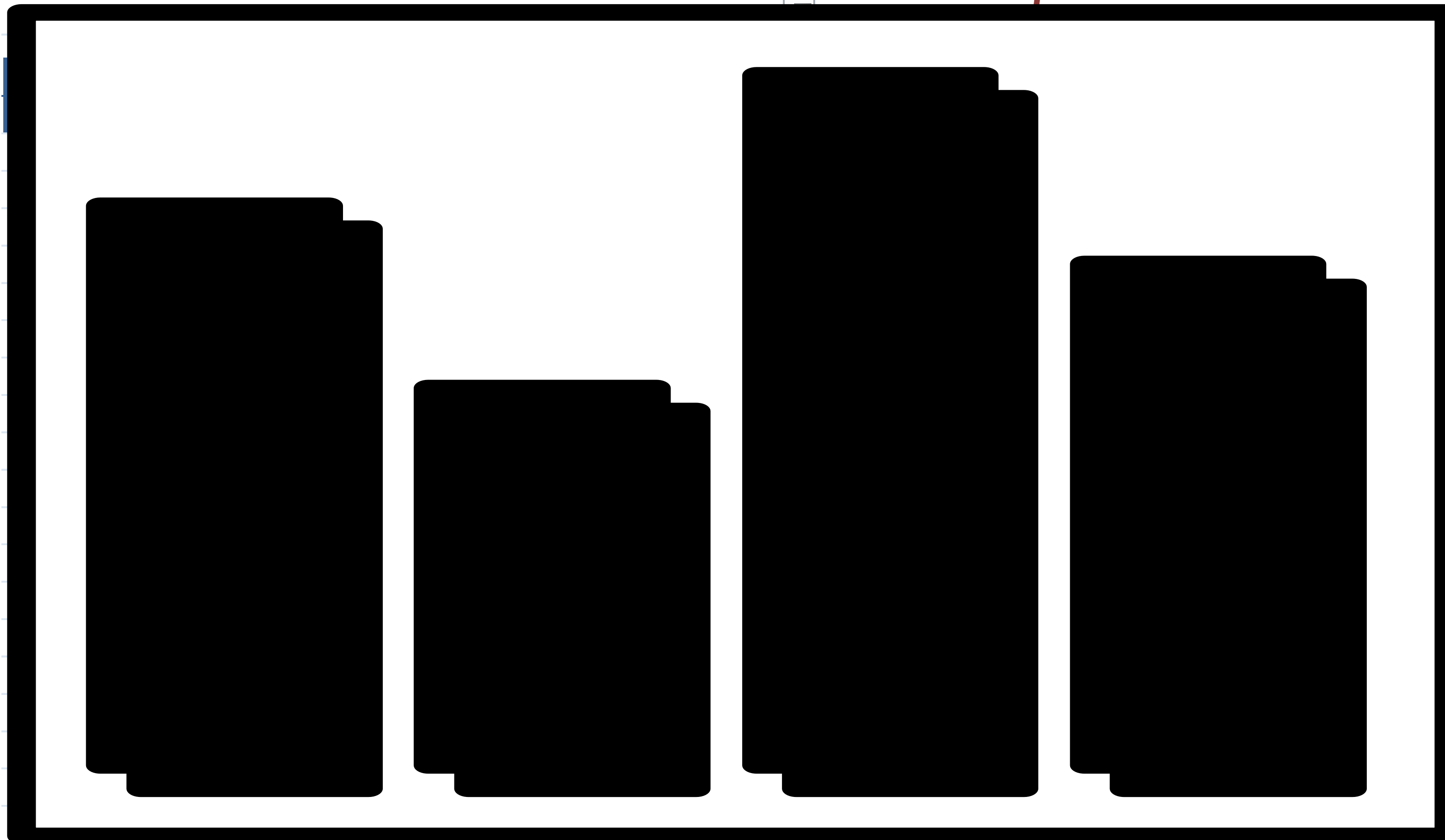
True North: People
Mandatory Training – Medical



Key Messages:

- >90% for 2 mandatory training requirements.
- Maternity staff recently required to undertake level 3 safeguarding adults training and staff are on an appropriate trajectory to achieve this by March 2024.
- 17 subjects below 90% requirement for compliance.
- Targeted interventions by line managers to support training compliance.

NHS
Medway
NHS Foundation Trust

Maternity Workforce Action Plan 2023

Overdue		Red
On Target		Green
Near Completion		Amber
Complete		Blue

NHS Medway NHS Foundation Trust

Action No.	Objective	Action Required	Update	Owner	Target Date	Completion Date	Current Position	Evidence
1	**Review Flexible working opportunities**	Survey staff feedback and suggestion	Staff survery undertaken in July 2023.	RA/KH/SC	31/08/2023	31/08/2023		Survey
2		Review and revise all JDs within care group	JDs revised as part of cultural improvement action plan and flexible working included.	RA/KH/SC	31/08/2023	31/08/2023		Updated JDs
3		Utlilise leavers interviews	Leavers interviews feed into workforce report and reasons for leaving monitored.	RA/KH/SC	31/08/2023	31/08/2023		Workforce reports
4		Include opportunities for flexible working in all interviews	Flexible working opportunities discussed as mandatory part of intereview process.	RA/KH/SC	31/08/2023	31/08/2023		HR recruitment forms
5	**Introduce yearly career MOT workshops to support personalised plans for all staff, ensuring both developmental and succession planning**	PMA to support facilitating workshops Diarise annual plan	Awaiting PMA to arrange workshops and annual plan.	YM	30/03/2024			
6		Utilise appraisal process to identifiy aspiring leaders and specialists to help with sucession planning.		KH	30/12/2023			

7	**Update escalation policy in place in line with the South East OPEL Framework**	Matron for intrapartum care to review and update	Escalation policy now updated and in place.	AC	31/07/2023			
8	**Increase registered nurse establishment in maternity**	Advertise and appoint suitable candidates	8WTE Nurses now part of establishement.	KF	31/08/2023			
9		Develop a competency framework to ensure safe deployment of RNs within maternity.	Competency pack for RN developed and in place.	KF	31/08/2023			Competency Pack
10	**Map the building blocks for MCoC in preparation for moving towards full implementation of the model in the future**	Review and map our most vulnerable groups Consider how MCoC could be commenced in one team Produce recommendation report at MNSCAB	Mapping completed and presented to MNSCAB	LP/MK	31/08/2023			MNSCAB presentation
11	**Triangulate red flag data with FFT, and datix**	Review and appraise harm	Triangulation report forms part of monthly MNSCAB reporting/governance/risk slides	KH	31/07/2023	30/10/2023		
12	**Review bank rates**	Produce report and recommendation to People committee	Lead for temporary staffing has presented the report to CPO, awaiting feedback.	Lead for Temporary staffing	31/07/2023	30/09/2023		
13	**Review and Revise IOL A3**	Work with transformation team and project lead to improve pathway	IOL A3 project completed and demonstrating improved quality outcomes.	MK/LP	31/07/2023	30/09/2023		
14		Utilise staff and patient feedback to develop action plan	Staff and patient feedback incorporated into plan.	MK/LP	31/07/2023	30/09/2023		

NHS
Medway
NHS Foundation Trust

Meeting of the Trust Board in Public
Wednesday, 17 January 2024

Title of Report	Patient Safety Incident Response Plan (PSIRP) and Policy (PSIRPol)	**Agenda Item**	4.3
Author	Katrina Andrew – Head of Patient Safety Improvement		
Lead Executive Director	Chief Nursing Officer		
Executive Summary	The Patient Safety Incident Response Framework (PSIRF) will replace the existing 2015 Serious Incident Framework. The framework represents a shift in the way the NHS responds to patient safety incidents and is a major step towards establishing a safety management system across the NHS and is a key part of the NHS patient safety strategy. The PSIRF supports the development and maintenance of a patient safety incident investigation response system that integrates four key aims: 1.Compassionate engagement and involvement of those affected by patient safety incidents 2.Application of a range of system-based approaches to learning from patient safety incidents 3.Considered and proportionate responses to patient safety incidents 4.Supportive oversight focused on strengthening system learning and improvement The PSIRF Plan and Policy set out how MFT plans to respond to patient safety incidents from 01 February 2024 under the new national guidance and is based on a MFT profile compiled from three years of patient safety related data and information.		
Proposal and/or key recommendation:	The Board is asked to approve the plan and policy ahead of submission to the Kent and Medway ICB for final approval and agreement for transition to investigating incidents under the PSIRF		

Purpose of the report (Please mark with 'X' the box to indicate)	Assurance		Approval	X
	Noting		Discussion	

Committee/Group and date submitted:	Meeting: Quality Assurance Committee (QAC) Date: 02.11.23

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

Patient FIRST

Medway NHS Foundation Trust

Identified Risks, issues and mitigations:	N/A
Resource implications:	Financial resource is required to deliver training of incident investigators to meet the requirements under PSIRF guidance.
Sustainability and /or Public and patient engagement considerations:	A communication plan has been agreed to communicate the roll out of the PSIRP to staff. This will be a publicly accessible document. Conversations have been held with key stakeholders and meetings with key staff continue. The plan will also be presented at grand round on 26 January 2024.
Integrated Impact assessment:	Yes
Legal and Regulatory implications:	Regulatory compliance with national framework
Appendices:	NIL
Freedom of Information (FOI) status:	Tick either: This paper is disclosable under the FOI Act
For further information please contact:	Name: Kat Andrew Job Title: Head of Patient Safety Improvement Email: katrina.andrew@nhs.net

Please mark with 'X' - 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 minor improvements needed.
	Significant Assurance	**X**	There are no gaps in assurance
	Not Applicable		No assurance required.

Patient FIRST

NHS

Patient Safety Incident Response Plan 2023/24

Medway NHS Foundation Trust

NHS England and NHS Improvement

Contents

Contents 2
1. Introduction 4
Foreword 4
2. Trust Values & Patient First 5
Core Values 5
Mission, Vision and Aspirations 6
3. Purpose, scope, aims and objectives 8
3.1 Purpose 8
3.2 Scope 8
3.3 Strategic aims 9
3.4 Strategic objectives 9
4. Situational analysis – national 11
5. Situational analysis – local 14
5.1 Results of a review of activity and resources 14
5.2 Sources for analysis: 15
5.3 Conclusions from review of the local patient safety incident profile 16
5.4 Maternity Incidents 16
5.5 Safeguarding 17
5.6 Gap analysis 17
5.7 Stakeholder engagement 18
6. Selection of incidents for patient safety incident investigation 19
6.1 Aim of a patient safety incident investigation (PSII) 19
6.2 Selection of patient safety incidents for PSII 19
6.3 Timescales for patient safety PSII 20
6.4 Nationally-defined priorities to be referred for PSII or review by another team 21
6.5 Nationally-defined incidents requiring local PSII 22
6.6 Locally-defined incidents requiring local PSII 23
6.7 Thematic analysis following the completion of a small number individual investigations of similar patient safety incidents 25

6.8 Continuous patient safety improvement plans underway ... 25
7. Selection of incidents for review ... 27
7.1 Learning review methods ... 27
7.2 Duty of Candour ... 29
7.3 Non- PSII Subject suggestions ... 29
7.4 Specialty Nursing Incident Review ... 30
8. Roles, responsibilities and reporting arrangements ... 31
Committees ... 32
9. Procedures to support patients, families and carers affected by PSIs ... 34
9.1 Patient and Family Liaison ... 34
9.2 Local support ... 34
9.3 National guidance for NHS trusts engaging with bereaved families ... 35
10. Procedures to support staff affected by PSIs ... 36
10.1 Local Arrangements ... 36
10.2 Support from Patient Safety Incident Investigators ... 36
11. Mechanisms to develop and support improvements following PSIIs ... 38
12. Evaluating and monitoring outcomes of PSIIs, Reviews etc. ... 39
13. Complaints and appeals ... 40
13.1 Raising a concern – Don't take your troubles home: ... 40
13.2 Patient Advice & Liaison Service (PALS): ... 40
13.3 Informal Complaints: ... 40
13.4 Formal Complaints: ... 40
13.5 Friends & Family Test: ... 41
13.6 NHS Choices / Care Opinion: ... 41
13.7 Local Surveys: ... 41
13.8 National Surveys: ... 41

1. Introduction

Foreword

I am really thankful for the ongoing commitment and dedication of all our staff, but particularly our clinical staff who play a key role in ensuring we deliver high quality, safe and effective care and services for our patients, their families and carers.

The delivery of high quality, safe and effective care and good experience for our patients, their families and carers remains a key focus for Medway NHS Foundation Trust (MFT) in making sure that risk and harm to patients is minimised, whilst ensuring that a just and learning culture, which enables psychological safety is embedded in everyday practice across the Trust.

I am delighted to introduce our new Patient Safety Incident Response Plan (PSIRP), highlighting our methodology for improving and providing high quality care, reducing harms and improving patient experience and outcomes. This plan will support the Trust's philosophy of Patient First, delivering on the following two True North Domains;

- Quality: Excellent outcomes, ensuring no patient comes to harm and no patients dies who should not have, and
- Patients: Providing outstanding, compassionate care for our patients and their families every time

It has been compiled with our local system partners and aligns to the National Patient Safety Incident Response Framework to ensure we work collaboratively for the best outcomes for our patients

Evonne Hunt, Chief Nursing Officer

2. Trust Values & Patient First

At Medway NHS Foundation Trust (MFT) we are dedicated to putting our Patients First, at the heart of everything we do. Over the past year Medway NHS Foundation Trust has improved its Quality Governance arrangements, systems and processes and is now in a position to implement a plan for continued improvement, ensuring we learn from incidents and near misses to prevent future harm.

Following the Covid-19 Pandemic there were a number of national backlogs across the integrated governance and quality agenda as business as usual systems and processes where placed on hold, including complaints, incident investigations, coroners inquests, clinical audit and the review of NICE Guidance.

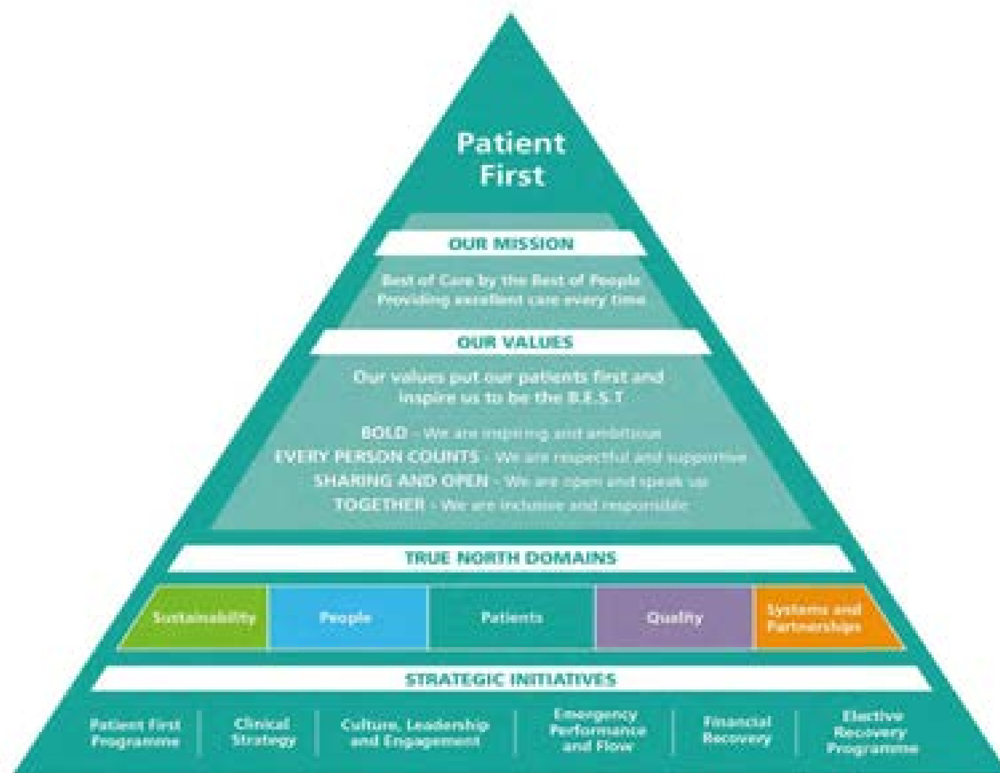
As MFT reduce these back logs and return to business as usual, and in implementing the National Patient Safety Strategy, we have opportunities to review, revise and improve the business as usual systems and processes.

This Patient Safety Incident Response Plan (PSIRP), along with the different initiatives arising from it, will enable MFT to embed important and substantial improvements in the quality of our patient's care and experience and to ensure they are kept safe from avoidable harms, and have the best possible outcomes.

Combined with our quality strategy, this is a critical and key part of our aspirational journey to provide care and treatment rated as 'Outstanding' by the Care Quality Commission (CQC).

Core Values

The Trust's values underpin everything we do, and we expect our staff to work to these values in the delivery of safe, consistent and high quality patient care. The guiding principles of our overarching Patient First programme highlights that the Quality Strategy is part of supporting our Trust's True North vision for the future and journey of continuous improvement.



The PSIRP aligns to our True North Domain of Quality, ensuring that we are providing high quality care to improve outcomes and reduce harm to our patients. Further to this, there are a number of relevant strategies and policies Trust-wide that link into the PSIRP, (such as the Quality Strategy, Patient Experience Strategy and Infection Prevention and Control Strategy).

Mission, Vision and Aspirations

Here at MFT we are dedicated to putting our patients first by continually improving. All staff are responsible for ensuring the safety of our patients, challenging poor practice, reporting and learning from incidents. Keeping our patients safe from harm is everyone's business.

We know that there is still work to be done to recover from the Covid-19 backlogs, implement and embed the NHS Patient Safety Strategy and improve evidence based practice and outcomes for our patients, and this strategy will make sure that we;

i) Reduce harm to patients and create a culture of safety responding to and learning from patient safety incidents
ii) Provide the best experiences of care for our patients, families and carers and respond appropriately when we get this wrong
iii) Provide evidence based and best practice care
iv) Develop, implement and monitor quality improvement plans

This Strategy supports the Patient First methodology and is our structured approach and plan to enhance our quality practices and improve our patients' quality of care.

By implementing this plan, our vision is to be recognised by the Care Quality Commission (CQC) and our patients as an outstanding and innovative Trust, working collaboratively across the system.

3. Purpose, scope, aims and objectives

3.1 Purpose

This patient safety incident response plan (PSIRP) sets out how MFT will seek to learn from patient safety incidents reported by staff and patients, their families and carers as part of our work to continually improve the quality and safety of the care we provide.

This plan will help us measurably improve the efficacy of our local patient safety incident investigations (PSIIs) by:

a. refocusing PSII towards a systems approach[1] and the rigorous identification of interconnected causal factors and systems issues
b. focusing on addressing these causal factors and the use of improvement science[2] to prevent or continuously and measurably reduce repeat patient safety risks and incidents
c. transferring the emphasis from the quantity to the quality of PSIIs such that it increases our stakeholders' (notably patients, families, carers and staff) confidence in the improvement of patient safety through learning from incidents
d. demonstrating the added value from the above approach.

3.2 Scope

A PSIRP is a requirement of each provider or group/network of providers delivering NHS-funded care.

[1] The approach is broken down into units to make it easier to understand the complexity, interactive nature and interdependence of the various external and internal factors.
[2] "Improvement science is about finding out how to improve and make changes in the most effective way. It is about systematically examining the methods and factors that best work to facilitate quality improvement." Health Foundation (2011) https://www.health.org.uk/publications/improvement-science.

This document should be read alongside the introductory Patient Safety Incident Response Framework (PSIRF) 2020, which sets out the requirement for this plan to be developed.

We have developed the planning aspects of this PSIRP with the assistance and approval of the organisation's local commissioner(s).

The aim of this approach is to continually improve. As such this document will be reviewed annually to start with.

3.3 Strategic aims

Improve the safety of the care we provide to our patients, and improve our patients', their families' and carers' experience of it.

Further develop systems of care to continually improve their quality and efficiency.

Improve the experience for patients, their families and carers wherever a patient safety incident or the need for a PSII is identified.

Improve the use of valuable healthcare resources.

Improve the working environment for staff in relation to their experiences of patient safety incidents and investigations.

3.4 Strategic objectives

Act on feedback from patients, families, carers and staff about the current problems with patient safety incident response and PSIIs in the NHS.

Develop a climate that supports a just culture[3] and an effective learning response to patient safety incidents.

Develop a local board-led and commissioner and integrated care system (ICS)/sustainability and transformation partnership (STP)-assured architecture

[3] A culture in which people are not punished for actions, omissions or decisions commensurate with their experience and training, but where gross negligence, wilful violations and destructive acts are not tolerated. Eurocontrol (2019) Just culture.

around PSII and alternative responses to patient safety incidents, which promotes ownership, rigour, expertise and efficacy.

Make more effective use of current resources by transferring the emphasis from the quantity of investigations to a higher quality, more proportionate response to patient safety incidents, as a whole. The aim is to:

- make PSIIs more rigorous and, with this, identify causal factors and system-based improvements
- engage patients, families, carers and staff in PSII and other responses to incidents, for better understanding of the issues and causal factors
- develop and implement improvements more effectively
- explore means of effective and sustainable spread of improvements which have proved demonstrably effective locally.

4. Situational analysis – national

Many millions of people are treated safely and successfully each year by the NHS in England, but evidence tells us that in complex healthcare systems things will and do go wrong, no matter how dedicated and professional the staff.

When things go wrong, patients are at risk of harm and many others may be affected. The emotional and physical consequences for patients and their families can be devastating. For the staff involved, incidents can be distressing and members of the clinical teams to which they belong can become demoralised and disaffected. Safety incidents also incur costs through lost time, additional treatment and litigation. Overwhelmingly these incidents are caused by system design issues, not mistakes by individuals.

Historically, the NHS has required organisations to investigate each incident report that meets a certain outcome threshold or 'trigger list'. When this approach was developed it was not clear that:

a. Luck often determines whether an undesired circumstance translates into a near miss or a severe harm incident.[4] As a result, focusing most patient safety investigation efforts on incidents with the most severe outcome does not necessarily provide the most effective route to 'organisational learning'.[5]
b. There is no clear need to investigate every incident report to identify the common causes and improvement actions required to reduce the risk of similar incidents occurring. To emphasise this point, it has been highlighted that in-depth analysis of a small number of incidents brings greater dividends than a cursory examination of a large number.[20]

An increased openness to report patient safety issues has also led to an ever-growing number of incidents being referred for investigation. NHS organisations are now struggling to meet the number of requests for investigation into similar types of

[4] Health and Safety Executive (2014) Investigating accidents and incidents: A workbook for employers, unions, safety representatives and safety professionals.
[5] Vincent C, Adams S, Chapman A et al (1999) *A protocol for the investigation and analysis of clinical incidents*.

incident with the level of rigour and quality required. Available resources have become inundated by the investigation process itself – leaving little capacity to carry out the very safety improvement work the NHS originally set out to achieve.[6,7,8,9,10]

In addition, the remit for patient safety incident investigation (PSII) has become unhelpfully broad and mixed over time. This originates from an attempt to be more efficient by addressing the many and varied needs of different types of investigation in a single approach. Sadly, the very nature and needs of some types of investigation (eg professional conduct or fitness to practise; establishing liability or avoidability; or establishing cause of death) have frustrated the original patient safety aim and blocked the system learning the NHS set out to achieve.

Many other high-profile organisations now identify and describe their rationale for deciding which incidents to investigate from a learning and improvement perspective. While some industry leaders describe taking a risk-based approach to safety investigation (eg the Rail Accident Investigation Branch and Air Transport Safety Board), others list the parameters that help their decision-making processes (the police, Parliamentary Health Service Ombudsman and Healthcare Safety Investigation Branch).

We need to remove the barriers in healthcare that have frustrated the success of learning and improvement following a PSII (eg mixed investigation remits, lack of dedicated time, limited investigation skills). We also need to increase the opportunity for continuous improvement by:

a. improving the quality of future PSIIs
b. conducting PSIIs purely from a patient safety perspective
c. reducing the number of PSIIs into the same type of incident
d. aggregating and confirming the validity of learning and improvements by basing PSIIs on a small number of similar repeat incidents.

[6] Public Administration Select Committee (2015) *Investigating clinical incidents in the NHS. Sixth report of session 2014–15*.
[7] Parliamentary and Health Service Ombudsman (2015) *A review into the quality of NHS complaints investigations where serious or avoidable harm has been alleged*.
[8] Care Quality Commission (2016) *Learning from serious incidents in NHS acute hospitals. A review of the quality of investigation reports*.
[9] NHS Improvement (2018) *The future of NHS patient safety investigation*.
[10] NHS Improvement (2018) *The future of NHS patient safety investigation: engagement feedback*.

This approach will allow NHS organisations to consider the safety issues that are common to similar types of incident and, on the basis of the risk and learning opportunities they present, demonstrate that these are:

a. being explored and addressed as a priority in current PSII work or
b. the subject of current improvement work that can be shown to result in progress or
c. listed for PSII work to be scheduled in the future.

In some cases where a PSII for system learning is not indicated, another response may be required. Options that meet the needs of the situation more appropriately should be considered; these are listed in Section 5.

As part of this approach, incidents requiring other types of investigation and decision-making, which lie outside the scope of this work, will be appropriately referred as follows:

a. professional conduct/competence – referred to human resource teams
b. establishing liability/avoidability – referred to claims or legal teams
c. cause of death – referred to the Medical Examiners/coroner's office
d. criminal – referred to the police.

5. Situational analysis – local

5.1 Results of a review of activity and resources

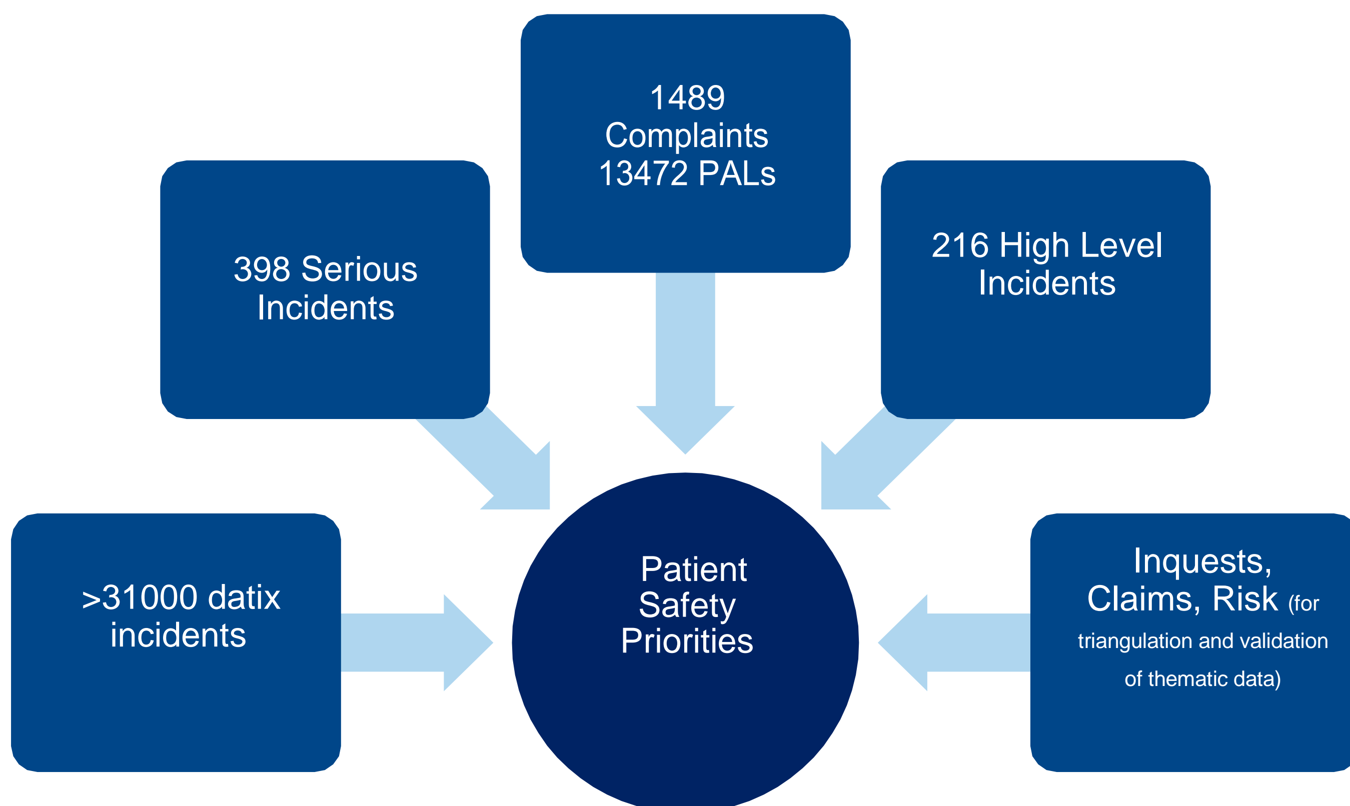
Patient safety incident investigation (PSII) activity: March 2020 to April 2023:

	2020/21	2021/22	2022/23	Annual Average
Never Events	2	1	3	2
Serious Incident investigations (ie StEIS reportable and including IMRs submitted to DHR,SCR etc)	216	97	80	131
HLI Investigations	87	82	47	72
Local Investigations	8596	8756	13490	10280
Incidents **referred** (to HSIB/Regional independent investigation teams (RIITs)/PHE, etc) for independent PSII				6

The patient safety incident risks for Medway NHS Foundation Trust have been profiled using organisational data from recent patient safety incident reports, complaints, Serious Incidents (SIs), High Level Incidents (HLIs), mortality reviews, case note reviews, claims, risk assessments. Resources mined for this data include:

a. staff survey explorer tool results:
   - https://www.nhsstaffsurveys.com/Page/1058/Survey-Documents/Survey-Documents/
b. organisation patient safety reports:
   - https://report.nrls.nhs.uk/ExplorerTool/Report/Default
   - https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-march-2019/

5.2 Sources for analysis:



The Trust is currently using the Manchester Patient Safety Framework (MaPSAF) to gauge the safety culture of the organisation, this work is ongoing at the time of this plan but will be included within the next plan. Work has been completed over the last 18 months to increase incident reporting across the organisation, and this has seen incident reporting double during this period. When reviewing staff survey results from 2022 (the 2023 survey is currently running at the time of this plan's creation), the trust is generally just below the benchmarking group average for encouraging reporting , taking action and acting on incident s and near misses. Work is underway to improve the culture in the organisation including:

- New methods of sharing learning
- Staff involvement in investigation
- Embedding of a just culture

An improvement plan will be devised following analysis of the results following the MaPSAF rollout across the organisation.

5.3 Conclusions from review of the local patient safety incident profile

Following thorough analysis of 3 years of safety data from the organisation, the current top 10 local priorities/risk register for a Patient Safety Response are:

	Incident type	Investigation Type
1	**Escalation and care of Deteriorating Patients**	**PSII**
2	**Patient handover**	**PSII**
3	**Diagnostic Testing**	**PSII**
4	**Medication Incidents**	**PSII**
5	**Delays in treatment**	**PSII**
6	**Falls where learning not addressed by QIP**	**AAR + Toolkit**
7	**Pressure damage where learning not addressed by QIP**	**AAR + Toolkit**
8	**12 Hour breach in admission from DTA (Decision to admit)**	**Initial harm review + “further in care” review**
9	**Incidents where a patient that lack capacity absconds from a ward**	**Harm review**
10	**DOLS/MCA care**	**AAR + Toolkit**

5.4 Maternity Incidents

Following a review of the Trust’s maternity incidents and discussion with maternity stakeholders, it was felt maternity priorities align with those set out above. Current maternity themes in the organisation are:

- Post-partum Hemorrhage
- Labour and Delivery incidents
- Lack of/availability of beds/staff
- Third or fourth degree tears

If an emerging trend is identified, this will be reviewed against the PSIRP to identify opportunities for additional learning. The maternity team are working on a number of ongoing QI projects, and this may identify further themes within the next PSIRP.

5.5 Safeguarding

Safeguarding requires consideration throughout all patient safety events. Whilst there are some specific incidents that will follow the specialty nursing pathway for review, others may require safeguarding input or referrals. These will be reviewed by the Trust safeguarding team who attend the Trust IRG and PSIRG meetings.

5.6 Gap analysis

The Trust currently works on a clinically led investigative model. Root Cause Analysis (RCA) trained investigators conduct investigations as part of their daily workload. This does not allow staff the dedicated time and resource to complete full investigations and embed learning from these investigations. To ensure adequate resources are dedicated to Patient Safety Improvement the Trust has:

- Developed a dedicated Patient Safety Improvement Team (PSIT) who will:
  (1) Be specialist investigators for PSII
  (2) Work with a clinical lead as a subject matter expert to complete PSII investigations
  (3) Co-ordinate Swarms, interviews and debriefs with staff and patients/ families/carers involved in a patient safety incident
  (4) Act as a specialist liaison point for families involved in a PSII to ensure their voice is heard and they are involved with an investigation as much as they would like to be
  (5) Ensure reports are easily understood, free from jargon and used a systems based approach to investigating outcomes and identifying learning
- Following a review of the Trust capacity for investigations the Trust will endeavour to complete 20 PSII per year, determined by the PSIRF priorities in addition to any mandated PSIIs. This is an estimated as 4 PSII per priority.
- The Trust has a number of Quality Improvement Plans which are held and monitored by specialist teams and overseen by the central Patient Safety Team

5.7 Stakeholder engagement

The Trust has consulted and engaged with a range of stakeholders both internally and externally within the Trust.

This has included but not limited to:

- Patient Safety Leads
- Patient Safety Specialists
- Nursing staff
- Medical Staff
- Corporate teams
- Neighboring Organisations
- The local Health Care Partnership (HCP)
- Integrated Care Board (ICB)
- Academic Health Service Network (AHSN)
- Trust Executive Team
- Patients and relatives
- Quality Management System provider

6. Selection of incidents for patient safety incident investigation

6.1 Aim of a patient safety incident investigation (PSII)

PSIIs are conducted for systems learning and safety improvement. This is achieved by identifying the circumstances surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

There is no remit in a PSII to apportion blame or determine liability, preventability or cause of death.

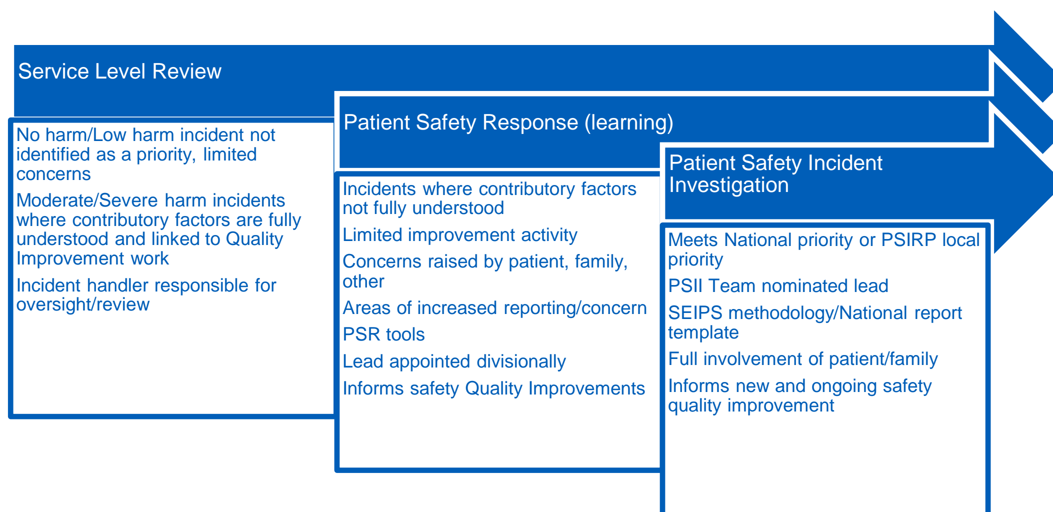
There are several other types of investigation which, unlike PSIIs, may be conducted for or around individuals. Examples include complaints, claims, human resource, professional regulation, coronial or criminal investigations. As the aims of each of these investigations differ, they need to continue to be conducted as separate entities to be effective in meeting their specific intended purposes.

6.2 Selection of patient safety incidents for PSII

In view of the above, the selection of incidents for PSII is based on the:

a. actual and potential impact of the incident's outcome (harm to people, service quality, public confidence, products, funds, etc)
b. likelihood of recurrence (including scale, scope and spread)
c. potential for new learning in terms of:
    - enhanced knowledge and understanding of the underlying factors
    - improved efficiency and effectiveness (control potential)
    - opportunity to influence wider system improvement.

The Trust will use its Incident Review Group to review incidents meeting the objectives set out in the PSIRP and identify the appropriate response to such incidents in line with the PSIRP.



6.3 Timescales for patient safety PSII

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

PSIIs should ordinarily be completed within one to three months of their start date.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisation with the patient/family/carer.

No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

6.4 Nationally-defined priorities to be referred for PSII or review by another team

The national priorities for referral to other bodies or teams for review or PSII (described in the PSIRF) for the period 2020 to 2021 are:

a. **maternity and neonatal incidents:**

- incidents which meet the 'Each Baby Counts' and maternal deaths criteria detailed in Appendix 4 of the PSIRF must be referred to the Healthcare Safety Investigation Branch (HSIB) for investigation (https://www.hsib.org.uk/maternity/)
- all cases of severe brain injury (in line with the criteria used by the Each Baby Counts programme) must also be referred to NHS Resolution's Early Notification Scheme
- all perinatal and maternal deaths must be referred to MBRRACE

b. **mental health-related homicides by persons in receipt of mental health services or within six months of their discharge** must be discussed with the relevant NHS England and NHS Improvement regional independent investigation team (RIIT)

c. **child deaths** (*Child death review statutory and operational guidance*):

- incidents must be referred to child death panels for investigation

d. **deaths of persons with learning disabilities:**

- incidents must be reported and reviewed in line with the Learning Disabilities Mortality Review (LeDeR) programme

g. **safeguarding incidents:**

- incidents must be reported to the local organisation's named professional/safeguarding lead manager and director of nursing for review/multiprofessional investigation

e. **incidents in screening programmes**:

- incidents must be reported to Public Health England (PHE) in the first instance for advice on reporting and investigation (PHE's regional Screening Quality Assurance Service (SQAS) and commissioners of the service)

h. **deaths of patients in custody, in prison or on probation** where healthcare is/was NHS funded and delivered through an NHS contract:

- incidents must be reported to the Prison and Probation Ombudsman (PPO), and services required to be registered by the Care Quality Commission (CQC) must also notify CQC of the death. Organisations should contribute to PPO investigations when approached.

6.5 Nationally-defined incidents requiring local PSII

Nationally-defined incidents for local PSII are set by the PSIRF and other national initiatives for the period 2020 to 2021. These are:

a. **incidents that meet the criteria set in the** Never Events list 2018
b. **incidents that meet the** 'Learning from Deaths' criteria; that is, deaths clinically assessed as more likely than not due to problems in care - using a recognised method of case note review, conducted by a clinical specialist not involved in the patient's care, and conducted either as part of a local LfD plan, or following reported concerns about care or service delivery. Further, specific examples of deaths where a PSII must take place include:
    i. **deaths of persons with mental illness whose care required case record review as per the Royal College of Psychiatrist's** mortality review tool and which have been determined by case record review to be more likely than not due to problems in care
    ii. **deaths of persons with learning disabilities** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS. In these circumstances a PSII must be conducted in addition to the LeDeR review
    iii. **deaths of patients in custody, in prison or on probation** where there is reason to believe that the death could have been contributed to by one or more patient safety incidents/problems in the healthcare provided by the NHS
c. **suicide, self-harm or assault resulting in the death or long-term severe injury of a person in state care or detained under the Mental Health Act.**

Where the Trust has a regulatory or contractual duty to report an incident we will follow the recognised process for the type of incident.

6.6 Locally-defined incidents requiring local PSII

Based on the local situational analysis and review of the local incident reporting profile, local priorities for PSII have been set by this organisation for the period **January 2024 – January 2025**.

a. **Locally-defined emergent patient safety incidents requiring PSII.** An unexpected patient safety incident which signifies an extreme level of risk for patients, families and carers, staff or organisations, and where the potential for new learning and improvement is so great (within or across a healthcare service/pathway) that it warrants the use of extra resources to mount a comprehensive PSII response.

b. **Locally-predefined patient safety incidents requiring investigation.** Key patient safety incidents for PSII have been identified by this organisation (through analysis of local data and intelligence from the past three years), and agreed with the commissioning organisation(s) as a local priority in line with the following guidance:

   - **Criteria for selection of incidents for PSII:**

     a. actual and potential impact of outcome of the incident (harm to people, service quality, public confidence, products, funds, etc)

     b. likelihood of recurrence (including scale, scope and spread)

     c. potential for learning in terms of:

        – enhanced knowledge and understanding

        – improved efficiency and effectiveness (control potential)

        – opportunity for influence on wider systems improvement.

Based on the analysis of historical data for the organisation, the most commonly occurring incidents were identified. Whilst a wide range of incidents occurring in the organisation, the incident categories selected for PSII represent the areas where the most incidents occur and robust exploration and improvement work could make a substantial impact in improving care and safety of our patients. Other common themes will be investigated locally, or via AAR, SWARM or thematic analysis. For the period January 2024– January 2025 local priorities for PSII have been agreed as follows:

	Incident type and specific description	Quantity
1	**Escalation and care of Deteriorating Patients/Failure to Rescue** Incidents where failures in the early detection, escalation and care of a patient whose condition was deteriorating, led to an adverse outcome for that patient.	4
2	**Patient handover** Incidents where the handover of a patient either internally or externally led to an adverse outcome for a patient or unnecessary readmission.	4
3	**Diagnostic Testing** Incidents or groups of incidents where failure to follow up on diagnostic tests has led to an adverse outcome for that patient or where a misdiagnosis has been made	4
4	**Medication Incidents** Incidents or groups of incidents where an error or delay in administration or prescribing of medication led to an adverse outcome for the patient. (The Trust rolled out EPMA in September 2022)	4
5	**Delays in treatment** Incidents or groups of incidents where a delay in treatment of a patient due to multifactorial issues had led to an adverse outcome for a patient.	4

Based on analysis of resources, the Trust plans to investigate a minimum of 4 PSII under each category. This is flexible to allow for variations within the incident profile. In addition, maternity have an additional 3-5 allocations within the Trust priorities for maternity specific incidents.

It is also possible that emerging or individual incidents may require a PSII. This decision will be made by the IRG. The trust will use an incident decision matrix to support these decisions, however this is not exhaustive and a multidisciplinary approach to decision making will be taken.

Using other learning response techniques the Trust will review incidents to identify learning. Not all incidents will require a full PSII. This methodology will support the Trust to use proportionate responses to incidents as they arise.

6.7 Thematic analysis following the completion of a small number individual investigations of similar patient safety incidents

A valuable and thorough way of accomplishing thematic analysis of PSII findings is to select a few (three to six) recent and very similar incidents and **investigate each individually** with skill and rigour to determine the interconnected contributory and causal factors.

The findings from each individual investigation are then collated, compared and contrasted to identify common **causal factors** and any common interconnections or associations upon which effective improvements can be designed.

Importantly, investigation of recent incidents allows more accurate information gathering from properly specified, good quality PSIIs, and detailed analysis of the system as it currently stands.

Where it is felt a thematic analysis provides an opportunity for system learning, this will be shared throughout the Health Care Partnership and with the ICB for potential application across the system.

6.8 Continuous patient safety improvement plans underway

Locally designed patient safety improvement plans underway. This relates to full plans, rather than individual actions, designed and prescribed to address previous PSII, review, audit or risk assessment findings (e.g. national suicide prevention plan).

	Local **patient safety incident improvement plan/scheme title**
1	Falls
2	Tissue Viability
3	Deteriorating Patient *under development*
4	Infection Prevention and Control *under development*
5	Mental Health *under development*
6	Safeguarding *under development*
7	Maternity *under development*
8	Medication *under development*

The Quality Improvement Plans described above will be monitored via specific committees such as the falls steering group. These will then be discussed at PSG with key matters escalated to QPSSC. Each plan has an owner who will regularly review the actions and escalate as appropriate.

7. Selection of incidents for review

7.1 Learning review methods

Some patient safety incidents will not require PSII but may benefit from a different type of examination to gain further insight or address queries from the patient, family, carers or staff.

A clear distinction is made between the activity, aims and outputs from reviews and those from PSIIs.

Different review techniques can be adopted, depending on the intended aim and required outcome. The most commonly used are:

Technique	Method	Objective
Immediate safety actions	Incident recovery	To take urgent measures to address serious and imminent: a. discomfort, injury, or threat to life b. damage to equipment or the environment.
'Being open' conversations	Open disclosure	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
Case record/note review	Clinical documentation review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
Hot debrief	Debriefing	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety huddle	Briefing	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns • focus on the patients most at risk

Technique	Method	Objective
		• share understanding of the day's focus and priorities • agree actions • enhance teamwork through communication and collaborative problem-solving • celebrate success in reducing harm.
Incident timeline	Incident review	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
After-action review	Team review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.
SWARM	Team review	Immediately after an incident, staff 'swarm' to the site to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk. Swarms enable insights and reflections to be quickly sought and generate prompt learning.
LeDeR (Learning Disabilities Mortality Review)	Specialist Review	To review the care of a person with a learning disability (recommended alongside a case note review).
Perinatal mortality review tool	Specialist review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
Mortality review	Specialist Review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
Transaction audit	Audit	To check a trail of activity through a department, etc, from input to output.
Process audit	Audit	To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended

Technique	Method	Objective
Outcome audit	Audit	To systematically determine the outcome of an intervention and whether this was as expected/intended
Clinical audit	Outcome audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
Risk assessment	Proactive hazard identification and risk analysis	To determine the likelihood of an identified risk and its potential severity (eg clinical, safety, business).

7.2 Duty of Candour

Priorities for 'being open' conversations and Duty of Candour include:

- all patient safety incidents leading to moderate harm or above
- all incidents for which a PSII is undertaken.

Engaging patients and families in patient safety incidents including being open and Duty of Candour policy and SOP

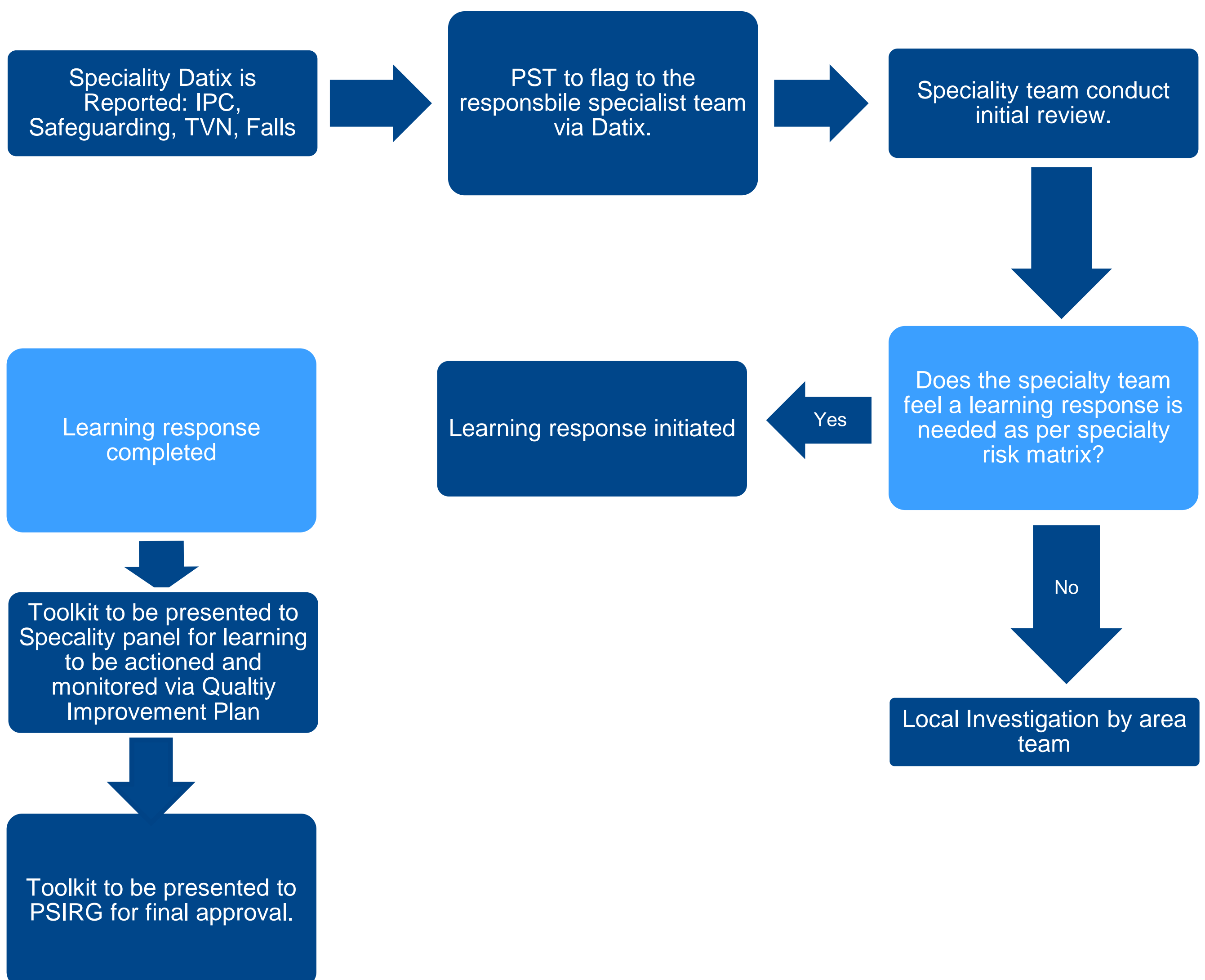
7.3 Non- PSII Subject suggestions

Key subject suggestions for patient safety reviews (Non-PSII):

	Incident type	Specialty	Year
1	**Falls**	Corporate Nursing	2023-2024
2	**Pressure damage**	Corporate Nursing	2023-2024
3	**12 hour breaches**	Acute and Emergency Medicine	2023-2024
4	**Absconding patients**	All	2023-2024
5	**DOLS/MCA care**	Safeguarding	2023-2024

7.4 Specialty Nursing Incident Review

Some incidents need to follow a slightly different process. This relates to incidents where there is a corporate nursing team for specialist input. Current investigations in this category include: Tissue Viability, Falls, Infection Prevention and Control, Safeguarding specific incidents.



8. Roles, responsibilities and reporting arrangements

This organisation describes clear roles and responsibilities in relation to its response to patient safety incidents, including investigator responsibilities and upholding national standards relating to patient safety incidents.

Chief Executive Officer:

As Accountable Officer has overall responsibility for ensuring compliance with our regulatory and legal responsibilities, ensuring the Trust has a suitable and effective policy, standard operating procedures and infrastructure in place to provide a comprehensive system of internal control and systemic and consistent management of incidents across the Trust. The Chief Executive will delegate specific roles and responsibilities as required, to ensure incident management is coordinated and implemented effectively.

Chief Nursing Officer:

Has delegated board level responsibility for ensuring that processes for investigating and managing incidents are devised, implemented and embedded, reporting to the Chief Executive Officer and Executive Team any significant issues arising from the implementation of this framework including evidence of non-compliance or lack of effectiveness arising from the monitoring process so that remedial action can be taken. They also have delegated board level responsibility for quality, and patient experience and hold the responsibility for risk of non-compliance with regulatory and legal responsibilities such as the CQC fundamental standards.

Chief Medical Officer:

The Chief Medical Officer will ensure that the Trust takes action upon issues arising from patient safety and clinical risk management. Together with the Chief Nursing Officer, they will champion a strong patient safety culture and lead on Sharing the Learning that arises from patient safety incidents investigations.

Director of Integrated Governance, Quality and Patient Safety:

Has the operational responsibility for ensuring the delivery and effectiveness of the processes for the management of patient safety incidents including timely engagement of patients and families in patient safety incidents, and the direct line management of the patient safety team through which their duties are discharged.

Patient Safety Specialists:

Have responsibility to ensure the principles of PSIRF are maintained at the organisation and have responsibility to support the implementation and embedding of the patient safety strategy within the organisation.

All Staff:

Have a responsibility to report patient safety incidents including near misses and no harm incidents via the Trust reporting system to ensure they can be reviewed and corrective and preventative action be put in place to prevent re-occurrence.

Clinical Staff:

Clinical staff involved in care are responsible for participating in learning events and investigations, to identify system concerns and remedial actions.

Coroner:

Has a Statutory Duty under Regulation 28 to issue a PFD Report where their investigation gives rise to a concern that circumstances exist which create a risk of future deaths.

Medical Examiners:

Have a responsibility to escalate to the Trust any deaths where there may be an area of concern which needs further exploration.

Committees

Incident Review Group:

Is co-chaired by the Medical Director for Quality & Safety and Director of Integrated Governance, Quality and Patient Safety and is responsible for reviewing all incidents to determine if they meet the

threshold to be declared as a Notifiable Patient Safety Incident, confirming the level of harm and investigation to be completed. The IRG reports to the Patient Safety Group.

Patient Safety Investigation Review Group (PSIRG):

Is co-chaired by the Medical Director for Quality & Safety and Director of Integrated Governance, Quality and Patient Safety and is responsible for reviewing all PSIIs to determine if appropriate learning has been established from the review. This group has board level authority to approve investigation reports. The PSIRG reports to the Patient Safety Group.

Quality and Patient Safety Sub-Committee (QPSSC):

Is co-chaired by the Chief Medical Officer and Chief Nursing Officer and has responsibility for monitoring the operational effectiveness of patient safety incidents, including timely compliance with requirements to engage patients and families in patient safety incidents, and duty of candour regulations. The operational management of this function is delegated to the Patient Safety Group.

Quality Assurance Committee (QAC):

Is chaired by a Non-Executive Director of the Trust Board and has responsibility to seek assurance on behalf of the Trust Board as to the effectiveness of the arrangements in place to manage patient safety incidents, including timely compliance with requirements to engage patients and families in patient safety incidents, and duty of candour regulations.

Health & Care Partnership Quality & Safety Board

Is co-chaired by the chief nursing officers from MFT and Medway Community Health and has a responsibility to assurance for system and partnership quality and patient safety improving outcomes for patients across Medway & Swale.

9. Procedures to support patients, families and carers affected by PSIs

The Trust is dedicated to Engaging Patients and Families in Patient Safety Incidents Including Being Open and Duty of Candour.

9.1 Patient and Family Liaison

The Trust is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. The Engaging Patients and Families in Patient Safety Incidents Including Being Open and Duty of Candour sets out the responsibilities and guidance surrounding being open and Duty of Candour.

For the Patient Safety Incident Investigations identified in this PSIRP family liaison will be undertaken directly by the PSIT Lead for the investigation. For all other types of Patient Safety Review family liaison it is the responsibility of the nominated Clinical Lead.

9.2 Local support

The Patient Advice and Liaison Service at Medway NHS Foundation Trust is a free and confidential service to support patients and their families

The PALS team act independently of clinical teams when managing patient and family concerns. The PALS service will liaise with staff, managers and, where appropriate, with other relevant organisations to negotiate immediate and prompt solutions.

The trust is firmly committed to continuously improving the care and the services provided. There will be occasions when actions do not meet the expectations of patients, service users, family members or carers. On these occasions the trust aims to achieve a satisfactory resolution to concerns, comments and complaints and to learn from them to reduce the likelihood of recurrence.

Trust staff are empowered to resolve concerns immediately and informally, where this is possible. People with a concern, comment, complaint or compliment about care or any aspect of the trust services are encouraged to speak with a member of the care team.

Should the care team be unable to resolve the concern then the patient advice and liaison service can provide support and advice to patients, families, carers and friends.

PALS can help and support with:

- advice and information
- comments and suggestions
- compliments and thanks
- informal complaints
- advice about how to make a formal complaint

If the PALS team is unable to answer the questions raised, the team will provide advice in terms of organisations which can be approached to assist.

- Telephone 01634 825004
- Email: medwayft.pals@nhs.net

9.3 National guidance for NHS trusts engaging with bereaved families

 Learning from deaths – information for families explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.

 The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints process.

 Healthwatch Medway provides information to help make a complaint, including sample letters.

Address: Healthwatch Medway, 5A New Road Avenue, Chatham ME4 6BB

Telephone : 0800 136 656 between the hours of 10:00 – 16:00 Monday to Wednesday and Friday. We are closed Thursdays, weekends and Bank Holidays

Text : 07525 861 639

Post: FREEPOST RTLG-UBZB-JUZA, Healthwatch, Seabrooke House, Church Rd, Ashford, TN23 1RD (please note that Freepost can take up to 10 days to reach us)

Email: enquiries@healthwatchmedway.com

 Parliamentary and Health Service Ombudsman makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations.

 Citizens Advice Bureau provides UK citizens with information about healthcare rights, including how to make a complaint about care received.

10. Procedures to support staff affected by PSIs

10.1 Local Arrangements

Medway NHS Foundation Trust is committed to the principles of the NHS Just Culture Guide for ensuring the fair, open and transparent treatment of staff who are involved in patient safety incidents. We have embedded these principles in to our procedures for the review of incidents. The Trust recognises the significant impact being involved in a patient safety incident can have on staff and will ensure staff receive the support they need to positively contribute to the review of the incident and continue working whilst this takes place.

Trust Patient Safety Team - The Trust Patient Safety Team will advise and signpost staff involved in patient safety incidents to the most appropriate information about the patient safety incident review process and further support functions.

Psychological support - NHS Our People - for confidential support lines, free apps and resources. Carefirst 24/7 counselling on 0800 174 319. The Trust Wellbeing team are also available for support: Email medwayft.yourwellbeing@nhs.net for a listening ear or health and wellbeing advice

Occupational Health Service – The Trust has an Occupational Health service which managers or staff are able to refer to for further support.

Schwartz Rounds - Schwartz Rounds provide a structured forum and safe space where staff come together to discuss the emotional and social impact of working in healthcare. You can join the conversation, share your experience or simply listen to their stories. Sessions are themed and a place can be booked by emailing.

Freedom To Speak Up Guardian - A confidential service for staff if they have concerns about the organisation's response to a patient safety incident.

Second Victim - A website resource for healthcare staff and managers involved in patient safety incidents.

10.2 Support from Patient Safety Incident Investigators

All staff with knowledge of the events being reviewed are encouraged to actively participate in the learning response. That may be through submitting written information, joining a debrief meeting or a one-to-one conversation with the incident review team.

Review teams will agree with staff the timescales for feedback of progress and findings in accordance with the type of review method being utilised.

All contact with staff will involve the collection of their account of the events and also their views and opinions on how systems can be improved.

11. Mechanisms to develop and support improvements following PSIIs

The Trust views learning from patient safety events as essential to the development of a safe and open culture. This includes learning from good or positive care in addition to learning from adverse or negative events.

At the conclusion of a Patient Safety Incident Investigation (PSII) the final report will be submitted to the Patient Safety Incident Review Group. The improvement plan will be agreed in collaboration with existing Trust quality improvement frameworks.

A Trust-wide Safety Improvement Group and Patient Safety Network will also be formed to facilitate cascade of relevant information across the organisation through various mediums including the safety bulletins, safety newsletters and existing communication functions. This will include involving patient safety leads in the dissemination of learning across the organisation. Improvement plans will be reviewed by the Patient Safety Group to enable delivery of actions, monitoring and evaluation of improvement outcomes and provide Board assurance.

The Patient Safety Group will have oversight and undertake monitoring of all improvement plans created following a PSII. The Patient Safety Group reports to the Trust Quality and Patient Safety Sub-Committee. The group promote a positive culture of continuous learning and improvement using Improvement Methodology to facilitate Trust-wide learning and improvement.

Monitoring through the use of audit should be undertaken when improvement plans are complete to ensure that changes are embedded and continue to deliver the desired outcomes. When changes have led to measurable improvements then these will be shared and implemented with other areas of the organisation and shared with peer organisations.

12. Evaluating and monitoring outcomes of PSIIs, Reviews etc.

Robust findings from PSIIs and reviews provide key insights and learning opportunities, but they are not the end of the story.

Findings must be translated into effective improvement design and implementation. This work can often require a different set of skills from those required to gain effective insight or learning from patient safety reviews and PSIIs.

Improvement work should only be shared once it has been monitored and demonstrated that it can be successfully and sustainably adopted, and that the changes have measurably reduced risk of repeat incidents.

Reports to the board will be monthly via escalation and will include aggregated data on:

- patient safety incident reporting
- audit and review findings
- findings from PSIIs
- progress against the PSIRP
- results from monitoring of improvement plans from an implementation and an efficacy point of view
- results of surveys and/or feedback from patients/families/carers on their experiences of the organisation's response to patient safety incidents
- results of surveys and/or feedback from staff on their experiences of the organisation's response to patient safety incidents.

The PSIRP will be reviewed annually with the ICB. This is a living document and may be subject to change upon discussion prior to it's review date.

13. Complaints and appeals

The Trust has a Patient Complaint and Feedback Management Policy where concerns cannot be resolved as part of the investigative process.

The following routes are in place for the people who use our services, their families and carers to make a complaint, raise concerns or provide feedback:

13.1 Raising a concern – Don't take your troubles home:

The people who use our services, their family or carer should be able to raise a concern or feedback with any member of staff during their care or treatment with the opportunity for this to be resolved locally without the need for intervention by the PALS or Complaints Team.

13.2 Patient Advice & Liaison Service (PALS):

The Patient Advice & Liaison Service (PALS) managed by the PALS and Complaints Manager offers confidential advice, support and information on health-related matters. They provide a point of contact/escalation for the people who use our services, their families and carers.

13.3 Informal Complaints:

The route for the people who use our services, their families or carers to informally raise concerns, issues or feedback for resolution at a service level, with the ability to escalate to a formal complaint should the issue remain unresolved. Submission can be verbal or in writing to the service or the PALS & Complaints Team. The service/care group will manage informal complaints.

Telephone 01634 825004

Email: medwayft.pals@nhs.net

13.4 Formal Complaints:

The formal route for handling complaints, managed by the PALS & Complaints Team, whereby a complaint can be made by:

Telephone: 01634 825216

Email: medwayft.complaints@nhs.net

Post: The Central Complaints

Medway Maritime Hospital

Gillingham

Kent

ME7 5NY

Complaints and concerns received will be assessed and where a formal complaint is received the PALS & Complaints Team will acknowledge the complaint within 3 working days. The Trust aims to respond to formal complaints within 25 working days, although complex complaints may take up to and over 60 days.

13.5 Friends & Family Test:

The Friends and Family Test (FFT) is a service level nationally mandated survey relating to the most recent episode of care and is usually sent by text message, card or electronic submission. The Patient Experience Team are responsible for the management of FFT across the Trust.

13.6 NHS Choices / Care Opinion:

Care Opinion is a system where the people who use our services, their families or carers can share their experiences of the care and treatment received at MFT. The Patient Experience Team will respond to feedback and refer concerns to the appropriate route for investigation.

13.7 Local Surveys:

The Patient Experience Team is responsible for conducting local surveys of the people who use our services, their families or carers to enable them to share their experiences of the care and treatment received. The Patient Experience Team will respond to feedback and refer concerns to the appropriate route for investigation.

13.8 National Surveys:

National Surveys are mandated by the Care Quality Commission and provide an opportunity for the people who use our services and/or their families and carers to provide feedback of the care and treatment received during the set survey period, with National benchmarking results

published. The Patient Experience Team are responsible for ensuring the Trust participates within all mandated surveys, producing improvement action plans where required.

Contact us:

NHS Improvement

NHS England

0300 123 2257
enquiries@improvement.nhs.uk
improvement.nhs.uk

@NHSEngland

This publication can be made available in a number of other formats on request.

Publication approval reference: 000682

NHS
Medway
NHS Foundation Trust

Patient Safety Incident Response Policy

Policy Reference Number:	
Version Number:	1.0
Approving Committee/Group	Trust Management Board
Department / Category	Quality & Patient Safety
Accountable Executive Lead	Chief Nursing Officer
Author's Job title	Head of Patient Safety Improvement
Brief Outline of This Policy and Standard Operating Procedure	This policy is a replacement for previous incident management policies. It aligns to the new national Patient Safety Incident Response Framework (PSIRF).

Date Approved	
Approved By	Trust Management Board
Date Ratified	
Ratified By	
Published Date	

(made live for use)	
Review Date	
Target Audience	All staff

Key Principles of This Policy	
1.	Compassionate engagement and involvement of those affected by patient safety incidents
2.	Application of a range of system-based approaches to learning from patient safety incidents
3.	Considered and proportionate responses to patient safety incidents
4.	Supportive oversight focused on strengthening response system functioning and improvement

Document Control/History List			
Version No	**Date**	**Author's Job Title**	**Reason and Summary of Change**
1.0	17.01.24	Head of Patient Safety Improvement	Version 1

POLICY ON A PAGE

1. Why do we need this Policy
This document is to provide guidance to staff within Medway NHS Foundation Trust (MFT), about the process and responsibilities, for reporting, investigating and learning from incidents. MFT aims to analyse all incidents, and near misses, along with all identified good practice to ensure that we are striving to learn and improve internally on a continual basis.

2. What do I need to know	3. Quality Standards
• It is the responsibility of all staff to report near misses and incidents across the organisation. • All incidents will be reviewed and identified for an appropriate learning response. • The Trust will analyse patient safety data for emerging themes and trends and take relevant action to improve the safety for its patients, staff and visitors.	
4. Understanding the Process	**5. Contact**

Contents

Purpose 7
Scope 8
Definitions 8
Our patient safety culture 10
Patient Safety Partners 12
Addressing health inequalities 13
Oversight roles and responsibilities 14
Chief Executive Officer: 14
Chief Nursing Officer: 14
Chief Medical Officer: 14
Director of Integrated Governance, Quality and Patient Safety: 14
Patient Safety Specialists: 14
All Staff: 14
Clinical Staff: 15
Coroner: 15
Medical Examiners: 15
Committees 15
Incident Review Group (IRG): 15
Patient Safety Investigation Review Group (PSIRG): 15
Quality and Patient Safety Sub-Committee: 15
Quality Assurance Committee: 15
Health & Care Partnership Quality & Safety Board 16
Integrated Care Board (ICB) Oversight 16
Key Section 1: Reporting 17
Reporting an incident 17
Immediate Actions following an incident 18
Completing Incident Reports 18
Grading Incidents – Impact 19
Previous harm grades 19
New physical harm grades 19
New psychological harm grades 19
Physical harm 19
No physical harm 19
Low physical harm 19

Moderate physical harm 20
Severe physical harm 20
Fatal (previously documented as 'Death' in NRLS) 20
Psychological harm 20
No psychological harm 21
Low psychological harm 21
Moderate psychological harm 21
Severe psychological harm 21
Engaging and involving patients, families and staff following an incident 22
Daily incident review: 22
Key Section 2: Responding to Patient Safety Incidents 24
Patient safety incident response planning 24
Resources and training to support patient safety incident response 24
Our patient safety incident response plan 25
Reviewing our patient safety incident response policy and plan 25
Responding to patient safety incidents 25
Patient safety incident response decision-making 25
Responding to cross-system incidents/issues 27
Timeframes for learning responses 28
PSII Feedback meeting 29
Key Section 3: Non-Patient Safety Incidents 30
Key Section 4: Post Incident Guidance 31
Safety action development and monitoring improvement 31
Monitoring of action plans 31
Trust wide Quality Improvement plans 31
Sharing Learning 32
Training 34
Communication 35
Media Interest 35
Process for Staff to Raise Concerns (E.g. 'Whistleblowing') 35
Supporting Staff 36
Briefing the Board 36
Incidents subject to a complaint or claim 36
Staff performance identified through an incident 37
Legal services 37

Reporting to external agencies/organisations 38
Complaints and appeals 39
Raising a concern – Don't take your troubles home: 39
Patient Advice & Liaison Service (PALS): 39
Informal Complaints: 39
Formal Complaints: 39
Friends & Family Test: 40
NHS Choices / Care Opinion: 40
Local Surveys: 40
National Surveys: 40
Appendices 40
Appendix 1: IRG Incident Decision Matrix 40
Appendix 2: Specialty Nursing risk matrix 41
Appendix 3 – AAR template 43
Appendix 4 – Thematic review template with thanks to Dr Samantha Machen University Hospitals Sussex. 46
Appendix 5 - Extended Rapid Review 62
Appendix 6 – PSII Template 63
Appendix 7 – Standard Local Quality Improvement Action Plan 64
Appendix 8 – Equality Impact Assessment Screening Tool 65

Purpose

This policy sets out **Medway NHS Foundation Trust's** approach to patient safety incident management across the organisation.

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out **Medway NHS Foundation Trust's** approach to developing and maintaining effective systems and processes for responding to incidents and issues for the purpose of learning and improving patient, staff and visitor safety.

This policy is split into four Key sections:

- Reporting incidents
- Patient Safety incidents
- Other incidents (with references to additional policies for specific incident management across the organisation such as fire, health and safety etc.)
- Post incident guidance

All sections follow the same fundamental principles based around the PSIRF.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports the development and maintenance of an effective incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to incident responses conducted solely for the purpose of learning and improvement across all services provided by Medway NHS Foundation Trust. Other responses are referenced within the document.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. We recognise that even a '*simple'* error such as the administration of the wrong drug will often have many complex systemic causes, and it is increasingly recognised in healthcare that such systemic problems cannot simply be addressed by local initiatives. Therefore, it is key to have an approach which drives learning and improvement at scale whilst remaining compassionate and supportive to those harmed. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

This document provides the framework for the management of incidents, which all members of staff and contractors working on our premises and contracts, including staff on interim or honorary contracts and volunteers must follow if they occur on Trust property or as a result of any work activityconducted by or on behalf of the Trust. It is accompanied by a corresponding SOP to provide guidance on how to comply with this policy.

Definitions

Terminology	Definition
Immediate safety actions	To take urgent measures to address serious and imminent: a. discomfort, injury, or threat to life b. damage to equipment or the environment.

Terminology	Definition
'Being open' conversations	To provide the opportunity for a verbal discussion with the affected patient, family or carer about the incident (what happened) and to respond to any concerns.
Case record/note review	To determine whether there were any problems with the care provided to a patient by a particular service. (To routinely identify the prevalence of issues; or when bereaved families/carers or staff raise concerns about care.)
Hot debrief	To conduct a post-incident review as a team by discussing and answering a series of questions.
Safety huddle	A short multidisciplinary briefing, held at a set time and place and informed by visual feedback of data, to: • improve situational awareness of safety concerns • focus on the patients most at risk • share understanding of the day's focus and priorities • agree actions • enhance teamwork through communication and collaborative problem-solving • celebrate success in reducing harm.
Incident timeline	To provide a detailed documentary account of an incident (what happened) in the style of a 'chronology'.
After-action review	A structured, facilitated discussion on an incident or event to identify a group's strengths, weaknesses and areas for improvement by understanding the expectations and perspectives of all those involved and capturing learning to share more widely.
LeDeR (Learning Disabilities Mortality Review)	To review the care of a person with a learning disability (recommended alongside a case note review).
Perinatal mortality review tool	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
Mortality review	Systematic, multidisciplinary, high quality audit and review to determine the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies in the post-neonatal period having received neonatal care.
Transaction audit	To check a trail of activity through a department, etc, from input to output.

Terminology	Definition
Process audit	To determine whether the activities, resources and behaviours that lead to results are being managed efficiently and effectively, as expected/intended
Outcome audit	To systematically determine the outcome of an intervention and whether this was as expected/intended
Clinical audit	A quality improvement cycle involving measurement of the effectiveness of healthcare against agreed and proven standards for high quality, with the aim of then acting to bring practice into line with these standards to improve the quality of care and health outcomes.
Risk assessment	To determine the likelihood of an identified risk and its potential severity (eg clinical, safety, business).
MFT	Medway NHS Foundation Trust
PSII	Patient Safety Incident Investigation
LFPSE	Learn From Patient Safety Events
STEIS	Strategic Executive Information System
IRG	Incident Review Group
PSIRG	Patient Safety Investigation Review Group
SEIPS	Systems Engineering Initiative for Patient Safety

Our patient safety culture

MFT promotes a climate that fosters a just culture by working closely with its staff across all services and listens to their voices. Through various mechanisms the Trust captures rich information about the climate of the organisation and makes BOLD decisions and takes action TOGETHER. This climate of nurturing 'A Just Culture' is encapsulated within the Trust's value of being 'sharing and open', whereby we speak up when we see issues that affect the safety and well-being of others, by questioning, challenging and embracing innovation, and by reflecting and sharing what we learn.

MFT recognises the value of having an open and just culture, which is why every year the Trust promotes staff engagement with the annual staff survey to better understand its safety culture. Trust leaders interpret the information gained from the staff survey with great importance and seek to make improvements year on year with the safety culture of the organisation. Similarly, MFT will use other sources of information such as friends and family test responses and staff feedback to obtain an

accurate understanding of its culture. More recently MFT has rolled out the Manchester Patient Safety Assessment Framework from the National Patient Safety Agenda (NPSA) to help the organisation assess its progress with developing a safety culture, which it will then use to help evaluate any specific intervention needed for change.

In order to support development of a Just culture, the organisation is undergoing a review and revision of its patient safety related policies and processes to ensure that there is clarity around its patient safety incident responses, and that these are being conducted for the sole purpose of learning and identifying system improvements to reduce risk (not accountability, liability, avoidability or cause of death) and that they do not also undermine a just culture by requiring inappropriate automatic suspensions of staff involved in patient safety incidents or their removal from business as usual activities.

The Trust also subscribes to 'A Just Culture' guide whereby wider systemic issues are considered when things go wrong, enabling professionals and those operating the system to learn without fear of retribution. Linked to this is a recognition at MFT that almost all excellence in healthcare is dependent on teams, and that teams work best when all members feel safe and have a voice. This is why the Trust is raising the awareness of the power of civility to saves lives, in recognition that civility between team members creates a sense of safety and is a key ingredient of great teams. One further change that the Trust has initiated in its development of a safer culture is the concept of patient safety-II, which shifts the focus onto what's going well in a system or process rather than always focusing on what went wrong.

Encapsulating all of the work we have undertaken to promote a climate of a just culture is the language that we use at MFT. We do not apportion blame to staff that have been involved in patient safety incidents and we are BOLD in challenging conversations when blame arises. Equally, as we roll out PSIRF we have moved to using nationally recognised terminology such as patient safety incident investigations and fact finding rather than 'staff statements' to denote the focus we a placing on learning and improvement rather than on a level of 'seriousness' that is associated with disciplinary procedures. These changes will also enable our staff to feel safer and more confident when starting at MFT as they will be able to recognise NHS-wide incident management methodologies and recognise MFT as a promotor of a just culture.

MFT promotes a number of mechanisms that allow staff, patients, and the public to record patient safety-related issues, concerns and incidents. These include an easily accessible incident management system that can be accessed by all staff at any time to raise a concern. Every single incident raised undergoes a review by the patient safety team and is managed according to guidance within our incident management policy, which includes providing the reporter of the incident with a summary of learning from the incident upon closure. Staff also have the ability to

raise any concerns through their line management structures or anonymously via our freedom to speak up (F2SU) guardians. Patients and the public similarly have multiple ways to raise a patient safety related concern including speaking directly to our Patient Advice and Liaison Service (PALS) or by making a complaint to our complaints team. MFT also has two campaigns running throughout the hospital for enabling patients and the public to raise concerns via our 'don't take your troubles home' initiative and our 'call for concern' line.

Moving forwards the Trust is focused on undertaking better triangulation of the data that it captures in relation to patient safety concerns. We recognise the importance of linking together valuable sources of information so that we can better understand the culture of the organisation but also so that we can provide the best learning and improvement opportunities to make MFT the safest place for patients and staff.

When things do unfortunately go wrong MFT similarly demonstrates openness and transparency with its regulators at NHS resolution, the Care Quality Commission, the Medicines and Healthcare products Regulatory Agency (MHRA), the ICB, HM Coroners and others. We do this as we are an organisation committed to learning not only when things go wrong, but also when things go right, and we use our regulators to support us in this process and to help us deliver wider improvements at a local, regional and national level.

Patient Safety Partners

The involvement of patient safety partners (PSPs) is considered an important step in MFTs journey to delivering safer care for patients. We recognise the value of engaging with patient safety partners to improve safety within healthcare and are committed to embedding 'critical friends' in all of our quality and patient safety related work streams.

Patient safety partners will be engaged in the design and development of incident response processes including engagement and involvement processes with those involved in a patient safety incident investigation, as set out in our patient safety partners policy. They will also be an important member of providing oversight and scrutiny of MFTs response to patient safety related issues.

We will ensure that our patient safety partners are trained to the necessary level so that their involvement with us delivers the most effective outcomes. We will do this through aligning each PSP to a member of staff from the patient safety team who will support and train the individual in the principles of patient safety, systems engineering initiative for patient safety, human factors, and improvement methodologies. The patient safety partners will also complete the patient safety syllabus levels 1 and 2 training and undertake a formalised programme of training that includes equality, diversity and inclusion, safeguarding, infection prevention and information governance.

Future iterations of our PSIRP will continue to champion the voice of our patients in the areas of local priority for investigation and learning through the engagement with our patient safety partners.

Addressing health inequalities

MFT is an inclusive organisation that is committed to reducing inequalities of care for its patients and staff. As a result, health equality has been a golden thread running throughout the Trust's implementation phases of PSIRF and is recognised as a fundamental component of our patient safety incident response processes.

Through undertaking an in-depth analysis of the last three years of patient safety related data, as set out in our PSIRP, we have been able to analyse and triangulate the information at a level never before achieved. By doing this we have been able to identify areas of health equality that have informed our patient safety incident response processes.

Two particular areas that our PSIRP focuses on are ensuring that our methods of communication meet the needs of our patients and their families. Our intelligence analysis told us that we need to ensure that a patient's specific communication needs are met, every time. Therefore, as part of our response to incidents and learning we will ensure that this is a key focus of consideration when developing any safety actions so that our communication methods e.g. language or understanding barriers, and patient access to information, are in a form that is most appropriate for them.

The second area where our patient safety incident response processes will support health equality and reduce inequality is with our patients that present with a mental health diagnosis or symptoms. Where this is the case we will be taking important steps within our processes and improvement forums to ensure that any inequalities of care or outcome are recognised and that the appropriate support systems are put in place.

Whilst we strive to achieve equity, we also recognise that this can differ between patients, families, and healthcare staff in what they consider is the appropriate response to a patient safety incident. When this is the case the opportunity for learning will be weighed against the needs of those affected by the incident. This is where our patient engagement leads will seek information on the impact of an incident and guide our incident response types whilst being aware of the risk of introducing inequity into the process of safety responses. Our engagement leads will be fundamental in engaging and involving patients, families and staff following a patient safety incident and therefore their role in considering the different needs of patients is paramount to reducing any inequalities for patients.

Oversight roles and responsibilities

The following details the individual, departmental, committee, group roles and levels of responsibility for incident and SI reporting and investigation

Chief Executive Officer:

As Accountable Officer has overall responsibility for ensuring compliance with our regulatory and legal responsibilities, ensuring the Trust has a suitable and effective policy, standard operating procedures and infrastructure in place to provide a comprehensive system of internal control and systemic and consistent management of incidents across the Trust. The Chief Executive will delegate specific roles and responsibilities as required, to ensure incident management is coordinated and implemented effectively.

Chief Nursing Officer:

has delegated board level responsibility for ensuring that processes for investigating and managing incidents are devised, implemented and embedded, reporting to the Chief Executive Officer and Executive Team any significant issues arising from the implementation of this framework including evidence of non-compliance or lack of effectiveness arising from the monitoring process so that remedial action can be taken. They also have delegated board level responsibility for quality, and patient experience and hold the responsibility for risk of non-compliance with regulatory and legal responsibilities such as the CQC fundamental standards.

Chief Medical Officer:

The Chief Medical Officer will ensure that the Trust takes action upon issues arising from patient safety and clinical risk management. Together with the Chief Nursing Officer, they will champion a strong patient safety culture and lead on Sharing the Learning that arises from investigations.

Director of Integrated Governance, Quality and Patient Safety:

Has the operational responsibility for ensuring the delivery and effectiveness of the processes for the management of patient safety incidents including timely engagement of patients and families in patient safety incidents, and the direct line management of the patient safety team through which their duties are discharged.

Patient Safety Specialists:

Have responsibility to ensure the principles of PSIRF are maintained at the organisation and have responsibility to support the implementation and embedding of the patient safety strategy within the organisation.

All Staff:

Have a responsibility to report patient safety incidents including near misses and no harm incidents via the Trust reporting system to ensure they can be reviewed and corrective and preventative action be put in place to prevent re-occurrence.

Clinical Staff:

Clinical staff involved in care are responsible for participating in learning events and investigations, to identify system concerns and remedial actions.

Coroner:

Has a Statutory Duty under Regulation 28 to issue a PFD Report where their investigation gives rise to a concern that circumstances exist which create a risk of future deaths.

Medical Examiners:

Have a responsibility to escalate to the Trust any deaths where there may be an area of concern which needs further exploration.

Committees

Incident Review Group (IRG):

Is co-chaired by the Medical Director for Quality & Safety and Director of Integrated Governance, Quality and Patient Safety and is responsible for reviewing all incidents to determine if they meet the threshold to be declared as a Notifiable Patient Safety Incident, confirming the level of harm and investigation to be completed. The IRG reports to the Patient Safety Group.

Patient Safety Investigation Review Group (PSIRG):

Is co-chaired by the Medical Director for Quality & Safety and Director of Integrated Governance, Quality and Patient Safety and is responsible for reviewing all PSIIs to determine if appropriate learning has been established from the review. This group has board level authority to approve investigation reports. The PSIRG reports to the Patient Safety Group.

Quality and Patient Safety Sub-Committee:

Is co-chaired by the Chief Medical Officer and Chief Nursing Officer and has responsibility for monitoring the operational effectiveness of patient safety incidents, including timely compliance with requirements to engage patients and families in patient safety incidents, and duty of candour regulations. The operational management of this function is delegated to the Patient Safety Group.

Quality Assurance Committee:

Is chaired by a Non-Executive Director of the Trust Board and has responsibility to seek assurance on behalf of the Trust Board as to the effectiveness of the arrangements in place to manage patient safety incidents, including timely compliance with requirements to engage patients and families in patient safety incidents, and duty of candour regulations.

Health & Care Partnership Quality & Safety Board

Is co-chaired by the chief nursing officers from MFT and Medway Community Health and has a responsibility to assurance for system and partnership quality and patient safety improving outcomes for patients across Medway & Swale.

Integrated Care Board (ICB) Oversight

Maintaining positive working relationships with the ICB is essential to the implementation of PSIRF at MFT. With the introduction of PSIRF, new ways of keeping the ICB informed of patient safety matters at the organisation have been established. Whilst the organisation will continue to use the LFPSE and STEIS to report patient safety incidents, the approval and oversight of PSIIs and new learning responses will be as follows:

- Invitation to IRG – this will allow the ICB to gain assurance the Trust is working to it's PSIRP
- Invitation to PSIRG – this will allow the ICB equal opportunity to scrutinise PSII investigations, to ensure a patient centred approach and application of the SEIPS methodology in investigations.
- Quarterly patient safety focussed reports to MFT provider Quality Meeting for monitoring and assurance.
- It has been agreed that providers can escalate any concerns outside of these meetings to the ICB Patient Safety Team.
- Providers can share existing Patient Safety/Quality reports with ICB.
- Thematic reviews/reports on learning responses to be shared with ICB for wider learning and sharing.
- Improvement visits; announced and unannounced.
- Informal, update meetings on progress with plan & priorities, as these will continuously evolve. Monthly at first, then to be reviewed.
- Single Oversight Framework (SOF) Level and Soft Intelligence will help determine frequency of meetings. This is all subject to change as we move through the PSIRF journey and we reserve the right to adapt and evolve meetings, frequencies and attendance.

Key Section 1: Reporting

Reporting an incident

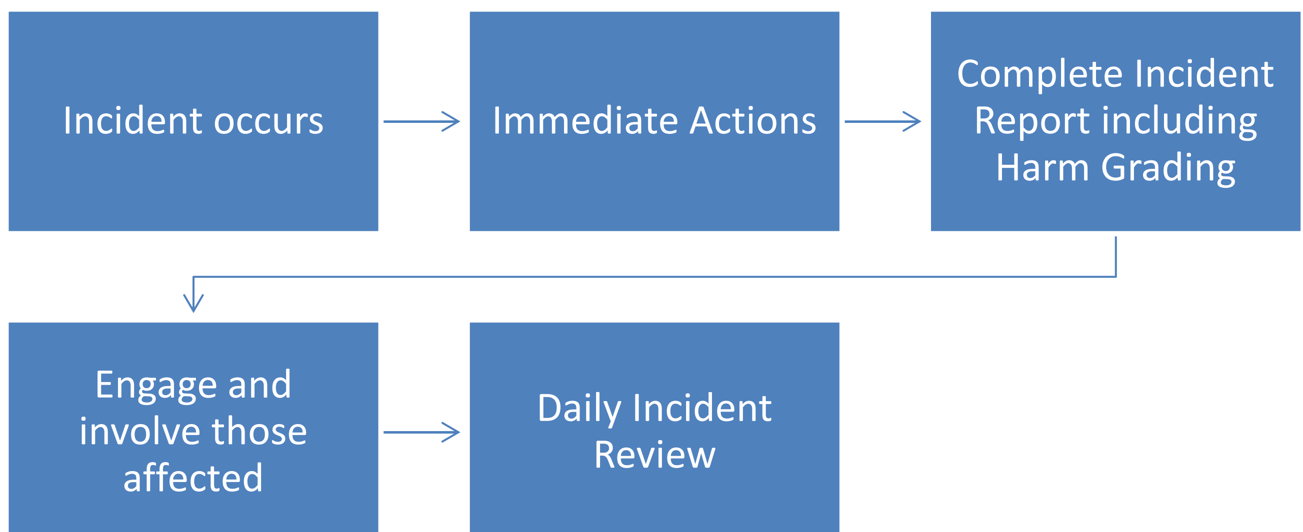
The Trust maintains a central incident reporting system. The Trust's incident reporting system known as Datix provides a generic incident form for reporting all incidents; clinical and non-clinical, patient safety and non-patient related incidents. An incident or near miss may be notified or identified by a person who uses our services, visitor, or any staff member. It is important that all staff recognise when an incident or near miss has occurred.

If for any reason access to the electronic reporting system is not available, Please follow: OTCGR123 Information technology asset business continuity plan available on Q-Pulse.

All incidents and near misses are to be reported no later than 2 working days after an incident is discovered.

It is the duty of all staff to report an incident or a near miss that has had a significant potential for harm or had caused harm. For registrants of the NMC, GMC or HCPC the Duty of Candour regulation imposes a legal duty (since November 2015) that they report any incident that has caused or may later cause moderate harm or above.

Employees who become aware of actual or potential malpractice is encouraged to come forward without fear of victimisation and speak up (Speak Up - Whistleblowing policy and procedure).



Immediate Actions following an incident

When an incident or near miss is identified, prompt actions are necessary to reduce further risk. Some incidents will require prompt and specific action to deal with the problem. This may include:

- Summoning assistance
- Ensure the safety of the patient, or other individual(s) involved however, not compromising their own health & safety
- Ensure that any immediate health needs are met e.g. Provide emergency medical care and treat any injured people
- Inform line manager or Ward/Service Manager
- If equipment/device is involved, removing it from service (marking it clearly "out of order") and contacting the Estates and Facilities Team
- Retain any equipment that may have been at fault and if applicable check any medical devices with the Medical Devices Team for serviceability, maintenance and identify faults if applicable
- Notifying senior members of staff on duty and the person affected and/or their family
- Gathering essential information about a chain of events
- Consider completing a Safeguarding referral including notifying the police and documenting any action taken by them resulting from the referral
- If necessary, take picture evidence. This can be uploaded onto Datix
- Request that all those who observed what happened prepare a witness statement as soon after the event as possible
- Identify the level of harm caused or potential risk for harm
- Share any immediate learning with colleagues
- Recording the action taken in the patient's medical records
- Inform senior management of any incident which caused harm
- Report the incident (within 24 hours) including the actions taken following the incident

Completing Incident Reports

Appropriate details should be entered in the fields provided on the incident form. ***The content must be FACTUAL and NOT include OPINIONS. Patient details should not be included within the incident description.*** (If a future challenge is made to the standard of care or working conditions incident report forms are potentially disclosable to a patient and/or claimant or their representatives.)

Reports can be reported anonymously, but this limits the depth of investigation and analysis and opportunity to learn and improve. In order to receive feedback on the reported incident, staff must use their nhs.net email address.

Once the incident has been reported on Datix, an automatic notification is provided to key individuals including subject matter experts based on the incident type chosen, e.g. Fire to ensure that prompt and appropriate support is provided.

Grading Incidents – Impact

Incidents can have an impact on patients and/or staff at various levels, from no harm to death of one or more persons. A best assessment at the time of the incident should be carried out and if, at a later date, more information is received, the incident degree of harm and other details about the incident can be amended.

Following the introduction of the LFPSE in autumn 2023, the Trust has moved to a new harm grading system. This accounts for both Physical harm and psychological harm.

Where practical, it is good practice to discuss the level of harm with the patient affected and to consider the patient's perspective on the harm definitions stated below.

Previous harm grades	New physical harm grades	New psychological harm grades
No Harm	No physical harm	No psychological harm
Low harm	Low physical harm	Low psychological harm
Moderate harm	Moderate physical harm	Moderate psychological harm
Severe harm	Severe physical harm	Severe psychological harm
Death	Fatal	n/a

The full definitions of the harm grading are as follows:

Physical harm

No physical harm

No physical harm

Low physical harm

Low physical harm is when all of the following apply:

- minimal harm occurred – patient(s) required extra observation or minor treatment
- did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit

- did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication
- did not or is unlikely to affect that patient's independence
- did not or is unlikely to affect the success of treatment for existing health conditions.

Moderate physical harm

Moderate harm is when at least one of the following apply:

- has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention
- has limited or is likely to limit the patient's independence, but for less than 6 months
- has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm.

Severe physical harm

Severe harm is when at least one of the following apply:

- permanent harm/permanent alteration of the physiology
- needed immediate life-saving clinical intervention
- is likely to have reduced the patient's life expectancy
- needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment
- has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions
- has limited or is likely to limit the patient's independence for 6 months or more.

Fatal (previously documented as 'Death' in NRLS)

You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

Psychological harm

Please note that when recording psychological harm, you are not required to make a formal diagnosis; your answer should be an assessment based on the information you have at the point of recording and can be changed if further information becomes available.

No psychological harm

Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.

Low psychological harm

Low psychological harm is when at least one of the following apply:

- distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit
- distress that did not or is unlikely to affect the patient's normal activities for more than a few days
- distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition

Moderate psychological harm

Moderate psychological harm is when at least one of the following apply:

- distress that did or is likely to need a course of treatment that extends for less than six months
- distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months

Severe psychological harm

Severe psychological harm is when at least one of the following apply:

- distress that did or is likely to need a course of treatment that continues for more than six months
- distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months
- distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months

Further guidance and frequently asked questions regarding harm levels can be found here:
NHS England » Policy guidance on recording patient safety events and levels of harm

Engaging and involving patients, families and staff following an incident

The Trust recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. The same is true of other incident types. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

The Trust has a separate Engaging Patients & Families in Patient Safety Incidents (Including Being Open & Duty of Candour) Policy & Standard Operating Procedure which describes how the Trust involved those affected by Patient Safety Incidents.

Daily incident review:

The Patient Safety Team will complete a daily incident review at the beginning of each day (excluding weekends). The Monday morning review will include all incidents reported over the weekend including Friday.

When a new incident is reported the Patient Safety Team will:

- Check that relevant Patients details have been entered in the appropriate section. If this is not completed, this may mean that the investigation is not able to be completed.
- Check the description of the incident to ensure that there is no patient or staff identifiable data. Incident descriptions will also be checked for spelling and grammar and to ensure it has not been completed all in capitals.
- Assignment of the handler of the incident is checked to ensure the most appropriate person is assigned. This may be the Patient Safety Lead/Ward Manager for the particular area, or the specialist lead.
- The location is checked to ensure that this is the area in which the incident occurred. This may differ to the Division, Care Group and Speciality. These must be specific to the patient/area. For example, if it was a Pressure Ulcer that was discovered on a Ward, the location would be the ward but the division would be Corporate, care group Nursing and speciality Tissue Viability. This is to ensure the correct people have access to the incident and can assist in the investigation.
- At this section of the reporting form, any additional teams or locations can be allocated.

- The categorisation of the incident will be checked to ensure this is completed appropriately and correctly.
- The harm level will be reviewed. If an incident has been flagged as potentially meeting the criteria set out in the PSIRP this will be referred to the Incident Response Group (IRG).
- Following the completion of the previous sections, The Patient Safety Team will then complete the Investigation Tab. The review date must be added and the incident must be categorised via multiple choice selection for:
    - Local investigation
    - Verbal Update to IRG
    - Rapid Review
    - Extended Rapid review
    - Thematic review
    - Potential A3 thinking
    - AAR
    - PSII
    - Structured Judgement Review
    - At this stage any specialist investigation types can also be highlighted for example – Medication, Infection Control, Safeguarding, Falls, Tissue Viability, Health and Safety etc.
- Any duplicate records can either be rejected or linked and the duplication closed.
- If known, the incident can be linked to any complaints, inquest and claims data.
- Any incidents highlighted for IRG will be added to the IRG agenda and the IRG SOP will be followed.
- The Patient Safety Team will produce a weekly flash report for all incidents that have occurred that week, which will be shared with relevant colleagues. The weekly flash offers and opportunity for shared learning across all quality domains.

Key Section 2: Responding to Patient Safety Incidents

Patient safety incident response planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Beyond nationally set requirements, the organisation has outlined within its Patient Safety Incident Response Plan (PSIRP) how it will respond to areas of concern across the next 18 months.

Resources and training to support patient safety incident response

To ensure adequate resources are dedicated to Patient Safety Improvement the Trust has:

A dedicated Patient Safety Improvement Team (PSIT) who:

- Are trained, Specialist investigators for PSIIs
- Work with a clinical lead as a subject matter expert to complete PSII investigations
- Co-ordinate SWARMs, interviews and debriefs with staff and patients/ families/carers involved in a patient safety incident
- Act as a specialist liaison point for families involved in a PSII to ensure their voice is heard and they are involved with an investigation as much as they would like to be
- Ensure reports are easily understood, free from jargon and used a systems based approach to investigating outcomes and identifying learning

Following a review of the Trust capacity for investigations the Trust will endeavour to complete a minimum of 24 PSII per year, determined by the PSIRF priorities in addition to any mandated PSIIs. This is an expected 4 PSIIs per priority. In addition, maternity have an additional 3-5 allocations within the Trust priorities for maternity specific incidents.

It is also possible that emerging or individual incidents may require a PSII. This decision will be made by the IRG. The trust will use an incident decision matrix to support these decisions, however this is not exhaustive and a multidisciplinary approach to decision making will be taken.

There is no outlined requirement for the amount of patient safety learning responses completed by the Trust. Patient safety learning responses will be determined by the incident profile of the organisation to drive patient safety improvement across the organisation.

Our patient safety incident response plan

Our plan sets out how **Medway NHS Foundation Trust** intends to respond to patient safety incidents over a period of 18 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan.

Reviewing our patient safety incident response policy and plan

Our patient safety incident response plan is a ‘living document’ that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 months.

Updated plans will be published on our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, patient safety incident investigation (PSII) reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement

Responding to patient safety incidents

Patient safety incident response decision-making

The Trust will use a dynamic response to incident decision making. Every incident reported in the organisation is reviewed to determine the next steps for the investigation. Incidents that meet the PSIRP requirements or are suggestive of a

need for a patient safety response will be discussed at the Trust Incident Review Group for multi-disciplinary decision.

Patient safety event recorded on Datix

Compassionate engagement
Respond to the needs of those affected
Ensure Duty of Candour is upheld where required

Review by Patient Safety Team and response considered against Patient Safety Incident Response Plan

Escalated to IRG for decision on appropriate learning response

Engagement and Involvement of those affected

Does a national or regulatory requirement exist for a response?

Yes

No

Local organisation or other body where indicated undertakes the response required

Is there a response planned within your PSIRP?

No

New/additional issues highlighted by those that are impacted/affected?

No

Does this incident/issue (when considered alongside other insight) highlight changing or new/emerging risk which may need to be explored?

Yes

Yes

Yes

No

Undertake the response agreed as part of planning (if appropriate)

Discuss and agree, with input from those affected, the most proportionate response (capture rationale)

Log event for future incident response planning and continue with improvement work or risk mitigation strategies

All learning responses must be undertaken using a system-based approach to:
- Gather information
- Involve those affected where possible (required for PSII if agreement)
- Understand everyday work
- Define areas for improvement (consider against wider improvement work) where applicable

Develop safety actions collectively (consider against ongoing improvement work)

Information from the recorded event used as part of ongoing risk management activity

Monitor and adapt

Improvement

Future incident response planning

Specialty Nursing Incident Review

Some incidents need to follow a slightly different process. This relates to incidents where there is a corporate nursing team for specialist input. Current investigations in this category include: Tissue Viability, Falls, Infection Prevention and Control, Safeguarding specific incidents.

Speciality Datix is Reported: IPC, Safeguarding, TVN, Falls

PST to flag to the responsbile specialist team via Datix.

Speciality team conduct initial review.

Does the specialty team feel a learning response is needed as per specialty risk matrix?

Yes

Learning response initiated

No

Local Investigation by area team

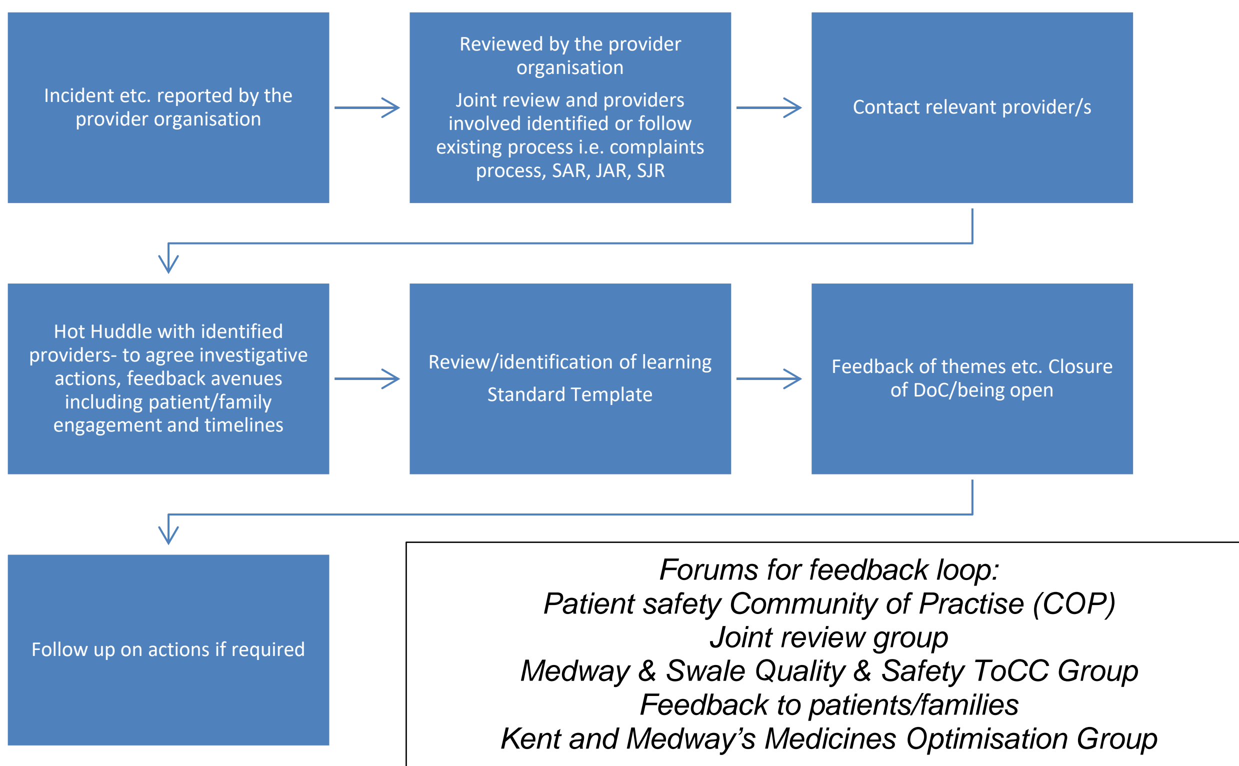
Learning response completed

Toolkit to be presented to Specality panel for learning to be actioned and monitored via Qualtiy Improvement Plan

Learning response to be presented to PSIRG for final approval.

Responding to cross-system incidents/issues

In collaboration with other local Trust's in the region, a process has been agreed for cross system incidents/issued. It identifies a process of collaborative review across organisations to highlight and share learning to improve the experiences of patients and their families and carers. This is for a variety of concerns including transfer of care concerns.



The following organisations have signed up to participate in collaborative reviews

MCH

DGS/DVH – KCC

Swale/MFT – KCC

West Kent/MGH/TWH -KCC

East Kent/QEQM/WHH/K&C – KCC

G4S

ICB

HCRG

HCRG TOCC queries

SECAmb

MFT

Timeframes for learning responses

Where a PSII for learning is indicated, the investigation must be started as soon as possible after the patient safety incident is identified.

PSIIs should ordinarily be completed within one to three months of their start date.

In exceptional circumstances, a longer timeframe may be required for completion of the PSII. In this case, any extended timeframe should be agreed between the healthcare organisations with the patient/family/carer.

No local PSII should take longer than six months. A balance must be drawn between conducting a thorough PSII, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety or require further checks to ensure they remain relevant. (Where the processes of external bodies delay access to some information for longer than six months, a completed PSII can be reviewed to determine whether new information indicates the need for further investigative activity.)

All patient safety learning responses should be completed within 1 calendar month. In exceptional circumstances, this may be extended to 2 months with IRG agreement and rationale for delays.

PSII Feedback meeting

It's important to share the final PSII report with the team in a timely manner. Lack of feedback from incident reporting has been highlighted as inhibiting the willingness of staff to report incidents.

A feedback meeting will be organised by the Patient Safety Improvement team to meet with all persons involved in the incident and the investigation of the incident. This feedback meeting could be via the team's Huddle or via a separate meeting arranged by the Patient Safety Improvement Team. The feedback meeting will be opened to all involved in the investigation, including any other members of staff within the division who would like to attend in order to facilitate learning. It is good practice for the co-reviewer and medical reviewer (if relevant) to be present at the feedback meeting

This meeting is an opportunity to present, discuss and ask questions about the investigation, findings, recommendations and actions. This meeting should take place within 21 – 45 working days of the investigation process

The corporate governance team will share all completed PSII investigation reports with the relevant divisional leads and key people involved in the incident and investigation as they have been approved. This will ensure that the divisions are sighted on all completed investigation reports and can update regarding implementation of the action plan.

Key Section 3: Non-Patient Safety Incidents

Any incident reported on the Datix system will require a level of investigation. If the incident relates to a non-patient safety incident, it will be investigated as required by the relevant speciality some of which include:

- Information Governance Incidents
- Health and Safety Incidents
- Fire Safety Incidents
- Risk Incidents
- Emergency Preparedness Incidents
- Security Incident
- HR Incidents
- Safeguarding Incidents

Details regarding each of their investigation processes can be located in the below documents:

- Information Governance Incidents
- Health and Safety Incidents
- Fire Safety Incidents
- Risk Incidents
- Emergency Preparedness Incidents
- Security Incident
- HR Incidents

Key Section 4: Post Incident Guidance

Safety action development and monitoring improvement

Relevant, timely, specific actions are vital to make changes to our services to improve safety and care provided. The Trust will ensure staff are provided with the necessary training and support to develop robust action plans to address contributory factors to an incident to improve patient safety. Action plans will be monitored, reviewed and updated to ensure best practise is embedded and a culture of continuous leaning is encouraged.

Monitoring of action plans

Action plans produced as a result of safety investigations should be implemented and monitored locally e.g. through Speciality Governance meetings. All actions from Incidents are to be uploaded to the actions module of Datix by the relevant investigating manager.

The Patient Safety Group will seek assurance from regular Datix reports that action plans are being implemented.

Audit can be used to monitor the efficacy of actions.

Trends identified through incidents will be monitored by the Patient Safety Team, Heads of Nursing,Heads of Service, Service Managers, and the appropriate groups.

Trust wide Quality Improvement plans

The Trust has a series of Quality Improvement Plans (QIP) based on thematic analysis of current and past incidents. A quality improvement plan (QIP) is a document that outlines how an organization or a team will address a specific problem or goal related to quality, efficiency, or effectiveness. A QIP can help you identify the root causes of the issue, set measurable objectives, implement changes, and monitor the results. The current ongoing Trust wide improvement plans are:

	Local **patient safety incident improvement plan/scheme title**
1	Falls
2	Tissue Viability
3	Deteriorating Patient *under development*
4	Mental Health *under development*
5	Safeguarding *under development*
6	Maternity

Quality Improvement plans (QIPs) are monitored via the Patient Safety Group (PSG) for effectiveness. Each QIP also has a responsible group at which the QIP is monitored. QIPs monitoring will be escalated through the Trust governance structure and feedback provided to the ICB via the PQM meeting and standalone reports where required.

As the Trust progresses from a reactive to a proactive patient safety culture, more QIPs will be developed to address commonly occurring themes across the organisation.

All actions should be recorded on the action module on Datix for development of future QIPS.

Sharing Learning

One of the key aims of the PSIRF is the learning process which aims to reduce the risk of re-occurrence and avoidable harm, where the incident originally occurred, elsewhere in the organisation and across the NHS. The timely and appropriate dissemination of learning following the review of a PSII is core to achieving this and to ensure that lessons are embedded in practice. Consideration should be given to the sharing of lessons learned at all levels of the organisation.

Level:	**Examples of sharing learning**
Individual / patient	• Presentations at staff meetings • Team meetings • Trust 'Spotlights' and newsletters • Conferences and Sharing the Learning events • Intranet site • Notice boards • Big four • Friday news (maternity) • Emails • Investigation reports • Themes and trends analysis reports • Training sessions • Clinical Supervision/reflective practice • Individual reflections • Datix Incident "feedback" • Sharing the completed investigation report with the affected person who uses services and/or their relative/carer • Meeting with families/carer to give them the opportunity to be involved in the investigation process and providing them with interim findings for their comments

Divisionally	• Team meetings /multidisciplinary meetings • Pressure Ulcer/Falls Panels • Other subject specific training courses • Sharing the Learning events • Chief Executive Bulletin • Conferences, seminars and workshops • Learning folders • Use of Patient Stories • Adult Safeguarding Assurance Group • Patient Safety Leads • Feedback meeting organised by the Investigating Manager with the co-reviewer and medical reviewer present to meet with all the persons involved in the incident and the investigation of the incident
Service/Directorate	• Divisional Governance meetings • Newsletters • Weekly Quality Flash
Trust	• Sharing the Learning Events • Trust wide workshops • Newsletters • Intranet – Sharing the learning page • Through reports and discussion of trends, themes, and patterns at various meetings • Monthly risk and safety induction session delivered • Task and finish groups for various improvement activities to address key issues and themes which emerge from PSIIs • Monitoring and auditing key systems and processes via clinical effectiveness and outcomes plan and policies • Gap analysis against the Trust's systems and processes undertaken of high profile incidents that occurred in other organisations with the findings discussed at QAC • Completed investigation report and action plans published on the Trust Intranet on the Risk and Safety page to ensure that the findings are shared with all staff (all reports are anonymised) • Reviewing and considering the implication of National reports e.g. Francis report, National Confidential Inquiry • Thematic reviews of common features to a number of incidents. Common features may include similar location, type of incident and the goal of the thematic review is to enable wider systemic learning from the

	incidents and to ensure that commonalities between individual incidents and investigations are identified and addressed
Outside of the Trust	• Providing anonymised information about patient safety incidents recorded on Datix to the Learn from Patient Safety Events (LFPSE) • Undertaking a joint investigation or inviting other NHS Trust to be involved in an investigative process, where an event also involves another agency or as a critical friend to provide an independent view. This will be decided on a case-by-case basis • Sharing of thematic reviews with colleagues via the ICB

Training

Training is an important part of ensuring compliance with this policy including high quality incident reporting and investigation. We are committed to equipping staff with the necessary skills required to undertake their roles competently and confidently. In turn, staff must take responsibility for developing these skills and participating in the lifelong learning process

The Patient Safety Team provides the following training:

- Incident Reporting.
- Patient Safety Investigation training for staff leading on investigations/learning responses

Where required, staff will be given the following training:

- Structure Judgement Review training. This will ensure and enable an understanding of how to use the methodology when involved in mortality case note reviews.
- Datix training for all staff. This will give:
    - Context to patient safety and incident reporting principles
    - Understanding why and how to report incidents and record actions effectively and accurately taken
    - Guidance for all staff on how incidents are reported using Datix
    - Guidance for managers on identifying, managing, and approving incidents on Datix to meet external reporting requirements, including how to use Datix to search, report and analyse data for their service area

The above training programme will be available from the Patient Safety Team.

For staff undertaking PSII investigations or leading on learning responses, additional training will be provided. This will include:

- AAR training
- PSII training (2 day course)
- Oversight of learning from patient safety incidents
- Involving those affected by patient safety incidents in the learning process
- Investigative Interviewing
- Human Factors

All staff will undertake Patient Safety Syllabus Level 1 as a mandatory training module. Some staff will undertake Level 2, dependant on their role. Patient Safety Specialists within the organisation will be offered to undertake Level 3 and 4 when available.

Communication

Media Interest

Responsibility for developing and managing communications with the media lies with the Trust communications department. No staff member should communicate in any way with the media without first consulting and gaining permission from the Communications Department. Staff must be alert to the media trying to speak and gain confidential information from them. Normally events giving rise to media interest are those graded as serious incidents.

Where there is media interest, the patient and/or their family must be informed and involvedin the decision as to whether and what information may be disclosed, before the media are informed or involved.

In forensic and/or criminal cases the police will lead all communications with the media andliaise with relevant agencies involved with the incident.

If an incident involves the potential of a breach of confidentiality or loss of person identifiable information then the incident must be reported and all Information Governanceprocesses and procedures must be followed.

Process for Staff to Raise Concerns (E.g. 'Whistleblowing')

The Trust encourages openness in all aspects of its work and services. On occasions staffmay not feel it appropriate to raise a concern, or not feel comfortable about raising a concern, through the normal line management channels e.g. reporting via an Incident Report Form which will be forwarded to managers who may be perceived as part of the problem. The Speak Up – Whistleblowing Policy &

Procedure gives staff support and protection to enable them to raise such concerns and should be consulted.

Supporting Staff

Incidents can be distressing for staff. Staff involved in a complaint or a negligence claim, required to be a witness at an inquest hearing, or required to attend an Employment Tribunal (ET) as a Trust witness, may also suffer stress (especially if significant harm has resulted). If inadequately supported, staff may be unable to provide care to the best of their ability for patients and/or may go off sick. It is not only just, fair and compassionate, but it is in everyone's interest to support staff appropriately.

Immediate (or as soon as practicable) ongoing support should be proactively offered to staff by line managers, senior staff and other Trust staff as applicable.

Members of the Patient Safety team, Legal Services team and Health and Safety & Integrated Governance team can provide staff with support and advice. Surveys of staff involved in incidents, inquests, complaints, or claims will be carried out to continuously improve the support service offered with the aim of offering the best support possible.

Briefing the Board

The Chief Nursing Officer and/or Medical Director will be responsible for briefing the Trust Board in relation to patient safety incidents (including Never Events). Where media interest is anticipated, the communications department will brief the Board outside of board meetings.

Incidents subject to a complaint or claim

In some cases, where a complaint or claim relates to an investigation or review, or there is the potential for an incident or death to become a complaint or claim. It is appropriate for the investigation or review to include the questions to be addressed from the complaints (if relevant) or claims in the investigation or review. The Patient Safety Team will discuss and agree how the investigation or review will inform the complaints (where relevant to the investigation) or claims management process.

The Complaints team will write to the complainant following discussion with them and inform them that an investigation or review is currently being carried out and the questions relevant to the investigation will be incorporated within the investigation or review; if they remain unhappy with the outcome, they are invited to come back to the Complaints Team. If complaint or a claim is received relating to an unreported incident, the complaints or claims team will ensure the manager for the area:

- Completes the Incident Report Form and that the incident is subsequently managed according to the Incident Management policy

- Identify why the incident was not initially reported and take actions to ensure incidents are reported in future
- Following settlement of a claim, the legal services team will liaise with the Head of CRS Manager to undertake a retrospective review of the incident to identify any further learning

Staff performance identified through an incident

Disciplinary and incident investigations are separate processes, and each process could contaminate the other. On occasions, if during the investigation, elements of misconduct/gross misconduct or poor staff performance are identified, this will be referred to HR for advice and guidance.

If a disciplinary investigation and report is required, it will be a separate process and conducted independently of the PSII or learning response, in accordance with the disciplinary policy. The two investigation processes can run in parallel - if the investigations do not in any way interfere with each other

Legal services

Coroner Process: When a death is sudden, unexpected, violent or unnatural, the Coroner will decide whether to hold a post-mortem and, if necessary, an inquest. The Coroner's court is a court of law, and accordingly the Coroner may summon witnesses to attend and give evidence. It is a legal requirement to attend, and failure to do so may result in a charge of contempt of court

The Legal Services Team will work with the corporate and divisional teams to obtain witness statement for the relevant incidents, working with the Health and Safety Manager for staff specific injuries.

If the Coroner identifies an unexpected death for the first time, the Trust would be notified. The incident must be reported on Datix to generate an incident number and commence investigation as per this policy. The Coroner may raise a Prevention of Future Death Report (Regulation 28) following an inquest and it may be at this stage that a PSII is raised. If the Coroner issues a 'Prevention of Future Death Report', and the death was not previously investigated as a PSII, then this must be escalated, and the investigation process followed (see Inquest Policy).

Where an inquest outline findings/recommendation not already identified by an incident investigation. The Legal Services Manager will work closely with the Deputy Director of Integrated Governance, Quality and Patient Safety to ensure the new actions identified are shared with the relevant divisional director and divisional representatives and are included in the action plan monitoring tracker by the head of patient safety. An AAR will be completed as a minimum for all coroner investigations.

The legal service team will inform the Deputy Director of Integrated Governance, Quality and Patient Safety of the inquest outcome. This will enable the head of patient safety to update Datix.

Reporting to external agencies/organisations

Where required through local or national protocol, we are required to inform external agencies and organisations in the event of specific types of incidents:

- Learn from Patient Safety Events LFPSE (formerly National Reporting and Learning System). This is undertaken by automatic upload from Datix
- Health and Safety Executive (HSE). Reporting certain incidents and certain work-related diseases of staff or dangerous occurrences to the HSE. RIDDOR requires the incidents of a specific nature to the HSE. This is done via the Health and Safety Manager.
- Medicines and Healthcare Products Regulatory Agency (MHRA): any incidents relating to medical equipment should be notified formally to MHRA using the relevant form supplied by that office. Incidents relating to adverse drug reactions are reportable on the yellow forms.
- NHS Estates: the trust is required to report incidents relating to Fire, buildings, plant, and non-medical equipment to NHS Estates. The Health and Safety Manager will inform the Estates Team who will report such incidents via the Estate return Information Collection system.
- NHS Resolution (NHSR): incidents where there are likely to be civil claims require, where practicable, to be notified to the NHRS as early as possible. The Legal Services Team and Health and Safety Manager will be notified of such incidents via the daily Datix review carried out a corporate patient safety team to enable as much information to be gathered prior to reporting. The Legal Services Team will contact NHSR as appropriate.
- Environmental Health Office and Food Standards Agency: incidents relating to food will, in addition to being notified internally using Datix. This will be done via the Facilities Team only
- Reporting PSIIs to commissioners via the STEIS systems. This is done via the corporate patient safety team

Supporting patients, families and carers affected by PSIs.

The Trust is committed to creating a culture of openness with patients, families and carers particularly when clinical outcomes are not as expected or planned. The Engaging Patients and Families in Patient Safety Incidents Including Being Open and Duty of Candour sets out the responsibilities and guidance surrounding being open and Duty of Candour.

For the Patient Safety Incident Investigations identified in this PSIRP family liaison/engagement will be undertaken directly by the PSIT Lead for the investigation. As part of our continuous training rollout, additional engagement leads will be identified and trained to support patients/families/carers through a Learning response.

For all other types of Patient Safety Review family liaison it is the responsibility of the nominated Clinical Lead.

Complaints and appeals

The Trust has a Patient Complaint and Feedback Management Policy where concerns cannot be resolved as part of the investigative process.

The following routes are in place for the people who use our services, their families and carers to make a complaint, raise concerns or provide feedback:

Raising a concern – Don't take your troubles home:

The people who use our services, their family or carer should be able to raise a concern or feedback with any member of staff during their care or treatment with the opportunity for this to be resolved locally without the need for intervention by the PALS or Complaints Team.

Patient Advice & Liaison Service (PALS):

The Patient Advice & Liaison Service (PALS) managed by the PALS and Complaints Manager offers confidential advice, support and information on health-related matters. They provide a point of contact/escalation for the people who use our services, their families and carers.

Informal Complaints:

The route for the people who use our services, their families or carers to informally raise concerns, issues or feedback for resolution at a service level, with the ability to escalate to a formal complaint should the issue remain unresolved. Submission can be verbal or in writing to the service or the PALS & Complaints Team. The service/care group will manage informal complaints.

Telephone 01634 825004

Email: medwayft.pals@nhs.net

Formal Complaints:

The formal route for handling complaints, managed by the PALS & Complaints Team, whereby a complaint can be made by:

Telephone: 01634 825216

Email: medwayft.complaints@nhs.net

Post: The Central Complaints

Medway Maritime Hospital

Gillingham

Kent

ME7 5NY

Complaints and concerns received will be assessed and where a formal complaint is received the PALS & Complaints Team will acknowledge the complaint within 3

working days. The Trust aims to respond to formal complaints within 25 working days, although complex complaints may take up to and over 60 days.

Friends & Family Test:

The Friends and Family Test (FFT) is a service level nationally mandated survey relating to the most recent episode of care and is usually sent by text message, card or electronic submission. The Patient Experience Team are responsible for the management of FFT across the Trust.

NHS Choices / Care Opinion:

Care Opinion is a system where the people who use our services, their families or carers can share their experiences of the care and treatment received at MFT. The Patient Experience Team will respond to feedback and refer concerns to the appropriate route for investigation.

Local Surveys:

The Patient Experience Team is responsible for conducting local surveys of the people who use our services, their families or carers to enable them to share their experiences of the care and treatment received. The Patient Experience Team will respond to feedback and refer concerns to the appropriate route for investigation.

National Surveys:

National Surveys are mandated by the Care Quality Commission and provide an opportunity for the people who use our services and/or their families and carers to provide feedback of the care and treatment received during the set survey period, with National benchmarking results published. The Patient Experience Team are responsible for ensuring the Trust participates within all mandated surveys, producing improvement action plans where required.

Appendices

Appendix 1: IRG Incident Decision Matrix

	PSIRP priority				
	1 Not	2 Area	3 Highlighted	4 Identified as key	5 Nationally

Potential impact of Learning Outcome	covered in PSIRP	highlighted in PSIRP played role in incident e.g. medication	for learning response in PSIRP (Excluding specialty nursing incidents)	priority for PSII in PSIRP	required PSII
1. No learning identified/Individual learning only					
2. Known theme – Addressed by ongoing improvement work					
3. Known theme – Not under ongoing improvement work. Potential to inform ongoing improvement work					
4. New emerging theme – for review to support improvement work					
5. New theme – requires immediate learning response and improvement work					

	Local Investigation
	SWARM
	AAR
	PSII

Appendix 2: Specialty Nursing risk matrix

Use this matrix to determine the risk score of reported incidents for IPC, Safeguarding, Tissue viability and Falls. The colour banding identifies the rating and guides the level of onward reporting and investigation. The score should be re-calculated following learning identified to reduce the risk.

Potential impact of Learning Outcome	Impact to Patient				
	1 No impact to patient quality of life/ no increase in LOS	2 Some short term impact to patient/ No increase to LOS	3 Short to Mid-term impact/ Increase in LOS	4 Long term impact to patient quality of life including after discharge/ Increased LOS	5 Death of patient/ Loss of quality of life
1. No learning identified/Individual learning only					
2. Known theme – Addressed by ongoing improvement work					
3. Known theme – Not under ongoing improvement work. Potential to inform ongoing improvement work					
4. New emerging theme – for review to support improvement work					
5. New theme – requires immediate learning response and improvement work					

	Local Investigation
	SWARM (Mini toolkit)
	AAR (Full toolkit)
	PSII

Appendix 3 – AAR template

AFTER ACTION REVIEW REPORT

The Event:	Date of Incident:	Points to consider:

After Action Review Date:

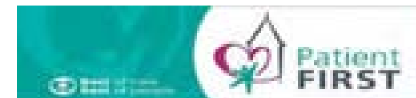
Lead of AAR:

Attendees:

WEB number:

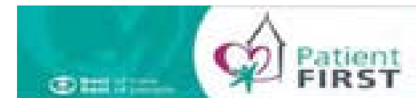
Level of Harm:

DOC applicable: YES/NO (please delete as appropriate)



The Event (What happened):
How is the Patient now?

Expected Outcome:



The Outcome/Analysis (What was the difference in the expected outcome and the actual outcome):

Contributory Factors:

Immediate Actions taken:

Areas for Improvement:

Patient FIRST

Appendix 4 – Thematic review template with thanks to Dr Samantha Machen University Hospitals Sussex.

Themed Review (TV) template

What is this for?

A themed review may be useful in understanding common links, themes, or issues within a cluster of investigations or incidents. It will seek to understand key barriers or facilitators to safety using reference cases (e.g. individual datix incidents or previous investigations).

What may benefit a themed review?

Grouped incidents, for example from the same portfolio like pressure ulcers, falls or deteriorating patient, may benefit from a themed review because they take the same safety concern and identify different reference cases and contexts. This helps the organisation make sense of the safety concern at different points of the system and with different aspects of variability e.g. staffing issues, high volume of acute patients. This is important, because safety incidents may occur when systems are 'pushed' or 'pressurised' and therefore our view of safety needs to be flexible to the variability around the context.

What should the output of a themed review be?

Themed reviews may identify fallibilities of the components of a safety system. For example, it may be that across all the reference cases a risk assessment was completed but the preventative measures were not actioned. Outputs of themed reviews can highlight these problems and identify safety recommendations. Themed reviews may provoke more questions than answers, and therefore may be best placed to link in to a quality improvement project for ongoing monitoring and PDSA-style improvement cycles. A themed review should be viewed as a diagnostic tool to help diagnose problems in the system, and therefore doing a themed review should **always** result in some improvement efforts after this diagnosis.

What are the stages of a thematic review?

Stage 1: Description of the reference cases

Stage 2: Description of the safety system

Stage 3: Relevant context to each reference case and key problems

Stage 4: Common themes across the reference cases – narrative analysis

Stage 5: Safety recommendations and future work

Stage 1: Description of the reference cases

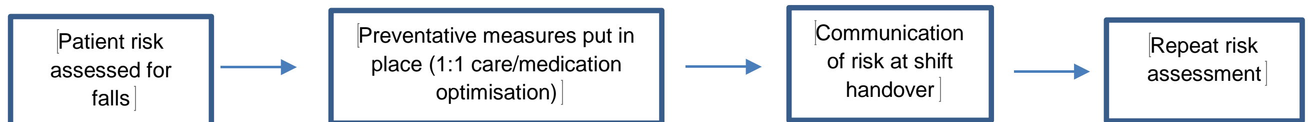
(In this stage, use the table below to list the reference cases using the headings. Remember, reference cases are the different incidents you are including in the themed review)

Date	Datix number	Harm	Description	Investigation level	Actions taken
Date of reference case	*Datix number for reference case*	*Harm level for reference case*	*Description of incident and findings of investigation (if applicable)*	*Level of investigation done (e.g. local investigation/RCA)*	*Actions taken as a result of individual incidents e.g. any recommendations/action plans from RCAs*

Stage 2: Description of safety system

(In this stage, describe the system of safety for the problem. That is, what safeguarding is in place to ensure patients' safety? This could be a list or a diagrammatic flow chart. Where there may be different systems in place (e.g. different processes for different locations or multiple safety risks), break them down in the box below.

E.g. A system of safety for falls below:



E.g. System of safety for deteriorating patient:

- Patient identified as being at risk of deterioration (clinical notes/observations)
- Clinical task of collecting observation data and calculating (NEWS2 score)
- Preventative/clinical measures put in place (e.g. increased observations/sepsis bundle)
- Senior review of deteriorating patient

System of safety for specific safety risk:

Stage 3: Relevant context to each reference case and key problems

E.g. Safety barrier 1: Risk assessment for VTE

What is supposed to happen? *Risk assessment done within X hours*

What did happen? *Risk assessment delayed by Y hours*

Why did this happen? *Junior doctor not aware of need to do risk assessment before prescribing enoxaparin and is used to prescribing it for all patients. Limited time to do assessment before prescription given volume of patients in the ED department and pressure to reconcile medications*

What can we learn from this? Importance of risk assessments prior to prescription was not clear to this prescriber. Need to identify why this is. Tendency to prescribe enoxaparin as a departmental norm.

Safety barrier 1:

What was supposed to happen?	What did happen?
Why was there a difference?	**What can we learn from this?**

Safety barrier 2:

What was supposed to happen	What did happen

Why was there a difference?	What can we learn from this?

Safety barrier 3:

What was supposed to happen?	What did happen?
Why was there a difference?	**What can we learn from this?**

Safety barrier 4:

What was supposed to happen?	What did happen?
Why was there a difference?	**What can we learn from this?**

Safety barrier 5:

What was supposed to happen?	What did happen?
Why was there a difference?	**What can we learn from this?**

Stage 3: Relevant context to each reference case and key problems

This stage refers to contributory factors (as classified by the contributory and mitigating factors classification here: https://www.england.nhs.uk/wp-content/uploads/2020/08/PSII_Contributory_and_Mitigation_Factors_Classification.pdf)

For each incident, mark down the external context factors, organisational and strategic, workplace, equipment, and task factors that affected the safety incident. All components that fall under each group can be seen below.

External context factors	Components
National guidelines and policies	• Impact of national policy/guidance (DHSC/professional colleges, etc) • Locum/agency policy and usage • Contractor related
Economic and regulatory context	• Service provision • Bed occupancy levels (opening/closures) • Private finance initiative related • Equipment loan related • Financial constraints • Resource constraints
Societal factors	• Values • Beliefs

Organisational and strategic	Components
Structure	• Hierarchical structure (discussion, problem-sharing, etc) • Roles, responsibilities and accountability • Multidisciplinary working • Clinical/managerial approaches • Maintenance • Service-level agreements/contractual arrangements • Safety terms and conditions of contracts
Priorities/resource	• Safety focus • Finance focus • External assessment focus • Workforce resource management • Estates and technology resource management
Safety culture	• Safety/efficiency balance • Commitment to safety • Openness of culture and communication • Risk tolerance • Approach to escalation of concerns • Leadership response to whistleblowing
Policy, standards and goals	• Organisational processes (formal) • Organisational processes (informal) • Processes between/spanning organisations

Operational management factors	Components
Safety focus	• Rule compliance • Dealing with risks from past incidents • Awareness of current practice • Adherence to current practice • Empowerment of staff to act
Work planning and delivery	• Risk management plans • Scheduling • Incentive schemes • Contingency planning
Staffing levels and skill mix	• Skill mix • Staff to patient ratio • Workload/weighting/dependency • Temporary staff • Staff turnover
Workload, shift patterns, hours of work	• Working hours • Work breaks • Workload (under/over/balanced) • Extraneous tasks • Social relaxation, rest and recuperation
Training design	• Training needs analysis • Training design • Training/education content • Targeted training • Style of delivery • Time of day provided
Training availability/accessibility	• Training availability/accessibility • Core skills training • On the job training • Emergency scenario training (skills drills) • Team training • Refresher training
Staff supervision	• Orientation • Personal supervision • Monitoring of supervision (assessment) • Mentorship
Staff competence	• Knowledge • Skill • Experience • Familiarity with task • Competence testing and assessment

Workplace factors	Components
Environmental factors	• Capacity • Fixture or fitting • Separation • Safety • Cleanliness/hygiene • Temperature • Lighting • Noise levels • Distractions (audio) • Distractions (visual) • Ligature/anchor points
Design of physical environment	• Work area design (eg size, shape, visibility, screens, space, storage) • Security provision • Lines of sight • Use of colour contrast/patterns (walls/doors/flooring, etc) • Space design (adjustable furniture, panic buttons, positioning, etc)
Administrative factors	• Administrative work systems • Administrative infrastructure (phones, bleep systems, etc) • Administrative support

Equipment and technology factors	Components
Displays	• Information/feedback available • Information clarity • Information consistency • Information legibility • Information interference • Information displays (colour, contrast, anti-glare screens, etc)
Integrity and maintenance	• Working order • Reliability • Safety features (fail to safe, etc) • Maintenance programme • Emergency back-up services (power, water, piped gases, etc)
Positioning and availability	• Availability • Accessibility • Position/placement • Storage • Emergency backup equipment
Usability/design	• Controls • Intuitiveness • Use of colour • Use of symbols • User manual • Detectability of problems • Use of items which have similar names or packaging • Compatibility

Team and social factors	Components
Culture	• Approach to newcomers • Approach to adverse events • Approach to conflict • Approach to rules/regulations • Approach to seeking support • Approach to interprofessional challenge • Interpersonal relationships • Power relationships
Team structure and consistency	• Shared understanding • Familiarity • Mutual respect • Clarity of roles and responsibilities • Congruence of roles and responsibilities • Informal support networks
Leadership	• Clinical leadership • Managerial leadership • Leadership impact • Leadership decision-making • Timeliness of leadership action • Respect for leadership • Formal support networks for staff
Communication management	• Communication strategy and policy documents • Involvement of patient/family/carers in treatment and decisions • Communication of risks to patient/family/carers • Communication of risks to staff • Communication of risks to the board • Information from patient/family/carers • Communication flow to staff up, down and across • Communication with other agencies (partnership working) • Measuring effectiveness of communication
Verbal communication	• Tone of voice • Style of verbal communication delivery • Use of language • Specificity • Direction • Channel/route • Verbal communication aids/equipment
Written communication	• Readability • Accessibility/availability • Collated • Completeness • Contemporaneous • Accuracy • Currency • Circulation of written information • Patient identification • Information to patients
Non-verbal communication	• Body language/gestures/facial expression

Patient FIRST

Task factors	Components
Clinical condition	• Pre-existing co-morbidities • Complexity of condition • Seriousness of condition • Options available to treat condition
Plans, guidelines, policies, procedures and protocols	• Informative • Instructional • Representative • Routine use • Usability • Currency • Accuracy • Availability • Accessibility (ambiguous, complex, irrelevant, incorrect) • Monitoring • Review • Targeting/focus (ie audience)
Decision-making aids (information/results/ tools/machines, etc)	• Available • Accessible • Working • Accurate • For prioritisation of tasks • Access to specialist advice • Access to technical information, flow charts and diagrams
Procedural or task design and clarity	• Task complexity • Task memorability • Understandable • Agreed with staff (feasibility) • Time allocation • Task sequencing/stage sequencing • Workload (under/over/balanced) • Compatibility of tasks/task stages • Competing task demands • Feedback from the task • Transferability to/from other situations • Influence on task/outcome • Automation • Audit, quality control, quality assurance

Individual patient factors	Components
Physical factors	• Physical health/condition • Nutrition/hydration • Age related • Body mass related
Social factors	• Cultural/religious beliefs • Language/communication • Lifestyle choices • Life events • Living accommodation • Support networks • Social protective factors (relevant to mental health services) • Risk tolerance • Engagement/motivation/compliance/concordance • Interpersonal relationships (staff-patient; patient-family; staff-family)
Psychological factors	• Mental health • Mental capacity • Learning disability • Intent (relevant to mental health services)

Individual staff factors	Components
Physical health	• General health (nutrition, hydration, wellness, fitness) • Health related conditions (eg eyesight, dyslexia)
Psychological/mental health	• Mental health • Mental alertness • Motivation level (boredom, complacency, low job satisfaction)
Social domestic factors	• Domestic (family related) • Lifestyle (financial, housing, etc) • Language
Personality factors	• Confidence • Risk awareness/risk tolerance
Social factors	• Motivation and values • Beliefs and expectations • Attitudes • Habits
Cognitive factors	• Focus/attention • Perception • Reasoning and decision-making • Group influence • Workload (underload/overload/well-balanced)

Mark the factors that affected each reference case based on the description above:

Causal Factors	Domain	Components	Contributory, Causal and Mitigating Factors Analysis – for identified **PROBLEMS/WEAKNESSES** and **STRENGTHS**									
Incident numbers			1	2	3	4	5	6	7	8	9	10
CONTRIBUTORY and MITIGATING FACTORS Described as they relate to the **PROBLEMS/WEAKNESSES and STRENGTHS** identified (NB: There may be none, one or more CF/MF in each category)	**External Contextual Factors**	*National guidelines and policies*										
		Economic and regulatory context										
		Societal factors										
	Total											
	Organisational Strategic Factors	*Structure*										
		Priorities/resource										
		Safety culture										
		Policies, standards, and goals										
	Total											
	Operational Management Factors	*Safety focus*										
		Workplanning and delivering										
		Staffing levels and skill mix										

		Workload, shift pattern, hours of work										
		Training										
		Staff supervision										
		Staff competence										
	Total											
	Workplace Factors	*Environmement factors*										
		Design of physical environment										
		Administrative factors										
	Total											
	Equipment & Technology Factors	*Display*										
		Integrity and maintenance										
		Positioning and availability										
		Usability/design										
	Total											
	Team & Social Factors	*Culture*										
		Team structure and consistency										

		Leadership										
		Communication management										
		Verbal communication										
		Written communication										
		Non-verbal communication										
	Total											
	Task Factors	*Clinical condition*										
		Plans/policies/procedures in place for task										
		Decision making aids										
		Procedual or task design and clarity										
	Total											
	Individual Patient Factors	*Physical factors*										
		Social factors										
		Psychological factors										
	Total											
		Physical health										

	Individual Staff Factors	*Psychological factors*										
		Social/domestic factors										
		Personality factors										
		Social factors										
		Cognitive factors										
Incident numbers			**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Stage 4: Narrative analysis

Use the space below to compile narrative data surrounding the above sections. For example, if 2 or more incidents have a X by the group, then clarify the similarities/differences in the boxes below:

External Contextual Factors	*E.g., How did national guidelines affect the reference cases?*
Organisational Strategic Factors	*E.g., How did local guidelines/organisational resource affect the reference cases?*
Operational Management Factors	*E.g., How did local organisational level factorsl (e.g. staffing, skill mix, training, and staff supervision) affect the reference cases?*
Workplace Factors	*E.g., How did environment factors/design of workplace affect the reference cases?*

Equipment & Technology Factors	*E.g., How did equipment/technology affect the reference cases?*
Team & Social Factors	*E.g., How did local team dynamics/team culture/leadership/communication affect the reference cases?*
Task Factors	*E.g., How did task clarity/decision-making prompts affect the reference cases?*
Individual Patient Factors	*E.g. How did individual patient factors (e.g. acuity/clinical/psychological) affect the reference cases?*
Individual Staff Factors	*E.g. How did individual staff factors (e.g. social/psychological) affect the reference cases?*

Stage 5: Safety recommendations

In this section, linking to the sections above, list the safety recommendations based on this thematic review using the Standard Quality Improvement Action Plan (Appendix 8)

Appendix 7 – Standard Local Quality Improvement Action Plan

Safety recommendation	**Category** (Fix/improvement/change/further insight)	**Person Responsible**	**Deadline**	**Evidence**

Category	Definition	Example
Fix	Resolve problems in reliably doing what we said we would do. These were usually issues that could be resolved with rapid operational changes.	Linear or more 'simple' things you can do to help the process. E.g., if you identify that there are conflicting local policies which meant a clinician was confused with the task, then the **fix** would be to resolve the confusion by rewriting the policy
Improvements	Find better ways of delivering standard care; improve what is currently being done.	Where improvement need to be made in an already defined process. This may be linked to a Quality Improvement (QI) project and should involve metrics to measure improvements.
Changes	Significant changes in clinical or operational practice.	Where a system, process, or pathway needs to change. N.b. this should be based on multiple cases of evidence, rather than being linked to one case. Where change is needed, an output may be a task and finish group, and this will involve multiple stakeholders.
Further insight	Where investigations have resulted in more questions relating to a safety issue, it may be appropriate for a safety recommendation to involve gaining more insight	If you do an investigation for a particular safety risk but are not sure of the scale of the problem or the mechanism of action then collecting further data may then help identify safety recommendations later.

Appendix 8 – Equality Impact Assessment Screening Tool

Is there any evidence that some groups are affected differently? (use the screening below)

Protected Characteristic	Could there be an adverse impact? Yes/No/ Unknown	Relevance None/Low/ Medium/High	Proportionality (likelihood of risk/impact)		Notes
			None/Low/ Med/High	+ve / -ve	
Age	No	None	None		n/a
Disability	No	None	None		n/a
Gender / Sex	No	None	None		n/a
Gender Identity	No	None	None		n/a
Race	No	None	None		n/a
Religion/Belief	No	None	None		n/a
Sexual Orientation	No	None	None		n/a
Pregnancy & Maternity	No	None	None		n/a
Marriage / Civil Partnership	No	None	None		n/a

Questions		
1	Does the proposal …	
a	• promote equality of opportunity?	Yes
b	• eliminate unlawful discrimination?	Yes
c	• good community relations?	Yes
d	• amount to illegal discrimination?	No
e	• create an inequality?	No
2	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable? Is the impact of the case likely to be negative and if so can the impact be mitigated? Can we reduce the impact by taking different action: what alternatives are there to achieving the aim?	

NHS
Medway
NHS Foundation Trust

Meeting of the Trust Board in Public
Wednesday, 17 January 2024

Title of Report	Finance Report – Month 8			Agenda Item	7.1
Author	Alan Davies, Chief Finance Officer Paul Kimber, Deputy Chief Finance Officer Matthew Chapman, Head of Financial Management Mark Pordage, Associate Director Income & Contracts Isla Fraser, Financial Controller				
Lead Executive Director	Alan Davies – Chief Finance Officer				
Executive Summary	1) The Trust reports a £30.1m deficit YTD, this being £18.5m adverse to the plan. 2) Efficiencies to date total £8.7m, this being £7.2m adverse to the plan. There are a further £0.6m of cost avoidance schemes, with the total efficiency delivery reporting £9.3m YTD. 3) The capital position is underspent by £7.8m due to delays in progress across the main major projects. 4) Cash is £14.4m adverse to plan, this is mainly due to the unplanned deficit.				
Proposal and/or key recommendation:	This report is provided for assurance				
Purpose of the report (tick box to indicate)	Assurance		Approval		
	Noting	✓	Discussion		
Committee/Group at which the paper has been submitted:	Finance, Performance and Planning Committee: 24 August 2023 and 21 December 2023				
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:	Non-delivery of the breakeven control total				
Resource implications:	N/A				
Sustainability and /or Public and patient engagement	N/A				

<table>
<tr><td>considerations:</td><td colspan="2"></td></tr>
<tr><td>Integrated Impact assessment:</td><td colspan="2">N/A</td></tr>
<tr><td>Legal and Regulatory implications:</td><td colspan="2">Achieving breakeven is a statutory duty</td></tr>
<tr><td>Appendices:</td><td colspan="2">N/A</td></tr>
<tr><td>Freedom of Information (FOI) status:</td><td colspan="2">This paper is disclosable under the FOI Act</td></tr>
<tr><td>For further information or any enquires relating to this paper please contact:</td><td colspan="2">Alan Davies – Chief Finance Officer

Alan.Davies13@nhs.net</td></tr>
<tr><td rowspan="5">Reports require an assurance rating to guide the discussion:</td><td>No Assurance</td><td>There are significant gaps in assurance or actions</td></tr>
<tr><td>Partial Assurance</td><td>There are gaps in assurance</td></tr>
<tr><td>Assurance</td><td>Assurance with minor improvements needed.</td></tr>
<tr><td>Significant Assurance</td><td>There are no gaps in assurance</td></tr>
<tr><td>Not Applicable</td><td>No assurance required.</td></tr>
</table>

Finance report

For the period ending 30 November 2023

Contents

1. Executive summary
2. Income and expenditure
3. Pay
4. Clinical Income and ERF performance
5. Efficiencies programme
6. Balance sheet
7. Capital
8. Cash
9. Risks and forecast
10. Conclusions

1. Executive summary

£'000	Budget	Actual	Var.	
Trust surplus/(deficit)				
In-month	(799)	(3,777)	(2,978)	The Trust is reporting a £3.8m deficit for November, reducing to £3.6m after removing the impairment adjustment; the overall position is a £30.3m deficit YTD, this being £18.6m adverse to plan. The main deficit variance to budget is due to overspending on medical staff (£12.0m), and nursing staff (£4.9m) as well as the unfound efficiencies to date (£6.0m); this is partially offset by the phasing of Central reserves into the position. £6.8m of the medical staff adverse variance relates to non-operational issues including industrial action £2.2m, stretch efficiency target £3.4m and pay award under funding £1.0m. The in-month deficit run-rate has reduced by £0.2m compared to October due an increase in capital charges funding of £0.7m and a reduction to the pay run rate of £0.3m; the prior month included a non-recurrent benefit of a rates rebate of £0.8m. A revised forecast of £35.6m has been agreed with the Executive Team and in discussion with the Integrated Care Board (ICB), although the system is tasked by NHSE with further improvement. The efficiency programme and further mitigations identified continue to be prioritised with a view to delivering the revised forecast.
Donated Asset Depreciation	22	187	165	
In-month total	**(777)**	**(3,590)**	**(2,813)**	
YTD total (adjusted)	**(11,608)**	**(30,086)**	**(18,478)**	
Efficiencies Programme				
In-month	2,744	961	(1,783)	The delivered efficiency programme totals £1.0m for November, this being £0.7m less than October which included £0.8m non-recurrent rates rebate. The position is £6.7m adverse to plan as some schemes have not delivered as expected; in addition to this additional schemes to meet the stretch target have not been fully identified.
YTD	16,021	9,336	(6,685)	

1. Executive summary (continued)

£'000	Budget	Actual	Var.	
Cash				
Month end	28,350	13,963	(14,387)	Cash is £14.4m adverse to plan, this has not worsened in line with the unplanned deficit due to a £6.3m draw down of capital PDC. This, along with a reduction in the overspend run rate, has improved the cash outlook. Based on this improvement being recurring and the agreement of additional cash-backed income, cash flow forecasting indicates the Trust would not need to borrow in 2023/24 and therefore no application has been made to NHSE for quarter 4. Working balances will need to be closely monitored and carefully managed. Should the revenue run rate worsen beyond the ability to manage within reasonable expectations an emergency loan application could be made.
Capital				
In-month	1,884	1,446	(438)	YTD underspend of £7.8m is due to delays in progress across the main major projects as reported in M7: CDC, endoscopy, diagnostic equipment replacement and fire. Some delays will catch up in year whilst others will produce slippage in the 2023/24 programme for which a £2.9m slippage plan has been implemented. £0.1m of additional PDC has been issued to the Trust for Cyber resilience in month 8, increasing the overall capital programme to £28.4m. Key risks to the delivery of the plan are: - £1.2m MOU for EPR PDC funding has not yet been issued by NHSE - £2.3m Endoscopy PDC cannot be drawn in 23/24 if the project is not going ahead. An agreement with NHSE will be required to defer funding until 24/25 or utilise for other purposes. As the slippage has not yet been declared to NHSE due to options around mobile units being considered, forecast is still currently to draw and spend the funding. - Yet to be quantified CDC works could slip into 2024/25 without availability of any external funds.
YTD	15,108	7,351	(7,757)	
Annual Forecast	28,442	28,442	0	
Of which				
System Capital	13,423	13,423	0	
Donations	86	86	0	
PDC Capital	14,933	14,933	0	

The forecast exercise undertaken nationally during November was explicitly required to assume that there was no further industrial action. Since then, further industrial action has been announced by the BMA for doctors in training to take place 20-23 December and 3-9 January. This is therefore likely to have an adverse impact on the forecast; and currently being evaluated, together with a re-evaluation of other risks and opportunities to support the delivery of the £35.6m forecast deficit.

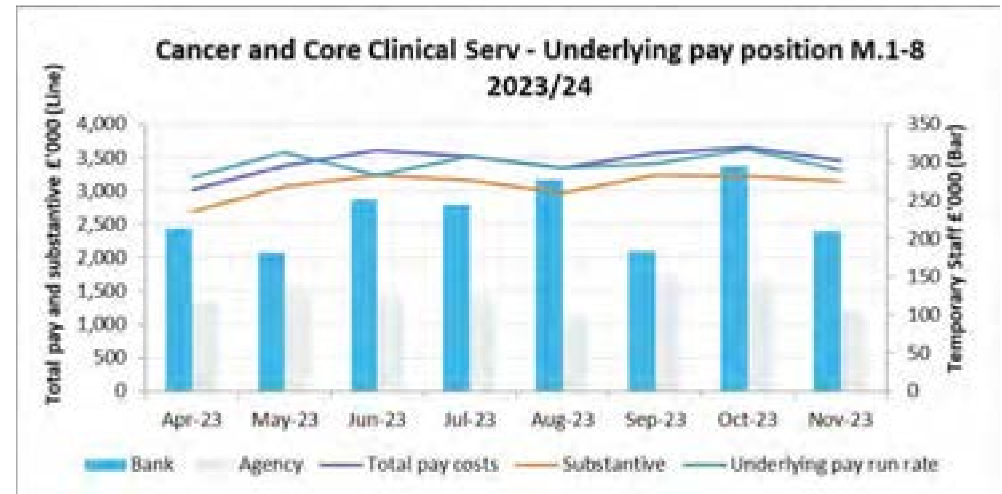
2. Income and expenditure

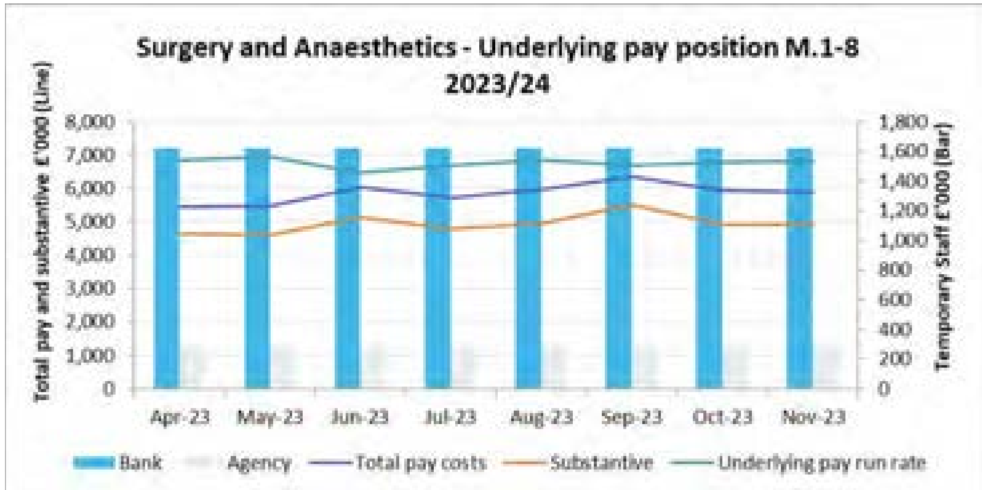
£'000	In-month			Year-to-date		
	Plan	Actual	Var.	Plan	Actual	Var.
Clinical income	31,063	32,249	1,186	242,252	245,183	2,931
High cost drugs	2,030	2,497	466	16,241	17,410	1,169
Other income	1,472	1,887	415	18,042	21,735	3,693
Donated Asset Adjustment	-	-	-	-	41	41
Total income	**34,565**	**36,633**	**2,067**	**276,535**	**284,368**	**7,833**
Nursing	(9,582)	(10,371)	(789)	(74,701)	(79,599)	(4,897)
Medical	(6,801)	(7,638)	(837)	(54,539)	(66,577)	(12,038)
Other	(4,847)	(6,918)	(2,071)	(48,803)	(53,234)	(4,431)
Total pay	**(21,230)**	**(24,927)**	**(3,697)**	**(178,044)**	**(199,410)**	**(21,366)**
Clinical supplies	(3,609)	(4,599)	(990)	(32,047)	(36,791)	(4,744)
Drugs	(854)	(1,094)	(240)	(7,092)	(8,804)	(1,713)
High cost drugs	(2,041)	(2,365)	(324)	(16,330)	(17,545)	(1,215)
Other	(5,507)	(5,125)	382	(37,822)	(35,053)	2,768
Total non-pay	**(12,011)**	**(13,183)**	**(1,172)**	**(93,291)**	**(98,194)**	**(4,903)**
EBITDA	**1,324**	**(1,477)**	**(2,802)**	**5,200**	**(13,236)**	**(18,436)**
Depreciation	(1,508)	(1,673)	(165)	(12,063)	(12,229)	(166)
Donated asset adjustment	(22)	(22)	-	(177)	(90)	87
Net finance income/(cost)	96	84	(12)	767	998	232
PDC dividend	(689)	(689)	-	(5,512)	(5,804)	(292)
Gain/Loss on Disposal	-	-	-	-	19	19
Non-operating exp.	**(2,123)**	**(2,300)**	**(177)**	**(16,985)**	**(17,105)**	**(120)**
Reported surplus/(deficit)	**(799)**	**(3,777)**	**(2,978)**	**(11,785)**	**(30,341)**	**(18,556)**
Adj. to control total	**22**	**187**	**165**	**177**	**255**	**78**
Control total	**(777)**	**(3,590)**	**(2,813)**	**(11,608)**	**(30,086)**	**(18,478)**

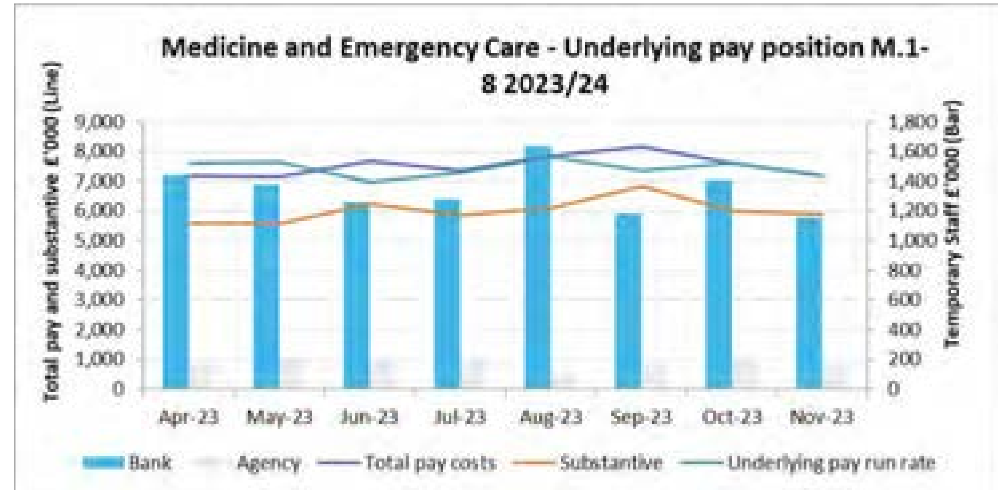
1. The YTD clinical income reported position includes the full value of ERF funding and Community Diagnostics Centre (CDC) income; there is now a reduced risk on ERF following changes to the target as reported last month and a forecast of over performance for the first half of the year.
2. The associated cost to the independent sector and additional consultant sessions to deliver this additional elective activity is £4.0m YTD.
3. Other income YTD favourable variance includes recharges for homecare provider drugs costs of £0.8m, international nurse recruitment £0.8m and medical education £3.1m; this is offset by an under recovery for virtual wards income of £0.2m.
4. Pay adverse variance £21.3m YTD includes £9.3m of the efficiency stretch target, £2.0m impact of the vacancy factor negative reserve held centrally, £2.2m industrial action costs and £3.8m unidentified efficiencies included specifically in the Medicine and Emergency Care division.
5. The remaining variance of £4m includes £1.1m enhanced care costs, continued overspending driven by premium costs for temporary staff due to activity pressures, mainly in emergency care and escalation capacity, as well as temporary staff cover for rota gaps from vacant posts and staff absences.
6. In-month total pay costs have reduced by £0.3m since month 7. This is due to the release of additional sessions accruals of £0.2m in the Medicine and Emergency Care division as well as an overall reduction in bank staff £0.3m; these are offset by £0.2m increase in the run rate for agency staff costs.
7. To date, a benefit of £3.9m of the ERF reserve is offsetting some of the adverse variances from overspending and non-delivery of the efficiency targets in the other non-pay category.
8. The drugs adverse variance YTD includes £0.8m of costs being offset in the Other Income category.
9. Other non-pay includes favourable variance from reserves held centrally, with £4.8m offsetting some of the unfound efficiencies in the clinical areas.

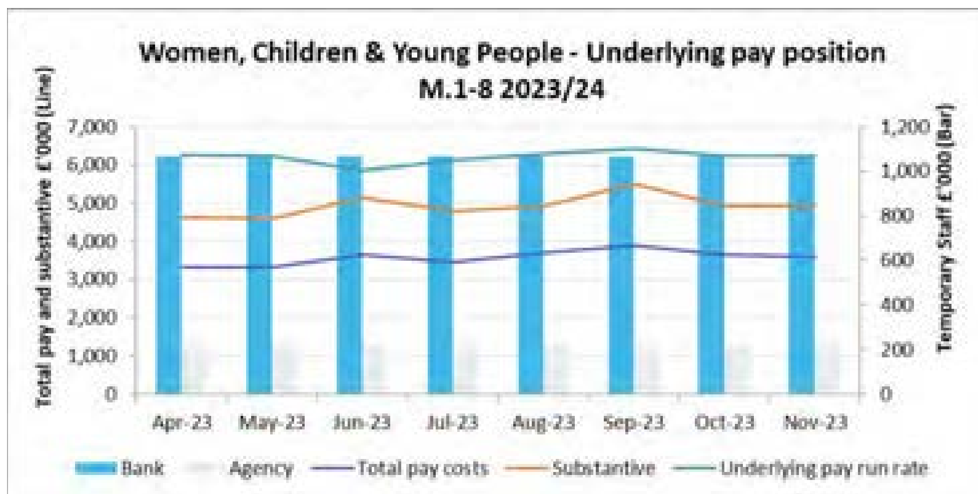
3. Pay

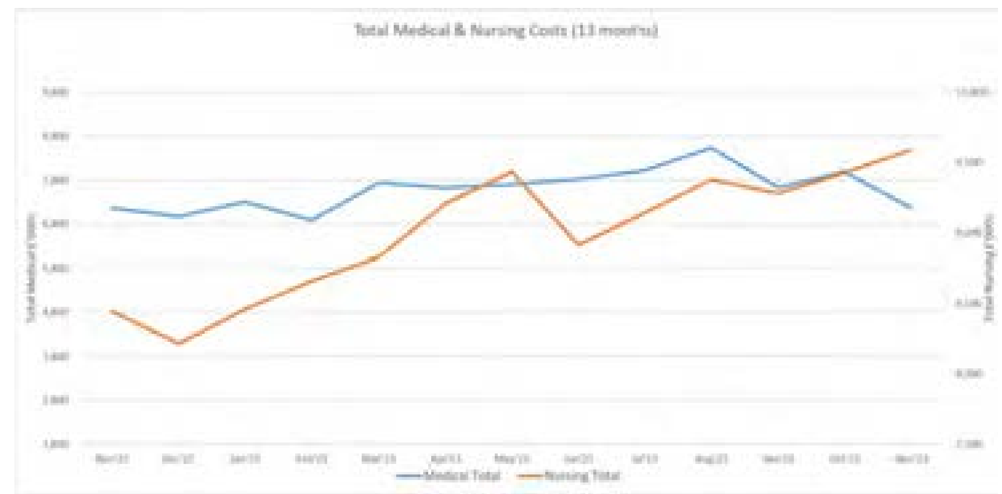
Pay is overspent by £21.4m YTD and is the leading cause of the Trust's adverse financial performance. Medical and nursing pay accounts for £16.9m of the overspend with a further £4.4m within the remaining other staff category. The charts below present the underlying pay position by division after removing non-recurrent items and phasing the back dated pay awards over the months to which the costs relate. The overall underlying pay position shows a marginal reduction since month 7 and a relatively flat trend of costs once adjusting for the phasing of the pay award.











The key drivers of the deficit pay position along with the counter measures remain unchanged from month 7:

Drivers (summarised):

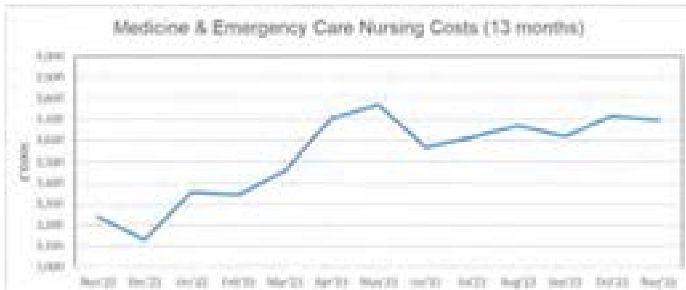
- Industrial action (£2.2m)
- Patient acuity/escalation (c.£2.0m)
- Medical pay award (£1.0m): gap between actual cost and funding uplift.
- Vacancies, rota gaps and backfill of vacant clinical posts, difficult-to-recruit positions, supernumerary nursing cover with a growing workforce.
- ERF / activity,
- Efficiencies (£4.3m): shortfall in delivery against the phased operating plan.

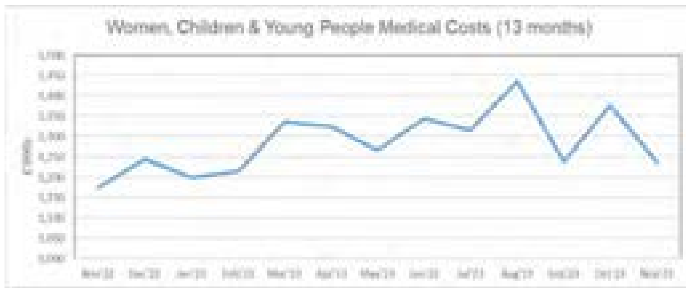
Counter measures (summarised)

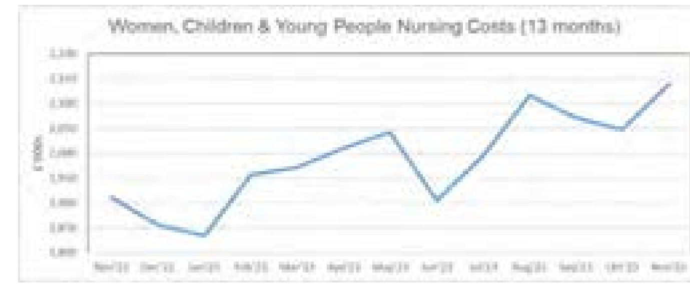
- Development of SHOs to registrar posts, consultation conclusion and implementation of GIM rota as well as new junior doctor block rota Implemented.
- Sickness absence management.
- Finalisation of job planning for 2024/25 will be completed by Q4, reduction in use of additional sessions to cover job plan, annual leave and on call.
- Options appraisal of a new medical rota systems to be completed by Q3 for implementation in Q4
- Demand and capacity planning to completed in November and alignment with job plan
- Demand driven escalation capacity being managed through corporate projects
- Patients are assessed using a new enhanced care assessment tool. The assessment is now approved by the Divisional directors of nursing as additional control

After phasing the backdated pay award over the financial year, the trend chart above shows medical staffing costs have reduced by 6% in November from April; whereas nursing staff costs have increased by 4%; as mentioned above this is mainly due to medical staff costs including the impact of industrial action costs in April and nursing staff cost increasing from escalation capacity, enhanced care and activity pressures.

The following charts present the 13 month view of medical and nursing costs within the four clinical divisions.







4. Clinical Income

Clinical Income by Commissioner	Current Month			YTD Month 08		
	Plan £'000	Actual £'000	Var £'000	Plan £'000	Actual £'000	Var £'000
NHS Kent and Medway						
Fixed	20,175	20,175	-	157,993	157,993	-
ERF - Variable	5,756	5,756	-	45,093	45,093	-
Non-ERF Variable	2,750	2,844	94	20,110	20,861	751
Sub-Total	**28,681**	**28,774**	**94**	**223,196**	**223,946**	**751**
NHS England						
Fixed	3,235	3,235	(0)	25,721	25,721	(0)
ERF - Variable	411	411	-	3,439	3,439	-
Non-ERF Variable	254	777	523	2,037	2,648	612
Sub-Total	**3,900**	**4,422**	**523**	**31,197**	**31,808**	**612**
Other Contracted ICBs						
Fixed	110	110	-	877	877	-
ERF - Variable	55	55	-	438	438	-
Non-ERF Variable	15	15	(0)	131	129	(2)
Sub-Total	**181**	**181**	**(0)**	**1,446**	**1,444**	**(2)**
Non-Contracted K&M	-	972	972	-	1,634	1,634
Non-Contracted (LVA)	193	193	(0)	1,545	1,541	(4)
Other	139	203	65	1,110	2,218	1,108
Grand Total	**33,093**	**34,746**	**1,653**	**258,493**	**262,593**	**4,100**

The table outlines clinical income for the Trust split by NHS contracted and non-contracted services as at month 8. The variance to plan YTD equates to £4.1m favourable. A summary of the key drivers are provided below:

- All ERF variable income is currently set to plan. Agreement of the final ERF targets with all commissioners is close to completion. This will account for the various changes introduced during the year to compensate for the impact of the industrial action and tariff changes published. A full YTD and retrospective adjustment will be applied in the Month 9 report. A summary of the YTD actual ERF achievement is included in section 4a and includes the expected forecast achievement for the year.
- NHS Kent and Medway ICB is over-performing by £0.75m YTD which relates to High Cost Tariff excluded Devices (Insulin Pumps) and matches overspends in expenditure.
- High Cost Drugs are above plan (over-performance £0.6m YTD) which is mostly recoverable from NHSE as these costs are on a pass-through basis for Specialised Commissioning and offsets expenditure.
- Non-Contracted income from Kent & Medway ICB has a positive variance YTD for funding that was not planned at the beginning of the year, this relates to in-year allocations for Sheppey Frailty Unit (£0.4m), Capital Charges support (£0.7m), Winter Schemes (£0.2m) and funding for the reinstated Diabetic Foot service (£0.1m).
- Contracts with the ICB and NHSE are expected to be finalised and signed in the near future, the delay is due to the changes to ERF guidance and the need to calculate and agree the movement between the fixed and variable elements of the contracts. The final agreed values may result in adjustments to reported income where the fixed and variable values have changed since the plan was submitted; any adjustments will be applied retrospectively and incorporated into the Month 9 report.

4a. Elective Recovery Fund (ERF)

The Trust ERF under-achievement YTD is currently a financial risk to the financial position of £0.8m, but the full year forecast is expected to over-perform by £2.4m. With no industrial action adversely affecting capacity in November, services were able to improve the ERF achievement YTD by £0.6m, however the forecast year end over-achievement has deteriorated by a £1m due to the announcement of further industrial action and the continued reduction in additional sessions being delivered, this may adversely impact on the re-forecast £35.6m deficit submission but has not been factored in to date.

	YTD ACTUAL PERIOD									FORECAST PERIOD				
Plan	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	YTD	Dec	Jan	Feb	Mar	FY Forecast
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Adjusted Plan	**5,565**	**6,161**	**5,913**	**6,042**	**6,078**	**6,136**	**6,173**	**6,393**	**48,460**	**5,562**	**5,617**	**5,753**	**6,022**	**71,414**
Actual	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	YTD	Dec	Jan	Feb	Mar	FY Forecast
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Actual / Forecast	**4,802**	**5,903**	**6,142**	**6,029**	**6,163**	**6,081**	**6,159**	**6,524**	**47,803**	**5,377**	**6,222**	**6,122**	**6,122**	**71,647**
Re-Forecast Adjustments														
Additional Counting and Capture										320	320	320	323	**1,282**
Additional Capacity										0	251	403	403	**1,056**
NHSE and LVA ERF Zero Clawback	-51	-54	-20	-15	-10	13	-1	-8	-147	0	-10	-3	0	**-161**
Adjusted Forecast Actual	**4,751**	**5,848**	**6,123**	**6,014**	**6,153**	**6,094**	**6,158**	**6,515**	**47,655**	**5,697**	**6,783**	**6,842**	**6,847**	**73,824**
Variance to Revised Plan	**-814**	**-313**	**209**	**-28**	**75**	**-41**	**-16**	**123**	**-805**	**135**	**1,166**	**1,089**	**826**	**2,410**
% Achievement of Plan	*85.4%*	*94.9%*	*103.5%*	*99.5%*	*101.2%*	*99.3%*	*99.7%*	*101.9%*	***98.3%***	*102.4%*	*120.8%*	*118.9%*	*113.7%*	***103.4%***
2019/20 Baseline	4,920	5,317	5,979	5,410	5,249	5,298	5,296	5,822	**43,292**	4,679	5,408	5,926	5,701	**65,006**
Variance to Baseline	**-170**	**532**	**143**	**604**	**903**	**796**	**862**	**694**	**4,363**	**1,018**	**1,375**	**915**	**1,147**	**8,818**
% Variance to Baseline	*96.6%*	*110.0%*	*102.4%*	*111.2%*	*117.2%*	*115.0%*	*116.3%*	*111.9%*	***110.1%***	*121.7%*	*125.4%*	*115.4%*	*120.1%*	***113.6%***
Impact of Industrial Action	-640	0	-202	-937	-380	-227	-351	0	**-2,737**	-161	-191			**-3,090**

- National ERF guidance changes have been included for 2.3% Pay Award Uplift and accounts for both the Agenda for Change Pay Award (1.6%), the Medical Staffing Pay Award (0.7%) and a 4% ERF Target reduction for the various industrial actions impacted from April to October (which reduces the annual target by 4% in total, profiled equally across the year). There is not expected to be any further reduction to target to allow for the recently announced junior doctor industrial action in December and January.
- Additional Capacity includes the planned investments in Harvey Ward, Theatre 5 and the Mobile Endoscopy Unit expected to be open during Quarter 4.
- Industrial action impact accounts for the previous action in April, June, July, August, September and October and an estimate for the future industrial action in December and January has been assumed in the forecast.
- Based on the Counting and Capture review completed to date, it is estimated that this will improve ERF performance by circa £1.2m which will include activity reported and backdated to April 2023. This is increasingly becoming a financial risk to the ERF forecast due to a lack of progress in implementing the changes to recording of the activity which is needed to realise the financial benefit in 2023/24; a Programme Board has now been established to oversee and monitor the changes and report on progress.
- The ERF forecast includes an adjustment for NHSE and Low Value Activity (LVA) due to the expected removal of clawback in H2 for under-achievement and that the NHSE Health & Justice contract and LVA will not be subject to variable payments for ERF.

5. Efficiency programme

Status £'000	Blue	Green	Amber	Red	Sub-total	Cross Cutting	Sub-total Identified	Over / (un-) identified	Plan Target	Cost reductions	Total Efficiencies
Planned care	88	1,358	0	0	1,446	3,656	5,103	(700)	5,803	276	5,378
UIC	0	35	0	0	35	4,330	4,365	(1,206)	5,571	2,052	6,417
E&F	251	1,433	0	0	1,684	0	1,684	409	1,275	0	1,684
Corporate	6	142	0	0	147	394	542	(809)	1,351	0	542
Central	0	555	0	0	555	3,000	3,555	3,555	0	0	3,555
Sub-total	**346**	**3,522**	**0**	**0**	**3,868**	**11,381**	**15,249**	**1,249**	**14,000**	**2,328**	**17,576**
Unidentified	0	0	0	0	0	0	0	(13,000)	13,000	0	0
Total	**346**	**3,522**	**0**	**0**	**3,868**	**11,381**	**15,249**	**(11,751)**	**27,000**	**2,328**	**17,576**
Month 7 position	*346*	*3,522*	*0*	*0*	*3,868*	*11,381*	*15,249*	*(11,751)*	*27,000*	*2,328*	*17,576*
Movement in-month	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***

Cross cutting schemes BRAG status

Status £'000	Blue	Green	Amber	Red	Sub-total
Total	231	11,604	154	-	**11,990**

Summary £'000	In-month			Year-to-date			Outturn		
	Budget	Actual	Var.	Budget	Actual	Var.	Budget	Forecast	Var.
Trust total	2,744	961	(1,783)	16,021	9,336	(6,685)	27,000	15,472	(11,528)

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 Project Management Office (PMO) 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 for the year to date is £9.3m; this includes £5.6m from the cross cutting schemes, mainly for procurement £0.7m, clinical productivity in theatres £1.0m, patient flow length of stay reduction £0.5m, medical job planning £0.3m, interest received £0.2m, medicines management £0.6m, reduced staff sickness £0.3m and elective work efficiencies £2.0m. The total of identified "cash out" schemes remains at £15.2m, these are budgets being reduced to that value, with a further £2.3m of run-rate improvements in the form of cost reductions or income generation.
The efficiency programme continues to be prioritised by the Executive Team along with support from the project management office (PMO). There are regular check & challenge meetings where all schemes are addressed or discussed in more detail with divisions, with specific feedback and actions requested as well as finalising of PIDs to be presented at the panel. Please see separate efficiencies report for further detail.

6. Balance sheet

Prior year end	£'000	Month end actual	Var on PY.
273,519	**Non-current assets**	**268,463**	**(5,056)**
6,375	Inventory	6,478	103
29,119	Trade and other receivables	26,218	(2,901)
34,742	Cash	13,963	(20,779)
70,206	**Current assets**	**46,659**	**(23,577)**
(953)	Borrowings	(307)	646
(50,315)	Trade and other payables	(41,829)	8,486
(1,320)	Other liabilities	(5,884)	(4,564)
(52,557)	**Current liabilities**	**(48,020)**	**4,568**
(1,952)	Borrowings	(1,825)	127
(1,031)	Other liabilities	(1,031)	0
(2,983)	**Non-current liabilities**	**(2,856)**	**127**
288,185	**Net assets employed**	**264,246**	**(23,938)**
475,198	Public dividend capital	481,600	127
(251,419)	Retained earnings	(281,760)	(30,341)
64,406	Revaluation reserve	64,406	0
288,185	**Total taxpayers' equity**	**261,246**	**(23,938)**

Key messages:

1. Non-current assets are £5m lower than year end, being the net impact of investment expenditure of £7.3m and £12.3m depreciation.

2. In Month 8 the Trust has net current liabilities of £1.4m, due to the need to use cash reserves to cover the unplanned deficit.

3. Trade and other receivables are £26.2m (75% of average monthly income). Work is underway to recover debts as quickly as possible to aid the cash position, however there are a number of large longstanding disputes within the balance which will also involve settling creditor debt once finalised.

4. Cash has decreased by £20.8m since the start of the financial year due to the Trust deficit of £30.3m, partially offset by the drawdown of £6.4m PDC. Should deficits continue at the current rate cash management will be key in remaining months.

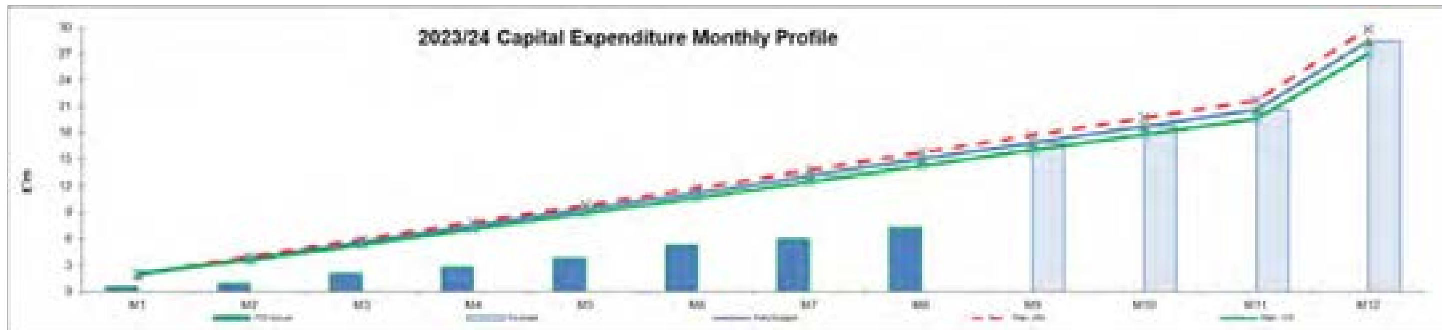
5. Trade and other payables are £41.8m (121% of average monthly expenditure), being an £8.5m reduction on the year-end balance due to the net impact of the pay deal and settlement of March capital creditors.

6. Other liabilities are £4.6m higher as a result of deferred income relating to contracts paid in advance throughout the year which are unwound by year end.

7. Capital

2023/24 Capital Expenditure Update

£'000	In-month			Year To Date			Annual				Funding		
	Plan	Actual	Var.	Plan	Actual	Var.	NHSI Plan	Revised Trust Plan	Forecast	NHSE Reported Variance	Internal (system capital)	PDC	OTHER
Backlog Maintenance	207	245	38	1,653	1,544	(109)	2,480	2,480	2,693	213	2,693	0	0
Routine Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	0
Fire	104	24	(80)	834	472	(362)	972	1,251	1,251	0	1,251	0	0
Medical and Surgical Equipment Programme	406	13	(393)	3,247	557	(2,690)	5,150	4,871	3,987	(884)	3,987	0	0
IT	47	101	54	375	427	52	1,362	562	585	23	585	0	0
Service Developments	217	85	(132)	1,739	268	(1,471)	2,451	2,609	414	(2,195)	414	0	0
Total System Capital	**981**	**468**	**(513)**	**7,848**	**3,268**	**(4,580)**	**12,415**	**11,773**	**8,930**	**(2,843)**	**8,930**	**0**	**0**
IT - EPR	167	714	547	1,333	2,314	981	1,200	2,000	2,000	0	800	1,200	0
IT - PACS/RIS/IREFER	6	(23)	(29)	51	80	29	0	76	80	4	4	76	0
Endoscopy	192	0	(192)	1,533	480	(1,053)	2,300	2,300	2,300	0	0	2,300	0
CDC	547	337	(210)	4,376	985	(3,391)	6,564	8,428	8,428	0	1,008	7,420	0
Total Planned Additional Capital	**912**	**1,028**	**116**	**7,293**	**3,859**	**(3,434)**	**10,064**	**12,804**	**12,808**	**4**	**1,812**	**10,996**	**0**
Total Planned Capital	**1,893**	**1,496**	**(397)**	**15,141**	**7,127**	**(8,014)**	**22,479**	**24,577**	**21,738**	**(2,839)**	**10,742**	**10,996**	**0**
Cardio Village	0	2	2	0	68	68	0	3,854	3,854	0	0	3,854	0
IT- Paeds Adoption	0	0	0	0	0	0	0	0	0	0	0	0	0
Elective Hub	0	0	0	0	0	0	0	0	0	0	0	0	0
Cyber	7	0	(7)	7	0	(7)	83	83	83	0	0	83	0
Donated Equipment - LOF	0	(4)	(4)	86	86	0	0	86	86	0	0	0	86
Total Additional Capex	**7**	**(2)**	**(9)**	**93**	**154**	**61**	**83**	**4,023**	**4,023**	**0**	**0**	**3,937**	**86**
Unplanned Expenditure*	0	(50)	(50)	0	174	174	0	219	391	172	391		
Approved Slippage schemes	0	2	2	0	2	2	0	2,903	2,905	2	2,905		
Slippage Target	(16)	0	16	(126)	(106)	20	0	(3,280)	(615)	2,665	(615)		
Total Capex	**1,884**	**1,446**	**(438)**	**15,108**	**7,351**	**(7,757)**	**22,562**	**28,442**	**28,442**	**0**	**13,423**	**14,933**	**86**



7. Capital (continued)

YTD Capital is £7,757k behind plan, mainly due to the following;

Project	YTD Budget £'000	YTD Actual £'000	YTD Var. £'000	23/24 Budget £'000	23/24 Fcst £'000	23/24 Var. £'000	23/24 Var. %	Narrative	Funded by
Endoscopy	1,483	0	(1,483)	2,225	0	(2,225)	(100%)	Deferral of the project has now been approved. These funds have been released for contingency projects as confirmed in last month's papers.	Internal Funds
Endoscopy	1,533	480	(1,053)	2,300	500	(1,800) reported as 0	(78%) reported as 0%	No change from M7 report. Project build cannot commence in 23/24. Slippage will be £1.8m but deferral is yet to be agreed with NHSE - until this happens the Trust continues to forecast at on plan as monies cannot be reinvested elsewhere.	PDC
CDC	4,376	985	(3,391)	8,428	8,428	0	0%	£1m spent to date, £4m of orders awaiting receipt. Property leases could be £2-3m depending on annual cost and term. External PM indicates potential underspend in current year but overall project overspend into 24/25 for which there is no external funding. Trust is working to agree a robust forecast and quantify the level of risk to ICB in month 9 reporting.	PDC
Gamma Camera	1,333	4	(1,329)	2,000	2,000	0	0%	No change from M7 report. Forecast to complete on budget, as supported by orders raised, but possible this may slip immaterially into 2024/25	£1m prior year system capital / current year internal funds
MRI Enabling	1,200	37	(1,163)	1,800	1,000	(800)	(44%)	No change from M7 report. Forecast to complete £800k less than budget as supported by orders raised, but possible this may slip immaterially into 2024/25. Slippage used to cover originally planning over commitment, prior year overspend and contingency plan.	Prior year PDC/current year internal funds
CR replacements	333	230	(103)	500	416	(84)	(17%)	Vested equipment from prior year being installed in 2nd room, almost complete. Expected to complete at £84k less than budget.	Prior year PDC/current year internal funds
Fire urgency works	834	472	(362)	1,251	1,251	0	0%	No change from M7 report. Forecast to complete on budget by 31st March as supported by orders raised.	Internal funds
Sub-total	**11,092**	**2,208**	**(8,884)**	**18,504**	**15,395**	**(4,909)** reported as **(3,109)**	**(27%)** reported as **(17%)**		

7. Capital (continued)

The following are overspent YTD or in forecast outturn

Project	YTD Budget £'000	YTD Actual £'000	YTD Var. £'000	2023/24 Budget £'000	2023/24 Forecast £'000	2023/24 Var. £'000	Var. %	Narrative	Funded by
Courtyard lifts	987	878	(108)	1,480	1,608	128	9%	No overall change from M7 report. Project will complete before 31st March but over budget due to increased contractor costs.	Internal Funds
Harvey Ward	333	428	94	500	585	85	17%	No overall change from M7 report. Project will complete before 31st March but over budget due to additional requirements from service.	Internal Funds
EPR	1,333	2,313	980	2,000	2,000	0	0%	No overall change from M7 report – ahead of plan but expected to be on plan at year end. MOU for PDC funding has still not been received which needs to be highlighted as a potential risk to the overall programme.	Internal Funds & £1,200k PDC
PACS/RIS/Irefer	105	170	165	158	181	23	15%	Project ahead of plan due to £76k of ICB costs being billed annually in advance whilst budget was phased in equal 12ths.	Internal Funds & £76k PDC
Unplanned Projects	0	174	179	0	391	391	100%	This overspend primarily relates to the Laundry ironer approved in March form 22/23 slippage, increased costs in relation to VAT and other issues.	Internal Funds
Sub-total	**2,758**	**3,963**	**1,205**	**4,138**	**4,765**	**627**	**15%**		

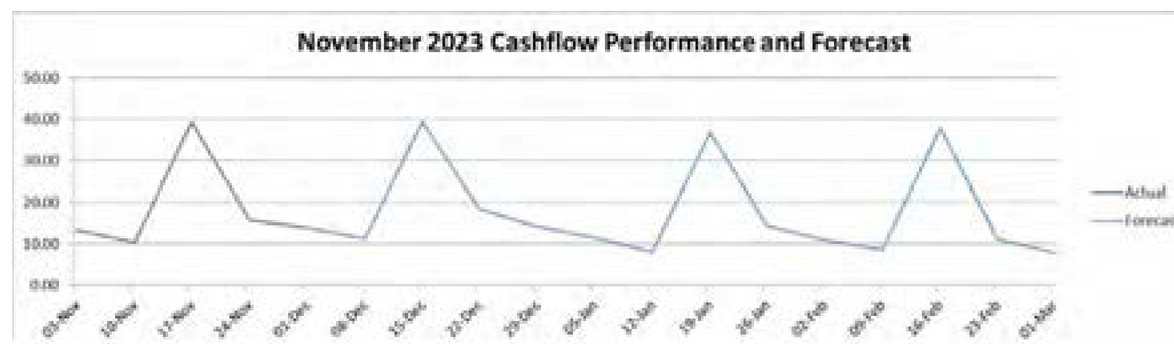
Overall the planned capital programme including new funding is budgeted at £28,442k and forecast at £25,761k, i.e. £2,681k underspent.

The following originally unplanned aspects bring the forecast to the required £28,442k

- Unplanned project expenditure £391k
- Original planning over commitment shortfall £83k
- Slippage plan £2,903k
- Required additional slippage to remain on plan £613k

8. Cash

	Actual					Forecast												
£m	03/11/23	10/11/23	17/11/23	24/11/23	01/12/23	08/12/23	15/12/23	22/12/23	29/12/23	05/01/24	12/01/24	19/01/24	26/01/24	02/02/24	09/02/24	16/02/24	23/02/24	01/03/24
BANK BALANCE B/FWD	**14.71**	**13.39**	**10.47**	**39.26**	**15.94**	**13.95**	**11.30**	**39.36**	**18.51**	**14.22**	**11.48**	**8.16**	**36.74**	**14.48**	**11.02**	**8.60**	**37.95**	**11.08**
Receipts																		
NHS Contract Income	0.04	0.11	32.13	0.26	0.09	0.00	32.93	0.00	0.00	0.00	0.00	36.92	0.00	0.00	0.00	32.93	0.00	0.00
Other	0.55	0.21	0.37	0.32	0.78	0.17	0.68	0.63	0.15	0.20	0.33	0.64	0.63	0.25	0.33	0.65	0.25	0.63
Total receipts	**0.59**	**0.32**	**32.50**	**0.57**	**0.87**	**0.17**	**33.61**	**0.63**	**0.15**	**0.20**	**0.33**	**37.56**	**0.63**	**0.25**	**0.33**	**33.58**	**0.25**	**0.63**
Payments																		
Pay Expenditure (excl. Agency)	(0.44)	(0.45)	(3.86)	(19.38)	(0.41)	(0.46)	(0.44)	(23.22)	(0.44)	(0.44)	(0.44)	(3.97)	(19.69)	(0.47)	(0.44)	(0.44)	(23.22)	(0.47)
Non Pay Expenditure	(1.10)	(2.70)	(6.02)	(4.13)	(2.44)	(2.27)	(4.40)	(2.70)	(3.40)	(1.80)	(2.50)	(4.26)	(2.45)	(2.30)	(2.55)	(2.65)	(3.01)	(2.53)
Capital Expenditure	(0.36)	(0.11)	(0.07)	(0.38)	(0.02)	(0.09)	(0.71)	(0.60)	(0.60)	(0.70)	(0.70)	(0.75)	(0.75)	(0.95)	(0.95)	(1.15)	(0.89)	(0.77)
Total payments	**(1.91)**	**(3.25)**	**(9.96)**	**(23.89)**	**(2.87)**	**(2.81)**	**(5.55)**	**(26.52)**	**(4.44)**	**(2.94)**	**(3.64)**	**(8.98)**	**(22.89)**	**(3.72)**	**(3.94)**	**(4.24)**	**(27.12)**	**(3.77)**
Net Receipts/ (Payments)	**(1.31)**	**(2.93)**	**22.54**	**(23.32)**	**(2.00)**	**(2.64)**	**28.06**	**(25.89)**	**(4.29)**	**(2.74)**	**(3.31)**	**28.58**	**(22.26)**	**(3.47)**	**(3.61)**	**29.34**	**(26.87)**	**(3.14)**
Funding Flows																		
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
MRET	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PSF	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
DOH/FTFF - Capital	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	6.33	0.00	0.00	0.00	0.00	5.03	0.00	0.00	0.00	0.00	0.00	0.00	1.20	0.00	0.00	0.00
Loan Repayment/Interest payable	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	0.00	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Total Funding	**0.00**	**0.00**	**6.25**	**0.00**	**0.00**	**0.00**	**0.00**	**5.03**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**0.00**	**1.20**	**0.00**	**0.00**	**0.00**
BANK BALANCE C/FWD	**13.39**	**10.47**	**39.26**	**15.94**	**13.95**	**11.30**	**39.36**	**18.51**	**14.22**	**11.48**	**8.16**	**36.74**	**14.48**	**11.02**	**8.60**	**37.95**	**11.08**	**7.94**



Prior year end	£'000	Month end actual	Var.
34,742	Cash	13,963	(20,779)

The overall cash balance has increased by £0.5m in November.

£40.9m of cash was received in month
£32.5m NHS contract income for the month, £6.3m PDC funding and £2.1m cash receipts in relation to trading activities and settlement of prior period sales invoices.

£40.4m of cash was paid out by the Trust in month
£14.4m (36%) in direct salary costs to substantive and bank employees
£10.1m (25%) employer costs to HMRC and NHS Pensions
£15.9m (39%) in supplier payments, including NHSR, Agency staff, capital and revenue non-pay.

8. Cash (continued)

Cash management is key for the remainder of 2023/24 to enable the Trust to fulfil its obligations without the need to borrow funds from NHSE/DHSC. Borrowing in this way costs 3.5%per annum interest and then becomes a permanent monthly need whilst the Trust runs at a deficit.
Based on mitigations and revised expenditure controls highlighted in the month 7 report forecast cash flow for the remainder of the year is as below.

Monthly Forecast w/e

	Actual								Forecast			
£m	April	May	June	July	August	September	October	November	December	January	February	March
BANK BALANCE B/FWD	**34.65**	**30.40**	**31.25**	**30.13**	**24.98**	**23.66**	**14.43**	**13.36**	**13.84**	**13.85**	**12.82**	**7.96**
Receipts												
NHS Contract Income	33.44	33.85	43.34	37.91	32.46	33.67	38.26	32.54	33.02	36.92	32.93	36.63
Other	1.74	1.30	3.62	2.15	2.16	1.67	1.58	2.12	2.00	2.00	2.00	2.00
Total receipts	**35.17**	**35.15**	**46.96**	**40.06**	**34.62**	**35.35**	**39.83**	**34.66**	**35.02**	**38.93**	**34.94**	**38.64**
Payments												
Pay Expenditure (excl. Agency)	(22.77)	(22.49)	(29.23)	(27.54)	(23.80)	(25.82)	(25.39)	(24.51)	(24.55)	(24.56)	(24.56)	(24.56)
Non Pay Expenditure	(10.30)	(11.03)	(16.60)	(16.43)	(11.47)	(12.72)	(14.44)	(15.34)	(13.50)	(12.50)	(12.50)	(12.50)
Capital Expenditure	(6.36)	(0.71)	(2.25)	(1.23)	(0.67)	(1.27)	(1.07)	(0.57)	(2.00)	(2.90)	(3.94)	(3.02)
Total payments	**(39.42)**	**(34.23)**	**(48.08)**	**(45.20)**	**(35.94)**	**(39.81)**	**(40.90)**	**(40.42)**	**(40.05)**	**(39.96)**	**(41.00)**	**(40.08)**
Net Receipts/ (Payments)	**(4.25)**	**0.93**	**(1.12)**	**(5.14)**	**(1.32)**	**(4.47)**	**(1.07)**	**(5.76)**	**(5.02)**	**(1.03)**	**(6.07)**	**(1.44)**
Funding Flows												
DOH - FRF/Revenue Support	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
PDC Capital	0.00	0.00	0.00	0.00	0.00	0.08	0.00	6.33	5.03	0.00	1.20	0.45
Loan Repayment/Interest payable	0.00	(0.08)	0.00	0.00	0.00	0.00	0.00	(0.08)	0.00	0.00	0.00	0.00
Dividend payable	0.00	0.00	0.00	0.00	0.00	(4.84)	0.00	0.00	0.00	0.00	0.00	(4.43)
Total Funding	**0.00**	**(0.08)**	**0.00**	**0.00**	**0.00**	**(4.77)**	**0.00**	**6.25**	**5.03**	**0.00**	**1.20**	**(3.97)**
BANK BALANCE C/FWD	**30.40**	**31.25**	**30.13**	**24.98**	**23.66**	**14.43**	**13.36**	**13.84**	**13.85**	**12.82**	**7.96**	**2.54**

Should Income and Expenditure deficits worsen stretching creditors from contractual 30 day payment terms will need to occur. Based on average supplier payment stretching by 1 day could push £0.5m forward, 1 week £3.5m. Prior to additional cash funds being loaned to the Trust before the pandemic and breakeven funding throughout the pandemic the Trust was required to borrow significant cash balances on a monthly basis in addition to stretching creditors to 60day+ payment terms. The Trust will need to plan a return to this position in 2024/25 unless it can return to a monthly breakeven position.

9. Risks and Forecast

The national forecast exercise undertaken during November indicated that the Trust would not be able to meet its control total of £15m deficit in 2023/24; this is for the operational reasons and consequential financial impacts as explained in the analysis of the current year financial performance above.

There will always remain an inherent risk to delivery of the forecast, not least in respect of crystallising the stretching mitigations and counter measures to have a meaningful impact on the current run-rate.

The guidance for production of the forecast was clear that it should assume no further costs of industrial action. Since the submission, the BMA has announced further industrial action for doctors in training across 20-23 December and 3-9 January.

This industrial action will undoubtedly have an impact on the Trust's ability to meet its forecast deficit of £35.6m; this manifests in both additional costs to provide safe medical cover during the period of industrial action itself, together with a loss of income through reductions in elective activity.

The full estimated impact of this action is still being developed at the time of writing. Clearly any further action beyond those announced dates could also adversely impact the forecast position.

10. Conclusions

The Finance, Performance and Planning Committee is asked to note the report and financial performance, which is £3.6m deficit in-month and £30.1m deficit YTD; this being £18.5m adverse to the deficit plan position as agreed with the ICB and NHSE.

Work to deliver the counter measures and improved run-rate per the November forecast are underway and in the process of being fully tracked. KPMG are providing on-site turnaround support aligned to this work.

With the recently announced industrial action the forecast is now at risk; we await further national guidance in response.

Alan Davies
Chief Financial Officer
December 2023

NHS
Medway
NHS Foundation Trust

Integrated Quality & Performance Report

November - 2023

Executive Summary

Jayne Black
Chief Executive

Key Messages

- The Workforce sub-domain is showing the highest volume in metrics improving for Statistical Variance, with no areas of concern
- The Access sub-domain has the highest number of variances that are statistically showing concern
- Incident Management, Mortality and Financial Position domains indicate a mix of metrics that are both statistically concerning and improving.
- Whilst the FFT sub-domain is showing the largest number of metrics not meeting the Assurance thresholds, 50% of them are showing consistent or improved variation
- Both Systems & Partnerships sub-domains (Access & Emergency Care) are demonstrating a mix of metrics that both pass and fall short of the thresholds
- Overall, 46 metrics are showing improved statistical variance (+1 from last month) against 40 which are showing concern (-1 from last month) in month. The remaining metrics are showing no significant change and therefore are consistent.

True North	Sub Domain	Variation			Assurance		
			L / H	L / H	P	F	?
Patients	Complaints	4	2	0	0	1	1
	FFT	3	5	2	0	9	1
	PALS	3	1	0	0	0	0
	Patient Experience	2	0	0	0	0	2
	PHSO	3	1	0	0	0	0
People	Workforce	8	9	0	0	6	7
Quality	Falls	6	0	1	0	0	3
	Health & Safety	1	1	0	0	0	0
	Incident Management	9	6	5	1	3	1
	IPC	5	1	4	1	0	3
	Legal & Information Governance	1	1	1	0	0	0
	Maternity	7	0	2	0	0	0
	Medicines	1	0	1	1	0	0
	Mortality	5	5	3	1	3	4
	Pressure Ulcer	4	0	4	0	0	2
	Risk & Policy	4	2	0	0	0	0
	VTE	0	1	0	0	0	1
Sustainability	Financial Position	7	2	5	0	0	9
Systems & Partnerships	Access	13	3	10	3	5	11
	Emergency Care	3	6	2	1	4	3

Patients

NHS
Medway
NHS Foundation Trust

Evonne Hunt
Chief Nursing Officer

Operational Lead:
Dan Rennie-Hale - *Director of Quality & Patient Safety*
Nicola Lewis - *Associate Director of Patient Experience*

Committees:
Quality Assurance Committee (QAC)

Patient FIRST

Patients

Ambition: Providing outstanding, compassionate care for our patients and their families, every time

FFT

Total FFT Recommend %

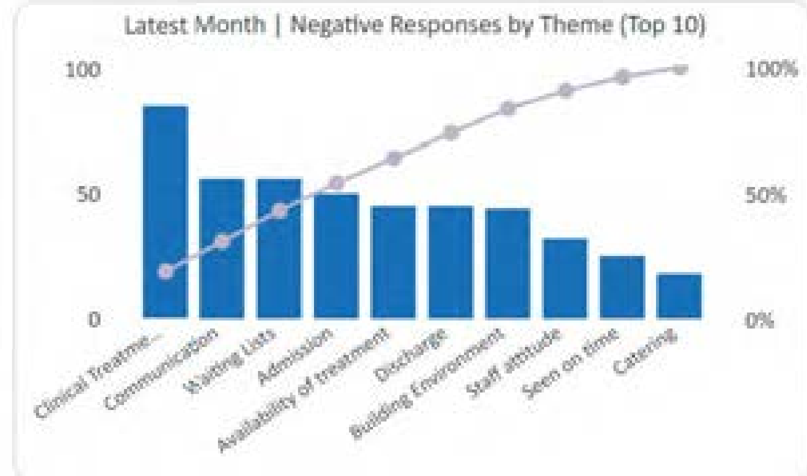
Type	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
	95.0%			84.3%	87.9%	87.7%	87.5%	88.4%	89.9%	89.6%	89.8%	89.2%	89.3%	88.2%	88.8%

True North Domain: Patients

KPI Threshold: 95.0%

Sub Domain KPIs: 10

Variation Summary:



Key Messages

Focused work continues regarding capturing all opportunities for patients to provide feedback. Arethusa ward has achieved a response rate of 70% within move, which is a success given previous low response rates.

The overall Trust response rate remains static however it is of note that the in patient rate has increased to 46.2 %.

Issues, Concerns & Gaps

Emergency care and outpatient response rates remain low at 8.3% ED and 9.7% OPD

Emergency care demands and reduced patient flow out of ED continues to contribute to a reduced response rate and below expected recommend rate.

Actions & Improvements

The negative feedback themes continue to be around clinical treatment, communication and waiting lists.

An A3 refresh is underway relating to communication with the support of the transformation team.

Weekly breakthrough huddles continue to create appropriate counter measures weekly as indicated.

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Patients	FFT			Total FFT Recommend %	95.0%			84.3%	87.9%	87.7%	87.5%	88.4%	89.9%	89.6%	89.8%	89.2%	89.3%	88.2%	88.8%
				Total FFT Response Rate %	45.0%			10.6%	10.0%	10.0%	10.1%	9.6%	11.4%	11.7%	11.8%	12.1%	10.8%	13.1%	14.6%
				Inpatients FFT Recommend %	95.0%			86.0%	87.6%	89.1%	85.5%	85.7%	90.7%	92.5%	93.2%	93.5%	91.3%	90.7%	92.2%
				Inpatients FFT Response Rate %	45.0%			14.7%	14.9%	16.2%	17.5%	15.8%	25.3%	31.1%	32.7%	32.3%	28.6%	35.5%	46.2%
				Emergency Care FFT Recommend %	95.0%			67.3%	75.7%	73.5%	73.7%	82.9%	81.1%	75.3%	75.2%	73.1%	74.8%	75.2%	67.9%
				Emergency Care FFT Response Rate %	45.0%			9.0%	8.1%	7.5%	7.3%	7.6%	8.5%	7.0%	7.1%	8.1%	6.0%	9.5%	8.3%
				Outpatient FFT Recommend %	95.0%			90.3%	91.4%	91.1%	91.7%	91.4%	92.8%	92.2%	91.9%	91.6%	92.0%	91.1%	92.4%
				Outpatient FFT Response Rate %	45.0%			10.5%	9.3%	9.4%	8.8%	8.4%	8.8%	8.7%	8.7%	8.5%	8.3%	8.9%	9.7%
				Maternity FFT Recommend %	95.0%			55.6%	97.3%	92.5%	95.1%	95.6%	89.5%	83.8%	82.3%	87.8%	92.5%	92.5%	90.5%
				Maternity FFT Response Rate %	45.0%			2.4%	31.8%	22.3%	55.4%	32.3%	44.3%	35.1%	16.9%	31.3%	31.4%	33.3%	26.3%
	Patient Experience			Mixed Sex Accommodation (MSA) Compliance %	0.0%			2.0%	2.1%	5.1%	4.3%	1.2%	1.1%	0.8%	0.8%	0.5%	0.6%		
				Mixed Sex Accommodation Breaches	0			348	389	835	795	205	189	130	147	83	109		
	Complaints			Complaints	-			37	34	52	44	32	24	23	28	42	35	28	33

Patients

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Patients	Complaints			Complaints Closed	-			21	43	39	27	15	38	90	59	46	52	37	38
				Complaints Open - Month End	-			195	186	200	218	235	221	154	123	121	104	95	91
				Complaints Re-Opened	-			0	2	3	6	0	0	7	2	2	1	0	0
				Complaints Acknowledged Within 3 Working Days %	95.0%			94.6%	91.2%	96.2%	95.5%	100.0%	100.0%	95.7%	100.0%	97.6%	100.0%	100.0%	100.0%
				Complaints Breached %	5.0%			75.0%	73.0%	77.3%	82.5%	82.9%	88.6%	58.6%	45.0%	51.4%	61.8%	37.1%	42.4%
	PALS			Patient Advice and Liaison Service (PALS) Concerns	-			367	433	376	348	253	404	380	334	425	388	417	529
				PALS Closed	-			352	378	293	275	199	297	277	309	408	372	387	564
				PALS Open - Month End	-			60	117	200	273	328	435	540	565	583	599	627	595
				PALS Converted to Complaints	-			6	4	8	4	2	2	0	7	6	4	0	0
	PHSO			Parliamentary and Health Service Ombudsman (PHSO) Cases	-			0	1	2	3	1	1	2	2	0	0	0	1
				PHSO Cases Closed - Partially Upheld	-			0	0	0	0	0	0	0	0	1	0	1	0
				PHSO Cases Closed - Upheld	-			-	-	-	-	-	-	-	-	-	-	-	-
				PHSO Cases Closed - Not Upheld	-			0	0	0	0	0	0	0	0	0	0	0	0

SIOR - Patients

Patient FIRST | BUSINESS INTELLIGENCE Medway NHS Foundation Trust | NHS Medway NHS Foundation Trust

Successful Deliverables

- Complaints – Closed more complaints than opened (38 vs 33) in November for the 7th consecutive month.
- Complaints – Downward trend in total open complaints since April-23; in line with improvement trajectory
- Complaints – 100% of complaints acknowledged within 3 working days
- PALS – closed more PALS than opened in month for first time – downwards turn in overall open PALS
- PALS – retrospective review and closure of PALS concerns with HONs

Next Steps

- Complaints – continue to meet monthly objectives of the complaints recovery plan

Identified Challenges

- Complaints – unable to provide a complaint response within 25 working days for ~40% of complaints
- Complaints – >70% of complaints responses are awaiting comments from specialist teams
- PALS – obtaining confirmation from specialist teams that PALS concern has been dealt with and can be closed
- MSA – unable to report on MSA breaches currently as waiting configuration of Teletracking system

Next Steps

- PALS – continue improvement work commenced in November on PALS feedback/closure loop
- MSA – waiting for configuration of Teletracking to include MSA reporting

Opportunities

- Complaints – responses for those already breached are being pre-drafted whilst awaiting comments which will enable faster response times for complainants
- PALS - All concerns relating to a current inpatient are flagged and dealt with immediately to help mitigate against a formal complaint being received

Next Steps

N/A

Risks

- Complaints – If turnaround times for comments from clinical teams are not received in a timely manner, then complaint responses will exceed the Trust’s 25 working day KPI, leading to increased dissatisfaction from complainants.
- PALS – if concerns remain open there is no assurance that an enquiry has been dealt with. Leading to increased dissatisfaction from complainants and potential increase of formal complaints.

Next Steps

Continue to deliver the complaints and PALS improvement plans in line with trajectories

Quality

NHS
Medway
NHS Foundation Trust

Evonne Hunt
Chief Nursing Officer

Alison Davis
Chief Medical Officer

Operational Leads:
Dan Rennie-Hale - *Director of Quality & Patient Safety*
Vacant - *Medical Director for Quality & Safety*

Committees:
Quality Assurance Committee (QAC)

Patient FIRST

Quality

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

Incident Management

Low or No Harm Incidents %

Type	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
	95.0%		P	98.9%	98.8%	99.6%	99.7%	99.3%	99.1%	99.2%	99.2%	99.2%	99.2%	99.2%	98.7%

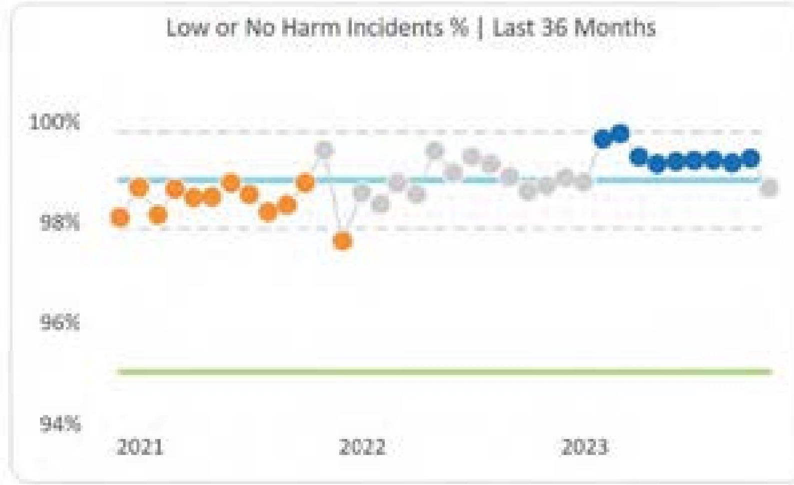
True North Domain: Quality

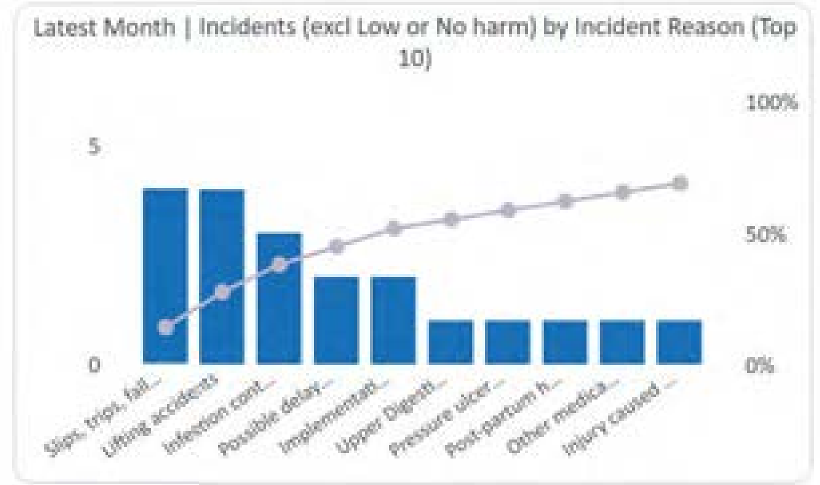
KPI Threshold: 95.0%

Sub Domain KPIs: 20

Variation Summary:

	L	H	L	H
9	0	5	2	4





Key Messages

16 Serious Incidents declared in November and 29 incidents caused > moderate harm – themes to be pulled into Q3 pt safety report in January

100% second stage DOC achieved and 100% of SIs taken to ICB panel closed on 1st submission

PSIRF – in final stages of transition to new framework for investigating incidents which will enable proportionate investigations based on opportunities for learning rather than a rigid framework e.g. slips, trips and falls. PSIRF policy and plan now ready for final ICB sign off and TMB approval

Issues, Concerns & Gaps

Incidents – increased number of incidents causing moderate harm and above and number of SIs declared – need to review commonality between incidents to pull out any trends

Serious Incidents – Majority of SI investigations continue to exceed 60 working day target while backlog is addressed

Actions & Improvements

Incidents – deep dive into November moderate harm incidents and SIs to understand any trends in causes of harm – will form part of Q3 analysis

PSIRF – QIPs now being used to support SI closure enabling more timely responses to those affected by serious incidents

Quality

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

Mortality

Crude Mortality Rate %

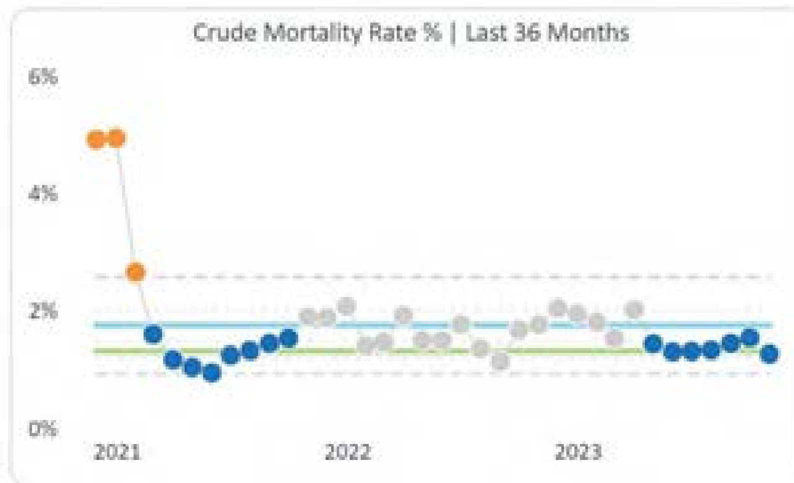
Type	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
	1.30%			2.03%	1.93%	1.79%	1.51%	2.00%	1.42%	1.29%	1.30%	1.32%	1.43%	1.52%	1.25%

True North Domain: Quality

KPI Threshold: 1.30%

Sub Domain KPIs: 13

Variation Summary: 5 | 0 | 3 | 3 | 2



Key Messages

- HSMR for Aug 22- Jul 23 is 108.48 and 'higher than expected'. This is yet another improvement in overall HSMR
- HSMR for Jul 23 is 99.64 and 'within expected'. This is the second lowest single month HSMR reported by the Trust in the last year
- Emergency weekend HSMR is 109.6 and 'within expected'
- Emergency weekday HSMR is 106.6 and 'within expected'
- SHMI for Jul22- Jun 23 is 1.14 and 'higher than expected'
- 10.1% of deaths were subject to SJR reviews with no failings in care identified

Issues, Concerns & Gaps

- Incorrect consultant data on PAS is effecting the RIP validation process for coding which, if rectified, could make a significant difference to the improvement of primary diagnosis and comorbidity recording which significantly impacts both HSMR and SHMI
- Incorrect discharge codes on PAS for deceased patients means some of the deceased patients are not included in deceased patients list on the mortality dashboard. These data quality issues are being highlighted by mortality and BI to ensure accurate numbers are recorded between the teams.
- In hospital deaths remains a concern and is rising fast than the out of hospital deaths, which is affecting SHMI

Actions & Improvements

- When benchmarking to the comparable peer group, Medway have made greater improvement than the peer group and now report a HSMR which is only marginally higher. Statistically, the Trust are not significantly different than the comparable peer group.
- Both Emergency weekend and weekday HSMR are now 'within expected'
- SHMI has reported an improvement for this reporting month and data released for next month shows yet another significant improvement which will return this metric to 'as expected'.
- Working groups for the outlying diagnosis groups revealed further education around primary diagnoses and comorbidity reporting is required. LFD lead and coding to support teams at speciality M&M meetings

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Quality	Incident Management			Low or No Harm Incidents %	95.0%			98.9%	98.8%	99.6%	99.7%	99.3%	99.1%	99.2%	99.2%	99.2%	99.2%	99.2%	98.7%
				Total Incidents Reported	-			1,405	1,464	1,358	1,538	1,102	1,154	1,463	1,505	1,650	1,766	1,984	2,155
				Incidents with Harm (Moderate and above)	0			16	18	5	4	8	10	12	12	13	15	15	29
				Incidents Open - Month End	-			1,137	1,614	1,432	1,585	1,291	1,121	1,254	1,237	1,304	1,646	2,109	2,361
				Incidents Overdue - Month End	-			93	127	363	474	270	236	180	162	190	349	434	654
				Serious Incidents	-			9	8	11	10	2	8	4	3	4	7	7	16
				Serious Incidents Closed	-			11	9	2	9	10	9	11	8	14	12	11	6
				Serious Incidents Open - Month End	-			60	59	68	69	61	60	53	48	39	32	27	37
				Serious Incidents Responded to Within 60 Days %	95.0%			37.5%	44.4%	14.3%	22.2%	30.0%	14.3%	57.1%	40.0%	0.0%	40.0%	25.0%	33.3%
				Serious Incidents Closed by ICB 1st Time %	-			0.0%	0.0%	0.0%	11.1%	40.0%	44.4%	36.4%	62.5%	35.7%	75.0%	81.8%	100.0%
				Never Events	0			0	0	0	0	0	0	0	0	0	0	0	0
				Duty of Candour Compliance Stage 1 %	-			90.9%	73.3%	87.5%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	90.0%	100.0%	90.9%
				Duty of Candour Compliance Stage 2 %	-			75.0%	100.0%	100.0%	71.4%	0.0%		77.8%	50.0%	72.7%	66.7%	75.0%	100.0%

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Quality	Incident Management			RIDDOR Incidents	-			1	5	3	1	3	2	4	4	5	4	2	0
				RIDDOR Compliance %	-			100.0%	80.0%	100.0%	100.0%	66.7%	100.0%	75.0%	100.0%	40.0%	75.0%	0.0%	-
				Health & Safety Incidents	-			43	38	31	19	25	17	19	107	118	118	92	107
				Sharps Injuries	-			6	10	7	8	8	11	8	15	14	10	6	12
				Violence & Aggression Incidents	-			45	56	54	60	74	83	155	141	109	136	127	138
				Assaults - Patient on Staff	-			24	23	27	36	41	44	71	58	63	75	55	64
				EDNs Completed Within 24hrs %	90.0%			66.9%	68.7%	69.5%	70.4%	70.7%	75.0%	75.6%	74.1%	72.7%	74.9%	78.8%	78.1%
	Falls			Low or No Harm Falls %	95.0%			96.9%	98.2%	95.5%	98.9%	96.4%	100.0%	100.0%	97.1%	96.2%	97.8%	97.4%	95.9%
				Falls - Total	-			96	111	89	90	84	61	71	69	78	92	78	74
				Falls - Low Harm	-			23	23	24	19	15	14	20	24	25	26	22	13
				Falls - Moderate Harm	-			2	1	4	0	0	0	0	1	2	0	2	1
				Falls - Severe Harm	0			1	1	0	1	3	0	0	1	1	2	0	1
				Falls Resulting in Death	0			0	0	0	0	0	0	0	0	0	0	0	1

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Quality	Falls			Falls per 1,000 Bed days	-			6.24	6.95	6.33	5.88	5.67	3.98	4.81	4.47	5.08	5.96	4.99	4.97
	Pressure Ulcer			Pressure Ulcers - Total	-			28	36	51	38	33	30	37	43	41	41	44	46
				Pressure Ulcers - Grade 1	-			0	7	12	15	8	2	6	16	15	14	19	16
				Pressure Ulcers - Grade 2	-			6	5	11	6	5	10	3	9	5	5	3	6
				Pressure Ulcers - Grade 3	0			0	0	0	0	0	0	1	0	0	0	0	1
				Pressure Ulcers - Grade 4	0			0	0	0	0	0	1	0	1	0	0	3	1
				Pressure Ulcers - Unstageable	-			11	12	19	10	9	9	14	7	9	6	7	7
				Pressure Ulcers - Deep Tissue Injury	-			11	12	9	7	11	8	13	10	12	16	12	15
				Pressure Ulcers per 1,000 Bed Days	-			1.82	2.26	3.63	2.48	2.23	1.96	2.51	2.79	2.67	2.66	2.81	3.09
	Medicines			Medicine Errors - Total	-			64	73	66	87	71	72	82	98	101	74	87	97
				Low or No Harm Medicine Errors %	95.0%			100.0%	100.0%	100.0%	100.0%	100.0%	98.6%	100.0%	99.0%	99.0%	100.0%	100.0%	97.9%
	IPC			IPC Incidents	-			21	22	9	19	11	7	24	30	54	41	56	39
				C-Diff Cases - Hospital Acquired Total	-			6	3	1	4	7	6	8	3	1	5	3	3

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Quality	IPC			C-Diff Cases - Hospital Acquired YTD (Cumulative)	33			38	41	42	46	7	13	21	24	25	30	33	36
				C-Diff Cases - Hospital Acquired (HOHA)	-			2	2	1	2	5	4	5	2	0	3	3	3
				E.coli Cases - Hospital Acquired	-			3	5	3	3	6	4	4	5	9	4	9	5
				E.coli Cases - Hospital Acquired YTD (Cumulative)	73			39	44	47	50	6	10	14	19	28	32	41	46
				MRSA Cases - Hospital Acquired	0			0	0	0	0	1	1	0	0	0	0	1	1
				MSSA Cases - Hospital Acquired	-			6	0	2	0	2	3	7	2	1	2	4	3
				MSSA Cases - Hospital Acquired YTD (Cumulative)	-			23	23	25	25	2	5	12	14	15	17	21	24
				Covid-19 Diagnosed - Total	0			136	96	155	190	105	24	48	42	73	104	41	
	Mortality			Crude Mortality Rate %	1.30%			2.03%	1.93%	1.79%	1.51%	2.00%	1.42%	1.29%	1.30%	1.32%	1.43%	1.52%	1.25%
				Avoidable 2222 Calls – Cardiac Arrest	1			3	3	1	3	2	1	1	2	0	1	1	2
				Avoidable 2222 Calls – Peri-Arrests	3			3	4	6	2	2	2	3	2	4	2	0	2
				Avoidable 2222 Calls	16			6	7	7	5	4	3	4	4	4	3	1	4
				HSMR (All)	100			116.82	115.10	115.13	113.18	113.26	111.27	110.94	108.20				
				Expected Death Rate %	-			3.6%	3.6%	3.7%	3.8%	3.8%	3.9%	3.9%	3.9%				

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Quality	Mortality			SHMI	1			1.14	1.13	1.14	1.14	1.14	1.15	1.14					
				Fractured NOF Within 36 Hours	92.0%			73.7%	83.3%	56.1%	48.6%	67.6%	72.2%	56.0%	48.4%	76.7%	31.3%	52.1%	
				Number of Deaths Reviewed via SJR	-			9	19	13	8	8	11	14	15	9	8	12	13
				SJRs Completed %	25.0%			4.7%	10.8%	8.1%	5.2%	5.0%	8.5%	11.1%	11.3%	7.1%	6.4%	8.1%	10.1%
				Total Number of Deaths Due to Failings in Care	-			0	2	0	0	0	0	0	0	0	0	0	0
				Number of LD Deaths Reviewed via SJR	-			0	1	3	0	1	1	0	1	0	1	1	1
				Total Number of LD Deaths Due to Failings in Care	-			0	0	0	0	0	0	0	0	0	0	0	0
	VTE			VTE Risk Assessment Completed %	95.0%			82.6%	73.7%	73.2%	80.6%	84.6%	88.4%	91.8%	98.2%	98.8%	99.5%	98.1%	98.7%
	Maternity			Caesarean Section %	-			50.1%	44.6%	52.5%	40.5%	49.3%	45.2%	50.8%	48.2%	44.9%	47.3%	46.7%	51.6%
				Elective C-Section %	-			19.1%	17.6%	22.7%	15.9%	17.2%	16.7%	20.8%	16.4%	16.9%	22.0%	21.0%	21.5%
				Emergency C-Section %	-			31.1%	27.0%	29.8%	24.7%	32.1%	28.6%	29.9%	31.8%	28.0%	25.3%	25.6%	30.0%
				PPH greater than 1000mls	-			36	52	35	34	40	35	44	35	56	30	39	49
				Total Number of Still Births Greater Than 24 weeks Gestation	-			0	0	1	1	3	0	2	1	1	2	2	3

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Quality	Maternity			Neonatal Deaths	-			1	1	0	0	2	2	1	2	4	4	0	1
				Maternity Serious Incidents	-			0	2	2	1	0	1	0	2	0	0	0	0
				Maternity HSIB Referrals	-			0	1	0	0	0	0	0	1	0	0	0	0
				Number of cases of Hypoxic Encephalopathy (HIE) grades 2 & 3	-			2	0	1	0	0	0	0	1	0	0	0	0
	Risk & Policy			Risks Approved	-			7	16	32	60	19	13	18	12	17	18	10	11
				Risks Approved - Low	-			0	0	0	0	1	0	0	0	0	0	0	0
				Risks Approved - Moderate	-			1	1	1	1	0	0	1	0	3	0	1	0
				Risks Approved - High	-			3	11	28	48	10	8	11	8	11	12	6	7
				Risks Approved - Extreme	-			3	4	3	11	8	5	6	4	3	6	3	4
				Risks Approved - Closed	-			0	1	3	1	6	33	24	3	6	15	12	18
	Health & Safety			Resuscitation Training Compliance %	-			78.6%	79.4%	79.1%	78.7%	79.4%	79.3%	80.9%	81.1%	78.6%	79.5%	81.3%	81.6%
				Mental Capacity Act Training Compliance %	-			79.9%	80.1%	81.0%	81.8%	81.9%	81.9%	83.1%	82.3%	81.3%	80.6%	80.3%	80.6%
	Legal & Information Governance			Inquests Received	-			8	7	8	10	0	5	3	14	18	16	6	8

Quality

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Quality	Legal & Information Governance			Inquest Hearings	-			4	5	3	0	2	4	3	3	5	6	7	13
				Regulation 28 Reports	-			0	0	0	0	0	0	0	0	0	0	0	0

SIOR - Quality

Patient FIRST

BUSINESS INTELLIGENCE
Medway NHS Foundation Trust

NHS
Medway
NHS Foundation Trust

Successful Deliverables

- IPC – Despite breaching threshold for C.diff only 3 cases are avoidable
- IPC – Covid numbers remain at a manageable level and no further outbreaks reported & rapid testing still in place for Covid, Flu A and B, RSV
- 100% SIs closed on 1st submission to the ICB
- 100% second stage DOC achieved
- HSMR for Jul 23 is 99.64 and 'within expected'. This is the second lowest single month HSMR reported by MFT
- Resus – 426 staff trained in Resuscitation during November
- VTE – VTE risk assessment has remained above 95% for the 5th consecutive month. Transfusion and thrombosis committee has comments . VQ scans have been added to audit data
- eDN - Framework established (SOP, Training, Monitoring Dashboard, Divisional Governance review) to reduce the volume of eDN's unsent for ongoing episodes of care

Next Steps

- IPC – Introducing new multiplex test for rapid testing that tests for all 4 respiratory viruses at once at a reduced testing time of 68 minutes
- Continue high quality of SI investigations and strong internal governance to ensure 1st time closure by ICB panel
- Resus - Continue to provide capacity to meet demand

Identified Challenges

- IPC – Trust has breached the threshold for C.diff this month at 36 cases
- IPC – Trust is now at 4 MRSA bacteraemias with themes around cannula care, PICC lines and screening
- Incidents – rising number of incidents reported, open at end of month and incidents causing harm
- SHMI for Jul 22- Jun 23 is 1.14 and remains 'higher than expected'
- Resus – Staff not booked to attend Resus training prior to expiry
- VTE - Information from the VTE risk assessment is not being pulled directly from EPR and being logged on a separate system. VTE team has requested support from BI to work through Risk assessment tracking issues
- eDN – slow pace in determining backlog extent due to high volume and complexity of problem reaching back circa 10 years

Next Steps

- IPC – Continue as part of the K&M CDI collaborative
- IPC – reviewing competencies for PICC line management and ANTT.
- IPC – Developing a quality improvement plan for both C.diff and MRSA to work through key themes
- Undertake review of November >moderate harm incidents for trends and commonality – into Q3 report
- Focus on causes of in hospital deaths rising faster than out of hospital deaths which is affecting SHMI data
- Resus – Divisions to identify individuals who are non compliant and ascertain why this is and rectify
- eDN – Agree high level plan for backlog resolution

Opportunities

- IPC – following PSIRF principles for HAI's and developing QIP and utilising actions to start to reduce infections
- PSIRF – transition to new framework in February for investigating incidents will enable proportionate investigations based on opportunities for learning rather than a rigid framework e.g. slips, trips and falls. PSIRF policy and plan now ready for final ICB sign off and TMB approval
- VTE – VTE nurse secondment has been extended for 3 months.
- eDN – Review data flows from EPMA & Telelogic through Docman to identify whether backlog eDN's have been sent to GP surgeries and confirm true number unsent

Next Steps

- eDN – validate number of unsent eDN's in the apparent Backlog

Risks

- Risk of harm to patients if we are not embedding learning from near misses, mod, severe harm and death incidents and investigations
- Resus – Risk to patient safety if staff are not appropriately trained in Resuscitation
- VTE – Staff capacity to investigate the backlog in cases in investigations where VTE service was no in place from October 2022 to July 2023
- eDN - Risk of harm to patients if information is not shared with GP's following an episode of care, particularly if there is a change in treatment plan or medication

Next Steps

- Strengthen how the trust learns and makes improvements following patient safety incidents
- Resus – Resus to meet with HRBPs to assist with Divisions meeting compliance

SIOR - Maternity

Patient FIRST | BUSINESS INTELLIGENCE Medway NHS Foundation Trust | NHS Medway NHS Foundation Trust

Successful Deliverables

- All MBBRACE notifications have been completed within 7 day reporting period
- >90% for all staff groups for Obstetric Emergency Training
- >90% for all staff groups for Fetal monitoring training.
- >85% for all staff groups for Newborn life support training.
- Maternity CQC (Picker) survey action plan co-produced with Maternity and Neonatal Voice Partnership lead
- SCORE staff culture survey completed in November.

Next Steps

- Action plan to reach >90% for neonatal nursing staff for NBLS training in place (currently at 89%)
- Monitor action plan via the BAF and MNSCAB and work closely with MNVP and service users to help improve patient experience.
- Await feedback from SCORE survey, implement action plan and share with staff.

Identified Challenges

- November 2023: No neonatal deaths 3 stillbirths:
  - 36+4 G1 P0 unexplained but history of 3/7 RFM did not report this as had a USS booked
  - 30+0 G1 P0 unexplained diagnosed at routine CMW visit, no RFM reported
  - 40+4 G1 P0 late onset PIH. Admitted for IOL, IOL commenced with CRB, RFM reported IUD diagnosed on Pearl - Also to be investigated as a HLI
  - 1 SI recommended to IRG 13L PPH
  - 1 referral to HSIB – cord prolapse at home.

Next Steps

- Coroner's case tabled for March 2024 in relation to a NND in April 2023

Opportunities

- Opportunity for service users to co-produce training material to help support staff to understand service user needs following CQC Survey (Picker)
- Opportunity to engage staff to co-produce improvement strategy in conjunction with Board Level Safety Champions/NED.
- Peer reviewed CNST position with LMNS colleagues.

Next Steps

- CNST Year 5 on track for submission to NHSR in February 2024

Risks

- Maternity Staffing remains the highest scoring risk on the Women's risk register (Risk ID Midwifery staffing ID 1134 Score= 20)
- Induction of Labour has been identified as a significant red flag within the acuity tool (Risk ID delays in induction of labour ID 1131)
- Level 3 Adult Safeguarding Training Compliance raised as a risk, awaiting care group approval for adding to risk register.

Next Steps

- Continue with recruitment and retention work, alongside business case for Birthrate Plus recommendations.
- Induction of Labour A3 QI project showing significant reductions in delays in IOL.
- Training trajectory in place for Adult Safeguarding Level 3 training – on track to achieve >85% compliance by March 2024.

Systems & Partnerships

NHS
Medway
NHS Foundation Trust

Nick Sinclair
Chief Operating Officer

Operational Leads:
Benn Best - *Divisional Director - Planned Care*
Holly Reid - *Divisional Director - Unplanned and Integrated Care*

Committees:
Finance & Performance Committee

Patient FIRST

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Access

RTT Incompletes Performance %

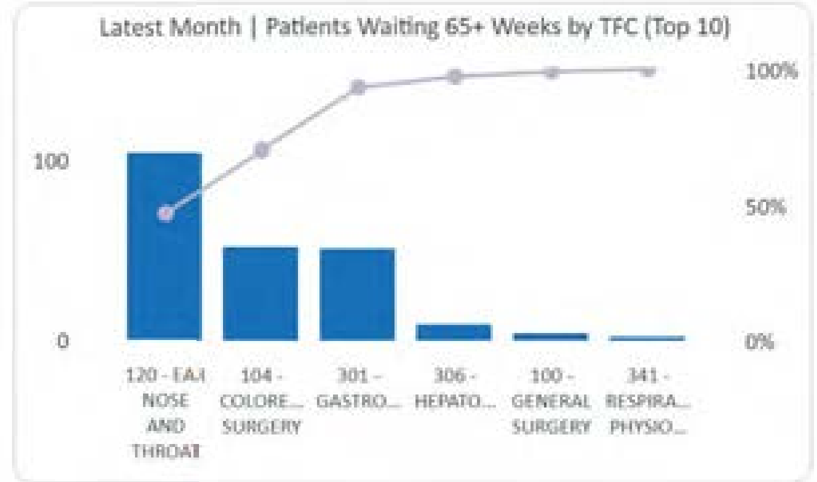
Type	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
	92.0%			60.0%	60.9%	61.4%	60.3%	59.7%	60.0%	59.8%	58.3%	56.6%	55.5%	55.2%	54.6%

True North Domain: Systems & Partnerships

KPI Threshold: 92.0%

Sub Domain KPIs: 26

Variation Summary: 13, 2, 8, 1, 2



Key Messages

- RTT continues to be a priority for the Trust. Treating all patients within 40 weeks is one of the Trusts key breakthrough objectives in the Patient First programme
- In November 2023 the number of patients waiting longer than 52 weeks has increased to 1499 (October 1303). Key drivers for the increase are capacity in ENT and Endoscopy and the impact of Industrial Action on Theatres and Outpatients

Issues, Concerns & Gaps

- Whilst ENT remains primary concern for 52 and 78 week risk. Colorectal, Gastro and Heptaology are also seeing an increase on long waiting patients due to a lack of Endoscopy capacity.
- Plans are being worked up around a NHSE funded mobile Endoscopy unit to increase capacity however this is delayed due to located and logistical issues
- Planned IA in December and January will potentially have an impact on outpatient capacity. Long waiters and cancer patients will be prioritised.

Actions & Improvements

- Recovery plans developed for specialties that are behind trajectory (ENT, Colorectal, Gastroenterology) to reduce first outpatient waiting times and to treat long waiting patients
- Outpatient meeting now set up around transformation projects to support various elements of sustainable RTT recovery
- Validation of patients with long waiting times and harm review process established in line with patient portal.
- Independent Sector capacity (insourcing and outsourcing) used where funded to support.

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Emergency Care

Total EC 4 Hour Performance %

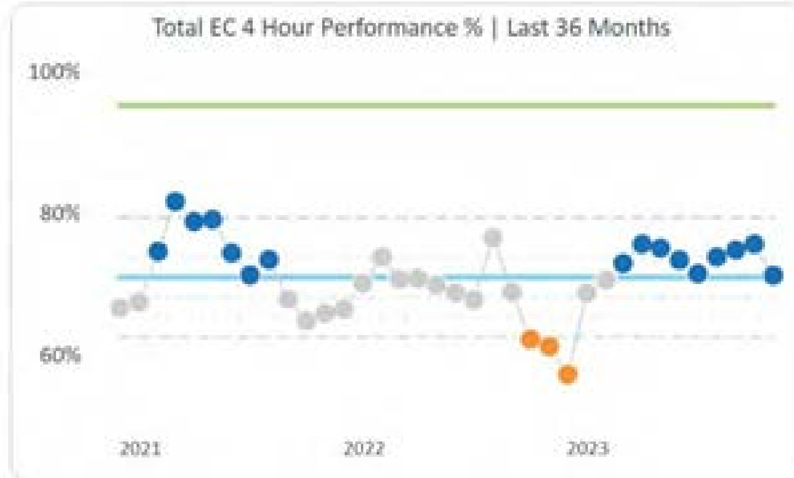
Type	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
	95.0%			57.0%	68.5%	70.4%	72.7%	75.4%	74.8%	73.2%	71.2%	73.6%	74.6%	75.4%	71.0%

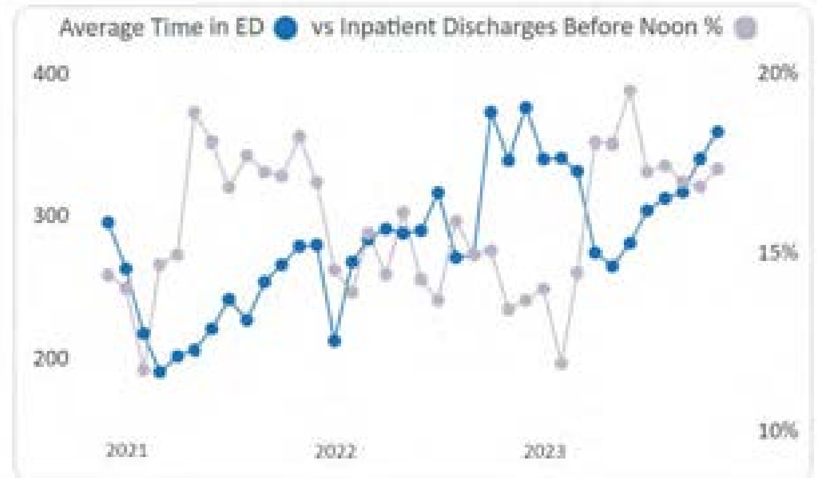
True North Domain: Systems & Partnerships

KPI Threshold: 95.0%

Sub Domain KPIs: 11

Variation Summary: 3 | 0 | 2 | 3 | 3





Key Messages

Total 4 hour performance stabilised throughout January and achieved incremental improvement since then. April saw the highest total 4 hour performance at 75.4%, in over 12 months. There has been a small deterioration to 71.3% in July, recovering to 73.6 % August, and achieving 74.6 & in September, being one of only 16 Trusts in the country to achieve the 74% metric. This was maintained through October at 75.5%, and has deteriorated in November to 71.2%. Type 1 maintained improved performance for September and October at 65.8% and 65.2% respectively, deteriorating to 62.0% for November. Type 3 Performance has also deteriorated to the lowest level since July, at 82.9%.

Issues, Concerns & Gaps

- Flow out of the acute floor continues to be a key contributor, with the Trust not yet achieving 40% of discharges by midday and caring for and increasingly large numbers of medically fit patients, reaching record highs in November.

Actions & Improvements

We strive to achieve continuous, incremental improvement in our patients journey through acute care, and have taken the following actions:

1. Refreshed CDU pathway live and improving in utilisation, with the greatest numbers in CDU in August (340) and 332 for September, 345 in October and 376 in November. compared to less than 200 April and prior.
2. SDEC saw record numbers for patients streamed from ED for both September (306) and November (303), despite escalation restricting physical capacity

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Systems & Partnerships	Access			RTT Incompletes Performance %	92.0%			60.0%	60.9%	61.4%	60.3%	59.7%	60.0%	59.8%	58.3%	56.6%	55.5%	55.2%	54.6%
				RTT 65+ Week Waiters	0			139	202	221	104	119	90	91	101	176	220	246	222
				RTT 40+ Week Waiters	-			2,258	2,370	2,569	2,726	3,083	3,236	3,139	3,465	4,235	4,370	4,395	4,534
				RTT Waiting List Size	-			34,615	35,403	35,991	36,835	36,659	37,018	37,847	38,661	39,676	40,403	41,150	41,612
				RTT 52 Week Breaches	0			603	590	560	471	581	820	877	1,019	1,143	1,209	1,291	1,450
				OP Average Time to First Appointment (days)	60			85.15	86.75	89	87.75	77.54	86.89	84.91	89.20	85.38	92.32	96.02	95.95
				Outpatient DNA Rate %	10.0%			7.8%	6.7%	6.5%	6.8%	6.6%	6.9%	7.1%	7.0%	6.8%	8.2%	7.0%	6.6%
				OP First to Follow Up Ratio	-			1.41	1.52	1.43	1.41	1.47	1.59	1.49	1.40	1.46	1.40	1.39	1.27
				Operations Cancelled by Hospital on Day	0			19	10	8	29	8	13	13	11	5	14	9	21
				Cancelled Operations Not Rescheduled < 28 Days %	-			36.8%	30.0%	25.0%	51.7%	37.5%	53.8%	7.7%	45.5%	80.0%	21.4%	22.2%	14.3%
				Urgent Operations Cancelled for 2nd Time	0			2	1	0	1	2	2	1	2	0	2	1	3
				Day Case Rate %	-			84.8%	85.7%	84.9%	84.9%	85.5%	85.1%	83.5%	85.2%	85.8%	85.2%	86.6%	84.8%
				Average Elective Length of Stay (days)	3			0.32	0.29	0.29	0.33	0.35	0.31	0.35	0.33	0.31	0.34	0.37	0.45

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Systems & Partnerships	Access			Average Non-Elective Length of Stay (days)	10			4.59	4.76	4.56	4.56	4.93	4.57	4.63	4.51	4.50	4.89	4.83	4.83
				104 Day Cancer Waits	-			3	11	4	5	6	9	4	11	10	10	12	
				Cancer 2ww Performance %	93.0%			92.8%	84.6%	70.7%	80.9%	94.5%	94.8%	92.2%	94.3%	88.5%	93.4%	90.2%	
				Cancer 2ww Performance - Breast Symptomatic %	93.0%			68.1%	44.4%	6.9%	16.7%	93.6%	100.0%	83.3%	100.0%	41.7%	83.1%	80.0%	
				Cancer 31 Day First Treatment Performance %	96.0%			98.2%	100.0%	98.2%	100.0%	100.0%	98.8%	98.7%	99.3%	98.3%	98.8%	98.1%	
				Cancer 31 Day Subsequent Treatments - Drugs %	98.0%			100.0%	100.0%	90.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%	97.5%	
				Cancer 31 Day Subsequent Treatments - Surgery %	94.0%			96.6%	88.9%	91.3%	100.0%	93.8%	91.3%	100.0%	100.0%	85.0%	95.0%	93.9%	
				Cancer 62 Day Treatment - GP Refs %	85.0%			84.8%	71.9%	85.6%	79.0%	80.1%	68.5%	72.7%	73.6%	75.2%	80.0%	65.6%	
				Cancer 62 Day Treatment - Cons Upgrades %	50.0%			76.2%	66.7%	75.0%	87.5%	77.8%	72.7%	37.5%	82.8%	73.3%	91.7%	81.3%	
				Cancer 62 Day Treatment - Screening Refs %	90.0%			66.7%	75.9%	72.7%	100.0%	88.9%	40.0%	90.0%	77.8%	55.6%	68.3%	72.4%	
				Cancer 28 Day Faster Diagnosis %	75.5%			62.4%	61.2%	75.3%	75.7%	77.5%	69.2%	72.3%	73.2%	73.9%	70.0%	67.0%	
				Cancer 28 Day Faster Diagnosis Screening %	-			56.3%	73.9%	86.2%	54.5%	81.8%	88.5%	56.4%	68.9%	68.5%	61.9%	68.5%	
				DM01 Performance %	99.0%			74.7%	71.1%	72.4%	72.2%	67.7%	65.5%	67.1%	65.1%	59.8%	61.6%	61.3%	62.1%

Systems & Partnerships

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Systems & Partnerships	Emergency Care			Total EC 4 Hour Performance %	95.0%			57.0%	68.5%	70.4%	72.7%	75.4%	74.8%	73.2%	71.2%	73.6%	74.6%	75.4%	71.0%
				IP Discharged Before Noon % (Inc transfers to ADL)	40.0%			13.6%	13.9%	11.8%	14.4%	18.0%	18.0%	19.5%	17.2%	17.4%	16.9%	16.8%	17.3%
				Type 1 EC 4 Hour Performance %	75.0%			46.5%	52.1%	58.2%	58.2%	62.8%	64.8%	65.9%	63.0%	64.2%	65.8%	65.2%	62.0%
				Total EC 12 Hour Breaches	0			560	422	428	540	131	106	190	344	387	572	742	766
				Average Time in EC Department (mins)	200			374.44	339.31	340.05	330.80	273.57	264.10	280.25	303.24	311.69	316.19	339.50	357.45
				Number of ED Arrivals by Ambulance	-			2,984	2,896	2,704	2,915	2,929	3,048	2,777	3,007	2,978	3,009	3,107	3,142
				Ambulance Handover Delays (> 30 mins)	-			277	103	111	77	57	32	40	59	42	46	73	85
				Ambulance Handover Delays (> 60 mins)	0			37	8	5	3	2	2	3	1	2	3	1	3
				Bed Occupancy - General & Acute %	92.0%			91.8%	91.9%	93.6%	93.1%	90.1%	89.7%	89.2%	89.2%	87.8%	88.8%		
				Medically Fit for Discharge Patients %	9.0%			-	-	-	-	-	-	-	-	-	-	-	-
				30 Day Readmission Rate	13.0%			9.3%	9.6%	9.7%	9.4%	10.0%	9.2%	10.0%	9.6%	9.1%	9.2%	10.3%	9.2%

SIOR - Access

Patient FIRST | BUSINESS INTELLIGENCE Medway NHS Foundation Trust | NHS Medway NHS Foundation Trust

Successful Deliverables

RTT
- Outpatient transformation task and finish group continues to work on further roll out of PIFU and backlog reduction

DM01
- Plans for additional Endoscopy capacity through mutual aid have commenced with MTW and DGT
- Non-obstetric Ultrasound and Echocardiography capacity at the Rochester CDC has commenced
- Funding for two mobile endoscopy units has been approved.

CANCER
- Ongoing work around UGI and LGI has led to reduction in overall cancer backlog – acknowledged by NHSE and ICB

Next Steps

RTT
- Continue rollout of PIFU in medical specialities to reduce Outpatient follow-ups and increase new appointment capacity
- Outpatient efficiency workshop planned for late November to identify improvement opportunities

CANCER
- Awaiting confirmation of location for funded mobile endoscopy unit to support backlog reduction

Identified Challenges

RTT
- ENT capacity will continue to be a challenge for 52 week plus and 78 week plus patients
- Colorectal and Gastroenterology 52 week waits are increasing due to limited Endoscopy capacity

DM01
- Endoscopy capacity continues to be a concern. Improvement plans in place.

Cancer
- Endoscopy capacity remains a challenge is affected both 28 day and 62 day compliance

Next Steps

RTT
- Additional Outpatient capacity for ENT is being identified to reduce waiting times
- Plan for the validation of long waiting ENT patients is being finalised

DM01
- Regular meetings taking place to identify with NHSE and KMCA around Endoscopy capacity

CANCER
- Continue to work with all tumour sites to ensure good performance. Lung and LGI FDS nurses now in place should help with 28 day performance . Await additional mobile unit to support with capacity

Opportunities

RTT
- Potential for ENT activity to be sent to the Independent Sector. This is being scoped with the ICB's support
- Admin validation underway to reduce the waiting lists across all areas

DM01 and Cancer
- Funding has been agreed for 1 mobile unit at the CDC in Sheppey which will provide 392 additional slots per month.

Next Steps

RTT
- Follow-up with ICB for potential ENT capacity
- Validation continues with the use of the new Patient Portal.

Cancer
- Await additional mobile unit to support with capacity

Risks

RTT
- The Trust is still unable to monitor ENT pathways at DVH due to data issues with the BI team (at DVH). Activity reports are being developed. Senior operational meetings are taking place to resolve the situation.

CANCER
- Ability to meet 28 day and 62 day targets remains a risk until mobile unit is up and running on Sheppey

Next Steps

RTT
- DGT ENT contract discussions have taken place. A new SLA is being developed.

CANCER
- Await additional mobile unit to support with capacity

SIOR - Emergency Care

Successful Deliverables

Non-Admitted 4 Hour

- Sustained improvements in non-admitted performance (80.5% for September), being one of only 16 Trusts in the country to achieve the 74% metric. This was maintained through October at 75.5%, but since deteriorated in November to 71.2%. Sustained improvement in utilisation of CDA admitted 4 Hour

Admitted 4 hour

- Small improvement from 4.9% in October to 5.1% in September
- Continued improvement in utilisation of SDEC pathways, avoiding DTA

Next Steps

Non-Admitted 4 Hour

- Sustain incremental improvement through increased utilisation of CDU for ambulant patients
- Work towards implementation of HARIS initiatives covering High Intensity Users and reduction of Ambulance Conveyance

Admitted 4 Hour

- De-escalation and protection of recently escalated EAU and Discharge lounge, and embedding of escalation processes to improve flow.

Identified Challenges

Non-Admitted 4 Hour

- Type 3 performance
- Type 1 performance due to physical capacity constraints during overcrowding
- Volume of mental health attendances

Admitted 4 Hour

- Flow from acute floor to admitted wards, including impact of ongoing Industrial Action
- MFFD Numbers / difficulty achieving 100% utilisation of community capacity

Next Steps

- Work with Medocc to change operational model to manage demand more appropriately with booked appointments
- Utilisation and expansion of “Safe Haven” for lower acuity mental health attendances
- Working with system partners to reduce empty capacity when Acute Trust is at critical occupancy

Opportunities

- Mental health pathways, enabling CDU to be more fully utilised
- Collaborative working with SECAmb to reduce direct conveyances to ED.
- A-Ted pathways, including M-TED and F-TED (Mental health and Frailty alternatives to ED).
- De-escalation allowing relaunch of Frailty Assessment Unit and increase in use of RACE clinic capacity.
- Utilisation of Amherst Capacity
- HARIS supported initiatives focussing on High Intensity Users and reduction of Ambulance Conveyance

Next Steps

- Improved utilisation and expansion of provision of Safe Haven, design new pathways working with KMPT for patients waiting inpatient mental health placement
- Meetings with SECAmb and Frailty specialty to design hospital avoidance pathway
- Progress on work streams focussing on ATED including hot clinics, in-reach and rapid access as part of job planning
- De-escalation allowing Refer and Move work-stream, and achievement of short stay acute ward.
- Implementation and monitoring of project to re-launch booked appointments for minor injuries within Area 3

Risks

Overall

- System capacity and Risk Sharing – ICB/Community/Medocc/Mental Health
- Operational capacity to enact change and improvements, competing priorities
- Availability of funding for capital changes, and invest to save models
- Acuity and volume of attendances
- Ongoing industrial action

Next Steps

- Work with Medocc to change operational model to manage demand more appropriately with booked appointments
- Utilisation and expansion of “Safe Haven” for lower acuity mental health attendances, continued collaboration with KMPT to address long waits
- Working with system partners to reduce empty capacity when Acute Trust is at critical occupancy

People

Leon Hinton
Chief People Officer

Operational Lead:
Dominika Kimber - *Deputy Director of HR & Organisational Development*

Committees:
People Committee

NHS
Medway
NHS Foundation Trust

Patient FIRST

People

Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

Workforce

National Staff Engagement Score

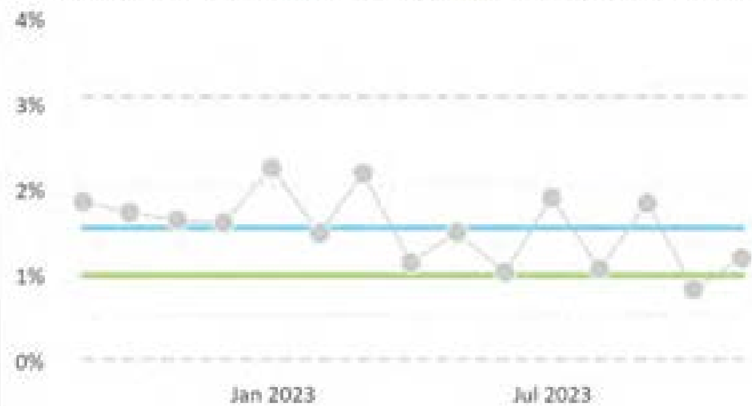
Type	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23
	6.93			6.63	6.63	6.63	6.63

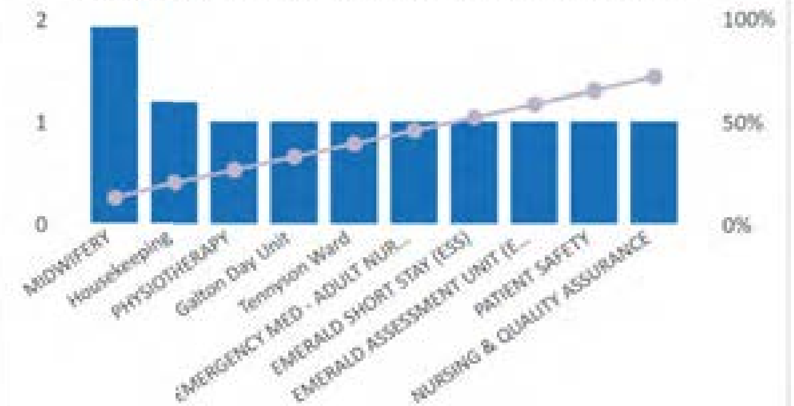
True North Domain: People

KPI Threshold: 6.93

Sub Domain KPIs: 17

Variation Summary:





Key Messages

The Trust's True North objective is to be in the top 25% of Trusts nationally for staff engagement reported through the national staff survey.

The new breakthrough objective, to reduce voluntary turnover within the first two years of employment to 12% is in operation with November 2023 reporting higher (negative) than the monthly target (a very slight positive direction over 12-months); the reports have now moved to the new divisions and will support a new level of details. The new stay conversation processes and intention to leave process are now both live with the first datasets to be presented to the huddle at the end of December

Issues, Concerns & Gaps

- Quality of the leaver process in ensuring exit interviews are carried out and learning applied;
- Limited data in real-time, to ensure we have a system in place to identify future leavers (intention to leave);
- Continue to make improvements to our WRES/WDES indicators to ensure our recruitment, promotion and development pathways are based on best practice;
- Limited data regarding flexible working take up.

Actions & Improvements

- New datasets for the stay and intention to leave processes to be presented to breakthrough huddle end of December.
- Delivery of improvement plan developed and governed by anti-bullying and harassment group;
- Breakthrough huddle pack to be improved to ensure divisions have quality stratified data with the new datasets.

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
People	Workforce			National Staff Engagement Score	6.93			6.63	6.63	6.63	6.63								
				Voluntary Turnover % - First 2 Years Employment	1.0%			1.6%	2.3%	1.5%	2.2%	1.2%	1.5%	1.0%	1.9%	1.1%	1.8%	0.8%	1.2%
				Staff Appraisal Rate %	90.0%			89.4%	90.2%	90.8%	91.8%	92.4%	92.2%	92.3%	91.5%	91.7%	89.9%	89.3%	88.8%
				Staff in Post (FTE)	-			4,596.81	4,615.74	4,634.59	4,689.60	4,685.21	4,702.76	4,736.07	4,768.67	4,847.81	4,843.98	4,925.14	4,961.31
				Staff Leavers (FTE)	-			58.66	63.97	55.81	66.40	55.76	50.59	45.45	59.55	128.36	80.43	63.93	53.88
				Staff Starters (FTE)	-			46.69	94.05	71	87.72	66.93	80.02	59.85	74.79	163.98	102.71	132.37	78.72
				Vacancy Rate %	9.0%			8.4%	8.2%	7.6%	6.5%	7.5%	7.3%	6.3%	5.7%	5.1%	4.5%	4.0%	4.1%
				Voluntary Turnover %	8.0%			12.0%	12.6%	12.6%	12.2%	12.3%	12.2%	12.2%	11.7%	11.3%	11.3%	10.8%	10.8%
				Staff Fill Rate - Total %	85.0%			78.6%	78.2%	80.0%	82.2%	87.7%	89.9%	91.1%	91.8%	90.5%	88.1%	89.5%	92.8%
				Staff Fill Rate % (Total) - Registered Nurse	-			78.2%	76.5%	78.3%	80.3%	86.0%	87.1%	88.4%	88.1%	86.3%	84.8%	87.7%	89.3%
				Care Hours per Patient Day (CHPPD)	9.50			8.03	8.10	8.53	8.52	9.14	9.21	9.27	9.14	9.16	9.04	9.06	9.18
				Sickness Absence Rate - Total %	4.0%			5.5%	4.8%	4.6%	4.6%	4.0%	4.0%	4.0%	4.3%	4.7%	4.9%	4.9%	4.3%
				Sickness Absence Rate - Short Term %	2.0%			3.3%	2.4%	2.4%	2.5%	2.1%	2.0%	1.8%	1.9%	2.4%	2.7%	2.4%	2.3%

People

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
People	Workforce			Sickness Absence Rate - Long Term %	2.0%			2.2%	2.4%	2.2%	2.0%	1.9%	1.9%	2.1%	2.4%	2.3%	2.2%	2.5%	2.1%
				StatMan Training Compliance %	85.0%			84.8%	84.9%	84.8%	85.1%	85.5%	86.2%	87.4%	86.5%	83.7%	84.9%	86.0%	86.7%
				Professional Registration Compliance %	100.0%			-	-	-	-	-	-	-	-	-	100.0%	99.9%	99.9%
				DBS Compliance %	100.0%			-	-	-	-	-	-	-	-	-	-	99.0%	99.3%

SIOR - People

Patient FIRST | BUSINESS INTELLIGENCE Medway NHS Foundation Trust | NHS Medway NHS Foundation Trust

Successful Deliverables

- All 14 participants from August 2023 cohort Level 3 ILM award in Leadership and Management are successful in the 3 assessments done so far and now on the last unit. 12 participants enrolled for the December 2023.
- Completed the mapping review of the Trust StatMan
- Staff Networks Day, to increase awareness of Networks, including the launch the Faiths and Beliefs Network
- Time to hire for both AfC and medical reduced again this month for the second consecutive month. AfC – 61.2 days, Medical -65.3 (within KPI target)

Next Steps

- Equality Impact Assessment Policy drafted for consultation

Identified Challenges

- High vacancy rate in resourcing team leading to stretched service
- HR KPI for Qualified Nursing filled rate remains below the target fill rate of 75%. (63% for Apr, 66.6% for May, 66.9% for June, 67.1% July, 69.31% August, 66.8% September, October 68.54%
- Industrial action requirements planning now pre IA having an impact on the day to day service for Temporary Resourcing and Medical Rota Coordination Service

Next Steps

- Prioritisation of seeking to appoint to vacant HR posts

Opportunities

- Connecting the ILM qualification to the appraisal, talent and (in consultation) management competencies
- Income generation from other NHS/public organisations to our ILM offerings.
- NHSE High Impact Actions for EDI has launched, and both MFT and K&M System discussions have taken place; meeting with the NHSE Lead for staff pay gaps arranged for December

Next Steps

- Current review of the Temporary Resourcing complaints process with support from Deputy Director of HR, Divisional Director of Nursing, Deputy Chief Nurse and Chief Nurse

Risks

- Delayed policy and documentation reviews impacting compliance
- Staff recruitment delays may result in gaps and delays to time to hire
- Unresolved issues with HIV prophylaxis support after inoculation and contamination injuries

Next Steps

- Escalation of contract for prophylaxis through contracting team

Sustainability

Alan Davies
Chief Financial Officer

Operational Lead:
Paul Kimber - *Deputy Chief Financial Officer*

Committees:
Finance & Performance Committee
Audit & Risk Committee

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

Financial Position

Breakeven Revenue Budget (£)

Type	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
	£0			2.10m	1.76m	-4.53m	-3.73m	-0.02m	-0.01m	2.57m	2.43m	3.91m	3.67m	3.04m	2.98m

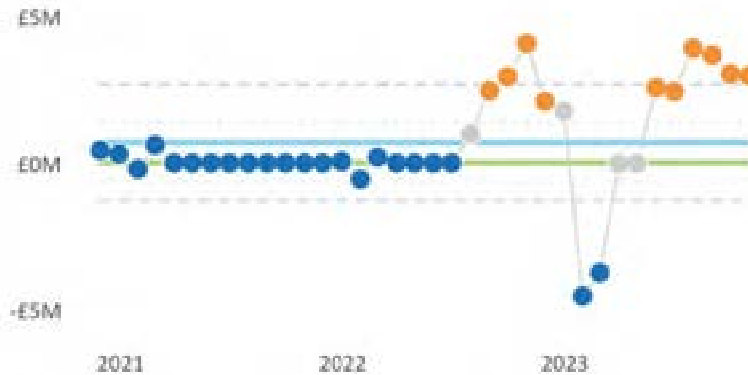
True North Domain: Sustainability

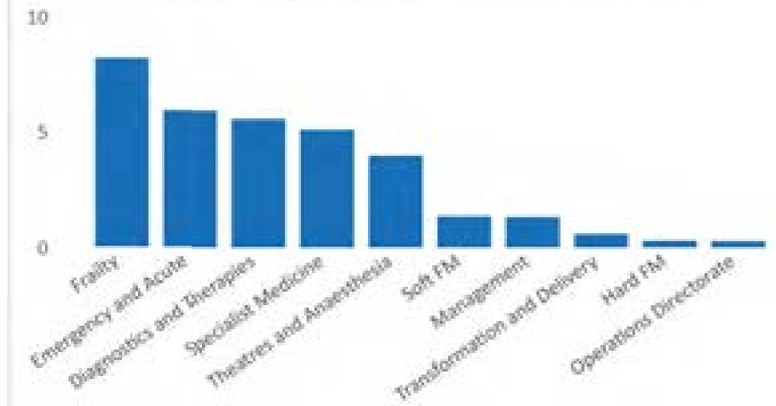
KPI Threshold: £0

Sub Domain KPIs: 14

Variation Summary:

7	0	5	0	2





Key Messages

The Trust reports a deficit of £3.8m in month 8 of 2023/24, reducing to £3.6m after removing the allowable adjustment for the impairment, The adjusted year to date deficit is £30.1m; this is £18.4m adverse to the YTD plan agreed with NHSE and ICB. The in-month run-rate has improved by £0.2m; this is mainly due to additional capital charges funding of £0.7m and a reduction to pay costs of £0.3m.

Trust is currently in SOF4 and must demonstrate delivery against its financial targets.

Issues, Concerns & Gaps

The full value of contract income for ERF and Community Diagnostics Centre (CDC) has been included in the position; there is now a reduced risk on ERF following changes to the target, any clawback of funding relating to H2 is yet to be confirmed and likely to be for local negotiation with commissioning teams. The CDC risk is £2.5m based on the movement from the re-submitted plan; confirmation to repay this is not yet agreed with the ICB. The full value of the £27m efficiencies target continues to be pursued with all services; There is a national drive for providers to deliver their financial plans; the Executive Team has identified further mitigations to achieve.

Actions & Improvements

Implementation of mitigations/counter measures within divisions to control overspending on medical and nursing pay costs, via the Breakthrough Objective for Sustainability.

Further development, approval and implementation of efficiency schemes continues.

Implementation of enhanced financial controls. Continued training to budget holders, as well as support with budget variance analysis.

Sustainability

KPI Scorecard

Domain	Sub Domain	Type	BO	Key Performance Indicator	Threshold	V	A	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23
Sustainability	Financial Position			Breakeven Revenue Budget (£)	£0			2.10m	1.76m	-4.53m	-3.73m	-0.02m	-0.01m	2.57m	2.43m	3.91m	3.67m	3.04m	2.98m
				Total Financial Overspend (£)	£0			2.86m	2.24m	2.55m	12.72m	1.02m	1.31m	3.30m	4.56m	5.33m	4.83m	5.43m	5.17m
				Agency Spend %	3.7%			2.8%	2.5%	3.5%	1.9%	2.6%	3.0%	2.7%	3.0%	2.9%	3.0%	2.6%	3.5%
				Bank Spend %	10.0%			11.2%	12.7%	11.6%	7.8%	12.8%	12.4%	11.1%	11.6%	13.8%	9.8%	12.2%	10.9%
				(Surplus) / Deficit (£)	£0			2.20m	1.76m	-4.63m	-4.83m	2.46m	2.47m	4.82m	3.42m	4.90m	4.66m	3.84m	3.78m
				Agency Spend (£)	-			0.63m	0.56m	0.78m	0.80m	0.60m	0.70m	0.71m	0.75m	0.74m	0.80m	0.65m	0.88m
				Income (£)	-			-34.20m	-34.37m	-39.66m	-60.80m	-34.16m	-34.78m	-35.20m	-36.16m	-35.35m	-36.35m	-35.74m	-36.63m
				Income (£) vs Budget	£0			-1.93m	-1.65m	-7.35m	-27.50m	-0.24m	-0.89m	-3.02m	-1.83m	-1.02m	-0.58m	-1.18m	-2.07m
				Total Pay Spend (£)	-			22.26m	22.69m	22.54m	42.56m	23.10m	23.32m	25.79m	24.45m	25.75m	26.83m	25.24m	24.93m
				Total Pay Spend (£) vs Budget	£0			1.78m	1.85m	2.02m	22.13m	0.88m	1.12m	2.51m	2.64m	4.04m	3.22m	3.25m	3.70m
				Total Non-Pay Spend (£)	-			12.32m	11.14m	10.99m	11.03m	11.58m	11.70m	12.29m	12.91m	12.52m	11.77m	12.22m	13.18m
				Total Non-Pay Spend (£) vs Budget	£0			2.30m	1.13m	1.17m	1.13m	-0.47m	-0.35m	0.26m	1.53m	1.04m	0.74m	0.97m	1.17m
				Actual Worked FTE	-			5,001.50	4,999.98	5,102.29	5,227.19	5,127.10	5,174.36	5,229.67	5,215.43	5,344.21	5,240.17	5,444.71	5,403.07
				Actual Worked FTE vs Budget	0			-31.02	-38.51	68.30	192.45	43.79	82.68	156.70	138.77	211.60	150.93	284.50	204.96

SIOR - Sustainability

Patient FIRST | BUSINESS INTELLIGENCE Medway NHS Foundation Trust | NHS Medway NHS Foundation Trust

Successful Deliverables

The overall run rate in-month is a £0.2m improvement from October, this is mainly due to additional capital charges funding of £0.7m and a decrease to the pay run rate of £0.3m. The previous month's position included the non-recurrent rates rebate of £0.8m.

A revised forecast has been discussed with the executive team, the position being a deficit of £35.8m. The original planned position for the year is a deficit of £15.1m.

Next Steps

Submission of the underlying financial position to the Integrated Care Board (ICB).

Agreement of reforecast with ICB and progress with mitigations / countermeasures identified.

Identified Challenges

The key challenges currently faced by the Trust continue to be:

1. Delivery of the mitigated forecast financial position.
2. Management of medical and nursing pay costs, both of which are significantly overspent year to date.
3. Identification, development, implementation and delivery of the efficiencies programme.

Next Steps

Progress with the counter measures following the development of A3 documents for nursing and medical pay costs, as part of the 'control of overspending' breakthrough objective.

External support from KPMG agreed with NHSE to support delivery of Countermeasures (in December)

Implementation of winter plans to cope with likely activity pressures in emergency care and bed capacity.

Opportunities

Mitigations identified as a result of Executive Team response to national drive to deliver financial plans. Efficiency schemes being developed to contribute towards the £27m target this year as well as next year's target. ICB system lead efficiencies involving all providers within Kent & Medway.
There is positive support to the Trust in developing an elective hub.
Recent implementation of TeleTracking and opening of additional stepdown beds in Amherst. Continued expansion of Virtual Ward.

Next Steps

Further progress with working alongside the ICB in populating the long term financial plan.

Using demand and capacity modelling to inform business plans for 24/25.

Risks

Ongoing risks continue, including:

- Identification and delivery of the efficiency programme for 2023/24.
- Delivery of the Elective Recovery Fund activity during winter.
- Ongoing control of recruitment, agency spend, additional sessions, independent sector costs and non-pay
- Reducing cash balance if deficit continues.

Next Steps

Ongoing monitoring and reporting of risks through to Execs and FPPC

NHS
Medway
NHS Foundation Trust

Meeting of the Trust Board in Public
Wednesday, 17 January 2024

Title of Report	Board Assurance Framework Quarterly Update (Q2)			**Agenda Item**	9.2
Author	Claire Cowell, Integrated Governance Practitioner				
Lead Executive	Chief Nursing Officer				
Executive Summary	The Board Assurance Framework is the Board level register of risks which may affect the achievement of the Trust's strategic objectives. Risks on the BAF are owned and monitored by the Trust Board of Directors and managed through the Executive Board. The Board Assurance Framework (BAF) consists of 20 strategic risks aligned to each of the Trust's True North Domains. There are a number of risks that have seen no movement for 6months or more – these have all been flagged with the relevant Executives and Operational risk owners to review as a priority action. The Integrated Governance Team are also working with the Executives on the BAF refresh following the revised breakthrough objectives.				
Proposal and/or key recommendation:	The Board is asked to note the report for assurance and discussion.				
Purpose of the report (tick box to indicate)	**Assurance**	✓	Approval		
	Noting	✓	**Discussion**	✓	
Committee/Group at which the paper has been submitted:	1) TMB (04 November 2023) 2) RCASC (24 November 2023) 3) Audit and Risk Committee (14 December 2023)				
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:	As outlined in the relevant sections of the Board Assurance Framework.				
Resource implications:	N/A				
Sustainability and /or Public and patient engagement considerations:	N/A				

Patient FIRST

NHS
Medway
NHS Foundation Trust

Integrated Impact assessment:	N/A		
Legal and Regulatory implications:	There are regulatory requirements on the Trust to have effective systems and processes for the identification and management of risk.		
Appendices:	Board Assurance Framework (excel spreadsheet) Board Assurance Framework Summary Report Q2		
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:	Integrated Governance Team medwayft.integratedgovernance@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 minor improvements needed.
	Significant Assurance		There are no gaps in assurance
	Not Applicable		No assurance required.

Patient FIRST

Board Assurance Framework Summary Report – Q2

19 October 2023

Claire Cowell

Integrated Governance Practitioner

NHS
Medway
NHS Foundation Trust

Patient FIRST

Executive Summary

The Board Assurance Framework (BAF) consists of **20** strategic risks aligned to each of the Trust's True North Domains. These BAF risks are broken down as follows:

- Patients: There are 5 risks with scores ranging between 8 and 12
- Quality: There is 1 risk with a score of 20
- People: There are 3 risks with scores ranging between 6 and 12
- Systems & Partnerships: There are 5 risks with scores ranging between 6 and 16
- Sustainability: There are 6 risks with scores ranging between 8 and 25

There have been 3 strategic risk scores reduced in Q2

- Patient 1c
- System and Partnership 4a and 4b

6 strategic risk scores have seen an increase in Q2

- Patient 1a, 1d and 1e
- Systems & Partnerships 4d
- Sustainability 5a and 5b

This summary report is accompanied by the full BAF report.

Executive Summary Continued

A total number of 11 strategic risks have had no movement for at least 6 months, including:

- Patient 1b
- Quality 2a
- People 3a, 3b and 3c
- System & Partnership 4c and 4e
- Sustainability 5c, 5d, 5e and 5g

Slides 6 to 16 provide an overview of strategic risks with no movement in the last 6 months.

The following BAF risks are rated 15 and above:

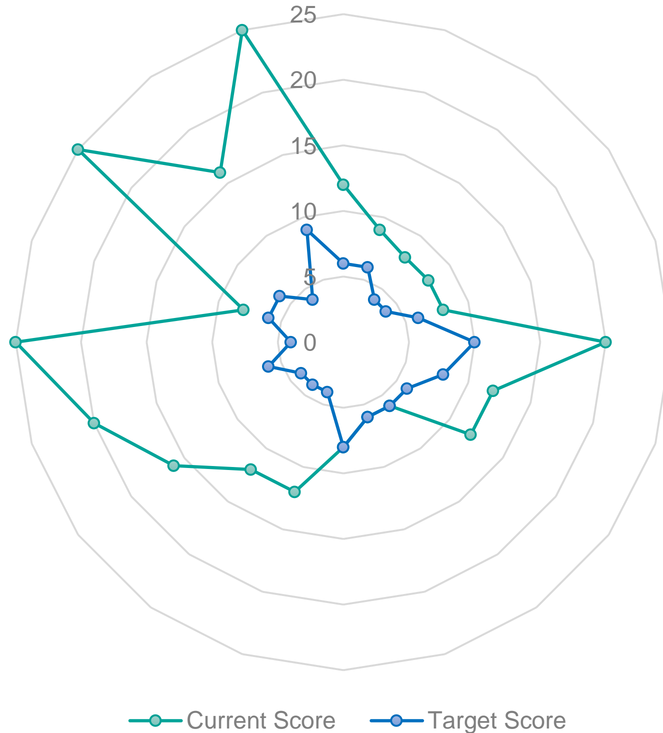
- Quality 2a - Lack of timely escalation and treatment of deteriorating patients
- System & Partnership 4e - There is a risk of financial impact if we are unable to increase flow and close escalation areas
- Sustainability 5a - The cost of our escalation capacity raises a risk against our current overspend *(if the Length of Stay efficiency cannot mitigate this there will be a financial impact)*
- Sustainability 5b – Not delivering the Efficiencies Programme will impact Trust overspend and increase cost pressures Trust wide
- Sustainability 5d - Mitigating against medical staffing (agency/locum/additional sessions) is a risk to overspend
- Sustainability 5e - Financial governance to be strengthened
- Sustainability 5g - Delivery of the control total and FRP

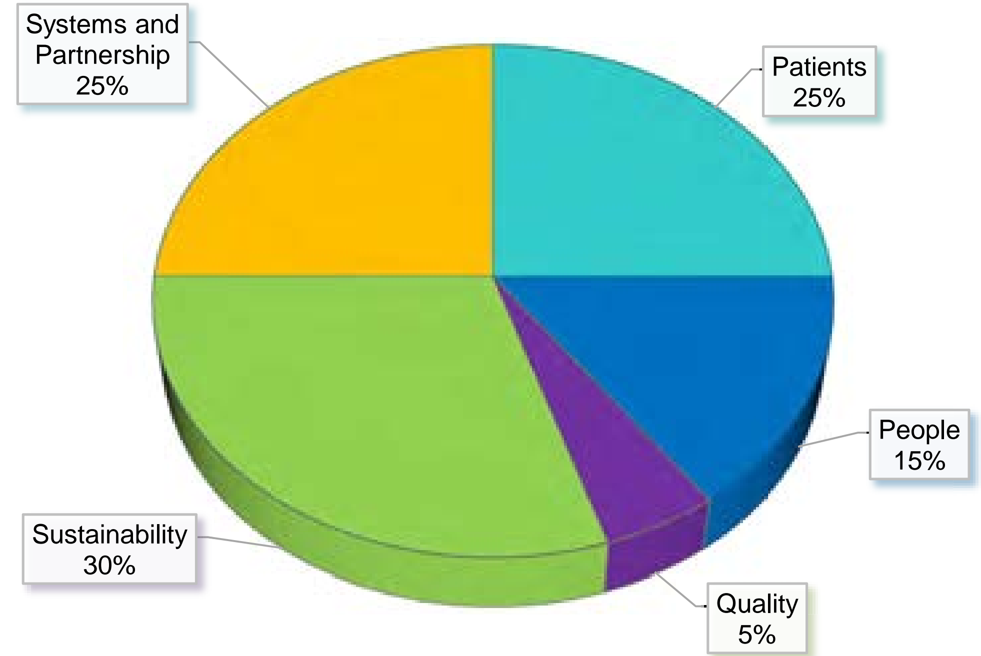
BAF; Heat Map

The heat map details the risk score of each BAF risk

Likelihood \ Consequence	1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
5 Almost Certain				Sustainability 5a	Sustainability 5b, 5d, 5g
4 Likely		Sustainability 5c	People 3b	Sustainability 5e System & P'ship 4e	Quality 2a
3 Possible			Patient 1b	People 3a Patient 1a System & P'ship 4c, 4d	
2 Unlikely			People 3c System & P'ship 4a	Patient 1c, 1d, 1e System & P'ship 4b	
1 Rare					

Risk Movement



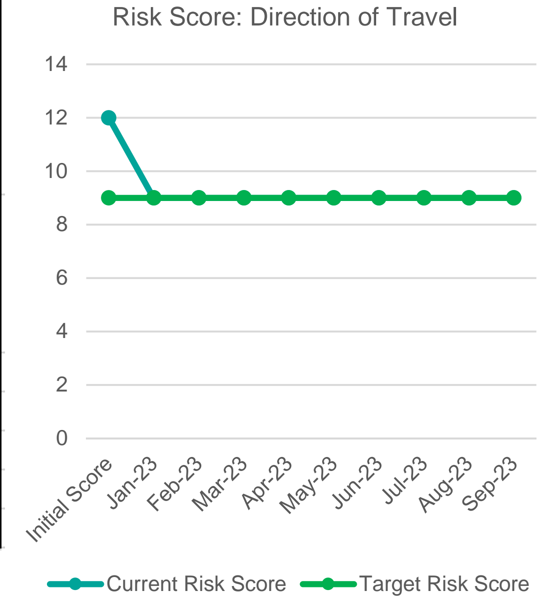


Patients

Ambition: Providing outstanding, compassionate care for our patients and their families, every time

Executive Owner: Chief Nursing Officer | Operational Owner: Associate Director of Patient Experience

Risk ID: Patient 1b	Principle Risk Name and Description: 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								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard) Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	4	3	12	Inpatients FFT Response Rate	45%	31.9%	31.6%	28.2%	30.6%
Current Risk Score:	3	3	9	Emergency Care FFT Response Rate	45%	7.0%	8.0%	5.9%	7.0%
Target Risk Score:	3	3	9	Outpatient Care FFT Response Rate	45%	8.9%	8.4%	8.5%	8.6%
Assurnce Strength	High			Maternity Care FFT Response Rate	45%	17.2%	31.9%	32.0%	27.0%
Adequacy of Controls:	Adequate			Total FFT Response Rate	45%	11.6%	11.9%	10.9%	11.5%



Key Messages

All surveys have been reviewed and updated. This action is complete and awaiting approval with Execs. **Once complete to consider this risk for closure.**

Issues, Concerns, Gaps

Mitigating actions to address gaps complete.

Actions & Improvements

Full review of all FFT surveys has taken place and cross reference the relevance against all clinical areas.

Quality

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

Executive Owner: Chief Medical Officer | Operational Owner: Deputy Chief Medical Officer

Risk ID: Quality 2a	Principle Risk Name and Description: Lack of timely escalation and treatment of deteriorating patients								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard) Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	5	5	25	Avoidable 2222 Calls - Total	0	4	4	3	4
Current Risk Score:	4	5	20	Avoidable 2222 Calls - Cardiac Arrest	12	2	0	1	1
Target Risk Score:	2	5	10	Avoidable 2222 Calls - Peri-Arrest	35	2	4	2	3
Assurnce Strength	Low								
Adequacy of Controls:	Inadequate								

Key Messages

- Targets set are for financial year 2023/24.
- Target for Peri-Arrest calls is based on 30% reduction on 2022/23 total.

Issues, Concerns, Gaps

- Three mitigating actions are overdue their due date:
  1. Improve monitoring, recognising and acting on patient observations.
  2. Culture improvement.
  3. Re-write of TEP form.

Actions & Improvements

1. Mitigate delays in review and treatment post referral – action complete, high NEWS score is visible to ART.
2. Improve ALS /BLS Training Compliance - progress made but still work to do – action complete.

People

Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

Executive Owner: Chief People Officer | Operational Owner: Deputy Chief People Officer

Risk ID: People 3a	Principle Risk Name and Description: There is a risk that the Trust may be unable to staff clinical and corporate areas sufficiently to function								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard)** **Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	4	4	16	Vacancy Rate	9.0%	5.5%	4.8%	4.2%	4.8%
Current Risk Score:	3	4	12	Sickness Absence Rate	4.0%	4.2%	4.6%	4.9%	4.6%
Target Risk Score:	2	4	8	Substantive Workforce	85.0%	91.8%	90.5%	88.1%	90.1%
Assurnce Strength	Medium								
Adequacy of Controls:	Partial								

Key Messages

- Two mitigating actions are overdue their due date:
  1. Introduction of culture and transformation climate survey for areas with Patient First rollout.
  2. Recruitment and Retention for difficult to recruit and retain roles: New approach to be explored with the system and new policy written.

Issues, Concerns, Gaps

- Safe staffing levels for the periods of industrial action.
- Improve our end to end recruitment and on boarding process.
- Improve our understanding of the reasons why staff leave clinical areas difficult to recruit to.

Actions & Improvements

1. Multi - disciplinary preparation for industrial action, open and transparent communications with staff and trade unions.
2. A3 on the recruitment and on boarding process.
3. New Intention to Resign process will include Stay Conversations and new approach to Exit interviews

People

Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

Executive Owner: Chief People Officer | Operational Owner: Deputy Chief People Officer

Risk ID: People 3b	**Principle Risk Name and Description:** 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								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard)** **Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	4	3	12	Staff Survey Engagement Score	6.93	6.63	6.63	6.63	6.63
Current Risk Score:	4	3	12	Appraisal Rate	90%	91.0%	91.7%	89.4%	90.7%
Target Risk Score:	2	3	6						
Assurance Strength	Medium								
Adequacy of Controls:	Partial								

Key Messages

- Staff Survey Engagement Score – Target delivery by 2025
- Two mitigating actions are overdue their due date:
    1. Relaunch of Trust Values
    2. Delivery of Freedom to Speak up Strategy

Issues, Concerns, Gaps

- Currently we have no data which could be used to improve staff retention e.g. reasons behind our high turnover of staff in the first two years of employment.
- To understand the engagement of newly recruited employees to be able to address any factors which may affect their engagement levels and their retention in the first two years of their employment.

Actions & Improvements

1. Design and introduction of processes which will improve our understanding of reasons why staff leave their employment with us (stay conversations, exit interviews) – on track for end Oct.
2. ICB New Starter Survey has been implemented and first results need to be analysed – on track for end Nov.

People

Ambition: To be the employer of choice and have the most highly engaged staff in the NHS

Executive Owner: Chief People Officer | Operational Owner: Deputy Chief People Officer

Risk ID: People 3c	Principle Risk Name and Description: 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. IMPACT: This may lead to an impact on patient experience, quality, safety and risk the Trust's aim to be an employer of choice.								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard) Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	4	3	12	StatMan compliance	85.0%	87.4%	83.6%	84.8%	85.3%
Current Risk Score:	2	3	6	Appraisal rate	90.0%	91.0%	91.3%	89.4%	90.6%
Target Risk Score:	2	3	6	Vacancy rate	9.0%	5.8%	4.8%	4.2%	4.9%
Assurnce Strength	High			Substantive workforce	85.0%	91.8%	90.5%	88.1%	90.1%
Adequacy of Controls:	Adequate								

Key Messages

- Three mitigating actions are overdue their due date:
  1. Review of induction process and management essentials Delivery of Freedom to Speak up Strategy
  2. Ensure competency profiles are up to date and correctly mapped for all positions.
  3. Encourage improved attendance of staff in Stat Man training, implement policy and fines for DNAs.

Issues, Concerns, Gaps

- Evaluate quality of appraisals.
- Development of succession plans and links with the Trust Talent Management Strategy.

Actions & Improvements

1. Evaluation of the quality of appraisals – action on track for end Dec.
2. Delivery of Trust Talent Management Strategy – this will form part of the People Strategy.

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Executive Owner: Chief Operating Officer | Operational Owner: Divisional Director of Operations (Planned Care)

Risk ID: System & Partnership 4c	**Principle Risk Name and Description:** Risk around lack of operational performance for example not meeting constitutional measures (new quality indicators)								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard) Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	3	4	12	Average time in EC Dept (mins)	7	303.24	311.71	316.19	310.38
Current Risk Score:	3	4	12	Ambulance HO delays >60mins	0	1	2	3	2.00
Target Risk Score:	1	4	4	Patients in ED for 12hr +	0	344	387	572	434
Assurnce Strength	Medium			Pre-noon discharge	40%	17.2%	17.4%	17.0%	17.2%
Adequacy of Controls:	Inadequate			ED 4hr performance	95%	71.2%	73.6%	74.6%	73.1%

Key Messages

- The score reflects the challenge with our MFFD position and the estate/environment restrictions that impact on the ability to achieve escalation capacity. However these controls are strengthened by the current Flow and Discharge Programme under the Patient First Programme.

Issues, Concerns, Gaps

- Consider benefit realisation for the Acute Medical Model and unintended consequences standard work for Board Round processes.

Actions & Improvements

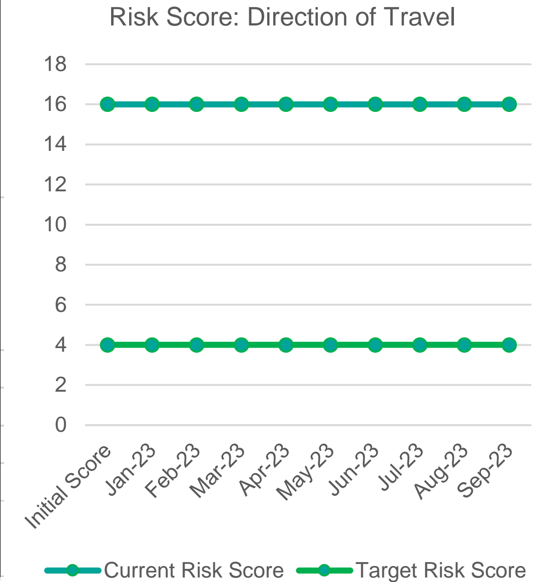
- Actions complete.

Systems & Partnerships

Ambition: Delivering timely, appropriate access to acute care as part of a wider integrated care system

Executive Owner: Chief Operating Officer | Operational Owner: Divisional Director of Operations (Planned Care)

Risk ID: System & Partnership 4e	Principle Risk Name and Description: There is a risk of financial impact if we are unable to increase flow and close escalation areas								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard) Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	4	4	16	Pre Noon Discharge - G&A Adult > 1 Day LoS	40%	17.2%	17.4%	17.1%	17.2%
Current Risk Score:	4	4	16	Avg. Length of Stay - G&A Adult > 1 Day LoS	7	10.8	10.9	12.6	11.4
Target Risk Score:	1	4	4	Bed Occupancy - G&A Adult > 1 Day LoS	92.0%	93.7%	92.4%	92.4%	92.8%
Assurnce Strength	Medium			NCTR at Midnight (count) - Month Average	80	54	63	72	63
Adequacy of Controls:	Inadequate			IP Discharges - - G&A Adult > 1 Day LoS (Including Transfer to ADL)		1854	1826	1823	1834



Key Messages

- The Trust is under increasing demand and is frequently operating in Opel 4 and Business Continuity our increase in patients without a criteria to reside (100 - 150) and the low discharge profile reduces flow and increases demand for bed capacity. The improvement activity taking place requires a cultural and transformational change as well as informed training to support best practice which will take some time to fully embed.

Issues, Concerns, Gaps

- An operational plan that supports the closure of escalations area's. Full collaboration with system partners in discharging patients that have no criteria to reside in an acute bed. Cultural change within clinical teams across the Trust. Training programme that emphasises golden standard discharge processes.
- Standardised LoS meetings with divisional care groups to challenge and escalate patients for MDT, Snr review.
- Review of discharge processes and pathways across the HaCP to reduce NCTR and NCTR LoS

Actions & Improvements

- Both Divisions providing senior oversight of BR's to support discharge planning against EDD.
- Each care group attends a LLoS meeting BiWeekly chaired by DoOF&I.
- HaCP discharge group reviewing pathways via an action plan following the Vital Hub audit.

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

Executive Owner: Chief Financial Officer | Operational Owner: Financial Improvement Director

Risk ID: Sustainability 5c	Principle Risk Name and Description: 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								
Risk Rating & Analysis:	Likelihood	Consequence	Risk Score	Relevant Key Performance Metrics (taken from the Patient First Dashboard) Indicator:	Tar	Jul-23	Aug-23	Sep-23	Average
Initial Risk Score:	5	5	25	Drugs variance to budget in-month (£m)		- 0.4	- 0.4	- 0.1	1.2
Current Risk Score:	4	2	8	Forecast variance to budget (£m)		-	-	TBC	TBC
Target Risk Score:	3	2	6						
Assurnce Strength	Low								
Adequacy of Controls:	Partial								

Key Messages

- Elements of the cost overspend is offset by income for these products.
- Appointment to medicines optimisation pharmacist post to review medicines usage and expenditure data with care groups MDTs – post appointed to with a start date of 14 Oct.

Issues, Concerns, Gaps

- Dedicated oversight of medicines usage and expenditure through detailed and automated analysis of data, linking to activity.
- Monthly and quarterly medicines usage and expenditure reports required for care group oversight of medicines expenditure.
- Analysis of last year and this year's budget against expenditure to understand key drivers to overspend.

Actions & Improvements

1. BI to develop a bespoke medicines usage and expenditure reporting tools (e.g. highlight top medicines expenditure in budgets, top changes in drug lines etc.) – action overdue.
2. BI to create a monthly and quarterly standardised medicines usage and expenditure report for commentary by care groups – action overdue.

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

Executive Owner: Chief Financial Officer | Operational Owner: Deputy Chief Financial Officer

Risk ID: Sustainability 5d	**Principle Risk Name and Description:** Mitigating against medical staffing (agency/locum/additional sessions) is a risk to overspend								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard)** **Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	5	5	25	Medical staff variance to budget in-month £m	-	- 2.0	- 2.7	- 1.4	9.3
Current Risk Score:	5	5	25	Forecast variance to budget £m	-	-	-	TBC	TBC
Target Risk Score:	3	2	6						
Assurnce Strength	Low								
Adequacy of Controls:	Inadequate								

Key Messages

- The YTD adverse variance to plan includes costs associated with the industrial action, vacancies, ED pressures, weekend anaesthetics cover and cover for ENT and HDU, together with rotational doctor/GIM costs.

Issues, Concerns, Gaps

- Job planning is current incomplete - work paused during August due to annual leave and is now subject to completion of demand and capacity modelling.
- Progression and implementation of medical efficiency cross-cutting scheme actions - additional support requested.

Actions & Improvements

- Recruitment plan development, particularly for hard to recruit to posts.
- Identify and procure an appropriate rostering platform to ensure all specialties have rostered medical staffing. Internal audit review of adequacy of rostering processes and controls.

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

Executive Owner: Chief Financial Officer | Operational Owner: Deputy Chief Financial Officer

Risk ID: Sustainability 5e	**Principle Risk Name and Description:** Financial governance to be strengthened								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard)** **Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	4	4	16	Number of lapsed budget holder training (no.)	0	86	86	86	
Current Risk Score:	4	4	16	Number of lapsed budget holder training (%)	0%	45%	45%	45%	
Target Risk Score:	2	2	4						
Assurance Strength	Low								
Adequacy of Controls:	Inadequate								

Key Messages

- 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. Communication will be released to emphasise the requirements and tools available.

Issues, Concerns, Gaps

- Review the scope and content of the financial training provided.
- Confirmation required for inclusion of budget holder training as part of statman.

Actions & Improvements

- Budget statement notifications have now been turned on for budget holders, including reference to upcoming dates for budget holder training.

Sustainability

Ambition: Living within our means providing high quality services through optimising the use of our resources

Executive Owner: Chief Financial Officer | Operational Owner: Deputy Chief Financial Officer

Risk ID: Sustainability 5g	**Principle Risk Name and Description:** Delivery of the control total and FRP								
Risk Rating & Analysis:	**Likelihood**	**Consequence**	**Risk Score**	**Relevant Key Performance Metrics (taken from the Patient First Dashboard)** **Indicator:**	**Tar**	**Jul-23**	**Aug-23**	**Sep-23**	**Average**
Initial Risk Score:	5	5	25	Variance to control total	-	- 2.4	- 3.9	- 3.7	- 12.5
Current Risk Score:	5	5	25						
Target Risk Score:	3	3	9						
Assurnce Strength	Low								
Adequacy of Controls:	Inadequate								

Key Messages

- The Trust reported a deficit for 2022/23 of £6m against an original operating plan (and Financial Recovery Plan year 1 position) of breakeven. The underlying position was a larger deficit given the support funding and non-recurrent mitigations deployed. The Trust reports an adverse position in month and YTD for 2023/24.

Issues, Concerns, Gaps

- Undertake further FRP reset work.
- Implementation of enhanced financial controls.

Actions & Improvements

- Clinical strategy and other strategic development opportunities will be a key element of the FRP refresh.