Ward move to
Sheppey Community Hospital - Minster Ward

Business Case

Specialty	Therapies and Older Persons
Directorate	Unplanned & Integrated Care
Author	Steve Reipond/Janine Fountain-Sharpe

Version Control and Amendment Record

Version No	Date	Comments	Author
0.1	28th July 2022	First draft	SR/SS/AS
0.2	1st August 2022	Updates	AS
0.3	19th August 2022	Financial amendments	JFS/AP
0.3	23rd August 2022	Presented to Executive Management Board	JFS/SS/SR
0.4	24th August 2022	Update outline requirements	JFS/SR
0.4	25th August 2022	Presented to Executive Management Board (2)	JFS/SS/SR/AP
0.5	26th August 2022	Sign off rejected – Clinical financials to be updated	JFS/SS/SR/LP
0.6	31st August 2022	Presented to Executive Management Board (3)	JFS/AP/SR/SS/LP/AS
0.6	31st August 2022	Sign off delayed due to further financial amendments required	JFS/AP/SR
0.7	1st September 2022	Additional Financials added	JFS
0.8	6th September 2022	Presented to Exec Management Board (4)	SR/SS/LP/AS/JFS
0.9	16th September 2022	Additional data and financials added, SOP's and Consultation Paper	JFS
0.9	20th September 2022	Presented to Exec Management Board (5) – Declined	JFS
1.0	26th September 2022	Business Case – Final (subject to board approval)	JFS

Contents

1. Executive Summary

The purpose of this paper is to layout the pathways involved in the clinical model for the safe relocation of Harvey Ward from the acute site at Medway Maritime Hospital to Sheppey Community Hospital - Minster Ward.

Harvey ward was previously the Trust Acute Stroke Unit and when the Stroke service moved off site in 2019 Frailty took responsibility for the ward. The current environment is in need of refurbishment and a lift and shift model would allow for estates improvements to be completed once the ward/unit is empty. The current plan is for the vacated Harvey Ward to be turned over to planned care team for transition into an 18-bedded elective ward.

This would involve a lift and shift of a current ward in Medway Maritime Hospital (Harvey) with staff and support services providing care at Minster, with a view to eventually taking patients direct from the Emergency Department to avoid admission into the acute trust. A workup of figures are presented through this Business Case and the project plan will be updated and included (including NHS Property Services plans).

This is an Acute frailty model that has been taken and developed from the Brentwood Community Hospital 'Programme 70' clinical model.

Minster Ward at Sheppey (Community Hospital) has the capacity for 22 inpatient beds and has been identified as an area that could work towards supporting the D2A (Discharge to Assess) model as well as acute frailty patients across Medway and Swale.

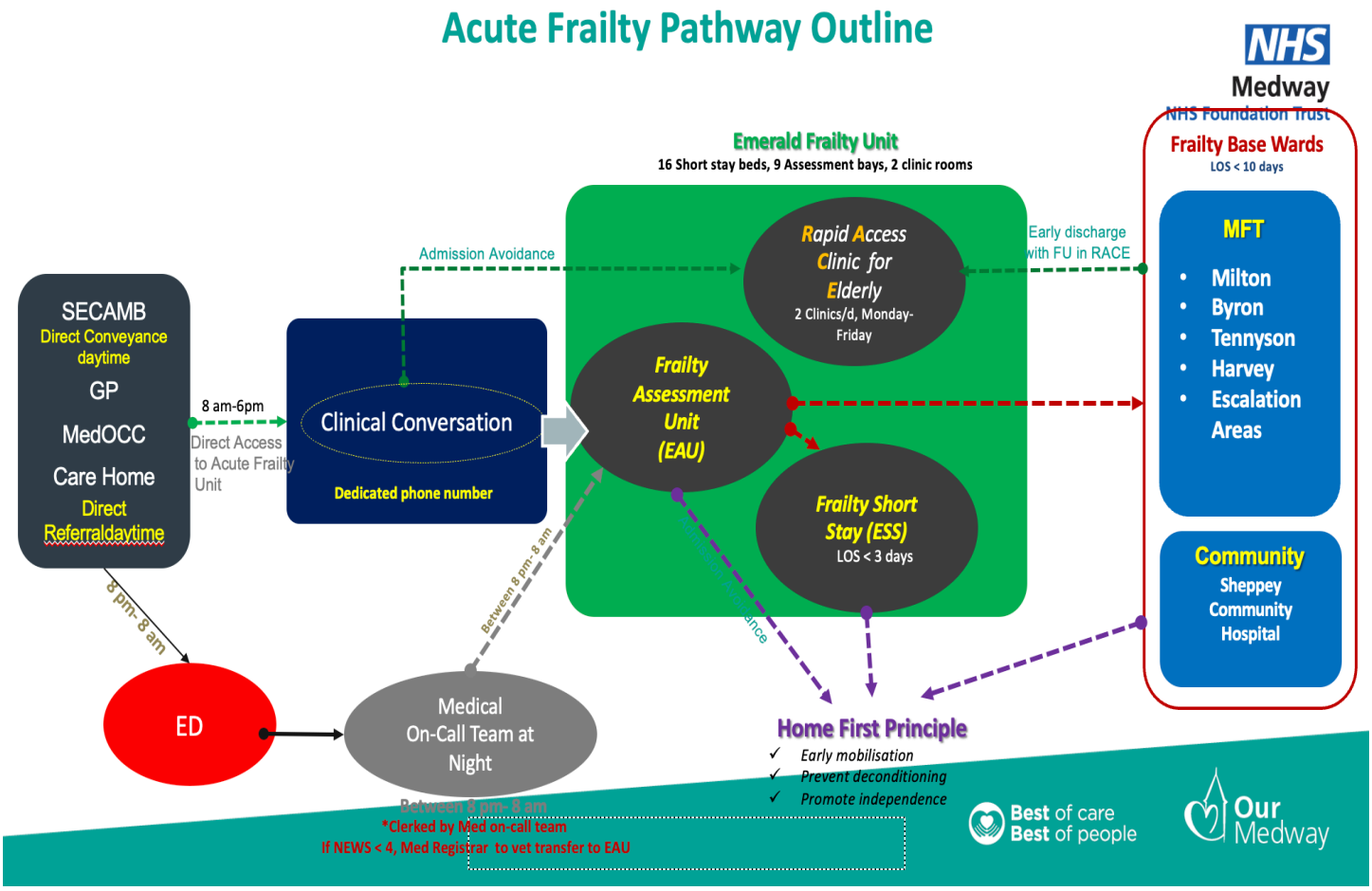
The investment will deliver a 24 hour, seven days a week sustainable model of care to this patient group of high dependency, low acuity, in which this 24/7 service will only be successful due to the additional therapy input provided in aiding reduced Length of Stay. This sustainable model will enable the following aims and benefits:

- Minster Ward will offer a valuable service for the Swale frail population to be managed closer to home if they need hospital-based treatment.
- Aid the elimination of multiple ward moves, reducing length of stay (LOS), enhancing patient experience and enabling compliance with NHS England nationally mandated standards of care.
- This service, as an acute frailty model will consider patients' grade of frailty and degree of illness, supported by clear reliable pathways direct from ED, reducing wait time, potential breaches and freeing up capacity within ED.
- Residents of Swale and Sheppey would get priority, but the service would extend to Medway residents if there were vacant beds.
- To create better integration with local population and community services.
- Offering opportunities for training and education.
- Career progression for staff working in this unit.

As the service matures, in time, we would also offer a Rapid Access Clinic for Elderly (RACE), this would provide a consultant-led assessment in a timely manner with a view to avoiding hospital admission.

The Head of Nursing, General Manager, Clinical Director and Therapies Lead, make up the Care Group Leads and decision makers for Frailty Service in the Trust. The Senior Nurse cover is provided by a Matron with oversight from the Head of Nursing.

Please see below - **ACUTE FRAILTY PATHWAY OUTLINE**



2. Strategic Case

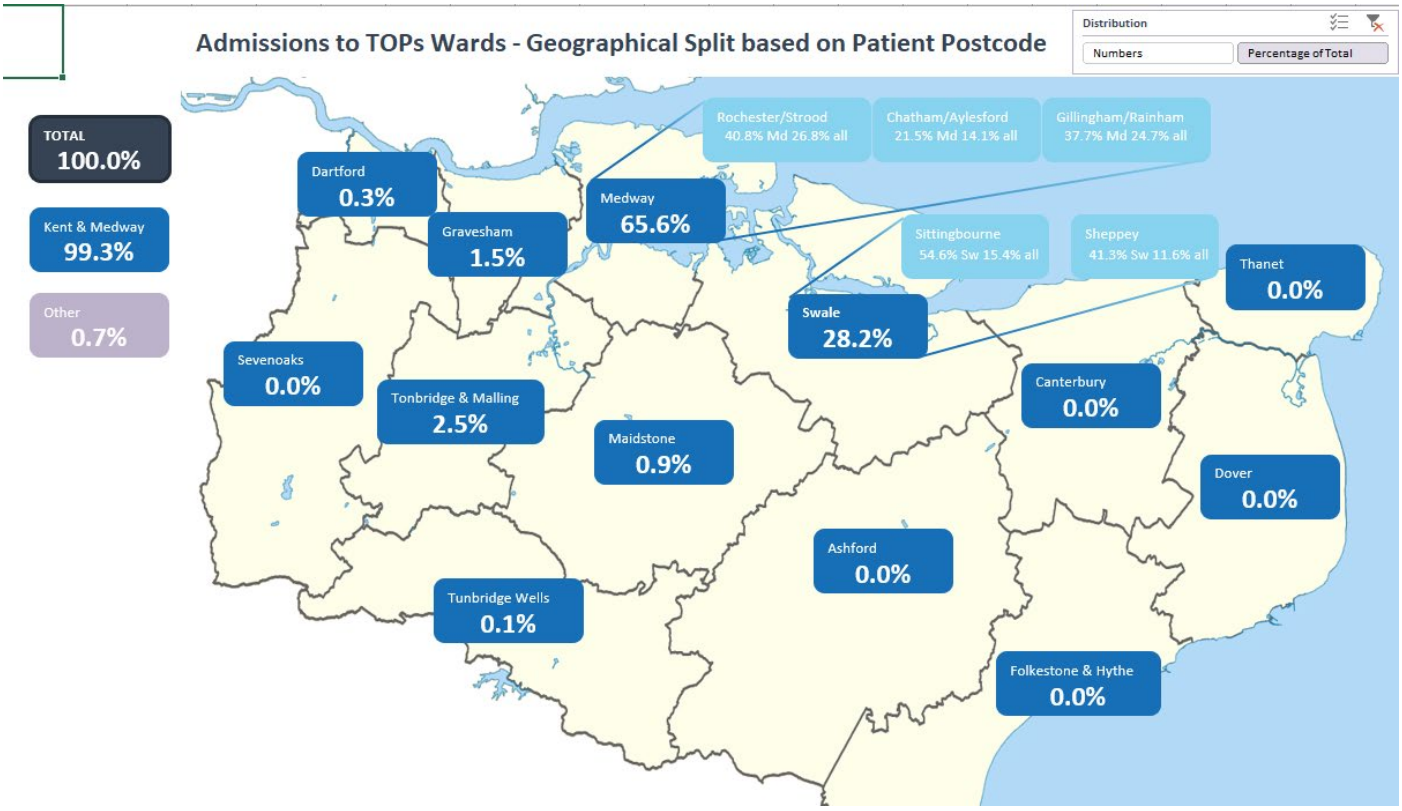
Harvey Ward is a 25-bedded Frailty Ward with an admission criteria in line with the Frailty bed base of CFS score of >6.

This approach is supported by the Medway and Swale Health and Care Partnership Executive and the wider healthcare system as a whole. This approach will ensure a Medway NHS Foundation Trust and expanded community presence within Swale. With the proposal to turn the vacated Harvey Ward over to elective services (18 beds), there will be an added benefit to residents of Medway.

Delivery and success of this service requires input from physiotherapists, occupational therapists, case managers, doctors with geriatric expertise and pharmacists for multidisciplinary (MDT) assessment.

This proposal brings benefits to both the population of Medway and Swale and therefore aligns to national priorities.

Please see below - Admissions to TOPs Wards - Geographical Split based on Patient Postcode:



The benefits from this model are:

- This is a new approach to using the vacant space in Sheppey Community Hospital and the proposal is to 'lift and shift' Harvey Ward to this new location as a Medway NHS Foundation Trust staffed and run acute frailty unit.

- This will promote close collaborative working with KCC, Sheppey Community Hospital and Outpatients, which in turn will provide positive impact and improved reputation for the Trust. By offering this increased nursing and medical model, the patient experience within the local community will be heightened, based on this positive 'doorstep' local service aimed at the ageing population of Swale, which accounts for almost 30% of admissions to MFT. The increased rotational support from Therapies will further aid the reduction of LoS.

- This 24/7 service will maximise the use of the facilities through efficient and effective admission, treatment and discharge processes, which will positively impact the reduction in the LoS

- No additional cost for Consultant cover is required as this is a lift and shift model. Consultants currently covering Harvey Ward would be aligned to Minster Ward (Sheppey Frailty Unit) as per their existing job plan.

- Moving Harvey ward to Minster would allow for 22 beds useable for D2A – currently the average NCTR number (formally Medically Fit For Discharge) has gone from an average of 70 a day to 95 a day but has consistently been above 105 in recent weeks which is partially linked to the removal of D2A funding.

- This adds between three and five bed days to the length of stay once patients are fit for discharge and as such would be a saving to the cost of additional/excess bed days.

- The current LOS data for Harvey Ward is 13.3 days, SFU is intended to have a LOS of less than 10 days at Minster to allow for assessment and with the unit, specifically designed to work seven days using a multidisciplinary team and will not only reduce LoS, but significantly improve discharges, including pre-noon discharges.

- In order to contribute and improve the flow of patients through ED, we aim to ensure that patients referred to the Trust's ED are seen in the most appropriate and shortest time possible. Following identification of a patient suitable for SFU initially within ED, as per the inclusion criteria, a clinical conversation will be had with SFU NiC, a handover will be given and transport arranged for transfer. We envisage that this entire process will be completed in less than four hours, thus accelerating the flow of patients from ED.

- Minster Ward will have access to a testing kit, available on the unit, to test for routine bloods, for an acutely deteriorating patient. This will streamline decision making and remote consultation, particularly with a view to avoiding unnecessary conveyance back to Medway.

- As the service matures and following a Safer Staffing Review, which is to be carried out three months after inorgeration, the Frailty Unit would move into Phase 2 and be able to offer a Consultant led Assessment and Rapid Access Clinic for Elderly (RACE), with a view to hospital admission avoidance. There will be no further requirement for additional medical costs in order for this to be established.

The benefits of Harvey being handed to surgical for an elective ward:

- This would allow for the removal of overnight electives in the day surgery unit (Sunderland) meaning the eight ring fenced beds could be used by the day surgery theatres, resulting in an additional 14 patients a day if the beds were used twice a day with LOS of at six hours and allowing for at least two slightly longer stays.

- This would increase the monthly day cases completed by a minimum of 224 and from around 75% to 87% in terms of 2019 activity (this could be slightly increased with additional anaesthetic and theatre support resourcing)

- This could also provide bed space for an additional 20 elective inpatients a month.

- Reduction in clinical risk from ED crowding.

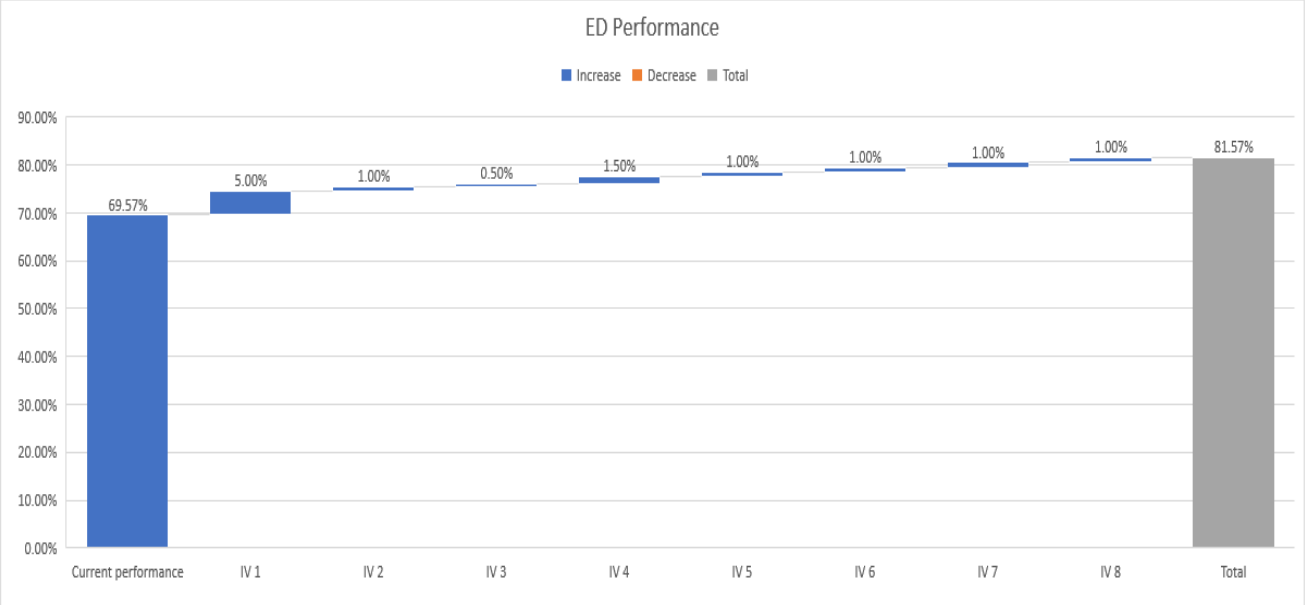
- This forms part of the Trust's clinical and quality strategies with our ambition to be an Emergency Centre of excellence for our local community.

3. Impact Assessment

The project aims to deliver Length of Stay (LoS) improvements through enhanced pathways and treatment provided within the 24/7 acuity model.

This is one of the many schemes being considered to bridge the gap from 69% to 80% ED 4 hour performance. This would have a knock on effect to the 12 hour LOS performance with a reduction of 0.5% against the current LOS. It has been measured as a phased approach with a 1% improvement expected by 31st December 2022 and a further 1% by the end of February 2023 as the service develops.

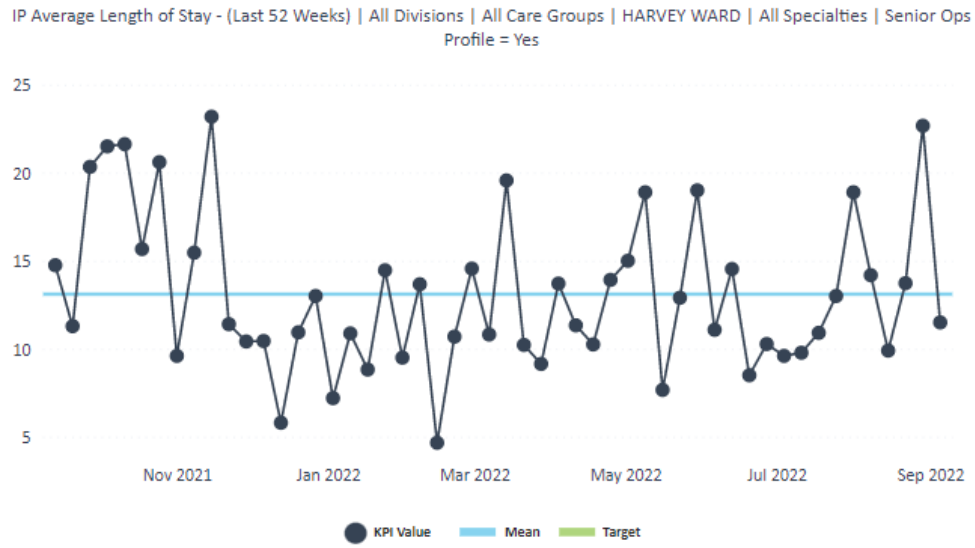
Intevention	Action	Date to be achieved by	Current performance	69.57%
Intevention 1	HARIS Project: Acute Medical Model - Ambulatory Acute Medical Centre (Phased approach)	31/10/2022	IV 1	5.00%
Intevention 2	Increase number of discharge beds before 12noon daily (Phased approach)	01/01/2023	IV 2	1.00%
Intevention 3	Robust board rounds with medical input in ED	30/09/2022	IV 3	0.50%
Intevention 4	HARIS Project: Frailty Assessment Unit (Phased approach starting with capacity for 4 pts at a time)	30/09/2022	IV 4	1.50%
Intevention 5	Consultant speciality in-reach	30/11/2022	IV 5	1.00%
Intevention 6	ADL: De-escalation and adjustment to fully operational to support flow through the trust. Strageic overview of ADL to monitor use and facilitate daily 'golden pts'	30/09/2022	IV 6	1.00%
Intevention 7	HARIS Project: Phase 3 AtED audit (Admissions avoidance, pathways and DoS review with all system partners)	30/11/2022	IV 7	1.00%
Intevention 8	Transfer of Minster to Sheppey as frailty hub. Direct admissions from ED following criteria	01/12/2022	IV 8	1.00%
			Total	81.57%



3.1

Table 1 – Average LOS Harvey Ward

Table 1 shows the average LOS within Harvey Ward to be 13.3 days. SFU is designed to work 7 days in a multidisciplinary team and will therefore significantly reduce LOS and improve discharges and facilitate the pathway from ED by reducing time spent.



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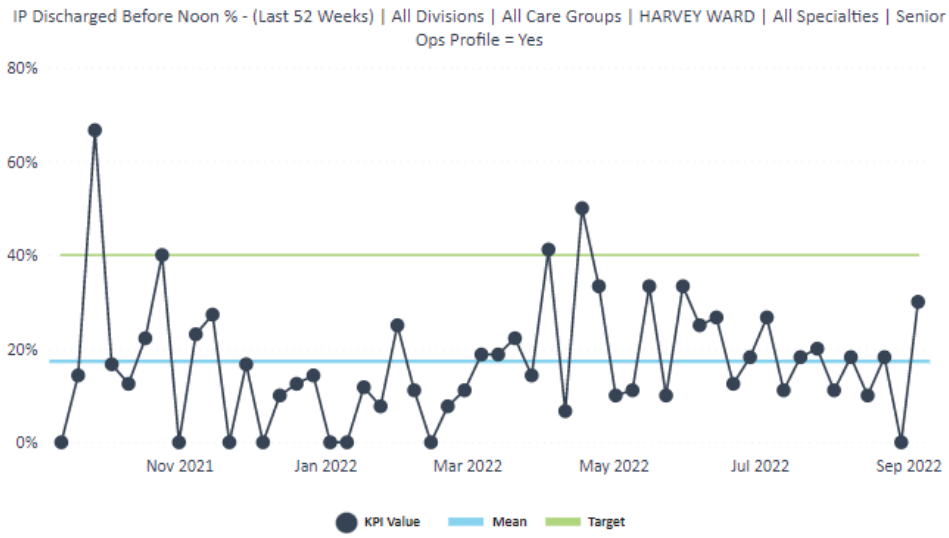
3.2

Table 2 – Harvey Ward Pre-noon discharges

Table 2 shows the IP discharges before noon. The target is 40% of the bed base per week. By working within a seven day multi-disciplinary team model, we aim to significantly improve the discharge percentage in line with the target, thus allowing for stabilization and an increased flow in the pathway from suitable patients in ED.



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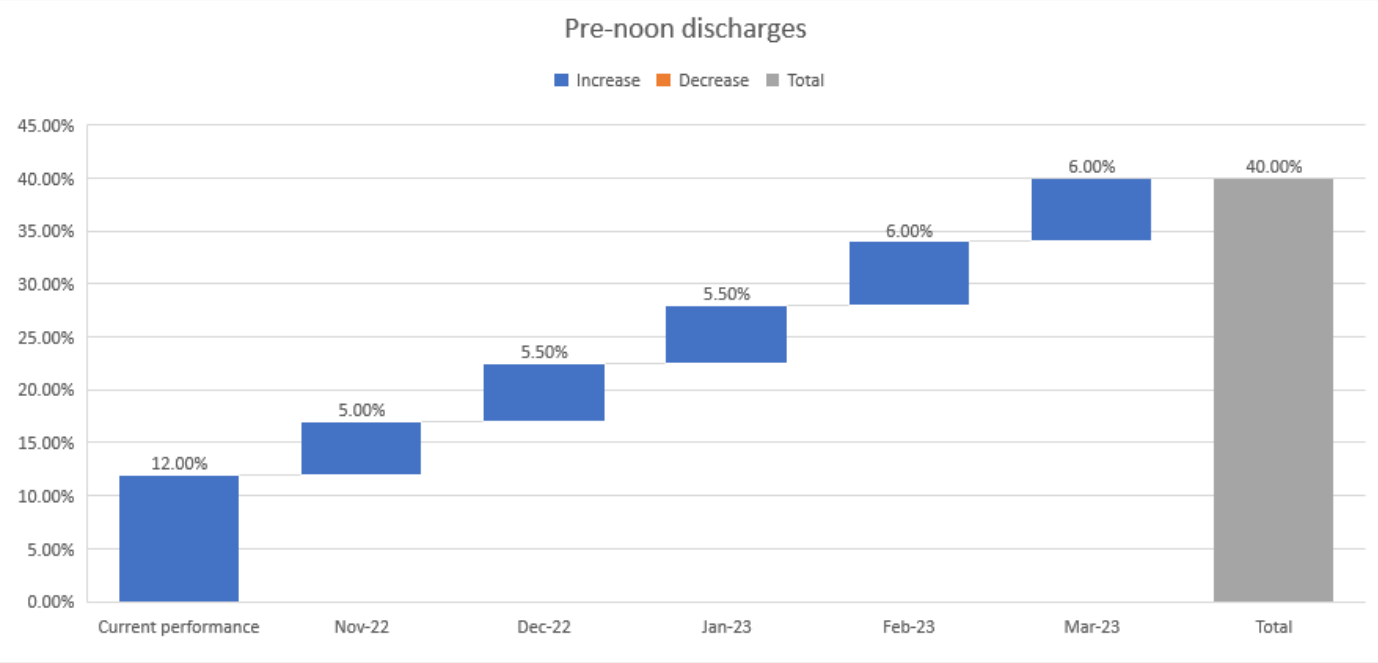
3.3

Table 3:

Current performance	12.00%	All types average
Nov-22	5.00%	but cannot rely on
Dec-22	5.50%	August data from
Jan-23	5.50%	Tableau as MEDOCC
Feb-23	6.00%	still in BCI due to
Mar-23	6.00%	clinical systems
Total	40.00%	issues with



4. Financial Case

4.1 Harvey Ward Annual Financial Breakdown

Harvey Ward has a current budget is 1,741,489 (Pay and Non Pay) with a Nursing workforce establishment of 45.72 WTE. This consists of the following:

- 1WTE Band 7 Ward Manager
- 5.26 WTE Band 6
- 18.54 WTE Band 5
- 18.95 WTE Band 2
- 0.97 WTE Ward Clerk
- 1 WTE Non Clinical Support Worker

Cost Centre:	AA802000
Description:	Harvey Ward
Period:	4
Period:	July
Year:	2023

Expense Head	Description	Original	YTD			Curr Mth					
		Ann Budget	Budget	Actuals	Variance	Budget	Actuals	Variance	Worked WTE	Bud WTE	WTE Variance
AS2010000000	Non Clinical Band 2	24,565	8,188	8,137	-51	2,077	2,034	-43	1	1	0
CB2010000000	Admin & Clerical Bank Band 2	0	0	541	541	0	0	0	0	0	0
CS2010000000	Admin & Clerical Band 2	37,806	12,600	7,297	-5,303	7,068	1,823	-5,245	0.97	0.97	0
NA5010000000	Agency Nurse Band 5	0	0	9,484	9,484	0	3,282	3,282	0.63	0	0.63
NB2010000000	Bank Healthcare Asst Band 2	0	0	64,278	64,278	0	21,508	21,508	7.4	0	7.4
NB5010000000	Bank Nurse Band 5	0	0	39,169	39,169	0	13,236	13,236	3.66	0	3.66
NB6010000000	Bank Nurse Band 6	0	0	8,686	8,686	0	-3,099	-3,099	-0.7	0	-0.7
NS2010000000	Healthcare Asst Band 2	518,616	172,872	156,684	-16,188	35,559	41,003	5,444	15.25	18.95	-3.7
NS5010000000	Nurse Band 5	736,204	245,400	236,674	-8,726	51,084	60,523	9,439	18.87	18.54	0.33
NS6010000000	Nurse Band 6	253,300	84,432	64,527	-19,905	21,015	15,387	-5,628	4	5.26	-1.26
NS7010000000	Nurse Band 7	54,454	18,152	26,419	8,267	4,856	8,894	4,038	2.8	1	1.8
Pay		**1,624,945**	**541,644**	**621,896**	**80,252**	**121,659**	**164,591**	**42,932**	**53.88**	**45.72**	**8.16**
1.01E+11	Drugs	46,896	15,632	20,425	4,793	3,908	4,578	670	0	0	0
1.02E+11	Dressings	12,852	4,284	4,705	421	1,071	932	-139	0	0	0
1.06E+11	Med & Surgl Equip - Disp	25,416	8,472	9,920	1,448	2,118	2,923	805	0	0	0
1.0615E+11	Clin Sundries	0	0	15	15	0	0	0	0	0	0
1.2E+11	Med & Surg Equip - Gen	3,456	1,152	5,927	4,775	288	743	455	0	0	0
1.55E+11	Cardiac packs	192	64	17	-47	16	17	1	0	0	0
1.7E+11	Surg Instruments General	924	308	0	-308	77	0	-77	0	0	0
1.9E+11	Prosthesis	5,760	1,920	1,248	-672	480	149	-331	0	0	0
1.9016E+11	TED Stockings	600	200	66	-134	50	66	16	0	0	0
2.15E+11	Med & Surg Equip - Purchase	10,464	3,488	2,907	-581	872	1,286	414	0	0	0
2.56E+11	Lab MES	0	0	5	5	0	2	2	0	0	0
4.01E+11	Stationery	2,448	816	289	-527	204	54	-150	0	0	0
4.3001E+11	Travel & Subsistence	3,192	1,064	0	-1,064	266	0	-266	0	0	0
4.3401E+11	Training Expenses	288	96	0	-96	24	0	-24	0	0	0
4.45E+11	Furniture & Fittings	0	0	150	150	0	0	0	0	0	0
4.46E+11	Office Equipment	0	0	41	41	0	0	0	0	0	0
4.9101E+11	Interpreting services	216	72	0	-72	18	0	-18	0	0	0
4.99E+11	Miscellaneous	1,260	420	0	-420	105	0	-105	0	0	0
5.1E+11	Provisions	0	0	123	123	0	28	28	0	0	0
5.15E+11	Hardware & Crockery	540	180	52	-128	45	15	-30	0	0	0
5.3001E+11	Cleaning Materials	1,824	608	397	-211	152	86	-66	0	0	0
5.4001E+11	Bedding & Linen	216	72	47	-25	18	8	-10	0	0	0
7.4E+11	Losses & Comps	0	0	88	88	0	0	0	0	0	0
Non Pay		**116,544**	**38,848**	**46,421**	**7,573**	**9,712**	**10,887**	**1,175**	**0**	**0**	**0**
TOTAL INCOME & EXPENDITURE		**1,741,489**	**580,492**	**668,317**	**87,825**	**131,371**	**175,478**	**44,107**	**53.88**	**45.72**	**8.16**

NOTE:

There is a YTD overspend on Harvey based on the Aug-22 budget statement (above) of £87.8k. This overspend is sitting on pay and largely due to premium costs on Bank HCA and Bank Nurse Band 5's, which are above the budgeted WTE. This is related to the need for one to one nursing and RMN specials. Based on the patient cohort in the Community, this would not be a recurrent issue at Minster Ward as patients with delirium or dementia will not form part of the selection criteria, reducing the one to one nursing.

4.2 Financial Summary

Please see below a full costs breakdown:

			Annual Cost		
		WTE's	Existing Budget	Additional Requirement	Total
Harvey Ward Staffing Budgeted WTE	Substantive Rate	45.72	£1,624,945		£1,624,945
Existing Tier 1 Doctors for Harvey Ward	Substantive Rate	3.00	£240,000		£240,000
Existing Tier 2 Doctors for Harvey Ward	Substantive Rate	2.00	£175,200		£175,200
Existing Consultant	Substantive Rate	1.00	£144,000		£144,000
Existing Non-pay Budget			£116,544		£116,544
New Matron for Minster Ward	Substantive Rate	1.00		£55,000	£55,000
New Tier 1 doctors to cover out of hours	Bank Rate	3.60		£447,408	£447,408
New Tier 1 doctors to cover out of hours	Substantive Rate	1.00		£87,600	£87,600
New Therapy Staff	Substantive Rate	3.00		£106,642	£106,642
New Pharmacy Staff	Substantive Rate	1.00		£37,500	£37,500
Bank & Agency Premium (40%)	Bank & Agency			£293,660	£293,660
Additional Staff Travel Budget	Non pay			£232,010	£232,010
TOTAL		**61.32**	**£2,300,689**	**£1,259,821**	**£3,560,510**

The following table was submitted to the NHSE/I as part of their demand and capacity funding requirements submission. The update on the 1st August is that the £1.2M requested has been agreed in its entirety.

Minster - 22 additional beds	Annual Cost (£'s)	5m cost from 1st November	
NURSING	**£55,000**	£22,917	1 x WTE Band 8a Matron Plus existing Harvey Ward establishment
MEDICAL	**£535,008**	£222,920	1 x Tier 1 1700-0900 x 5 days (£257,920) 1 x Tier 1 0900-1700 Sat+Sun (£48,360) 1 x Tier 1 1700-0900 Sat+Sun (103,168) 1 x Tier 2 Mon-Fri (£87,600) 1 x Tier 2 0900-1700 Sat+Sun (£37,960 sub) (3 x Tier 1 + 2 x Tier 2 already in Harvey budget)
ADMIN	**NIL**		Lift And Shift of Harvey existing budget
THERAPY SERVICES	**£106,642**	£44,434	1 x WTE Band 6 (£41,788) 1 x WTE Band 5 (£34,138) 1 x WTE Band 4 (£28,586) (with the Band 4 supporting across OT/PT and Dietetics)
PHARMACY	**£37,500**	£15,625	1 x WTE Band 5 Pharmacy Technician (£37,500)

BANK & AGENCY PREMIUM	**£293,660**	£122,358	Will have a better understanding following staff consultation
PHLEBOTOMY	**NIL**		No requirement
TOTAL PAY	**£1,027,810**	£428,254	
Non-pay (Inc. staff transport)	**£232,010**	£96,671	3 x models have been worked up, to include different assumptions for percentage of staff eligible to claim travel expenses. (Page 12 for full breakdowns)
Estates indicative cost	**N/A**	N/A	To be covered from £200,000 Estates Fund held by CCG
TOTAL	**£1,259,820**	**£524,925**	

4.3 Additional Medical Cost Breakdown

Existing Junior Doctors Medical Budget associated with Harvey Ward:							**Tier 1**	**3.00**	**WTE**																
							Tier 2	**2.00**	**WTE**																
Below is the additional requirement for Minster Ward/ Sheppey:																									
				Hours	**Cost per day**	**Cost Per Week**	**Bank Cost Per Year**							**Hours**	**Cost per day**	**Cost Per Week**	**Bank Cost Per Year**								
Bank SHO	F-SDEC	**17:00**	**09:00**	16	£ 992	£ 4,960	£ 257,920		Bank SHO	F-SDEC	**17:00**	**09:00**	16	£ 992	£ 1,984	£ 103,168	£ 361,088							
									Bank SHO	F-SDEC	**09:00**	**17:00**	7.5	£ 465	£ 930	£ 48,360	£ 86,320							
							£ 257,920										£ 151,528								
				Hours	**Cost per day**	**Cost Per Week**	**Substantive Cost Per Year**							**Hours**	**Cost per day**	**Cost Per Week**	**Substantive Cost Per Year**								
SpR	F-SDEC	09:00	17:00	8	£ 1,460	£ 7,300	£ 87,600		SpR	F-SDEC	09:00	17:00	8	£ 365	£ 730	£ 37,960								
											55,000		55000												
	Late change:										447,408		535008												
											146,200		192900												
	Additional Band 7 Pharmacist Added						55,000				55,000		110000												
	Additional SpR added per the green highlighted section above						87,600				125,000		125,000												
	Additional B6 Physio added						46,700				87,600														
	Additional Estates costs added						125,000				46,700	B6													
							314,300				55,000		7												

4.3.1 Medical Costs Justifications

The current medical establishment within Harvey Ward that will form part of the lift and shift is currently 3 x Tier 1 SHO's and 2 x Tier 2 SpR. This medical service provides cover Monday-Friday during working hours. No cover is provided out of hours or at weekends.

The additional medical investment will enable safe delivery of a 24 hour, 7 days a week sustainable model of care with the following aims and benefits:

- A 24 hour 7 day service, as an acute frailty model, which will have clear reliable pathways direct from ED, reducing wait time, potential breaches and freeing up capacity.
- No additional cost for Consultant cover is required. Consultants covering Harvey Ward would be aligned to Minster Ward, as per their existing job plan.
- Allows for consistent out of hours and weekend cover, which in turn enhance patient experience and reduce LOS.
- As the service matures, the Frailty Unit would also offer a Rapid Access Clinic for Elderly (RACE), this would provide consultant led assessment in a timely manner with a view to hospital admission avoidance.

4.4 Additional Therapies Cost Breakdown

Therapy

From	01 April 2022
To	31 March 2023
Bank holidays	8

		Annual		Weekdays 253				Saturdays 52				Sundays 60					
Role	Grade	WTEs	Cost	Day	Early	ong Da	Night	Day	Early	ong Da	Night	Day	Early	ong Da	Night	Cover	HCAS
2022/23																	
	Blank	-	-													N	None
	Band 2	-	-													y	None
	Band 4	1.00	28,586	0.73				0.25				0.25				Y	None
	Band 5	1.00	36,269	0.63				0.50				0.50				Y	None
	Band 6	1.00	41,788	0.73				0.25				0.25				Y	None
	Band 7	-	-													Y	None
	Blank	-	-													Y	None
	Blank	-	-													Y	None
	Blank	-	-													Y	None
	Blank	-	-													Y	None
	Blank	-	-													Y	None
	Blank	-	-													Y	None
Current structure		3.00	106,642														
5 months costs			44,434														
Proposed structure		-	-														
Change		3.00	106,642														

Specialing Pressure

Shift	Start	Finish	Duration	Breaks	Hours
Day	08:00	16:00	8.0	(0.5)	7.5
Early	07:30	15:30	8.0	(0.5)	7.5
Long Da	07:30	20:30	13.0	(1.0)	12.0
Night	20:00	08:00	12.0	(1.0)	11.0
Enhanc	20:00	06:00			

Days				
Net	Leave	Sick	Trainir	Gross
260	37	10	10	317

4.4.1 Therapies Staffing Model and Cost Justifications

The proposed staffing model does not meet the minimum staffing levels required for the service to be self-sufficient and not reliant on support from the existing therapy teams based at MFT for cover for sickness, annual leave, etc.

The existing therapies establishment at MFT is one of the lowest nationally, using Model Hospital data:

	Occupational Therapy	Physiotherapy
National Peer Average WTE	68.2	120.5
MFT WTE in post	16.6 (24.34% of peer average WTE)	30.31 (25.15% of peer average WTE)
MFT WTE budgeted	19.3 (28.29% of peer average WTE)	41.55 (34.48% of peer average WTE)

While working is ongoing to improve recruitment and retention within OT and PT services, even fully established, the Trust remain one of the lowest staffed Therapy departments nationally.

The additional Therapies investment proposal of an additional 3 WTE therapy staff for a 7-day model of care would provide the following service:

- An average of two contacts per patient per week. These contacts will consist of an initial therapy assessment within 24 hours of admission, meeting the requirements of an MDT Comprehensive Geriatric Assessment, identifying patient-centered goals and commencing discharge planning from the point of admission (unless patients are admitted over a weekend) and a discharge assessment (ensuring patients are safe for discharge, making onward referrals, providing advice/education to reduce the risk of readmission). It is unlikely patients will receive enablement/rehabilitation interventions due to the staffing model, this is likely to increase length of stay and care needs on discharge.
- It is anticipated that nursing staff and CSWs will provide support to patients to continue with rehabilitation/mobilisation plans between these therapy sessions; this supplements and enhances therapy interventions, but does not replace them.
- 3 WTE staff will be able to provide 5 day therapy cover however, there will be no backfill during periods of annual leave, sickness, study leave, etc.
- A Band 5 would provide continuity of PT and OT cover to the Unit, ensuring therapy interventions are delivered in a timely way to continually support prompt discharges.
- A Band 4 would support with PT and OT interventions and work with functional independence from a Dietetics perspective.
- The opportunity for rotations within the team would be improved, making MFT a stand out employer from a Therapies perspective.
- Other models have been considered to provide therapy input to Minster Ward, including seeking support from MCH and HRCG which has not been successful.

4.5 Additional Non-Pay Travel Cost Breakdown

4.5.1 Financial Assumptions for Non-Pay Travel Costs

The key financial assumptions behind the costing of staff travel claims are as follows:

- An element of all staff (existing and new) will fall in scope to claim travel expenses on the basis that all staff will need to rotate across both sites to ensure cover arrangements are in place.
- Staff are required to be able to travel to and from the Sheppey site through their own personal transport (should be an essential condition of interest to work at Minster Ward).

4.5.2 Financial Summary of Staff in Scope to Claim Travel

	WTE's
Harvey Ward Staffing Budgeted WTE	45.72
Existing Tier 1 Doctors for Harvey Ward	3.00
Existing Tier 2 Doctors for Harvey Ward	2.00
Existing Consultant	1.00
New Matron for Minster Ward	1.00
New Tier 1 doctors to cover out of hours	1.00
New Tier 2 doctors to cover out of hours	3.60
New Therapy Staff	4.74
New Pharmacy Staff	1.00
	63.06

4.5.3 Financial Models for Staff Travel Costs

Three models have been worked up which include different assumptions in terms of the percentage of staff eligible to claim travel expenses.

Model 1 - Assumes that 60% of the above staff will be eligible to claim travel expenses, and the annual cost is expected to be £232,000.

Minster Ward - Staff Travel Claims	
63.06	Staff numbers (Harvey Ward Budgeted at 45.72 WTE, medical staff 10 wte, therapy staff - 5 wte, pharmacy 1 wte, 1 Consultant & Matron 1.00 wte)
60%	% of staff expected to travel there at back on a daily basis
37.836	Total number of staff expected to make millage claims on a daily basis
30	Miles per day per staff (there and back)
365	Days a year
414,304	
0.56	Millage reclaim per mile
£232,010	

Model 2 - Assumes that 50% of the above staff will be eligible to claim travel expenses, and the annual cost is expected to be £193,000.

Minster Ward - Staff Travel Claims	
63.06	Staff numbers (Harvey Ward Budgeted at 45.72 WTE, medical staff 10 wte, therapy staff - 5 wte, pharmacy 1 wte, 1 Consultant & Matron 1.00 wte)
50%	% of staff expected to travel there at back on a daily basis
31.53	Total number of staff expected to make millage claims on a daily basis
30	Miles per day per staff (there and back)
365	Days a year
345,254	
0.56	Millage reclaim per mile
£193,342	

Model 3 - Assumes that 30% of the above staff will be eligible to claim travel expenses, and the annual cost is expected to be £116k.

Minster Ward - Staff Travel Claims	
63.06	Staff numbers (Harvey Ward Budgeted at 45.72 WTE, medical staff 10 wte, therapy staff - 5 wte, pharmacy 1 wte, 1 Consultant & Matron 1.00 wte)
30%	% of staff expected to travel there at back on a daily basis
18.918	Total number of staff expected to make millage claims on a daily basis
30	Miles per day per staff (there and back)
365	Days a year
207,152	
0.56	Millage reclaim per mile
£116,005	

It is recommended setting a budget for staff travel claims of £232,010, with an assumption that 60% of all staff will be eligible to claim travel expenses.

4.6 Financial Assumptions

- Sheppey would cost an estimated £2.9m - £3.9m dependent upon whether this is fully substantive or fully bank and agency staff.
- Calculation of annual, costs as per attached; this equates to £241k - £326k per month, so if applied from August would cost £1.7m - £2.3m.
- This includes non-pay costs, but not overheads or rental (which would likely be capital under IFRS16). It has been predicated on community beds.

4.7 Harvey Ward Re-Purposing Costs (Estimate)

Ward Manager	Band 7	1.00	£57,851
Senior Sister	Band 6	5.25	£318,495
Staff Nurse	Band 5	15.75	£768,630
CSW	Band 2	13.24	£429,657
Ward Clerk	Band 2	2.17	£63,319
NCSW	Band 2	1.00	£24,498
Total		38.41	£1,662,450
Non-pay			£142,758
Total			**£1,805,208**

5. Quality and Patient Improvements

Please see below embedded document – Quality Impact Assessment

QIA.docx Harvey lift and Shift to Minster

6. Procurement and Facilities Management Contracts

This is being managed with NHSPS, but where possible HCRG existing services will be 'piggy-backed' on to.

Estates:

- Tony Sampson within NHSPS Minor Works team is engaged and has commenced tender process with local contractors
- A 4-week window is required for contractor tenders, though it's hopeful we can obtain all costings prior to the end of August – works are expected to take 3-4 weeks

Please see **Annex 1** (Page 24) for full Heads of Terms

- Headlines as follows:
    - **Term** – 15 years
    - **Break** – Mutual Break at 10 years
    - **Area** - Net Internal Area - 540.64m2
    - **Rent** - Initial Rent of £54,064.00 per annum exclusive of VAT
      Rent review – Open Market – Upwards only - every third year anniversary – and on the last day of the term.

Minster Ward – Compliance Work (snagging list)

As the Ward is currently vacant and following inspection from MFT clinical and operational staff (frailty) the following works have been identified (from snagging list):

- Replacement of non-compliant wash hand basins
- Provide AC to clean utility
- Digi locks to cabinetry in utilities
- New clinical wash hand basins to day room and nurse station
- Create new wet room
- Install holdback facility linked to fire alarm to 3 pairs of doors
- Provide new blinds throughout
- Overhaul windows to ensure compliance
- Adapt roof ladder in corridor to make safe
- General making good to decorations
- Replace flooring to bedded bays to provide correct skirting detail
- Install fob access to Utilities
- Making good behind recent nurse call and LED lighting installation

Estates Costs & Procurement of works

- NHSPS Minor Works team is engaged and has commenced tender process with local contractors.
- MFT would prefer NHSPS to complete the works rather than tender themselves.
- A 4-week window is required for contractor tenders
- Following tender and contractor works period – target date for works to be completed would be mid to end October.
- HoTs issued to MFT for review
- Currently there is an estimated £200,000 in the estates fund (CCG held)
- The table (figure 1) above lists the estates costs at £125,000
- Current estimate from NHSPS Is between the range of £90,000 - £120,000

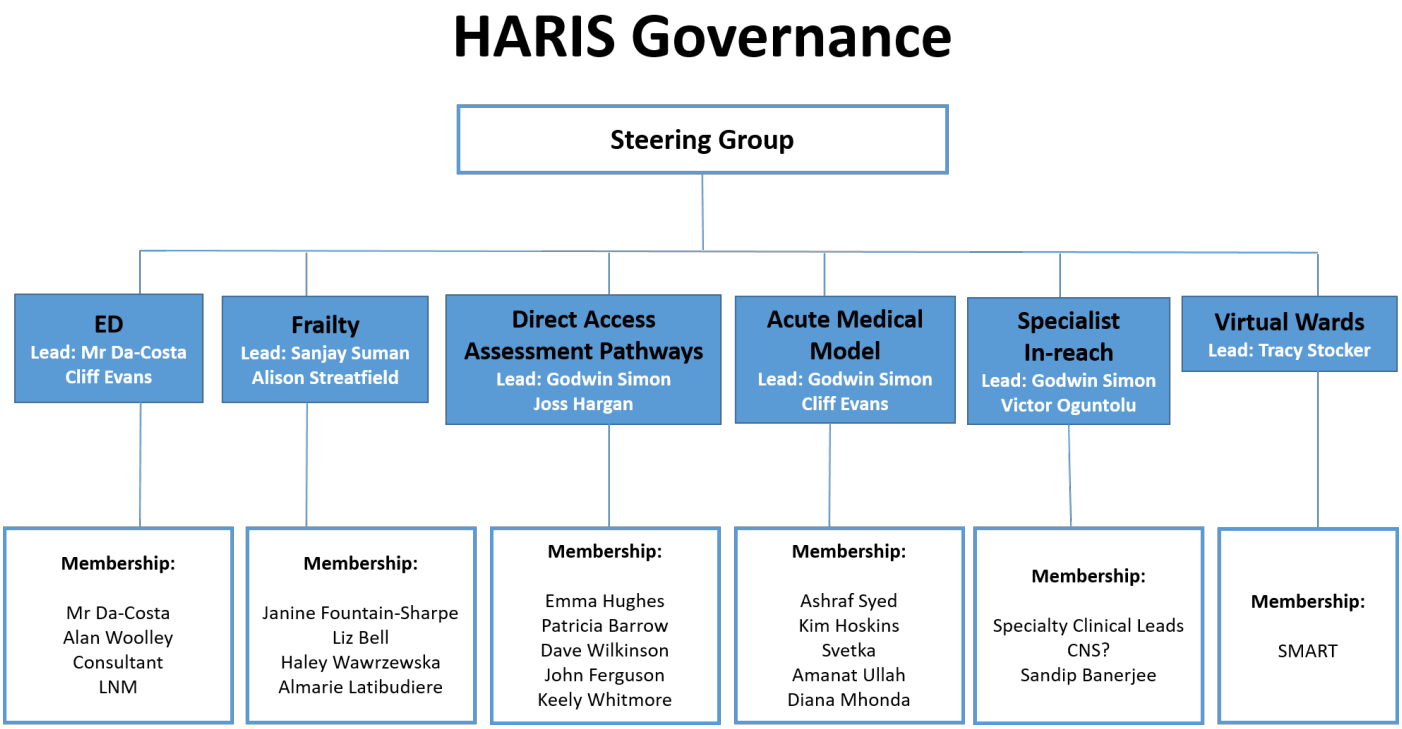
Please find the following Facilities Management Contracts embedded within the Appendices:

- Facilities Management SLA – Grounds and Gardens –**Appendix 4**
- Facilities Management SLA – M&E and Fabric – **Appendix 5**
- Facilities Management SLA – Pest Control – **Appendix 6**
- Facilities Management SLA - Portering – **Appendix 7**
- Facilities Management SLA – Post – **Appendix 8**
- Facilities Management SLA **–** Reception Services **– Appendix 9**
- Facilities Management SLA – Sanitary Waste – **Appendix 10**
- Facilities Management SLA – Security – **Appendix 11**
- Facilities Management SLA – Waste Management – **Appendix 12**
- Facilities Management SLA – Window Cleaning – **Appendix 13**

7. Management Case

7.1 Project Management

This project is being managed via the HARIS Steering Group, meeting on a monthly basis and is chaired by the CMO, Alison Davis (previously chaired by Jayne Black CEO).



7.2 Project Governance

This programme of work will update the LAE Delivery Board on a monthly basis and where appropriate and instructed, the HaCP Executive Group. Terms of reference and clear lines of reporting are agreed and in place.

7.3 Key Stakeholders

MFT Internal Stakeholders

Executive Sponsor(s)

Jayne Black	Chief Executive
Mandy Woodley	Interim Chief Operating Officer
Evonne Hunt	Chief Nursing Officer
Leon Hinton	Chief People Officer

Frailty

Sanjay Suman	Clinical Director Therapies and Older Persons Care Group
Alison Streatfield	Head of Nursing Therapies and Older Persons Care Group
Jazz Fountain-Sharpe	General Manager Therapies and Older Persons Care Group

Estates

MFT	Richard Daniels (interim) Director of Estates

External Stakeholders

MCH

Martin Riley	Managing Director Medway Community Healthcare
Penny Smith	Director of Operations Medway Community Healthcare

HCRG

Debbie Linden-Taylor	Head of Business Unit- North Kent HCRG
Patrick Birchall	National Director of Operations HCRG

CCG

Justin Chisnall	Director of Integrated Care Commissioning

Business Case Sponsors

Martin Riley	Managing Director Medway Community Healthcare
Jayne Black	Chief Executive
Justin Chisnall	Director of Integrated Care Commissioning

Communications Plan to include:

- Patient/family leaflets - clarity on services being provided not 'rehab' necessarily & why being treated in Sheppey rather than MFT.
- Inform system partners of changes - function, opening dates etc.
- Internal comms around changes to existing frailty arrangements.
- Local communication campaign.

8. Non-Financial Benefits, Performance & KPIs

- To have an integrated joined-up service following a single model and standards of care for rehabilitation and frailty assessment, including primary care, community physical, mental health, social care services and acute services.
- To have an effective pathway of care that reduces the avoidable acute hospital admissions through effective assessment and care planning to meet the needs of frail adults, either in the community or in step-up bedded facility. Direct admissions via Urgent care response teams, GPs or Ambulance services, with an access aspiration of 24-hours per day.
- To optimise the flow of patients from the acute hospital that requires bed-based rehabilitation as a key component of the hospital discharge pathways on their route to their place of residence.

- To provide high quality End-of-Life care where this is the most appropriate option when home and community hospice care have been suitably considered.
- To ensure care meets the needs of the cohort of patients including those with dementia and other old age psychiatric needs
- Analysis and ongoing monitoring of the demand and service capacity to ensure patients are flowing safely along the most appropriate pathway of care in the most appropriate setting.
- To nurture and develop an effective interface and joint working with community, voluntary and not for profit sector services.
- Provide an excellent patient and family experience.

What types of KPIs will be used to measure the success of the change?

- A reduced length of stay for patients.
- Swale patient management and transfer to Minster ward.
- Pathway metrics.

Is the data available for your proposed KPIs?

- Yes – this data will be pulled from the PTL and will be managed in the same way that acute wards currently are.

How will the provider be managed?

- This is a MFT managed ward.
- There will be close and cooperative working with HCRG and we are exploring shared services where appropriate and cross cover. We have also pursued a MFT only model and have reached out to NHSPS to provide all services to the ward, as if this was a stand-alone, MFT only operation.

9. Risks, Assumptions, Issues & Dependencies (RAID)

9.1 Risks

- Staffing – Transfer of MFT staff to Minster (whether this is welcomed by the current staff working on Harvey Ward). Consultation due to commence upon sign off.
- Recruitment does not lend itself to the timescale based on HR processes.
- Consultation process may not lend itself to the projected timescale.
- Access to the site should there be issues with transport.
- That the 22 beds at Minster are used correctly and in line with the pathway and processes in place – this cannot become a 'dumping' ward for any patients – the model needs to be upheld and the processes strong and understood by all staff.
- Transfer of patients to the ward.
- Stocking of equipment and medicines.
- As an acute ward, a requirement for DNAR and treatment escalation forms to be filled out (ward-based care only)
- Staff transport.

9.2 Issues

Will be managed through the project plan, HARIS Steering Group and (MOG) Minster Operational Group, which will be set up on completion of sign off and will include NHSPS, TOP Management Team, and other key stakeholders.

10. Key Milestones

Please describe the key milestones below including the timescale for approvals.

Key Milestone No.	Key Milestone Description	Owner	Planned Completion Date
1	*Decision to proceed*	*HaCP Executive*	*5th August*
2	*Decision to proceed*	*Medway FT*	*12th August*
3	*Funding agreed*	*HaCP Executive*	*12th August*
4	*Funding agreed - Exec Sign off of finance frailty SCH ward: therapies, medical, nursing & pharmacy*	*Medway FT*	*20th September*
5	*Sign-off - Exec Sign off of frailty ward - rental agreement (contract between MFT and NHS Property)*	*HaCP Executive*	*27th September*
6	*Sign-off - EXEC sign off for finance ward equipment or transfer from existing MFT stock*	*Medway FT*	*27th September*
7	*Staff Consultation* (Please see **Appendix 5 - Consultation Document - Harvey Ward)***	*Medway FT*	*30th September*
8	*Partner engagement and agreement (incl. communication)*	*All Stakeholders*	*On-going*
9	*Go live*	*MFT/Frailty*	*Nov/Dec 2022*

11. Record of Review History

Please ensure all reviewers identified below are contacted in advance to capture any final feedback or comments ahead of the sign-off process.

Department/Group/Organisation	Name of Reviewer/contributor/Approver	Date
Operations/Executive	Jayne Black	

12. Declaration

I have read and approved of the content of this business case and give authority to the author to proceed with assurance and approval:

Executive Sponsor approval	
Print Name:	Jayne Black Chief Executive Medway Foundation Trust
Signature:	
Date:	

HaCP Board approval	
Print Name:	Martin Riley Managing Director Medway Community Healthcare
Signature:	
Date:	

13. Appendices

Appendix 1 – Sheppey Community Hospital – Heads of Terms

Heads of Terms SFU.docx

Appendix 2 - Consultation Document - Harvey Ward - Draft

Harvey Ward Consultation Paper

Appendix 3 – Standard Operating Procedure (Criteria for Admission to Minster Ward - Draft

SOP admission to Sheppey Frailty Unit

Appendix 4 – Facilities Management SLA – Grounds and Gardens

FM SLA - Grounds & Gardens.docx

Appendix 5 – Facilities Management SLA – M&E and Fabric

FM SLA - M&E and Fabric.docx

Appendix 6 – Facilities Management SLA – Pest Control

FM SLA - Pest Control.docx

Appendix 7 – Facilities Management SLA – Portering

FM SLA - Portering.docx

Appendix 8 – Facilities Management SLA – Post

FM SLA - Post.docx

Appendix 9 – Facilities Management SLA – Reception Services

FM SLA - Reception Services.docx

Appendix 10 – Facilities Management SLA – Sanitary Waste

FM SLA - Sanitary Waste.docx

Appendix 11 – Facilities Management SLA – Security

FM SLA - Security.docx

Appendix 12 – Facilities Management SLA – Waste Management

FM SLA - Waste Management.docx

Appendix 13 – Facilities Management SLA – Window Cleaning

FM SLA - Window Cleaning.docx

Meeting of the Trust Board (Public/Private)/ Committee
Thursday, 15 December 2022

Title of Report	**Medical Education Report**	**Agenda Item**	
Author	Janette Cansick, Director of Medical Education Ginny Bowbrick, Deputy Director of Medical Education Shirley Chan, Deputy Director of Medical education Carol Atkins, Head of Medical Education Services		
Lead Executive Director	Alison Davis, Chief Medical Officer		
Executive Summary	To inform/advise the Board of: 1. Introduction & the structure of Medical Education 2. Changes in Trainee Establishment 3. National Workforce Expansion and Redistribution Programmes 4. Finance and Education Centre upgrade 5. COVID19 recovery funds from HEKSS 6. Update on HEKSS Quality Visit action plans 7. GMC 2022 survey 8. Simulation Report 9. Undergraduate Report, including KMMS and Accommodation 10. Library Report MFT has one Director of Medical Education supported by two Deputy Directors of Medical Education and Strategic Medical Education Manager to oversee medical training, with educational leads within different programmes and specialties to oversee delivery. The DME is accountable to the Trust Chief Medical Officer and Health Education Kent Surrey Sussex Postgraduate Dean. Our current priorities are: a. Our response to HEKSS Quality and the GMC survey principally for Medicine and Surgery b. Welcoming KMMS students on site and ensuring readiness for increase student numbers in 2023, both in education and training as well as accommodation c. Planning for expansion and redistribution of trainee posts nationally, working with Service to ensure we are ready for additional trainees which will improve patient care d. Completing the Education Centre refurbishment to ensure excellence in educational facilities.		
Proposal and/or key recommendation:	The Board is requested to: 1) Receive an update on the current HEKSS Quality Visits and GMC Survey responses 2) Receive an update on current and possible future expansion of postgraduate doctors in training (trainee) establishment		

	3) Receive an update on the start of KMMS students in MFT, and plan for increased student numbers going forward 4) Be aware of the risks and mitigations identified within Medical Education: a. Incomplete refurbishment of the Education Centre b. Accommodation requirements for additional medical students from September 2023 c. Long-standing open Quality Action plan in Acute and General Internal Medicine

Purpose of the report (tick box to indicate)				
	Assurance	√	Approval	
	Noting		Discussion	

(If appropriate) state reason for submission to Private section of Board:				
	Patient Confidentiality:	Staff Confidentiality:	Commercially Sensitive:	Exceptional Circumstances:

Committee/Group at which the paper has been submitted:	The People Committee meeting, 24 November 2022

Patient First Domain/True North priorities (tick box to indicate):	Tick the priorities the report aims to support:				
	Priority 1: (Sustainability) √	Priority 2: (People) √	Priority 3: (Patients) √	Priority 4: (Quality) √	Priority 5: (Systems) √

Relevant CQC Domain:	Tick CQC domain the report aims to support:				
	Safe: √	Effective: √	Caring: √	Responsive: √	Well-Led: √

Identified Risks, issues and mitigations:	The risks and mitigations identified within Medical Education: • Incomplete refurbishment of the Education Centre • Accommodation requirements for additional medical students from September 2023 • Long-standing open Quality Action plan in Acute and General Internal Medicine

Resource implications:	a. Expansion of KMMS students on site and ensuring readiness for increase student numbers in 2023, both in education and training as well as **accommodation** b. **Planning** for expansion and redistribution of trainee posts nationally, working with Service to ensure we are ready for additional trainees which will improve patient care c. **Completing** the Education Centre refurbishment to ensure excellence in educational facilities.

Sustainability and /or Public and patient engagement considerations:	The Medical Education Department supports the sustainability and development of the current and future medical workforce. It has key working relationships with both Health Education England (HEE) and the General Medical Council (GMC)	
Integrated Impact assessment:	**Please tick** the correct box and provide required information. Has the quality and equality assessment been undertaken? ☐ Yes (*please attach the action plan to this paper*) ☐ Not applicable (*please indicate why an equality assessment was not required)* **N/A to this full report, however an assessment has been completed for the Education Centre refurbishment previously.**	
Legal and Regulatory implications:	Education of the postgraduate doctors in training is scrutinised by the GMC annual survey. Regular reports are provided to HEE for both postgraduate and undergraduate students to ensure that we have ongoing approval for the training posts and are considered for expansion and redistribution posts.	
Appendices:	No appendices	
Freedom of Information (FOI) status:	This paper is disclosable under the FOI Act	
For further information or any enquires relating to this paper please contact:	Dr Janette Cansick Janette.cansick@nhs.net	
Reports require an assurance rating to guide the discussion:	No Assurance	There are significant gaps in assurance or actions
	Partial Assurance	There are gaps in assurance
	Assurance √	Assurance with minor improvements needed.
	Significant Assurance	There are no gaps in assurance
	Not Applicable	No assurance required.

1. Introduction & Structure of Medical Education at MFT

Health Education England (HEE) is committed to the provision of quality education and training for the development of healthcare professionals. Budget is allocated to every Local Education and Training Board (LETB) to fund specific education and training and to meet strategic education and training objectives. The NHS Education Contract is a 3 year contract managed on behalf of HEE by Health Education Kent, Surrey and Sussex (HEKSS).

HEE commissions a broad range of education and training services from a variety of Local Education Providers (LEPs, such as MFT) with the expectation of provision of high quality learning and training environments that support the learning and development of Learners undertaking education/training within the Trust. HEE expects the Trust to support national workforce priorities and those identified locally through HEKSS, and to make investment plans and decisions based on long-term workforce planning using local and national data sources including that currently produced by the Centre for Workforce Intelligence.

The Trusts have a duty to demonstrate that the quality of the education and training that they provide in the clinical environment is maintained and continuously enhanced so that Training posts and Practice Placement programmes are effective and responsive to needs of the learners, patients, service users and carers, employers, commissioners and professional/regulatory bodies. The expected outcome of quality placements and training is excellent patient care provided by competent and capable staff. The Trust has an Executive Education Lead (EEL) at Board level (this is the Chief Medical Officer) who will form the main point of contact for the organisation with HEKSS on all matters involving workforce or education contained within the Education Contract.

The Director of Medical Education (DME) is responsible for managing the KSS Contract on behalf of their LEP, within the national guidelines set out by the GMC and the medical Royal Colleges, and the regional systems set out in KSS Graduate Education and Assessment Regulations.

HEKSS expects the quality of training to be maintained and improved in terms of: administrative support for PGME; clinical medical education; programmed activities and local course delivery; provision of library services and resources supporting IT access; provision of simulation facilities; and faculty development.

As a result of the Covid pandemic, a hybrid approach to both teaching and induction has been embraced. This flexibility embraces new technologies particularly in relation to technology-enhanced learning. There has been development of the Education Centre, to improve and update facilities, both environment and technology. Notable changes include expansion of the simulation debriefing room, IT room in the library area and improved undergraduate facilities with the start of Kent and Medway Medical School (KMMS) students from October 2022.

<u>Workforce</u> (see Figure 1 & 2)

- DME dually accountable in the Trust to Miss Alison Davis, Chief Medical Officer (CMO), and at HEE to Prof.Jo Szram, Postgraduate Dean. Dr Janette Cansick, DME meets with the CMO fortnightly 1:1 and weekly at the CMO Operational Meeting.
- Deputy DME
- Strategic Medical Education Manager (SMEM, Carol Atkins) is responsible to the DME. The SMEM has an operations Medical Education Manager (MEM, June Mossop-Toms) and administration team (including the Undergraduate & Simulation team).
- LFG leads (College Tutors) in all clinical areas, Foundation Training Program Directors, Director of Undergraduate Medical Education (DUME) and specialist leads (e.g. Simulation, Careers, SAS tutors), who report into the DME.

- There are currently 160 Educational Supervisors in MFT with HEKSS approval.
- In addition the quality of Pharmacy education and training is overseen by the DME.
- The Library & Knowledge Services reports to the DME & SMEM.

Educational Quality Governance

- Voice of Postgraduate Doctors in Training
  - Trainee in Action groups in key areas of need (medicine, surgery, pharmacy)
  - Representatives at LFG and LAB
  - Meetings with DME and CMO
  - Junior Doctors' forum (contract issues)

- Local Faculty Groups (LFG, chaired by College Tutors) meet three times a year

- Local Academic Board (LAB) meets three times a year
  - reports from all areas of medical education, with joint learning
  - simulation, pharmacy and library reports
  - All LFG leads summarise improvements and any concerns arising
  - Trainee Representatives provide feedback, including patient safety concerns
  - GMC survey results and HEKSS visits are discussed.
  - All quality metrics are discussed.

Figure 1: Structure of Senior Medical Education with links and reporting lines

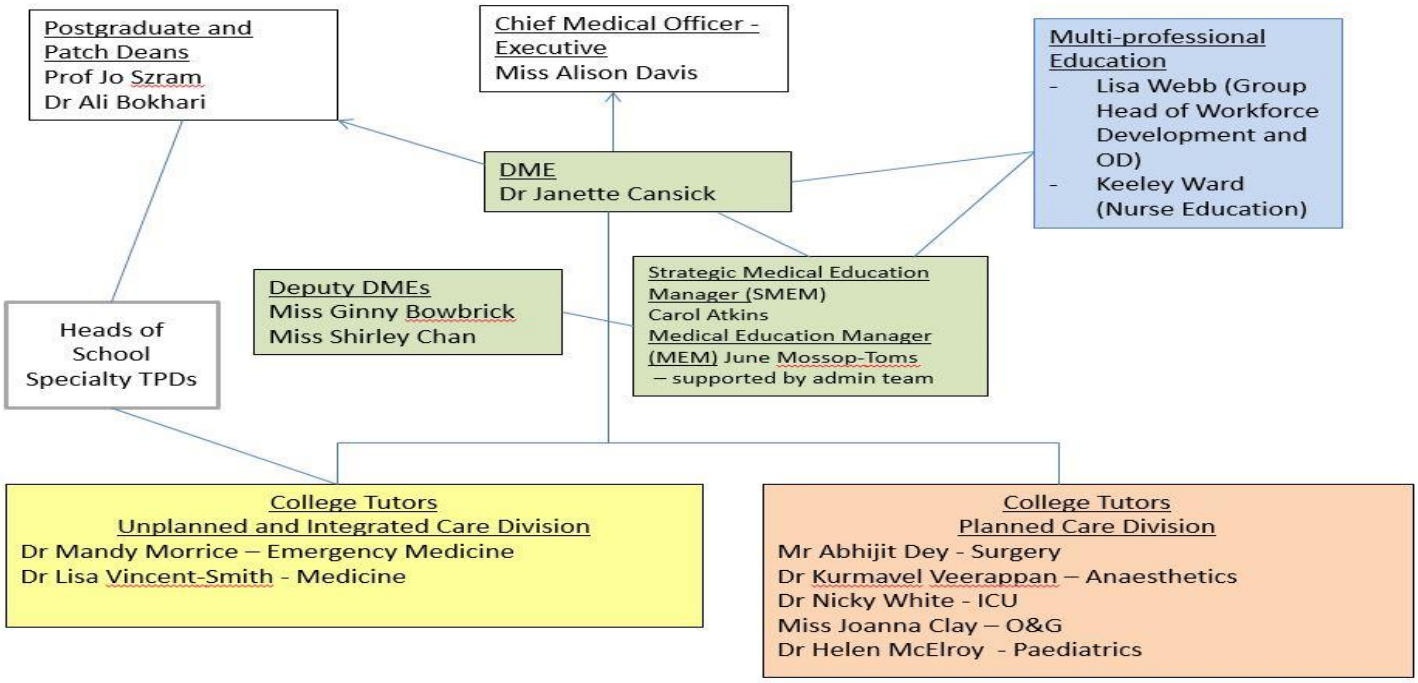
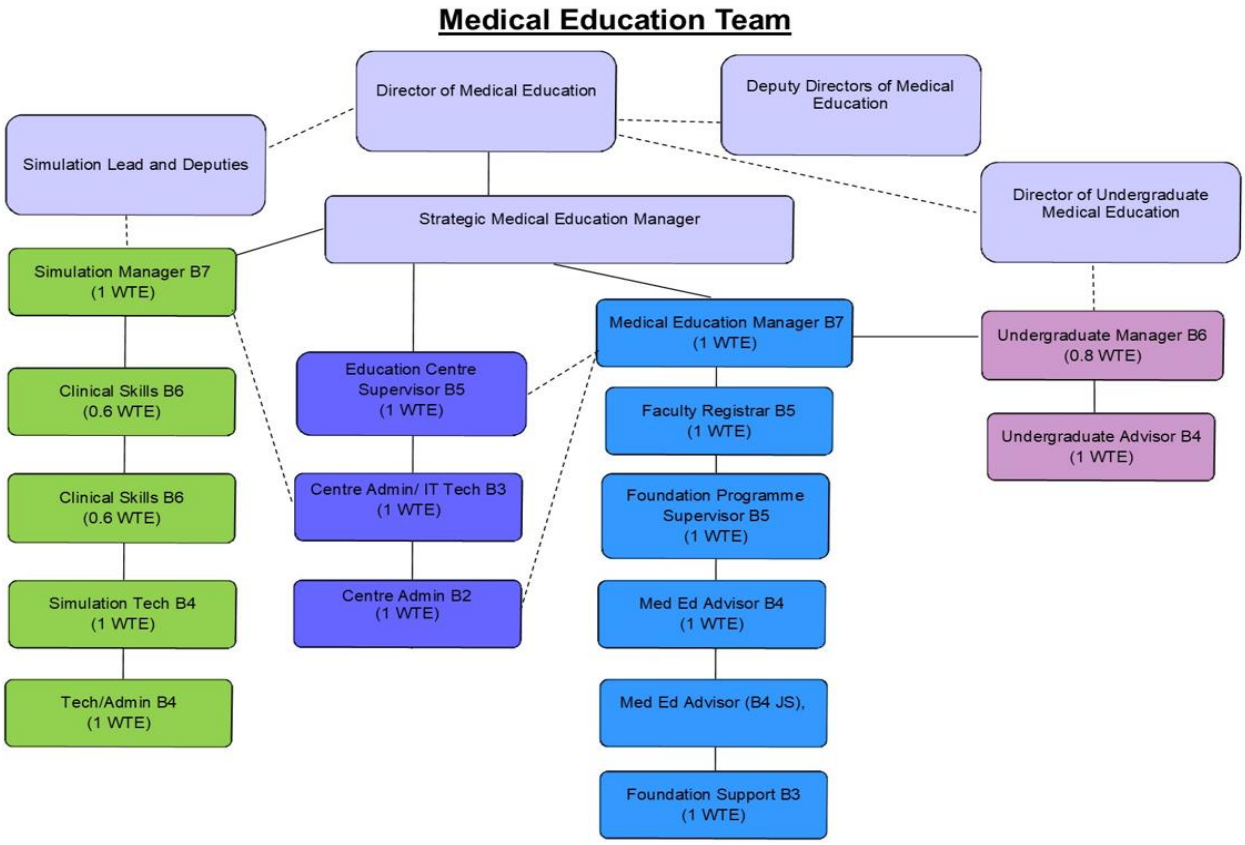


Figure 2: Structure of Operations Medical Education with links and reporting lines



2. Update on Trainee Establishment

1. Chief Registrar in Medicine
   The first appointment was made in October 2018 with a subsequent appointment in 2019. These posts, which sit within Unplanned Care, have been very successful in supporting quality improvements in Medicine, with significant involvement in Trust wide improvements such as Hospital at Night. After two years with no appointment, we are pleased to have been successful for 2022/23; our new Chief Registrar commenced in October 2022.

2. Rota gaps and recruitment
   HEKSS are responsible for the recruitment and allocation to the Trust training posts and programmes. Vacancies at Foundation and GP trainee level are very minimal, with one vacancy at F1 level, two at F2 and two at GP ST1 levels. This is a significant improvement on previous years. There has been an increase in International Medical Graduates in Foundation and GP programmes.

3. GP training
   The training programme for GPs has been reduced from 3 years to 2 years. In order to facilitate enough training within the GP surgeries, some posts have been changed from Trust placements to Integrated Training Placements (ITP) where trainees work in the allocated department 2 days per week, with 2 days in GP and 1 day for dedicated education. The impact in some departments (notably paediatrics, Obs and Gynae, ENT) is being mitigated by the increase in Foundation posts in Trust.

4. Expansion of training post numbers
   We have worked closely with HEKSS to accept 7 additional higher training posts (Registrar level), 3 in medical specialties, 1 ED, 1 radiology, 1 fetal medicine and 1 anaesthetics/ICU. Additionally we successfully created 12 additional Foundation Year 1 posts; there will be further expansion in Foundation year 1 posts in 2023, and subsequent increase in Foundation Year 2 posts as Foundation trainees are moving to stay in the same Trust for two years. Additionally there will be more expansion and redistribution posts in specialties (see Section 3).

3. National Workforce Redistribution & Expansion Programmes

Redistribution:

This programme of work is being undertaken nationally by NHSEI and HEE to address health inequalities by the distribution of training posts. This is to align specialty training placements to the areas of greatest need across England where the location of medical specialty training posts has often been based on historic arrangements and is not now reflective of current or future patient need. Remote, rural and coastal areas often do not have a fair distribution of training places which is reflected in the workforce issues that ensue from this as it is recognised that 80% of trainees will become consultants within 50 miles of where they train.

Individual trainees will not be moved as part of this programme. Only once the post becomes vacant such as when someone completes training, will the post number be moved. It is recognised that no area across England is considered “over doctored” but this programme is about ensuring the resource and workforce supply we currently have is distributed equitably.

At present the number of postgraduate doctors is going through a period of growth where HEE have already seen an additional 1,500 undergraduates begin their careers at medical school. There will be an increase locally due to the impact of KMMS, which will be first seen in 2025 when the first students graduate.

Redistribution applies to HEE funded posts in England only and the programme initially looked at three specialties (Cardiology, O&G and Haematology) which resulted in redistribution of posts in 2022. There will now be three phases moving forward and the next phase to run (Phase A) will be for 2023-2026. HEE/NHSEI will be reviewing the distribution of training posts in the following specialties relevant to MFT:

- Otolaryngology (ENT)
- Palliative Medicine
- Respiratory Medicine
- General Surgery
- Endocrinology & Diabetes
- Gastroenterology
- Neurology

KSS is seen as one of the biggest gainers nationally of these posts and Kent in particular will see large numbers of posts made available over the next 9 years as Phase A, B and C progress. These posts present an exciting opportunity to the Trust by reputation, workforce provision and also financially as the posts are tariff funded. The Trust via the Divisional MDs and Chief Finance Officer will need to work with the Medical Education team as the posts are offered to finalise acceptance but also to ensure that quality of training and educational supervision is maintained through job planning.

Ms Ginny Bowbrick (MFT Consultant Vascular Surgeon) has been appointed as a Clinical Advisor to HEE/NHSEI Workforce Alignment programme and will be working for Mr Aidan Fowler (National Director of Patient Safety and Deputy Chief Medical Officer, NHSEI) and Professor Adrian Brooke (Deputy Medical Officer, Workforce Alignment, HEE) to take this programme forward nationally.

Expansion:

This is a separate work stream from HEE to run over a 3 year year period and approximately 1000 extra posts are being made available to Trusts in England in all specialties. This was agreed with the Secretary of State for Health in response to the Five Year Plan and may be subject to change therefore looking forward. Extra posts were made available commencing in October 2022 and it is expected that further posts will be made available for 2023/24 and 2024/25. These posts are tariff funded and are planned to be time limited for the duration that training an ST3-7/8 takes depending on programme. Medway have already benefitted from this programme. They are subject to the same requirements as the redistribution posts as above with CFO and Divisional MD input required and also quality of training and educational supervision to be maintained through job planning.

4. Finance

Medical Education in MFT oversees the funding and quality for the training programmes and posts in a wide variety of specialties in the Trust and community. The DME carries direct responsibility for the financial management of the tariffs which cover funding for all direct costs involved in delivering medical education and training by the Trust. There is increasing oversight of expenditure by HEE. HEE Undergraduate Accountability report has been returned for the second year.

Education Centre Upgrade and Refurbishment

The Trust Board agreed in 2019 that the Education Centre needed an upgrade to its current facilities, in order to meet current requirements for all staff (including HEE contract and GKT medical school contract), prepare for a large increase in undergraduate medical students through KMMS, and be appropriate to support University status application.

Three out of four phases of works have been completed, largely from capital investment. These works include:

- Dedicated Clinical Skills room and Immersive simulation room – the Ralph Barrett room was opened in the presence of his relatives on 16th September 2022. With funding through bequeathed charitable donation, this has enabled us to install immersive and Virtual Reality (VR) simulation which have an increasingly important role in postgraduate and undergraduate training.

- Extension of Simulation debrief room to enable larger groups to be accommodated.

- Two designated undergraduate training rooms have been refurbished, in readiness for KMMS students arriving in October 2022

- New IT resource room (converted from journal storage room) near library, for use by all Trust staff. Additionally there has been upgrade of IT technology throughout the Centre.

- Refurbishment and redecoration of Lecture Theatre and some Seminar rooms.

Phase 4 works are now needing funding, in order to complete the redesign and refurbishment. There is inadequate space utilisation particularly in the reception area, which remains dated and unwelcoming. The Medical Education department is collaborating with Finance and Estates for completion.

5. COVID Recovery Funds from HEKSS

HEE requested funding for recovery of training post-COVID from the Secretary of State for Health and were successful in their bid for both 2021/22 and 2022/23. This money has been divided between all the regions for Trusts and Schools to bid for. There is much concern as to how the pandemic has affected training especially in the craft specialties such as all surgical specialties, gynaecology, anaesthetics, cardiology and gastroenterology.

We have bid for further funds to support our Simulation programme. We have now installed our Immersive Simulation room and have successfully bid to upgrade and add additional hardware to our arthroscopic simulator in the Ralph Barrett room to be able to undertake laparoscopic simulation with haptic feedback. This will enable its use to be expanded to trainees within General Surgery, Gynaecology and Urology, both within the trust and throughout KSS Deanery. This would provide help for our trainees to minimise their shortfall in numbers due to COVID, increase our educational profile within the Deanery and be a source of income generation when we run regional training days.

6. Quality Visits

A Senior Leadership Conversation was undertaken in January 2022 due to unresolved concerns following previous Risk Based Review. There was excellent Executive Support for this meeting, followed by workstreams focusing on the areas in focus. HEE then held a Quality Intervention Visit virtually with trainees on 14th June.

There are five open actions which include:

1. Hospital at Night (included in Patient First) – a band 7 Clinical Site Practitioner has been employed to support the Night teams within Medicine, to enable bleep filtering, with extra Clinical Support Worker available to undertake some tasks. This has reduced bleeps and workload for doctors and enabled the patients to receive timely care by the right person. There has been a consultant appointed to lead Hospital at Night.

2. Out of hours support from consultants for doctors on call. There is a new escalation policy, aligned with the Trust escalation process; consultants are required to be on site during Black Escalation (internal incident). Additionally, doctors can call the consultant for advice at other times, which may include the consultant attending. How this change is perceived by trainees is being monitored through LFG and LAB.
3. Improved Internal Medicine Trainee (IMT) access to clinics. IMTs have a required number of clinics to achieve annually; there was a significant shortfall in this. Mr Jeremy Davis, deputy CMO, has overseen this project to achieve IMT allocation to clinics on the rota, and clinic room space to be available. This is currently being audited.
4. Re-design of the Medicine rota to a block rota, with trainee input and feedback. This would enable better continuity of care for patients and enable trainees to be trained more effectively. The current plan is for implementation in August 2023.
5. Rota gaps at night. This is being monitored and managed closely to ensure safe patient care and doctors are working within their competencies.

7. GMC National Trainee Survey (NTS) 2022

Nationally the response rate from trainees was 76%, similar to 2021. The quality of training nationally remains high but the pandemic continues to impact on doctors' workload and wellbeing. Nearly two thirds of trainees report moderate or high risk of burnout. There is national concern about unsustainable workplace pressures, for both trainees and trainers. Inclusive and supportive environments need to be developed further.

Overall satisfaction of our trainees has improved slightly from 73.31 to 75.36, which places us 5th out of 11 acute Trusts in KSS.

We were pleased to see improvements in GP feedback for Paediatrics, with green flags for educational governance and feedback. Additionally neonates had a green flag in rota design, and EM for induction.

A few red and pink flags remain across General Internal Medicine and Acute Medicine, but this as improved from 2021, a reflection of the positive efforts across Education and Service as already outlined.

Disappointingly, there are a number of new red flags in Surgery, in particular General Surgery. These include induction, educational governance, teamwork and rota. There were two undermining / bullying reports in General Surgery, which both reflected the same event. Additionally there was a patient safety report about acute admissions in Emergency Department. A new Trainee in Action group has been established, and the DME is supporting the College Tutor to implement improvements to the education and training within surgery, as well as in closer working with the Clinical Director and service leads.

We have reported to HEKSS Quality our initial responses and actions.

8. Simulation Report (Dr Manisha Shah, Gemma Dockrell)

The simulation department has overseen many exciting new projects. We are very proud to develop immersive simulation, the only one in Kent. 360 VR films are being developed, supported by HEE funded simulation fellow; these address clinical skills and medication errors. We are one of six pilot centres for Sim EPR funded by HEE.

The Ralph Barrett room contains the VirtaMed (arthroscopic orthopaedic simulator), and we have successfully bid for Covid recovery funds to upgrade the caddy to implement a new surgical module alongside the orthopaedic modules.

The simulation department is an integral part of delivery of postgraduate and undergraduate medical education in the Trust. We have included this year in Foundation Year 1 induction an Introduction to clinical systems and practice, which includes escalation scenarios, clinical skills and clinical systems. There is specialty support for clinical skills and simulation, particularly in Anaesthetics, Acute Medicine, EM, Critical Care, Surgery and Paediatrics. A programme for International Medical Graduates has been introduced, to include clinical skills, communication skills, clinical assessment and familiarisation of systems and equipment. A new programme to deliver the simulation requirements of year 3 KMMS students has been implemented.

Additionally simulation has continued to support integrated health care. Examples include a contract with Mid Kent College to introduce students to different healthcare roles; supporting work experience (5 placements); exercises for Medway Leadership Programme.

The team has received excellent feedback evidencing its contribution to high quality care including: Trust award for Education Team of the Year; BMJ Award- Finalist for Diversity and Inclusion category; 1st Prize at Sim for Safety conference in oral presentation category

The numbers of postgraduate doctors in training and medical students are increasing; additionally there are increasing specialty based requirements for training, for example Ultra-sound training becoming a mandatory skill for all specialities (covers scanning of lung, very basic heart, kidneys, FAST, biliary and pelvis. Further investment through tariff will be provided to maintain and expand the training excellence provided. This will include financing Clinical Simulation facilitators and fellows at the appropriate level to enable this work.

Additionally the vision is to further develop multiprofessional training in the Trust. This will be crucial in enhancing patient safety through simulation and skills as well as Human Factors training. It will also enable our postgraduate doctors in training, particularly at Foundation level, to develop their skills within the multidisciplinary team.

9. Undergraduate Medical Education (Dr Priya Krishnan)

We now receive medical students from two medical schools. We have established links with GKT School of Medical Education (King's College, London) and have 44 students on site, from years 4 and 5. Additionally, Kent and Medway Medical School (KMMS), which took its first intake in September 2020, has allocated 16 year 3 medical students to us; they started in October 2022 and are placed with us for the whole academic year. This has required considerable planning, in terms of understanding the curriculum leads, recruiting 3 new module leads plus 12 new clinical supervisors, and negotiating accommodation on site.

From Autumn 2023, we will have both year 3 and year 4 KMMS students (an increase in 16 students). We are recruiting a deputy Director of Undergraduate Medical Education who will have responsibility for Year 4 students from both medical schools, in order to ensure parity of opportunities and sharing of learning between the two groups.

Accommodation on site needs to be expanded, and the CMO is in discussion with CFO to take this forward; in total 92 rooms will be needed by 2024. We currently have 44 GKT and 16 KMMS students on site. In 2023 a further 16 rooms will be required, with an additional 16 again in 2024. GKT and KMMS students are housed in Willow house (54 beds) and two flats in Rowan house (10 beds). KMMS only pays for 37 weeks accommodation, although the CFO from this and other Trusts made the case for 52 weeks payment. However, moving forward, we do need to provide parity in accommodation for the students. Options off site are not viable because a 52 week contract would be required by the landlord, shorter lets are too expensive, and there would be transport and safety issues.

10. Library Services (Richard Pemberton)

During 2022 the Knowledge and Library Service (KLS) has seen significant positive change. A new Strategic Manager was appointed in January 2022. Since then the library has moved to 24-hour opening with a new RFID security, self-issue and returns system. This has improved access to the physical collections, computers and study space for MFT staff and learners, while freeing up staff time from simple tasks, like issue and return of items, to increase focus on other more complex tasks such as literature searching and horizon scanning, These tasks especially support the Research and Innovation (R&I) Team. The KLS has worked closely with R&I this year to deliver training and provide support to take the heavy lifting out of evidence and literature searching for researchers.

The national Knowledge and Library Hub was rolled out as a desktop link to every computer in the Trust alongside the browser extension Nomad LibKey, providing instant full text access to the library's journal collection 24 hours a day, 7 days a week, through Open Athens. This collection was enhanced by adding the Royal College of Nursing journal collection, in partnership with the Nurse Education Team. Many Trusts have still not managed to roll out the Knowledge and Library Hub or LibKey, which MFT staff and learners have been benefitting from for most of the year.

A new IT Suite was launched in a room formerly housing, seldom used, physical journals. This room has been used to deliver training sessions and student induction sessions. A presentation TV is to be installed in November 2022 to further improve the flexibility of the room. It contains 10 computers for students, including one on an electronic raising desk and one PC for a tutor. All the computers for staff and students in the library were upgraded in 2022 and moved to the corporate single sign on. This included significant reduction in the use of generic logins and the associated GDPR risk of shared logins.

MFT became the host organisation for the Regional Library System Manager, administering the library management system (LMS) for all libraries in Kent, Surrey and Sussex. This role is fully funded by Health Education England (HEE). A new regional LMS was implemented and MFT's KLS team were influential in the user acceptance testing and parameterisation of this system. This has had a positive impact on the organisation's regional reputation.

The Strategic Manager became the regional representative for the National Copyright Responders. This has enhanced the service's and MFT's reputation nationally, demonstrated by a recent request to buddy a new Library Manager in another Trust.

The KLS team, supported by an MFT consultant, convinced HEE to contact BMJ Best Practice to add the Comorbidities Tool to the national clinical decision making tool. This was successful and has been added nationally at no cost to Trusts. Feedback from clinical staff has been very positive and it is expected that this tool will have a significant impact on the care of patients with comorbidities. BMJ Best Practice is to be embedded in the Electronic Patient Record system imminently.

The KLS team worked in partnership with other departments to improve staff wellbeing. The Culture Café was launched encouraging staff from a wide range of cultural backgrounds to talk and learn about each other. Understanding different cultures will not only improve working relationships but will also help improve patient care through improved understanding of patients' backgrounds. The team partnered with the catering team, dietitians team and public health to deliver two healthy eating on a budget sessions to help staff manage the rising cost of living. The library added cookery books to support staff making affordable healthy choices to the wellbeing collection.

Quality Assurance Committee
Tuesday 29th November 2022

NHS Medway NHS Foundation Trust

Title of Report	**Organ and Tissue Donation Annual Report 2021-22 and strategy 2022-23**	**Agenda Item**	**3.1**
Lead Director	Dr Alison Davis, Medical Director		
Report Author	Dr Paul Hayden, Clinical Lead for Organ Donation (CLOD) Dr Gill Fargher, Chair Organ and Tissue Donation Committee, Alison Hill, Specialist Nurse for Organ Donation (SNOD)		
Executive Summary	Organ Donation is an incredibly altruistic act that is only possible thanks to the selflessness of our donors and their families. In 2021-22, 11 patients donated their organs after death, leading to 26 patients receiving life-saving transplants. This is a significant increase compared to 2020-21 (4 organ donations with 11 patients receiving transplants), and reflects the impact of the COVID pandemic in 2020-21. The Trust referral rate was 82% overall with 92% for DBD potential donors (12 referred vs 13 meeting criteria for referral) and 76% for DCD potential donors (19 referred vs 25 meeting criteria for referral). Tissue donation referral rates have remained fairly static from 25 (2020-21) to 24 referrals for 2021-22 with a slight reduction in actual tissue transplantations from 13 to 11. We will continue to support initiatives to improve this, working in collaboration with other stakeholders. The Organ and Tissue Donation Committee (OTDC) oversees all aspects of organ and tissue donation within the Trust in accordance with the Memorandum of Understanding shared with NHSBT. The key responsibility of the OTDC is to scrutinise the Potential Donor Audit (PDA) and oversee the investigation of any potential missed donors. The Organ and Tissue Donation Committee continues to co-ordinate educational and public awareness work to promote organ donation within the Trust and to the local community. The Committee was proud to be able to support several areas of the hospital whose efforts are integral to organ and tissue donation with the purchase of equipment including bespoke critical care transfer bags, trauma resuscitation mannequins for use in high fidelity simulation, and ceiling light panels for the intensive care unit to improve the environment for critically unwell patients. The strategic objectives for 2022-23 are: • 0% missed opportunities for organ donation • Maintaining Trust education, knowledge and skills in organ and tissue donation. • Increase tissue donation referrals • Continue to promote organ donation and membership of the Organ Donor Register (ODR) to the local community		

Link to strategic Objectives 2020/21	**Innovation:** We will embrace innovation and digital technology to support the best of care	☐
	Finance: We will deliver financial sustainability and create value in all we do	☐
	People: We will enable our people to give their best and achieve their best	☒
	Integrated Health Care: We will work collaboratively with our system partners to establish an Integrated Care Partnership	☒
	High Quality Care: We will consistently provide high quality care	☒
Committees or Groups at which the paper has been submitted	Quality and Patient Safety Sub-Committee	
Resource Implications	NA	
Legal Implications/Regulatory Requirements	NA	
Quality Impact Assessment	NA	
Recommendation/ Actions required	The Board is asked to note the contents of the report and endorse the continued commitment to supporting organ and tissue donation within the Trust and in the local community.	

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

Appendices	Appendix A: National Potential Donor Audit 2021-22 Appendix B: Financial summary

Medway NHS Foundation Trust Organ & Tissue Donation Annual Report 2021-2022 & Strategy for 2022-2023

Dr Paul Hayden	*Clinical Lead Organ Donation*
Dr Gill Fargher	*Chair Organ and Tissue Donation Committee*
Mrs Alison Hill	*Specialist Nurse Organ Donation*

Dr Dale Gardiner, National Clinical Lead for Organ Donation and Transplantation, unveils the "hero wall" addition to the Trust's commemorative artwork in the hospital atrium, September 2021, with Jo Palmer, Medway NHS Trust chair; Dr Gill Fargher, Organ and Tissue Donation Committee chair; and Dr Paul Hayden, Clinical Lead for Organ Donation.

Contents

Glossary

- CLOD Clinical Lead Organ Donation
- SNOD Specialist Nurse Organ Donation
- OTDCC Organ and Tissue Donation Committee Chair
- OTDC Organ and Tissue Donation Committee
- NHSBT NHS Blood and Transplant
- DBD Donation after Brain Death
- DCD Donation after Circulatory Death
- PDA – Potential Donor Audit (national audit of activity by NHSBT)
- ICU/ITU Intensive Care Unit
- ED/A&E Emergency Department
- HDU High Dependency Unit
- ODR Organ Donor Register

Definitions

POTENTIAL DONOR AUDIT / REFERRAL RECORD	
Data excluded	Patients who did not die on a critical care unit or an emergency department and patients aged over 80 years are excluded.
Donors after brain death (DBD)	
Suspected Neurological Death	A patient who meets all of the following criteria: Apnoea, coma from known aetiology and unresponsive, ventilated, fixed pupils. Excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates - less than 2 months post term'.
Potential DBD donor	A patient who meets all four criteria for neurological death testing excluding those not tested due to reasons 'cardiac arrest despite resuscitation', 'brainstem reflexes returned', 'neonates – less than 2 months post term' (ie suspected neurological death, as defined above).
DBD referral criteria	A patient with suspected neurological death
Discussed with Specialist Nurse – Organ Donation	A patient with suspected neurological death discussed with the Specialist Nurse – Organ Donation (SN-OD)
Neurological death tested	Neurological death tests were performed
Eligible DBD donor	A patient confirmed dead by neurological death tests, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DBD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's op-out decision via the Organ Donor Register
Consent / authorisation ascertained	Family supported expressed or deemed consent/authorisation, nominated/appointed representative gave consent, or where applicable the family gave consent/authorisation
Actual donors: DBD	Neurological death confirmed patients who became actual DBD as reported through the PDA
Actual donors: DCD	Neurological death confirmed patients who became actual DCD as reported through the PDA
Neurological death testing rate	Percentage of patients for whom neurological death was suspected who were tested
Referral rate	Percentage of patients for whom neurological death was suspected who were discussed with the SN-OD
Approach rate	Percentage of eligible DBD families or nominated/appointed representatives approached for formal organ donation discussion
Consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
Expected consent / authorisation rate	Consent / authorisation rate adjusted for ethnicity case mix (white or BAME (black, asian and minority ethnic)), based on those patients whose family or nominated/appointed representative were approached to discuss organ donation where consent/authorisation was ascertained and patient ethnicity was known
SN-OD involvement rate	Percentage of family or nominated/appointed representative approaches where a SN-OD was involved
SN-OD consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion by a SN-OD where consented / authorisation for organ donation was ascertained

Donors after circulatory death (DCD)	
Imminent death anticipated	A patient, not confirmed dead using neurological criteria, receiving assisted ventilation, a clinical decision to withdraw treatment has been made and death is anticipated within 4 hours
DCD referral criteria	A patient in whom imminent death is anticipated (as defined above)
Discussed with Specialist Nurse – Organ Donation	Patients for whom imminent death was anticipated who were discussed with the SN-OD
Potential DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours
Eligible DCD donor	A patient who had treatment withdrawn and death was anticipated within four hours, with no absolute medical contraindications to solid organ donation
Absolute contraindications	Absolute medical contraindications to organ donation are listed here: http://www.odt.nhs.uk/pdf/contraindications_to_organ_donation.pdf
Family approached for formal organ donation discussion	Family of eligible DCD asked to: support the patient's expressed or deemed consent/authorisation decision, informed of a nominated/appointed representative, make a decision themselves on donation, or informed of a patient's op-out decision via the Organ Donor Register
Consent / authorisation ascertained	Family supported expressed or deemed consent/authorisation, nominated/appointed representative gave consent, or where applicable the family gave consent/authorisation
Actual DCD	DCD patients who became actual DCD as reported through the PDA
Referral rate	Percentage of patients for whom imminent death was anticipated who were discussed with the SN-OD
Approach rate	Percentage of eligible DCD families or nominated/appointed representatives approached for formal organ donation discussion
Consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion where consent/authorisation was ascertained
Expected consent / authorisation rate	Consent / authorisation rate adjusted for ethnicity case mix (white or BAME (black, asian and minority ethnic)), based on those patients whose family or nominated/appointed representative were approached to discuss organ donation where consent/authorisation was ascertained and patient ethnicity was known
SN-OD involvement rate	Percentage of family or nominated/appointed representative approaches where a SN-OD was involved
SN-OD consent / authorisation rate	Percentage of families or nominated/appointed representatives approached for formal organ donation discussion by a SN-OD where consented / authorisation for organ donation was ascertained
UK Transplant Registry (UKTR)	
Donor type	Type of donor: Donation after brain death (DBD) or donation after circulatory death (DCD)
Number of actual donors	Total number of donors reported to the UKTR
Number of patients transplanted	Total number of patients transplanted from these donors
Organs per donor	Number of organs donated divided by number of donors. The maximum number of solid organs that can be donated are 7 for a DBD and 6 for a DCD.
Number of organs transplanted	Total number of organs transplanted by organ type

1. Executive Summary

There were **11** successful organ donations at Medway in 2021-2022 leading to **26** patients receiving life-saving organ transplants (see appendix A). This was only possible thanks to the incredible altruism of the donors and their families and the hard work of the staff at Medway, the transplant centres, and NHSBT.

The Trust continues to strive to ensure that all potential organ donors have the opportunity to donate their organs after death and identified **92%** of potential DBD donors (13 potential, 12 referred) and **76%** of potential DCD donors (25 potential, 19 referred).
Tissue donation referrals have remained relatively static from **25** in 2020-21 to **24 i**n 2021-22 with a slight reduction in actual tissue donations from **13** to **11**. Considerable scope to improve this remains and this is being addressed by collaboration with the end of life care teams on the wards and by providing training for the critical care nursing teams to promote tissue donation discussions with families after the loss of a loved one in the critical care department.

The strategic objectives for 2021-2022 were;

- 0% missed opportunities for organ donation
- Increase tissue donation referrals
- Continue to promote organ donation and membership of the ODR to local community
- Install a “hero wall” addition to the Trust’s commemorative artwork to celebrate individual organ and tissue donors

The Organ and Tissue Donation Committee (OTDC) oversees all aspects of organ and tissue donation within the Trust in accordance with the Memorandum of Understanding shared with NHSBT. The key responsibility of the OTDC is to scrutinise the Potential Donor Audit (PDA) and oversee the investigation of any potential missed donors.

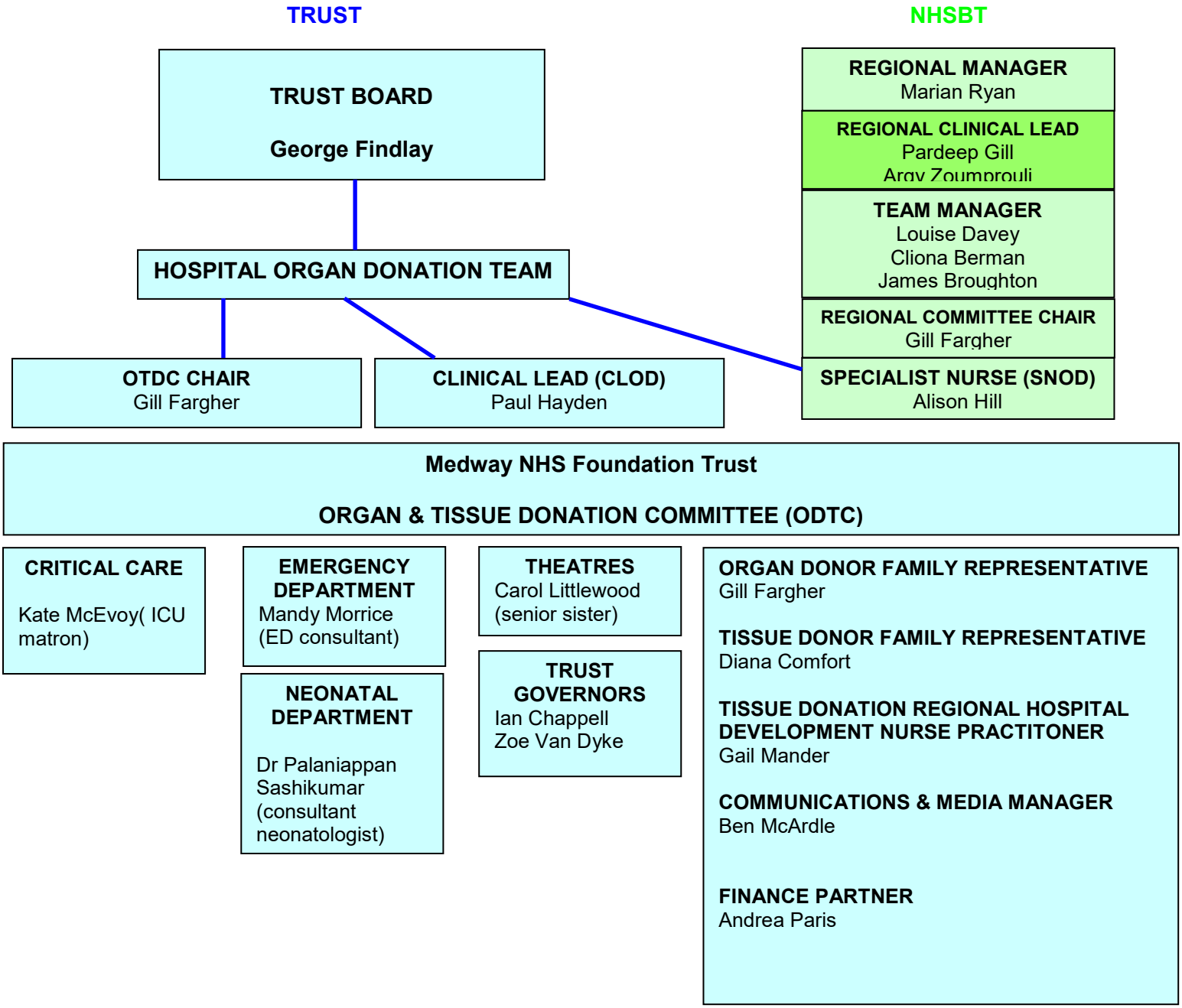
There were 7 (18%) potentially missed opportunities for organ donation referral during 2021-22 although only 1 of these patients had any potential as organ donors after review and the family had previously expressed a wish not to donate. It is one of the primary functions of the OTDC to discuss potential missed referrals and any areas for improvement are identified and routinely discussed with the relevant clinical teams.

The organ and tissue donation committee receives funds annually to support departments within the Trust that are integral to the organ and tissue donation programme. This year, the committee has been proud to fund the purchase of bespoke critical care transfer bags, 2 high fidelity trauma mannequins for use in the simulation suite, and the purchase of ceiling light panels for the intensive care unit to improve the environment for patients recovering from critical illness. This is in addition to funding the “hero wall” additions in the atrium.

The strategic objectives for 2022-2023 are:

- **0% missed opportunities for organ donation**
- **Maintaining Trust education, knowledge and skills in organ and tissue donation.**
- **Increase tissue donation referrals**
- **Continue to promote organ donation and membership of the ODR to the local community**

2. Trust Organ Donation Team Structure



3. Report from the Organ & Tissue Donation Committee (OTDC)

Medway NHS Foundation Trust Organ and Tissue Donation Committee and the work of the Trust in organ and tissue donation has been profoundly affected by the Coronavirus pandemic but has continued throughout. We have embraced virtual working in our OTDCs and in all meetings supporting this work, so the momentum, scrutiny and governance continues to be robust and progressive.

Nationally, regionally and locally, the impact of Coronavirus has meant that organ donors were fewer, consequently reducing the possibility of life saving organ transplants for those on the transplant waiting list. Medway NHS Foundation Trust facilitated 4 organ donors from 2020 -2021. This number has risen to 11 organ donors for the year 2021-2022. Every donation necessitates, and is supported by, the professionalism and expertise of every single health and Trust professional involved.

The OTDC role in evaluating the Potential Donor Audit (PDA) resulted in an additional annual retrospective analysis of the missed referrals during the year. These missed referrals did not have organ donation potential on further analysis. Analysis of the PDA is a key function of the OTDC in order to avoid missed potential donor referrals.

Additional scrutiny both within and external to the OTDC has been achieved by inviting observers to the OTDC and by ensuring that relevant metrics and information has been presented to the senior team members within the Trust. Observers have included Quality Assurance Committee (QAC) Chair and Non-Executive Director of the Trust, Tony Ullman, Jill Featherstone, Medical Education Lead for the national Professional Development Team for NHSBT, Regional Team Manager for the southeast, James Broughton and local Organ Donation Committee chairs from the southeast region.

Dr Paul Hayden and I have met separately with the Trust CEO Dr George Findlay, Tony Ullman QAC Chair and Jo Palmer Trust Chair. We presented our annual metrics to the Public Council of Governors meeting on the 28th of January 2021. Dr Hayden and I presented to the Quality Assurance Committee on the 19th of October 2021, which forms part of the OTDC governance. Regional team personnel have standing invitations to attend OTDC meetings for Medway NHS Foundation Trust.

We have welcomed Trust Governors Ian Chappell and Zoe Van Dyke as members to the OTDC. Their contributions and commitment are insightful and highly valued. The OTDC is especially indebted to Communications Manager Ben McArdle. He has been an essential support to the OTDC work, providing invaluable expertise.

The Trust is a Level 2 hospital for organ donation. This is based on organ donor numbers. We were one of the first Trusts in the region to participate in the national SIGNET trial. This trial is to consider the potential value of simvastatin in improving utilisation of organs from DBD donors.

In September 2021 our Trust memorial honouring organ and tissue donors individually was unveiled in the hospital atrium. Four commemorative wall panels compliment the Trust Gift of Life organ donor artwork. The project has taken 3 years to come to fruition. Thanks however to the collaboration and hard work of many people across 3 organisations, success was achieved and on the 23rd of September 2021, in Organ Donation Week, the first

memorial wall panel was unveiled by Dr Dale Gardiner, Associate Medical Director NHS Blood and Transplant. We were honoured to welcome Jo Palmer, Trust Chair, to the ceremony. Covid restrictions necessitated a virtual ceremony which was joined by donor family members. Organ and tissue donor names will continue to be added to the wall panels, subject to appropriate family consent, on an annual basis.

The biannual southeast Regional Collaborative meetings have continued throughout the Coronavirus pandemic on a virtual basis. There is an expectation that all Clinical Leads for Organ Donation (CLODs), Specialist Nurses for Organ Donation (SNODs) and Organ Donation Committee Chairs attend to share metrics and join presentations and learning in organ and tissue donation. The organ donation team from Medway NHS Foundation Trust attend and regularly participate in these meetings.

Whilst virtual meetings have provided a safe and efficient way of ensuring continuity, there is no substitute for meeting in person. In person meetings are now being re-established and we look forward to our first OTDC in over 2 years when we will meet in July.

Dr Hayden and I delivered our long overdue presentations on organ and tissue donation to Rochester Rotary Club and to Medway Health and Wellbeing Board in October and November 2021 respectively. We have subsequently been supported by Medway Council and Councillor Martin Potter in particular, in sharing the NHSBT lesson plans and learning in organ donation corresponding to the national curriculum with Medway Education Partnership Group. This will be further disseminated to Medway school headteachers in order to facilitate learning in secondary school pupils.

Finally, the Order of St John Ceremony has been held in Kent for the first time in 3 years. This posthumous award is presented to the families of organ donors and now tissue donors, in recognition of their loved one’s gifts of life. This meaningful and emotive ceremony is a powerful reminder, should one be needed, of the ultimate selfless gift, the gift of life, donated in the face of devastating personal loss, to save the lives of others.

Dr Gill Fargher
OTDC Chair Medway NHS Foundation Trust
Regional Organ Donation Committee Chair (southeast)
June 2022

4. Organ Donation Rates / PDA Benchmarking 2021/22

4.1 Medway Trust overview of PDA metrics 2021-22 with 2020-21 data for comparison (see appendix A)

Whilst the total number of patients admitted to the Intensive Care Unit who may be potentially suitable for organ donation is variable, the Trust is benchmarked against other Trusts in the UK based on a number of metrics that measure performance towards nationally agreed best practice for the identification and management of potential donors. These metrics are summarised in Appendix 1 (PDA – Potential Donor Audit).

The table below shows the total numbers of organ donors based on the donor type (Donation after Brain Death: DBD, versus Donation after Cardiac Death: DCD) with the previous year's data for comparison.

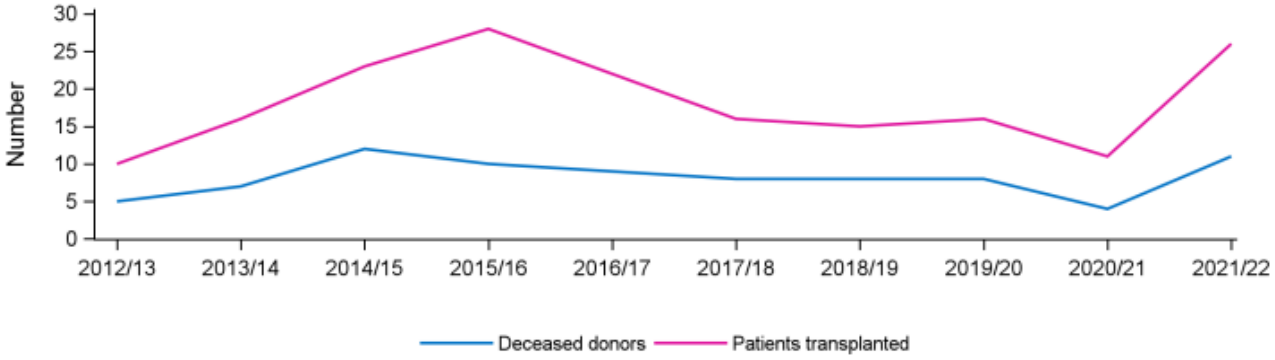
There were a total of **13** consented donors with **11** patients proceeding to organ retrieval leading to **26** organ transplants.

Donor type	2021-22 (2020-21)	Number of patients receiving transplants	Average number of organs donated per donor 2021-22 (2020-21)	
			Trust	UK
DBD	7 (3)	19 (8)	3.0 (3.0)	3.5 (3.3)
DCD	4 (1)	7 (3)	3.0 (4.0)	2.8 (2.6)
TOTAL	**11 (4)**	**26 (11)**	**3.0 (3.3)**	3.2 (3.0)

The table below shows the number of individual organs transplanted (with previous year's data for comparison in brackets)

Donor type	Number of organs transplanted by type 2021-22 (2020-21)				
	Kidney	Pancreas	Liver	Heart	Lung
DBD	**10 (4)**	**3 (0)**	**5 (3)**	**0 (0)**	**2 (2)**
DCD	**6 (2)**	**0 (1)**	**1 (1)**	**0 (0)**	**0 (0)**
Totals	**16 (6)**	**3 (1)**	**6 (4)**	**0 (0)**	**2 (2)**

The number of organ donors and patients transplanted has increased significantly following the abrupt decline because of the impact of the COVID pandemic in 2019-20.

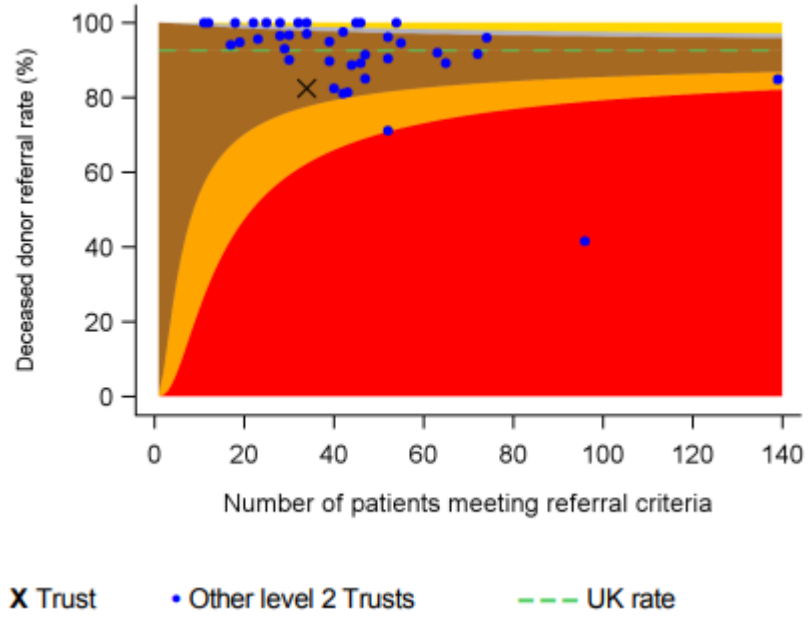


The Trust's metrics for the referral rate for potential organ donors has decreased slightly compared to previous years. This is predominantly because of a change in workforce following the pandemic and pressures on clinical teams managing a more complex cohort of COVID/ non-COVID patients. Every potential missed opportunity is investigated and improvements are made where possible to reduce the likelihood of any missed opportunities occurring.

	DBD		DCD		Deceased donors	
	Trust	UK	Trust	UK	Trust	UK
Patients meeting organ donation referral criteria[1]	13	1919	25	5198	34	6767
Referred to Organ Donation Service	12	1894	19	4700	28	6258
Referral rate %	B 92%	99%	B 76%	90%	B 82%	92%
Neurological death tested	11	1530				
Testing rate %	B 85%	80%				
Eligible donors[2]	9	1373	14	2972	23	4345
Family approached	9	1239	7	1445	16	2684
Family approached and SNOD present	9	1188	7	1306	16	2494
% of approaches where SNOD present	G 100%	96%	G 100%	90%	G 100%	93%
Consent ascertained	8	861	5	902	13	1763
Consent rate %	B 89%	69%	B 71%	62%	B 81%	66%
- Expressed opt in	2	522	2	550	4	1072
- Expressed opt in %	100%	95%	100%	90%	100%	92%
- Deemed Consent	4	260	1	267	5	527
- Deemed Consent %	100%	63%	50%	56%	83%	59%
- Other*	2	78	2	83	4	161
- Other %*	100%	66%	100%	47%	100%	55%
Actual donors (PDA data)	7	787	4	602	11	1389
% of consented donors that became actual donors	88%	91%	80%	67%	85%	79%

Of note, there was SNOD presence for 100% of family discussions regarding organ donation, which is deemed best practice. Overall consent rates for organ donation were also above national averages.

The graph below shows the Trust's referral rate compared to peer Trusts. Of note, this "peer" group comprises predominantly large district general hospitals and teaching hospitals.



Contra-indications to solid organ transplant

There was **1** patient with medical contraindications to solid organ donation for the period April 2021-22. The reason listed was that the organs were deemed medically unsuitable by the recipient centres:

	DBD		DCD	
	Trust	UK	Trust	UK
Clinical - Absolute contraindication to organ donation	-	4	-	6
Clinical - Considered high risk donor	-	3	-	5
Clinical - No transplantable organ	-	5	-	21
Clinical - Organs deemed medically unsuitable by recipient centres	1	25	-	70
Clinical - Organs deemed medically unsuitable on surgical inspection	-	8	-	4
Clinical - Other	-	3	-	10
Clinical - PTA post WLST	-	-	1	135
Clinical - Patient actively dying	-	6	-	14
Clinical - Patient's general medical condition	-	-	-	6
Clinical - Positive virology	-	3	-	5
Consent / Auth - Coroner/Procurator fiscal refusal	-	11	-	11
Consent / Auth - Known wish not to donate	-	1	-	1
Consent / Auth - NOK withdraw consent / authorisation	-	5	-	8
Consent / Auth - Other	-	-	-	2
Logistical - No critical care bed available	-	-	-	1
Logistical - Other	-	-	-	1
Total	**1**	**74**	**1**	**300**

Reasons why families did not support organ donation

The process of consent for organ donation has now changed in English Law. Whilst this process now assumes a patient has consented to organ donation unless they are known to have explicitly refused donation via the national organ donor register, families will always be consulted and may still refuse donation.

For 2021-22, there were **3** instances where families did not support organ donation. The reasons listed were:

- Family did not want surgery to the body 1
- Patient previously expressed a wish not to donate 2

5. Performance against 2021/22 Objectives

Item	Objectives for 2021/22	Outcomes
1	0% missed opportunities for organ donation	**Not achieved. Reduction in potential referral rates due to high turnover in nursing staff post pandemic and limited educational opportunities. Additional pressure on clinical teams managing complex cohort of COVID and non-COVID patients. All potential missed opportunities investigated with scrutiny from OTDC and this review revealed no genuine missed opportunities for donation. Regular review of progress and ongoing education for staff with new donation link nurses to champion organ and tissue donation.**
2	Increase tissue donation referrals	**Not achieved. Significant change to critical care nursing experience and departure of tissue donation champions during the pandemic has contributed to a static referral rate. Lack of referral from ward staff has hindered increases in referrals. Education and support in liaison with EOLC teams and renewed tissue donation champion nurse in critical care is now in place to hopefully increase referral and donation rates for 22/23. Additional challenge in accessing tissue donor numbers.**
3	Continue to promote organ donation and membership of the ODR to local community	**Achieved. Successful live-streamed event to unveil the new "hero wall" in the Trust atrium during national organ donation week (see below). Presentations to Rochester Rotary club, Medway Health and Wellbeing board, and invitation to present to Medway Education Partnership group to increase organ donation specific teaching plans at schools across the Medway area.**
4	Install a "hero wall" addition to the Trust's commemorative artwork to celebrate individual organ and tissue donors	**Successful installation of "hero wall" with unveiling by National Clinical Lead for organ donation and transplantation during National Organ Donation Week in September 2021.**

6. Strategic objectives for 2022/23 and Monitoring Arrangements

Objectives for 2020/ 21	Actions Required to Deliver Objective	Measurable Outcome / Milestones	Delivery Lead	Risks to completion
1. 0% missed opportunities for organ donation	Ensure 100% referral for potential DBD and DCD donors on ICU and ED Follow national best-practice for collaborative approach. Key function of OTDC	PDA data	OTDC CLOD SNOD ED champion	Increased clinical workload may mean organ donation cannot proceed in suitable individuals at times of high clinical intensity particularly during the COVID pandemic
2. Maintaining Trust education, knowledge and skills in organ and tissue donation.	Ensure delivery of educational content relevant to areas of the Trust active in organ and tissue donation	Avoidance of missed opportunities for organ/ tissue donation	CLOD SNOD Tissue donation link nurses	Clinical pressures on staff. Staff not present for education sessions.
3. Increase tissue donation referrals	Education for all ward nurses Work with regional/ national tissue donation nurse educators to strengthen internal and external knowledge base. Collaborative working with palliative care colleagues in progress	Measure percentage referrals vs total number of deceased patients per ward. Overall target 100% but year on year targets need to be realistic.	CLOD SNOD OTDCC EOL team Tissue donation link nurses	Lack of retention of ward staff to sustain efforts to inform relatives. Lack of educational sessions for staff Significant challenge in accessing tissue donor numbers and data and work is ongoing to address this
4. Continue to promote organ and tissue donation and membership of the ODR to local community	Consider potential to speak to schools	Local ODR membership Family assent percentage for organ donation in ICU	CLOD SNOD OTDCC	Potential initial negative response to national changes to organ donation (“opt out” policy)

7. Critical Incidents

There were no critical incidents reported in 2021-22.

8. Appendices

A: **NATIONAL POTENTIAL DONOR AUDIT REPORT 2021-22**

B: FINANCE OVERVIEW FOR 2021-22

NHS
Blood and Transplant

Detailed Report
Actual and Potential Deceased Organ Donation
1 April 2021 - 31 March 2022

Medway NHS Foundation Trust

3.1-ODTC summary
Q2 22-23 pgh revised

Appendix B: Organ and Tissue Donation Committee Finance Summary 2021-22

Organ & Tissue Donation Financial Summary									
Financial Year	**TOTAL 2016-17**	**TOTAL 2017-18**	**TOTAL 2018-19**	**TOTAL 2019 - 20**	**TOTAL 2020 - 21**	**TOTAL 2021 - 22**	**2022-23 Q1**	**TOTAL 2021 - 22**	**Notes**
Balance b/f	£0.00	£22,946.30	£45,770.09	£49,104.80	£55,563.81	£60,042.11	£65,871.77	£65,871.77	
Income									
Lead clinician	£12,892.00	£12,892.00	£12,892.00	£12,892.00	£12,969.50	£12,892.83	£3,098.00	£3,098.00	Expected income not received yet
Organ Donation Committee	£500.00	£500.00	£500.00	£500.00	£500.00	£500.00	£0.00	£0.00	
Donor Reimbursement	£22,946.00	£25,032.00	£10,315.39	£10,280.76	£10,286.00	£7,234.00	£0.00	£0.00	
TOTAL INCOME	**£35,838.00**	**£60,370.30**	**£23,208.39**	**£23,072.76**	**£23,755.50**	**£20,125.83**	**£3,098.00**	**£3,098.00**	
Expenditure									
Lead clinician (1PA per week)	£12,892.00	£14,187.48	£14,187.48	£15,473.52	£13,063.60	£12,892.04	£3,098.01	£3,098.01	
RESUS - TruMan Trauma manikin x2	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£10,756.80	£10,756.80	
Hospital Art Studio name blocks	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£94.68	£94.68	
Patient Transfer Bag - 1x ICU, 1x4DU (company Openhouse)	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£708.00	£708.00	Critical Care Allocation
Sky Ceiling Panels for ICU	£0.00	£0.00	£0.00	£0.00	£0.00	£0.00	£2,604.00	£2,604.00	Critical Care Allocation
TOTAL EXPENDITURE	**£12,891.70**	**£15,100.21**	**£20,917.85**	**£15,613.75**	**£20,277.70**	**£14,296.17**	**£17,261.49**	**£17,261.49**	
NET (balance carried forward)	**£22,946.30**	**£45,770.09**	**£49,104.80**	**£55,563.81**	**£60,042.11**	**£65,871.77**	**£51,708.28**	**£51,708.28**	